Insurance Institute of India
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INSUNEWS

- Weekly e-Newsletter

22nd – 28th September 2018

• Quote for the Week •

" The role of a creative leader is not to have all the ideas; it's to create a culture where everyone can have ideas and feel that they're valued."

Ken Robinson

INSIDE THE ISSUE

Insurance Regulation

Irdai raises minimum driver insurance cover to Rs 15 lakh - Financial Express – 22nd September 2018

Insurance Regulatory and Authority of India (Irdai) in its circular has asked insurers to enhance capital sum insured in compulsory personal accident cover for owner-driver under motor insurance policies to Rs 15 lakh.

Currently, the mandatory cover is capped at Rs 1 lakh for two-wheelers and Rs 2 lakh for private or commercial cars, respectively. The premiums for Rs 15-lakh cover have been fixed at Rs 750 per annum.

Stakeholders in the industry say even as premium rates go up, coverage will also increase, and it's a very welcome move for the policyholders. Earlier, the premiums were Rs 50 for two-wheelers and `100 for cars.

Speaking on the new circular from Irdai, Tapan Singhel, managing director & chief executive officer, Bajaj Allianz General Insurance, said, "This move of enhancing the Capital Sum Insured (CSI) of Compulsory Personal Accident (CPA) cover to `15 lakh is a step in the right direction. I strongly believe that it's vital to have an appropriate personal accident cover since it provides the much-needed financial support to the policyholder and their family members if s/he is disabled or succumbs to an injury due to an accident. We, as a company, support and welcome this move."

The regulator also said a higher CSI may be provided over and above Rs 15 lakh through optional covers under liability only and under Section III of package policies/bundled covers on the payment of additional premium at the option of the insured. Policyholders who buy a new vehicle would get higher cover, but their premiums will also go up. The new third party long-term policy for two-wheelers is for five years whereas for four-wheelers, it is three years.

Source

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General Insurance

Vector-borne disease claims fall over 90% this year - Financial Chronicle – 27th September 2018

Despite floods in several parts of the country, claims of vector-borne diseases have reported a steep decline during this monsoon season. Some insurance companies have seen over 90 per cent decline in claims.

In the June-September monsoon period, ICICI Lombard witnessed its vector-borne disease claims falling by 92 per cent against the previous season. Dengue claims dropped by 95 per cent, malaria 86 per cent, chikungunya and arena viral disease 100 per cent, other viral diseases 82 per cent and other arthropod-borne diseases 92 per cent.

"We also have seen a drastic decrease in the claims of vector-borne diseases this year. Naturally, we should think that the public awareness has gone up. Some of the flood-affected states like Kerala have managed the health situation effectively. The claims are much less than what we had anticipated," said Dr Prakash, senior executive director, Star Health and Allied Insurance.

According to him, the ongoing effort of insurance companies to prevent the conversion of outpatient cases to inpatient claims has been bearing fruits. Insurance companies have been able to bring in discipline among the unregulated hospital sector from resorting to unwanted hospitalisation.

Sanjay Datta, chief underwriting (claims and reinsurance), ICICI Lombard, finds that the preventive action taken up against vector-borne diseases have been going up. With emphasis on preventive health, early detection of diseases is happening more and many diseases are being contained at the outpatient level.

Claims for the monsoon period this year are the lowest in the last three years. However, there was a consistent rise in the incidence of infectious and vector-borne diseases till 2017-18.

According to Bhasker Nerurkar, head (health administration team), Bajaj Allianz General Insurance, the firm's internal data for the last 3 years showed a two-fold rise in number of chikungunya cases. The CAGR of malaria and dengue cases has been around 15-16 per cent, though dengue accounted for a large chunk of claims.

But this monsoon season, all the regions and key cities recorded a decline in claims. Western region, which accounted for 49 per cent claims of ICICI Lombard, witnessed 86 per cent decline. South zone, with a share of 28 per cent, too recorded 86 per cent decline. North zone had a share of 13 per cent and the decline was 94 per cent. East and central zone have share of 5 per cent each. The claims data also revealed maximum number of disease-related claims is filed by people in the age group of 0-30 years due to the increased awareness of health insurance.

Source

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Critical issues about dread disease insurance policy - Financial Chronicle – 24th September 2018

Critical illnesses happen when it is least expected and brings ample amount of stress and worries. At a time like this, finances should be the last issue that one should have to worry about. Seeing an increase in the number of cases for critical illness over the past years, it is advised to avoid being caught in a rut, financially, and leave the finances to your insurance.

A critical illness insurance cover at such a time could serve as a form of protection and financial assurance. Although, only few Indians opt for health insurance, and of that, only a handful get the additional critical illness cover. Hence, the need to understand critical illness insurance and why you or any of your family members may need it.

Critical illness insurance, otherwise known as critical illness cover or a dread disease policy, is an insurance product in which the insurer is contracted to typically make a lump sum cash payment if the policyholder is diagnosed with one of the specific illnesses on a predetermined list as part of an insurance policy.

The policy may also be structured to pay out regular income and the payout may also be on the policyholder undergoing a surgical procedure, for example, having a heart bypass operation.

According to claims data from SBI General Insurance, breast cancer comes fourth among top diseases that women have been paid claims for between FY16 and FY18. With hospitals investing heavily in super specialty equipments, the cost of treatment is only increasing. Various studies have shown that medical inflation will continue to rise over 7 per cent each year.

A basic health insurance policy takes care of hospitalisation costs and offers coverage for illnesses that require basic hospital care. A critical insurance policy, on the other hand, pays the insured a fixed amount in the unfortunate event that they are diagnosed with a critical illness. Critical illnesses are high impact-diseases that can alter life drastically even after treatment.

Insurance agencies in the country typically cover 12-15 ailments in their critical insurance policy. A critical illness policy is crucial in cases where the victim is the sole earning member in the family. Anyone with a family history of critical illness ought to have a critical illness health policy.

Given below are a few points to keep in mind when signing up for a critical insurance policy:
Understand the fine print: A critical illness policy covers a pre-listed set of illnesses. It is imperative to read the fine print of the insurance document to understand which illnesses are covered and which are not. For instance, if the policy cites cancer as one of the diseases that are covered, it is important to check which

cancers are covered and which are not. Before buying a policy, always consider the number of critical illnesses covered in it.

Check waiting and survival periods of policy: Insurance policy have waiting period that is applicable at the time of buying a policy and spans around 90 days. This means that any claim that falls within the first 90 days after buying the insurance policy will not be payable by the policy.

Survival period is applicable if a policyholder is diagnosed with a critical illness. This will span over a period of 30 days. If the insured dies within 30 days of being diagnosed with a critical illness, then the claim is not payable.

Clearly present all facts: If the insured misrepresents or forgets to mention any relevant information about their illness, their request for a claim could be challenged. Always be honest while disclosing health information, as this information determines the quantum of coverage you will receive.

Health insurers today allow health insurance portability for critical insurance policies along with a free-look period of 15 days. This free-look period can be used to evaluate the policy and return it if not satisfied. In the case of claims, once the complete claim is paid to the insured, the policy is terminated.

A free look period is a period of time in which a new life insurance policy owner can terminate the policy without penalties, such as surrender charges.

As with any other financial product, it's important to keep oneself aware of the essential details when evaluating a critical illness plan. One must always consider the list of illnesses covered, sum assured, the claim procedure and the claim payment history of the insurer before buying the plan. Keeping these things in mind, one can rest assured that finances will be the least of their worries, if such a time ever comes.

The policy may require the policyholder to survive a minimum number of days (the survival period) from when the illness was first diagnosed. The survival period used varies from company to company, however, 14 days is the most typical survival period used. In the Australian market, survival periods are set between 8 days and 14 days.

In some markets, however, the definition of a claim for many of the diseases and conditions have become standardised, thus all insurers would use the same claims definition. The standardisation of the claims definitions may serve many purposes including increased clarity of cover for policyholders and greater comparability of policies from different life offices. For example, in the UK the Association of British Insurers (ABI) has issued a Statement of Best Practise, which includes a number of standard definitions for common critical illnesses.

There are alternative forms of critical illness insurance to the lump sum cash payment model. These critical illness insurance policies directly pay health providers for the treatment costs of critical and life-threatening illnesses covered by the policyholder's insurance policy, including the fee of specialists and procedures at a select group of high-ranking hospitals up to a certain amount per episode of treatment as set out in the policy.

Source

Back

India: Kerala floods to have limited impact on strength of rated non-life insurers – Asia Insurance Review

Flooding in the southern Indian state of Kerala is not expected to have a significant impact on the balance sheet strength of rated Indian non-life insurers, says A.M. Best.

However, the losses may add to the unfavourable underwriting performance that the international credit agency has flagged as a negative rating factor for some of these insurers, says a new Best's Briefing, titled, "Kerala Floods: Limited Impact on Rated Insurers' Capital, May Add to Performance Issues".

A.M. Best notes that Kerala represents a significantly smaller portion of the Indian non-life market and the international credit agency rated insurers' overall gross premiums. Additionally, insurance penetration in India is low and insurance penetration in Kerala is estimated to be below the national average.

The cumulative rainfall this year during the 2018 summer monsoon period in Kerala was significantly higher than normal, and together with the release of waters from dams, created severe flooding in the region.

A.M. Best expects fire and motor to be the most impacted lines of business. Motor own damage is one of the leading sources of business, accounting for 30% of gross premiums in the state. Four large insurers, which wrote an estimated 70% of Kerala's gross non-life premiums in 2017, are likely to absorb the majority of claims. The affected insurers rated by A.M. Best are expected to have adequate reinsurance protection, with deductibles that are small percentages of their premium base and capital sizes.

Source

A.M. Best will continue to closely monitor developments at its rated insurers as more information becomes available on the ultimate gross and net impact of the floods on their profitability.

Back

Health Insurance

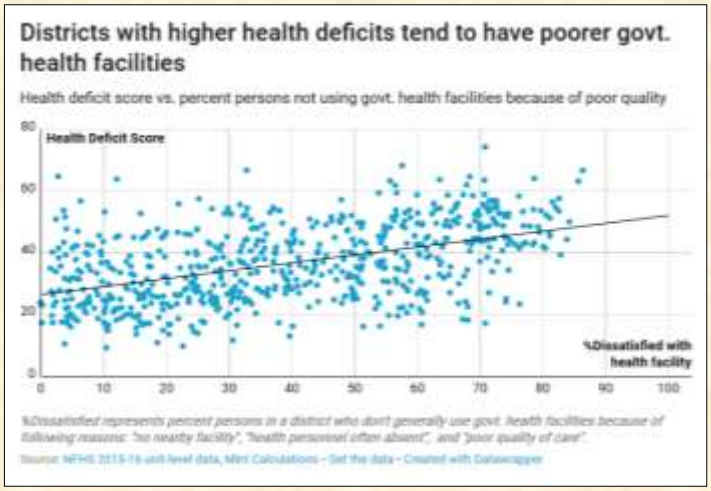
The 50 districts with the poorest health outcomes in India – Mint – 28th September 2018

Over the past decade, India has made significant strides in bringing down rates of child undernutrition and infant mortality. Yet, several parts of India continue to be weighed down by some of the worst health outcomes in the world, with rates of undernutrition and infant mortality much higher than some of the poorest parts of Sub-Saharan Africa.

