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INSUNEWS

- Weekly e-Newsletter

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• Quote for the Week •

"Three things cannot be long hidden: the sun, the moon, and the truth."

– Gautama Buddha

INSIDE THE ISSUE

Industry

Insurance sector needs comprehensive over-haul: Report - The Economic Times – 9th July, 2017

The insurance industry needs a comprehensive over-haul across segments to boost performance as compliance cost is high and regulatory policy is less development oriented, says a report by former Irdai member.

"The regulatory framework and support system tends to over-regulate. Predictably the cost of compliance is high and regulatory policy is less development oriented," the report prepared jointly by former Irdai member H Ansari and an industry expert Arun Agarwal, said.

The essential elements of 'Ease of doing business' framework have not been incubated within the policy and regulatory framework to establish a credible, proportionate and supportive regulatory regime, the report said.

The report was recently submitted to the government, Niti Aayog and regulator Irdai.

The report has identified areas that need reformatory steps by stakeholders, including policy makers, Irdai, judiciary and insurance players to develop a modern, transparent and progressive industry framework and a global (re)insurance platform.

According to the report, the regulations are prescriptive and rule-based and often there is carping on 'market not mature' and 'data not adequate'.

Further, the regulatory anchors relating to products, pricing, placement and promotion, outsourcing and many more under the banner of protecting policy holders' interest, do not meet modern and global standards which fulcrum on 'Contract certainty and effective litigation', the report said.

The digitisation goals for the insurance industry, the report said, seem to be a far-fetched one.

The big data tech revolution that is setting to shake up insurance, including distribution, process digitalisation, products, pricing and customer engagement where digital will enable customer centricity seem far-fetched in country since these challenge current silos between life, non-life and health and reinsurers as different regulations sit with different priorities, it said.

Commenting on the report, Sanath Kumar, chairman and managing director, National Insurance Company said, "We have found Irdai regulations quite contemporary and has been focusing a little heavily on policy holder protection.

"Their digital initiatives have been dealing with cutting edge technology and insurers have found it beneficial to adhere to. The descriptive regulations are a general trend in the country with Sebi, RBI and Trai adopting it."

"For the past 17 years, there have not been underwriting surplus in Indian general insurance industry and it is because of the long pendency of legal cases in India and the large technical reserves that it entails.

"Yes, there is a capital crunch, especially in the wake of Rs 21,000 crore of Prime Minister Suraksha Bima Yojana (PMSBY)," he added.

The report points out that the industry too has strengthened the current intrusive regulatory mechanisms with investments led rather than underwriting led profits, with life insurance industry delivering returns below the cost of capital for years and non-life insurance industry having the highest combined ratios across developed and emerging countries for last many years.

Lack of profitability and underwriting disciplines, the report goes on, means that the right talent not attracted and there is virtually no research spend into lowering the risk thresholds.

The capital accumulation is not enough to fund more growth and the fresh capital is not easy to get-internal accruals, public listing or external borrowing or equity-all of which demand greater control and improved performances.

"Annuities are the future growth areas, especially in view of the introduction of NPS and removal of pensions across many sectors. The structure of guarantees and the taxation of annuities, implying taxation of principle itself is well brought out and needs attention of the government," RM Vishakha, managing director and chief executive, IndiaFirst Life Insurance said.

Source

"While the paper comments on the loss to the customer in case of non par and par products, it does not draw enough attention to the fact that insurance companies carry the risk of long term guarantees in these products, with no control on the market dynamics. The contract to pay a guaranteed amount as income needs to be supported by a contract to pay the premium," she added.

Back

GST and the insurance sector – Mint – 11th July, 2017

The Indian life insurance industry has come a long way indeed, especially in the last decade. Back in the day, people viewed insurance primarily as a tax planning and investment tool, something that people thought gave better returns while saving on pesky taxes.

In a country like ours, where social security doesn't exist and one cannot boast of viable retirement schemes, seeking protection for the future becomes a compelling preoccupation. And that is where buying insurance comes into play.

Post-liberalization, the insurance sector witnessed significant growth spurred by the joining of private insurers, product innovation, and induction of multiple distribution channels. This was further encouraged by the increase in the foreign direct investment (FDI) limit, from 26% to 49%. Since then, insurance companies, along with the Insurance Regulatory and Development Authority of India (Irdai), have been making concerted efforts to develop the insurance sector in India.

As a result, we see a significant number of private players operating in the market today, and a lot of product innovation catering to specific consumer needs.

In spite of all the progress in the sector, India continues to be a massively under-penetrated market. We are the world's second most populous nation, and yet we account for less than 1.5% of the world's total insurance premiums and about 2% of the world's life insurance premiums.

According to a Swiss Re report, there is a big gap in insurance in Indian households. For every $100 needed for protection, only $7.8 of saving and insurance is in place for a typical Indian household, leaving a massive mortality protection gap of $92.2, says the report.

Given the scenario, how will the goods and services tax (GST) impact the growth momentum of this industry?

Of the four GST slabs—5%, 12%, 18%, 28%—insurance falls under the 18% slab, as against the previous service tax of 15%. The increase in indirect taxation is contrary to the positive measures that have been taken over the last few years to develop this sector.

Governments across the world, even in the more mature markets, are known to make conditions favourable for insurance protection. In many countries, life insurance is outside the purview of GST.

In a few, cash flow system is followed for general insurance, e.g. in countries like Australia, Singapore, and South Africa. For the latter, tax is charged on the premiums received and credit is allowed for claims that are paid.

In the Asia-Pacific, where some countries account for the world's highest insurance penetration, GST and value-added tax (VAT) are not levied on insurance products. Exceptions would be some cases in China, where policies of less than one year attract a 6% tax and Taiwan and the Philippines, where tax of 2-5% is charged outside GST framework.

Even in the West, countries like Canada, and the European Union, do not tax life insurance. This tells us that these governments understand the need for insurance protection and encourage it by supportive policy.

Under the GST regime in India, taxability on the gross premium for pure risk policies is contrary to the principle of taxing the "value addition". GST is a tax on value addition and net premium after deduction of claim is the net value addition. It is very difficult to segregate the "savings" component and find a "value" that could be treated as the proper base for tax, particularly for every premium transaction during the life-cycle of an insurance policy.

