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QUOTE OF THE WEEK

"Leaders must be close enough to relate to others, but far enough ahead to motivate them."

John C. Maxwell

INSIDE THE ISSUE

INSURANCE TERM FOR THE WEEK

Underinsured Motorist Coverage

Underinsured motorist coverage is an addition to your auto insurance policy. It protects you if you're in an accident involving someone who doesn't have sufficient insurance of their own. In an accident, the insurance of the at-fault person is supposed to compensate the other injured person. If the at-fault party's policy has a limit below the cost of the damages, the injured party's underinsured motorist coverage would cover the rest.

Underinsured coverage is not the same as uninsured coverage, which covers cases in which the at-fault driver has no insurance at all, though the two types may be bundled together. A handful of states require underinsured motorist coverage, while more require uninsured motorist coverage.

INSURANCE INDUSTRY

Insurance companies seek early implementation of IFRS from govt - Business Standard – 28th May 2021

Insurance companies have sought early implementation of the International Financial Reporting Standards (IFRS) from the government. The move would help insurers in India in shifting towards a risk-based solvency and supervision regime. The request was made when the government had sought suggestions on amendments to the Indian Insurance Companies (Foreign Investment) Rules, 2015, that impose certain restrictions on insurers with foreign investment over 49 percent. The industry has been seeking clarity on the implementation of IFRS, as its timeline has been deferred by the Insurance Regulatory and Development Authority of India (Irdai), said a senior government official. “Insurance companies have been keen on the early implementation of IFRS. It will not require them to maintain or reserve anything extra,” he added. The adoption of the new accounting standards will help in moving towards a risk-based solvency and supervision regime, which will be “easier and attractive” to foreign investors, said the official. This will further boost foreign capital in the insurance sector, he added. The government is likely to take up the issue with Irdai.

Currently, India follows the old solvency standards where insurers have to hold a percentage of reserve as capital. Insurance companies have to maintain a solvency margin - the extent to which insurer’s assets exceed its liabilities - of 150 percent, irrespective of the risks the promoter entities carry or the liabilities that arise from the pricing of policies. If insurance companies or their parent units are listed abroad, they need to have an IFRS balance sheet, said Rajesh Dalmia, a partner at EY India. Foreign companies that have joint ventures (JV) with Indian insurance companies have to maintain two sets of balance sheets - IFRS as mandated by their respective countries, and another especially for their JV in India, said Dalmia.

“Early implementation of IFRS 17 is advisable. It will offer a true reflection of an insurer’s balance sheet. Right now, life and non-life insurance acquisition expenses pinch balance sheets, whereas globally, these expenses can be deferred,” said Dalmia. Implementing global practices in the country will help in attracting more investments from foreign players, said Vikas Gupta, a partner at Nangia & Co LLP. Since new norms require foreign-owned insurance companies to maintain a solvency margin of 180 percent if they declare a dividend, the shift to IFRS will help foreign investors with easier repatriation of profits,

added Gupta. However, the government official quoted earlier said there are many challenges in the implementation of the new accounting standards. Although some major players are ready for the transition, the industry-wide application of the new accounting standards is slow, added the official. "Although India can't implement the new accounting standards as early as the global deadline of January 1, 2023, it shouldn't be any later than April 2025," said Dalmia. This will help in establishing comparability among insurers the world over, and their balance sheets will give potential investors a true picture, he added.

(The writer is Nikunj Ohri.)

TOP

The Sector Awakening: Liberalization of FDI in insurance to 74% - The Economic Times – 26th May 2021

The Indian insurance sector has been parched for committed funds for years now. For a sector with alarmingly low market penetration, increase in the FDI cap has the potential to benefit the economy, the sector, insurance companies and also, ultimately the consumers. The consistent and multiple initiatives of the Insurance regulator, the IRDAI also seem highly promising for the growth of the sector.

A thriving insurance sector offers an important source of funds for multiple other sectors and serves as a pillar of the economy. Indian consumers currently have limited options while choosing a policy. India has less than 60 insurance companies (compared to close to 6000 in the US). More players entering the market would provide competitive price and better options for corporates and individuals to insure risks.

The foreign investment limit in the Indian insurance sector has been liberalized to 74%, a much awaited change. In several cases, foreign partners of existing Indian insurance companies have risked sharing their expertise with the hope of securing proportionate equity incentive and more control. This change is likely to provide the needed impetus to the Indian insurance sector through investment by existing and new players.

Unlike in most other sectors, liberalization of foreign investment limit in an insurance company requires an amendment of the law (required to be passed by both houses of the legislature). The aforesaid amendment took effect on March 25, 2021 subject to such conditions and manner, as may be prescribed. For the change to be effective, an amendment to the exchange control regulations and a number of changes in the regulations issued by the insurance regulator (the IRDAI) are yet awaited. Indian banks have historically been benefactors of insurance companies in India through equity investment. Despite consistent advice from the RBI to banks to reduce insurance exposure, a few banks continue to hold over 50% equity in their respective insurance arms. The current liberalization proposal will provide a viable opportunity for banks to exit/ reduce exposure.

The Government has also formulated a framework to safeguard against excessive foreign control through an amendment of the Indian Insurance Companies (Foreign Investment) Rules, 2015. The rules remove the requirement for Indian insurance companies to be "controlled" by Indian partners. The rules have a clever proposal with respect to governance. Indian residents are required to form (a) majority of the directors, (b) majority of the KMPs and (c) atleast one of the following – chairman of the board, MD or CEO. These positions are proposed to be filled by Indian residents and not nominees of the Indian resident shareholder/s. Further, the board is required to have 50% independent directors (or 1/3rd if the chairman is an independent director).The rules also propose tightening of the requirement to maintain solvency (an insurer with over 49% foreign investment is required to retain at least 50% of the

net profit for a financial year (FY) in its general reserve if, for such FY, dividend is paid on equity shares; and at any time during the FY, the solvency margin of such company is less than 1.2 times the control level solvency of 150% (i.e. 180%). The proposed safeguards under the rules seem fair and practical.

A recent circular of the IRDAI that consolidates 28 regulations promulgated through the last two decades offers an insight on the phylogeny of insurance regulation in India. The regulatory framework now offers different forms of capital, opportunity to consolidate (through amalgamation) and access public capital. The IRDAI has recently also permitted insurers to invest in debt securities of InVITs and REITs subject to prescribed thresholds and notified the extension of its sandbox regulations (regulations aimed at promoting innovation in insurance products) by two years.

Simplification of processes and broad outlook of the regulators have historically helped in increasing the ease of doing business and encouraged talent across the globe. The IRDAI Chairman has in a recent message encouraged the industry to recognize the potential and identified factors likely to transform the sector, including Indian demography, potential of high economic growth and low penetration level.

TOP

LIFE INSURANCE

Embedded Value: New areas of insurance unfold in Covid-19 pandemic - Financial Express – 28th May 2021

The entire world is in the midst of a catastrophe triggered early last year by the Covid-19 virus. The financial and physical health of all stands unpredictable. In such a scenario, insurance is the best rescuer. Those who are protected with suitable health insurance plans can hope for best possible treatment and meet their medical expenses without their own finances being adversely affected or depleted. Similarly, those who have taken adequate life insurance for themselves are leaving behind some financial corpus for their loved ones to hang on to till they are able to fend for themselves.

Financial protection

This magical protection through small monthly or periodical outgo can save lives from financial crisis. But unfortunately the trail of miseries that corona victims have been leaving behind for dependent family members scripts a very pathetic story .For this escapable plight of the people I would point my fingers towards the insurers who do not conduct their business with the commitment to provide financial protection to each eligible individual in the society through different insurance plans.

This pandemic must force the insurers to rethink their business in respect of product design, premium rates, policy conditions and privileges as also about the methods, medium and strategies to distribute the products in the market to achieve full coverage for all the eligible individuals. Selling insurance is not just a business to garner huge profit by denying rightful benefits to the insured persons by exploiting the fine print while settling claims. Selling insurance is a kind of social responsibility which demands a missionary zeal to serve the people individually and the society at large.

On the otherhand, the pandemic has created the need for different variants of insurance too. During lockdowns people have lost jobs, partially or fully lost their income, entrepreneurs have faced partial or full business interruptions leading to suspension of production andeven complete or partial suspension of demand. Such a scenario has caused defaults in EMI payments and accentuated the financial hardship when one or more family members have fallen sick due to the corona virus necessitating hospitalization or even prolonged treatment. All these factors emerging in the current scenario were perhaps beyond the

imagination of the insurers hence even those who adopted health insurance policy or life insurance policy have found their policies woefully deficient in nature and extent of cover.

New areas for insurance

Several new areas have emerged during the pandemic which require urgent initiative by the insurers, leading to growth opportunities as well as customer satisfaction. Health coverage during overseas trip following flight cancellation, forced quarantine at foreign locations at own cost, expense on rent for accommodation not in use, expense on vaccination, expense on preventive gears and on Ayurvedic and other immunity boosters; as also on cremation and burial.

The pandemic has pointed out the deficiencies not only in the scope of coverage but also in the nature of coverage. Insurers still design their products, delivery and service culture on the models introduced by insurers globally who have been very conservative by tradition. They do not want to innovate and risk their profitability. Current opportunities in insurtech, however, facilitate cost cutting in a big way. Hence harnessing the internet of things, artificial intelligence and data analytics can help to provide cost effective and wide ranging cover to the policyholders. What the industry needs is a mindset that recognises the opportunities provided by the pandemic to look at its business and products very differently. The pandemic has not only brought to surface the deficiencies but also the opportunities.

(The writer is Kamalji Sahay, former MD & CEO, Star Union Dai-ichi Life.)

TOP

PMJJBY benefit can be availed by nominee in case the insured dies from covid – Live Mint – 26th May 2021

The government-backed Pradhan Mantri Jeevan Jyoti Bima Yojana (PMJJBY) is a one-year life insurance scheme that was launched around six years back. The insured's nominee gets ₹2 lakh payout upon death from any cause. If you know someone who has lost a family member, especially the breadwinner, due to covid-19, ask the family to check if the deceased had enrolled for the scheme. For a family that lost the breadwinner, such schemes can help provide some financial stability in the interim.

The scheme is available to individuals aged between 18 and 50 years and hold a savings bank account. The life cover is up to 55 years. Such depositors should have consented to join the scheme and permitted the bank to auto-debit the premium from the bank account. The policy must be renewed every year, and the cover is from June to May. The cover commences from the date of account holder's request and ends on 31 May of next year. The annual premium is ₹330 if you sign up between June and August.

According to ICICI Bank's website, the premium reduced to ₹258 if the person signs up between September and November, ₹172 between December and February, and ₹86 between March and May. Once signed up, the following year's premium will be ₹330, and the bank will debit it between 25 May and 31 May.

The cover will be terminated under three conditions—the person attains the age of 55, the account is closed with the bank if there's insufficient balance for debiting the premium, and if the person has the insurance from different banks, the cover will be restricted to ₹2 lakh. The cover from other banks will be terminated, and the premium will be forfeited. If you have a joint account, both parties can sign up for it by submitting a separate enrolment request.