A Mint analysis of the National Family Health Survey (NFHS) data released earlier this year shows a stark gap in health outcomes between the north and the south. Most districts with a high health deficit score are clustered in the middle and the northern parts of the country.

Most districts with better health outcomes are clustered in the extreme south.

The health deficit score is a normalized score that is based on five indicators—infant mortality rate (IMR, per 1,000 live births), share of underweight children, shares of adult men and women with low body mass index (BMI), and tuberculosis prevalence (per million adults). Given the problems with administrative data on illnesses, only data from the latest NFHS survey of more than 600,000 households in 2015-16 has been used. Beyond the north-south divide, the analysis shows a sharp divide between the 50 worst districts (marked in red in the map) and the rest of the country. The IMR for the 50 worst districts is 64 compared with 37 for the rest of the country. The share of underweight (low-BMI) women is 34% in the worst-performing districts, 12 percentage points higher than in the rest of the country. And TB prevalence at 9,440 (per million adults) is more than double the rest of the country.



While 24 of these districts are part of the list of the so-called 'aspirational districts' of the NITI Aayog, 26 of them are not part of that list.

More than two-thirds of the 50 districts lie in just three states—Uttar Pradesh, Bihar, and Jharkhand.

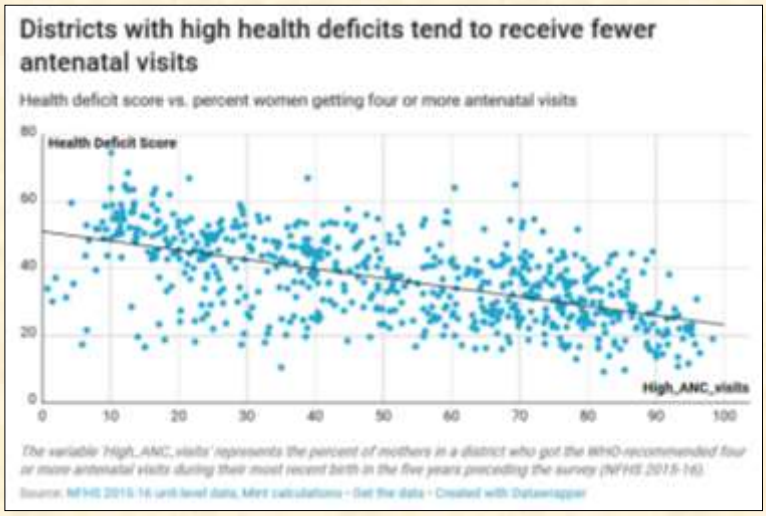
Life in these districts is marked by low life expectancy, and high morbidity. And things are unlikely to improve soon given that these districts also tend to be under-served by health services.

Across India, districts with poorer health outcomes tend to have lower proportion of pregnant women who receive the recommended number (four) of antenatal care visits. These districts also have a higher proportion of people who are dissatisfied with the public health system.

While the less storied component of the Ayushman Bharat health insurance scheme is aimed at revamping India's poorly performing public health system, the measly outlay of Rs 1,200 crore for that programme—it amounts to less than 5% of the health budget—is unlikely to make much of a difference.

The major component of the Ayushman Bharat programme, focused on medical insurance, is likely to receive a far bigger outlay of Rs 10,000 crore.

But while it may offer respite to the poorest when faced with health shocks, it won't fix India's basic health deficits.



As several health economists have noted, the biggest bang for buck in healthcare comes from investments in preventive public health—including waste-management, sanitation and disease surveillance systems.

It is investments in these systems that have helped most countries lower infant mortality and improve health outcomes since the second World War, the Nobel Prize winning economist Angus Deaton wrote in his 2013 book The Great Escape: Health, Wealth, and the Origins of Inequality.

Unfortunately, such lessons have been ignored by Indian policymakers for most of independent India's history.

Source

Back

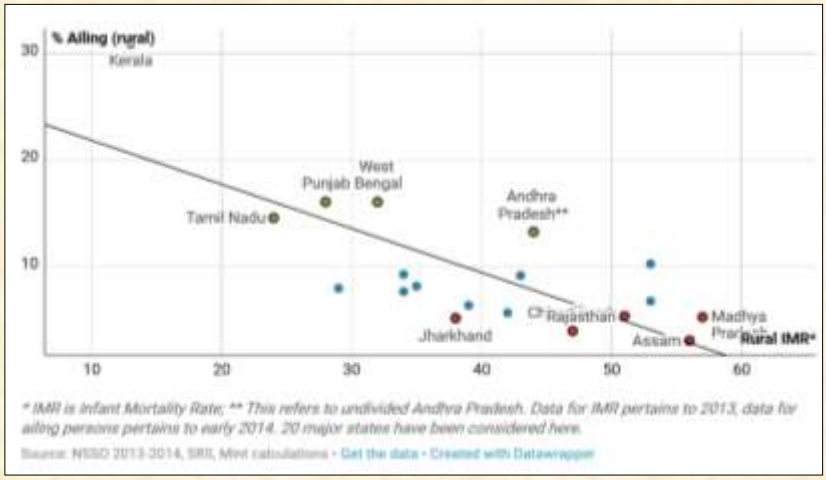
The data challenges before Ayushman Bharat – Mint – 27th September 2018

The launch of Ayushman Bharat-Pradhan Mantri Jan Aarogya Yojana (AB-PMJAY) has generated an intense debate on the scheme's ability to offer respite to India's poor and vulnerable. The scheme's performance may well depend on an oft-ignored ingredient in Indian policymaking: data.

What will make or mar the AB-PMJAY scheme is the pricing of various procedures that the scheme covers for. And that will depend on a regular flow of credible and granular data.

To calculate the odds of patients opting for a certain procedure in a certain district, for instance, the insurer must know the disease burden in that district. The government too must know this to be able to regulate insurers and service providers effectively.

However, such data simply does not exist. Even state-level data on ailments, reported by the National Sample Survey Office (NSSO), can't be taken at face value as it suffers from gross under-reporting of illnesses in poorer and resource-poor states.

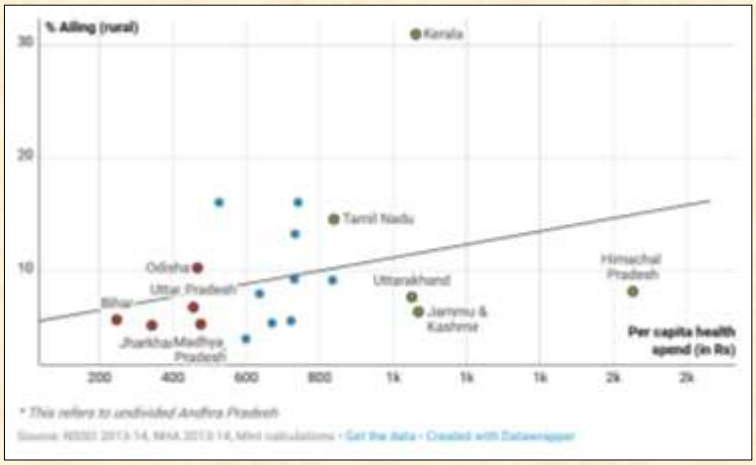


An analysis of the 2013-14 data from the last NSSO health survey shows that the proportion of people reporting ailments is higher in states where the infant mortality rate (IMR) is low, and where the per capita health expenditure is high.

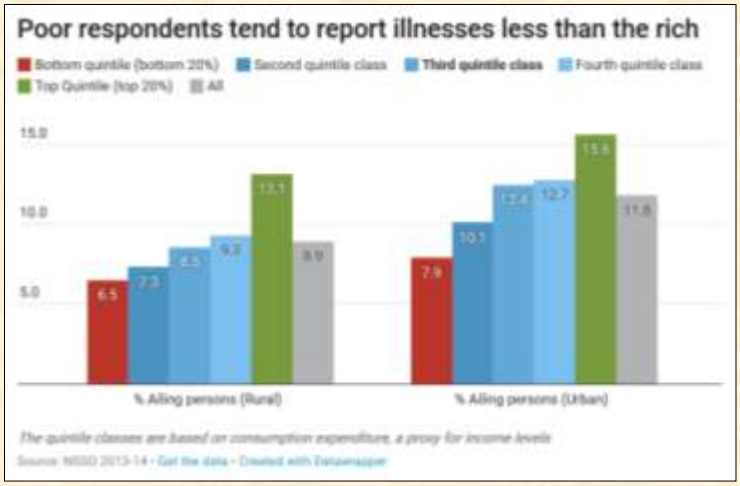
This suggests that the reported rate of ailments corresponds more to health awareness and ability to access healthcare than to one's actual state of health.

Reported illness is inversely related to health performance (IMR) ...

... and is directly related to public health spending



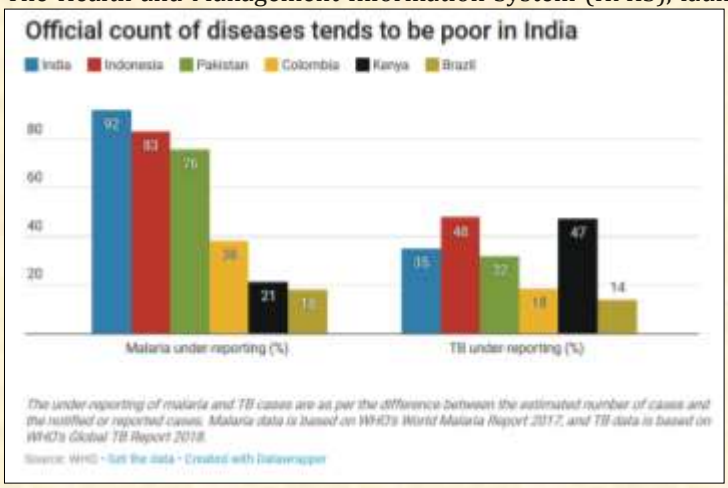
A look at the quintile-wise distribution of ailing people confirms this. Poor families are much less likely to report illnesses compared with richer ones.