We have witnessed impressive growth in this sector so far, but there needs to be a sustained effort to retain the growth momentum. Imparting financial literacy, incentivizing Indian households to transfer savings from physical assets to financial assets and taking the distribution network to rural areas are expected to help bring more individuals under the insurance blanket.

The coming years are critical as the policy and regulatory environment and consumer response will govern the growth and stability of this industry.

Buying insurance will continue, provided insurance companies have the right kind of solution-based selling approach and to that extent, a favourable indirect taxation structure would have helped.

Source

Insurance companies in India have strived hard to create financial awareness and increase insurance penetration in the country. As the country strides into a new economic phase, we hope that the industry gets the attention and support that it rightfully deserves.

Back

Life Insurance

New business premium income of life insurance companies up 6 per cent - The Economic Times – 13th July, 2017

The new business premium of life insurance companies grew 6 per cent to Rs 33,156 crore in the June quarter, compared to a year ago, aided by private sector.

The first year premium, or premium earned by selling new policies by private sector industry rose 12% to Rs 9,872 crore, data from the Insurance Regulatory and Development Authority showed.

State run Life Insurance Corporation saw new business income grow by 3% to Rs 23,284 crore.

Among the private sector, listed insurer ICICI Prudential reported strong 57% growth in new business income to Rs 1,973 crore in the quarter. SBI Life, the second largest private sector life insurer, saw 3% decline in new business to Rs 1,798 crore, the data showed.

Other bank promoted insurance company PNB Metlife saw income go up 22% to Rs 230 crore at the end of June 30, 2017.

The regulator added a new category group yearly renewable premium, which captures the growth in the group term insurance space. While the industry collected a total of Rs 606 crore under this segment, private sector contributed a large chunk of Rs 536.44 crore. Earlier, group term was clubbed in group insurance premium, which are fund management for corporate either on an annual or regular basis.

Source

HDFC Life saw 15% growth while Max Life saw 16% increase in new business income during the quarter.

"The first quarter is generally a lean quarter for insurance sales," said a CEO of a life insurance company. "We will see growth coming in coming months."

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General Insurance

IBM's research lab may help farm sector in India with Watson cognitive technology - The Economic Times – 11th July, 2017

IBM's India research lab is looking at ways of using its Watson cognitive technology to help farmers determine potential crop yields and protect against pests, an effort that could increase the use of such data in farmer loans and insurance.

The India research lab counts agri-business as one of the three industries it focuses on in India. The technology — part of a solution called Precision Agriculture — involves the use of a few strategically placed sensors and remote sensing data from satellites to answer questions about the state of the soil, moisture content, weather data and susceptibility to pests.

"Blanketing a farm with sensors is extremely expensive and hard to manage. But data from a small amount of local sensors and data from satellites can be married using cognitive technologies — a process called cognitive fusion. We can answer those questions in a cost-effective way," Sriram Raghavan, director of India Research Labs, told ET.

Cost is of great importance in a country like India, where farms are small and organised farming of large plots of land is still rare. IBM is looking at large agri-businesses and financial institutions as its potential market.

"Agri-businesses have the ability to invest in technology and have an interest in increasing productivity even if the farms are run by individual farmers. The other model is to look at financial institutions," Raghavan said. "We have seen a lot of issues with agri insurance and credit. And while there are definitely non-technology issues to be solved, but there is an opportunity for technology to help provide better visibility to financial institutions."

He added that the company has already had some preliminary discussions with financial institutions.

"With the technology, the financial products they issue in the agri space do not have to be driven just by the credit history of a farmer, which may not be a viable model, but can be driven by knowledge of the farm and focus on health on the farm. This will increase risk awareness."

The company is also using its cognitive technology to help farmers identify pest infestation earlier and in working out supply chains and grain storage.

The research lab also focuses on the financial sector and education space in India and is one of the company's most prolific labs in Asia-Pacific when it comes to patent filings, Raghavan said. IBM was granted 8,088 patents in 2016, out of which 658 were filed by IBMers in India.

"I am not surprised by the fact that India does so well because we have all the different labs in the country. Think we are also seeing a lot of interaction between the labs here and the innovations happening around us and in the market itself," Raghavan said.

Source

The India labs focuses its innovation on three main pillars — blockchain, artificial intelligence and cognitive.

Back

Farmers urged to insure crops under Fasal Bima Yojana – Deccan Herald – 11th July, 2017

In case of crop loss due to natural disasters, such as drought, farmers should enrol for Pradhan Mantri Fasal Bima Yojna (PMFBY) instead of depending on the input subsidy, said Deputy Commissioner D Randeep.

Addressing a media conference, after holding a meeting with Agriculture and Horticulture department officials, at his office, here, on Monday, he said, the input subsidy is meagre when compared to the expenses incurred by the farmers to cultivate the crops, so the only solution to recover the costs, in case of crop loss, is to get insurance claims.

He said, for Mysuru district, 17 agricultural crops and six horticulture crops have been shortlisted for coverage under PMFBY. Appealing to the farmers to enrol for the insurance even though they have not received the claims last year, he said, Rs 6,800 per hectare granted for rain-fed fields, Rs 37,000 for irrigated lands and up to Rs 16,000 for horticulture crops as compensation does not cover the costs incurred by the farmers.

"PMFBY is compulsory for farmers who avail crop loans from banks. The premium is deducted from their bank accounts. Other farmers too should enrol in the banks of their area. Some facilitation centres are also being opened in the rural areas for the convenience of the farmers. Last year, over eight crore claims of farmers for insurance has been made for a total amount of Rs 8.70 crore. There were some lapses in nearly two crore claims. However, Rs 2.35 crore has been settled so far. The claims of the rest of the farmers will be settled shortly. So, farmers should not think that it is of no use to pay the premium this year, as they have not received the claims of last year," he said.

For some crops, the deadline for paying the premium is over. For some others, the deadline is approaching, so the officials have been directed to create awareness among the farmers about the insurance, he added.

Pointing out that 80 suicide of farmers was reported in the last fiscal (2016-17), Randeep said, families of 54 victims have received Rs 5 lakh compensation each, claims of 18 families have been dismissed and the process in under progress for eight claims. "This year, since April 1 to June 11, 2017, 11 suicide of farmers has been reported. Two families have already received the compensation of Rs 5 lakh each. The rest of the claims will be considered before July 15," he said.

