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QUOTE OF THE WEEK

"Trust is the glue of life. It's the most essential ingredient in effective communication. It's the foundational principle that holds all relationships."

Stephen Covey

INSIDE THE ISSUE

INSURANCE TERM FOR THE WEEK

Life Assured

Definition: Life assured or insured is the person(s) whose life is covered in the insurance contract.

Description: In the event of a contingency, the insured can claim the amount or in the event of the death of the assured, the nominee will receive the insurance amount.

Source

INSURANCE REGULATION

Proposed insurance regulations opposed – The Times of India – 18th November 2019

The Hubballi unit of Indian Institute of Insurance Surveyors and Loss Assessors (IIISLA) has opposed the Insurance Regulatory and Development Authority of India (Insurance Intermediaries) (Amendment) Regulations, 2019.

The proposed regulations will adversely impact the interest of insuring public and economy of the country, it said.

M N Hegde, coordinator, IIILSA, Hubballi unit, said on Saturday that the Insurance Regulatory and Development Authority of India (IRDAI) has the text of the proposed regulations as exposure draft for opinion of all stakeholders including the public till November 21.

"If insurance employees are engaged to interpret the policy contract of which they are the party and also settle the claim, then the outcome would be obviously be inclined towards company's benefit instead of instead of insuring public. It's a serious case of conflict of interest and breach of natural justice," he said.

Bharat Dharamshi, former secretary, IIISLA, South Zone, said that customers not well versed with the fine prints of policy will fall prey as the employee surveyor will either reject or reduce his legitimate claim on the pretext of small and avoidable technical deficiencies.

"As a result, the customer will not only suffer but also lose confidence on insurance protection. The cascading effect of this fall out will be similar as seen in the banking sector" he worried.

Sriranga Hanamasagara, former secretary, IIISLA Karnataka chapter, said that in the absence of neutral body like IRDAI and licensed and independent surveyors, such practices will go out of bound like we have seen in agriculture insurance. "The regulation has no mechanism in place to check these malpractices" he mentioned.

The trio said that various committees have made unanimous recommendation that each claim arising out of insurance policy should be settled by an independent and licensed insurance surveyor, but not by in-house employee or surveyor, to avoid conflict of interest.

TOP

Source

LIFE INSURANCE

Banking set to see a recovery, life insurance the next big sector: BNP Paribas - Moneycontrol – 21st November 2019

The economic slowdown is likely to weigh on the credit offtake of the banking system, but brokerage firm BNP Paribas says in India the sector will recover, thanks to lower cost of funds, cost efficiencies and lower tax.

The brokerage said higher operational efficiency driven by digital initiatives and lower workforce requirements will ensure that the cost to income ratio maintains its downward trajectory.

"We believe a lower cost of funds, cost efficiencies, and the benefit from lower tax rates should lead to return on equity (RoE) accretion of 370bps for private banks. Higher RoEs should warrant much higher price-to-book ratios (P/Bs). We see a 10-15 percent upside from current valuations for private banks over the next five years," said BNP Paribas.

Given that the asset quality cycle has peaked, the credit cost should be lower than those in the previous cycle, the brokerage said.

BNP Paribas see public sector banks (PSBs) back in the green over the next five years. However, their ROEs will be in mid-single digits, implying a limited upside to their valuations over the next five years, the brokerage said.

BNP Paribas said HDFC Bank still has the potential to deliver the strongest shareholder return over the next five years– a CAGR of more than 20 percent. Kotak Mahindra Bank can also deliver a significant return by unlocking shareholder value in its subsidiaries.

The brokerage says life insurance is the next big sector.

"We believe life insurance is likely to witness its 'Jandhan' moment soon, where Indian consumers start looking at insurance as essential rather than optional. As awareness spreads and the insurable pool increases, insurance is likely to be more affordable," the brokerage said.

BNP Paribas expects insurance penetration to increase significantly over the next 10 years. Given most regulatory challenges have been addressed and processes are in place, insurance should witness uninterrupted growth in the next ten years, similar to what banks saw in 2005-2015.

The brokerage expects life insurance players with strong bancassurance partners to stand out over the next 10 years. "The top three private players (that) qualify as our top picks are HDFC Life Insurance Company, SBI Life Insurance Company and ICICI Prudential Life Insurance," said the brokerage.

Over the last one year, most macro indicators have worsened consistently, pointing to a slowdown across sectors.

Auto sales, cement production, IIP, rural wage growth, unemployment numbers, export growth, etc are all at multi-quarter lows.

Of the 35 macro indicators, only four have shown a positive trend for the last three months, BNP Paribas Securities said.

Exhibit 66: Relative Valuations

	Rating	New TP	Chg	Price	Upside/ Downside	P/BV		P/E		ROA		ROE	
						FY20E	FY21E	FY20E	FY21E	FY20E	FY21E	FY20E	FY21E
		(INR)	(%)	(INR)	(%)	(x)	(x)	(x)	(x)	(%)	(%)	(%)	(%)
Private Sector Banks													
Axis Bank	Buy	909	2	717	26.8	2.4	2.1	26.1	13.9	0.9	1.5	10.2	16.0
HDFC Bank	Buy	1,550	2	1,256	23.4	4.1	3.4	24.6	19.0	2.1	2.2	17.5	19.5
ICICI Bank	Buy	530	-	489	8.3	2.7	2.4	30.9	18.2	1.0	1.5	9.4	14.3
IndusInd Bank	Buy	1,929	2	1,423	35.6	2.7	2.3	17.4	13.1	1.7	1.9	17.6	18.9
Kotak Mahindra Bank	Buy	1,953	9	1,600	22.0	4.5	3.9	30.7	25.3	2.3	2.4	16.0	16.6
AU Small Finance	Buy	812	1	690	17.8	5.8	5.0	44.2	31.8	1.5	1.5	15.2	17.2
Public Sector Banks													
State Bank of India	Buy	428	7	316	35.4	1.2	1.1	17.2	8.6	0.4	0.8	7.3	13.3
Insurance													
SBI Life Insurance*	Buy	1,030	11	982	4.9	3.8	3.2	61.1	54.7	1.0	1.0	19.9	19.0
HDFC Standard Life *	Buy	681	-	568	19.9	5.3	4.4	74.9	67.3	1.1	1.1	25.0	23.5
ICICI Prudential Life*	Buy	550	-	519	5.9	3.0	2.6	38.9	33.6	1.1	1.1	25.9	27.4
Housing Finance													
HDFC	Buy	2,711	3	2,233	21.4	4.5	4.1	38.2	32.1	2.1	2.2	12.4	13.5
LIC Housing Finance	Buy	566	9	440	28.8	1.2	1.0	9.1	7.0	1.0	1.1	13.5	15.6
PNB Housing Finance	Hold	521	6	571	(8.7)	1.1	0.9	7.8	6.1	1.2	1.3	14.5	16.5
Can Fin Homes	Buy	465	-	402	15.7	2.4	2.0	12.9	10.5	2.0	2.0	20.3	20.5
Asset finance													
Mahindra Finance	Buy	485	4	329	47.4	1.6	1.4	13.4	9.8	2.1	2.5	13.0	15.6
Shriram Transport Finance	Buy	1,443	4	1,116	29.3	1.4	1.2	9.7	7.8	2.4	2.6	15.6	16.9
Consumer finance													
Bajaj Finance	Buy	4,482	1	4,159	7.8	9.9	7.6	44.2	29.6	4.4	5.0	25.1	29.1

Source: BNP Paribas Estimates. CMP as of 15th November 2019

While there are expectations there could be a mild recovery in Q3FY20 on account of the festival season, there is a high probability that macro indicators turn negative after that.

The brokerage said the problem is not necessarily demand-related, it is likely on the supply side, too, such as manufacturers taking time to adjust to changing consumer preferences (eg better quality cars and ready to occupy houses), banks' reluctance to lend and regulations that need easing to boost sentiment for a CAPEX cycle revival.

BNP Paribas said there are multiple cushions to help avoid a hard landing for the Indian economy.

"Our analysis of housing finance companies (HFCs) and unsold real estate (RE) inventory indicates no systemic risk. Public sector bank balance sheets are stronger with H1FY20 CET 1 at 10.6 percent against 8.3 percent in FY14, PCR is at 59 percent against 41 percent in FY14," said the brokerage.

"We estimate the corporate tax rate cut to lead to an additional CET1 of 82bps, further improving bank balance sheets. Housing affordability is back at 2006 levels. A healthy monsoon has led to a 20 percent surplus in reservoir levels. Stressed sector balance sheets are seeing a mild recovery," BNP Paribas added.

(The writer is Nishant Kumar.)

Source

TOP

Evolution of ULIPs over the years – DNA – 21st November 2019

"You learn so much about a business in the months before launch, but your education really begins on the day you open doors to your customers." – Richard Branson

The very first and centre for any product evolution, across industries, is to provide more value to the customers. It is a constant process of change that helps one take maximum advantage of the changing environment and customer requirements. Just like any other product in the market, financial products have also evolved over the years from being just a simple saving an instrument to more sophisticated tools for creating wealth and assets.

The same is the story of 4G ULIPs (Unit Linked Insurance Plan) which have come out with a sea of change and eradicated almost all pain points of the older version of ULIPs. From being a reviled product due to their inflated cost structure and ambiguity, ULIPs are now being promoted as low-cost vehicles for those willing to invest in market-linked products.

First Avatar of ULIPs (Prior to 2010)

ULIP's were first introduced by UTI in 1971 as an effective financial tool with guaranteed additional cover. But due to high front-loaded charges and other charges by distributors and agents, its acceptance got hollow with time. Also, because of the lack of transparency in the product, the disappointment of policyholders intensified after they realised that a major part of the premium that they have paid has gone mostly into the disbursement of commissions charged by the agents and very less amount was invested in their net fund value. This led to low persistency ratio of continuing to invest in ULIPs giving rise to a high number of policy lapses. Secondly, distributors tricked customers into buying the products by making them believe that the investment included paying premiums for only three years, instead of continuing to pay for the full policy term that could help them earn good returns.

The Second Transition of ULIPs (2010-2015)

After realising the cause, the Insurance Regulatory and Development Authority of India (IRDAI) woke up to this menace and attained the need to formulate and execute necessary guidelines with a view to protecting the policyholders' interests. The regulations mainly aimed at educating customers about the significance of their investments into ULIPs by bringing down charges and ensuring that policyholders understand ULIPs as long-term products. IRDAI capped the annualised charges of ULIPs at 2.25% for the first 10 years of holding and increased the lock-in period to 5 years. The charges were fixed at this rate because it was the average cost charged by competing products such as mutual funds. Also, there was an increase in the minimum cover to ensure an appropriate insurance cover to protect the investors' financial interest.

Entry of 3G ULIPs in the Market (2015-2017)

Till 2015, most ULIPs worked more or less on the same pattern. The real change, however, began with the launch of low-cost ULIPs in 2015, including the online version, which addressed the transparency-related concerns of customers. As the charge structure of both policy administration and policy allocation charges associated with ULIPs underwent a major change with the unveiling of HDFC Life Click2Invest. The rest of the costs including mortality charges and fund management charges were capped to about 1.45 per cent. A similar plan, SBI LIFE — eWealth Insurance limited its premium allocation charges to Rs 45 in the first year only, removed its policy administration charges, while the total of mortality charges and fund management charges were limited to roughly 1.25-1.50 per cent of the annual premium paid.

4G ULIPs - A New Approach to Launch Excellence (2017 and continuing)

The journey of ULIPs has been a steady one. It has come a long way from its reputation of being a mis-sold product to being as transparent as the other financial products in the market. From the time they were introduced in the early 2000s to where they have reached today, these products have become a value-packed proposition for the customers. The ULIPs are now smart, investor-friendly, more transparent, cost and the tax-efficient. With new guidelines such as increasing disclosures, minimum lock-in period increased to 5 years and commissions capped, the new age ULIPs have become a better financial product.

If you think about it, it's a sort of a misconception now because people have the old memories about non-transparency in ULIPs but today if you look at the online ULIPs everything is available at the click of a mouse. And on a monthly basis, insurance companies publish their factsheet which discloses their entire portfolio where all expenses are clearly stated upfront. The charges of ULIPs were brought down and spread out evenly over the tenure of the policy and the disclosures were more detailed for the benefit of investors. To attract customers, insurers decided to remove policy administration and premium allocation charges completely. And the investors get the mortality charge back once the plan matures, indicating ULIP as a unique investment option with a free life cover. Also with time, FMS charges got capped at 1.35% per annum.

