भारतीय बीमा संस्थान
INSURANCE INSTITUTE OF INDIA

# INSUNEWS

**Weekly e-Newsletter**

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## QUOTE OF THE WEEK

**"When one door closes, another door opens; but we so often look so long and so regretfully upon the closed door, that we do not see the ones which open us."**

**– Alexander Graham Bell**

## INSIDE THE ISSUE

## INSURANCE INDUSTRY

### *Strengthening balance sheet: Government considering Rs 4,000 crore infusion into 3 insurers – Financial Express – 9th January 2018*


After public sector banks (PSBs), the government is considering infusing around Rs 4,000 crore next fiscal into three state-run general insurance firms — National Insurance Company, Oriental Insurance Company and United India Insurance Company — that it has proposed to merge. The capital infusion is aimed at improving the solvency of these companies, two of which (barring Oriental Insurance) are already struggling to meet the solvency ratio requirement of 1.5.

Sources told FE that the proposal by the department of financial services may be included in the upcoming interim Budget. "The infusion will strengthen the balance sheets of these insurers, which is essential before they are merged and listed," said one of the sources. Rising underwriting losses and higher claims have eroded the profitability of many general insurance companies, including the state-run ones, in recent years, causing their solvency ratio to slip.

According to initial estimates, the larger entity formed by the merger of the three insurers will be the largest non-life insurance company in India, with a value of Rs 1.2-1.5 lakh crore. While Oriental Insurance already complies with the solvency requirement, as stipulated by the regulator IRDAI, United India has a solvency margin of 1.21 and National Insurance is just around 1.5.

The process of the merger — announced in the Budget for 2018-19 — has started, with the shortlisting of management consultancy firm EY to advice on the proposed move. However, the merger is expected to be completed only in the next fiscal instead of the budgeted target of FY19, as various issues — ranging from the rationalisation of branches and workforce to integration of software — is yet to be chalked out. The government intends to list the broader entity after the merger.

The three insurance companies together accounted for 200 insurance products and a market share of around 35% as of March 2017. Their combined net worth was to the tune of Rs 9,243 crore and employee strength of around 44,000 across 6,000 offices. The government had, in 2017, raised more than Rs 17,500 crore by listing state-run New India Assurance Company and General Insurance Corporation of India.

The government has been infusing capital into PSBs in recent years to help them meet regulatory requirement and grow out of the bad loan mess. It has planned to infuse `1.06 lakh crore into PSBs in the current fiscal, compared with Rs 88,139 crore in FY18.

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**Source**

## IRDAI REGULATION

### *Health insurance segment posts growth of 20% for third time in a row: IRDAI - The Hindu Business Line – 10th January 2019*

The health insurance segment has reported a growth of more than 20 per cent in premium collection for the third year in a row. In 2017-18, general and health insurance companies collected Rs37,029 crore as health insurance premium, registering a growth of 21.8 per cent over 2016-17, according to the latest annual report of the Insurance Regulatory and Development Authority of India (IRDAI).

Group business accounted for 48 per cent (Rs17,757 crore) of the premium, followed by individual segment at 41 per cent (Rs15,291 crore), and government business at 11 per cent (Rs3,981 crore).


During 2017-18, general and health insurance companies issued around 1.47 crore health insurance policies (excluding policies issued under personal accident and travel insurance), covering 48.20 crore lives, a growth of 10 per cent in the number of lives covered over the previous year.

Three-fourths of the lives covered were under government-sponsored health insurance schemes, and the balance one-fourth by group and individual policies issued by general and health insurers.

There is an also improvement in net incurred claims ratio (ICR) during FY 2017-18. This is observed in all three classes of businesses. The four public sector general insurers held a combined market share at 58 per cent in 2017-18. However, their share declined from 63 per cent in 2016-17.

On the other hand, the share of private sector general insurers increased to 21 per cent in 2017-18 from 19 per cent in 2016-17, and the share of standalone health insurers in health insurance premium went up to 21 per cent from 18 per cent in 2016-17.

Standalone health insurers reported an increase in underwriting losses in 2017-18, which is Rs436 crore, compared to an underwriting loss of Rs261 crore in 2016-17.

Of the six standalone health insurers, three reported losses and three made profits in 2017-18. The three standalone health insurers that reported PAT include Apollo Munich, Max Bupa and Star Health. They reported PAT of Rs15 crore, Rs23 crore and Rs170 crore, respectively, during 2017-18.

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**Source**

## LIFE INSURANCE

### *Net profits of life insurers rise to Rs 8,512 cr in FY18 - The Hindu Business Line – 10th January 2019*

The net profit of life insurers increased 10.14 per cent at Rs8,512 crore in the year ended March 2018, compared to Rs7,728 crore in the previous year.


According to the data released in the annual report of IRDAI for the year 2017-18, of the 24 life insurers in operations during 2017-18, 19 companies reported profits. Life Insurance Corporation of India reported a net profit of Rs2,446 crore, registering an increase of 9.62 per cent over the Rs2,232 crore reported in 2016-17.

The life insurance industry recorded a premium income of Rs458,809 crore, against Rs418,476 in the year-ago period, an increase of 9.64 per cent. While private insurers posted a 19.15 per cent growth in their premium income, LIC recorded 5.90 per cent growth (against 12.78 per cent growth in the previous

year). While renewal premium accounted for 58 per cent of the total premium collected, the remaining was new business premium.

The general insurance industry, including standalone health insurers, underwrote total direct premium of Rs150,662 crore last year, against Rs128,128 crore during 2016-17. The growth, however, came down to 17.59 per cent against 32.94 per cent in the previous year.

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Source

***This tax season, don't give in to agents' calls, buy the life insurance plan you really need - Mint – 10th January 2019***

The New Year has just begun, but for corporate India this is the last quarter of the financial year with only three months left to meet the year-end target. Companies are on an overdrive and life insurance sector is no exception. In fact, according to Deepak Yohannan, founder and CEO, Myinsuranceclub.com, an insurance web aggregator, nearly 50-60% of the sale for life insurance happens in the last quarter.


For you this means constantly buzzing phones with call centre executives trying hard to sell you life insurance that you may find hard to ignore if you haven't made your tax saving investments and the company HR has handed you a deadline.

The premium that you pay on a life insurance policy qualifies for a tax deduction of up to Rs1.5 lakh under Section 80C of the Income Tax Act, 1961 and buying a big-ticket life insurance policy—that bundles investment—can take care of the entire 80C limit. But that's a mistake and you are bound to make it if you rush last minute to save taxes. Bundled life insurance plans are products that are complicated and need a lot of clarity on costs, returns and caveats.

What's worse is that you are unlikely to meet your insurance needs through these products as they come with a poor layer of insurance.

For your insurance needs what you need is a term plan that only provides insurance. You don't have to depend on an insurance agent to buy a term plan as most life insurance companies now offer term insurance online.

In fact, insurers have started innovating in term insurance as well. We help you understand the different designs of term plans and what may work for you.

**Payout structure**

A term insurance policy only carries an insurance cover, so if the policyholder dies during the policy term, the beneficiary gets the sum assured. If the policyholder survives, there is no maturity benefit. The basic structure of a term plan is to pay out the death benefit or the sum assured as a lump sum payment. So if the sum assured is say Rs 1 crore, then on death of the policyholder, the nominee gets Rs 1 crore in full. But newer policies now break the sum assured into periodic benefits instead of a lump sum payment. The sum assured here is typically broken down into monthly payments for a fixed number of years to provide regular cash flow to the nominee. Then there are plans that offer both lump sum and periodic payouts.

Another type of term plan is like an income replacement plan that offers only periodic income until a goal is reached. For instance, if the goal is linked to retirement—60 years of age—then on death of the policyholder during the term, the insurance cover to the beneficiary will continue till the retirement age of the policyholder. The drawback here is that if the policyholder dies closer to retirement, the sum total

of payouts would be less. Buying this plan can be tricky because it may appear to be cheaper but you will need to consider your liabilities and goals before buying this plan.

**How to choose**

As with most things in life, the basic term plan works well. "Customisation is good but I recommend taking a term plan that pays lump sum benefit. It's hard to predict the kind of financial stress death of the main breadwinner in the family may cause, therefore having the entire corpus helps," said Yohannan.

According to Kapil Mehta, co-founder, SecureNow.in, taking the money as lump sum payment gives you the opportunity to invest it well and earn a higher return. "Policies that stagger insurance money into periodic income take a conservative view on investment returns. So if you were to invest the insurance benefit, you will be able get a higher monthly payout. Taking the insurance money in a lump sum and a do-it-yourself approach is better," he said.

But this may not work for all, especially when your spouse is not financially savvy and this is where the flexibility may help. "In such cases term plans that break insurance benefit into periodic benefits works. Even in this case, it's always better to take at least 40% of the sum assured as lump sum," added Mehta.