Data on medical attention before deaths also leads us to similar conclusions. As the first part of this series showed, deaths in the poorest income classes are much less likely to get medical attention, compared with those among elites.

The gross under-reporting of illnesses among the poor means that the reporting rate as well as hospitalization rate among these sections is likely to increase if Ayushman Bharat takes off in a big way. But in the absence of adequate data on the health profile of the beneficiaries, regulators will find it difficult to gauge whether the spike in a certain procedure in a district reflects actual rise in coverage or is a case of insurance fraud. Even the limited data that is available from the NSSO surveys can be used only to derive state-level estimates, and is not suited for district-level analysis.

The Health and Management Information System (HMIS), launched under the National Rural Health Mission (NRHM) to digitize health records in 2008, should have been of help. But the HMIS suffers from poor quality and data gaps. A 2017 Comptroller and Auditor General (CAG) report showed that 18% of health facilities did not even report basic infrastructure data in the HMIS portal in 2015-16.



CAG also found wide-ranging discrepancies between what the HMIS system reported and the physical records. For instance, the number of infant deaths recorded by the HMIS in Jharkhand was substantially lower than the number in the physical records. The lack of capacity and accountability has meant that India squandered an opportunity to

collect rich granular data through the HMIS over the past decade. The poor state of health statistics means that India under-reports even common diseases such as malaria and TB, data from the World Health Organization (WHO) shows.

Ideally, the Ayushman Bharat scheme should have been preceded by an independently conducted large-scale morbidity survey to assess the state of health across Indian districts and to evaluate the costs associated with health shocks across districts and demographic groups. That would have helped generate credible baseline estimates and also provided a solid yardstick to measure the scheme's impact over the next few years.

Source

But perhaps that is too much to expect from a country that can't even measure its gross domestic product (GDP) satisfactorily.

Back

PMJAY based on failed insurance model: Activists – The Times of India – 26th September 2018

Health activist groups on Tuesday criticised the Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (AB-PMJAY), saying it is based on the 'discredited insurance model despite massive evidence against the effectiveness of such insurance based schemes involving major participation of the private sector in delivery.'

In a statement issued by Jan Swasthya Abhiyan (JSA), a federation of civil society groups working on public health, they pointed out that the Rashtriya Swasthya Bima Yojana, which offered a cover of Rs 30,000, had proved a failure and wondered why the cover was being raised to Rs 5 lakh when past experience had shown that an overwhelming majority of claims under insurance schemes were in the region of Rs 10,000- 50,000. Such a huge increase in the potential claim amount would not translate into a windfall for patients, the activists argued.

It also questioned the government's claim that AB-PMJAY would be the largest health protection scheme in the world, pointing out that the ongoing National Health Mission with an annual outlay of Rs 35,000 crore was much bigger given the Rs 2,000 crore allocated for the new scheme.

"Further the scheme will only cover hospital-based care, while data shows that the bulk of expenditure that patients incur is on conditions when they are not admitted to hospitals - such as patients receiving care for TB, cancers, etc," pointed out JSA. "The Niti Ayog claims that the AB-PMJAY will be 17 times bigger than the RSBY scheme but the moot question is: how can we expect the same government to effectively run a much larger scheme government to effectively run a much larger scheme when it failed entirely in case of the RSBY scheme and several state level schemes?" asked JSA.

Source

More than just the failure of RSBY, JSA expressed concern over the quality of services provided under it and clear evidence that the scheme was being milked by unscrupulous private providers to profiteer, often through unnecessary procedures.

Back

PM-JAY to cover treatments of all urological disorders - The Pioneer – 26th September 2018

Pradhan Mantri Jan Aarogya Yojna (PM-JAY) under Ayushman Bharat Mission will cover treatments of all urological disorders including prostate cancer and the charges have already been fixed, said Dr Anup Kumar, Head of Department, Department of Urology and Renal transplant, Safdarjung Hospital, on Tuesday.

Dr Kumar said, "Under PM-JAY, the government, in consultations with healthcare providers has fixed up charges for treatments for all urological disorders and that will be reimbursed by the insurers."

According to Dr Kumar, the cancer treatment of any sort can cost up to 3 to 4 lakh per month in a good hospital which makes it unaffordable for many. "Due to lack of awareness in rural areas people tend to ignore prostate problems and now with PM-JAY in place, a large number of people can avail treatments for Prostate cancer which is the second largest cancer in the country," he said.

Source

Under the scheme, a large number of people can avail treatment for urological disorders, Dr P N Dogra, head of department of urology at the All India Institute of Medical Sciences (AIIMS), said, backing Kumar's views. Rising cases of enlargement of the prostate, which is not a result of cancer and is called benign prostatic hyperplasia, and prostate cancer are major challenges for the Indian health systems, said Dr Dogra.

Ayushman Bharat: An IV drip for healthcare in India – Mint – 25th September 2018

When Amit Kumar, a daily wage labourer who lives in a small town called Indri in Haryana, welcomed his first-born three years ago, he received a bill of around Rs 1.5 lakh from the private hospital. His wife Mausami had developed some complications and needed to be operated on. Unable to pay that kind of money, Kumar turned to a money lender. He is repaying that debt to this day. "I pay some Rs 2,000 every month and I have no idea when this debt will get over. But at that time, it was the only way out," said Kumar.

So imagine Kumar's surprise when he visited the billing section of the Kalpana Chawla Government Medical College and Hospital after the birth of his second child in August 2018. The bill: a mere Rs 35 for the birth certificate of his baby girl, who they named Karishma (miracle) because the family was able to access healthcare in time and with no financial burden.

Kumar and Mausami were the beneficiaries of the all-new Ayushman Bharat. The scheme was officially launched this week, but in the month of August, Haryana had pilot tested the scheme. PMJAY promises to insure nearly 40% (about 50 crore people) of India's population that's underprivileged. This makes PMJAY one of the largest state sponsored health insurance schemes. And one that is being closely watched—its fate could potentially change the face of healthcare in India.

Ayushman Bharat is an entitlement-based scheme that targets India's poor as identified by latest Socio-Economic Caste Census (SECC) data. Individuals can walk into any empanelled hospital that can process cashless payments. Once identified by the database, the beneficiary is considered insured. PMJAY offers a sum insured of Rs 5 lakh per family for secondary care (which doesn't involve a super specialist) as well as tertiary care (which does). For the beneficiaries, this is a free scheme.

The insurance cost is shared by the centre and the state mostly in the ratio of 60:40. PMJAY is portable, which means the beneficiary can avail treatment in any of the states that has implemented the scheme. Empanelled hospitals agree to the packaged rates under PMJAY—there are about 1,400 packaged rates for various medical procedures under the scheme. These packaged rates also mention the number of average days of hospitalization for a medical procedure and supporting documents that are needed. "These rates are flexible, but once fixed hospitals can't change it and under no circumstances can they charge the beneficiary," said Indu Bhushan, chief executive of Ayushman Bharat-PMJAY. The scheme also has prescribed a daily limit for medical management.

State-led health insurance

For the government, Ayushman Bharat is an attempt at creating purchasing capacity among the poor. There are two ways of tackling the problem of affordable healthcare. It's either by financing services to keep price affordable or by financing the paying capacity of people. The first idea hasn't worked as more than 70% of the healthcare is concentrated in the private sector. "It's a known fact that government facilities suffers from acute shortage of human resources so the old school model of government-run clinics hasn't worked. It was against this backdrop that Rashtriya Swasthya Bima Yojana (RSBY) was designed," said a public policy professor, who didn't want to be named.

However, RSBY (which preceded PMJAY) got plagued by a host of issues. "The cover of 30,000 was found to be low and many states started introducing their own scheme with a higher cover and it covered tertiary care as well," said Malti Jaswal, former chief operating officer of Health Insurance TPA of India Ltd, who now is consulting on Ayushman Bharat.

But what broke the back of RSBY was the huge instances of fraud. "What went wrong was there was immense amount of collusion to generate fake bills. Health insurance companies found this to be a bleeding proposition and some refused to pay," said the professor.

Moreover, healthcare experts have argued that for state sponsored insurance to work, it's important to place emphasis on public health and create healthcare regulations. Conceptually, it is better to invest in preventive healthcare than on curative insurance.

However, according to Jaswal, the process can go hand in hand. "This is being done parallel to PMJAY as the government is establishing wellness centres that will focus on primary, preventive and promotive healthcare through public facilities," she said.

Is PMJAY the answer?

In the absence of healthcare regulations, some believe that PMJAY will meet with little success. But for others, the sheer magnitude of the scheme will herald much needed health insurance regulations. Indeed, the architecture of PMJAY inspires hope. "For the first time we have seen the focus on national pricing for health services, standardized protocols and coding. It has led to the creation of an independent body (National Health Agency) that will coordinate and improve the scheme over time, through investments in a robust IT infrastructure," said Nachiket Mor, country director (India) at Bill and Melinda Gates Foundation.

"If successful, this can well be replicated for the remaining 60% of the population on a contribution basis. The scheme also gives incentives to hospitals that get accredited for quality," he added.

The challenges

The immediate challenge is to get the private sector to participate. Ayushman Bharat, at present, has about 8,500 hospitals empanelled, and this includes public hospitals as well. According to experts, there are about 30,000-40,000 eligible hospitals in the country.

The lack of proper hospitals in smaller towns and few empanelled hospitals , can lead to unhappy experiences. For Kumar, for instance, this has already played out. He went back to Kalpana Chawla hospital a month later only to find out that he had a long line of patients to negotiate. "My life depends on daily wages, so I can't spend an entire day at the hospital only for consultation. Even if the services are free, I lose out on my daily income," he said. While PMJAY creates demand, it will need to provide supply—for that to happen, the private sector will have to rise to the occasion.

This may not happen immediately, but eventually. "There is no dearth of medical infrastructure, but the problem is functionality of this infrastructure and the fact that it's concentrated in the metropolis. PMJAY is addressing this problem by creating demand," said Dr Sabahat Azim, chief executive officer at Glocal Healthcare. Glocal runs a chain of ten multispecialty hospitals with focus on acute care and 250 digital dispensaries.

"In fact the packaged rates are reasonable if you look at the scale of PMJAY, so I suspect in about three years you will see expansion of healthcare. But for this to happen it's important hospitals are paid on time and premiums are sustainable because underbidding means insurers will refuse to pay," he added. Glocal has empanelled two of its hospitals for now.