TOP

Should you buy multiple life insurance policies? – Live Mint - 22nd May 2021

As people age, their responsibilities keep adding up. While a single insurance policy might suffice a 30 year old with a limited sum insured, by the time the person reaches 50, he or she might have to take care of a family of four, parents who would be senior citizens by then, and additional family members.

Often, a single policy cannot meet additional needs. In such a case, should a person purchase additional life insurance policies from time to time? If one can then how should they manage multiple policies?

It is possible to claim two or more life insurance policies, it is completely up to the policyholder/insured to figure out the insurance needs and which plan he/she should buy. Insurance companies have certain underwriting guidelines, which depend on the insured's annual income, age, and premium paying potential. Thus, based on these factors, insurance companies determine the limit (sum assured) of the insured. However, if a person is considering a second insurance policy, he or she should inform the insurance companies about the two policies and why he/she has opted for the second life insurance.

Indraneel Chatterjee, co-founder, Renew Buy Insurtech said, "While managing two or more policies, it is important to keep policies active by paying the premiums regularly. With most of the things going digital and with increased transparency in digital transactions, maintaining an e-insurance account in case of two policies can make things seamless and accessible to policyholders." Thus, taking two policies might be beneficial in many ways. With increased responsibilities of families, bigger financial needs, two insurance policies might be required to suffice the increased needs. Also, for any reason, if one claim gets rejected, the policyholder can rely on the second one.

Aatur Thakkar, co-founder and director, Alliance Insurance Brokers said that to ensure a person is adequately covered, he/she can increase his/her sum insured by taking multiple policies. You can normally make a claim from two life insurance policies up to 10 times the annual income. Besides, for the availing of claim, a nominee or family members can submit claims to multiple insurers, keeping his overall sum insured eligibility in mind.

What you should ideally do

“It is advisable to have one term insurance plan and one additional policy to take care of the additional needs which come with increased lifestyle needs and added responsibilities. One should avoid applying to multiple insurers at the same time to prevent complications and delays and should work with an insurance advisor to ensure that he or she is receiving the right policies as per his or her requirements," said Chatterjee. Echoing the same views, Thakkar said, “It is always advisable to take higher sum insured coverage at a younger age. This will ensure he gets a cheap rate per unit sum-insured. Premiums should be paid in time for hassle-free claims."

(The writer is Navneet Dubey.)

TOP

Opt for Centre’s life insurance scheme to support family amid COVID-19 worries: experts – The Hindu – 22nd May 2021

The second wave of the coronavirus pandemic across India has left people gasping for breath and running around to save their near and dear ones with no clear-cut relief in sight. Amid the increase in the number of deaths, experts have advised people to go in for the Pradhan Mantri Jeevan Jyoti Bima Yojana (PMJJBY), a one-year life insurance scheme renewable each year.

The PMJJBY scheme is available to people in the age group of 18 to 50 years who have a bank account and who give their consent to join/enable the auto debit facility. The Aadhar would be the primary KYC for the bank account.

The annual premium is ₹330 per annum, which is to be auto-debited in one instalment from the subscriber's bank account as per the option given by him/her on or before May 31, of each annual coverage period under the scheme. Risk coverage under this scheme is for ₹2 lakh in case of death of the insured, due to any reason and benefit will accrue to the nominee, according to the information on the Centre's Department of Financial Services website.

The scheme is being offered by the Life Insurance Corporation and all other life insurers who are willing to offer the product on similar terms with necessary approvals and tie-ups with banks for this purpose. The risk cover is applicable after the first 45 days (lien clause) of enrolment. However, deaths due to accidents will be exempt from the lien clause and will be paid for.

"This is a very useful life insurance scheme in the current circumstances. There is surely a lack of awareness about the product. Regulators like Reserve Bank of India and Insurance Regulatory and Development Authority of India should come together and ensure that such products are given more preference," Suresh Parthasarathy, financial planner, founder myassetsallocation.com, said.

"There is a challenge for the banks, when they push this product, some would allege mis-selling. The State governments can push the product through a campaign along with banks and also by roping in celebrities to create awareness about the product," he said.

Consumer activist T. Sadagopan echoed similar views, but said banks need to do more in creating awareness about the product especially in current times. He said banks need to send reminders about payment of renewal premiums and can set up exclusive helpdesks for claims processing. The proof required for claims settlement under the scheme are death certificate and bank statements with the premium debit proof, and a duly-filled claim form.

"While opening my account the bank duly deducted the first premium. After that they did not deduct the renewal premium, because of which my family will miss out on the benefits from the scheme. The onus is on both banks to send reminders about the premium and the Centre to create awareness on this scheme especially now," V. N. Mani, Administrative Officer, Jaya Group of Institutions said.

According to the Centre's health bulletin, there were 2,91,331 deaths in India due to COVID-19 as of May 21, till 8 a.m.

So far the PMJJBY scheme, which was launched in 2015, has seen gross enrolments of 10.32 crore and received claims of 2, 56,523 out of which 2,39,605 have been disbursed.

Mr. Parthasarathy, pointed out that for a domestic help earning ₹3,000-5000 a month, having an insurance cover of ₹2 lakh would be hugely beneficial. "Charity can begin at home, and those who employ domestic helps and drivers, can come forward to pay the premium under the scheme, like their employers providing insurance to them, which would help increase penetration of the scheme," he said.

(The writer is Sanjay Vijayakumar.)

TOP

GENERAL INSURANCE

49.1% bank deposits are not under Rs 5 lakh insurance cover: Check if your deposit is protected - The Economic Times – 27th May 2021

When a bank fails, the only respite a depositor has is the insurance cover offered by the DICGC. This cover was raised to Rs 5 lakh from Rs 1 lakh, effective from February 4, 2020.

According to the Reserve Bank of India's (RBI) latest annual report the number of fully protected accounts in banks stood at 247.8 crore at end March 2021, which is 98.1 per cent of the total number of accounts (252.6 crore). What this means that around 4.8 crore accounts do not enjoy the deposit insurance cover offered by Deposit Insurance and Credit Guarantee Corporation (DICGC).

Deposit amount coverage much lower than account coverage

As per the annual report released by RBI the total insured deposits stood at Rs 76,21,258 crore as at end-March 2021. This is only 50.9 per cent of the assessable deposits of Rs 1,49,67,776 crore. What this means that around 49.1% of the amount deposited with banks do not enjoy the DICGC cover.

While the deposit insurance cover on bank deposits has been raised to Rs 5 lakh, not all deposits are covered. Though this cover is available to all banks, they have to register for this facility and pay the corresponding insurance premium to keep enjoying the financial protection under this deposit insurance. Banks not being registered with DICGC or not paying premium are the main reasons for deposits not being covered, according to the RBI annual report. However, this can also happen in case of a higher deposit amount held by an account holder in the same right and capacity. For instance, if you hold a total deposit of Rs 25 lakh in same right and capacity then the maximum cover will remain only Rs 5 lakh and remaining R s20 lakh deposit will not have this protection.

Failure mainly in co-operative and local area banks

As per the annual report, five cooperative banks and one LAB (or Local Area Bank) were liquidated during the year 2020-21.

As per the un-audited data, the DICGC has processed claims amounting to Rs 993 crore during 2020-21 with a view to ensuring payment to insured depositors of liquidated banks under the prevailing pandemic situation. Of Rs 993 crore, the Corporation has settled claims amounting to Rs 564 crore in respect of nine co-operative banks during 2020-21.

An amount of Rs 330 crore has been settled in case of one cooperative bank in April 2021. However, the net outgo of funds towards settlement of claims from the Corporation was also lower as there was a recovery of Rs 568 crore during 2020-21.

Added to this, there was an amalgamation of a struggling private sector bank Lakshmi Vilas Bank and a foreign bank Development Bank of Singapore (DBS) during 2020-21.

Check if your bank deposit is protected

Deposit insurance provided by the DICGC covers all insured commercial banks, including LABs, PBs, SFBs, RRBs and co-operative banks. As per the report, the number of registered insured banks stood at 2,058 as on March 31, 2021. This includes 139 commercial banks out of which 43 are Regional Rural Banks (RRBs), 2 are Local Area Banks (LABs), 6 are Payment Banks (PBs) and 10 are Small Finance Banks. Apart from this 1,919 co-operative banks are also registered out which 34 are State Co-operative

Banks (StCBs), 347 are District Central Co-operative Banks (DCCBs) and 1,538 are Urban Co-operative Banks (UCBs).

Despite this there are good number of banks mostly co-operative which are not registered with DICGC to offer the insurance cover to their depositors. If you have a deposit in a co-operative bank, you need to check if it is registered for the deposit insurance.

(The writer is Naveen Kumar.)

TOP

Things to know about standard personal accident insurance – Live Mint - 27th May 2021

The standard personal accident insurance or Saral Suraksha Beema offers three mandatory base covers and three optional covers which can be chosen by the policyholder based on the requirement. The policy is offered for a tenure of one year. The Insurance Regulatory and Development Authority of India (Irdai) has directed all health insurers to mandatorily offer a standard personal accident insurance policy by 1 April. In this piece, we take a look at ten important features of the policy.

1. The minimum entry age is 18 years and the maximum age at entry is 70 years. Dependent children are covered from age 3 months to 25 years. The policy can be availed by a family on an individual basis which means that the chosen sum insured will apply to each family member separately.

2. You will get the minimum sum insured of Rs2.5 lakh and a maximum of Rs1 crore. You can choose any sum insured within these limits in the multiples of 50,000.

3. The policy has three mandatory base covers. These are death, permanent total disablement and permanent partial disablement. The policy also has three optional covers which can be chosen by the policyholder based on the requirement. These covers are temporary total disablement, hospitalization expenses due to accident and education grant

4. 100% sum insured benefit is payable on the death of the insured person, due to an injury sustained in an accident during the policy period, provided that the insured person's death occurs within a year from the date of the accident.

5. The benefit applicable to permanent partial disablement cover ranges from 1% to 50% of the sum insured payable to the insured. Loss of one entire hand, one entire foot, the sight of one eye or both ears' accounts for 50% sum insured payable. While the loss of four fingers and thumb of one hand or only four fingers' accounts for 40% and 35% sum insured payable respectively.

6. In the case of optional cover- education grant, if the insured person meets death or permanent total disability due to accident, a one-time educational grant of 10% of the base sum insured, per child, is payable to all dependent children of the insured if the dependent children are pursuing an educational course as a full-time student in an educational institution or the age of the child is not more than 25 completed years.

7. In the case of optional cover - hospitalisation expenses due to accident, the hospitalisation expenses arising due to the accident shall be payable under this cover, up to the limit of 10% of the base sum insured. Expenses related to hospitalisation, including the cost of prosthetic and other devices or equipment if implanted internally during a surgical procedure are covered under this optional cover. Further, expenses related to dental treatment, plastic surgery and all day-care treatments necessitated due to injury are covered under this policy.