Term plans are the cheapest form of life insurance. For example, a 35-year-old can buy a term plan with a sum assure of Rs 1 crore for around Rs 10,000 per annum for a policy term of 25 years. Of course, buying a term plan means you have a long way off to exhaust the Section 80C limit, but it's worth your while to consider other products in the Section 80C basket and stick to term plan for insurance needs.

***TOP***

**Source**

## *'Life Insurance reloaded' - Cover fox's revamped platform for a enhanced user experience – Business Standard – 8th January 2018*

Cover fox, India's largest Insurtech platform, has announced the launch of its revamped Life Insurance Product interface to meet users' goals.

The revamped version will provide an easy-to-use experience to the user through a guided structure. The new platform will aim not only to provide an enriched experience to the customer, by educating them on the range of products available, but also help advisors to sell with complete transparency.


Even today, on digital platforms, health and life insurance policies make for an assisted sale, largely due to the lack of an outlet that simplifies comparison, research and purchase of plans.

Cover fox's new product experience is a focused effort to transfer power back to the consumers, helping them choose the right insurance product and make necessary customization - with the option of on demand assistance from our tele-advisors as and when required.

Cover fox's research showed that while the demand and awareness for term insurance is increasing, the increased number of options available requires the customer to minutely understand each customization option clearly and make an informed decision on the same.

Comparison on the existing online portals in the market are not equipped to handle such complex personalization, which has resulted either in procrastination or customers being completely dependent on assistance from call centre advisors to make a decision.

**Key highlights of the new interface:**

- The new data-driven algorithm recommends the best plans which are unique for each and every individual
- With the new customization algorithm, the user will be able to easily understand the details of complex riders available in the market today and select the one that best suits his requirements
- Cover fox's recommendation engine helps a user to figure out the best plans according to his needs
- Cover fox's new customization feature helps a user to enhance the plan and cover disease and disability along with death cover

Cover fox's new feature "Understand your plan in 2 minutes" lays down all the plan details in a simple yet easy to understand language and terminology along with infographics. The user will now be able to understand his policy at just one glance.

Coverfox utilised the metrics such as analytics for understanding the user, persona-based user behaviour data and cohort-based user preferences while building the interface. The detailed analysis brought out some interesting findings on term life such as 70% of the policies are bought by users under 40 years of age, 80% of the users like to pay the premium for the policies on monthly basis, 70% of the policy holders opt for 1 rider while buying the policy.

**The findings**

With data collected from sources such as leads, calls, interactions, customers, customer feedback and feedback from the tele-advisors available, Cover fox analysed user behaviour, product affinity, market trends and user priorities across different cohorts to build a more customized and guided journey for every customer. This analysis is a combination of 25 million user visits and 0.3 million customer calls with the tele advisors.

"I think what Coverfox has done is come up with a new journey for its customers which is intuitive and offers them the ability to make the right decision about the term insurance product. All the choices are available on their platform at the click of a mouse. I commend Cover fox's efforts and wish them greater success." - Vishal Subharwal, Executive Vice President, HDFC Life.

"Life insurance purchase needs to be made simpler and easier for the customers. This is a good effort in this direction. The journey aims to help the customer understand the complex words associated with life insurance, compare different offers and features available without a bias and thereby enable the customer to make his own decision.

This will surely bring in lot of trust on the life insurance offers and reduce interference. It is a good customer centric initiative made by Coverfox and we wish them all the best.'' - Vineet Arora, Managing Director & CEO, Aegon Life Insurance.

"The market for health and life insurance products in India is quite vast, which is currently also complex. We, at Coverfox, are constantly working to simplify it and make it more transparent, easier and quicker for customers across categories.

The revamped platform focuses on not only educating the user about insurance products but also sensitizing them towards its pros and cons via a customer-centric approach and improvised user-journey that will enable the users to make an informed decision.

While a user may know the way his income impacts his policy, death coverage etc., what he might not know are the inclusions and exclusions under a term plan. The revamped platform guides a user through the same and the customer can himself buy the insurance within 10 minutes," said Premanshu Singh, CEO of Coverfox.com.

***TOP***

**Source**

## *India: Life Council highlights need to minimise fraud risk – Asia Insurance Review*

There is a need to minimise the risk of fraud in life insurance, according to Mr. V Manickam, the secretary general of the Life Insurance Council.


On an annual basis, the life insurance industry loses about INR400bn ($5.7bn) to fraud, reported *Money control*. Mr.Manickam said about 8.5% of revenue is lost to fraud by insurance companies.

Speaking at an event last month organised by the Association of Insurance Claims Management, he said that steps are being taken by the industry to identify fraud.

The Insurance Information Bureau of India is also helping to identify and help curb fraud. There is a need to eliminate fraud at the underwriting stage itself.

In the financial year ended 31 March 2018 (FY2018), about 49% of the total number of frauds detected was perpetrated by intermediaries while 28% were by policyholders. In certain cases, employees were also found to be involved.

**TOP**

**Source**

## *India: Many see life insurance as top vehicle to meet life goals – Asia Insurance Review*

Indians see life insurance as the most handy vehicle for planning their major life goals while nearly a third do not have any idea about how much insurance they need, a survey has found.

Life insurance is the top instrument for life goals such as building a house (43%), children's education (38%), retirement (49%) and legacy creation (50%), a survey by Exide Life Insurance showed.


When it comes to planning for child's marriage, they look at fixed deposits in addition to life insurance, the survey revealed.

It also finds that 30% of respondents admitted that they do not have any idea about how much life insurance cover is required, pointing towards the glaring protection gap among Indians.

Around 46% of surveyed feel that they should have a cover of at least 10 times their annual income but only 29% of individuals have such cover, it said.

The digital survey '*Exide Life Insurance 2018 Money Habits*' covered respondents from 12 cities including metros and emerging tier II cities to understand how life insurance customers look at dealing with their money.

**TOP**

**Source**

## GENERAL INSURANCE

### *IRCTC offers free travel insurance for air travellers - The Hindu Business Line – 9th January 2019*

In a bid to attract more airline bookings through its portal, Indian Railway Catering and Tourism Corporation (IRCTC), the Railways' subsidiary which is known more for online train ticket bookings, will offer insurance of up to Rs50 lakh for free for air passengers who book their tickets through its portal. IRCTC has tied up with Bharti-Axa for the offer.


MakeMyTrip, Yatra and other travel portals charge about Rs200-250 for flight insurance.

"We are offering insurance of up to Rs50 lakh for free," said Mahendra Pratap Mall, Chairman Managing Director, IRCTC, on Wednesday.

"The move is to attract airline booking through our portal," Rajni Hasija, Director-Tourism and Marketing, IRCTC, said.

**Service charge**

Incidentally, IRCTC's service charge of Rs59 is the cheapest compared with travel websites. IRCTC has tied up with Galileo, a computer reservation system, for powering the flight search engine. At present, over 30 lakh users login through its mobile app and three lakh ticket bookings happen daily through the app.

Currently, IRCTC books about 7-7.5 lakh tickets a day. In November, it had booked as high as 8.7 lakh tickets a day. Another move that could boost IRCTC's flight booking is its payment gateway aggregator — IRCTC Pay or iPay — which is currently operational on IRCTC airline or flight portal. The move is expected to speed up the payment process.

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**Source**

## HEALTH INSURANCE

### *'Hosps must follow govt's insurance plan to avoid confusion' – The Times of India – 10th January 2019*

District collector K Rajamani, on Tuesday, conducted a sensitization meet in order to avoid confusions and reduce complaints regarding the implementation of the state government's health insurance scheme-- 'New Health Insurance scheme-- 'New Health Insurance Scheme'- for government employees and pensioners by private hospitals in Trichy.

Sources from United India Insurance Company said that the meeting was organized mainly to address confusions that arose now and then over the hospitals providing reimbursement to patients and to make sure that all the hospitals that come under the government's network should provide treatment under the New Health Insurance scheme for beneficiaries without declining it.

Officials from total 59 hospitals – that are under the government's network – attended the sensitization programme. During the meeting, Rajamani laid out certain instructions for the private hospitals to follow to ensure that there were no discrepancies.

A source from the insurance company told TOI that they received few complaints from the beneficiaries that they were declined treatment under the insurance scheme by certain hospitals. The source went on to claim that since hospitals would not be able to charge additional treatment fee – if it's under insurance scheme – they sometimes deny treatment for beneficiaries. "It's because if a procedure comes under insurance, the hospitals wouldn't be able to charge extra fees for visiting doctors etc.," The insurance company pays the hospitals for the respective treatments that come under the New Health Insurance Scheme. Under the schemes, married partners of the employees and pensioners would also be a beneficiary.