The potential of reform

The scheme has three important takeaways for the health insurance sector in terms of coverage, pricing and service levels. PMJAY covers all instances of hospitalization, even if it's on account of a pre-existing ailment. A retail health insurance policy, apart from a list of exclusions, has leakages built-in in the form of what's not payable. These can constitute up to 8-10% of the hospital bill.

Ayushman Bharat not only provides a comprehensive cover, but its sheer size can pull the pricing down. The incurred claims ratio—ratio of claims paid to premiums received—for retail segment is well below 100% indicating an overcharge by the insurer. "PMJAY has a time barred system of enrolment and approval. In retail, delays mar the cashless system," adds Kapil Mehta, co-founder, SecureNow Insurance Brokers Pvt Ltd.

Opinion

Whether Ayushman Bharat will succeed will get clearer once the rubber meets the road. But for now, PMJAY has certainly brought a glimmer of hope.

Source

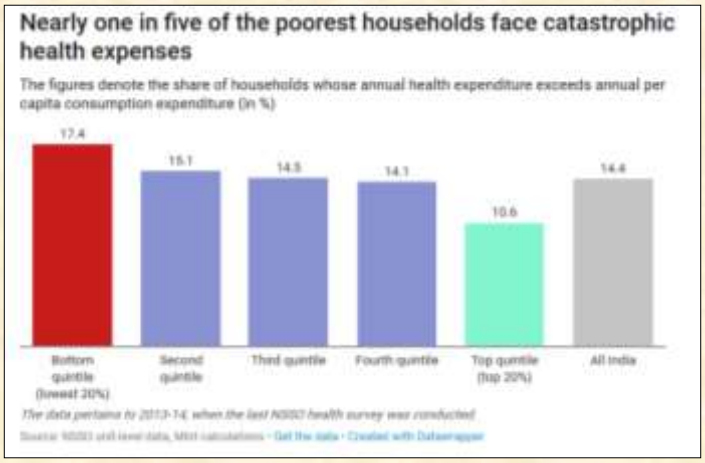
Back

The staggering costs of India's failing health systems – Mint – 24th September 2018

Over the past few decades, rapid economic growth has allowed millions of Indians to lift themselves out of poverty. But the lack of quality and affordable medical care has meant that millions continue to be deeply vulnerable to health shocks.

A Mint analysis of data from the last National Sample Survey Office health survey conducted in 2013-14 shows that 36 million households incurred health expenses that exceeded the annual per capita consumption of those households.

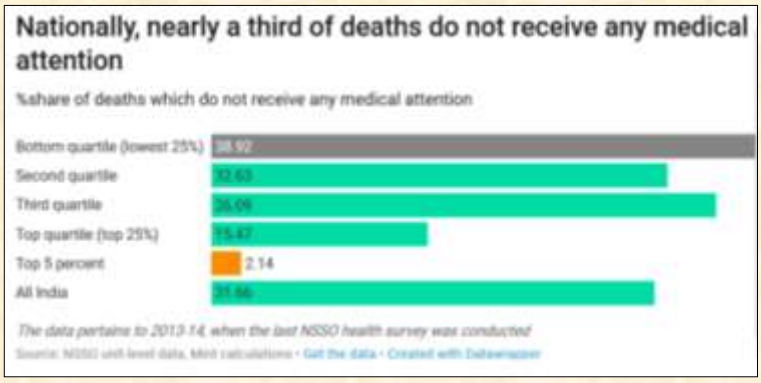
To put the number in perspective, India's most populous state, Uttar Pradesh, consisted of 33 million households when the last census was conducted in 2011. Rural India accounted for 25 million of the 36 million households, which faced catastrophic health shocks, while urban India accounted for the remaining 11 million.



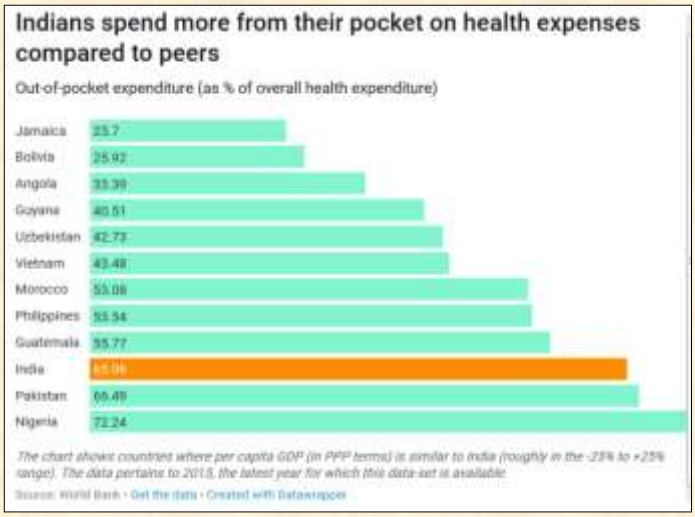
Catastrophic health shock is defined as something that leads to annual expenses greater than the annual per-capita consumption of a household. We use per capita consumption expenditure to assess the extent of health shock rather than the overall household expenditure since household sizes vary across income classes in India.

While the poorest are the most exposed financially to health shocks, even among those who are better-off, a significant proportion face health-related financial shocks.

Among the bottom quintile (poorest 20% based on household consumption expenditure), nearly one in five households witness a health shock that wipes out the annual consumption expenses of at least one member of that household. Among the top quintile, it is about 11%. Nationally, 14.4% households face catastrophic health expenditure, the analysis shows. It is, however, worth noting that these figures are likely to underestimate the true burden of health shocks in the country, given that many families opt not to go for any treatment even when a member faces a life-threatening disease. Many families are simply too poor to contemplate a long-haul hospital stay.

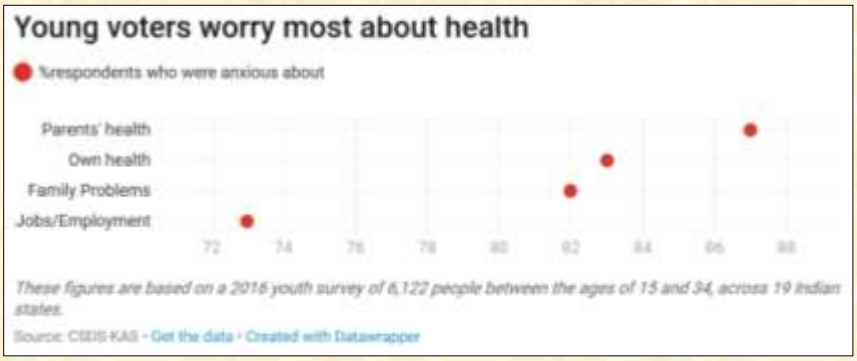


While the exact extent of this phenomenon is not known, there are some clues that one can obtain from the NSSO data. The data show that among India's elites (or top 5%), most people (98%) receive some kind of medical attention before death. However, when it comes to the bottom quartile (or the bottom 25%), a staggering 39% do not receive any medical attention before death.



Nationally, medical attention was missing in the case of nearly one-third of all deaths. It is likely that most of those deaths warranted some kind of medical attention, and that such attention would have been provided if the households in which these deaths took place were as rich as the top 5%. The absence of a well-functioning public health system and the low penetration of health insurance has created a situation, wherein a significant share of India's population seem to avoid the formal medical system, lest they face a debilitating financial burden, and land in a debt trap. The high financial burden is also reflected in the extraordinarily high share of out-of-pocket health expenses in the country. Out-of-pocket expenses are high not just in comparison to

other large emerging markets, most of which are richer than India, but also in comparison to countries with a per-capita income level similar to that of India.



The crisis in Indian healthcare has meant that health worries are not limited to the elderly. Even among the youth, health tops the list of anxieties. A 2016 survey conducted by the Delhi-based Centre for Studies of Developing Societies and German think tank, Konrad-Adenauer-Stiftung, showed that the top concerns of young voters are their parents' and their own health. Anxieties regarding health have increased since 2007, when a similar survey was carried out.

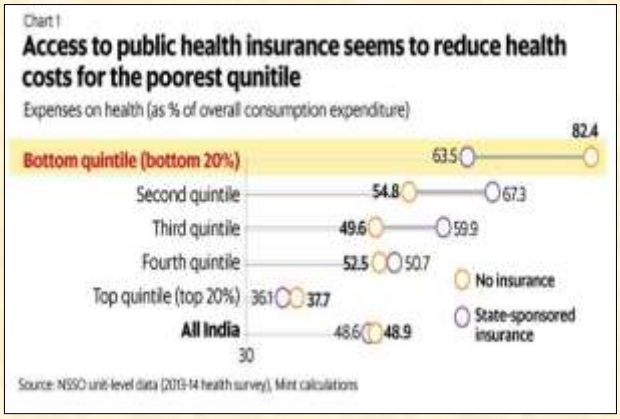
A voter survey conducted by the Association for Democratic Reforms based on a larger cross-country sample in 2017 also suggested that healthcare is among the top priorities of Indian voters, with better healthcare facilities ranked second, after jobs among the priorities listed by respondents. The Narendra Modi-led government's launch of the Ayushman Bharat scheme seems to be an attempt to assuage these anxieties.

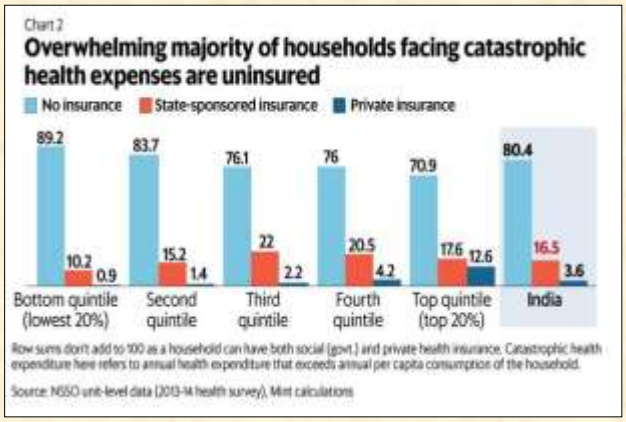
Source

Back

What ails government health insurance schemes – Mint – 24th September 2018

The Ayushman Bharat-Pradhan Mantri Jan Aarogya Yojana (AB-PMJAY) launched in Ranchi on Sunday may well turn out to be India's grandest experiment in state-funded health insurance, but it is certainly not the first of its kind.





Over the past few years, several government-sponsored health insurance schemes have been launched in the country—largely by state governments, but also by the centre (Rashtriya Swasthya Bima Yojana), and the evidence on their impact is mixed, a Mint analysis shows.

The analysis, based on data from the last National Sample Survey Office health survey conducted in 2013-14, shows that access to a government health insurance scheme may have had uneven effects across income classes and regions.