Amongst the latest entrants in the sphere of low-cost ULIPs, Edelweiss Tokio's Wealth Plus has done away with the premium allocation as well as policy administration charges. With a product that 'returns' the mortality charges at maturity, Bajaj Allianz Life's Goal Assure would appeal to such investors.

ULIP also provide customers with the flexibility to choose their asset allocation between equity and debt, depending on their risk appetite. In fact, the customer has the option to choose their investment in 100 % equity or debt. Further, many insurance companies do not even levy charges for switching between the funds. After 5 years the policyholder can choose to withdraw their investments partially or fully.

With careful planning over the years, the wealth created from ULIPs can be used for the child's higher education or other requirements like retirement planning. For a consumer, if you are putting Rs 15,000 per month for 10 years and stay invested for 20 years, you would probably accumulate around Rs 60 lacs at the rate of 8%, which is a lot of money when the power of compounding works on your investment and will work well for your wealth creation.

(The writer is Santosh Agarwal.)

TOP

Source

How and where to check death claim settlement ratio of life insurers - The Economic Times – 21st November 2019

The purpose of buying a life insurance policy is that your nominee gets the sum assured after you die. Therefore, it is important to know which insurance company has a better track record in settling death claims over the years. Death claim settlement ratio of a life insurer is one of the most important parameters to check when choosing a policy.

What is the death claim settlement ratio?

The death claim settlement ratio is the indicator (in percentage) that shows how many death claims an insurer has settled in any financial year.

It is equal to the total number of death claims settled/paid during a financial year as a percentage of the total number of death claims against policies received during the year by the insurer.

For instance, if an insurer received 100 death claims during a financial year and settled or paid 95 claims, then the claim settlement ratio will be 95 percent (95/100*100). This means that the remaining 5 percent death claims were either rejected, written back (claims that remained unclaimed because of incomplete documentations, etc.) or, were pending by the insurer at the end of the financial year.

The IRDAI rule on advertising death claim settlement ratio

The Insurance Regulatory and Development Authority of India (IRDAI) has, in a master circular issued on October 17, 2019, updated the restrictions placed on the advertising of insurance policies and the advertising rules that insurers have to follow to safeguard consumer interests.

The regulator said, "If an insurance advertisement contains death claims paid ratio, then the data for individual and group policies shall not be clubbed together. The insurance advertisements for group products shall reflect only group death claims paid ratio and individual products shall reflect only individual death claims paid ratio. In the case of advertisements' promoting the company's brand without reference to products, only individual death claims paid ratio to be used."

Therefore, life insurance companies are required to show the details of individual death claims ratio and group death claims ratio on their websites separately. If they are showing death claim settlement ratio by clubbing the data for individual and group policies, then they are violating IRDAI rules.

Where should you check the death claim settlement ratio?

The IRDAI annual report issues death claim settlement ratio company-wise for individual and group policies separately every year, where 'Statement 6' in the annual report shows individual death claims ratio and 'Statements 7' shows group claims ratio.

You can also check details of individual death and group death claims ratio on the life insurance companies' website for each company specifically or, you can see a consolidated report on online insurance web aggregators' websites.

However, for more accurate information, you should visit the IRDAI website and check the details in its annual report. IRDAI has a set method of calculation for the arrival of death claims paid to the nominee by the insurer.

IRDAI states, "The method of calculation for the arrival of Death Claims paid ratios for a financial year shall be as followed for reporting in statements 6 & 7 of IRDAI Annual Report of 2015-16."

Statement 6 of IRDAI's annual report shows individual death claims paid ratios of each insurers separately

STATEMENT 6

INDIVIDUAL DEATH CLAIMS FOR THE YEAR 2015-16

(Benefit Amount in ₹crore)

Life Insurer	Claims pending at start of the period		Claims intimated / booked		Total Claims		Claims paid		Claims repudiated / rejected		Claims written back		Claims pending at at end of the period		Break up of claims pending - duration wise (Policies)				
	No of Policies	Benefit Amount	No of Policies	Benefit Amount	No of Policies	Benefit Amount	No of Policies	Benefit Amount	No of Policies	Benefit Amount	No of Policies	Benefit Amount	No of Policies	Benefit Amount	< 3 mths	3 - < 6 mths	6 - < 1 yr	> 1 yr	Total
Aegon Religare	1	0.10	532	42.54	533	42.64	508	40.15	20	1.12	0	0.00	5	1.37	5	0	0	0	5
					100%	100%	95.31%	94.16%	3.75%	2.63%	-	-	0.94%	3.21%	100.00%				100%
Aviva	9	2.07	1522	138.54	1531	140.60	1255	101.39	266	36.02	0.00	0.00	10	3.20	10	0	0	0	10
					100%	100%	81.97%	72.11%	17.37%	25.62%	-	-	0.65%	2.27%	100.00%				100%
Bajaj Allianz	624	36.36	17343	404.30	17967	440.67	16404	352.46	1140	56.47	0.00	0.00	423	31.73	377	46	0	0	423
					100%	100%	91.30%	79.98%	6.34%	12.82%	-	-	2.35%	7.20%	89.13%	10.87%			100%
Bharti Axa	32	3.29	1229	68.70	1261	71.99	1009	50.79	166	13.66	0.00	0.00	86	7.55	68	18	0	0	86
					100%	100%	80.02%	70.55%	13.16%	18.97%	-	-	6.82%	10.48%	79.07%	20.93%			100%
Birla Sunlife	142	17.72	7062	259.79	7204	277.51	6372	215.97	566	37.40	0.00	0.00	266	24.14	225	10	5	26	266

Statement 7 of IRDAI annual report shows group death claims paid ratios of each insurers separately

STATEMENT 7

GROUP DEATH CLAIMS FOR THE YEAR 2015-16

(Benefit Amount in ₹crore)

Life Insurer	Claims pending at start of the period		Claims intimated / booked		Total Claims		Claims paid		Claims repudiated / rejected		Claims written back		Claims pending at at end of the period		Break up of claims pending - duration wise (Lives)				
	No of Policies	Benefit Amount	No of Policies	Benefit Amount	No of Policies	Benefit Amount	No of Policies	Benefit Amount	No of Policies	Benefit Amount	No of Policies	Benefit Amount	No of Policies	Benefit Amount	< 3 mths	3 - < 6 mths	6 - < 1 yr	> 1 yr	Total
Aegon Religare	0	0.00	1	0.09	1	0.09	1	0.09	0	0.00	0	0.00	0	0	0	0	0	0	0
					100%	100%	100.00%	100.00%	-	-	-	-	-	-					0%
Aviva	0	0.00	2075	10.85	2075	10.85	2068	10.76	7	0.09	0.00	0.00	0	0	0	0	0	0	0
					100%	100%	99.66%	99.16%	0.34%	0.84%	-	-	-	0.00%					0%
Bajaj Allianz	323	9.16	150211	509.14	150534	518.30	148840	486.44	1595	23.22	0.00	0.00	99	8.64	96	3	0	0	99
					100%	100%	98.87%	93.85%	1.06%	4.48%	-	-	0.07%	1.67%	96.97%	3.03%			100%
Bharti Axa	0	0.00	209	15.48	209	15.48	175	12.45	28	2.32	0.00	0.00	6	0.71	6	0	0	0	6
					100%	100%	83.73%	80.41%	13.40%	15.01%	-	-	2.87%	4.58%	100.00%				100%
Birla Sunlife	0	0.00	2312	113.29	2312	113.29	2309	112.97	3	0.33	0.00	0.00	0	0.00	0	0	0	0	0
					100%	100%	99.87%	99.71%	0.13%	0.29%	-	-	-	0.00%					0%
Canara HSBC OBC	1	0.00	540	5.35	541	5.35	525	4.33	15	0.72	0.00	0.00	1	0.30	1	0	0	0	1
					100%	100%	97.04%	80.99%	2.77%	13.47%	-	-	0.18%	5.54%	100.00%				100%

No other information related to death claim payments than what is specified above shall be used as part of any insurance advertisement/s, as per the IRDAI rule.

Mahavir Chopra, Director - Health, Life & Strategic Initiatives, Coverfox.com said, "From IRDAI's annual report, you will get relevant information along with details around claims for every insurer from claims pending, claims intimated/booked, total claims, claims paid, claims repudiated/rejected, unclaimed, claims pending at the end of the period, break up of claims pending duration-wise (policies). Besides this, you can also look for public disclosures on the website of the life insurance company," he said.

"The most trusted source for checking the claim settlement ratio of life insurance companies is the IRDAI Annual Report. The IRDAI Annual Report is available on the IRDAI website for the public," Chopra added.

(The writer is Navneet Dubey.)

TOP

Source

Insurance for protection & investment: where are we headed? – Republic World – 19th November 2019

The Policy Bazaar Show is a brand- new series that decodes the grey areas of purchasing insurance. Through the 26-episode series, the show will highlight and discuss a magnitude of topics essential to everyone trying to secure their future.

From purchasing the right cover, to switching policies while shifting jobs, to ensuring a comprehensive child cover, insurance experts deliberate, simplify and shine light on the complexities of purchasing insurance in India.

In this week's episode, our eminent anchor Vivek Law will be talking about the evolution of the insurance sector with Vibha Padalkar, Managing Director and CEO of one of India's leading insurance companies, HDFC Life Insurance. Taking her mother as an idol, Vibha has been a part of the insurance sector for more than a decade. Today, she is one of the most lauded leaders of the insurance industry.

What drives one to buy insurance?

It has been a challenge for the insurance companies in India to be accepted by the population. Today, owing to the millennials taking up the charge of securing their future at an early stage of life, there is a widespread growth in the insurance sector. The insurance companies are trying to tap into the ecosystem that a millennial relates to and the kind of lifestyle choices one makes. The government has also introduced schemes like the Pradhan Mantri Jivan Jyoti Yojana (PMJJBY) and Ayushman Bharat. These initiatives by the government helps in promoting insurance investment and makes the common man aware of the need to buy an insurance.

Insurance companies, in the recent times, have been working towards making the process of buying an insurance cover, a customized experience for the buyer. Most of the insurance companies have varied products and distribution channels that help reach varied customer segments. They have tailor-made simple products that can easily convince a millennial to invest in a policy. It becomes easy for the buyer to choose from products available at the rates of INR 500/ month. Insurance players also tie up with small finance banks to reach a consumer base in the rural parts of the country.

Digitizing the Insurance Sector

The digitization of the insurance sector has majorly helped the finance and insurance sector as they have allowed a large part of the population to have easy access to policy buying and proper knowledge about all the products available in the market. The digital space also allows the insurance companies to do a research on the consumer based on his digital footprint including his online presence. Companies like HDFC Life Insurance also use the digital space to understand the current trends and launch products and covers that cater to the trending issues. One of the most premium examples of this can be 'Cancer Care' that not only provides a variety of covers but also makes the onboarding process easy.

In addition to digitizing the sector to be closer to the consumer base, the insurance sector has also ensured that the reasons often given for not buying insurance are taken care of. There are covers that have premiums as low as 10-15 INR and can then be upgraded according to the situation. However, to avoid frauds, the sector deems it important for the customer to have proper documents and identification proofs.

(The writer is Debolina Datta.)

TOP

Source

Insurance Riders: Do you need them? Know about different kind of riders - Financial Express – 19th November 2019

Insurance covers risks like – risk of early death, risk of living too long, health risk, risk of accidental injury or death etc. However, in some instances, some incidents may not result into insurable events that would lead to payment of claim amounts to policyholders or their nominees, but may seriously hamper policyholders' ability to work to generate income. In such cases, riders prove handy to provide partial relief to policyholders either by waiving further premium or by providing partial claims or both.

Riders are additional benefits, which are optional and insured persons may opt to avail such benefits by paying extra premium. The premium for riders are generally lower than the premium of the full-fledged policies containing such benefits.

Riders may be of different types – Critical Illness, Disability, Accidental Death, Premium Waiver, etc.

Critical Illness Rider
Critical illness rider are offered with both life insurance and health insurance. If opted along with life insurance, insured persons are exempted from paying further premium after they start suffering from a specified critical illness, like cancer, heart disease, kidney failure etc. Apart from premium exemption, insurers may also start paying death benefits in installments depending on terms and conditions.

In case of health insurance, if opted for, the insured persons get full Critical Illness Sum Assured if they survive one month after first diagnosis of any of the specified critical illness.

Disability Rider
If opted for, the life insureds may get benefits of exemption in paying further premium depending on the extent of disability they suffer following an accident. They may receive part of death benefits as well as temporary relief, which may be paid in lump sum or in installments.