This insurance scheme covers around 850 surgical procedures and also medical management (drug treatment) for cancer and dialysis patients and those, who are put under ventilators. Rajamani gave main emphasis on how the payment process should be done. He said that the moment a patient goes to a hospital, the administration should check if he/ she comes under the health insurance scheme and should not charge money from them.

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Source

## *States with existing schemes do well in enrolling hospitals - The Hindu Business Line – 10th January 2019*

At first glance, the number of hospitals empanelled under the Centre's flagship Pradhan Mantri Jan Aarogya Yojana (PM-JAY) — or Ayushman Bharat scheme — within 100 days of its launch appears heartening.

But dig a bit deeper and it transpires that States that already had health insurance schemes have done well on empanelment. Thus, of the over 16,200 hospitals empanelled, as per PMJAY, just five States — Gujarat, Tamil Nadu, Uttar Pradesh, Chhattisgarh and West Bengal — account for half the number.

Barring UP, the rest already had health insurance schemes and these have been dovetailed with PMJAY. With basic systems, infrastructure and operating procedures in place, it was easy for these States to implement PMJAY.

In greenfield States, with no existing health insurance scheme, such as Madhya Pradesh and Haryana, the hospital empanelment number is just 200-300.

"Other than in M.P. — where it was decided to limit empanelment to NABH (National Accreditation Board for Hospitals and Healthcare Providers) accredited hospitals — all other greenfield States have done well in enrolling hospitals," says Dinesh Arora, Deputy CEO, National Health Agency.

Gujarat, which tops with 2,700 hospitals empanelled, already had a medical care scheme, Mukhya Mantri Amrutam Yojana, providing cover of up to Rs. 3 lakh per family per annum to Below Poverty Line families (launched by Narendra Modi as Chief Minister in 2012). Transitioning into Ayushman, which offers a cover of Rs. 5 lakh per family, was thus easy.

Chhattisgarh, where about 1,300 hospitals are on board, had two schemes — Rashtriya Swasthya Bima Yojana for unorganised workers and Mukhya Mantri Swasthya Bima Yojana (MSBY) offering cover of up to Rs. 50,000 per family per annum (up to five members).

The 40 lakh beneficiaries under MSBY were moved to Ayushman and recent figures reveal that over 55 lakh PMJAY cards have been issued.

Tamil Nadu, which ranks No 2 with 1,700 hospitals, integrated its Comprehensive Health Insurance Scheme (CMCHIS) — offering a cover from Rs. 1 lakh per year to Rs. 2 lakh for specified procedures for people with annual income of less than Rs. 72,000 — with PMJAY. West Bengal integrated its 'SwasthyaSathi' with PMJAY.

"Obviously, in States with existing schemes, the progress has been healthy. In some greenfield States such as UP, too, it has been good. In metros, bigger hospitals may be reluctant to come on board, given the higher cost of services, but we are not seeing any issue in hospitals with 50-100 beds," says Arora.

**Hybrid model**

Under the insurance model, the insurance company administers and pays the claim. Under the trust model, each State forms a trust to manage the scheme. Under hybrid, up to a specific amount, the claim is processed under the insurance model and amounts over the cap via the trust.

Market players explain that in States which already had schemes, and in those that adopted the hybrid model for Ayushman, empanelling bigger hospitals has been easier. This is because to some extent fraud-prevention is taken care of. Jharkhand is a Greenfield State that has adopted the hybrid model and is doing well.

"In Chhattisgarh, a claim package of up to Rs. 50,000 is taken under the insurance model and above that under the trust model. Since the claims ratio is high (9-10 lakh claims a year), a higher cover under the insurance model will mean a higher premium. But to handle large number of claims under the trust model, more resources are needed, and may be difficult for all States to implement," says the State's Health Director R Prasanna.

***TOP***

**Source**

## *'Tobacco not sole reason for cancer, insurer must pay claim' - The Economic Times – 10th January 2019*

A consumer court in Ahmedabad ordered insurance companies to pay the claim for a policyholder's cancer treatment with the observation that chewing tobacco cannot be considered the only cause for oral cancer. The complainant, Kanaiya lal Modi, smoked and chewed tobacco for the last four years.


The Consumer Dispute Redressal Forum, Ahmedabad city, asked New India Assurance Co Ltd and Health India TPA Services Pvt. Ltd to pay Modi Rs 1.12 lakh, which he had spent on his surgery for oral cancer in December 2014.

The court held that the rejection of his claim was improper and was a deficiency in service and unfair trade practice. It ordered the insurance companies to pay him Rs 3,000 extra as compensation for mental harassment and legal expenditure.

The court said, "It cannot be believed that cancer was caused solely because of his habit of chewing tobacco. His claim should have been accepted. It is a clear deficiency in service and unfair trade practice on the part of the opponents."

After being treated at an oncology centre, Modi made a claim for the sum. The companies rejected it citing the treating doctor's certificate and clinical history. These revealed that Modi habitually used chewing tobacco and this was a breach of the policy conditions.

Modi argued that the doctor's certificate showed his tobacco habits, but it also mentioned that the habit could not be considered the sole reason for his cancer. The court said his cancer was not a pre-existing disease as Modi had held the policy since 2003. It acknowledged that the doctor's certificate revealed tobacco use habits, but the certificate also said the "exact reason for oral cancer cannot be determined".

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Source

## *Government rolls out broad guidelines for hospitals in Tier 2, 3 cities under PMJAY – The Economic Times – 9th January 2019*

New Delhi, The government on Tuesday rolled out broad guidelines to improve the supply of healthcare services in the underserved areas to ensure maximum utilisation of benefits under Pradhan Mantri Jan Arogya Yojna (PMJAY) and to improve demand for quality healthcare services at affordable prices to general public.


According to the Health and Welfare Ministry, it has formulated three hospital models -- Doctor Owner (30 to 50 beds), Doctor Manager Partnership-Multispecialty (100 beds), and Multispecialty (100 beds or more) to be followed under the health scheme.

The private sector has been regularized to build, design, finance, manage operate and maintain with quality standards, take market risk and provide services at PMJAY rates.

The government authorities will provide unencumbered land on lease or through bidding, facilitate various permissions and clearances through special window with timelines, compulsory empanelment of the hospitals for PMJAY.

The Pradhan Mantri Jan ArogyaYojana (PMJAY) was launched on September 23, last year with an aim to provide hospitalisation cover of up to Rs 5 lakh per family per year to over 10 crore poor and the deprived families (about 50 crore people) in the empanelled hospitals throughout the country.

As per the Health Ministry, 33 states/UTs have signed MoU for implementing PMJAY out of which 29 have already launched the scheme.

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Source

## *Maharashtra set to enrol private hospitals in Ayushman Bharat scheme - The Indian Express – 7th January 2019*

Three months after the launch of Pradhan Mantri Jan ArogyaYojana (PMJAY) or Ayushman Bharat scheme in the state, the Maharashtra government is now set to enroll private hospitals in the cashless health scheme.


As many as 1,100 private hospitals, including 30-bedded nursing homes, from across the state have been waitlisted under the Ayushman Bharat programme.

The programme already has 79 government hospitals empanelled in the state, in addition to the 500 hospitals enrolled under its state health insurance scheme — Mahatma Jyotiba Phule Jan ArogyaYojana (MJPJAY).

Officials said a fresh list of hospitals wanting to enroll in the Ayushman Bharat has been submitted to the state government.

The scheme, launched in September 2018, covers 83 lakh beneficiaries and provides cover for 1,300 medical procedures with a cap of Rs 5 lakh. Till now, over 2,500 procedures have been conducted.

With the current tenders for MJPJAY about to end for the existing state health insurance scheme in January, the government plans to call fresh tenders quoting Rs 640 from insurance companies per family, a reduction from Rs 690 per family in current tender. "We will save Rs 100 crore annually by reduction in premium cost," said Dr.Sudhakar Shinde, CEO of MJPJAY.

State officials said that if insurance companies agree with the new rates, a hybrid model would be used to run PMJAY and MJPJAY.

Maharashtra follows the hybrid model, a combination of insurance and trust scheme, to run the latest scheme, on the lines of Gujarat and Chhattisgarh governments. While treatment cost up to Rs 1.5 lakh is covered under the insurance model, the cost escalating beyond Rs 1.5 lakh is covered under the trust model.

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**Source**

## *Kumbh Mela 2019: UP government mulls insurance for pilgrims visiting Prayagraj during Kumbh Mela – Financial Express – 7th January 2019*

The Uttar Pradesh government is planning to give insurance cover to devotees visiting Prayagraj for Kumbh Mela beginning January 15, 2019. UP Deputy CM Keshav Prasad Maurya on Saturday said that the government was considering the move and the decision on this would be taken soon.

Speaking on insurance, Maurya said that the administration was considering in the direction to insure the lives of devotees.

"I have seen several Kumbh Melas at Prayagraj. I have full faith that nobody will even get a minor injury given the preparations made this time.