The good news is that access to such health insurance schemes appears to have reduced health costs for the poorest quintile (or bottom 20%) significantly.

The impact on health costs is, however, less visible among other income groups.

More importantly, the analysis shows that an overwhelming majority of those facing catastrophic health expenditure are the uninsured, suggesting that access to health insurance may be offering some level of protection to those who need it.

Catastrophic health expenditure, here, is defined as a health shock that leads to annual expenses greater than the annual per-capita consumption of a household.

We use per-capita consumption expenditure to assess the extent of health shocks rather than overall household expenditure, since household sizes vary across income classes in India.

Chart 3

All's not well with state-funded health insurance schemes in the country

	Percentage of households (hh) with state-sponsored insurance*	Percentage of households (hh) with any insurance*	% poor hh with state-sponsored insurance among those facing catastrophic expenditure*
Andhra Pradesh	63.9	65.7	60
Telangana	62.9	65.5	71
Kerala	41.4	47.2	62
Chhattisgarh	40.1	40.2	31.8
Rajasthan	25.4	25.8	26
Odisha	20.2	21.9	24.2
Tamil Nadu	18.2	22.9	10.5

*atleast 1 member

Households in the bottom three quintiles (or bottom 60%) have been considered as poor here to include households that may not be considered poor officially but which may still be vulnerable.
Only states with relatively high health insurance penetration have been considered here.

Source: NSSO unit-level data (2014 health survey); Mint calculations

Eighty percent of those facing catastrophic health shocks in India lack insurance cover, the analysis shows.

Among the poorest quintile, this figure is even higher at nearly 90%.

Though it is likely that access to state-sponsored health insurance schemes may have attenuated the financial hardship of those facing health shocks, it is worth noting that a significant chunk of those facing catastrophic health shocks (17%) do so despite having access to state-sponsored health insurance.

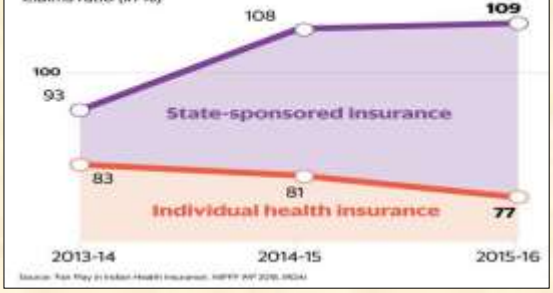
This suggests that India's experiments with state-sponsored health insurance have been far from perfect.

A state-wise analysis shows that in three states with high insurance coverage—Telangana, Andhra Pradesh and Kerala—a majority of the relatively poor households facing a catastrophic health shock was covered under a government health insurance scheme.

In three other states with a relatively high insurance coverage—Chhattisgarh, Odisha, and Rajasthan—roughly one-fourth of the relatively poor households facing a catastrophic health shock belonged to the ranks of the insured.

Chart 4

Claims ratio in public health insurance disturbingly high



One reason for the high health expenses among the insured could be "health-seeking behaviour", a term health economists use to describe the increased access to medical care among newly insured households, which could raise medical bills beyond what is insured. But there could be less benign reasons for the high expenses as well.

As researchers Jishnu Das, Yamini Aiyar and Jeffrey Hammer have pointed out in an article—'Will Ayushman Bharat Work?'—on Centre for Policy Research's website, in many cases, those with insurance cover are either denied services, or charged more than what is warranted.

Patients may be turned back when hospitals are not being reimbursed for their claims on a timely basis. Others may charge extra—off the books—when they have a monopoly on a certain procedure in a district, and know that monitoring is weak. With increased coverage, both regulatory and fiscal pressures on the government increase.

Already, the claims ratio of insurers servicing state-funded insurance schemes has surpassed 100%, suggesting that the insurance payouts are higher than the premium collected, a May 2018 working paper by Ila Patnaik, Subho Roy and Ajay Shah of the National Institute of Public Finance and Policy (NIPFP) shows. The costs paid out by insurance companies will ultimately translate into fiscal costs, wrote Patnaik, Roy and Shah, pointing to the fiscal risks that lie ahead if insurance programmes are implemented without adequate fiscal analysis.

It is also possible that despite rising fiscal costs, out-of-pocket expenditure also continues to rise—partly because of increased "health-seeking", and partly because insurance cover makes it more lucrative to perform medical interventions and investigations, even when they are not really needed.

Source

Avoiding such risks of moral hazard won't be easy unless India revamps its regulatory and governance architecture for medical care.

Modicare rolls out today: Centre, state cooperation a must, say experts - Business Standard – 23rd September 2018

As the Centre's ambitious project, the Pradhan Mantri Jan Aarogya Yojana (PMJAY), widely touted as Ayushman Bharat or Modicare, is all set for a launch on Sunday, states are gearing up to implement the scheme, integrating it with their own public health insurance plans and tying up the loose ends.

Experts feel that the initial days of the scheme are likely to see teething troubles, like lack of manpower.

Sample this: Tamil Nadu, the only southern state to be on board for now for Ayushman Bharat, has a tough task at hand. It has said that the Chief Minister's Comprehensive Health Insurance Scheme (CMCHIS), in

operation since 2008, would be suitably linked with the PMJAY. It plans to extend the Rs 500,000 cover per family per year not only to those eligible under the PMJAY, but also to those already covered under the CMCHIS. The PMJAY is expected to cover 28.5 million individuals in 7.7 million poor families under the socio-economic caste census (SECC) list. In contrast, the existing CMCHIS covers 15.7 million families with Rs 100,000 per year for 1,027 procedures. Around 154 procedures are entitled for grant of Rs 200,000 per year. Tamil Nadu chief minister Edappadi K Palanisamy ordered that the CMCHIS coverage would be raised up to Rs 500,000 to ensure uniform benefit for all. Experts feel that this may increase the financial burden for the state government significantly.

Tamil Nadu has opted for a model wherein the Centre would provide 60 per cent of the net expenditure for 7.7 million families which is estimated to be around Rs 3.5-4 billion. At present, the state government is spending around Rs 13.50 billion. The premium per family works out to around Rs 699. Tamil Nadu would implement the scheme through a mix of both assurance and insurance models.

In Gujarat, the existing beneficiaries of its Mukhyamantri Amrutam (MA) Yojana (who now get around Rs 300,000 cover) would stand to gain from the enhanced cover. While the Gujarat government claims to have covered around 90 per cent of beneficiary families as on date under its existing Mukhyamantri Amrutam (MA) and Mukhyamantri Amrutam Vatsalya (MAV) health insurance schemes, a recent Comptroller and Auditor General (CAG) probe has found serious lapses in implementation of the plans. According to the audit report for the year 2016-17, Gujarat was able to manage only 54.54 per cent of enrolment of total below poverty line (BPL) beneficiary families under the existing health schemes as on March 2017. The total number of BPL families as on March 2017 as per the CAG audit report were 4.15 million.

Till March 2017, only 2.263 million or roughly 54.54 per cent of the total BPL beneficiaries were enrolled in the MA scheme. Even the high percentage of BJP enrolment in the years 2012-13 and 2013-14 was due to issuance of bulk printed MA cards for BPL families already registered under the Rashtriya Swasthya Bima Yojana (RSBY). The government, however, claims that by now it has covered 4.485 million families under its MA Yojana. Enrollment issues apart, experts feel that lack of adequate manpower could emerge as a major hurdle for implementation of the new scheme.

Experts from the Centre for Policy Research (CPR) said that besides manpower, other challenges would include getting the price right for procedures, negotiating them frequently and updating them based on data, for such schemes to benefit the patients.

Implementing the scheme would require significant investments in a state's capacity. "As in the RSBY, state governments will handle most of the implementation and this will require an interest, willingness and, above all, capacity within state governments to make massive investments in the administrative structure," according to a group of experts who wrote in CPR's blog.

CPR experts also pointed out that in states like Uttar Pradesh where the scheme may cover 50 per cent of the population or around 100 million people, it implied that the administrative staff number should be above 10,000 to run a single purchaser scheme. "But the RSBY headquarters in UP had 42 staff, including a chief executive officer, nodal officer, contractual staff and medical officers," experts at CPR said in their blog. To run a scheme as complex and large-scale as Ayushman Bharat, significant investments in human resources are required at the state level, said the CPR experts.

Telangana, on the other hand, which is not on board for the Ayushman Bharat roll out at the moment, is of the opinion that there were anomalies related to rates for medical procedures. There are certain anomalies as

rates prescribed for various procedures are different for state and central schemes in certain cases, said sources from Telengana. Also, the number of BPL cards are higher in both Telengana and Andhra Pradesh than the ones approved under the Central food subsidy scheme. Sources from the health department of Kerala, which has not signed the MoU for the scheme so far, alleged that the Centre has not explained the terms and conditions of the scheme properly. While the state is studying the scheme, some of the officials said it could be a burden considering that the state government may have to pay more premium under the PMJAY scheme.

Kerala finance ministerT M Thomas Isaac alleged that the Ayushman scheme is on the same track as the poorly implemented Rashtriya Swasthya Bima Yojana (RSBY). Karnataka, which is also reluctant, recently launched a flagship universal healthcare coverage scheme Arogya Karnataka, with an estimated cost of Rs 10.11 billion a year.

Source

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Ayushman Bharat: 8 stunning facts about world's largest healthcare scheme launched by PM Modi – Financial Express – 23rd September 2018

PM Modi launches Ayushman Bharat: Nearly seven months after first announced — Ayushman Bharat — Modi government's flagship healthcare programme, which will provide Rs 5 lakh cover each to 10 crore poorest families, was launched officially today. Also known as Prime Minister Jan Arogya Yojna (PMJAY), the scheme has 30 states and union territories on board. The scheme was launched today by Prime Minister Narendra Modi in Ranchi along with the inauguration of ten healthcare and wellness centers as its part.

Here are 8 stunning facts about the world's largest healthcare scheme:

1. The scheme will cover 50 crore people from 10 crore families, which will be more than the combined population of the European Union and close to the combined population of the United States, Mexico, and Canada.
2. Over 13,000 diseases including heart and liver ailments, cancer, tuberculosis will be covered under the scheme.
3. Under the scheme, over 13,000 hospitals, both government and private, have been brought on-board to provide healthcare for free to beneficiaries. No hospital will be allowed to charge extra money for providing treatment for diseases covered in the scheme.
4. There are over 3 lakh common service centers, within the radius of 2-3 kms, which will provide information on Ayushman Bharat.
5. At every impaneled hospital, there will volunteers, known as Pradhan Mantri Aarogya Mitra, to help the beneficiaries at every step of the scheme.
6. Ayushman Bharat will be a paperless and cashless scheme. The E-card will have details of beneficiaries and can be used to access treatment at any impaneled hospital across India.
7. 2,500 new modern hospitals are estimated to be built under the scheme in tier 2 and tier 3 cities, in addition to 14 new AIIMS hospitals that have already been approved.
8. 82 new government medical colleges are also being built, which will be helpful in the smooth implementation of the scheme. The idea is to have 1 medical college in every 3-4 parliamentary constituency.