Speaking about the payment of compensation for crop loss, the DC said, Rs 45.83 crore has been paid to 89,491 farmers for the loss of kharif crop last year. "For the rabi crop this year, details are being entered online and a total compensation of Rs 16 crore is expected," he added.

He said, both the Agriculture and the Horticulture departments are ready to tackle any situation this year. "The officials have listed out alternative crops, if the rains fail in either July or August, the main sowing season. The necessary seeds and fertilisers have also been stocked adequately. Besides Raitha Seva Kendras, Primary Agriculture Cooperative Societies have also been equipped to distribute the seeds," the deputy commissioner added.

Source

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Insurance a must read for studying overseas – Mint – 11th July, 2017

Indian students are increasingly opting to study abroad. According to EducationUSA, the number of Indian students in the US rose 24.9% in 2015-16 compared to 2014-15. EducationUSA is a US Department of State network of international students advising centres in over 170 countries.

While these numbers are only for the US , they indicate that the number of Indian students going abroad is growing rapidly. "Over 50% of the students from India go to the US. The other major destinations are Germany, UK, Australia and New Zealand," said Puneet Sahni, head, product development at SBI General Insurance. And all these students have to take medical insurance because all the major universities mandate it. For this, students can either get health insurance or a travel policy that provides medical cover in foreign countries. We take a look at some basics of travel insurance policies specifically aimed at students studying abroad.

Student insurance vs regular insurance

Mukesh Kumar, executive director, HDFC Ergo General Insurance Co. Ltd said that students' overseas travel insurance plans provide coverage throughout the tenure of the education programme of the student. "Apart from covering accidents and medical treatment, the policy also covers loss of baggage, loss of passport and documents," he added.

Sahni said compared to a regular travel insurance policy, those directed at students are more like mediclaim covers as they are customised to suit students' requirements for longer stays abroad. In fact, today there are policies that provide cover for up to 3 years at a go.

More than basic health cover

Travel policies, especially those aimed at students, are more than medical covers. "Students must opt for a policy that goes beyond health related coverage. While certain universities may not prescribe this requirement, it is advisable to opt for a policy that covers other contingencies such as sponsor protection, coverage for study interruption and bail bond," said Anuj Gulati, chief executive officer, Religare Heath Insurance Co. Ltd.

A regular travel policy covers only one trip and provides cover for, among others, loss of baggage, health emergencies, trip cancellation, delay in flight and loss of passport. However, the covers for students travelling abroad are more comprehensive. Students should ensure that their insurance provides covers for "sponsor protection—to reimburse tuition fee in case of death of sponsor—and bail bond; for false arrest or wrongful detention" in addition to what regular overseas insurance policies provide, said Anand Roy, executive director and chief marketing , Star Health Insurance Co. Ltd.

"Student travel insurance policies these days also cover risks like suicide, treatment of mental or nervous disorders, and treatment for alcohol and drug dependency. Some policies also cover extended treatment in India," said Mahavir Chopra, director-health, life and strategic initiatives, Coverfox.com. On payment of extra premium, students can opt for additional covers like psychological coverage, treatment for expectant mothers, childcare benefit and cost of screening and examinations, Kumar said.

Mistakes to avoid

Most importantly, the travel insurance policy for students has to be in line with the guidelines of their particular university. "This is important because a student stands a chance to lose the benefit of insurance waiver offered to them by the university in case their policy's coverage does not meet with the respective university's guidelines," Gulati said.

Check that the policy covers out-patient expenses outside the campus too, as some policies limit coverage to in-campus clinics only. Also, check if there are any co-payments or sub-limits applicable on the policy, Gulati added.

Check if your university allows you to buy a policy from outside. "Some universities tie up with local insurers and the students are then mandated to buy those policies," Sahni said.

The cost of policies bought in India is much cheaper compared to insurance policies bought abroad.

However, "Not understanding the requirements laid down by the educational institute before deciding on policy is one of the common mistake made by students. Apart from this, many students buy policies from the university as well as from a local insurance company, which turn out to be way expensive than the Indian policies with equal or better benefits," Chopra said.

For instance, Sahni said, a policy with a medical cover upwards of $250,000 in the US could cost you around $700-750 a year, with sub-limits like out-patient, dental and sports-related treatments, while you can buy a similar student travel cover for Rs15,000-20,000 in India. "There have been product improvements that actually aim at matching the coverage that universities demand. More or less, those are covered but there are certain aspects like a very high OPD limit or a very high dental cover limit, which the Indian policies may not be able to cover as these are very expensive services there," he said.

Source

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Focus on Prudent Underwriting, Govt. to PSU General Insurers – The Pioneer – 13th July, 2017

Sensing a gross violation of underwriting advisory, the Government has directed all State-owned general insurers to strictly focus on the Government's prudent underwriting in their respective companies, a move aimed at reducing insurers' stress on their financial stability and protecting the interests of the policy holders as well.

"In order to protect the interests of the policy holders, ensure that the public sector general insurers continue to effective players in the market for provision of insurance services on a long term basis, and ensure that unhealthy underwriting practices in these companies do not cause unnecessary financial strain on their financial stability. It is desirable that prudent underwriting practices suggested in the Government advisories are followed strictly," said the Department of Financial Services under the Ministry of Finance.

Underwriting services are provided by some financial institutions, such as banks, insurance or investment houses, whereby they guarantee payment in case of damage or financial loss and accept the financial risk for liability arising from such guarantee.

Underwriting losses not only cause financial strain to the insurers due to inter-company competitions but also result in spiking the policyholders' premium in some way or the other. Raising serious concerns over various

undue practices on underwriting by indulging in unhealthy inter-company competition, the Department has shot a letter to chiefs of all Public Sector Unit (PSU) general insurers on June 28, 2017, saying that they need to strictly follow the Government's advisory in this regard.