There would be no discomfort to the visitors. All should come there with their families,' PTI quoted him as saying.

Maurya made this statement in Madhya Pradesh where he had gone to promote Kumbh Mela. During his visit, the deputy CM invited top BJP leaders including MP Governor Anandiben Patel and Shivraj Singh Chouhan to visit UP.

He also met MP Chief Minister Kamal Nath and invited him to visit Kumbh Mela. According to Maurya, the government has also sent invitations to Congress chief Rahul Gandhi and UPA chairperson Sonia Gandhi.

Kumbh Mela preparations are in a full swing in the state which is expected to witness an attendance over 20 lakh devotees. The government has allotted Rs 4,300 crore for creating the necessary infrastructure for the Kumbh Mela.

Recently, Uttar Pradesh Tourism Minister Rita Bahaguna Joshi said that the Mela is being organised at 3,200 hectares of land this year against 1700 hectares of last time.

She further said that the government has constructed 1.22 lakh toilets apart from 40,000 LED lights. Kumbh Mela will begin on January 15 and will continue till March 4, 2019.

***TOP***

**Source**

## *Chaddar trek: Insurance, check-up must for tourists - The Tribune – 7th January 2019*

In view of casualties every year, tourists now have to undergo a compulsory health check-up and get medical insurance to get permission to trek the frozen Zanskar riverine route in the Ladakh region, officials said.

The decision was taken as every year four or five deaths and several injuries are reported during the trek, they said.

People have to brave inhospitable conditions to trek the frozen river at a height of 11,150 feet. The average temperature during the day is -10°C and below -20°C in the night, the officials said.

Ice breaks and changes colour on the river every few hours. In some place the "chaddar" or ice sheets do not form, they said.

In view of the safety and security of those undertaking the 100-km Chaddar or Zanskar trek between January and February, the Leh administration has issued several guidelines and standard operating procedures (SOPs), said Deputy Commissioner Avny Lavasa.

The trek on the Zanskarriver in the Himalayas, which is frozen between January and February, is one of a kind and takes at least seven days to complete with tourists crossing frozen waterfalls, caves and ice slides on the way.

Officials said that as per rules and regulations, tourists have to spend a minimum of three nights in Leh for acclimatisation. "On the third day, tourists will take the compulsory pre-medical check-up in Leh," she said. The administration has set up high-altitude medical rescue centre, free treatment facilities and three rescue posts for the safety of tourists.

Under the guidelines and SOPs, trekkers will be issued adventure travel insurance and a medical rescue card. They will also have access to doctors and paramedics during the journey, officials said. She said the regulations and SOPs came into effect this year in view of four or five deaths every year.

In another regulation, tourists, foreign or domestic, have to get a medical insurance when applying for the trek, failing which the administration will not issue a permit. The medical check-up and insurance cover will be provided by the district administration.

"Post medical check-up, tourists will get their adventure insurance. But persons found medically unfit will not be issued clearance for the Chaddar trek," the guidelines state.

Indian nationals will be insured for Rs 2 lakh for hospitalisation expenses, Rs 3 lakh for death and disabilities and Rs 4 lakh for medical evacuation among others, it said. For each tourist, medical check-up and wildlife fee will be Rs 200 and Rs 2,200, respectively.

The Chaddar route was primarily used by natives to get their basic supplies and sell copper utensils, goatskin and yak butter for a livelihood. To maintain the ecology of the fragile region, tourists now have to also get a permit from the wildlife department.

Tour operators have to give details of the food items being carried by tourists, who will be provided garbage bags. On their return, the department will check if the group has brought back trash like tin cans, bottles and plastic items, the SOPs said.

Taxi operators will also have to keep garbage bags in their vehicles and deposit them at the waste segregation centre at Solan Colony, the DC said.

The SOPs have come against the backdrop of reports that the Chaddar trek would be closed by 2020 due to global warming and rush of people in the region. It has also been made mandatory for the wildlife department to not allow more than 100 tourists on the trek per day and issue permits only to tourists coming through recognised travel companies.

To deal with emergencies and evacuations, the district administration shall provide sat-phones to the agencies to facilitate communication.

"It is a six-day trek in inhospitable conditions over the frozen Zanskarriver in Ladakh," said a senior official of the tourism department. Officials said the Chaddar trek was like no other trek in the Himalayas and walking on a frozen thick glass-like river, with dramatic mountains on both sides, is an experience of a lifetime.

"At 11,150 feet altitude, the Chaddar trek almost feels like an expedition to the North Pole, where the temperatures drop down to -30°C at night, the ration is transported on sledges, you find refuge in caves and life blossoms on survival instincts, making it an eminently 'do before you die' trip," he said. One of the highlights of the frozen river trek is the Nerak waterfall. It is frozen from top to bottom.

"The best time to do the Chaddar trek is from mid-January to mid-February, that is when the river freezes and you get to walk on massive slabs of ice spreading for miles," he said.

***TOP***

**Source**

## CROP INSURANCE

### *Insurers hit: Climate change wreaking havoc on insurance industry – Financial Express – 10th January 2019*

It may get increasingly impossible to recover from the damage inflicted by anthropogenic climate change. Insurers have been researching what climate change effects mean for their business, and there is more or less a consensus that pricing in the impact of extreme weather events that are already becoming common will jack up premiums manifold, even as property, health and life in some areas become uninsurable. The Economist reports that Munich Re, a large reinsurer, estimated the losses from global natural disasters in 2018 at $160 billion—with half of that value uninsured.

In 2017, thanks to three big hurricanes battering the American coast and the Caribbean islands, the estimated losses totalled $350 billion, of which less than half was insured. But this is only a fraction of what could be in store—a 2013 study published in Nature found that the average annual flood losses for 136 of the world's largest coastal cities could rise from $6 billion in 2005 to over $1 trillion by 2050—thanks to extreme weather events and the rise in sea level—unless the cities invested about $50 billion annually in climate change adaptation.

Add to the flooding the threat from landslides, hurricanes, drought and crop failure, and insurers are indeed looking at a very bleak risk future. High-vulnerability areas such as coastal cities and cities abutting forests—bear in mind the California and the Greek forests fires of 2018—could see costs of insuring property soar sharply. In 2016, Climate Wise, a coalition of 29 of the world's biggest insurers on climate risk assessment, had warned that the "protection gap"—the difference between the costs of natural disasters and the amount insured—had quadrupled since the 1980s.

The Bank of England had warned, at the time, that climate change could threaten "economic resilience and financial stability" severely. Climate Wise had concluded that the insurance industry needed to use more of its $30 trillion of investments in funding society's resilience to climate change effects—not an easy path for insurers given the investment many have made in fossil fuel—and must lend its risk management heft to convince private and public sector movers and shakers on the urgent need to act on climate change.

The challenges before the insurance industry from climate change will hit those seeking cover. The 2015 wildfire in Canada's Fort Mc Murray hit insurer Aviva Plc hard as it had, for decades, estimated the risk of wildfire in the region as marginal to non-existent. Now that Aviva has ascertained that the wildfire was an example of how the Earth's warming is impacting the likelihood of a natural disaster happening, it has increased premiums in Canada.

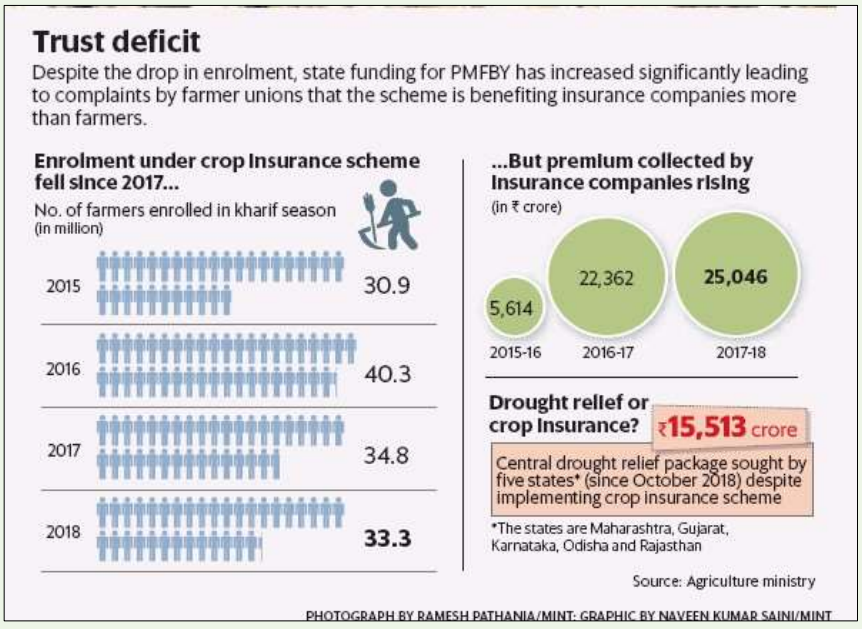
But given the predictions over even the short-term are imprecise and the deliberate attempt to cast doubt on the anthropogenic nature of climate change, covering against extreme weather events/disasters is proving incredibly difficult to design. A country like India, where rain-fed agriculture is the mainstay of millions of families, insurance penetration is poor to begin with, and that faces unprecedented threat from climate change, would need to figure out a sound risk-cover strategy. Else, climate change adaptation could prove a gargantuan challenge.