8. In the case of optional cover - temporary total disablement, the cover compensates the insured person at the rate of 0.2% of the base sum insured per week if the insured person is completely incapacitated from engaging in any employment or occupation, due to accident. The minimum period of the disablement shall be four weeks, for the benefit to be payable under this cover. After completion of a minimum of four weeks, the policyholder is entitled to the benefit from the date of temporary disablement.

9. Cumulative bonus (CB), which means any increase or addition in the sum insured granted by the insurer without an associated increase in premium, is applicable only in respect of base cover. Sum insured (excluding CB) will get increased by 5% of sum insured in respect of each claim-free policy year subject to a maximum of 50% of the sum insured, provided the policy is renewed without a break. If a claim is made in any particular year, the cumulative bonus accrued will be reduced at the same rate at which it has accrued.

10. You can pay a premium on a yearly, half-yearly, quarterly and monthly basis. However, you must know that for yearly payment of mode, a fixed period of 30 days is allowed as a grace period and for all other modes of payment, a fixed period of 15 days is allowed as a grace period.

TOP

Soon risky banks to pay higher deposit insurance premium: What it means for depositors - The Economic Times – 27th May 2021

The Reserve Bank of India has said that the Deposit Insurance and Credit Guarantee Corporation (DICGC) can soon charge a risk-based premium for all financial institutions to enjoy insurance cover under the scheme. What this means is that, once this comes into effect, banks with strong risk profiles offering better risk adjusted returns on deposits like fixed deposits and savings accounts as compared to weaker banks.

"Although flat rate premium systems have the advantage of being relatively easy to understand and administer, they do not take into account the level of risk that a bank poses to the deposit insurance system and can be perceived as unfair in that the same premium rate is charged to all banks regardless of their risk profile," the Reserve Bank of India (RBI) stated in its latest annual report.

Why this was needed

The deposit insurance cover for bank depositors was raised from Rs 1 lakh to Rs 5 lakh in case the bank fails and this became effective from February 4, 2020. However, this cover is not free for financial institutions like banks as they have to pay insurance premium to DICGC to enjoy this insurance cover. Based on the risk profile of the financial institution DICGC collects premium either at a flat rate or a differentiated rate. The primary objective of a differential premium system is to provide incentives for banks to avoid excessive risk taking and introduce more fairness into premium assessment processes.

"The introduction of RBP in order to address the issue of moral hazard inherent in flat rate premium is a natural corollary. The Internal Committee on RBP (Chairman: Shri V. G. Venkata Chalapathy) undertook the risk assessment of banks, primarily based on CAMEL parameters and recommended the introduction of RBP," says the RBI report. The recent recommendations made by the Internal Committee under chairmanship of Shri V. G. Venkata Chalapathy are currently being considered by the RBI for their implementation.

Several committees in past had also recommended RBP, however, it could not be operationalised because the roll out of the process was linked with hike in deposit insurance cover. Though the insurance was raised to accommodate the rise in cover from Rs 1 lakh to Rs 5 lakh, however, the increase in the

premium rate was marginal, as it was increased to 12 paise per Rs 100 of deposits from April 1, 2020, from 10 paise earlier.

What it means for deposit holders

To implement the RBP the premium may go up further. However, risky financial institutions will have to pay much higher premium for the cover while the strong ones will be rewarded for their prudence and pay a lower premium. As mentioned above, the banks with strong risk profile will offer much better risk adjusted return to their depositors compared to those with weaker risk profile once this is implemented. So even if you are getting a similar interest rate on your deposit in a strong bank and a weak bank, it would be much better to go with the former as the return will come at a lower risk.

(The writer is Naveen Kumar.)

TOP

Needed, better home loan insurance - The Economic Times – 25th May 2021

Death brings not just emotional trauma but also, often, financial distress for the family of the deceased. It is to guard against this that the prudent often take, along with their home loan, an insurance policy that would take care of repayment of the loan, in case of the untimely demise of the borrower. The pandemic has taken many lives, including of those who showed such prudence. However, it turns out that most such policies would not kick in, in the case of Covid victims. The need is to have better designed home loan insurance products that cover all exigencies, rather than specific illnesses. The pandemic has turned the spotlight on many home loan insurance products that fail to cater to death due to Covid. Home loan insurance is designed to spare surviving family members the burden of repaying the outstanding home loan of the deceased and also protect the lenders.

Typically, life insurance covers that are bundled with home loans make provision for death regardless of illness. This is in sync with global practice. Death due to Covid also gets covered, automatically. The insurer would have to mandatorily pay the outstanding loan to the housing finance company. But that is not the case with home loan insurance products sold by general insurers. These policies cover death due to specified illnesses such as cancer or heart attack or due to personal accident, but do not cater to death due to Covid. So, insurers are likely to reject the claims for settlement of outstanding home loans of the deceased loanee.

The solution is to have better designed products. Most home loan protection schemes come with a one-time premium. Advancing the premium as part of the loan and recovering it along with mortgage payments makes sense.

TOP

Pandemic gives insurance a boost - The Hindu Business Line - 24th May 2021

The life and non-life insurance market in India is estimated to register a CAGR of around 7 per cent over the next five years. India's share in the global insurance market was a mere 1.92 per cent in 2018. Insurance penetration and density, which are the key performance indicators of the insurance industry, are especially low in India.

Further, there is a significant gap between insurance coverage and value. Insurance penetration (measured as the ratio of insurance premium paid and GDP of the country) in India, according to Economic Survey 2020-21, increased from 2.71 per cent in 2001 to a mere 3.76 per cent in 2019 — much below the global average of 7.23 per cent. The survey also highlighted that the penetration in India was particularly low for the non-life segment.

The IRDAI, since the onset of the Covid-19 pandemic, has been striving to reach insurance products and services to the people in the most convenient way possible.

The pandemic has changed the landscape of the Indian insurance industry in a big way. Over the last 10 months, business from the protection portfolio has leapfrogged. Insurance is gradually being seen as a pull, rather than a push, product. For the first time, customers are asking insurers about the right protection products that would meet their needs. Digitisation has been the key pillar in the growth of the insurance ecosystem — from marketing and policy issuance to claim submission.

Also, the way people accepted digital processes has been commendable and was a driving factor behind the growth of the industry, especially the life and health sectors The financial impact of Covid will take time to play-out and will be mostly (re)insurer specific. It is likely to depend on the circumstances of each enterprise — the classes and mix of business they underwrite, their pricing, policy wordings, and reinsurance coverages. Falling equity markets and interest rates could put pressure on (re)insurers' balance sheets.

(The writer is Satyajit Tripathy.)

TOP

HEALTH INSURANCE

Not following these 7 points will make Covid-19 claim difficult for you - Financial Express - 27th May 2021

Unexpected Covid-19 deaths have devastated families across the country. Not just emotionally, Covid has destroyed families financially as well. In times like these, an insurance cover against Covid-19 may provide some respite. But even then, making a Covid-19 claim may not be easy, considering the technicalities and complexities of insurance claim process. There are certain points that need to be considered before making a Covid-19 claim. Take a look:

1. Try choosing Network / Empanelled Hospital instead of going for reimbursement claim

According to Ankit Agrawal, CEO and Co-founder, InsuranceDekho, going to a panelled hospital helps ease the process as in that case, the hospital's dedicated Insurance help desk /TPA raises a cashless settlement request with the insurance company which also helps resolve many document and other discrepancies then and there only. Customers should avoid going to any non-listed/blacklisted hospital. In case the insured chose to avail services of non-network hospital, a prior approval should be taken from insurer by submitting the information (Test report, Medicine prescribed, Consultant cost, Nursing charges, Cost of oxygen, nebulizer etc), Agrawal suggested. Following the government's guidelines, a certain amount can only be claimed for covid patients and hospitals cannot overcharge for the same.

2. Continuous line of treatment

For Covid claim, there should a continuous line of treatment with monitoring each day throughout the duration of home care treatment. The document should be signed by the medical practitioner, Agrawal told FE Online.

3. Waiting period

Customer should be aware of waiting period, if applicable, which is generally of 15 days for Covid protection policies. Insurance company do not take any liability for illness during that period.

4. No claim on expenses incurred on verbal advise
Agrawal said that expenses incurred against a verbal advice given by doctor will not be considered (For e.g. Teleconsultation without prescription which advises bed rest and routine tests like CBC, Urine or Routine health check) This can be also classified as unproven treatment.

5. Treatment outside India
Also, no claim can be made on Diagnosis/Treatment outside the geographical limits of India.

6. Costs to be covered
Cost of maximum two covid tests as per govt approved rates will be paid. The second test should be supported by the prescription. Cost of PPE kit up to 1500 per day is payable only if a qualified nurse is hired by the insured subjected to doctor's advice.

7. Home Isolation during the covid conditions:
"The claim here also comes with an underlined condition that customer can only look for a home isolation claim if the same has been prescribed by the doctor that the patient under certain conditions has the following plan for home isolation. There are further 3 conditions that are attached in relation to the condition of the patient – Oxygen saturation, Temperature level and other associated conditions of the patient basis the govt regulations. What insurance companies are facing is that customers testing positive are self-isolating themselves and are opting for insurance claims which in turn leads to their own dissatisfaction and further chaos," said Agrawal.

(The writer is Rajeev Kumar.)

TOP

Large number of people can't get insurance benefit for want of hospitalisation, says HC - The Economic Times – 27th May 2021

The Delhi High Court Thursday said a large number of COVID-19 infected people would not be able to get insurance benefit as they could not secure a hospital bed due to the dearth of medical infrastructure and asked sectoral regulator IRDA to look into the issue. The court was also informed that effectively even black fungus infection will not be covered in COVID specific polices as they are only for 14 days period.

"As a matter of common knowledge and we can take judicial notice of the same that for about three to four weeks when the current wave of the pandemic was at its height, there was acute shortage of hospital beds not only in Delhi but in the entire country," a bench of Justices Vipin Sanghi and Jasmeet Singh said. The bench said people suffering from COVID-19 who required hospitalisation were not able to secure hospital beds, much less ICU or ICU with ventilators, and thus thousands of those who required hospital beds could not get them and had to take treatment at home with oxygen supply and other equipment.

The court noted that the insurance policies issued by various companies which have been in existence do not cover claims unless the insured is hospitalised and it appeared it is only 'corona Kavach' policy which covers home treatment. "Therefore, large number of insured people would not be able to receive any benefit under the policy held by them only because they could not get a hospital bed of no fault of their and due to dearth of medical infrastructure," the bench said.

It asked the Insurance Regulatory and Development Authority (IRDA) to discuss with insurance companies the terms and conditions under which they can be covered. During the hearing, one of the advocates suggested that existing policy holders of medical health insurance be sent messages and given an option if they want to be covered under the corona Kavach policy by paying additional premium and once it is accepted they can be covered under it and this would extend the reach to a large number of

people. "We are of the views that these are valid point placed before the court and we direct IRDA to examine these aspects and place further status report," the bench said while listing the issue for further consideration on July 14.