The Government's move came after the department found gross misuse of underwriting practices in almost all PSU general insurance firms in the country. In the letter, a copy of which has been accessed by The Pioneer, the Finance Ministry said that a proper underwriting mechanism should be put in place. "In order to contain the underwriting losses of the PSU insurers on account of various practices, including lack of prudent underwriting by indulging in unhealthy inter-company competition so as to snatch each other's business by offering uneconomical and unviable discounts, it was felt necessary that a proper underwriting mechanism be put in place."

When contacted, a senior official of the concerned department in the Ministry told The Pioneer, "It is true that we have noticed the gross misuse of underwriting rates in almost all general insurance firms in India. So, we have decided to take prompt and corrective action against those wrongdoings in the interest of customers/policy holders in this matter. We have also asked Chairmen and Managing Directors (CMDs) of all PSU general insurers to kindly note the concern and strictly focus on prudence in underwriting."

However, the Ministry further said in the letter that it found flouting Government advisories by PSU general insurance firms, leading to huge underwriting losses. "As a result, these companies are solely dependent upon the investment income or profit from sale of investment. However, these are limited investments and are fast depleting as a result of indiscriminate disposal by the companies to make up for the losses on underwriting premium. Such an arrangement is not sustainable in the long run and has the capacity to permanently harm the competitiveness of the public sector insurers," it added.

In most of the cases, it has been observed that insurers, both life and non-life, generally show huge underwriting losses following 'fake or unjustified claims by policyholders in some way or the other. In general insurance case, natural death is often passed off as an accident to get personal accident claims. Further, in areas like health insurance and motor insurance, fake bills for hospitalisation or vehicle repair are presented so that an insurer is forced to pay cash to the policyholders. However, industry sources said Oriental Insurance among other PSU general insurers incurred underwriting loss to the tune of around Rs 1,600 crore last year.

Citing yet another example, the Ministry said that a case of violation in health insurance scheme was brought to its notice and disciplinary action against the insurer was also contemplated. Issuing a note of warning for such insurers, it further said, "An appropriate pricing mechanism for pricing group health insurance should take into account the existing incurred claims ratio or ICR, management expenses, medical inflation, commissions, likely increase in quantum of claims due to ageing of covered group, increase in size of group, cost of underwriting of business and other such associated factors."

Even after 17 years of liberalisation, the insurance industry continues to register huge underwriting losses every year, and it is an investment income which drives the growth of the industry. As per industry estimates, the general insurance industry pays around Rs 70,000-75,000 crore in claims annually, mostly towards motor, health and marine cases. However, experts said that numerous false road accidents have become a curse for general insurers in most parts of the country.

Source

"In an investigation, it was found that it was flooded with disproportionate road accident claims from Uttar Pradesh. In many cases, those who died of natural causes were filed as road accident victims, causing enormous losses to insurers. After getting a handle on a few false claims, it managed to file 30 complaints with the police after the Lucknow High Court ordered special investigation into the cases," said a top insurer on condition of anonymity.

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Bank locker insurance: How to buy cover under householder's policy – The Financial Express – 12th July, 2017

How can I take insurance cover for contents of my bank locker? – Deepak Sharma

Many banks offer safe-deposit locker facility to their customer for depositing their personal belongings, mainly gold ornaments, cash and other important documents in lockers in exchange of a particular annual charge/fee. However, the bank is in no position to compensate for losses as there is no way to identify the locker contents.

Hence, necessity for insurance cover for contents in the bank locker arises. 'All Risk cover' offered by a few general insurance companies as an optional cover under householders policy (home insurance) would provide some comfort. This cover provides coverage for gold ornaments and other valuables outside the residential premises, including that kept in the bank locker.

Is it mandatory to take an insurance cover for my bike which I ride once in six months? —Ravi Razdan

It is mandatory for every vehicle in India, irrespective of it being a bike, car or a truck to have third-party insurance while plying on the roads. However, it is not necessary to have an own damage cover. Though there has been rise in two-wheeler thefts and accidents in India, we always advise two-wheeler vehicle owners to opt for comprehensive policy (third-party + own damage), whether they ride it on a daily basis or once in six months, for indemnifying the damages caused to the bike or for any unfortunate incident of theft taking place.

Can household items be insured in my second flat in the hills which I visit only during summer breaks? — Subir Ray

Yes, the content as well as structural damages due to fire and allied perils can be covered for your vacation home. It is prudent to mention to the insurance company about the frequency of your visits to your second flat at the time of purchasing the home insurance policy, to avoid any hassles at the time of a claim, if any. For content insurance like coverage towards television sets, refrigerator and other electronic items, ensure you maintain original receipts of the electronic items at the time of indemnifying and evaluating the losses with the appointed surveyor of the insurance company during the time of claim.

Source

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Regulations

New rules to protect policyholders – Mint – 12th July, 2017

The Insurance Regulatory and Development Authority of India (Irdai) has notified new rules to protect policyholder's interest. You can read the full notification here. While the regulations work towards ensuring that insurers settle all kinds of claims on time by defining the penalty on delays, there is much left to be desired in addressing better disclosures for the customers. We take you through some key provisions of the notification and also bring you experts' views on what more could have been included in it.

Penalty on late payments

If an insurer delays claims payments, it has to pay a penalty that's 2% over the bank rate, which is specified by the Reserve Bank of India, as on 1 April of that fiscal. For instance: in life insurance, after a claim is made, the insurer needs to ask for all the documentation within 15 days and take a decision on the claim and make the payment within 30 days. This is the norm even now. And, if a claim has to be investigated further then the insurer gets up to 90 days for investigating. If the insurer decides to pay, it has to do so within 30 days from when the decision to pay was taken. Insurers will attract penalties for not adhering to these timelines. The notification also clarifies that if a claim is ready for payment but the payment cannot be made due to reasons of proper identification of the payee, the insurer will still pay a penalty. For settlement for maturity proceeds and annuities, insurers have to notify the policyholder in advance or send post-dated cheques or transfer money to the bank account so as to pay the claim on or before the due date. For surrenders, free-look cancellations and withdrawal request, the insurers will have to pay within 15 days of receiving the request, or the last necessary document. A delay in this case will also invite penalty.