TOP

Source

## *Decline in enrolments show waning interest in PM's crop insurance plan – Mint – 9th January 2019*

Sharad Markad, a lanky teenager from a marginal farming family in Maharashtra, spent the first day of 2019 scrounging for funds. Faced with a drought, the third in the past five years, Markad had taken it upon himself to build a community cattle shed in November. Due to an acute shortage of fodder and water, farmers in his village in Ahmednagar district were struggling to tend to their livestock. Now, Markad's shed is home to 250 cattle and he is desperate for funds to keep it running. When asked if his family had crop insurance that would help cover daily expenses during a drought, Markad said he couldn't care less. "We did not enroll last season since it is of no use… our crop was damaged in the past but we did not receive any money."




Markad's loss of interest in the scheme which was launched with much fanfare in 2016 echoes the sentiment of farmers across India. After an initial spurt in enrolment during the kharif crop season beginning June 2016, enrolment under the flagship crop insurance scheme— named Pradhan MantriFasalBimaYojana (PMFBY)—has seen a steep decline, driven by payouts which are either delayed by months or not settled altogether.

In April 2016, Prime Minister Narendra Modi launched PMFBY as a key scheme to help farmers cope with weather uncertainties. In a country where over half of the unirrigated crop area is dependent on the vagaries of the four-month-long southwest monsoon, PMFBY promised increased cover for a variety of risks at a premium of just 2% (of

sum assured) for kharif and 1.5% for winter or rabi crops. It was decided that the centre and states will equally share the cost of actuarial premium payable to insurance companies.

**FALLING ENROLMENT**

Data from the agriculture ministry shows that enrolment (during the rain-fed kharif season) rose from 30.9 million farmers in 2015 to 40.3 million in 2016, an impressive 30% jump. But delayed assessment of crop loss and settlement of claims which took six to nine months to complete led to farmers losing interest; enrolment fell to 34.8 million in 2017 and further plunged to 33.3 million in kharif 2018. Part of the decline was also because fewer farmers' accessed fresh credit (due to a spate of loan waivers since mid 2017) since enrolment under crop insurance is mandatory for farmers availing crop loans.

However, despite the drop in enrolment, state funding for PMFBY has increased significantly leading to complaints by farmer unions that the scheme is benefiting insurance companies more than farmers. Available numbers show that premium collected by insurance companies rose from a meagre Rs 5,614 crore in 2015-16 to Rs 22,362 crore in 2016-17 and further to Rs 25,046 crore in 2017-18 (including rabi and kharif crop seasons).

**RUNNING AGROUND**

Several studies and field investigations point to a host of reasons which has led to a trust deficit among farmers. To begin with, insurance companies are selling the product piggy backing on the banking infrastructure. For farmers availing crop loans, banks deduct the premium amount from the loan without even issuing a receipt. Farmers are never asked if they want insurance, and the product has become an easy way for banks to insure their loans.

Further, in the event of any crop damage, farmers are at a loss as to whom to reach out to since most companies have not set up field offices to attend to customer complaints. A major challenge is conducting faster and accurate assessment of crop loss which is the responsibility of state governments. Assessment of crop losses is often delayed due to a paucity of local staff. There's more. According to an assessment released by the Delhi-based think tank Indian Council for Research on International Economic Relations in February 2018, a reason why insurance companies charge high actuarial premiums is that cut-off dates for enrolment are frequently extended by states, often beyond the forecast and onset dates of the annual monsoon. "The litmus test of any crop insurance programme is quick assessment of crop damages and payment of claims into farmers' accounts directly, and from that point of view, the first year of implementation of PMFBY (2016-17) has not been very successful," the study observed.

Since October 2018, at least five states— Maharashtra, Karnataka, Gujarat, Odisha and Rajasthan—have declared a drought and sought a central assistance of over to Rs 15,500 crore. This is testimony to the ground reality that the Prime Minister's flagship crop insurance scheme has failed to provide farmers with timely and adequate cover against climate risks.

***TOP***

**Source**

## *In state, only 6,409 opt for PM's crop insurance cover - The Tribune – 7th January 2019*

The Pradhan MantriFasalBimaYojana has received a poor response in Haryana as only 6,409 non-loanee farmers have adopted this scheme voluntarily since its launch in 2016.

As per the 2011 Census, there were 16.37 lakh farmers' families in Haryana and now, as per the authorities, the number has increased. The scheme, however, also witnessed a downfall in the enrolment of the loanee farmers.

From 1,942 in 2016, the number of non-loanee farmers covered under this weather-based crop insurance scheme has reached just to 6,409 during the 2018 kharif

season. The delay in disbursing the payment to farmers is said to be the main reason for their lack of interest in the scheme.

Official data reveals, during the 2016 kharif season, as many as 7,36,853 loanee and 1,942 non-loanee farmers were enrolled under the scheme, covering 11,92,604 hectares. "The insurance companies had collected Rs 127.35 crore from farmers as premium and distributed Rs 234.23 crore."

The data shows during the 2016-17 rabi season, the number of both loanee and non-loanee farmers was reduced and it reached to 5,96,115 and 1,183 respectively, covering 9,00,720 hectares. The insurance companies had collected Rs 69.94 crore and distributed Rs 57.02 crore among farmers.

In the 2017 kharif season, the number of loanee farmers increased to 6,40,509, but the voluntary ones declined to 1,053. However, the area covered under this insurance scheme was increased to 9,79,187 hectares and the insurance companies had collected Rs 126.74 crore as premium and distributed Rs 599 crore among farmers, the data revealed.

In the 2017-18 rabi season, the number of loanee and non-loanee farmers increased to 6,96,692 and 1,285, respectively, covering 9,35,786 hectares. The insurance companies had collected Rs 82.24 crore while the distribution of claims is underway. Meanwhile, the 2018 kharif season had witnessed an improvement in both the numbers as 7,10,785 loanee farmers were registered while the non-loanees reached to 6,409. The insurance companies had collected Rs 137.91-crore premium but the settlement of claims is still under process.

Sewa Singh Arya, national vice-president, Bharatiya Kisan Union (Arya faction), said the government had fixed three to four insurance companies that had failed to provide the benefits of the scheme to the farmers on time. "The farmers should be given a free hand to select the insurance company as per their own will."

Suresh Gehlawat, additional director (extension), admitted that non-loanee farmers were showing lack of interest in the crop insurance scheme, but the department was trying its best to increase the enrolment. "Our employees are geared up to motivate the farmers for adopting the scheme as it is beneficial for them in case of any loss or damage to the crop due to any calamity," he said.

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**Source**

## MOTOR INSURANCE

### *Huge damage to car in accident? Revealed, how insurers pay for Total Loss – Financial Express – 9th January 2018*

When it comes to the settlement of claims, the car insurance policyholders are often at the receiving end.

This is more pronounced at the time of making a claim in case of motor vehicle 'total loss' (TL) or a theft claim. However, going by the recent Orders passed by the Insurance Regulatory and Development Authority of India (Irdai) against most of the general insurance companies, the policyholders can heave a sigh of relief and be forewarned not to let the insurers take them for a ride.

**The rule in case of Total Loss**

According to the General Regulation 8 of India Motor Tariff, 2002, while settling motor claims, "For the purpose of Total Loss (TL) / Constructive Total Loss (CTL) claim settlement, this IDV will not change during the currency of the policy period in question." The

rule further states that, "The IDV shall be treated as the 'Market Value' throughout the policy period without any further depreciation for the purpose of TL / CTL claims." In case of a total loss of a vehicle, the overall cost of repair and retrieval of the vehicle exceeds 75 per cent of the Insured Declared Value (IDV) of the vehicle. In case of a constructive total loss of the vehicle, the total cost of retrieval of the vehicle exceeds its current market value.

Going by the Irdai's Jan 3, 2019 Order and a few other such Orders against other insurers in the past, it appears that it has been an industry-wise concern. And, that is why IRDAI states – "On receipt of a few complaints relating to General Insurers settling lesser amounts than the IDV in case of motor vehicle total loss / theft claims, the Authority had called for motor claims data from General Insurers."