On being informed that COVID specified polices are for people of 18 to 65 age group, the bench said that as per data, people above the age of 60 years are more prone to coronavirus issues and excluding them will not help in the purpose of overcoming COVID-19 issues. The bench asked IRDA to consider coming up with a COVID specified insurance policy for citizens above the age of 65 years. The court noted that IRDA has taken steps to mitigate the sufferings of people on account of COVID-19, however, there are a couple of issues that it should consider.

The bench was informed by advocate Abhishek Nanda, appearing for IRDA, that in the wake of the pandemic, it has notified two policies, that is, Corona Kavach Policy and Corona Rakshak Policy and apart from them, various companies are offering other policies on individual and group basis. While corona Kavach policy covers cost of COVID-19 treatment on hospitalisation and home care, corona Rakshak policy's pays a fixed amount on showing COVID-19 positive status.

The IRDA counsel said till April 30, 26.37 lakh corona Kavach policies were issued and 4.73 lakh corona Rakshak policies were issued and added that they were available at reasonable premiums. On this, the bench said, "if you were to compare the premium collected with the amount disbursed, the premium would be much more and insurance companies are not doing any charity."

TOP

Can second Covid-19 wave lead to increased penetration of health insurance in India? - Financial Express - 26th May 2021

If 2020 was worse, ongoing 2021 looks like a nightmare. Health infrastructure not only in urban areas but even in semi-urban and rural areas has crumbled. The sheer pace of rising in the second wave of Covid-19 cases has impacted everyone in the country—in some way or the other. We have been highlighting for many years regarding the under penetration of life as well as health insurance in India. But steps taken by the government and Insurance Regulatory and Development Authority of India (IRDAI) will improve the reach of insurance products in the coming years.

The way claims have been coming in for the health insurance players and burden on the insurance companies—health insurance needs some overhaul. Once this ongoing crisis diminishes one needs to look at how to secure health insurance for the family as well as how the insurance companies write the risks. General health insurance companies have seen a surge in claims and as of May, non-life insurance companies have received 14.8 lakh claims amounting to around Rs 23,000 crore. Since the start of the current financial year only, general insurance companies have received claims amounting to around Rs 8,400 crore.

The non-life insurance industry is increasingly in fear that their balance sheet might get impacted due to the novel Coronavirus. The blow could be worse for the specialized health insurance players in India. Insurance players have long been fought prices wars to increase the premiums. The kind of claims public sector companies have seen in retail health, as well as corporate plans, are a cause of concern. Insurance companies should go for a mix of offensive and defensive actions to accelerate long term recovery efforts. Insurers should use more data analytics and artificial intelligence for claims management. At the same time increase automation for tight underwriting standard. In India, even now most of the general insurance companies are making and underwriting losses, which broadly means higher claims compared to the premiums they have received.

For example, a Chinese insurance company named, Ping and Life launched an underwriting risk model on its smart underwriting platform, with an accuracy rate of 90.8% in risk identification. In 2019, the platform served over 18 million policyholders and approved 96% of policies through automatic underwriting. The underwriting turnaround time per case was shortened from 3.8 days of manual underwriting to ten minutes, optimizing customer experiences. Why can't someone in India adopt some kind of tech models from the globe and implement them in India for its underwriting purposes?

Health insurance contributes 20% to the non-life insurance business, making it the second-largest portfolio in the industry. Indian population covered under health insurance has been relatively insignificant, but things have been improving as a number of people have been opting for health insurance over time. The PM-JAY launched by the government as part of the Ayushman Bharat initiative could increase the penetration of health insurance in India from 34% to 50%. The insurance regulator has announced various standard schemes in health insurance like Arogya Sanjeevani, Corona Kavach and Corona Rakshak.

In the second wave, we have seen that medical bills have been piling up, impacting the middle-class the most. Out of pocket expenses for Indians is one of the highest in the world. Now it's up to the policyholders to buy the health policy and not just depend on the corporate plans and for insurance companies to grow from hereon they need to adopt technology at much quicker pace.

(The writer is Rakesh Goyal.)

TOP

Things to know about reimbursement claims - Live Mint - 26th May 2021

Claiming reimbursement of health insurance for the first time can be a tedious process. There could a lot of questions that might pop up when it comes to filing a reimbursement claim. In this piece, we take a look at how you can file a reimbursement claim and receive the claim amount from the insurer. First, you must inform your insurer/Third Party Administrator (TPA) about the treatment within the stipulated time. If there is an emergency case then the intimation can be given to the insurer/TPA after being admitted.

Rakesh Goyal, Director, Probus Insurance said, "Once the treatment is done, policyholders need to collect all the bills invoices along with the exit file, discharge summary and pharmacy bills. Later they need to fill the reimbursement claim form along with an original copy of the medical documents to show it to insurance companies. Once everything is done and approval is granted by the insurance companies, the insured person will receive the claim amount in few days."

Documents required

The documents required to file for reimbursement claim are health card issued by TPA, original copy of hospital discharge summary, duly filled claim form, investigation reports (like X-rays, blood report, etc.), invoices of pharmacy/chemist supported by respective prescriptions, copy of KYC documents, and bank details for NEFT purposes.

Point to note

You must review all the documents carefully before sending them to the insurer. Also make sure you keep photocopies of all the documents such as claim form, medical bills, before sending them to the insurer. These copies will help you for future reference purposes. If any document is missing, the claim can get rejected or the insurer may ask you to submit the document as soon as possible.

(The writer is Navneet Dubey.)

TOP

How to choose the right TPA to settle health policy claims – Live Mint - 26th May 2021

If your health insurance third-party administrator (TPA) isn't proactive or does not have modern systems in place, it may not only make the claim settlement process time-consuming but also cumbersome. A TPA is a company registered with the Insurance Regulatory and Development Authority of India (Irdai) and engaged by a health insurer, which helps in providing healthcare services to policyholders, primarily claims settlement. It is an intermediary between policyholders and the insurance company.

You can choose a TPA at the time of buying the policy and if you aren't satisfied with its services, you can change the TPA at the time of renewal. However, if you don't choose while buying the policy, then the insurer will allot a TPA of its choice.

A health insurance TPA does not sell insurance policies. The key function of a TPA is to process and settle claims with the help of documents provided by the policyholders. A TPA issues health cards to policyholders that are used at the time of hospitalization and filing of claims. It also helps in maintaining the policy database, tracking claim status, among others.

Rakesh Goyal, director, Probus Insurance, said that TPAs are not responsible for claims rejection or acceptance. "TPAs scrutinize only documents, hospital bills and give the go-ahead for the claims," he said. Not all insurers use TPAs; some have in-house settlement systems in place.

TPA vs in-house settlement

There are various services and day-to-day operations of health insurers that are handled by TPAs. TPAs employ professionally qualified doctors to ensure all claims are fairly reviewed for medical treatment as well as commercial charging. TPAs have also built relationships with hospital networks to ensure policyholders get the best rates. However, since TPAs act as an intermediary between policyholders and the insurer, the settlement of the claim process can get delayed due to the negotiation between the hospital, TPA and the insurer.

Moreover, TPAs with primitive technology can also cause delays compared to an in-house claim settlement process. In the case of the in-house claim settlement process, insurers set up an entire department within their own company to act as an in-house claims processing department, instead of taking the services of a TPA.

"The most important advantage of having an in-house claim settlement process is that the turnaround time for claim settlement is faster as the decisions are directly taken between insurers and policyholders," said Goyal. Echoing similar views, Sanjay Datta, chief - underwriting, claims and reinsurance, ICICI Lombard General Insurance, said that the TPA and in-house claim settlement teams both do the same job of servicing the policyholders for claims and other services.

In the in-house claims process, the claims settlement has the advantage of leveraging the scale and investments in technology, being part of large organizations. "Also, the in-house processing team focuses on turnaround times and quality and make constant investments in technology for the same," added Datta.

How to choose a TPA

Not every insurer has an in-house claim settlement process. Hence, you may have to choose a TPA while buying a health policy. Therefore, while opting for a TPA, you must consider looking at the list of network hospitals under a TPA. Figure out which hospitals are close to your home, or you are likely to visit frequently. Then find out the TPAs engaged with those hospitals.

Compare the healthcare services offered by those TPAs online by visiting their website. Some TPAs also provide value-added services such as wellness programmes and health facilities during emergencies. Some TPAs also deliver their services through a mobile app.

According to Shankar Bali, joint managing director, Vidal Health, a TPA: “TPAs have been adjudicating claims fairly for nearly two decades. You must go with the TPA that has built robust processes, invested in technology and created efficiencies in claims processing."

(The writer is Navneet Dubey.)

TOP

Do Insurance Schemes Cover Mental Health Issues? Know All About It Here – NDTV – 26th May 2021

With the coronavirus pandemic exacting a heavy toll, there has been a significant rise in mental health issues throughout the world. While a number of people rushed to buy health insurance policies to cope with the challenges and meet the rise in sudden expenses, it is becoming increasingly important to check whether the insurance policies they bought cover mental health issues like anxiety and depression. The Insurance Regulatory and Development Authority of India (IRDAI) has mandated insurance providers to include mental illnesses under the scope of health cover via a circular in June last year.

According to IRDAI, all insurance providers must offer coverage to persons diagnosed with mental illnesses. It gave all insurance companies in the country —be it life, health or general insurers — to comply with its instructions by October 1 last year. The benefits under health insurance with mental illness cover are similar to a normal health plan that covers hospitalisation expenses, and other treatment.

Private insurer ICICI Lombard, for example, covers mental health issues in some of its policies. The company's flagship product — Complete Health Insurance Product — provides hospitalisation coverage for all declared and accepted mental health problems. It has also launched ‘Santulan', a helpline for employee mental and emotional health.

Star Health and Allied Insurance offers policies that cover in-patient hospitalisation for all mental illnesses that require hospitalisation. HDFC Ergo covers mental illness in its ‘My Health Suraksha' insurance cover. Max Bupa and Manipal Cigna also cover conditions related to mental illnesses.

According to recent research and studies, most people in the country have shown signs of frustration or anxiety at some level. The primary reason for their mental status was not able to do what they normally enjoyed doing due to the pandemic. A number of people are showing signs of panic and anxiety apart from sleep disorders. Considering all these aspects, it is important to go for an insurance plan that covers mental illnesses.