Accidental Death Rider
As the name suggests, life insurance companies usually pay double the basic sum assured (SA) if death occurred due to accident, provided the life assured opted for the rider and paid the additional premium for it. However, total benefit under this rider can't exceed the statutory limit, taking together all the life insurance policies in his/her name.

Premium Waiver Rider
This is an important rider related to children-oriented life insurance policies. According to this rider, insurance policy of a child would continue without paying further premium in case of unfortunate death of the earning parent. So, this rider would ensure that the goal of the insured child would not go unfulfilled even after demise of the parent, who was supposed to pay the premium.

So, riders are quite useful as they provide crucial benefits at the time of need with marginal increase in premium.

(The writer is Amitava Chakrabarty.)

TOP

Source

Term Insurance Premium Options: Pros and cons of paying regular, limited and single premium – Financial Express – 18th November 2019

The primary aim of taking life insurance is to cover the risk of early death of the earning member of a family, so that the financially dependent members of the family may maintain the standard of living even after unfortunate early demise of the bread winner. So, the sum assured (SA) should be enough to replace the loss of future earnings after early death of the life insured.

Term insurance is the cheapest form of life insurance as it pays the insurance money only to the nominee in case of unfortunate demise of the life assured and nothing is payable if the life assured survives the policy term. As a result, it is feasible to take adequate term insurance cover by paying much less premium compared to endowment and other insurance plans that contain survival benefits also.

In simple term plans, insurance companies try to bring some variation by adding different options in premium payments, rider benefits etc that come with some extra premium.

Premium payment options include limited premium and single premium along with the traditional regular premium option. Another premium related option is 'Return of Premium' if the life assured survives the policy term, which is not related to premium payment option, but inflates the amount of premium compared to the simple term option.

Here are the pros and cons of choosing the different premium paying options:

Regular Premium

Death is certain, but the timing is uncertain. The doctrine of life insurance is based on the uncertainty in timing of death. Moreover, term insurance is considered best due to its low premium. As the aim is to cover the risk of early death, it's better to pay lesser premium, because nobody knows if the life assured would survive the entire policy term or die after paying the first premium or after paying few installments. So, regular premium is undoubtedly the best suited option for the life assured.

However, the major cause of insurance claims getting declined is due to non-payment of premium on time, resulting into policies not in force at the time of death and hence claims become non-admissible. So, lower the premium paying term, lower would be the risk of policies getting lapsed.

Limited Premium

There may be options of paying premium for the entire policy term in few years – say in 5 years or 10 years, or to pay premium few years less than the policy term – say 5 years less than the policy term or 10 years less than the policy term. Apart from minimising the chance of lapsation of policies due to non-payment of premium on time, policyholders may get a small part of premium back if they surrender their policies before completion of the policy term, while no surrender value is there in case of regular premium.

However, the principal aim of choosing term insurance cover is to minimise the premium, so there is no point in paying insurance companies in advance.

Single Premium

Although, there are surrender values are there in case premium is paid in one go, but the primary aim of paying an insurance company the entire amount in advance through single premium is to eliminate the chance of lapsation of the policy.

Unlike endowment insurance plans, there is no survival value in case of term insurance. As timing of death is also uncertain, there is no way to predict if there will be any return in the form of insurance claim or to calculate the rate beforehand, even if any claims arise during the policy term. So, apart from ensure that the policy remains in-force throughout the policy term, there is no rationale in choosing single premium or even limited premium.

(The writer is Amitava Chakrabarty.)

TOP

Source

GENERAL INSURANCE

Marriage on the cards? Secure your BIG DAY through a wedding insurance plan – India TV – 22nd November 2019

To protect you from any misfortune during your marriage, Wedding Insurance is the one which can save you from any physical, personal or accidental loss. This is the time of the year which is known for the marriage season. Are you the one who is planning for a marriage, and no idea about how you can protect your marriage jewelry or any other physical or personal item/situation during the marriage from uncertainty? Then, this piece of information is for you. Just read out the report on how you can protect your marriage by taking a wedding insurance cover.

Why to take Marriage Insurance?

Life is very uncertain and misfortune can come anywhere, anytime. So, to avoid any misfortune like cancellation of your marriage, loss due to date postponed, death, burglary, fire, hospitalisation, venue cancellation or any other major emergency one can protect his or her marriage by taking a wedding insurance cover. With the help of the cover, you can get each single penny of the sum insured.

What covers Wedding Insurance?

Wedding insurance gives cover under various situations
and the categories are:

1. Liability Coverage: Any loss, damage to the third party due to major accident or injury is covered
2. Cancellation Coverage: Marriage cancelled due to sudden or unexplained reason
3. Physical Loss: Any damage which is caused to the property related to marriage due to fire, theft, burglary, earthquake, material damage of jewelry or precious metals as mentioned in the policy
4. Personal Loss: Any loss to the Bride/Bridegroom due to uncertainty, accidents

During wedding cancellation:

The insurance plan covers any advances paid for -

- Catering
- Venue
- Travel agencies
- Hotel room bookings
- Cost for printing invitation cards
- Decoration cost

Standard Exclusions in Insurance:

- Act of terrorism
- Strike/Civil unrest
- The person covered under the policy is/are kidnapped
- Not reaching to the venue (Policyholders) on time due to unavailability of transport services or delay of flight or train
- Major losses due to cancellation of the wedding event
- Damaged caused by the policyholders against the policy rules
- Any injury or death due to war or war-like situation of the insured person
- Any self-made damage or suicide

Premium Cost:

The cost of the premium depends always on the type of insurance you take and what you want to cover. In general, the cost of the premium is from 0.7% to 2 % of overall cost of the sum assured while taking a policy. Suppose you have taken wedding insurance of rupees 10 lakhs then the cost of premium will be between rupees 7, 500 to 15000 rupees. According to Dr. Shreeraj Deshpande, Chief Operating Officer, Future Generali India Insurance “Average sum insured varies from INR 1 Crore to INR 6 Crores, the premium would be in the range of 0.50% to 0.75% depending on section-wise sum insured, outside India locations are always come with a higher premium as the cost of the overall wedding increases”.

How to claim the money?

- While facing any uncertainty (as per the policy) inform the insurance company immediately
- Inform the police about the mishap by doing a FIR. Submit the copy of the FIR to the insurance company
- Fill the insurance claim form to claim the money due to any loss you faced (as per the policy)
- Insurance company will always recheck the facts by sending their representative at the location of the wedding

• If the representative will find the claim authentic the compensation will be paid to the policyholder as per rules. Else it will be rejected
• Insurance company can directly pay the claim money to the venue or vendor
• One can also re-claim the exact money if he or she is not happy with the settlement money
• Policyholder can also go the court and fight for the disputed money

Wedding Insurance Providers in India:
• Future Generali
• HDFC Ergo
• ICICI Lombard
• Bajaj Alliance General Insurance

Few facts to keep in mind:
• Do give all the correct information of your wedding venue, guest numbers and other details to the insurance company
• Before claiming the money always keep a copy of your policy, FIR, original documents
• From the date of incident only the wedding insurance claim money will be settled within 30 days
• The insurance company is liable to pay only the sum insured
• Remember, any loss or damage to the gifted jewelry by in-laws will only be covered
• If your caterer or vendor is having a cover plan then do check what benefits you will get from them.

Else don't take the insurance again
• Keep all the bills, pictures, bonds, certificates to claim the sum insured
• Always check the policy details before taking any insurance cover

(The writer is Sarabjeet Kaur.)

TOP

Source

Making insurance claims made easy - The Hindu – 20th November 2019

The process of claiming insurance is set to become easier, at least in certain cases, with IRDAI, regulator for the insurance sector, notifying as many as 16 classes of claims that will no longer require the intervention of a licensed surveyor or loss assessor (SLA).

The regulator's order, in other words, is aimed at cutting down on the time taken for the claim settlement process. This is sought to be done by doing away with the assessment by SLAs and going with other documents substantiating the damage or incident such as a police report.

Under the existing practise, SLA report forms an integral part of claims process, if the damages are sought above certain prescribed limits.

"The Authority hereby exempts the [following] classes of claims..." an Insurance Regulatory and Development Authority of India order said, listing 16 motor and non-motor claims. These include that, under motor vehicle insurance, made on account of theft or injury/death to third parties and under health insurance policies, including travel and personal accident cover.

Some of the other claims exempted are public liability policies, including third party liability, professional indemnity, products liability and personal liability except where liability arising out of property damage or defect to physical property/goods are involved; claims under money insurance, including cash in

transit policies; and claims under all risks and burglary insurance policies on personal effects and jewellery.

Sources in insurance companies said the move would expedite the claim settlement process. In the absence of SLA reports, the companies, however, do their own assessment of the damage. A few companies, in case of motor insurance claims, have introduced a system of settling the claim based on the photographic evidence of the damage caused.

The IRDAI order comes on the heels of a proposed move to enhance the limit of claims for which SLA report will not be required.

As per the proposal, motor insurance claims limit for damages upto ₹75,000, as opposed to ₹50,000 now, can be made without SLA report. In the case of non-motor claims, this limit is to be increased from ₹1 lakh to ₹1.5 lakh.

"We not happy", Indian Institute of Insurance Surveyors and Loss Assessors (IIISLA) Council Member P.Sowjanya Kumar said since the move is bound to impact the SLAs. Noting that the role of the professionals is to assess the loss without prejudice, he said the changes were likely to lead to a situation where the customers will have accept what the insurers offered.

Also figuring in the exempt list are claims under race horses insurance policies and live-stock insurance policies; in respect of loss or damage to crop, trees, plantations and forests which are covered by government sponsored schemes; and claims, the amount of which has been adjudicated upon or decreed by courts.

(The writer is N.Ravi Kumar.)

TOP

Source

General insurance premium outgo to increase from January 1 – Goodreturns – 20th November 2019

Your general insurance premium outgo may get more from January 1 as there is an increase in reinsurance rates. These rates are the charges that insurers have to pay to secure a cover and the extra cost is passed to customers as higher premium charges and as the renewals of reinsurance contract happens from January 1, the same will be passed on to customers from that day.

Insurers need to buy the cover for them just to cover the risk in case they are turned to for a bulk claim. In a case when they confront a larger claim their appetite for risk goes down and premiums trend on the higher side.

The premium of general insurance are decided basis both the internal and outer factors as these reinsurance firms out of India as well as internationally. In general all of the general insurance categories including liability insurance, fire insurance, motor insurance as well as group health covers will see a hike in premium rates by as much as 10-15%.

Also, as in the current situation, the higher claim in one category tends to impact overall claim losses for insurance companies. In FY20, insurance companies have been hit hard due to higher crop insurance claims. Rates for comprehensive motor insurance policies may also be hiked from next financial year.

(The writer is Roshni Agarwal.)

TOP

Source

Coughing up a lot for cracked mobile screens? May be an insurance can help – The Times of India – 20th November 2019

Frequent physical damages and rising cost of smartphone repairs — sometimes equal to cost a brand new phone — is driving more phone buyers to insure them.

Insurers see a 50%-60% rise in policies sold covering mobile phones. Mobile insurance policies range between Rs 20,000 and Rs 50,000 for high-end phones.

"We have seen about 50%-60% higher sales on mobile phone insurance compared to last year. About, 60%-70% of claims were requested against cracked screen, as the demand matches the customer's concern," Vivek Chaturvedi, head of marketing and direct (online) sales, Digit Insurance, said. Digit Insurance has seen loss claim ratio at 75% for its mobile insurance product.

A 26-year-old, Aparna Vijay, purchased an insurance for her iPhone. "I have finally bought a 12-month mobile insurance cover for my iPhone at Rs 1,300, which is much cheaper than the five screen guards at Rs 4,500 (Rs 900 each), which were replaced last year. People purchase high-end phones for many reasons, while the sophisticated experience tops the list. Why use a phone case or a screen guard ruin that very experience."

Unlike internal damages like software failure which are covered under protection plans offered directly by mobile phone companies, eligibility criteria for external damages to be covered under insurance policies differ from player to player.

Water seeping in, malfunctioning touchscreen, faulty earphone jack or charging port problem, damage to phone screen due to fire, explosion, implosion or lightning, are the various physical damages that are normally covered.

Online mobile insurer, Acko General Insurance's Ashwin Ramaswamy, head of strategic partnerships, said, over 70% of claims are settled within 48 hours of the application submission. "We charge premium between the range of Rs 149 and Rs 2,999 (from low to high-end phones) on buyers.

Screen damage is by far the single largest damage issue that we have received," he added, which has a partnership with Amazon to sell mobile insurance policies, alongside phones.

In the case of a phone loss due to theft, insurance companies entertain claims only with the First Information Report (FIR), without which the claim is rejected.