Source

Back

Mental illness to be covered under health insurance: Will premiums rise? - The Economic Times – 22nd September 2018

Health insurance plans are usually associated with physical ailments, such as the malfunctioning of any body organ and the hospitalisation that follows for its treatment. However, from now on, even mental illness will covered under insurance policies where the costs involved in its treatment will get reimbursed.

The Mental Healthcare Act, 2017, which came into force in May of 2018, says that every insurer shall make provisions for medical insurance for the treatment of mental illness on the same basis as is available for treatment of physical illnesses.

Consequently, the insurance regulator issued a circular asking all insurers to comply with this provision of the Mental Healthcare Act with immediate effect. What this means is that the mental health benefits cannot have more restrictive requirements than those which apply to physical health benefits.

How does the Act define mental illness?
For insurers, the definition of mental illness will be guided by its definition as stated in the Mental Healthcare Act, 2017, which says, "Mental illness means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognise reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterised by sub normality of intelligence."

Exclusions
Two important things emerge from the definition - One, it clearly excludes mental retardation and secondly, it includes mental conditions associated with the abuse of alcohol and drugs. Now, the latter could be put under exclusions by insurers. "The current exclusions in physical illness like 24 hours of hospitalisation required or alcohol-induced outcome which is excluded from physical illness might be excluded from mental illness as well," says Vaidyanathan Ramani, Head Product and Innovation, Policybazaar.com.

Further, there could be few more exclusions specific to mental illness and it remains to be seen as and when insurers launch the revamped versions. There could also be certain waiting periods for some of the illnesses. Interestingly, it remains to be seen how the mental illness will get cover under the pre-existing ailments clause. As of now, most brochures and policy documents exclude mental illness in this way - "Treatment of any mental or psychiatric condition including but not limited to insanity, mental or nervous breakdown / disorder, depression, dementia, Alzheimer's disease."

Common mental illnesses
As per the Act, mental illness shall be determined in accordance with such nationally or internationally accepted medical standards including the latest edition of the International Classification of Disease of the World Health Organisation as may be notified by the Central Government. "Whatever is classified as mental illness as per World Health Organisation ICD (International Classification of Diseases) classifications will be considered as being covered. The normal norms here will be as per ICD-10 and ICD-11. For example, bipolar disorder and schizophrenia are considered as mental illnesses as per WHO," says Ramani.

In case of hospitalisation during mental illness, the coverage will include analysis and diagnosis of a person's mental condition and treatment as well as care and rehabilitation of such person for his mental illness or suspected mental illness. The 24-hour mandatory hospitalisation is to be a part of this healthcare process.

Will it apply for existing plans?
The insurer's existing plans may have to be re-filed with the regulator and there could be a price revision as well. "Insurers are to start covering mental illness from the day the regulation was issued which is 16th Aug, 2018 and the mental illness will be covered in the existing plans to the extent specified by the National Mental Healthcare Act, 2017. With more coverage, an increment in premium is expected in 6-10 months as companies go for revision in the policies," says Ramani.

Source

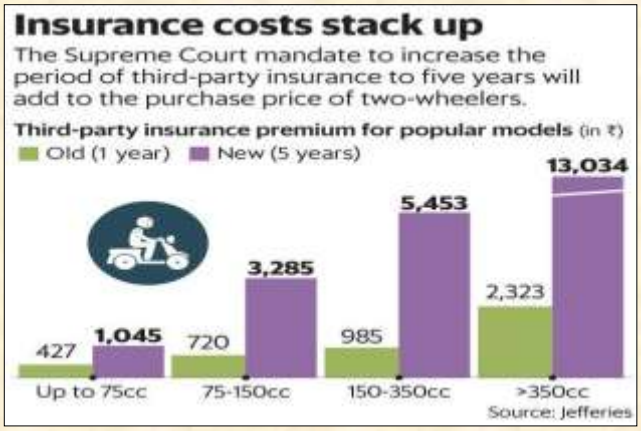
Back

Motor Insurance

Higher insurance fee is not the only spoke in wheel for 2-wheeler sales – Mint – 27th September 2018

The Supreme Court's mandate to increase third-party insurance cover for new bikes and scooters to five years, will have a significant impact on two-wheeler owners, more so, considering the other cost pressures faced by the industry. The manufacturers are left with a tough choice to either pass on the costs to maintain their profit margins, or absorb some of it to support demand.

The premium appears small (see chart), but it is significant considering the price of two-wheelers.The five-year premium for third-party insurance is a lump sum payable upfront as opposed to an annual premium earlier. This adds to the purchase price of the vehicle. Moreover, in case of annual payments, the consumer had the benefit of a drop in value of the vehicle after the second year (depreciated value) due to which the insurance premium was also lower.



"Based on IRDA rates, this implies an increase of Rs 2,500 for entry/executive motorcycles and scooters (up to 150cc) and Rs 4,500 for premium motorcycles, a substantial increase especially at the lower end," says a report by Jefferies India Pvt. Ltd. Irda stands for the Insurance Regulatory and Development Authority of India.

Unfortunately, the timing is inappropriate. Costs for auto firms as a whole are stacking up. Although more stable now, the cost of raw materials especially metals and more recently rubber have all been rising. This may hurt profitability if costs are not passed on to the consumer, in the long run.

Add to this, about six months from now, the mandatory introduction of anti-locking braking system and combined braking system would also imply additional costs. Then, analysts foresee a cost increase due to technological changes required to comply with new emission norms from 1 April 2020.

All these costs put together would lead to pricing pressure for two-wheeler manufacturers. They will stack up to make a significant difference to two-wheeler sales and the manufacturing companies' prospects. Companies such as Bajaj Auto Ltd with high exports may be able to withstand the cost pressures better than firms such as Hero MotoCorp Ltd and TVS Motor Co. Ltd.

The heightened competition in the domestic two-wheeler market may make it hard for companies to pass on costs to consumers. If so, it may hurt sales growth and consequently profitability too. Alternatively, sales may grow at the expense of margins. In any case, for the current quarter, analysts have forecast a moderation in sales because the festive season of Dussehra falls in the next quarter.

Highlighting the cost pressures, the Jefferies India report points out, "All these known cost increases add up to at least 10-25% increase in the on-road prices of two-wheelers, over a two-year period."

The moot question is whether such a steep increase will affect sales or profit margins of entry-level motorcycles and mopeds. The base is also higher now, given that the auto industry as a whole experienced robust demand for about two-three years.

Source

Any such adverse impact is bound to hurt the share prices of two-wheeler makers, which have anyway come off substantially from their highs in the past seven months.

Back

Motor plans to get costlier as Irdai hikes sum insured for personal accident cover – Mint – 26th September 2018

The premiums for motor insurance policies are set to go up by at least Rs 650, owing to an increase in the sum insured for the compulsory personal accident cover you need to take when you buy a motor insurance. The Insurance Regulatory and Development Authority of India (Irdai), through a circular released on 20 September, has instructed general insurance providers to increase the sum insured under the compulsory personal accident cover to Rs 15 lakh from the present cover of Rs 1 lakh for two-wheelers and Rs 2 lakh for four-wheelers. The circular is based on directions the regulator received from the Madras high court.

Irdai has given insurance companies time till 25 October to file products, in accordance with the new guidelines.

What is compulsory personal accident cover?

A motor insurance policy has two parts. One is third-party liability cover, which covers loss of life or damage to a third party and is to be taken mandatorily, and the second is own damage cover, which covers damage to the insured vehicle and theft and is optional. The premium for third-party insurance is decided by the insurance regulator each year, while that for own-damage cover is decided by individual insurance companies.

According to the India Motor Tariff, 2002, a compulsory personal accident cover has to be part of the motor insurance policy. This cover is applicable in both cases: if a person buys only a third-party policy or a comprehensive policy which has both third-party and own-damage covers. The liability part in your policy document lists this as "PA cover for owner driver". An "owner-driver" is the owner of the insured vehicle having a valid driving licence, according to the India Motor Tariff.

COMPULSORY PAYMENT

With the increase in compulsory personal accident cover, here is how much yu will pay for a motor policy

(Figures in ₹)

	5-year policy for New two-wheeler (150 to 350 cc)	1-year policy for Old two-wheeler (150 to 350 cc)	3-year policy for New private car (1000 to 1500 cc)	1-year policy for Old private car (1000 to 1500 cc)
Third-party liability premium	5,453	985	9,534	2,863
Personal accident cover	3,750	750	2,250	750
Total premium	9,203	1,735	11,784	3,613
Total (with 18% GST)	10,860	2,047	13,905	4,263

Premium taken only for third-party liability policies bought after 20 September; Compulsory personal accident cover premium for multi-year policies taken as multiples of one-year premium

Source: Irda, Mint research

Until now, the premium for this compulsory personal accident cover was Rs 50 for a two-wheeler for a cover of Rs 1 lakh, and Rs 100 for a private car or commercial vehicle for a cover of Rs 2 lakh. Now, a uniform cover of Rs 15 lakh is applicable for all two-wheelers, private cars and commercial vehicles at a premium of Rs 750 (plus taxes). Insurance companies can also offer a higher sum insured for personal accidents as an add-on cover.

This personal accident cover provides compensation in case of death or permanent disabilities due to an accident involving the insured vehicle. Under this, 100% of the sum insured is payable in case of death, or loss of two limbs, or loss of sight of both eyes, or loss of one limb and loss of sight of one eye, or permanent total disability from any other injury in the accident. In case of loss of one limb or loss of sight of one eye, 50% of the sum insured is payable.

Only the registered owner-driver, in whose name the policy is issued, is entitled to this compulsory cover, provided the person holds a valid driving licence. Hence, the cover cannot be granted where a vehicle is owned by a company. In this case, where personal accident cover can't be granted to an individual, the additional premium can't be charged, as per the India Motor Tariff.

Also, if the owner-driver owns more than one vehicle, the personal accident cover can be given for only one vehicle as chosen by the insured person. However, if the person meets with an accident from the second vehicle, the cover (taken along with the first vehicle) may be payable. For this, the owner, while buying the second car, has to submit a proof that a personal accident cover has already been bought for the first vehicle, which is also in his name.