"Earlier there was some ambiguity in the way penal interest for delayed settlement of claim was calculated.... But now we have brought about clarity in the rate at which it has to be calculated and the duration for which it has to be paid," said Nilesh Sathe, member, life, Irdai. "Now, if an insurer is supposed to settle the claim in 30 days, but takes 31 days, then it needs to pay interest for 31 days and not just 1 day," he added. This would lead to faster settlement of claims. "The timeline mandated for investigation of a death claim has been reduced to 90 days from 180 days. This, along with a penalty on delays, will help in speedier settlement of death claims," said K.S. Gopalakrishnan, managing director and chief executive officer, Aegon Life Insurance Co. Ltd. "But this alone may not solve all the problems regarding settlement of claims. For instance, the industry has to look at ways of simplifying surrender requests," he added.

For non-life policies also, there is now a limit of 30 days to settle claims—after insurers get all the documents, including surveyor's report . And if insurers don't follow the timeline, they have to pay a penalty. In health insurance, if a claim needs to be investigated, the insurer will need to complete it within 30 days and settle the claim within 45 days from the date of receipt of the last necessary document, or pay a penalty.

For other non-life policies where a surveyor is appointed, the regulations have laid down timelines to appoint the surveyor and submit the report. Further, the surveyor's report needs to be given to the policyholder if she asks for it—which is important because a surveyor is appointed by the insurer to investigate claims and is the basis on which an insurer takes the decision on a claim. "The notification also mandates insurers to categorise exclusions that are standard, specific to policy, those that can't be waived and those that can be waived on payment of extra premium. This is important because in motor insurance there are many exclusions such as depreciation or engine loss that can be covered by paying extra," said Puneet Sahani, head, product development, SBI General Insurance Co. Ltd. "This will also make people aware of add-on covers that take on such exclusions. In motor there are about 20 add-ons that people don't know much about," he added. The notification outlines features and other terms and conditions that needs to be stated explicitly in a policy. For instance, in life insurance an insurer needs to state things like the type of policy, features, information on premium payment, riders, exclusions, policy conditions for surrender or discontinuance, revival of the policy and the grievance redressal mechanism. Insurance Regulatory and Development Authority (Irdai) has given the insurers till 31 December to make such changes in their policy documents.

The notification also states that distributors will provide all the material information regarding the policy, and that the insurers will have to obtain a certificate from the policyholder certifying that the proposal form and policy documents have been fully explained and that the policyholder understands the policy.

What it lacks

The notification is missing the 'key features document', which aims to simplify the salient features of a policy. Irdai, in its draft released in February 2017, had asked for this document, which would carry the main features of the policy in simple language and in bold and attractive print. This document was intended to make policyholders aware of the most important features.

However, according to Gopalakrishnan, this is still being deliberated upon by the Life Insurance Council, an industry body. "The insurers are jointly working on introducing a simple key features document that will help customers understand what they have bought, including their obligations, in a simpler language," he said.

According to Kapil Mehta, co-founder SecureNow.in, the notification is a baseline that must be built on overtime. "The regulation doesn't recognize verbal complaints but it's important that verbal complaints also get recorded and measured. There should be an onus on the insurers to deliver a renewal notices particularly in health insurance," he said.

For instance, if a policyholder does not pay health insurance premiums on time, she loses all the benefits with regard to the waiting period and has to apply for a fresh policy. "Also, health insurers shouldn't be allowed to add exclusions when insurances are renewed," added Mehta. Mint has been stressing on the need for meaningful disclosures and one important step towards this would be to disclose the net return on investment for guaranteed insurance-cum-investment products.

In fact, for non-guaranteed products that come with benefit illustrations assuming a rate of 4% and 8%, a disclosure of net return is important to understand the costs.

Source

This is already mandated in the case of unit linked insurance plans (Ulips). Such disclosures didn't find a mention in this notification but according to insurers these are being reviewed by the product committee that was set up by the regulator.

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Health Insurance

IRDAI issues new norms for mediclaim policies – The Times of India – 13th July, 2017

Many customers only realise at the time of making a claim that their health insurance policy does not cover certain medical conditions or ailment. Policy holders usually depend on what has been told to them by their

insurance agents, who sometimes overstate the coverage. To prevent such cases, the Insurance Regulatory and Development Authority of India (IRDAI) has asked insurers to group together all policy exclusions upfront in the policy document.

Misselling is a huge problem for the insurance industry as, of 1.72 lakh complaints in 2016-17, about 50% related to unfair business practices, according to IRDAI's consumer booklet 2016-17.

SBI General Insurance head (health) Puneet Sahni said, "Many a times, exclusions are lost in a maze of fine print. But the IRDAI has now said that the terms and conditions for claims, renewals have to be bifurcated. So that customers exactly know the coverage limits of their policy." Another change with the new regulation is the introduction of penal interest. "If customer is not paid the claim within 90 days of reporting, the insurer has to pay the bank rate + 2% interest for every day of further delay," said Sahni.

An important addition pertinent to policyholders is the regulator's insistence that the insurer mentions service parameters or turnaround time.

"Often, there is a delay in the settlement of claims. It could be a three-month or six-month delay, or more. And the insurer's lethargy over the claim would be made known to the public only when IRDAI publishes its annual report. Now the regulator is trying to increase accountability by insisting they put up on their website the average servicing time taken for claims - as approved by their board," said an executive at a private general insurer.

The 'IRDAI Protection Of Policyholders' Interests Regulations 2017', released a couple of days ago, said, "Every insurer shall display the service parameters and turnaround times as approved by the board in its website and keep the same updated as and when the service parameters are revised by the board."

Source

With the prevalence of employer-paid health insurance, IRDAI now insists that the policy document mention upfront co-payer limits if the policy is co-paid by the employees. Insurers are also now required to update on their website the terms and conditions of every insurance product that is withdrawn or modified. And update the list at frequent intervals.

Back

Settle heatlh policy claim in 30 days or pay penal interest – Financial Chronicle – 13th July, 2017

Insurance sector regulator Irdai has directed health insurers to settle claims within 30 days and in case of delay they will have to pay interest at the 'bank rate plus 2 per cent' on the claim amount.

The directive, Irdai said, seeks to protect the interest of policyholders.

"An insurer shall settle the claim within 30 days from the date of receipt of last necessary document. In case of delay in the payment of a claim, the insurer shall be liable to pay interest from the date of receipt of last necessary document to the date of payment of claim at a rate 2 per cent above the bank rate," it has said in a notification.