Likewise, any defects caused while repairing or cleaning the device is not eligible for a claim. "Little did I know damages caused while cleaning the device is not covered under insurance. I could not claim insurance as I tried to fix my OnePlus 6T phone in a local mobile phone dealer," Vignesh S, a software engineer, said.

There are exceptional cases when insurers reject a claim as the damage to phone is caused by a friend or a relative. Chaturvedi, said, "In such case, International Mobile Equipment Identity (IMEI) linked covers will be helpful. Whether you use the phone or your family or friend does, this mobile insurance policy will be valid for all, as it is linked to the IMEI of the phone and not the user."

(The writer is Mamtha Asokan.)

TOP

Source

Should you go for cyber insurance? – The Hindu Business Line – 18th November 2019

Recently, reports of a breach of the WhatsApp network sparked panic among users. With such instances of data breach and digital theft on the rise, cyber security has become one of the pressing issues not only for the government and corporates but also for individuals. While data theft or financial frauds may be irreversible in most cases, the financial loss can be compensated through cyber insurance to some extent.

(The writer is Bavadharini KS.)

TOP

Source

Bank Deposit Insurance: Are bank deposits adequately insured? - Financial Express – 18th November 2019

The recent incident of restriction by the Reserve Bank of India (RBI) on the withdrawal of money kept with a failing bank has raised several questions for the common man. "Is my money safe with banks?, "Why is my money blocked?, "Is keeping money in bank in savings / deposit account akin to lending to a bank? "Why is my deposit amount not fully covered by insurance?", are some of the queries that keep rising.

Banks, including regional rural banks, local area banks, foreign banks with branches in India, and cooperative banks, are mandated to take deposit insurance cover with the Deposit Insurance and Credit Guarantee Corporation (DICGC) constituted by a Central Act and governed by the RBI. The DICGC has been in existence since 1978 to serve as deposit insurance and credit guarantee for banks in India.

How is the premium paid by banks calculated?

All registered insured banks are liable to pay to the DICGC deposit insurance premium at the rate of 10 paise per annum for every deposit of Rs 100 (i.e 0.10 percent p.a) for the half year ending March and September on the total deposits of the bank as on the preceding half year. The premium paid by the insured banks are computed on the basis of their assessable deposits.

How much of the deposit amount is insured?

Initially, under the provisions of Section 16(1) of the DICGC Act, the insurance cover was limited to Rs 1,500 only per depositor(s) for deposits held by him (them) in the "same right and in the same capacity" in all the branches of the bank taken together. However, the Act also empowers the Corporation to raise this limit with the prior approval of the Central Government. Accordingly, the insurance limit was enhanced from time to time and the current limit of Rs 1 lakh was fixed with effect from 1 May 1993 onwards.

Each depositor in a particular bank is insured up to a maximum of Rs 1 lakh for both principal and interest amount held by him in the same right and capacity as on the date of liquidation or cancellation of the bank's licence or the date on which the scheme of amalgamation or merger or reconstruction comes into force.

So, if a person in his individual capacity owns various accounts such as a savings account, current account, fixed deposit or a recurring deposit in his sole name, the insurance cover will be limited to Rs 1 lakh for all accounts. Having deposits in different branches of the same bank under same ownership capacity will restrict the total cover to Rs 1 lakh.

If individuals jointly hold more than one deposit account in one or more branches of a bank and if their names are registered in the same order everywhere, then all these accounts are considered as one. However, depositors get separate insurance cover of up to Rs 1 lakh for joint accounts where the names appear in different order or the set of names are different in each account.

Should there be a restriction of Rs 1 lakh for the deposit insurance cover?
Banks pay insurance premium on the total value of the deposits held by the bank. However, the insurance cover is restricted to Rs 1 lakh value of the deposit only. Why should there be a restriction on the deposit insurance claims as it appears that the full amount of deposits are insured?

Further, for illustrative purposes only, when compared with life insurance cover, it appears that the premium paid for a term life policy of insurance cover of Rs 1 crore is approximately Rs 5,880 while the deposit insurance premium paid by the bank to the DICGC for a deposit of Rs 1 crore is Rs 10,000.

Should this insurance cover of Rs 1 lakh be increased?
The insurance limit of Rs 1 lakh is effective from 1 May 1993 onwards. However, as indicated by the following table, there is a need to increase this cover.

Deposit Insurance at Glance

(Rs.in billion)

At year-end*	1962	1972	1982	1992-93	1993-94	2004-05	2016-17	2017-18	2018-19
Insured Banks (Nos in actual)	276	476	1,683	1,931	1,990	2,547	2,125	2,109	2,098**
Insured Deposits***	4.5	46.6	317.7	1,645.3	1,684	9,913.7	30,509	32,573	33,700
Assessable Deposits	19	74.6	423.6	2,443.8	2,490	16,198.2	1,03,531	1,12,020	1,20,051
Total number of Accounts (in million)	7.7	34.1	159.8	354.3	350	649.5	1,884.8	1,940.9	2,174
Number of fully protected accounts (in million)	6	32.8	158.1	339.5	350	619.5	1,737.2	1,775	2,000
Claims paid since inception	-	0.01	0.03	1.8		14.9	50.3	50.8	51.2

** As at end March from 1992-93 onwards*
*** The number of registered insured banks as on March 31, 2019 stood at 2,098, comprising 157 commercial banks [including seven Payment Banks (PBs), 10 Small Finance Banks (SFBs), 51 Regional Rural banks (RRBs) and three Local Area Banks (LABs)] and 1,941 co-operative banks.*
**** Deposits eligible for deposit insurance up to Rs. 1 lakh each*

It can be observed from the table above that all 350 accounts were fully protected in 1993-94 as compared to 92 percent of the accounts that are now protected in 2018-19. Further in 1993-94, 67.67 percent of the Assessable Deposits were Insured Deposits, while in 2018-19, only 28.07 percent of the Assessable Deposit are Insured Deposits.

Information on claims settled in the past years

(Rs.in billion)

At year-end*	2016-17	2017-18	2018-19
Claims paid	50.3	50.8	51.2
Premium income	101.22	111.28	120.43
Investment income	56.19	64.18	72.45
Revenue surplus after tax	97.15	115.07	119.31

A common man typically places his money in a savings bank account and deposit account with banks. He is not in the business of lending the money to banks. So the entire amount of money placed with banks should be safe and guaranteed to be returned to depositor holders.

(The writer is Bahroze Kamdin.)

TOP

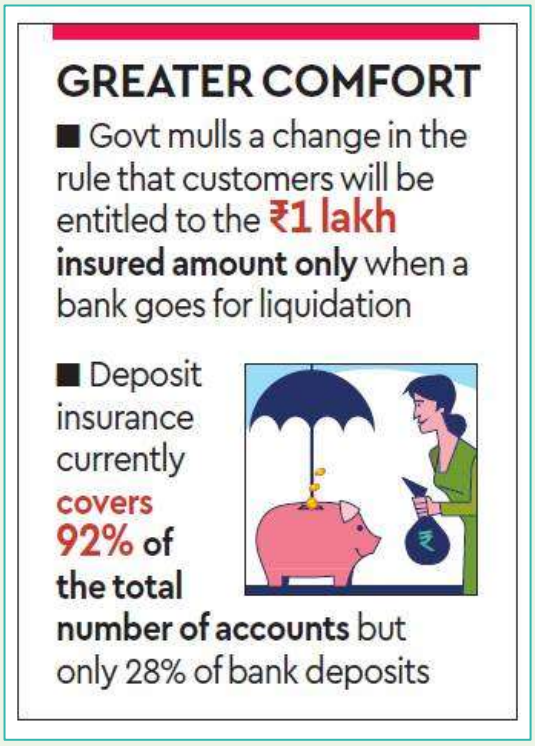
Source

Bank deposits to get doubly safer: This clause in FRDI bill is music to the ears of depositors – Financial Express – 18th November 2019

The government is considering raising the insurance cover for bank deposits to anywhere between Rs 2 lakh and Rs 3 lakh from the current level of Rs 1 lakh under a modified Financial Resolution and Deposit Insurance (FRDI) law, a source told FE. The finance ministry is also debating whether the minimum insured amount can be allowed to be withdrawn by the depositors of a troubled bank even when it is continuing operations as a going concern, said the source. Under the extant rules, depositors are entitled to the insured amount of Rs 1 lakh only when the bank is liquidated, he added.

The latest move comes at a time when fraud-hit Punjab and Maharashtra Co-operative Bank is facing a grave crisis and customers have been demanding their entire money back, apart from lifting the daily withdrawal curbs.

"The deposit insurance cover could be at least doubled. There is also a thumb rule in some countries that such a cover should be at least the double of the per capita GDP. This possibility is also being looked at. So the cover can be hiked up to Rs 3 lakh as well. A final decision will be made soon," said the source. The country's per capita GDP was Rs 1,42,719 in FY19. After a meeting with chiefs of state-run banks on October 14, finance minister Nirmala Sitharaman had said the government would soon introduce the revised FRDI Bill in Parliament and that there were discussions in the government to raise the cover on deposits. The Bill is still in the works.



The government has kept the deposit cover unchanged at Rs 1 lakh since May 1993, when it was raised from Rs 30,000 after the security scam in 1992 had led to the liquidation of Bank of Karad in Maharashtra. The hike then was aimed at placating angry and concerned depositors of this private bank so that a run on even other banks could be avoided.

Banking analysts say there is no hard rule for deposit insurance in India, although there are two thumb rules, based on international experiences. First, the cover should be double the per capita GDP. Second, it must cover 80% of the number of depositors fully but only 20% of the value of deposits, which is also known as the '80-20 rule'. According to the Reserve Bank of India's (RBI's) latest data, deposit insurance covers 92% of the total number of accounts in India but only 28% of the total deposits with the banking system.

In its 2018-19 annual report, the central bank said: "With the current limit of deposit insurance in India at Rs 1 lakh, the number of fully protected accounts stood at 200 crore at the of end-March 2019, which constituted 92% of the total number of accounts, as against the international benchmark of 80%." As of March 2019, the number of registered insured banks in India stood at 2,098 —157 commercial banks and 1,941 cooperative banks.

However, analysts say although the current cover of Rs 1 lakh satisfies the so-called "80-20 rule", such an international experience should not ideally be applicable to India. Unlike in the West, the high incidence of fully-covered accounts is mainly due to the aggressive opening of small accounts, especially under the Jan Dhan scheme, where the deposit per customer is typically low. In fact, according to the 2018 International Association of Deposit Insurers Survey, India was ranked 102nd out of 115.

Interestingly, the Report of the Committee on Customer Service in Banks of the RBI had in 2011 suggested that the cover be raised dramatically to at least Rs 5,00,000 to draw more people to the banking fold.

(The writer is Banikinkar Pattanayak.)

TOP

Source

We will move forward on insurance PSUs merger: Finance Minister Nirmala Sitharaman – The Hindu – 17th November 2019

Finance Minister Nirmala Sitharaman has said the government would move forward on the merger of the three state-run general insurance companies as announced in the previous Budget.

"This was a Budget announcement and I will be moving forward on that", she said in a media interaction.

The proposed merger of National Insurance Co. Ltd., United India Insurance Co. Ltd. and Oriental Insurance Co. Ltd. has not been able to move forward due to their weak financial position, official sources said.

The Budget for 2018-19 had proposed their merger and subsequent listing the merged entity on stock exchanges.

"Citing weak financial positions, these PSUs have sought capital infusion from government. There is a need for immediate recapitalisation in them as per their current balance sheet position where they are either on borderline or below the insolvency ratio. Unless their losses are written off, the merged entity will have a very weak balance sheet", officials said.

Since the Budget did not make any provision for funds for insurers, the department of financial services (DFS) will have to seek supplementary demand of ₹12,000 crore for this purpose, sources said.

General insurers have sought around ₹2000 crore to ₹3000 crore each for avoiding falling below solvency ratio, sources said. The three insurers have struggled to maintain the minimum required solvency ratio of 1.5 in recent years.

According to the guidelines of Insurance Regulatory and Development Authority of India, general insurance companies need to maintain a minimum solvency ratio of 1.50. As on March 31, 2019, the

solvency ratio of National Insurance Co. was 1.04 and for Oriental Insurance Co it was 1.57, while solvency ratio for United India Insurance, as on Mar 31, 2018, was 1.54.

Currently, New India Assurance Co and General Insurance Corp of India Ltd are the only two listed state—owned non—life insurance companies.