**Submissions made by the Insurer**

According to the insurers, reduction of IDV happens in some cases due to non-standard settlement of the claim owing to delay in claim intimation and delay in filing FIR and non-submission of keys. Most insurers have documented guidelines for settlement of claims on non-standard basis with a reduction limit up to 25 per cent or minor deductions wherein there is deficiency or breach of policy conditions, which are determined according to the merits of the claim and the particular deficiency or shortfall in requirements.

**Irdai's take**

Irdai doesn't seem to have fully satisfied with the submissions that are made by the insurers. Primarily, Irdai seems to have the opinion that rules have been "violated to the extent of having been non-transparent regarding deductions made from the claims." Here are Irdai's observations – "This, however, does not offer any ground for the Insurer to deduct amounts from the claims with the claimants and arriving at 'negotiated amounts'.

There is no transparency about what can constitute a non-standard claim and the amounts deducted from the IDV in various cases seem to have been made arbitrarily." In the interest of policyholders, the regulator has often penalised the insurers in order to make them comply with the rules in letter and spirit and not let the policyholder suffer.

**Policyholder watch outs**

At times, especially while renewing the policy, a car owner is tempted to increase the IDV even if there is a slight increase in the premium. This may actually go against the policyholder at the time of a claim. As can be seen in the submissions made by insurers to Irdai, the insurers accept that the settlement amount was reduced due to gross overvaluation of IDV at the time of underwriting.

Finally, it is important to fully understand the implication of signing the consent form and then act. Most insurers will try to negotiate and make an attempt to settle the claim after taking the consent in writing by a separate declaration or full and final discharge voucher. Now that you know the rules, let the insurer treat you fairly.

***TOP***

**Source**

## *All you need to know about endorsement in policies for car insurance - The Economic Times – 4th January 2018*

If the policyholder needs to change the scope of the existing policy, they can approach the insurer to make the required changes by way of an endorsement.

Driving a car on the road requires a valid car insurance policy but more than that, it has to carry all the correct details of the car. At times, there could be certain changes which need to be incorporated in the policy document. Such changes are reflected as endorsements in the policy document.

Technically, an endorsement is a document that incorporates amendments and additions in the existing terms of the policy. It is a written evidence of an agreed change to the policy. If the policyholder needs to purchase more coverage, add riders or change the scope of the existing insurance policy, they can approach the insurance company to make the required changes by way of an endorsement.

An endorsement can be issued at the time of purchase, mid-term or during the renewal period. It can be used to provide additional benefits and cover (for example, legal liability to driver) or to impose restrictions (say accidental damage deductible). Subsequently, any amendments regarding policyholders' documents such as change of name, change of address, change of vehicle, etc. can also be implemented by way of an endorsement.

Here are some important changes that can be endorsed in the policy document:

" A change/correction in the engine number
" A change/correction in the chassis number
" A change/correction in the Registration Number
" A change/correction in your name
" A change/correction in your address
" A change/correction in your mobile number and/or your email id
" An inclusion of a CNG/LPG Kit
" Including or increasing the voluntary deductible
" A change/correction in passengers covered or the seating capacity of your vehicle
" A change/correction in your car's variant
" A change/correction in your car's cubic capacity
" A change/correction in the make and model of the car
" Any correction in the No Claim Bonus
" Any premium mismatch
" Change in the details of the nominee
" A change/correction in your vehicle's fuel type
" A change/correction in the vehicle's year of manufacturing
" A change/correction in the Insured Declared Value (IDV) of your vehicle
" A transfer of ownership
" Any addition or deletion of electrical accessories

To bring into effect the endorsements, one can submit a request letter to the insurance company along with the documents to substantiate the change. The insurance company will then make the necessary changes after checking for the correctness of the changes sought.

For the following endorsements, these are the documents required:

- Addition of Bio-fuel - Duly endorsed RC copy
- Addition of Cover - RC Copy / Invoice Copy in case of New Vehicle
- Change in Cover - RC Copy / Invoice Copy in case of New Vehicle
- Nominee Modification - No documents required

In ownership transfer endorsements, if transfer date can't be ascertained from the RC/notarised sale deed, then pre-inspection is mandatory for such cases. Where ownership transfer request date is within 14 days of transfer date, pre-inspection is not required.

**Impact on premiums**

Some endorsements may also call for an increase or decrease in the amount of premium. For instance, if the cubic capacity of the vehicle changes or if the make and model of the vehicle is upgraded, the premium will increase and you will be required to pay an additional amount of premium. On the other hand, any deletion of electronic accessories or addition of safety devices may also reduce the premium. The decision to increase or decrease the premium and the relevant amount rests with the company.

**What you should do**
If there are material changes in your car ownership or make or model, it's important to get them updated through endorsements. Failing in doing so may result in repudiation or a delay in the claim settlement process.

***TOP***

**Source**

## *When not to file a car insurance claim - The Economic Times – 4th January 2018*

It should be remembered that the NCB discount is only given on the 'Own Damage' portion of the total premium and not on the 'Liability' portion.

Accidents can occur anytime and anywhere. When it comes to accidents related to one's car, the insurance cover comes to mind. However, making an insurance claim after an accident can strip one of the benefits of no-claim bonus (NCB) accrued on the motor cover.

There is no hard and fast rule for filing a claim and one should work out on one's own as to how much of benefit will be lost if a claim is filed.

Whether to file a claim or not will largely depend on these four important factors - The quantum of loss, the impact on NCB, applicable deductibles, and future premiums. And most industry experts advise against filing a claim for smaller amounts. Here is why you should avoid doing this.

**Impact on NCB**
A no claim bonus (NCB) is a discount normally given by insurers on the renewal premium at the end of a claim-free year. This NCB starts at 20 percent at the end of the first claim-free year and increases steadily with every claim-free year to a maximum of 50 percent. Even if a single claim is made, the NCB goes back to zero, which is another reason for not making small claims.

**Role of deductibles**
Further, most car insurance policies specify an amount called 'deductible' or 'excess', which is the portion of any claim amount that the insured will have to compulsorily bear oneself. In case of a claim, only the balance after subtracting the 'deductible' amount is payable, subject to other deductions such as depreciation etc. Thus, it is pointless to claim small amounts which are close to or less than the 'deductible' amount specified in your car insurance policy as you would gain little to nothing.

Let us take an example. Assume that your policy has a deductible of Rs 2,000 and the NCB discount on the policy works out to Rs 6,000. In this case if you make a claim of, say Rs 4,000, you will have to pay Rs 2,000 of the claim bill yourself and also lose the NCB discount of Rs 6,000. Here it makes monetary sense to make a claim only if the claim amount is well over Rs 8,000, say Rs 13,000 plus. This is because the outgo from your pocket plus loss of NCB discount would equal Rs 8,000. However, if the claim amount is say Rs 10,000, then it may be wiser to get the car repaired at your own cost and forgo the claim. Work out the numbers and see what suits you.

Further, filing insurance claims frequently adversely impacts the claim history of the insured. The quantum of increase in renewal premium rate that may result from repetitive claims depends on the nature of the claims and also varies from insurer to insurer. Here 'nature of claim' refers to whether the damage to the car is your fault or that of someone else (third-party). If someone hits your car from behind, prompting you to file a claim, your rates are unlikely to be raised in normal circumstances. However, if the fault is yours and such claims are frequent, then it would probably be difficult for you to escape a rate hike.

However, if the accident is due to the fault of a third-party, the NCB on your policy is not impacted. So, while doing one's calculations, it should be remembered that the NCB discount is only given on the 'Own Damage' portion of the total premium and not on the 'Liability' portion.

Therefore, a good rule to follow is to only make a claim in the event of a big loss and avoid filing it in case of little mishaps, such as a minor dent on the bumper or the body of your car. Discussing the claim with your insurance agent before you file a claim also helps.

TOP

Source

## REINSURANCE

### *India: New reinsurance regulations will support risk management by insurers – Asia Insurance Review*

New reinsurance regulations that took effect on 1 January are credit positive for the Indian insurance industry because they will improve Indian insurers' access to a broader reinsurance base, which will support their management of underwriting risk and performance, according to Moody's Investor Service.


On 12 December 2018, the IRDAI published the Insurance Regulatory and Development Authority of India (Re-insurance) Regulations, 2018.

Under these new regulations, the Indian reinsurers retain the first right of refusal. Cedants have to seek terms from all Indian reinsurers which have undertaken reinsurance business continuously during the immediately preceding three years and from at least four foreign reinsurance branches, allowing the non-Indian reinsurers to compete for business on equal terms with Indian reinsurers.

Previously, Indian reinsurers have the first preference and right of refusal, but the only active India-based reinsurer is state-owned GIC Re. Non-domestic reinsurers were offered business if only Indian reinsurers refused the business.