TOP

Out of pocket expenses in health policies: What you need to know – Live Mint – 25th May 2021

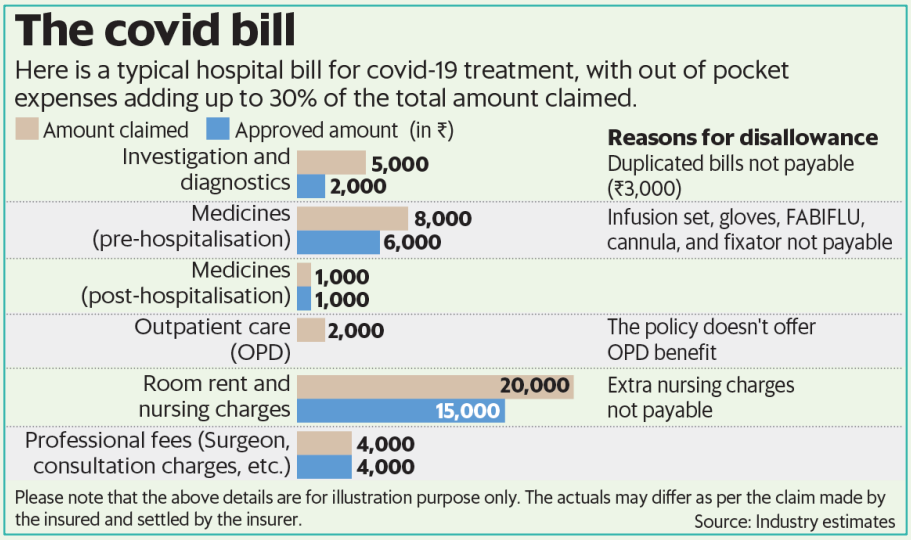
The covid-19 pandemic has sharply underlined the importance of having a health insurance policy to deal with treatment costs. But there are major gaps in the design of such policies—in costs which are not covered. Mint explains the typical gaps and how to fill them.

What are out of pocket expenses?

Out of pocket expenses are costs associated with an illness that you pay from your own pocket. They are not covered by your health insurance policy. For instance, money spent on consumables (such as medicines and PPE kits), deductibles (amount you must pay before the policy kicks in), co-payments (expenses that you must pay alongside the insurer), and sub-limits (such as insurance caps on room rent). Therefore, this is something that the insured ends up paying from his or her pocket. Media reports suggest that such expenses make up to 30-50% of the total amount spent on covid-19 treatment.

Why are these expenses so high?

Today, while providing treatment to patients, the use of personal protective equipment (PPE) kit is necessary to contain the spread of covid-19. The PPE kit normally includes a pair of nitrile gloves, a single-use coverall, glasses, an N-95 mask, shoe covers and a face shield. Since each of these items is separately considered as a consumable, there is a significant increase in the number of consumables used in the treatment of diseases such as covid-19. In addition, your insurance policy may not cover all diseases, and it may have high deductibles or sub limits such as caps on room rent.



What is not covered under a health insurance?

Generally, insurers don't provide coverage for any pre-existing diseases (PEDs) for 2 to 4 years when buying a health policy. These include high blood pressure, diabetes, thyroid, asthma and even covid-19. Other common exclusions are maternity benefits, cosmetic surgery, dental surgery, joint replacement, etc. Also, outpatient treatment isn't covered by insurers.

How can you take care of such expenses?

Careful selection will cut down your out of pocket expenses, but no insurance policy is going to take care of all expenses. So build an emergency corpus of 6-12 months of expenses in a savings account, fixed deposit, or liquid fund. Consider topping up your emergency corpus if you already have one. If you do not have an emergency corpus, you will have to liquidate assets. As a very last resort, you can borrow money, but avoid taking on credit card debt. A loan against property or a personal loan will have lower interest rate.

What can youdo to minimize expenses?

Buy a comprehensive health policy with low deductibles and exclusions to minimize the overall treatment cost. Review the insurance coverage every year and top it up as medical costs increase. While taking treatment, you should go with the network hospitals of the insurer. Ask for options for the recommended tests or procedures and over the counter medicines. Carefully check the medical bills—some hospitals may tend to overcharge for various procedures and insurers reject such claims.

(The writer is Navneet Dubey.)

TOP

All you wanted to know about co-payment - The Hindu Business Line - 24th May 2021

Most of us buy a health insurance policy to avoid shelling out money to settle unaffordable hospital bills during a medical emergency, such as a Covid-19 hospitalisation. But while we may assume that we're fully covered by our health policy, there are situations when we may have to bear part of the bill. One

such situation is when your health policy has a co-pay clause. This clause, which is often buried in the fine print, must be evaluated at the time of purchase to avoid burning a hole in your pocket.

Co-pay or co-payment is a clause in a health insurance plan that requires the policyholder to bear a specified percentage of the admissible claim amount. In other words, if your medical expenses work out to ₹50,000 and your health policy has a 10 percent co-pay, you will pay ₹5,000 from your pocket and balance will be paid by your insurer. Co-payment doesn't reduce your sum insured in your health policy but only reduces the claim you can make. Insurers including Bajaj Allianz General, Max Bupa Health, Manipal Cigna, Star Health, United India Insurance and Aditya Birla Health are some insurers that have co-pay clauses in some of their policies. Insurers originally started to levy co-pay clauses as a check against inflated bills and insurance fraud. For insurance buyers, it is one of the important clauses in a health policy they should be aware of before signing up for one. In some health policies co-payment will apply on the total claim amount, while in others it applies on specific medical expenses such as OPD (out-patient department), and day-care procedures. While the applicability of co-pay clause varies with insurers and their plans, there are a few common scenarios where it is applicable.

One, co-pay depending on the location of hospitalisation. If you have purchased a health policy in a non-metro city (tier 2 or tier 3) and get hospitalised in a metro city (tier 1), then many health policies levy a co-pay clause. This is because hospitalisation expenses in tier 2/3 cities are usually lower when compared to tier 1 cities. Co-pay is usually not applicable if you purchase a policy in a tier 1 city (metro) and avail of medical treatment in non-metro cities. Insurers normally don't apply co-payment for services such as emergency ambulance and diagnostic tests. Two, co-pay may be applicable based on the age of the policyholders. There are policies which require co-pay only for those availing themselves of insurance above a certain age, say 60 or 65 years. Three, some of the insurers apply co-pay on claims exceeding the room rent limit mentioned in the policy. If your health policy states that your room rent limit is ₹5,000 per day (in case of hospitalisation), then you may have to co-pay if your actual bill exceeds this.

Understanding of the co-pay clause helps you avoid unnecessary financial hassle during illnesses requiring sudden admission. Though co-pay must not be a deciding factor in buying a health policy, it is an important aspect to consider. Health policies with co-pay are often offered at a lower premium. But some insurers leave the choice to the policyholders on whether they would like to do away with the clause and shell out higher premiums instead. Most health policies launched in the last one or two years don't have an explicit blanket co-pay clause, but it may apply in specific situations still. This clause could be applicable both on cashless insurance claims and reimbursement claims.

(The writer is Bavadharini KS.)

TOP

Covid-related health insurance claims top ₹23,000 crore - The Hindu Business Line – 24th May 2021

Reflecting the surge in cases, Covid-related health insurance claims have crossed ₹23,000 crore for non-life insurers. However, the average duration of hospitalisation and claim amount has come down in the second wave of the pandemic as against the first wave last year. Data with General Insurance Council (GIC) reveals that insurers had received 15.32 lakh Covid-related claims by May 20 amounting to ₹23,715 crore. Of this, 12.59 crore claims worth ₹12,133 crore have been settled.

About 1.13 lakh patients who had filed claims were still under treatment, while 22,461 had died, the data revealed. The remaining 13.96 lakh have been discharged.

Speedy clearance

Insurers said the average claim size is now lower at about ₹95,000 against the earlier ₹1,15,000 for patients hospitalised for Covid-19. The duration of stay has also come down to about six days from the previous nine-day period.

"The average claim size has slightly come down mainly because the duration of hospitalisation has come down to about six days now from the earlier average of nine days. Treatment protocols are standardised now. Hospitals are also flooded with patients and so are sending them for home quarantine once they are not critical," said Bhaskar Nerurkar, Head, Health Claims, Bajaj Allianz General Insurance.

Another insurer said that despite the huge number of cases, both hospitals and insurers are better prepared to deal with claims this year and said timely clearance of claims is the main focus at present. "Since the order by the IRDAI, all efforts are on to ensure that Covid-related hospitalisation claims are cleared within one hour," noted the insurer who did not wish to be named.

The GIC data further revealed that amongst States, Maharashtra had the largest number of Covid claims at 5.51 lakh, followed by Gujarat with 1.72 lakh and Karnataka with 1.28 lakh claims. Meanwhile, 1.23 lakh claims have been filed from Tamil Nadu and over 85,000 claims have come from Delhi.

(The writer is Surabhi.)

TOP

Banks to deduct premium of Rs 12 before May 31: PMSBY scheme details - Financial Express – 22nd May 2021

Banks are sending SMS and informing their savings account holders also through other modes of communication about the deduction of premium towards Pradhan Mantri Suraksha Bima Yojana (PMSBY). The bank account will get debited only for those who had enrolled for the PMSBY scheme. One can even join the PMSBY scheme by filling up the application in a bank or by applying it online after logging on to the net banking of their bank.

Pradhan Mantri Suraksha Bima Yojana (PMSBY) is a scheme offering insurance against accidental death and disability. It is a one-year cover and may be renewed each year by the individual. For those who had already enrolled for the PMSBY scheme, the premium of Rs. 12 per annum (including GST) is deducted from the bank account of the insured through 'auto-debit' facility in one instalment. Your bank account will typically get debited between May 25 and May 31 of each year.

For renewal of the policy, the required premium will be auto-debited generally between May 25 and May 31, unless the account holder has given a cancellation request to the bank for the policy.

The coverage period of PMSBY is from 1st June to 31st May each year. Therefore, if one wants to continue with the scheme, the renewal premium is to be paid in the month of May each year. It is compulsory to give consent to join or enable the auto-debit in the bank account while joining the scheme.

The eligibility conditions are simple as all those between the age of 18 and 70 years with a bank account can enroll in the scheme. In the case of multiple bank accounts held by an individual in one or different banks, the person would be eligible to join the scheme through one bank account only. If you find more than one bank deducting the same amount, it is better to approach all of them except one where you wish to continue with the scheme.

PMSBY is an Accident Insurance Scheme offering accidental death and disability cover for death or disability on account of an accident. Death due to natural reasons such as heart attack etc will not be covered. The risk coverage under the scheme is Rs. 2 lakh for accidental death and full disability and Rs.1 lakh for partial disability. Claim settlement will be made to the bank account of the insured or his nominee in case of death of the account holder.

Death: Rs 2 lakh
Total and irrecoverable loss of both eyes or loss of use of both hands or feet or loss of sight of one eye and loss of use of one hand or one foot: Rs 1 lakh

Total and irrecoverable loss of sight of one eye or loss of use of one hand or one foot: Rs 1 lakh

(The writer is Sunil Dhawan.)

TOP

Can Insurtech sustain the demand rush for employee health covers? – INC42 – 22nd May 2021

Health insurance is critical in nature, but a couple of years ago, it was more of a fringe benefit provided by startups (and other small enterprises) and not a key trigger for recruiting and retention. However, the onslaught of Covid-19 pandemic since 2020, especially this year's more deadly second surge, makes it a top benefit and most people are likely to choose companies that provide comprehensive health cover for employees and their families.