TOP

Source

HEALTH INSURANCE

Fitness insurance: the newbie in town – Outlook – 20th November 2019

Nimit Bavishi, Co-founder and Head – Networks at Symbo India Insurance Broking, in a conversation with **Himali Patel**, explains the trend of fitness insurance for enthusiasts and sports persons

Can you explain the concept of fitness insurance and its features?

Fitness insurance is a bite-sized insurance product catered towards workout enthusiasts and sports persons. While most comprehensive health insurance plans require the patient to be hospitalised for 24 hours, injuries such as fractures and ligament tears come under out patient treatment and are generally not covered. Fitness insurance provides cover for such injuries with premiums starting at just Rs 25 per day. Fitness insurance provides coverage for:

- Fracture: Rs 5,000
- Dental injuries: Up to Rs 10,000
- Ligament tear: Up to Rs 25,000
- Hospi-cash, (a daily allowance for expenses incurred during hospitalisation): Up to Rs 1,000 per day
- Supporting accessories: Up to Rs 50,000
- Accidental Death Benefit: Rs 1,00,000

Who are your target audience?

Fitness insurance is targeted towards workout and sports enthusiasts. The target audience includes gym goers as well as groups that book turfs for playing sport. Due to their active lifestyle such individuals are at a higher risk of fitness related injuries than ailments such as diabetes or heart disease. Over 90 per cent of fitness related injuries do not require 24 hours hospitalisation and are not covered under most standard health insurance plans. Fitness insurance fills this gap by providing comprehensive cover to its target group by covering the risks that they are most prone to.

What are the other trends the Insurance companies are likely to witness in the coming days?

The insurance sector is rebuilding itself around creative and innovative structures. Bite-sized context-based insurance products such as fitness insurance and vision insurance are growing in popularity and such products are likely to gain more traction over time. Insurance companies and intermediaries such as brokers are breaking away from the one-size fits all philosophy and are targeting niches with relevant need-based products.

Such a transition is enabled with rapid technological progress. Big data analytics, machine learning and Artificial Intelligence (AI) can be leveraged to analyze behavioral patterns of a target group through which insurance providers can build suitable coverages for its audience.

The trend for innovative context-based insurance is in line with the millennial generation, which believes in seizing the day rather than investing in the long term. Health insurance provides cover for an entire

year, but sports enthusiasts can always buy fitness insurance while booking a turf where there is an immediate risk of suffering from an injury. Similar products such as vision insurance, car rental insurance, mobile phone and laptop insurance from various insurance providers are designed to fulfill a context and to cater to a specific need.

What is the Insurance broking companies' role when it comes to bridging the gap in the development of the industry?

Insurance brokers and intermediaries add value and facilitate bridging the gap in the development of the insurance industry by:

- Innovating much faster than the market by leveraging technology and gaining insights into target groups to develop context-based products.
- Combining the elements of life, health and general insurance to provide comprehensive covers to the appropriate target audience.
- Simplifying the insurance process end-to-end right from policy issuance to the claims service experience.

(The writer is Himali Patel.)

TOP

Source

Stay fit and pay less for your health insurance – Mint – 20th November 2019

With medical expenses increasing by the day, it's important to be conscious about preventive healthcare, which includes keeping yourself fit. Not doing enough could make you vulnerable to diseases, especially if you have a sedentary lifestyle. Insurers too emphasize on preventive healthcare; in the last few years, many of them have started bundling reward programs to encourage fitness. In fact, not keeping fit can add to your health insurance premiums, especially if you are 40 or above.

Recognizing the need of the hour, the Insurance Regulatory and Development Authority of India (Irdai) has also sought to promote preventive healthcare, through its latest draft guidelines on wellness and preventive benefits. The biggest takeaway from these guidelines is the fact that insurers can now offer a discount on premiums or bump up your sum insured if you keep fit.

"It has become important to prioritize health and include preventive healthcare measures in one's daily life. With this move, we believe that health insurance will no longer be perceived just as a measure to secure oneself against unforeseen illnesses; rather it will become a part of one's daily health needs," said Ashish Mehrotra, managing director and chief executive officer, Max Bupa Health Insurance Co. Ltd.

The guidelines shall come into force with immediate effect. We tell you how the health insurance industry rewards you for keeping fit and what's on the cards.

Taking a step ahead

Wellness is already being promoted as part of many health insurance policies across insurers, but not in a big way. The Health Insurance Regulations (HIR), 2016, included guidelines on wellness. However, it allowed only OPD consultation or treatment, some discount on pharmaceuticals and free health check-ups and diagnostics. Amit Chabbra, head, health insurance, Policybazaar.com, an online insurance marketplace, said the OPD benefits didn't become mainstream because insurers had to build in the cost of OPD expenses which are more common than hospitalization.

Mehrotra said the new draft guidelines take the earlier regulations a step forward to increase the bouquet of health services which can be provided to policyholders.

Shreeraj Deshpande, chief operating officer, Future Generali India Insurance Co. Ltd, said these new guidelines complement the earlier ones by allowing ways in which utilization of the wellness features can be incentivized. “While the earlier guidelines introduced wellness as a feature in health insurance, there were no avenues of encouraging customers to actually use those features," added Deshpande.

Wellness perks

Irdai has proposed certain ways through which insurers can offer wellness perks to policyholders.

Based on the disclosed fitness and wellness criteria, insurers can offer redeemable vouchers for the purchase of protein supplements and other consumable health supplements. Policyholders may also get redeemable vouchers for memberships in yoga centres, gymnasiums and for participating in other fitness activities. The earlier discounts (through vouchers) on OPD consultations and treatments, pharmaceuticals and health check-ups done by network hospitals would also continue.

Of all the benefits proposed, what stands out is the discounts on premiums and an increase in sum insured at the time of renewal, depending on how well you’ve followed the wellness regime.

Irdai has also allowed insurers to stretch the benefits by covering non-payable items of cost of treatment. “Insurers can vary the benefits offered on the basis of geography, product design and claims experience. Insurers could come up with customized health-risk assessment tools to help policyholders realize their fitness levels. The associated cost may vary from insurer to insurer based on the design of the wellness programme," said Subrata Mondal, executive vice-president, IFFCO Tokio General Insurance Co.

The benefits can be offered only after they are filed or incorporated as part of a product in line with product filing guidelines. Insurers cannot discriminate in providing the wellness features and benefits offered to the same or similar category of policyholders for a specific product. However, there would be some distinction in the kind of benefits offered based on the cost of the policy. “Distinction would be there because product differentiation can be brought about only if wellness benefits are graded based on premium paid," Deshpande said.

Insurance companies have also been asked to assess the impact of such features on pricing. If there’s any impact on pricing, the insurer will have to disclose it upfront.

What the draft says

Irdai has asked insurers to refrain from promoting third-party merchandise in their advertisements. However, they can disclose the items or services offered on their website in detail and also provide a link in the policy documents. They also can’t accept any liability towards quality of the products or services offered by a third party.

Insurers have been asked to ensure that the agreed services or products under the wellness programme of every product are discharged accurately by the service providers. Also, other than the monetized value of reward points redeemed by policyholders, insurers can’t make payments to the third party service or product providers. Insurance companies will have to, as a rule, disclose product-wise payouts for every third-party merchant in the annual public disclosures.

All insurers will have to factor in the costs towards wellness services into the pricing of the product which shall be disclosed in all the advertisements promoting wellness features. “The regulator has allowed insurers to appropriately price the products based on predefined factors. The costs towards wellness services are to be kept transparent in the insurance advertisements," said Mondal.

For family floater plans, insurers will have to disclose the manner in which the accrual and redemption of benefits will be considered with respect to all the members covered. For all policies, whether the accrued benefits can be carried forward or not at the time of renewal will have to be specified clearly in the policy document stating the period of validity of the benefits. Benefits accrued cannot be linked to any dynamic factor and will have to be declared upfront at the commencement of the policy.

At least once every year, insurers shall notify the benefits accrued to the policyholder. In view of policyholders' privacy, insurers must ensure that the information gathered during the process of offering wellness benefits is kept confidential and isn't used for other purposes.

How you will benefit

Though these benefits could impact premiums, it will help insurers reduce the claims ratio, which would encourage them to provide wellness features at affordable prices. "The wellness regime followed by the policyholders would help in keeping them fit and in turn could result into lesser claims which would help us in providing better discounts to customers," said Mehrotra.

Most insurers said there would be a pricing impact on the policies but because companies would be sourcing these services at an aggregate level on behalf of customers, access to preventive healthcare would end up becoming cheaper.

Health insurers in developed countries and some developing countries like South Africa have a strong wellness framework embedded in their business strategy, which has helped them in getting detailed information about customers' lifestyle and frame customized wellness interventions for them, said Deshpande. "South African insurers such as Discovery and Clover Health are able to do far better disease management for their policyholders through wellness benefits," said Chabbra.

With the new guidelines, Indian insurers too will now be able to incentivize people to adopt a healthy lifestyle. This would lower the chances of hospitalization due to lifestyle-related diseases. Experts said what the guidelines aim to achieve will be a win-win for both the policyholders and insurers.

(The writer is Disha Sanghvi.)

TOP

Source

5 questions to ask your insurance agent before buying a policy - Financial Express – 20th November 2019

Slowly but surely, insurance penetration in India is rising. Be it for the rise in medical cost, to save tax or just to stay safe, an increasing number of people are opting for health insurance policies. With plenty of health insurance policies available in the market, policyholders are most often spoiled for choice. It becomes a challenge to find the right policy, and most often insurance buyers need guidance with that.

There is also a large percentage of people who research policies online but want to buy their policy offline. Experts say these kinds of people feel safe talking to a company representative or an agent before signing off a policy.

Here is a list of questions you should get answered from your agent before opting for a policy:

Inclusions in a policy cover

The premium should not be the only look-out when buying a policy. Buyers need to check for coverage too. To find out how much coverage your policy offers, find out from your agent what type of policy it is, as different types of policies such as basic hospitalization plan, daily hospitalization plan, or critical illness plan have different types of coverage.

Additionally, ask about the extent of the coverage. For instance, a certain type of critical illness plan covers up to 37 illnesses whereas another might cover just 15 critical illnesses. Hence, the scope of coverage differs from company to company and policy to policy. Find out from your insurer or agent what all is covered in your policy before buying one.

Exclusions in a policy cover
As insurance policies vary, the exclusion list of every policy also varies. All policies come with exclusions. Find out from your agent before confirming a policy.

Exclusions are an important part of a policy. Know about it in advance so that you don't get surprised later.

Under basic health insurance policies, note that claims cannot be made during the first 1-2 months from the date of buying the policy. Other than general exclusions some policies also have time-based exclusions. For instance, after the diagnosis of a critical illness, a policyholder has to survive for at least 30 days before the policy pays out.

Sub-limits in a policy
Sub-limits on a specific treatment means there is a cap on how much the policyholder can claim. It is a fixed amount that is paid out for a particular disease or it can also be a cap on room rent. Sub-limits are set on 2 expenses, the sum assured on a specific disease or on hospital room rent. In the case of room rent, a certain percentage of the total sum insured is the capping of room rent.

Hence, ask your agent about what expenses are capped, and the limit that is set for the policy. Health insurance policies come both with sub-limits and without sub-limits. Other than room rent, sub-limits are also set on doctor's fees, OPD, etc. You can also ask your agent for a policy without sub-limits if you do not want expenses to be capped.

Waiting period
In most health insurance policies, pre-existing diseases are not covered. However, even if covered, it doesn't get activated before 3-4 years. A few companies have come up with policies with a shorter waiting period, but find it out from your agent in advance.

Other than pre-existing diseases, policies come with a waiting period for other medical expenses also, such as arthritis, stone in the gall bladder, maternity coverage, cataract and eye ailments. Expences for these treatments might not be covered in the first 1-2 years. Hence, ask your agent details about the waiting period associated with your policy.

Add-on covers
Mostly new policies cover features such as Ayurvedic treatments, treatments abroad, and maternity expenses even though with a waiting period. Find out from your agent if your policy includes any of these add-ons.

Depending on your lifestyle, some of these add-ons can be of help. Hence, ask your agent what all is included in your policy, and the premium you are being charged for it.

(The writer is Priyadarshini Maji.)

TOP

Source

Porting your insurance may be beneficial, but make sure you do it right – Mint – 20th November 2019

Last month, two friends called to discuss issues in porting their insurances. In both cases the facts were similar—they had long-standing health insurance policies from a public sector insurer. All waiting periods had been completed, which meant that even claims pertaining to pre-existing conditions would be paid for. Both friends had ported their health policies to a private sector insurer. However, they were in for a surprise when they filed claims in the newly ported policies. The claims were rejected for non-disclosure of previous ailments. Ideally, this should not have happened because they had already run through the waiting periods of their previous policies.