The Irdai notification comes under Irdai (Protection of Policyholders' Interests) Regulations, 2017. The Insurance Regulatory and Development Authority of India (Irdai) said the objective of the guideline is to ensure that policyholders' interest are protected as well as to ensure policyholder-centric governance by insurers with emphasis on grievance redressal.

However, in cases where the claim process warrants an investigation by the insurer, Irdai said it must be completed not later than 30 days from the date of receipt of necessary document. "In such cases, insurer shall settle the claim within 45 days from the date of receipt of last necessary document."

In case of delay beyond 45 days, the health insurer should pay interest 2 per cent about the bank rate from the date of receipt of last necessary document to the date of payment of claim, it added. The regulator has also directed insurers should have a proper policy in place to resolve complaints and grievances of policyholders, claimants effectively and speedily.

Among others, insurers need to display service parameters and turnaround time, as approved by the board on their website and update as and when the parameters are revised. Further, the policy document must also state clearly the scope of policy benefits, extent of insurance cover, allowable riders or add-on covers on the insurance products.

Source

"The premiums pertaining to health related or critical illness riders shall not exceed 100 per cent of premium under the basic product, the premiums under all other life insurance riders out together shall not exceed 30 per cent of premiums under the basic product and any benefit arising under each of these mentioned riders shall not exceed the sum assured under the basic product," it said.

Back

Claim rejection lower in health policies purchased online – Financial Chronicle – 13th July, 2017

DisclosureS made by the customer about health issues and habits is much higher in an online purchase of policy compared to offline purchases. Claim rejection is also lower in this category of policies, according to insurers.

Rejection of claims, including those filed before the end of the waiting period, is 1.5 per cent in digital policies, whereas it is 4 to 5 per cent in offline policies, finds insurance aggregator Policybazaar.

“The level of understanding of the policy and disclosure is higher in online purchases. An agent may try to hide exclusions and waiting period details from the customer on one hand and withhold details of the customer to the company on the other for the sake of a sale. An online customer, however, knows the risk of not disclosing details,” said Vaidyanathan Ramani, joint head, health insurance business unit, Policybazaar.com.

“Self-disclosure by the customer is always more detailed and credible. The customer buying online is in a risk reduction mode, hence the desire to clearly express and disclose health conditions and any other relevant information is high. Further email ID and mobile number capture is almost certain, thus the ability to contact a customer is higher,” said Gunjan Ghai, SVP and ntional head-branding and marketing and product development, SBI General Insurance Company.

Customers buying online or direct are more aware in general. Also the need to declare everything accurately to prevent any issues, at the time of claim, is a strong motivator, he added.

Sandeep Patel, MD and CEO, Cigna TTK Health Insurance too finds that the level of disclosures is high wherever customers self-declare. “This is because customers would rather err on the side of caution and online customers are far more educated and aware about claims rejection,” he said.

The customers who buy online would have usually researched the product and its fitment to their needs adequately. Hence the risk of mis-selling or not understanding the product being bought is lower. Further, distance marketing guidelines of the Irdai offer a great deal of protection to customer interests when buying online or direct. Hence post-purchase dissonance is also handled better, said Ghai.

Moreover, the communication made between the company or aggregator and the customer is transparent in an online transaction.

“All product and policy related documentation is available online at the convenience of a click / tap. All call recordings can be made available and are frequently referred to in case the need arises,’’ said Patel.

Source

“The communication between us and the customer before the purchase is recorded and it is possible for the company to go back and check whether the customer was aware of the terms and conditions. Increased transparency and better disclosure leads to lesser claim rejections,” said Ramani.

Back

How Useful are Value-added Benefits of Health Insurance? – The Economic Times – 10th July, 2017

THE RIGHT FIT Understand the range of offerings made by cover companies: how they work and their benefits Health insurance companies today offer a range of value-added benefits that enhance your base coverage. We look at the some of the most common offerings to understand how they work and whether they are useful.
WELLNESS PROGRAMMES

Wellness programmes are nothing but the reward points that you get from your insurer for staying fit and healthy. Of course, the main motive is to lower the insurer's costs in the long run. “Not only would these wellness programmes inculcate a healthy lifestyle among the customers, but shall also reduce the incoming claims for the insurers,“ says Sasikumar Adidamu, CTO ¬ Non-Motor, Bajaj Allianz General Insurance. You would need to work hard to keep yourself physically active to ear n those reward points. For one, ICICI

Lombard offers you maximum 100 points for quitting smoking based on selfdeclaration.Likewise, there are maximum 5,000 reward points per insured for other fitness ac tivities like gym, yoga, marathon, etc.Each reward point is equivalent to 25 paise. That means, if you to gain all 5,000 points in a year, you will get `1,250 as benefit. This can be used for reimbursing expenses that are not covered under your basic policy such as consultation charges and dental expenses.

Cigna TTK, on the other hand, offers you reward points for the number of steps taken on a daily basis under its `Get ProActiv India' wellness programme. For every 12,500 steps or more daily , you get 1.25 points. One reward point is equivalent to `1, which makes to `1.25 for 12,500 steps. The programmes and benefits vary from one insurer to another.

OUR ASSESSMENT

Difficult to get rewarded as benefits do not come easy .

AYUSH BENEFIT

AYUSH stands for Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy . It is an alternative form of treatment and the benefit is available as an in-built feature under some health insurance policies. “In India, a lot of people believe in the Ayurveda andHomeopathic system of medicine and are not inclined towards allopathy especially for chronic care. This benefit is useful for treatments which would be otherwise non-payable un der a basic policy ,“ says Puneet Sahni, head product de velopment, SBI General Insurance.

Adidamu con curs: “AYUSH may be particu larly beneficial for those suffer ing from life style related and chronic diseases and those who may be allergic to allo pathic drugs.“

While AYUSH can be beneficial, it comes with its own terms and conditions. First, the coverage is subject to a sublimit which is either specified as a percentage of the sum insured or a maximum amount that you can avail. For instance, Apollo Munich's Easy Health policy offers AYUSH benefit of maximum up to `50,000 only , depending on the plan variant and the sum insured. Second, the AYUSH benefit is rarely available on an outpatient basis. One has to stay for a minimum 24 hours in the hospital offering AYUSH treatment. “The H premium is also higher g by about 5 1 0 % fo r Y plans offering AYUSH benefit as t compared to basic policies,“ says Har jot N a r u l a , C E O, ComparePolicy .