Health benefits started trending in 2020 as part of a value-added social benefits package offered by companies to attract the blue-collar workforce. But it is now essential to offer this powerful perquisite across the board to ensure better employee welfare, preserve employee morale and thus improve productivity. Besides, a good health insurance coverage often helps startups stand out in the competition for talent and bring down operational costs by reducing sick days and high employee turnover.

As employers are leveraging health benefits to attract and retain people during the ongoing pandemic, it has been a big shot in the arm for the health insurance industry in India. With more and more people needing hospitalisation due to Covid and medical costs continuing to skyrocket, both individuals and enterprises are signing up for private health insurance. So, in 2020, for the first time, health insurance became the most valuable segment for non-life insurers in terms of premiums collected, leapfrogging motor insurance. According to figures compiled by the General Insurance Council and the Insurance Regulatory and Development Authority of India (IRDAI), the health insurance portfolio grew 11% year on year in FY21 to INR 58,584 Cr, due to the pandemic.

The Spike In Insurance Demand Is Driven By Digital Initiatives
Historically, health premiums have been driven by 'group policies' as organisations typically buy umbrella covers for their employees. The pandemic has further accelerated these initiatives, especially during the second wave since March-April this year, as smaller businesses and startups impacted by the health crisis rush to safeguard their employees. According to him, the company started witnessing a demand spike in late March when the second wave hit India. Compared to a 30% month-on-month growth that the startup had seen in the number of policies prior to the second wave, it is dealing with a 90% MoM growth since mid-March.

Consequently, the burden of claim settlement has also increased. The second wave has resulted in higher hospitalisation and the need for extended hospital care, says Pradeep Satya, CEO and founder of Bengaluru-based Synergy Strategic Solutions, an insurance-focussed technology service provider. The

cost of treatment and medicines, and the associated costs of PPE kits, masks, gloves and post-hospitalisation care have driven up the number of healthcare claims during this period, he adds.

"The rise in health claims is certainly a cause for concern. On average, each Covid claim payout is in the range of INR 1.5-2 Lakh, with a settlement rate of nearly 83%. However, the group health portfolio has seen a modest premium increment of 10% in FY21," says Satya. Insurers have also seen a 10% rise in premium defaults in the months of March and April this year, according to industry estimates.

Given the grim nature of the second surge, it is not surprising that the number of claims filed in April 2021 equals around 60% of the total Covid claims in FY21, according to Ensured it, an insurtech startup from Bengaluru that helps insurers improve customer experience using AI. Considering the lead indicators in Covid claims, insurers expect the number of claims to shoot up in the coming days. "This is perhaps an inflexion point for mainstreaming health insurance in India. Higher loss ratios in group insurance will make all stakeholders in the industry focus more on retail insurance," says Rohit Sadhu, cofounder and COO of Ensured it.

The loss ratio is calculated by dividing the total incurred losses by the total insurance premium collected. Soo, the lower the ratio, the more profitable is a company, and vice versa. There is another paradigm shift. While traditional insurers have depended on a network of agents to push products and drive sales, pandemic-induced lockdowns and social distancing norms have been the perfect trigger for digital insurance channels. According to S&P Global market intelligence data released this week, at least 335 private insurtechs are operating in the Asia-Pacific region. China and India are collectively home to nearly half of the private insurtech companies in the APAC region. Understandably, these two will continue to corner the lion's share of investor interest due to their large and fast-growing insurance markets.

Does it mean that digital-first insurtech startups will rule the roost and personnel-intensive traditional businesses will gradually shrink and disappear? It may not be so. Eventually, digital businesses are also run by people who are equally susceptible to the virus. According to various estimates, 25-35% of startup employees have been impacted by the pandemic during the second wave, which means people responsible for underwriting and processing policies and claims are also struggling to cope with their capacity crisis.

A look at some recent data may also help ascertain whether the staff crunch due to Covid is affecting speedy settlements. As of April 28, 2021, 1.1 Mn Covid-19 health claims worth INR 15,568 Cr were filed with insurers (starting from May 2020, across all channels). Of these, 84% or 9,30,729 claims worth INR 8,918.57 Cr had been settled, according to GI Council data shared with the finance ministry. Of course, the delays may have stemmed from the fact that hospital bills have overheads that insurers and hospitals cannot agree upon. But that is a separate story.

How Startups Can Tap Insurtech To Budget For Employee Insurance

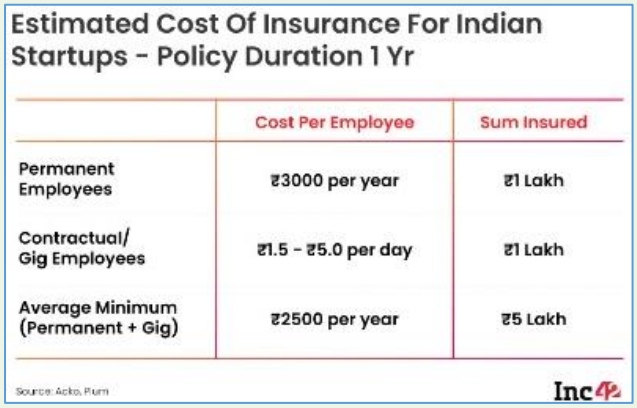
Earlier, only mid-to-large companies used to opt for employee health insurance, but the current health crisis is compelling even smaller startups and SMEs to come on board. What's more, these policies are not limited to permanent employees. Even gig workers working for tech platforms are supposed to get their rightful share of benefits here. At least, that is what most of the leading startups are claiming. The actual story on the ground will unfold as and when such claims are raised.

All insurers which have spoken to Inc42 further underline a product preference sought by most employers. Instead of buying a basic cover with inpatient (IPD) benefits, companies now opt for a higher sum insured, outpatient (OPD) coverage and additional wellness benefits such as mental wellness consultation and physical activity monitoring. In addition, they are increasingly seeking life cover for their employees owing to the fatal nature of the pandemic.

But how will early-stage startups and small businesses with small budgets plan insurance for their employees?

Generally speaking, a good IPD cover costs a company around INR 3,000 per employee for an annual policy with INR 1 lakh sum insured, says Biresh Giri, executive vice-president, actuary and underwriting, at Acko General Insurance. A comprehensive health policy covering other benefits like the OPD can cost up to INR 5,000 per employee for the same sum insured for a year. However, the per-employee premium also depends on various factors such as the sum insured, benefits, dependents covered in a policy and more. It can go up to INR 20,000 per employee with INR 5 Lakh sum insured that covers the employee and their parents.

Companies on a tight budget can even find daily plans ranging from INR 1.5-5 per employee based on the sum insured, benefits and specific requirements.



On average, the cost may reach INR 2,500 per employee or gig worker per year (about INR 200 per month). So, a company employing up to 200 people will have to spend INR 5 Lakh, says Poddar of Plum. "Even if one or two employees use the insurance, the company will recover the cost," he adds.

Miles To Go Beyond Startup Insurance

In recent months, IRDAI introduced several measures to open up the insurance ecosystem for better products. Again, in March 2021, Rajya Sabha approved a Bill to increase the foreign direct investment (FDI) limit to 74% from the current 49%. According to the Bill, the majority of directors on the board of an insurance company and the key management persons will be resident Indians. Moreover, at least 50% of the directors will be independent directors, and a specified percentage of profits will be retained as a general reserve. These initiatives are expected to bring more new-age insurers into the ecosystem and help build better underwriting technology.

In April this year, IRDAI submitted a report in which it made recommendations related to retail insurance products and also underlined certain standard covers to meet the needs of retail customers. The report says that better clarity of coverage and terms and conditions in the policy document will help in "realigning the industry to meet customer expectations better and vice versa". The recommendations suggest relying on better data-driven insights and improving the language of policy documents to help buyers make informed decisions.

For instance, industry experts think that micro-insurance is one area where insurance companies have razor-thin margins. Hence, the reliability of the data and its correct interpretation will help improve consumer trust in insurance products. Overhauling traditional insurers to adopt more digital channels and data-driven approaches is essential in a country where insurance penetration is abysmally low at 3.7%, according to the latest Economic Survey. That brings us back to the overall state of things in the insurance sector. Right now, businesses are pushing insurance adoption numbers to an unprecedented level due to the pandemic. But this does not essentially indicate a rise in overall demand or better awareness and penetration.

In essence, the sector has miles to go to keep pace with more mature economies. Most of the insurtech players with whom Inc42 has spoken also say that the adoption of companywide insurance products is yet to come from smaller towns and SMEs. While the businesses in Tier 3 and Tier 4 markets have a strong network of informal channels to support employees, such informal support is not on a par with formal insurance and its many benefits which are instantly available via digital tools during lockdowns. Indian insurtech startups can definitely play a key role here.

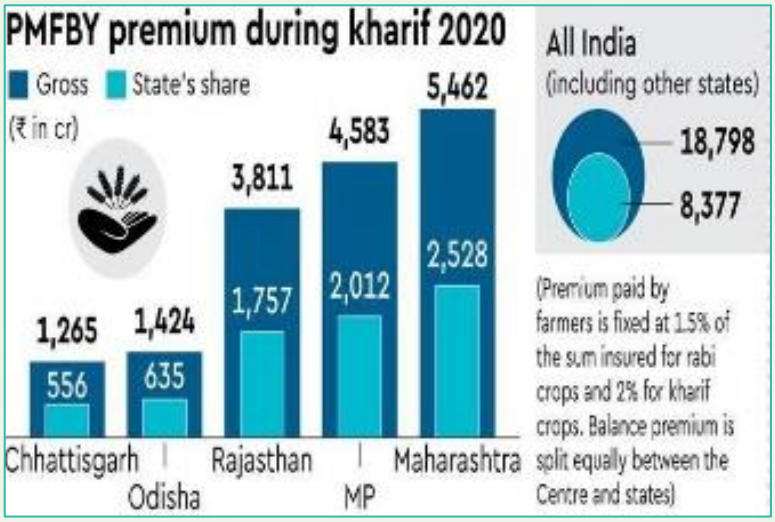
(The writer is Romita Majumdar.)

TOP

CROP INSURANCE

Crop insurance: States seek 'Beed formula' to cut costs for upcoming kharif season - Financial Express – 25th May 2021

Fiscally-stressed states have over the years turned averse to footing the premium bill for the Pradhan Mantri Fasal Bima Yojana (PMFBY), resulting in insurers not honouring the farmers' claims on time – as last reported, claims worth over Rs 1,800 crore were yet to be settled. But at least two states – Maharashtra and Rajasthan – have now written to the Centre seeking the 'Beed district formula' to run the crop insurance scheme for the upcoming kharif season. The reason: The states reckon that given the normal monsoon predicted for this year, there could be a 'surplus' in gross premiums to be collected by insurers and the Beed formula, also called the '80-110 Plan', would in such case ensure that premium above a threshold is refunded to the state government.