In health insurance, waiting period is the time after which claims related to pre-existing conditions cannot be rejected. It is a maximum of four years but two-three years is becoming the norm. Additionally, the insurance regulator has recently introduced the concept of an eight-year look-back. This means that after eight years, a claim cannot be rejected, except for proven fraud. These features imply that the more you renew your health insurance, the higher the certainty that a claim will be paid.

This may have been a disincentive for persons to buy new health products had it not been for the facility of porting. Porting allows you to switch your health insurance to a new product, provided by any insurer. Porting can be done to another product with the same insurer or to a new insurer.

In both cases, the insurer being switched to gives credit for the time spent in the previous health insurance by reducing the waiting period in the new product purchased. For example, in the two cases that I described, the new insurer had waived off the waiting periods completely because the previous policies had already run for over five years.

Porting to newer and better insurance is helpful because products are rapidly improving. What you bought a decade ago will most likely be overpriced and outdated. However, do know that porting is only an adjustment of waiting periods.

You will be bound by the benefits, exclusions, premiums and contracts of the new health insurance that you buy. Also, insurers are not obliged to accept a porting request. They are entitled to set their own underwriting norms and reject a porting request if they wish to.

Practically, many insurers encourage portability by waiving the requirement for additional medical tests or the need to complete detailed forms. They always ask for a declaration of good health, existence of pre-existing conditions and claims history. An adverse report will result in your porting request being rejected. This makes it important to fully disclose your medical history, even when porting. Porting is not a way to hide medical problems and claim a larger insurance benefit.

The regulator has an in-built safeguard to reduce porting-related misselling—intermediaries, agents and brokers do not earn a commission on ported policies. This prevents situations where an intermediary will switch your insurance for its own financial gain. The flip side is that intermediaries may not advise you to port an insurance even if better alternatives are available.

If an insurer rejects your porting request, you can still buy a top-up health cover that enhances and adds another layer of insurance over your base plan. These top-ups pay a benefit above a threshold and this makes them more cost-effective than buying regular mediclaim.

Porting also works in motor insurance. However, here it is the no-claim-bonus (NCB) that is ported. This NCB can reach 50% of the premium and is a sizeable amount. Porting motor insurance allows you to retain the premium discount even if you switch insurers for a particular car or buy a new vehicle. You will lose the NCB if your insurance is not renewed on time or if you make a claim.

As I dug deeper into the rejected claims of my friends, one claim was rejected because she did not disclose a pre-existing condition, incorrectly assuming that this was not required during porting. For the other friend, the case is curiouser. He was not explicitly asked for a declaration of good health or medical history at all, yet the insurer expected this information.

A failed health insurance porting is disastrous for policyholders because it leaves you uninsured. The previous insurance would have lapsed without a new cover being in place.

The single most important consideration, then, while porting, is to apply for a port at least a month before renewal, declare your health conditions accurately and close your previous insurance only after the porting request is accepted by the new insurer.

(The writer is Kapil Mehta.)

Source

TOP

Universal health coverage key to achieving sustainable development goals: Vardhan – The Economic Times – 19th November 2019

Access to medical products and creating an enabling legal and trade environment for the public were critical to achieving the Sustainable Development Goals 2030 agenda, Union Health Minister Harsh Vardhan said on Tuesday. Inaugurating the "2019 World Conference on Access to Medical Products: Achieving the SDGs 2030", Vardhan said the Indian government was initiating measures and making constant efforts for providing the highest possible standards of healthcare to the citizens.

"A universal health coverage is key to the Sustainable Development Goals 2030 agenda and to which India is firmly committed. Access to medical products and creating an enabling legal and trade environment for the public are critical to achieving the SDGs," Vardhan said.

The main objective of the conference is accelerating access to medical products for achieving a universal health coverage in the context of the SDGs.

The conference, organised by the Health Ministry and the World Health Organisation (WHO), will spur innovative thinking around issues surrounding the provisioning of affordable, quality medical products as part of public healthcare delivery systems, Vardhan said.

"We must optimally develop a robust system of sharing knowledge and other resources and to practically translate discussions held at this World Conference for larger public welfare," he added. Vardhan further announced that the 2020 World Conference will be held from September 23 to 25 next year.

It will be followed by the "International Conference of Drug Regulatory Authorities (ICDRA)", which India will be hosting for the first time. The event will take place from September 28 to October 2, 2020. Following the UN high-level meeting on Universal Health Coverage during the United Nations General Assembly (UNGA), the 2019 World Conference seeks to take forward the international and national agenda on access to medical products.

Established in 2015, the SDGs include 232 individual indicators to monitor 17 goals and 169 targets, ranging from energy, climate change, economic growth to health and education. The 2030 Agenda commits the global community to "achieving sustainable development in its three dimensions -- economic, social and environmental -- in a balanced and integrated manner".

Health is an important cross-cutting policy issue in the international agenda, as it is a precondition and an outcome and indicator of all three dimensions of sustainable development.

TOP

Source

Can health insurance premiums go up due to poor air quality? – Mint – 19th November 2019

Delhi-NCR has been battling acute air pollution with the Air Quality Index (AQI) readings between “severe" and “hazardous" levels for most of the past two weeks. While the condition is acute in Delhi-NCR, some other metros are also witnessing increased levels of air pollution. The depleting air quality is a health hazard, especially for those with respiratory ailments. In some cases, it even leads to hospitalization. But can increasing air pollution, which in turn increases the chances of falling ill, impact health premiums?

What happens now

"A few insurers already have slightly higher premium rates in Delhi-NCR and most parts of north India because the loss ratio in this region is higher compared to the rest of the country," said Amit Chabbra, head, health insurance, Policybazaar.com, an online insurance marketplace. This is because the lifestyle in north India, in terms of fitness and eating habits, calls for more claims, he said. Another reason for higher premiums is that medical facilities are more expensive in Delhi-NCR compared to other metros.

"Pollution has been around for long but this is a spike that prevails for a month or so and should pass soon. I don't think it'll have a bearing on premiums anytime soon," said Gurdeep Singh Batra, head, retail underwriting, Bajaj Allianz General Insurance Co. Ltd.

Revising health insurance premiums is a complex process as it requires regulatory approvals. It takes about six to nine months from the time an insurance company files for a change in premiums to actually reflect on the price chart.

Insurers told Mint that insurers, typically, have different premiums for different zones, primarily based on the cost of hospitalization which is relatively higher in metros compared to tier II and tier III cities. Zones are divided based on city type or north, south, east and west. So if you're a 40-year-old living in Delhi (which falls under tier I), your premium would be about ₹12,540 for a ₹10 lakh cover, but if you were living in Dehradun (tier II), your premium would be about ₹10,450 for the same cover.

"As the underwriting becomes more sophisticated and insurers are able to see a higher claim incidence in Delhi-NCR compared to other places, they may consider increasing premiums in this region," said Abhishek Bondia, principal officer and managing director, Securenow.in, an insurance broking firm.

Bondia said insurers haven't started having serious discussions on the issue of air pollution yet, primarily because the data needs to be put together first. "Of course, there's been a rise in hospitalization but the impact on claims has not been much," he said.

Considering the overall pie of claims, for asthmatic patients or people with respiratory disorders, the chances of surgery (which is expensive) are low compared to someone with cancer, heart problems, and so on. "If acute pollution creates long-term health hazard and it shows up in five-seven years, then insurers may consider it," said Bondia.

Specific products

If pollution in Delhi-NCR does not come under control, insurers may introduce specific policies. Batra said insurers could come up with bite-sized policies like the ones that are available for vector-borne diseases like malaria and chikungunya, which are usually seasonal. These policies, typically, come at a lower premium.

While there isn't much clarity on what these sachet policies would cover, insurers said they may primarily target individuals with existing respiratory disorders who are prone to hospitalization when pollution levels skyrocket.

It seems insurers aren't seeing pollution as a cause for a spike in claims as yet and may not hike premiums immediately. However, if pollution keeps getting worse, it could have a bearing on premiums.

(The writer is Disha Sanghvi.)

Source

TOP

Chief Minister's health insurance scheme in Tamil Nadu to cover mental illnesses too - The Hindu – 19th November 2019

The Chief Minister's Comprehensive Health Insurance Scheme (CMCHIS) is all set to cover mental illnesses. To start with, it will be rolled out for patients requiring admission for treatment of various psychiatric disorders in government hospitals.

CMCHIS, that was launched in 2012, was integrated with the Central government's flagship health insurance scheme Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) in September, 2018. The move to bring mental health under CMCHIS comes after the integration, as PMJAY has a package covering a list of mental illnesses including schizophrenia and mental retardation, according to officials.

In fact, the Mental Healthcare Act 2017 laid down the need to extend insurance cover for treatment of mental illness as part of right to equality and non-discrimination: "Every insurer shall make provision for medical insurance for treatment of mental illness on the same basis as is available for treatment of physical illness".

T. S. Selvavinayagam, additional director, Public Health and Preventive Medicine, said CMCHIS had earlier introduced coverage for autism. PMJAY consisted of a package for patients requiring admission in the general ward or intensive care unit for any psychiatric illnesses.

In-patient admissions

"Right now, we do not have much experience in managing psychiatric disorders. So, to start with, the insurance cover will be reserved to government institutions for in-patient admissions. We will try this for a year, and based on how it works, we will decide on extending it to the private sector," he said.

As per the AB-PMJAY, the following conditions are covered in packages: organic, including symptomatic, mental disorders; mental and behavioural disorders due to psychoactive substance use; schizophrenia, schizotypal and delusional disorders; mood (affective) disorders; neurotic, stress-related and somatoform disorders, behavioural syndromes associated with physiological disturbance and physical factors, and mental retardation.

It also includes pre-electro convulsive therapy and pre-transcranial magnetic stimulation package for investigations and electro convulsive therapy (per session) and transcranial magnetic stimulation (per session).

Equal importance

"It is good that mental health is being given equal importance like physical health. Covering therapies such as electro convulsive therapy and transcranial magnetic stimulation will be beneficial," a psychiatrist in a government hospital said.

Lakshmi Vijayakumar, psychiatrist and founder of SNEHA, said it was an absolutely important move. "Many private insurers do not cover mental health disorders. This is a proactive step from the government to make mental illness and mental disorders less stigmatising," she said,

"The government should ensure that it is available in all in-patient settings," Ms. Vijayakumar added.

(The writer is Serena Josephine M.)

Source

TOP

Niti Aayog looking at providing middle class with health cover – The Times of India – 19th November 2019

Government think tank NITI Aayog has suggested "consolidation" of healthcare services and providers to reduce health expenditure and improve access.

In a new report on building a 21st century health system for India, the Aayog proposed "strategic purchasing" of services, "risk pooling" and digitisation of health records for transformation of the healthcare sector.

The report identifies four focus areas on future health systems: delivering on unfinished public health agenda, empowering citizens to become better buyers of health services, integration of health services to reduce out of pocket spend and digitisation of healthcare.

"Imagine a billion transactions every year where individual patients seek care from a million healthcare providers dominated by the private sector negotiating their own prices for the procedures they undergo," the report titled 'Health Systems for a New India: Building Blocks—Potential Pathways to Reforms' says .

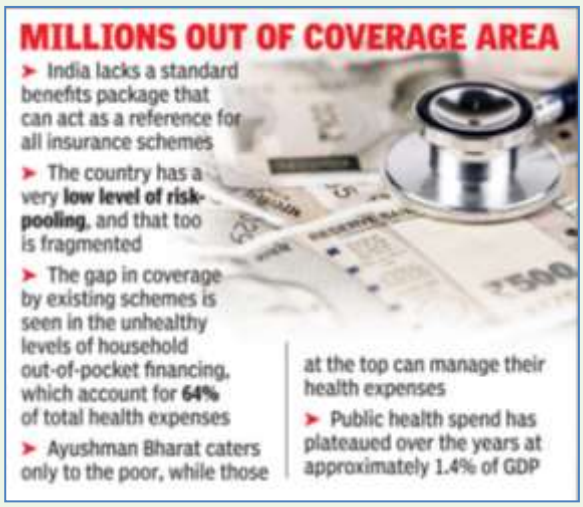
"Even among the organised payers, there are multiple schemes," the report said, highlighting multiplicity of purchasing platforms along with a highly fragmented pool of services which prevents standardisation and the best economic results.

The report was released on Monday by NITI Aayog vice chairman Rajiv Kumar in the presence of co-founder of Microsoft and co-chairman of Bill and Melinda Gates Foundation, Bill Gates.

The Aayog is mulling building up a healthcare system for the middle class which is still not covered under any public healthcare system.