The IRDAI's new reinsurance regulations are another step towards liberalising the reinsurance market which, according to industry estimates, totals INR450bn ($6.3bn) to INR500bn. They will provide local insurers broader access to foreign reinsurers and encourage the latter to sharpen their use of reinsurance as a risk management tool with the aim to reduce P&L and balance sheet volatility. Currently, foreign global reinsurers present in India include Gen Re, Munich Re, Swiss Re, SCOR, AXA France Vie, RGA Re, XL Re, Hannover Re and Lloyd's of London.

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Source

## OPINION

### *Multiple gaps in implementing flagship crop insurance scheme – Mint – 9th January 2018*

Instead of appreciation, the Modi government’s flagship schemes for crop insurance, the Pradhan MantriFasalBimaYojana (PMFBY) and Restructured Weather Based Crop Insurance Scheme have attracted criticism even though the PMFBY is substantially superior to crop insurance schemes under previous governments.

There are five major stakeholders in crop insurance. They are farmers, banks, central and state governments, and insurance and reinsurance companies. Farmers would like prompt payment of claims if their crops are hit by a calamity. They would also like to know the name of the insurance company and the premium paid by them.

At the ground level, the scheme is implemented by banks that have to deduct the premium and remit it to insurance companies. Banks also have to provide detailed data of insured farmers to insurance companies.

The central government makes the rules for the scheme while the state governments do all the important work of tenders and crop-cutting experiments (CCE), etc. They would like the actuarial premium to be low as they have to pay premium subsidy in excess of the farmers' share, which is just 2% for kharif crops, 1.5% for rabi crops and 5% for annual commercial and horticulture crops.

The insurance companies would like to receive the insurance premium in time and the insurance claims to be low. They would also like CCEs to be transparent.

The reinsurance companies provide underwriting and financial support beyond the capacity of the insurance companies. They decide the financial terms and conditions which the insurance companies have to follow. In 2017-18, about 33% of the total premium went to reinsurance companies. They would like the governments to follow the guidelines issued by the government itself.

In 2017-18, the central government launched an insurance portal which sought to capture information of each farmer. The portal captures Aadhaar numbers of the farmers so bogus cases of insurance can be eliminated. However, the farmers are still not being informed about the premium deducted and the insurance cover provided to them.

The objective of getting lower actuarial rates in tenders, however, depends on a number of factors, including policies of the government. In September 2018, the government had issued new operational guidelines which give thrust to enrolling more non-loanee farmers and to settle the claims within 21 days. While they seek to bind the insurance companies, a similar dispensation for state governments is missing and there are no penalties for wrong or delayed CCEs.

In fact, there are several conditions in the new guidelines which are likely to result in higher actuarial rates. For example, the states can now provide add-on coverage for crop loss due to attack by wild animals. This additional risk alone will invite higher premium. The cut-off date for taking insurance in most states is 31 July for the kharif season. By this time, the pattern of monsoon is well known, especially in south Indian states (monsoon hits Kerala on 1 June). In the event of deficient monsoon, the state governments are likely to push for increasing insurance coverage so that the farmers can get the claim. Ideally, the centre should insist that state governments finalize tenders before the onset of monsoon in Kerala so that the companies are not able to factor in the behaviour of monsoon.

In 2017-18, out of the total premium of Rs25,173 crore, farmers paid Rs4,317 crore. Another freebie in the form of zero premiums from farmers may leave even smaller amount in state budgets for investments in agriculture.

At the end of the day, more investment is needed in agriculture and food processing to make farming viable.

*(The writer, Siraj Hussain is former secretary, agriculture to government of India. He is currently Visiting Senior Fellow at ICRIER)*

***TOP***

**Source**

## *Here's why you need to make full disclosure to health insurer – Financial Express – 8th January 2019*

We are seeing steep escalation of medical costs making it unaffordable for many to opt for quality treatments. Health insurance plays a critical role in case of any unforeseen medical exigency. To have an appropriate and uninterrupted health cover, it is vital for you to make proper disclosure to your insurance company.


Here are the stages during which you need to make proper declaration to your health insurer.

**Purchase of health insurance**

An honest proposal from your end is quite important for the insurance company. The declarations made by you on your health status in the proposal form is the basis on which your insurance company will underwrite your policy, that is, gauge the risk and calculate the premium to cover that risk.

Hence, while buying your health insurance policy, it's important for you to make full disclosures, especially about your health and not just in the present, but also in the past.

How healthy you are or were in the past is a determining factor for the insurance company. For instance, if you had any ailments, say around three to four years before buying the policy, it is considered a pre-existing ailment.

Insurers usually apply waiting period or choose to load premium for the pre-existing ailment. Concealing any such facts will amount to misrepresentation or non-disclosure of material facts. Such act may mean that insurer may reject your claim and you will be left with no cover when you need the most.

**At the time of claim**

There are two ways in which you can make health insurance claim—cashless claim or reimbursement. In case of cashless claim, the insurer and hospitals are connected through a seamless network where the hospital shares all the medical reports and bills with insurer.

The policyholder has very little role to play here. However, in case of reimbursement, the policyholder needs to fill the claim form and disclose all the details about the medical treatment.

Necessary original documents like diagnosis report, medical bills, health check-up reports, treatment details, etc., need to be shared with the insurer based on which the claim will be paid. Before lodging the claim, it is essential to be aware of what is covered under your policy terms and conditions.

Especially, whether or not your medical condition is related to pre-existing ailment, which may have a certain waiting period for it to be covered or may be excluded for coverage by the insurer.

**At the time of renewal**

It is always advisable to increase your sum insured and revisit your coverage at the time of renewal keeping in mind medical inflation and your medical needs. If you wish to do so, the insurance company will review your claims history.

Be honest about the medical details furnished at the time of renewal to avoid any hassle when you need to make a claim in future.

It is also your responsibility to disclose any health history of the past one year during which you held the policy with the insurer and for which you may not have claimed. Such history is important for the underwriter to decide the increase in sum insured and change your coverage.

It is always advisable to be safe and disclose the facts about your medical history, than be sorry when the policy will be cancelled due to non-disclosure of material facts. Read policy terms and conditions carefully, make full disclosure so that when you or your loved ones are unwell you can focus on nurturing yourself or your loved one back to proper health rather than being worried about paying out of your pocket for any non-disclosure to your insurance company.

*(The writer is head, Health Administration Team, Bajaj Allianz General Insurance)*

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Source

## *Health insurance customers can hope for a better tomorrow: Here's why - Business Standard – 5th January 2019*

In a compelling case for universal health coverage, the World Bank argues that it "allows countries to make the most of their strongest asset: Human capital." This idea has very real relevance for India, which will have the world's largest workforce by 2027. To harness our demographic dividend for economic growth, we need a healthy workforce. It follows that all Indians must have access to the health services they need, without impact to their productivity or a crippling financial burden.

To that end, 2018 was a pivotal year for health insurance in India. Ayushman Bharat, the world's largest public health insurance scheme, will benefit an unprecedented 500 million Indians. With forward-looking regulation, The Insurance Regulatory and Development Authority of India (IRDAI) paved the way for greater inclusion, bringing treatment of HIV and mental illnesses within the ambit of health insurance. Going into 2019, these measures and other emerging trends will unlock value for millions of customers, while simultaneously increasing penetration of health insurance in the country. A look at the shifts I see panning out in 2019.

**Increasing inclusion with customer-focused regulation**

Customers have often complained about the complex terminology in health insurance policies. That is set to change in 2019. An IRDAI working group has made significant recommendations on standardisation of exclusions in health insurance. A proposed change is to limit the number of illnesses and diseases that remain outside the ambit of insurance coverage. As per another key recommendation, after 8 years insurers will not be able to deny a claim based on non-disclosures at the time of taking the policy, thus protecting the interests of customers. Standardisation of exclusions would benefit customers on many levels. It would regulate insurance contracts through uniformity in policy wordings, minimising differences across products and insurers. It would lead to more comprehensive products. Most importantly, it would improve the customer experience, with policies that are unambiguous and simple to understand.

Through 2018 the IRDAI stepped up efforts to bring greater inclusivity and make health insurance more comprehensive. The impact will follow in 2019, as insurers solve challenges to implementation. For instance, while data is available on the mortality rate of HIV in India, it is inadequate on morbidity, making it challenging to set premiums. While insurers might initially introduce supplementary coverage for HIV and mental illnesses, stand-alone products will emerge with experience over a longer period of time.

**Towards a tech-powered value proposition**

Wearable tech and the Internet of Things (IoT) are poised to upend health insurance in India. Wearables can capture data that lead to actionable insights – from monitoring the heart rate to tracking blood pressure and sugar levels. Within the ambit of data privacy guidelines, insurers would be able to leverage

insights to develop products that are tailor made for the customer. This could be based on age, geography, current health condition, family history and exercise regimen, among other factors. Since insurers would know the risks associated with a customer's lifestyle, they would be able to design coverage best suited to that customer's needs, at an appropriate price.