Under the 80-110 plan, the insurer's potential losses are circumscribed – the firm won't have to entertain claims above 110% of the gross premium. The state government has to bear the cost of any claims above 110% of the premium collected to insulate the insurer from losses. The premium surplus (gross premium minus claims) exceeding 20% of gross premium is refunded by insurer to the state government.

Last year, two far-below-normal monsoon rainfalls in central Maharashtra's Beed district dissuaded insurers from covering farmers in the district under the PMFBY for kharif 2020, and the Centre then asked public sector Agriculture Insurance Company of India (AIC) to oblige. AIC was assured that it won't have to entertain claims above 110% of the gross premium. It was also told that the state government could bear the cost of any claims above the premium collected to insulate the insurer from losses. The scheme ran successfully.

According to sources, the Centre is not averse to the idea; it has, however, asked the two states to wait as the '80-110 Plan" needed detailed evaluation and probably Cabinet clearance. "Since it (80-110 Plan) was implemented in Beed district and also in Madhya Pradesh as special cases last year, the outcome has to be analysed on premiums collected by insurer and claims made by farmers," said a source.

For instance, under the '80-110 Plan', in case the claims reach 60% of premium collected, the insurance company will have to refund 20% to the state government and if the claims are 70%, the refund to state will be 10%. In case of claims above 80%, the state will not get any refund.

Under PMFBY, premium to be paid by farmers is fixed at 1.5% of the sum insured for rabi crops and 2% for kharif crops, while it is 5% for cash crops. The balance premium is split equally between the Centre and states. Many states have demanded their share of the government-paid premium be capped at 30%, with the balance 70% borne by the Centre.

"Many states are not too eager to run PMFBY due to financial constraints, particularly after the Covid pandemic. Besides, since India Meteorological department (IMD) has predicted a normal monsoon, the states do not expect claims to soar during this kharif season unless there is an unforeseen natural calamity. Chances of crop failure due to less rainfall this year are very low," said an insurance company official requesting anonymity.

With the view to reduce expenditure on crop insurance, the Maharashtra government has cancelled its 3-year contract with insurance companies approved last year, while Rajasthan is also mulling a similar action, sources said.

As many states were complaining about the "ever-increasing premium", the Centre in February last year had changed the guidelines and allowed them the option of three-year contract with insurers on the premium charged in crop insurance. States also can continue with the existing system of inviting bids for premium every year, as per the guidelines.

The Centre foots the PMFBY subsidy bill to the extent of its formulaic share so long as gross premium level is up to 30% of the sum assured in non-irrigated areas and 25% in irrigated areas. The onus is on the states if they want to implement the scheme even if insurers quote any premium above 25-30%.

(The writer is Prabhudatta Mishra.)

TOP

SURVEY & REPORTS

COVID-19: Wide mismatch in death toll, insurance claims reveal uninsured India – Moneycontrol – 27th May 2021

The COVID-19 outbreak in India has officially claimed 3,11,388 lives, as of May 26. While the second wave continues to rage across the country, so far just 35,500 death claims have been filed of which close to 29,300 have been settled.

As of May 15, death claims worth approximately Rs 2,400 crore have been paid out by life insurance companies, according to data filed with Life Council, an industry body. The big mismatch between actual deaths and the number of death claims could come as a shocker to many but it is, in fact, a reflection that insurance penetration in India is far lower than it ought to be.

"It is only in large metros and semi-urban areas where insurance awareness exists. Life insurance continues to be a push product, even though the country doesn't have any social security net. And this reflects in the low COVID-19 death claims," said Suresh Bhatt, CEO, InsurrRisk Consulting.

Uninsured India

The result is that a large proportion of the 1.3 billion Indian population is uninsured. While experts are of the view that the government's Prime Minister Jeevan Jyoti Bima Yojana (PMJJBY) has helped, the year-on-year increase (YoY) has not been commensurate with the risk.

In FY21, a total of 33.1 million new people came under the PMJJBY scheme, which provides Rs 2 lakh term insurance for an annual premium of Rs 330. This is a term cover, meaning that the policyholder's kin will get the insurance claim in the event of death during the policy term. Former banker Jyotsna Patnaik, who now assists insurance customers in filing death claims, says that the initial fervour around PMJJBY has now subsided.

"In 2015 and 2016, there was high pressure on banks to sell these products to customers. But now the traction is going down. While overall the numbers show that 102 million PMJJBY policies have been issued on a cumulative basis, compared to the population this is very low," she points out. Patnaik believes that the thrust should be to make this an opt-out facility rather than an opt-in facility so that more customers in rural areas are able to own a basic Rs 2 lakh term policy.

Low insurance penetration
Insurance penetration is taken as an indicator to show how financially assured a country is. When it comes to insurance penetration and density, the figures for India are flat, as per the Swiss Re's FY20 sigma report. Insurance density, which is premium per capita, stood at $78 (approximately Rs 5,850) in FY20 compared to $74 (approximately Rs 5,550) in FY20. In contrast, the world average for insurance density stood at $818 (Rs 61,350 approximately). In FY20, insurance penetration (premiums as a percentage of gross domestic product) were calculated to be 3.76 percent in India. Life insurance penetration was estimated at 2.82 percent while non-life stood at 0.94 percent.

The world average was 7.23 percent; 3.55 percent for life and 3.88 percent for non-life insurance. Swiss Re Institute estimates that total premium volumes in advanced markets (life and non-life) will shrink by 4 percent this year and return to growth of more than 2 percent in 2021. In FY19, India had an insurance penetration of 3.7 percent - 2.74 percent for life and 0.97 percent for non-life. Insurance agent Sakina Siddique says that term insurance is among the toughest products to sell in India.

"I have been in this industry for the past 20 years, but it still takes at least seven calls and visits on an average to encourage a customer to buy a term plan. Premium payment is not the issue. He/she would buy a Rs 15,000 mobile phone without thinking twice, but won't invest in this product," she explains.

Post-COVID
It is only after the COVID-19 gripped the country in April 2020 that she witnessed a marginal change. Siddique says that those who have lost close family members and friends in the pandemic are motivated to buy the product.

"If the awareness could even spread through word of mouth, it will make a massive difference," she adds. Close to 30 million life insurance policies are sold in India every year. Here, the term constitutes about 45 percent, while the rest of the policies are savings/investment products.

Is there a way to bridge the gap?
Experts are of the view that bit-sized insurance products could be a good way to get customers used to the term insurance segment. And once they reach a critical mass, standard life insurance plans could be cross sold to them. "It is as simple as this. Bundle a Rs 50,000 term insurance cover, with prices as low as Rs 80-100 per annum, and add an FMCG purchase or say a mobile recharge. Once the customer sees the benefit of a claim being paid among peers, he/she could be motivated to buy a higher insurance cover,'' points out Jennifer Lobo, Vice President at SafalBima Consulting.

She adds that products could be bundled with coffee shop payments, ticket booking for films and shows and popular purchases like electronics on e-commerce platforms. "Once the idea takes off, there is no looking back," Lobo concludes, on an optimistic note.

(The writer is M Saraswathy.)

TOP

Over 85 percent of policyholders renewed family floater health policies before expiry – Live Mint - 25th May 2021

In the backdrop of the raging coronavirus pandemic, it has been observed that most people have been renewing their health insurance policies on time so that they can avoid problems that arise out of missing the due date. According to a study by Policybazaar.com, over 85% of all family-floater health insurance policies sold last year were renewed before expiry. Also, roughly 80% of customers with individual health insurance plans renewed their policies by the scheduled deadline.

Amit Chhabra, Head-Health Insurance, Policybazaar.com said, "People are terrified that the novel coronavirus will infect them at anytime, anywhere, and have realized that the only way to protect themselves financially from the pandemic is to invest in a comprehensive health insurance plan. Surprisingly, the number of people renewing their health insurance policies this year is much higher than in previous years." According to the online insurance marketplace, renewal rate for customers with

individual health policies older than a year was 94%, while the same was 97% for family floater plans. Such high renewal rates indicate that while the initial decision to purchase a health insurance policy may have been influenced by the ongoing pandemic, people have gradually realised the role insurance can play in securing the best possible health care facilities without having to worry about the cost.

By renewing health insurance policy by the due date, one gains access to a slew of continuity benefits such as uninterrupted coverage, No-Claim Bonus benefits, and no new waiting period. Another noteworthy trend has been that consumers are now using their 'wellness points' during health insurance renewal to obtain premium discounts. Over 20% of people who purchased health insurance plans in March and April last year renewed their policies through wellness points this year. This demonstrates how people have gradually begun to shift toward a preventive mindset.

"When it comes to health insurance, a significant number of consumers have shown a proactive interest in staying healthy and have requested wellness-oriented health insurance plans over the last two years. Recently, there has been an increase in products that reflect daily priorities or life goals," said Chhabra.

(The writer is Navneet Dubey.)

TOP

Insurtech Is the Future of Insurance Market, Says BLinC Invest – Outlook – 25th May 2021

BLinC Invest released its Insurtech Report 2021 that focuses on global insurtech followed by Indian insurtech. The cornerstone of the report lies in its analysis of key emerging trends and the fund's view on what it takes to be successful in Insurtech across different parts of the value chain.

The Indian insurance industry has a market size of $106 billion and life insurance accounts for 75 per cent of that after private players entered the industry in 1999 and contributed to its exponential growth.

The report also focuses on the impact of IRDAI's strict ULIP norms on the Indian insurance industry after 2009, which triggered people to opt for term plans as compared to other forms of investment plans. This also pushed insurance providers to diversify the product portfolio of the general insurance segment.

"Our Insurtech Report highlights the significant gaps in the Indian insurance market and discovers a huge market opportunity in the non-insured and the under-insured segments. Technology will be the key enabler and we will be looking at investing in companies that understand that penetration across all segments is key to scale. Data and product innovation are critical to attracting the right customers," commented Amit Ratanpal, Founder & Managing Director, BLinC Invest.

The report included details about the key emerging trends starting with the power shift from underwriting to distribution and data and also how industry players are exploring various D2C digital channels while leveraging the online footprints of their customers across various functions like pricing, claim prediction. The industry is introducing solutions for AI-based underwriting, virtual claim, among others. It is also supported by IRDAI's Regulatory Sandbox which is stimulating innovation in the sector.

Globally, the industry has been attracting a lot of interest from the investor community. Their funding has grown at a CAGR of 40 per cent over the last 3 years. Indian InsurTechs have raised over $1 billion in the last 5 years and the Indian market has already produced two unicorns in the Insurtech space (PolicyBazaar and Go Digit).

TOP

PENSION

Pension Fund Regulatory and Development Authority rule clarity for NPS sponsors - The Telegraph – 27th May 2021

The Pension Fund Regulatory and Development Authority of India has further streamlined the regulations for the eligibility criteria of fund managers of the National Pension Scheme, bringing in clarity on the net worth and the minimum capital requirement. According to the original Pension Fund Regulatory and Development Authority (Pension Fund) Regulations 2015, clause 8(1)(c), sponsors, either individually or jointly, need to have a positive tangible net worth of at least Rs 25 crore on the last day of each of the preceding five financial years.