Niti Aayog has recommended that health system financing structure should be changed in such a way that predominant undesirable out-of-pocket expenditure is reduced and spending is directed towards larger risk-pools with strong strategic purchasing capabilities.

The public health expenditure in India (total of Centre and state governments) has remained constant over years at approximately 1.4% of the GDP. On the other hand, out-of- pocket payments remain common and high in India, with only around 20% of the population covered by health insurance. Though Ayushman Bharat aims to expand the coverage significantly, it will take time and funding to ramp it up.



"Successful health sector transformation in India will require simultaneously reducing funding and provision fragmentation. This will facilitate the necessary leverage for effective strategic purchasing to occur, which in turn will determine the incentives for consolidating service providers and improving India's capacity to enforce much needed patient protection, fair competition, as well as quality and efficiency regulations," the report said.

(The writer is Sushmi Dey.)

Source

TOP

Maternity Benefits Restricted to Handful of Urban Women in India, Finds Survey - The Wire – 18th November 2019

The recent Jaccha-Baccha Survey 2019 conducted in six states – Chhattisgarh, Himachal Pradesh, Jharkhand, Madhya Pradesh, Odisha and Uttar Pradesh, is a picture of the hardships faced by pregnant and nursing women in rural India, who have to contend with frugal diet, lack of rest, weakness, dismal health services and insufficiently-supporting government schemes. The survey also reveals how maternity benefits are restricted to a handful of women in India.

Background of maternity benefits in India

In 2013, maternity benefits became a legal entitlement of all Indian women (except those already receiving similar benefits as regular government employees or under other laws) under the National Food Security Act. "Every pregnant and lactating mother shall be entitled to [nutritious food and] maternity benefit of not less than Rs 6,000, in such instalments as may be prescribed by the Central government," a provision in the act read.

At that point, a pilot scheme called Indira Gandhi Matritva Sahyog Yojana (IGMSY) that entitled women to receive a monetary benefit of Rs 4,000 per child [restricted to two live births], was being implemented in 53 districts. On October 30, 2015, the Ministry of Women and Child Development (WCD) filed an affidavit in the Supreme Court, claiming that it was planning to extend IGMSY from 53 to 200 districts in 2015-16 and all districts in 2016-17.

Yet, the budget allocation for IGMSY in the 2016-17 Union Budget remained the same at Rs 400 crore, as it was in 2015-16 and 2014-15. On December 31, 2016, Prime Minister Narendra Modi announced that pregnant women across India would get maternity benefits worth Rs 6,000. An allocation of Rs 2,700 crore was made in the Union Budget 2017-18. However, that too wasn't adequate for effective coverage.

What's wrong with PMMVY

In August 2017, ministry of WCD released the guidelines and draft Rules for Pradhan Mantri Matru Vandana Yojana (PMMVY) that provided for maternity benefits worth Rs 5,000, but restricted to the first live birth in a flagrant violation of NFSA.

An RTI query has revealed that only half of eligible women have received PMMVY benefits in 2018-19. "Since 55% or so of pregnant women are not even eligible (because of the 'first living child' condition), this means that the effective coverage of PMMVY is just 22%. In fact, in terms of disbursement of all three instalments of PMMVY women, coverage is just 14%," reads the survey.

Apart from the statistics, the survey points to several other difficulties in implementation of the scheme in rural India.

To receive the benefit, eligible women need to fill a long form of about 23 pages for each of the three instalments. They are also required to produce various documentary proofs like a mother-child protection card, an Aadhaar card of their own, plus their husband's Aadhaar card and bank passbook, aside from proof that their bank account has been linked with Aadhaar.

All the applications are required to be submitted online, which poses yet another challenge as online applications are often rejected, delayed, or returned with error messages for a series of issues related to Aadhaar-enabled payments of welfare benefits.

Signs of hope in Odisha

The survey noticed positive results in Odisha, that has its own maternity benefit scheme called Mamata. This scheme covers two births and seems to work relatively well. Not only do children aged between

three to six years get an egg five times a week in their mid-day meal, it is also distributed as Take-Home-Ration (THR) for younger children as well as pregnant and nursing women. In fact, eggs are included in the menu in primary and upper-primary schools.

Signs of active team work between anganwadi, ANM and ASHA workers in Odisha was also reported in the survey. Basic services like health check-up, tetanus injections, iron and folic acid tablets and food supplements are provided to pregnant and nursing women registered at the anganwadis.

Odisha was the only survey state where a majority of the households were covered under some form of health insurance – Rashtriya Swasthya Bima Yojana, Ayushman Bharat or the state's own health insurance scheme (Biju Swasthya Kalyan Yojana that was launched in 2018).

Chhattisgarh was also found to have made sustained efforts to improve anganwadis and primary health care by initiating a joint health checkup and immunisation session, involving the ASHA, AWW and ANM forces.

Maternity benefits for only a handful of women

India's Maternity Benefits (Amendment) Act in 2017 was widely celebrated as it raised the number of weeks of paid maternity benefits to 26 weeks. However, these provisions apply only to a tiny fraction of women in the country – those working in formal employment.

A legal recognition of universal maternity entitlements in India came with the enactment of the National Food Security Act, 2013 which made a provision of a benefit of Rs 6,000 per child. Even the PMMVY is in violation of the NFSA as it restricts the benefits to the first child and reduces the amount to be paid to Rs 5,000.

In other words, some women are more equal than others as far as maternity benefits are concerned. The most privileged women get maternity benefits using the wages compensation principle (as they should), but the most disadvantaged are entitled to very low amounts. The existence of stark discrimination is not even acknowledged.

TOP

Source

Cashless patients sick of delays as insurance firms, hospitals haggle – The Times of India – 18th November 2019

In an emergency or even for a long-awaited surgery, opting for cashless insurance cover is always a judgment call. Can one afford to wait, as hospitals and insurance companies haggle before authorising payment? Or does one pay upfront for the treatment required?

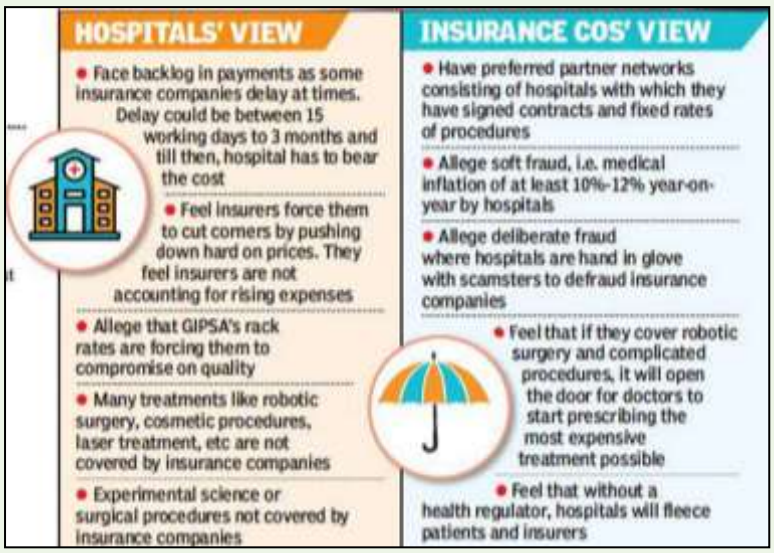
Insurers also have a long history of rejecting cashless policies. Sangamesh Patil, who fractured his ribs recently and was in the ICU for a couple of days, could not claim his cashless policy.

"The insurance company wanted medical documents from 2013, when he was playing cricket and injured his head," Patil's brother Ganesh said. "Because it was not a life- threatening injury, he was an OPD patient. The doctor who treated him in 2013 had moved on to another hospital. How were we supposed to get records from so many years earlier?"

Chandan Kumar's Diwali this year was marred by his 8-year- old daughter having to be admitted to a private hospital for dengue. Despite having a medical insurance policy for five years, the insurance company said it could not offer cashless payment. Company executives advised Kumar to claim for reimbursement because they would need documents for a declaration of epilepsy from five years

previously. Not wanting to haggle because his daughter's condition was critical at the time, Kumar paid up front for the treatment and is now waiting for the reimbursement.

Court battle



Needless pain and suffering are de rigueur these days. The fate of about 48.2 crore people with health insurance in India could be impacted as hospitals decide to take insurance companies to court over cashless claims and the decision by the insurance industry as a whole to fix rack rates (the officially advertised price) for medical procedures. [TOI had on November 6 reported on 31 insurance companies and 26 third-party administrators (TPAs), which process insurance claims, deciding to fix rack rates for common medical procedures].

Giving strength to a recent contempt petition, which will come up for hearing on December 24, filed by private hospital associations in the Delhi high court, is an earlier interim order by the same court preventing four general insurers from fixing rack rates for hospitals. An interim order by the court in July, forced GIPSA — the association of public-sector general insurers, National Insurance, Oriental Insurance, New India Assurance and United India Insurance — to honour cashless claims by all hospitals.

GIPSA, which services more than 6 crore policyholders, most from public-sector companies, accused private hospitals of shocking instances of overpricing. In an attempt to combat deliberate fraud by hospitals and ballooning medical costs, GIPSA created its own preferred partner network (PPN) of hospitals. The deal was if a hospital entered the PPN, only then would GIPSA honour its cashless claims. As insurers knew how much a certain medical procedure is likely to cost, they were unlikely to be duped into paying higher charges.

Upset with GIPSA, hospitals and associations like the All India Ophthalmological Society moved the high court, which passed the interim order in July. Hospitals argue that the recent move by insurers is in contempt of the earlier order.

Patients harassed: Hospitals

Hospitals now allege that patients face harassment and are unable to avail of the benefits of complicated and advanced technical procedures because insurance companies are forcing hospitals to cut corners.

"Insurance companies and TPAs fixing rates for medical procedures is nothing but a cartel trying to control the industry and doctors' professional fees. We faced the same with GIPSA — a large number of claims denied clearance for want of the treating hospital not being registered with this body," says Dr Mahipal Sachdev, president Delhi Ophthalmological Society.

Hospitals say insurance companies have systematically refused to cover robotic surgery and other advanced treatments. "In something as simple as cataract surgery, insurance companies refuse to cover more advanced lenses. Insurers want us to charge what we were charging 10 years ago — not accounting for rising costs and newer technology," Sachdev said.

Insurers' contention

Insurers, for their part, accuse private hospitals of arbitrary pricing. They say hospitals fleece both patients and insurers. A hospital can charge anywhere between `25,000 and `3.5 lakh — depending on the quality of the material used and the hospital carrying out the procedure — could cost between `7 lakh

and and `15 lakh. Insurers say because there is no health regulator to ensure fair pricing by hospitals, it is up to them to fix the rates.

"There is steep medical inflation, with hospitals charging 10%-12% more each year, and there is no regulator cap on the rates," said General Insurance Council secretary general, MN Sharma. "That's why insurance regulator IRDAI mooted this plan. We have seen one hospital charge different rates for a surgery at different locations, or different rates depending on the insurance company or TPA. We want fair and uniform pricing across the industry."

Insurers also say they know better than the average customer what a particular medical procedure would cost. "We have been in this business for decades," New India Assurance Co CEO Atul Sahai said. "We know when a hospital is trying to pad its books."

Insurers say private hospitals touting "technology advancements" are pulling off a scam. "They want robotic surgery for complicated lung procedures. Now, if we start covering that, that will open the door wide. Next, they'll want robotic surgery for cataracts," an official with a PSU insurer said. "Hospitals and doctors recommend unnecessary MRI scans and diagnostic tests for minor ailments. Technological advancement is another way to mint money."

Customers at a loss

But as insurers and hospitals battle it out in court, what happens to policyholders and patients? They could face the same plight patients did in Karnataka in April — when they were told to arrange, at short notice, sums ranging from `10 lakh to `25 lakh as hospitals stopped honouring cashless policies.

The Private Hospitals and Nursing Homes Association (PHANA), unhappy with GIPSA rates, refused to honour cashless claims for nearly a month, putting thousands of policyholders of the four public-sector insurers at great inconvenience. With more than 400-plus hospitals in its network, boycotting insurers cost patients more than it did insurance companies. Two years prior to that, hundreds of patients in Pune faced a similar situation, when a network of 125 hospitals refused to honour cashless claims.

A journalist, whose father was in and out of hospitals for cancer treatment, had a choice: Fight endless battles with the hospital and insurance company over a cashless policy or pay up front. She paid `9.5 lakh, an amount that is yet to be reimbursed three months on. In her case, too, the insurer and TPA have problems with the hospital's charges.