OUR ASSESSMENT

Stringent rules, useful for Ayurveda and Homeopathic treatments.

MEDICAL REPATRIATION

This used to be a feature for travel policies, as the patient may be required to be moved to the nearest available facility or sometimes the nearest country .But nowadays this benefit is also being offered under some health insurance policies. Medical emergencies overseas could be really expensive or facilities may not be available for the right treatment. In such cases, this benefit can come handy .

But like other benefits, it comes with strings attached. For instance, Max Bupa offers emergency medical evacuation benefit under its Heartbeat Family First Platinum Plan. The cover is available worldwide but excludes locations such as the USA and Canada. Aditya Birla's Activ Health policy covers worldwide emergency assistance services, but for outside India, hospitalisation and surgery expenses are not covered. “One should also note that such evacuation expenses become payable only when the main claim for hospitalisation is payable,“ cautions Roy .

OUR ASSESSMENT

Limited and condition al coverage.

SUM INSURED RESTORATION

With this benefit, you can restore the base sum insured to the original amount in the event of its exhaustion. For instance, if you ex haust your base cover, you can restore it back to in a year. But is it any use 100% in a year. But is it any useful? Industry numbers show that health claims hardly get fully exhausted. You could be better off purchasing a top-up or super-top up plan to enhance your cover. Though it may come at a

comparatively higher cost, it gives you better coverage. Not only is the sum insured available beyond the selected threshold of the deductible amount, but also there are no restrictions on the same illness.

OUR ASSESSMENT

Top-up or super top-up plans provide better coverage and enhancement than a restoration option.

CUMULATIVE BONUS

Cumulative bonus in health insur Cumulative bonus in health insurance is like no claim bonus in motor insurance. It is a reward given to the policyholder in the form of increased sum insured in specified percentage for every claim-free year. For instance, Bajaj Allianz's Health Guard Individual Plan offers a cumulative bonus of 10% of base sum insured per annum and the maximum is limited to 100% for 10 years.

Source

OUR ASSESSMENT

Can be useful for increasing base sum assured.

Back

How to make a claim on multiple health insurance policies - The Economic Times – 10th July, 2017

Not many people hold health insurance policies but some of those who buy it have bought it from more than one insurer. Some policyholders could simultaneously be covered under a group cover.

Holding a policy from more than one insurer would make sense if the coverage, benefits are somewhat different from one another.

"Multiple indemnity policies having identical coverage does not benefit the policyholder, ideally coverage in multiple policies should be mutually exclusive. When buying multiple benefit policies it is utmost important that the second insurer is made aware of the existence of the first policy as that forms a crucial part of underwriting," says Parag Gupta, Chief Underwriting Officer, Bharti AXA General Insurance.

The health insurance policies such as Mediclaim are indemnity covers i.e. only the hospital bills get reimbursed up to the sum insured of a policy. The other variant of health insurance policies are the defined-benefit policies i.e. the entire sum insured gets paid on the occurrence of the defined event (ailment) irrespective of the hospital bills.

Holding multiple policies: indemnity covers

If someone holds more than one health insurance policy, as a policyholder, the claim can be settled from any of the insurers. It is not mandatory that the policyholder has to approach all the insurers whose policy he or she holds. The claim can be settled from any insurer which the policyholder prefers to go with.

The total hospital bill need not be shared between the insurers as the claims settlement is not on the basis of 'contribution clause' which was done away with, a few years back. Under that, the claim had to be settled by all the insurers in the ratio of sum insured of the policies held by the policyholder.

Partly paid by insurer

In case an insurer doesn't make the entire payment and disallows a certain amount, a policyholder can still approach the other insurer. Last year, IRDAI had clarified that "the policyholder having multiple policies shall also have the right to prefer claims from other policies for the amounts disallowed under the earlier chosen policy, even if the sum insured is not exhausted."

Exhaustion of sum insured

If the hospital bill exceeds the sum insured in a policy, one may apply for claiming the balance from the other insurer. "If the amount to be claimed exceeds the sum insured under a single policy after considering the deductibles or co-pay, the policyholder shall have the right to choose insurers from whom he/she wants to claim the balance amount," says M Ravichandran, President, Tata AIG General Insurance.

Which policy to choose

As a policyholder, if you are holding more than one policy, one can ask any one insurer to honour the claim. But, how should one decide as because a claim will have an impact on the no-claim bonus (NCB) and the waiting periods in an existing policy? "Cumulative Bonus is reduced in the same proportion that it increases every year but there is no impact on the waiting period," says Gupta.

For someone who is also insured under a group health insurance plan, the choice is much easier. "If a customer has one retail policy and a group policy, it is better to claim first under the group policy as there are no accrued benefits like NCB, no claim health checkup, etc in it. Also, group policies would generally have wider coverage than a retail policy, especially related to waiting periods," says Ravichandran.

How to claim

For claims, insurers insist on original hospital bills and discharge summary. If a policyholder has to make claims from more than one insurer, there could be concerns regarding documentation. Gupta informs, "For claiming from the second insurer customer can submit true copies (self-attested) of documents along with the original settlement letter from the first insurer."

Holding multiple policies: fixed-benefit covers

Critical illness plans are typical fixed-benefit insurance policies. They come as a rider (with a life insurance policy) or a standalone policy. As per the IRDAI rules, all the claims on multiple fixed-benefit insurance policies have to be honoured by each insurer. "Section 24 of the Health Insurance Regulations 2016 states that in the case of multiple policies which provide fixed benefits, on the occurrence of the insured event in accordance with the terms and conditions of the policies, each insurer shall make the claim payments independent of payments received under other similar policies," says Ravichandran.

In the case of critical illness plans, the claim is relatively simpler. " Critical Illness policies are the defined-benefit policies and the claim is payable immediately at the time of occurrence of the illness covered under the policy without any need of submission of hospital bills, informs Atrey Bhardwaj, Head, General Insurance BankBazaar.