This clause was amended in February 2020 whereby the sponsors, either individually or jointly, were required to have a positive tangible net worth of at least Rs 50 crore on the last day of each of the preceding five financial years, out of which at least Rs 25 crore should be the capital. But the amendment was not clear about the nature of the capital.

This was subsequently clarified through a notification published on Tuesday whereby of the minimum positive tangible net worth of Rs 50 crore, the regulations now state that at least Rs 25 crore should be the paid-up equity capital on the date of making the application as a sponsor. "Initially, the sponsor was only required to comply with the net worth criteria of at least Rs 50 crore which, in accordance with the amendment mandated that Rs 25 crore out of such Rs 50 crore of net worth should constitute the capital of such sponsor.

"The criteria has been further amended to provide that the capital requirement of Rs 25 crore should be the paid-up equity capital and not any other form of capital on the date of making application as sponsor," said Suresh Surana, founder, RSM India. "It is to be noted that the notification dated May 25, 2021, provides for the aforementioned clause to substitute sub-clause (d) which provides for profit criteria and not sub-clause (c) which actually deals with the net worth and capital requirement. On an apparent basis, this may appear to be a clerical error to many people and a corrigendum providing clarification may be expected from the government," he added.

More players

At present, there are seven pension fund managers for NPS and industry sources said that at least two more private players are evaluating the eligibility criteria of the PFRDA. "Today, we have over 40 mutual funds and 27 private sector general insurance companies. There is a need for more participation in NPS. But the regulator has to ensure only serious players come into the industry," said an industry source. As on April 30, 2021, the assets under management in NPS is Rs 5,73,717.16 crore, covering a base of 1,45,04,489 subscribers.

TOP

Pension corpus under PFRDA swells over Rs 6 lakh crore – The Times of India – 26th May 2021

Pension Fund Regulatory and Development Authority on Wednesday said asset under management (AUM) generated by pension schemes has crossed the Rs 6 lakh crore-milestone. Pension Fund Regulatory and Development Authority (PFRDA) is the statutory authority established by an enactment of Parliament, to regulate, promote and ensure orderly growth of the National Pension System (NPS) and pension schemes. The AUM crossed the milestone of Rs 6 lakh crore under the National Pension System

(NPS) and Atal Pension Yojana (APY) after 13 years since the PFRDA came into being, an official statement said. The AUM growth of last Rs 1 lakh crore has been achieved in just 7 months, it added.

It is to be noted that the total pension fund under the management had swelled to Rs 5 lakh crore in October 2020. The pension sector regulator has witnessed remarkable growth in NPS subscribers over the years, with 74.10 lakh government employees in the scheme and 28.37 lakh individuals joining from the non-government sector, it said, adding the total subscriber base of PFRDA has increased to 4.28 crore. "The achievement shows the faith subscribers have in NPS and PFRDA. A growing realisation during this pandemic is the priority accorded by individuals to retirement planning, for preserving their financial wellbeing," PFRDA Chairman Supratim Bandyopadhyay said. As of May 21, 2021, the total number of subscribers under the NPS and Atal Pension Yojana has crossed 4.28 crore and the AUM has grown to Rs 603,667.02 crore. NPS was initially notified for central government employees, recruits with effect from January 1, 2004, and subsequently adopted by almost all state governments for its employees. Later, NPS was extended to all Indian citizens (resident/non-resident/overseas) on a voluntary basis and to corporates for their employees.

TOP

IRDAI CIRCULARS

Topic	*Reference*
Guidelines on settlement of Life Insurance Claims to the victims of Cyclone	https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo4499&flag=1
Gross premium underwritten by non-life insurers within India (segment wise) : For the month / upto the Month Of April, 2021 (Provisional & Unaudited)	https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo4496&flag=1

TOP

GLOBAL NEWS

Bangladesh: Regulator to explore insurance plans covering bond default risk – Asia Insurance Review

The Insurance Development and Regulatory Authority (IDRA) is making a move to find appropriate insurance products to protect the interests of bond investors and cover the risks associated with fixed-income financial instruments approved by the securities regulator. The Bangladesh Securities and Exchange Commission (BSEC) has approved a number of bonds, including perpetual bonds, and preference shares issued by corporate houses, reported The Financial Express.

"We have approved bonds worth BDT450bn ($5.3bn) over the last five years," a BSEC official said.

Many non-governmental organisations (NGOs) have also raised funds through bond issuances. For instance, the BSEC has approved a fund worth BDT13.5bn for BRAC, a leading global non-government organisation.

But the bonds and such other types of instruments are considered unsecured, says the BSEC official. If the issuers were to default on the bonds, the investors would face financial losses.

The IRDA is scheduled to hold a virtual meeting to deliberate the issue with its key stakeholders today. IRDA chairman Dr M Mosharraf Hossain will preside over the meeting. The BSEC, the state-owned non-life insurer and reinsurer Shadharan Bima Corporation (SBC), and other stakeholders are expected to join the meeting. Mr Syed Shahriyar Ahsan, managing director of SBC, said that an overseas reinsurance facility for such insurance would be needed.

TOP

Australia: Actuaries' report says challenge is to make change happen in disability insurance - Asia Insurance Review

The Actuaries Institute's Disability Insurance Taskforce has said that there is "real momentum for change" in a sector that continues to face significant financial stress and is subject to close monitoring by the Australian Prudential Regulation Authority (APRA). The challenge now is to make change happen. Insurance companies are estimated to have lost more than A$2b ($1.6bn) since 2018 in this line of business.

Addressing the issue, the Taskforce has released its final report on individual disability income insurance (IDII), including recommendations, after more than 12 months of critical examination of the sector, spurred by hefty and ongoing losses by life companies whose sale of complex products, ultimately, threatens the viability of the sector.

“Through its work, the Taskforce has developed a path forward for the industry. This will involve change and contribution by the many participants in the IDII ecosystem,” the report said.

Changes

In particular, the Taskforce is seeking a series of changes in the industry so IDII will sustainably provide:
-Products that perform as expected by customers, with features that, compared with the present situation:
better meet their needs without frills, and reflect their insurable interests – both on policy inception and subsequently, and at individual and community levels; and
provide more certain outcomes and are more readily understood.
-Prices for customers that are more stable and predictable over time, better understood and more consistent with underlying risk, compared with the present situation;
-Product features and underwriting that a) promote alignment between customer and insurer through appropriate consideration of each customer’s insurable interests, and b) support loss minimisation at time of claim;
-Financial outcomes for insurers that ensure a sustained ability to pay claims and that are sufficient to ensure insurers will continue to compete and provide valuable IDII products to the market; and
-Community confidence as to the enduring value and fairness of disability insurance.

The findings and recommendations section of the report runs to 68 pages.

The Taskforce’s recommendations reflect consultation and feedback from policymakers and regulators, insurers, consumer advocates, ratings houses, and industry representatives such as the Financial Services Council (FSC) and others. APRA and the FSC have had observer status throughout the development of the Taskforce’s recommendations and various hearings and seminars have helped formulate the findings.

To help address its recommendations, the Taskforce developed a ‘Reference Product’ which should be used by insurers and their Boards and executives to assess risk and uncertainty for both customers and the company.

The Taskforce, led by senior actuary and former APRA deputy chairman Ian Laughlin, has supported APRA’s actions in the sector, saying “APRA should maintain the current intervention until such time as industry demonstrates a sustained improvement in practices and outcomes.”

Sustainability Guide

As part of this reform template, the Taskforce also developed a Sustainability Guide which is designed to help insurers consider critical aspects of product design, operational practices, pricing uncertainty, risk management and risk appetite. The Taskforce said insurers should use the Guide to continually improve

their frameworks, policies and day-to-day practices to mitigate risks and improve long-term IDII sustainability for consumers and insurers.

Mr Laughlin noted that the Taskforce firmly believes that returning an employee to work at the appropriate time, where this is reasonable, should be a key objective of disability insurance sector reform.

TOP

China: General insurers expected to continue to show weak underwriting results this year - Asia Insurance Review

Chinese non-life insurers' overall underwriting margin will remain weak in 2021 despite the recovery of economic activity, says Fitch Ratings.

Non-life insurers suffered a decline in both motor premium volume and underwriting margin after the implementation of the comprehensive reform of motor insurance in September 2020. The loss ratio of the motor insurance segment increased by 14% to 71% for the six months after the launch of the reform, to March 2021, according to statistics from the CBIRC. Nonetheless, a reduction in the expense ratio due to lower commissions and administrative costs could alleviate the escalation in motor incurred claims. Insurers continue to shift the product focus to non-motor insurance policies, while Fitch believes earnings stability relies to a great extent on their capability to manage the underwriting risks associated with exposure to the non-motor business. Insurers' investment focus on shorter-duration fixed-income instruments — and a steady yield from investments — underpinned most companies' operating performance in 2020, buffering the earnings volatility from underwriting.

The comprehensive solvency ratio of the non-life sector fell to 278% by end-2020 from 288% at end-1Q20, although it was still comfortably higher than the statutory 100% minimum. Fitch believes that ongoing capital infusion in the form of either fresh equity issuance or issuance of supplementary capital bonds to support business expansion is likely to be unavoidable for smaller insurers with a weak operating margin.

TOP

Australia: Non-life insurance body releases paper on commercial insurance issues - Asia Insurance Review

The Insurance Council of Australia (ICA) has released for consultation an independent review that sets out options for tackling the availability and affordability of commercial lines of insurance, particularly for small and medium sized enterprises (SMEs).

The independent review finds issues around affordability and availability for SMEs are centred on public liability, professional indemnity, directors and officers, and business interruption cover.

The review argues that while there is no one-size-fits-all solution to these issues, solutions do exist but they will require collaboration between insurers, small businesses and government. The ICA commissioned former insurance executive and regulator John Trowbridge to conduct an independent review of these issues and present possible solutions.

The 16 options identified in the Trowbridge review fall into three broad categories:

- Awareness options such as standard documentation and advice and education on risk mitigation
- Insurance industry options such as underwriting consortia and industry association accreditation and standards

- Government-related options such as the removal of taxes and charges and collaboration to reduce regulatory barriers

The main themes arising from the review include:

- Market failure and criteria for government intervention
- Affordability concepts
- The SME insurance market
- Recognising availability issues.

The ICA will conduct a one-month consultation with stakeholders, following which a final response to the paper will be prepared for the ICA board.

ICA CEO Andrew Hall said, "The ICA engaged John Trowbridge to undertake his independent review to provide a summary of potential solutions to problems that have been challenging sectors of the economy for some time. "As risk increases so do insurers' costs; as a result, premiums may rise impacting the availability and affordability of some categories of insurance for certain sectors.

"While some small businesses are facing challenges in accessing the insurance they need to operate, in many of these categories, insurers are under pressure to provide a profitable product so solutions are often difficult to determine. "The Trowbridge review shows that insurers are serious about engaging with these issues for the benefit of individual commercial policyholders and the economy as a whole."

TOP