What will be the pricing for multi-year policies?

From 1 September, multi-year third party policies have become mandatory for new private vehicles. New two-wheelers now need to get a policy for five years and private cars for three years. For such policies, insurance companies are currently charging premiums in multiples of one-year premiums.

Since Irdai has announced the pricing for only single-year policies, how will multi-year policies be priced?

"The directive has just come and the premium for compulsory PA cover for multi-year policies is being filed with the regulator. In case of multi-year policies, some price variation may be there subject to approval by the regulator," said Sanjay Saxena, head , motor claims and motor underwriting, Bajaj Allianz General Insurance.

Source

Back

Uninsured vehicle owners should pay accident-compensation else vehicle to be auctioned: SC - The Economic Times – 21st September 2018

If you are driving an uninsured vehicle, you could end up losing it. The Supreme Court, in a recent judgement, has asked all the states in the country to ensure that in case of an accident, the owner of an uninsured vehicle is made to pay adequate compensation to the victim's family.

In the process, the uninsured vehicle may have to be auctioned, if the need arises, and the proceeds be deposited in the claims tribunal to compensate the loss of the victim.

Even though third-party insurance is a must, there are several vehicles moving on the road without it. If any such uninsured vehicle ends up in an accident, the compensation payable to victim's family becomes an issue.

The new rule

A recent Supreme Court judgement clears the air and sets a new provision in place. The court observes, "Where there is no insurance cover for a vehicle, the owner should be directed to offer security or deposit an amount, adequate to satisfy the award that may be ultimately passed, as a condition precedent for release of the seized vehicle involved in the accident.

If such security or cash deposit is not made, within a period of three months, appropriate steps may be taken for disposal of the vehicle and hold the sale proceeds in deposit until the claim case is disposed of."

The 3rd party insurance relates to cover the damage done by one's own vehicle to other vehicle or property or life.

"The need for this ruling arose based on that fact that every day numerous accidents occur on a road and the party in question may not have an insurance policy or is carrying an expired policy," says Tarun Mathur, Cheif Business Officer- General Insurance, Policybazaar.com.

He adds that currently, there is no such provision for such cases. "The new provision states that the vehicle in question will be seized by the local government for 3 months, if the vehicle owner fails to compensate for the loss then authorities have rights to auction the vehicle," says Tarun Mathur, Chief Business Officer- General Insurance, Policybazaar.com

The background

The judgment was delivered in a case in which the victim's family demanded compensation when an uninsured vehicle hit the victim that resulted in death. The Motor Vehicle Act Tribunal declined to pay up as the vehicle was uninsured. The judgment has finally made the states to own up in such cases and bear the responsibility.

The Delhi diktat

The Supreme Court had taken cognizance of the existing Delhi Government's 'Delhi Motor Accident Claims Tribunal Rules, 2008' and has asked all states) to follow it by issuing notifications within 12 weeks of this judgment that was delivered on September 13, 2018.

The Supreme Court specifically says that the appropriate (state) governments may consider incorporation of a rule on the lines of Rule 6 of the Delhi Motor Accident Claims Tribunal Rules, 2008.

The Delhi diktat states "no court shall release a motor vehicle involved in an accident resulting in death or bodily injury or damage to property, when such vehicle is against third party risks unless and until the registered owner furnishes sufficient security to the satisfaction of the court to pay compensation that may be awarded in a claim case arising out of such accident."

Further, it says that the "motor vehicle shall be sold off in a public auction by the magistrate having jurisdiction over the area where accident occurred, on expiry of three months of the vehicle being taken in possession and proceeds shall be deposited with the Claims Tribunal having jurisdiction over the area in question, within 15 days for the purpose of satisfying the compensation that may have been awarded, or may be awarded in a claim case arising out of such accident."

What you should do

While third party cover is mandatory, what remains optional is the 'own damage' portion. It refers to the damage or loss caused to the insured's vehicle due to any of the insured perils defined in the policy.

Among other things, it includes loss or damage due to fire, explosion, accidents or while in transit by road or rail, and even burglary and theft.

Together with 'third party' and the 'own damage' cover, the coverage is referred to as a comprehensive cover.

A comprehensive cover insures the vehicle against any risk arising out of theft or damage to the vehicle, death of the driver and/or passengers in the vehicle during an accident, and damage caused by the vehicle to other people or property. One should always go for a comprehensive cover and cover the risk from all fronts.

Source

Opinion

Explained: Why PPP is integral to success of Ayushman Bharat – Financial Express – 27th September 2018

Healthcare is one of India's largest sectors, both in terms of revenue and employment. However, the country's healthcare infrastructure is plagued with overcrowding, underfunding, a strong rural-urban divide, and an acute scarcity of resources in the public sector. Ayushman Bharat—National Health Protection Mission (AB-NHPM)—could provide a much-needed boost to India's over-burdened, struggling healthcare infrastructure. Aimed at bridging cost, quality, and access gaps in the current healthcare infrastructure, the programme proposes a combination of insurance cover and health and wellness centres (HWCs) to provide quality and affordable care to 10.74 crore families. The programme's ambitious targets and large-scale reach, as envisioned by the government, create an opportunity to increase public-private collaboration in healthcare.

Continuous technology advancement is helping transform healthcare delivery and introduce a multi-dimensional approach to increase healthcare access. Today, individuals have the option of getting a full health check-up in the privacy of their homes. Diagnostics can be conducted with sophisticated and digitised devices. Wearables and compact sensors are starting to replace conventional recording and monitoring systems. Medicines can be ordered online and health records updated digitally. Private players and healthcare start-ups have played a pivotal role in empowering primary care, and instituting a structure for secondary and tertiary care which has changed the overall experience of healthcare, including how patients seek help and how providers deliver care.

To compensate for the current deficiencies in infrastructure, India needs to leverage technology and develop innovative solutions for public health. The 1,50,000 HWCs, as envisioned by the government in Ayushman Bharat, can function as improved version of existing health sub-centres and Primary Health Centres (PHC), to provide a reliable, accessible, and scalable health care infrastructure.

However, to meet the targets set under Ayushman Bharat, the government would need the right infrastructure strategy to support the covered population. Currently, there are only13.5 lakh beds approximately for 18 crore people that are covered under the Rashtriya Swasthya Bima Yojana. Ayushman Bharat adds about 32 crore people to the coverage, thereby increasing the total number of covered to 40 crore. To bridge this wide infrastructure gap, studies have highlighted the need for public-private partnership (PPP).

NITI Aayog, the government think-tank, proposed adoption of the PPP model in 2017 to provide diagnosis and treatment for major non-communicable diseases in smaller cities. Several states have adopted the PPP model to improve infrastructure and care delivery at their regional and district-level hospitals and PHCs. States such as Odisha, Uttar Pradesh, Andhra Pradesh, Haryana, and Uttarakhand are also pushing for PPP at secondary and tertiary care facilities.

The private sector accounts for about 75% of outpatient and 60% of inpatient care provided in the country. For Ayushman Bharat to have far-reaching effects on India's healthcare scenario, PPP would need to be scaled up from a state level to a national level. The infrastructure would need to evolve to provide customised, high-impact, and affordable care so that diseases no longer pose a threat to health and economic security of India.

Source

(The author, Sameer Bansal is vice-president & head – India Business, Optum Global Solutions)

Back

How to buy the right life insurance policy – Mint – 24th September 2018

Tarun Chugh, Managing director and CEO, Bajaj Allianz Life Insurance

Life insurance has triple benefits—investment, security and tax advantages—and is ideal to help you meet your long-term life goals.

Having a policy is essential to ensure yours and your family's life goals are on track. The ideal life insurance strategy depends on the stage of your life, your life goals and the overall liabilities you have. To meet each of your life goals, there is a product, but planning is critical before investing.

One must have products that offer a life cover, so that in case of death of the breadwinner, the family is able to cope with income loss through this cover. Also, the product should help your investments grow over the long term by investing in India's dynamic markets. It's a fact that markets have given favourable returns over the

long run, and Ulips and other products not only help invest in the markets but also help manage downside risks. The chosen product should help you manage the income loss that may happen during critical illnesses. Critical illness or health products designed by life insurance covers work differently and one should have it in addition to a reimbursement health cover.

Investing in life insurance for tax-saving purpose only and signing up for it at the very the last minute is a common mistake.

Suresh Sadagopan, Founder, Ladder7 Financial Advisories
Life insurance is a safety net that we throw around the family to protect them against sudden loss of an income-earning member and the consequent distress that the family would be subjected to. A family would have a set of goals and lifestyle based on the income of the earning member.

That needs to be largely protected. Hence, a proper estimation of expenses and goals is necessary, based on which an appropriate life insurance cover should be taken. Any loans one may have should also be covered by the insurer.

An appropriate product to go for in this situation is a term insurance cover. This is the product that can offer a very high life cover for very low premium. A term insurance provides necessary security to the family in case of death of the income earner.

An appropriate term cover to take is one which has an income option. In such a case, about 10% of the sum assured is paid on the death of the policyholder and the balance is paid on a monthly basis to the family over a span of 10-15 years. This ensures that the family gets sustained income for a long period of time and can stabilise their position.

Melvin Joseph, Founder, Finvin Financial Planners
Many experts suggest a sum assured that is 15-20 times your annual income as the sum assured. But the practical method to calculate the sum assured for an insurance policy is expense replacement method.

This will ensure that your family can manage the financial goals like children's education and marriage, clear all the liabilities like home loan, car loan and have a decent life with dignity, in the absence of the breadwinner.

While there are a lot of products available in the market like whole-life policy, money-back policy, endowment plans and Ulips, few talk about the simple and most suitable product—term insurance. A person should choose term plan because it offers insurance at a low premium.

You should buy a pure-vanilla term cover without riders. You should mention the details of your existing policies, health conditions and habits while purchasing this policy.

Investment-linked insurance policies neither offer decent returns nor sufficient risk cover. Low returns, less cover and lack of flexibility are their biggest disadvantages.

Karthik Raman, CMO and head, products and strategy, IDBI Federal Life Insurance
When planning one's life insurance strategy, an individual has to consider various scenarios. To protect her loved ones in case of her unfortunate demise at an early age, an individual needs to select the ideal life cover, based on her human life value (HLV).

By calculating her economic value to the family, an individual will be able to decide on the appropriate life cover for herself.

It is also important for her to consider her financial situation once she retires. Purchasing a long-term investment-linked life insurance plan at an early age, would help to secure her and her family's lifestyle even post retirement.

Once she starts a family, an individual should also consider a child insurance plan with waiver of premium option, as it would help secure the child's dreams even in the absence of the family breadwinner.