Source

Conclusion

As a policyholder, holding more than one policy, disclosure and transparency are important. Make sure you disclose not only material health conditions, pre-existing ailments but also let the insurer know about the existing policies if any.

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First Year Premium of Life Insurers for the Period ended 30th June, 2017 – 12th July, 2017

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Roadmap for creating a database to be housed in IIB – 13th July, 2017

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Global

Nepal:Several new insurers to start ops, with more to follow – AIR edaily – 10th July, 2017

Three new players have received life insurance licences from the Insurance Board (IB), which regulates the insurance market in Nepal.

The three are IME Life Insurance Company, Jyoti Life Insurance and UniLife Insurance. They have to start operations within six months of 2 July when they received the licence, reported Himalayan News Service.

even other companies have already received a letter of intent from the IB. They are Citizen Life Insurance, Star Life Insurance, Sun Nepal Life Insurance, Sanima Life Insurance, Reliance Life Insurance, Reliable Life Insurance and Mahalaxmi Insurance.

These companies need to fulfil the minimump aid-up capital requirement and submit their documents to the IB within two months to get an operating licence.

Insurance companies must have a paid-up capital of NPR2 billion (US$19.3 million), according to letter of intent issued by the IB. Of the total paid-up capital, 30% should be set aside for the general public in the form of ordinary shares.

Source

The investors of the seven companies submitted applications to the IB in the fiscal year ended July 2008. Currently, there are eight life insurance companies operating in the market.

Back

Nepal:Premium for terrorism, strike cover to be cut wef 16 July – AIR e-daily – 13th July, 2017

Nepal's insurance regulator will lower insurance premiums against combined risks from terrorism, strikes and malicious damages with effect from 16 July, the first day of the next fiscal year for the country.

The Insurance Board (IB), the insurance sector regulator, has announced that the premium rate has been reduced to NPR200 (US$1.94) per policy amount of NPR1 million from the existing tariff of NPR260. The reduction is to be made because the incidence of terrorism, strikes and malicious damages has reduced in recent years.

"As we are hardly seeing any incident of terrorism- related sabotages and the number of strikes being organised by political and other forces is also nominal, we are implementing the reduced insurance premium for coverage of damages from terrorism and strikes," Shreeman Karki, IB director told the Xinhua News Agency.

During the years from 2008 to 2013, a total of 4,451 strikes, small and large, took place as the country underwent a turbulent period of transition after the end of the civil war in 2006, according to a study by Nepal Rastra Bank, the central bank of Nepal. However, since the second constituent assembly elections were held in 2013, the number and frequency of strikes have gone down sharply, barring a prolonged strike in the southern plain when Nepal promulgated the new constitution in 2015.

Source

Back

Saudi Arabia:Health insurers reject 25% of claims alleging fraud – AIR Middle East – 9th July, 2017

Insurance companies in Saudi Arabia are rejecting about 25% of medical claims from hospitals and other service providers on the grounds of fraud.

Identity fraud and other fraudulent practices committed by patients and service providers are the main reasons for heavy losses suffered by health insurance companies, said Mr Maher Al-Joairy, an insurance expert. He attributed the growing incidence of fraud to weak systems, reported The Saudi Gazette. He proposed affixing photographs of insured persons on health insurance cards in order to prevent misuse and foul play and to reduce losses for insurance firms.

Source

Health insurers are now thinking of how to avoid losses instead of how to make profits as a result of the fraudulent practices in the sector, he said.

Back

Oman:New rules for approving insurance products to be introduced – AIR Middle East – 13th July, 2017

Oman's Capital Market Authority (CMA) has plans to implement new rules for insurance products, including approval and marketing.

The new rules include classification of products according to type—life insurance, general insurance and takaful insurance, reported Times of Oman.

The directives for the approval of an insurance product contain several requirements. The product must be compatible with laws and regulations of the insurance sector and the requirements of the Code of Conduct for Insurance Companies. The product must be designed, based on proper insurance principles. The insured risks under the policy must be clear and transparent with no ambiguity.

All related printed material must be in simple and clear language. All technical terminology must be explained in simple language. In addition, the terms and conditions concluded between the insurer and the insured must be fair.

The product must comply with the approved underwriting and pricing policies set out by the board of directors of the insurance company, and certified by the actuary. Takaful products, in addition, must be certified by the Shariah Supervisory Board.

CMA's efforts are focused too on the rules relating to the marketing of insurance products, taking into account the technical and legal requirements for marketing each product, said Mr Rashid Mohammed Al Rashdi, director of the Department of Requirements and Licensing of insurance institutions.

Source

Mr Al Rashdi expressed the hope that the new measures would enhance competition and innovation among insurers.

To explain the new requirements, the CMA organised a workshop that was attended by representatives of national and foreign insurance firms operating in the Sultanate, as a prelude to implementation.

Back

Hong Kong:New insurance regulator to draft Code of Conduct – AIR e-daily – 14th July, 2017

The Insurance Authority (IA), which started operations last month, will work with the industry to draw up a code of conduct and other requirements for the licensing and training of salespeople over the next two years before licensing applications begin.

Mr Stephen Po, the IA's Executive Director of Market Conduct, said: "There will be a lot of guidelines, to make sure only fit and proper people can get a licence to sell policies to the public."

The regulator plans to spend its first two years determining new licensing requirements for the roughly 100,000 insurance salespeople in the city, but will not grant any exemptions from tougher regulations, reported South China Morning Post.

Mr Moses Cheng Mo-chi, IA Chairman, said: "At present, there is no plan for any grandfather clause for existing agents. This means all of the roughly 100,000 insurance salespeople in Hong Kong will need to meet the minimum qualifications to apply for the licence."

"They will all need to receive training every year to continue selling policies in Hong Kong. This means some existing agents may not be able to get a licence for them to stay in the industry."

Mr Cheng also said the authority has no plans to regulate products.

"Hong Kong is a free market so we don't want to add restrictions on the products. However, we would require companies to give fair treatment to policyholders when they design products," he said.

Source

The IA replaced the government department, The Office of Commissioner of Insurance, which was previously responsible for regulating insurance companies. Under the former system, insurance salespeople did not have to apply for a licence, but needed to register with three different self-regulating bodies.

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