Beyond being built into the product, wearables and IoT will also have applications at the onboarding stage. Monitoring a customer's blood glucose while underwriting the risk, would guide an insurer to offer a diabetes product that is customized and priced fairly for that customer. I also see wearables powering the growing shift from reactive to preventive care, as customers proactively look to stave off chronic illnesses.

Insurers will increasingly leverage technology in the near future, to create products that are specific in nature. This could be at a disease level, that is, products meant for cancer, cardiac ailments, diabetics, or customised for particular customer segments – like products that reward customers for a healthier lifestyle.

The IRDAI recently announced its "regulatory sandbox approach" towards fintech innovations, geared at bringing greater efficiency, managing risks better and enhancing value for customers. This will further encourage break-out thinking within the industry.

**Delivering value and convenience with service to match**

As customer expectations evolve, the breadth of expenses covered – from OPD to diagnostics, pharmacy and preventive health check-ups – will expand far beyond hospitalisation. While creating Go Active, which focuses on everyday health and fitness, our research revealed that customers wanted everyday convenience baked into the product.

They asked for overall expenses towards healthcare – 65 per cent of expenses are typically out of pocket – to be taken care of by insurance. Insurers are accordingly developing new models and ecosystems – driven by technology and data analytics — to cover a broader spectrum of expenses that deliver this convenience.

Customers want insurers to simplify the healthcare journey for them, and this will guide the direction of products in 2019. The growing breed of tech-savvy Indians put a premium on their time and wants regular health activities such as scheduling doctor's appointments or personalized health coaching to all be available on the go!

In a six city survey we conducted, more than a third of potential buyers said they were willing to download a health insurance app. Based on customer insights our health app built in real-time appointments with doctors, payment on a cashless basis, and online ordering of medicines – all in one place, accessible on the go and with just one click.

The health insurance industry grew by 40 per cent this year. This growth was largely driven by the launch of Ayushman Bharat, which has contributed hugely to the rising awareness about health insurance. Inclusive regulation will further level the playing field, bringing health insurance to many more Indians.

Insurers now have newer opportunities to expand their services by offering customers tremendous value, convenience and differentiated services, wrapped in a personalised experience. In this new landscape, I see the role of the insurer transforming from facilitator and provider to partner, for a new generation of customers.

*(The writer is MD & CEO, Max Bupa Health Insurance)*

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**Source**

## INSURANCE CASES

### *Denied claim, blind banker files plaint – The Times of India – 9th January 2019*

A 63-year-old banker from Bengaluru, who was denied health insurance owing to his blindness, has complained to the chief commissioner for persons with disabilities, New Delhi, against the insurance company.


RR Nagar resident TR Raghu Kumar suffered from optic nerve atrophy (ONA), a condition of permanent vision loss caused due to damaged optic nerve, in March 1991. "I suddenly lost my eyesight; I woke up one morning to know that my vision has been affected. This can happen to anybody," he said.

He bought a health insurance policy from Religare for Rs 5 lakh and paid one-year premium of Rs 16,597 on October 26, 2018. "I had declared my condition in the insurance proposal and submitted a copy of the medical certificate," he added.

A month later, Raghu received a call from the company stating that his insurance was rejected as he was totally blind and the premium was refunded. Alleging discrimination, Kumar wrote to the commissioner for persons with disabilities on November 29.

Responding to an email query, Religare said Kumar's insurance proposal was declined due to ONA. "ONA can be caused by multiple reasons and not limited to trauma (including stroke), tumour, and decrease in oxygen or blood supply, infections, disorders or hereditary reasons. There was no ascertainment with regard to the cause in his proposal. We cover persons with any kind of disability (physical/visual/hearing), provided there's no co-existing health condition that's in contravention with our medical underwriting guidelines," Religare said.

However, Kumar said the company never asked him anything pertaining to the cause of ONA. "I've submitted the disability certificate which is self-explanatory. The company collected money for the premium and rejected my proposal without raising any question. This is nothing but discrimination against a disabled person," he added.

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**Source**

### *Medical insurance must cover MRI, pre-operation expense: Consumer panel – The Times of India – 7th January 2019*

If you pay from your pocket for tests before a surgery, you are entitled to a refund from your mediclaim insurance company. This order favouring policy holders was passed recently by the state consumer commission. This includes expenses on an MRI scan done a month prior to the surgery, says the order. The consumer commission also specified that expenses incurred on consultation and pre-surgery tests cannot be refused just because the policy holder had spent the amount 30 days before the surgery.


The commission brought to book New India Assurance Company Limited for having rejected a reimbursement claim made by a Dombivli resident, V Sridhar. It

pertained to pre-surgery and non-medical expense (gloves for medical use) incurred for his son's knee surgery.

Sridhar's son had been hospitalised on April 18, 2012. While Sridhar had claimed Rs 58,000, the insurance company approved around Rs 49,000. The commission's order states that the company will now have to pay the entire claim of Rs 58,000 along with Rs 35,000 as compensation.

In his complaint, Sridhar had stated that the mediclaim policy covered his son, wife and himself for Rs 1 lakh. The complaint said that when he first submitted his claim, the company had agreed to honour it only to the extent of Rs 17,852. Sridhar said that when he made inquiries, the company agreed to reimburse Rs 30,856, but refused to compensate for expenses prior to hospitalisation and non-medical expenses.

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## IRDAI CIRCULAR

IRDAI Annual Report 2017-18 (Hindi & English) is available on IRDAI website.

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Terms and conditions of life products for F.Y. 2018-19 is available on IRDAI website.

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## GLOBAL NEWS

### *Australia: Private Health Insurance Ombudsman receives new powers – Asia Insurance review*

The Private Health Insurance Ombudsman has been given the power to raid insurers and insurance brokers to resolve complaints, under a package of reforms introduced by Health Minister Greg Hunt.

Documents obtained by *The Australian* show the ombudsman's office have already held meetings with industry representatives to explain its new powers.

As insurance premiums continue to increase and more Australians drop private hospital policies, there are concerns about affordability, and complaints from health fund members who find themselves without cover when they need it.

Health funds have been warned that investigators will raid their offices if there is a suspicion they have tried to cover up cases of members being misled or having their claims unfairly denied.

Insurers need to provide members with sufficient notice of planned policy changes. In some cases, more than 60 days' notice is required, and the wide-ranging reforms — intended to help stabilise the industry — only add to the need for insurers to keep members informed.

A spokesman for the ombudsman said it would work with stakeholders on a framework and protocols to support the use of the powers.

The ombudsman's office expects to commence inspections this year.

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## *Philippines: Govt places parametric insurance policy - Asia Insurance review*

The Philippines has successfully placed on the international market its parametric insurance policy with a maximum cover of PHP20.49bn ($391m) to provide quick liquidity to national and local governments, the Bureau of the Treasury has said.

The agency announced that with assistance of the World Bank, the programme includes coverage for national and local government assets against natural calamities including public elementary and high schools in 25 disaster-prone provinces in the country's eastern seaboard.

National Treasurer Rosalia de Leon said in a report to Finance Secretary Carlos Dominguez III that the parametric insurance policy would enable these 25 provinces and the national government to act faster and respond better to natural calamities. The policy became effective on 19 December 2018.

Ms De Leon said in addition to the reinsurers in 2017, which include Nephila, Munich Re, Swiss Re, AXA and Hannover Re, a new set of reinsurers also provided support for the cover. They are Hiscox Re, Allianz Re Switzerland, AP3 (Tredje AP-fonden) and Scor.

"With the increased market participation, we were able to achieve a tighter multiple this year compared to last year's transaction," she said.

Under the programme, the Government Service Insurance System (GSIS) provides catastrophe risk insurance coverage particularly for the Department of Education along with the 25 selected provinces.

The World Bank, through its International Bank for Reconstruction and Development, acts as the intermediary to transfer or cede GSIS risks to the global reinsurance market, thus minimising risks for the Philippine government. As the Bureau of Treasury is the designated policyholder, funds will be mobilised faster to first responders, namely, the national government and local government units.

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## *Vietnam: Robust prospects seen for life sector – Asia Insurance Review*

The life insurance industry in Vietnam is forecast to expand at over 25% this year, according to the Insurance Association of Vietnam (IAV).

IAV acting chairman, Tran VinhDuc, said, "The Vietnamese economy is expected to grow at a rate of between 6.8% and 7% in 2019. Demand for insurance, particularly life insurance, will increase as more and more people and organisations started caring about insurance products. Thus, the market will keep growing."

The association said that last year the life insurance market performed well, earning revenues of nearly VND116trn ($5bn), reported Vietnam News Agency. Of this, VND88trn was from premium income, an increase of 33%, and the remaining VND28trn was from investments, a 30% increase.

"Life insurers' financial capacity improved with total assets rising 25% to VND302trn," Mr.Duc said.

Life insurers settled claims of more than VND18.6trn in 2018, up by 17%.

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