An individual should definitely invest in a term insurance plan as these cover pure risk and give an individual substantial cover for a nominal amount. Moreover, these plans are easy on the pocket as they offer guaranteed premium over a longer period. Hence, the earlier they are purchased, the better it is for the individual.

Source

Insurance Cases

Murder to be treated as accidental death for insurance claim, says NCDRC – The Times of India – 28th September 2018

An insurance company cannot deny claim in case of the murder of a person insured for accidental death unless such crimes are excepted in the policy, the apex consumer body has ruled.

The ruling by National Consumer Disputes Commission (NCDRC) came in connection with a 2009 murder case in which it upheld the decision of the Maharashtra state consumer disputes redressal commission to direct the insurance company- Royal Sundaram- to pay the insured amount of Rs 20 lakh to one Pawan Muchandani whose father was murdered. The apex consumer body directed the firm to pay Rs 2 lakh compensation, over and above the claim, to the victim's kin while terming the insurance company's approach as an "unfair trade practice".

NCDRC has asked the company to pay the compensation within four weeks. The two-member bench comprising S M Kantikar and Dinesh Singh has also asked the insurance company to amend its terms and conditions and explicitly convey its position in respect of "murder"so that consumer can understand it easily at the time of purchase of the policy.

The company has been asked to file a compliance report with the commission within three months.

The NCDRC bench passed the order on Tuesday while hearing an appeal filed by the insurance company challenging the decision of the Maharashtra consumer body.

"Murder was not specifically excepted in the policy. If 'murder is not an accident' had to be adopted by the insurance company, or if every/select murder had to be inquired into and determined whether or not it was an accident covered under the policy, the same should have been explicitly and categorically stated in the policy. In the absence of 'murder' in the exceptions and in the absence of such explicit and categorical averment in the policy, a reasonable man of normal intelligence would conclude that murder is an accident within the terms of the policy," the NCDRC bench said in the order.

It added that the onus of being explicit and categorical from the beginning on its terms and conditions lied with the insurance company and not on the insured. "First not including murder in the exceptions and then, on murder occurring and claim being filed, raising the plea that 'murder is not an accident' and repudiating the claim, at it own end, as per its own interpretation, tantamount to unfair trade practice," it said.

Coming down heavily on the insurance company, the bench observed, "We are dealing with consumer justice, in a fight among unequal — an ordinary consumer who in good faith readily and straightaway believes that murder will (obviously) be an accident versus a pan country insurance company that first keep gaps and ambiguity in its terms and conditions and then comes forth with its own interpretation of its own gaps and ambiguity after the murder occurs and after the claim is made."

Source

Back

Insurance company ordered to pay Rs 15.95 lakh to widow – The Times of India – 23rd September 2018

The local consumer forum has ordered an insurance company to settle a claim for Rs 15.95 lakh of a widow whose husband was a policy holder, saying that pre-policy medical check-up report was "the key for knowledge pre-existing diseases".

Suvarna Tushar Kharote (40) had registered a complaint against HDFC Ergo Insurance Co Ltd on March 27, 2017 alleging that the firm had wrongly rejected her insurance claim after the death of her husband.

"My husband had insured our house in Home Security Plus scheme of HDFC Ergo from January 2016 to 2021, in which even his life was also covered. He passed away on October 1, 2016 following which I applied for the insurance claim of Rs 15.95 lakh. The company, however, was rejected the claim, saying that pre-existing illnesses was not disclosed," said the widow in her complaint.

As per the Home Security Plus insurance scheme, which was sought from 2017 to 2021 after payment of premium of Rs 94,865, the house was insured against fire, earthquake and terror attack. In the event of any such eventuality, the beneficiary was to get Rs 19.94 lakh. Also, in case of house break-in or theft, Rs 3.98 lakh

was to be paid by the firm. If the insured person was diagnosed with terminal illness or died, the next of kin were entitled to Rs 15.95 lakh. The company on January 3, 2017 rejected the claim under the pretext that the insured had not disclosed the pre-existing disease at the time of underwriting insurance.

The insurance company claimed that it had not violated any terms and conditions, given that it had learnt about the fact that the insured person was suffering from hypertension for more than four years before being insured. "The family doctor of the deceased had issued a certificate that he was suffering from hypertension," the company claimed and presented the certificate to the consumer forum.

The forum did not rely on the same, saying that the certificate was issued on November 11, 2016 (about a month after the death of the insured). The forum also ordered the company on November 2, 2017 to present the pre-policy medical health check-up certificate to know if the disease was revealed in the same.

"The company has failed to provide pre-policy medical health check-up report despite having been given enough. The report holds the truth of the facts. We are forced to believe that the company has produced the certificate of family doctor at a later stage, instead of the report, just to ensure it does not have to pay the insurance claim to the beneficiary," the order, signed by forum president Milind Sonawane and members Prerna Kalunkhe-Kulkarni and Sachin Shimpi said.

Source

The forum ordered the company to settle the claim of Rs 15.95 lakh in favour of the beneficiary and also pay 10% per annum interest from the date of rejection of the claim. The company will also have to pay Rs 10,000 for mental harassment and Rs 5,000 for costs incurred by the complainant.

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IRDAI Circular

Source

Updated List of Non-life Insurers is available on IRDAI website.

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Global News

Singapore: Insurers highlight continued increase in motor claims amid overall flat growth in 1H2018 – Asia Insurance Review

The General Insurance Association (GIA) of Singapore has raised red flags in the motor insurance segment as underwriting losses in this class of business reached about S$12.6m ($9.2m) in 1H2018, compared to a gain of S$17.2m in the corresponding period last year.

Claims costs increased significantly, amounting to S$291.3m for the first half of this year, an 11.8% increase over the corresponding period last year. This is also the third consecutive quarter this class of business has incurred a loss, which accounts for more than a quarter of the sector's total revenue.

However, the number of reported motor accidents fell by 4.3%, GIA says in a statement. Gross premiums for the motor insurance segment fell by 2.4% to S$600.9 million in the first half of the year.

Overall, the general insurance sector recorded flat growth of S$2.07bn, with a marginal 1.1% increase in total gross premiums. 1H2018 underwriting profits for the general insurance sector as a whole declined 94.5% to S$3.14m.

Mitigating claims costs inflation in the motor insurance segment, the sector is constantly tracking and enhancing the Motor Claims Framework (MCF) and Fraud Management System (FMS), and working closely with key stakeholders to seek public awareness and education efforts on the need for road safety.

To ensure the continued effectiveness and accessibility of insurance products, the general insurance sector is also pursuing greater collaboration with other stakeholders, focusing on areas such as improving efficiencies through digitalisation.

"Our top priorities include working with key stakeholders to reduce the severity and frequency of motor accidents, and leveraging digital technologies to continuously develop and enhance the GIA Fraud Management System, to lower and mitigate claims costs inflation," said GIA president Karl Hamann.

Outlook

The sector maintains a conservative outlook for the rest of the year as insurers work towards managing rising claims costs and underwriting losses across several segments. The sector also continues to be at the forefront of emerging trends including cybersecurity, with GIA's first Cyber Risk Forum which took place in mid-September, discussing the need for greater cyber resilience and awareness within the insurance community.

Source

Back

China: Insurers' bond issues to grow this year – Asia Insurance Review

Chinese insurance companies will see another boom in bond issues this year in response to strict regulations in the domestic financial market, Beijing-based United Ratings said in a report.

In the first half of the year, Chinese insurers made 118 domestic bond issues valued at CNY432.87bn ($63.1bn). There were 16 overseas issues valued at $8.91bn, reports Global Times citing the credit rating agency said.

The company forecast that domestic bond issues are likely to increase substantially in the second half, while overseas bond issues may slow. However, there is still much room for overseas bond issues in the long run, said the report.

Domestic insurance companies still face barriers such as low credit ratings when issuing bonds overseas, according to the report. It noted that most insurers issue senior debt overseas, although some larger companies have offered subordinated debt or even ultra-long-term subordinated bonds.

Since 2016, overseas dollar-denominated debt has risen significantly, lifted by the government's support for enterprises to issue bonds in foreign markets and the appeal of low interest rates in those markets.

Amid China's efforts to reduce leverage in the financial market, the domestic bond market has been shrinking rapidly, the report added.

Source

Back

Global: Reinsurance market players are preparing for a marathon – Asia Insurance Review

The reinsurance sector faces weak business conditions, even after modest price increases in 2018, says S&P Global Ratings which adds that this view remains unaltered even after it discussed reinsurance pricing and the latest market trends with reinsurers, insurers, brokers, and other market participants at the 62nd "Rendez-Vous de Septembre" in Monte Carlo this year.

S&P says, “We have maintained our stable outlooks on the sector and most of the reinsurers we rate, based on their robust capital adequacy and strong enterprise risk management. The main discussion points this year were related to long-term issues: the pick-up in merger and acquisition (M&A) activities, how reinsurers are adjusting their strategies to remain relevant, the persistence of alternative capital, whether the recent modest reinsurance price increases will carry into 2019, cyber risk, and the sector's reserve adequacy.”

To a lesser extent, the conversation also encompassed recent catastrophe events such as Typhoon Jebi in Japan and Hurricane Florence in the US, says the international rating agency. “We expect reinsurance pricing to stabilise as we head into 2019, and consider that alternative capital is here to stay.”

S&P also says that many reinsurers are turning to M&A in a bid to remain relevant, and spoke about how reserving policies could lead to greater volatility. Meanwhile, cedants are becoming more aware of how they could be affected by cyber risk and existing policies are being rewritten to more clearly delineate the cyber risk embedded within them.

Source

Back

Macau: Insurance claims from Typhoon Mangkhut reach around US$25m – Asia Insurance Review

Insurance claims for Typhoon Mangkhut have reached MOP200m ($25m), according to the latest figures from the Insurance Supervision Department of the Monetary Authority of Macao (AMCM).

Some 220 Typhoon Mangkhut related insurance claims had been filed totalling some MOP200m, the Authority revealed in a written reply to Macau News Agency (MNA).

A representative of AMCM told MNA that the data might be updated by the Insurance Supervision Department as data about the typhoon continues to be collected, with the Authority clarifying their latest data are from 19 September – three days after the passage of the super typhoon.

Mr Victor Lai, a financial manager at insurer AXA Group, told MNA that the property insurance sector would be more likely affected than life insurance.

Source

Typhoon Mangkhut caused 40 injuries although no deaths were reported, according to the head of the Unitary Police Service (SPU), Ma Io Kun. The figure was low compared to the passage of Typhoon Hato last year, which caused 10 deaths locally as well as losses of some MOP12.55bn.

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