"When they know the patient has insurance, the cost always goes up by 3×. When it comes to cashless, hospitals can fudge only up to an extent with the insurance company," the official with a PSU said. "Hospitals reject cashless policies and force patients to pay in full up front and claim reimbursement later. Insurers, knowing hospitals are overcharging, can only partially settle a claim."

Insurers and policyholders say a regulator for private hospitals could resolve the vexed issue.

(The writer isRachel Chitra.)

TOP

Source

Lack of awareness responsible for low health insurance penetration – Outlook – 17th November 2019

Sanjay Datta, Chief Underwriting, Claims, Reinsurance and Actuary, ICICI Lombard General Insurance *shared his view on low penetration of health insurance in the country in a conversation with* **Nirmala Konjengbam**.

Health insurance is the need of the hour for Indians and to make quality healthcare affordable, insurance service providers must be used effectively to ensure the health of citizens. The health insurance penetration in the country is below the desirable rate and the biggest factor that contributes to this unawareness of health insurance is illiteracy.

Edited excerpts.

What are the reasons behind low health insurance penetration in India?

Health insurance penetration in India is abysmally low. Currently, 34 per cent of the country's population is covered under any health Insurance. The percentage of people covered under health insurance in rural areas is much lower than that of urban areas, despite the fact they get benefits from government health insurance called Rashtriya Swasthya Bima Yojana (RSBY) for unorganised workers and those below the poverty line, CGHS for government employees, and ESI for organised workers.

The biggest factor that contributes to this unawareness of health insurance is illiteracy. The existing burdens of loans on the poor make them reluctant to think of the credit policies that are actually issued in their interest. Even though right to information is a fundamental right in our country, a considerable section of Indians lack the exposure to information that is issued in the national interest of the people.

We are all aware of the healthcare scenario and the rising costs but a large majority of people in India believe that health insurance is not a worthy investment and therefore, avoid buying such insurance products. Even when economically backward population is aware of such policies, it does not have the distributional cash flow.

What are the challenges faced by insurers?

Given the vast geographic and economic variations, it is difficult to cater to these differing markets - one of the key reasons for low coverage rates. Distributional challenges, such as last time access, lack of sustainable products, transactional inconvenience have been some of the key internal challenges plaguing insurers in the country.

How to increase health insurance penetration?

The penetration of insurance in India is much lower than most of the counties in the world.

The potential market is still untapped, and with the rising middle class, increasing awareness for health and increase in marketing efforts, insurance companies now have the opportunity to reach out to a broader customer base. With the use of technology and effective distribution channels we can now expand to a wider geography especially in Tier 2 and Tier 3 cities

What are the factors that lead to rise in health insurance demand?

The demand for health insurance is rising as a financing option to be able to afford quality healthcare. Some factors causing this shift are:

1. Changing disease profile of population

The prevalence of lifestyle diseases like diabetes and hypertension are rising due to changing lifestyles. Moreover, non-communicable diseases are now affecting more young adults than before. In rural areas and among urban poor, the burden is double since infectious diseases are prevalent too. All these are leading to increasing demand for healthcare.

2. Innovative products

Insurance companies are constantly trying to design innovative products with comprehensive coverage. Products with optimal pricing and coverage are being designed keeping in mind the healthcare needs of different strata of population.

3. Regulatory and technological advancements

Improved regulatory environment and technological advancements will help health insurance industry to better tackle the issues and challenges. This will definitely lead to growth and advancement in the market, enabling insurance companies to serve their customer better.

(The writer is Nirmala Konjengbam.)

TOP

Source

Health Ministry against allowing Ayushman Bharat beneficiaries to avail high-cost treatment under RAN - Business Standard – 17th November 2019

The health ministry has rejected a proposal for allowing Ayushman Bharat beneficiaries to avail high-cost treatment for life-threatening diseases under the Rashtriya Arogya Nidhi, and suggested that the health insurance scheme could be modified and the Rs 5-lakh ceiling enhanced to accommodate such patients.

The AIIMS and the National Health Authority (NHA) made the request to the ministry and cited cases wherein Ayushman Bharat beneficiaries could not avail treatment for blood cancer and chronic liver diseases as these are not covered under the health insurance scheme.

In a letter to the CEO of the Ayushman Bharat-Pradhan Mantri Jan Arogya Yojna (AB-PMJAY), Indu Bhushan, the health ministry said the suggestions of NHA and AIIMS cannot be agreed to as the eligibility criteria for both the schemes are different.

The eligibility criteria for financial assistance under Rashtriya Arogya Nidhi (RAN) is based on state-wise threshold poverty line decided from time to time, whereas PMJAY is an entitlement-based scheme with entitlement decided on the basis of deprivation criteria in the SECC database 2011, the ministry said.

"As such the eligibility criteria for both the schemes are different. Further AB-PMJAY is an entitlement based scheme whereas assistance under RAN scheme is provided to eligible patients within the available budgetary allocation," the ministry said.

The All India Institute of Medical Sciences and the NHA, the apex body implementing the Ayushman Bharat health insurance scheme, had written to the Health Ministry suggesting if the patients deprived treatment under AB-PMJAY could be covered in the RAN umbrella scheme.

They drew the ministry's attention to the cases of patients who were refused under PMJAY as they suffered from ailments such as blood cancer and chronic liver disease which do not figure among the 1,350 medical packages mentioned under the scheme.

These patients were also not able to avail treatment under the umbrella scheme of RAN since they are AB-PMJAY card holders. In its response, the health ministry further elaborating the grounds of rejection said that the funding pattern of PMJAY is 60:40 between the Centre and states whereas the RAN scheme is 100 per cent funded by the central government.

"The RAN scheme is not a general health scheme to provide treatment to all patients whose treatment cost is beyond Rs 5 lakh. It cannot be a substitution of health system of the government. "It is a scheme for providing treatment to patients suffering from life threatening diseases at government hospitals having super-speciality facilities and who are eligible for financial assistance as per the state-wise threshold poverty," the letter stated.

The health ministry also expressed concern about misuse of the provisions of financial assistance by beneficiaries of PM-JAY saying one family member may avail financial assistance for transplantation of organs beyond Rs 5 lakh under RAN scheme and other family members may also avail benefits under PM-JAY at a different hospital/state.

Patients having treatment in government hospitals are eligible for financial assistance under RAN whereas enlisted private hospitals are also providing treatment to patients under PM-JAY. "The NHA may consider for inclusion of transplantation of organs under the procedures covered under PM-JAY," the minister said in its letter.

It also suggested the NHA to consider enhancing the ceiling of Rs 5 lakh per annum so that patients eligible under PM-JAY may avail facilities under the programme only. According to Dr Vijay Gurjar, a faculty at AIIMS, several poor patients requiring kidney transplant, bone marrow or liver transplant are facing problem in getting treatment as they are PMJAY card holders.

Their treatments would cost more than Rs 5 lakh and still they are not able to avail benefits under the RAN scheme.

AIIMS Medical Superintendent Dr D K Sharma in his letter to NHA had mentioned that patients failing to avail financial assistance due to the lacunae between RAN umbrella scheme and AB-PMJAY schemes were approaching the hospital administration after their RAN application was being rejected and they having left with no option for financial assistance.

"Both schemes must complement each other to help patients suffering from life-threatening diseases. On the contrary, certain poor patients are deprived of healthcare benefits, against the situation before 2019, when all BPL patients suffering from life-threatening diseases were able to avail financial assistance from RAN," the letter read.

TOP

Source

Child healthcare turning expensive? See how family floater health plan can help you out – Financial Express – 15th November 2019

Unless you are sitting lavishly on a lot of money, paying for extensive medical treatment will surely burn a hole in your pocket. Health care costs are up and rising. Not only limited to medical treatment for the elderly or the senior citizen, but it is also expensive across all age groups. Even for newborns, most couples see a sudden rise in their expenses. Parents are also suggested by Hospitals and doctors to go for annual health care check-ups, not only for the child but for the whole family and most offer packages for the same.

Not only after the child is born that the medical cost rises, but the health care expenses also increase even before the child is born. For instance, other than the usual check-ups of the mother, normal delivery at a top hospital can cost anywhere between Rs 60,000 to Rs 1.5 lakh in a metro. Health insurance policies generally, do not extend their cover for this cost, but very few policies include this expense in their cover but only after a waiting period, which ranges from 2-4 years.

Maternity expenses are also covered by employee health covers, but the amount ranges between Rs 25,000 to Rs 50,000, which most likely will be insufficient. Hence, experts suggest buying a health insurance policy that includes maternity cover, can help out recently married couples.

Hospitalization of the child for infections and injuries can result in a bill of Rs 1.5 to Rs 3 lakh, or even higher. Hence, industry experts suggest the child should be added to the family health floater cover once the child is 90 days old. However, find out with your insurance provider, when can you do that as some insurers allow this only at the time of renewal of the policy, whereas some allow this at all times of the year.

Note that with the inclusion of a child, the sum insured should also be increased and because of this, the premium of the policy will also rise. The sum insured amount with the inclusion of the child should go up by 30 to 50 per cent at the least. Experts suggest a family with a family floater should have a sum insured of Rs 10 lakh or a minimum of Rs 5 lakh at least, given the rise of medical costs.

Here are some pros and cons of a family floater plan:

Pros

Under one insurance policy, the policyholder gets to take care of the entire family, which is easier to manage than managing separate policies.

When it comes to getting your parents insured, family floater stands out as a much cheaper option than getting a senior citizen's health plan.

It is easy to add the policyholders, immediate family members, be it a spouse or a new-born.

Also, if one of the family members gets sick and needs to be hospitalized, the total sum insured of the policy can be utilized by the family member for his/her treatment.

Family floater plans enjoy income tax benefits under section 80D, of the Income Tax Act.

Cons

In case of more than one claim within a year, the family member taking the second claim gets a thinned out cover. That is the left out the amount from the first claim, goes out to the second claimant.

Most family floater policies provide insurance cover only for the policyholder, the spouse, and their children. It generally excludes the policyholder's parents and siblings.

One of the major drawbacks, especially if senior citizen parents are also included in a family floater plan, is the renewability of the policy. The policy can only be renewed till the oldest member included in the cover reaches the maximum renewability age. However, with IRDAI's intervention of IRDA, insurers have started offering lifelong renewability.

(The writer is Priyadarshini Maji.)

Source

TOP

CROP INSURANCE

Rajasthan: Thousands of Crop Insurance Claims Denied as Premium 'Refunded' - The Wire – 21st November 2019

Thousands of farmers in the Satlana gram panchayat of Rajasthan's Jodhpur, insured under the Pradhan Mantri Fasal Bima Yojana (PMFBY), have been denied insurance claims for two crop seasons – kharif 2016 and kharif 2017.

The claims have apparently been denied because the Agriculture Insurance Company of India Limited (AIC) refunded their premiums to the Jodhpur Central Co-operative Committee Bank a year after they were paid, as the insurance details weren't provided in a "soft copy". The bank, however, has not credited the refund in farmers' accounts.

The matter was taken to the Rajasthan high court after farmers, with the support of their sarpanch, filed a public interest litigation to seek their insurance claims. "When the insurance claims didn't reach us when other villages in our gram panchayat had received them, we approached the concerned co-operative society, which is a unit of the Jodhpur Central Co-operative Committee Bank, but nothing substantial happened," Bhala Ram Patel, the sarpanch of Satlana, told The Wire.

On December 15, 2017, the co-operative society in Satlana wrote a letter to theJodhpur Central Co-operative Committee Bank saying that three patwar mandals under its jurisdiction – Satlana, Karniyali and Bhacharna – where close to 70% yield loss was assessed by the state revenue department, hadn't received insurance claims for kharif 2016 despite a premium of Rs 4,32,793 being debited from the farmers' accounts in the co-operative society.

The bank, on the next day (December 16, 2017), asked the AIC to "investigate the facts and initiate disbursal of insurance claims". However, it didn't receive a reply until the matter was taken to the high court.

Issues in handling PMFBY policies in kharif 2016

While it has been proven that the bank credited the premium debited from farmers to the insurance company, AIC submitted before the court that it had refunded the premium to the bank a year later as "no insurance details" of the premium were provided.

AIC, in its reply to the high court, said, "We had received a total premium of Rs 5,27,11,235.65 from Jodhpur Central Cooperative Bank for Kharif 2016. However, the booked premium was only Rs 5,10,48,379.14 since we had refunded Rs 16,62,856.57 back to the bank." As per a PMFBY notification dated July 23, 2016, farmers' insurance details must be provided both in hard and soft copies. AIC claimed that since a soft copy was compulsory, the premium could not be accepted.

As per the AIC's submission, even if insurance details were not in the requisite format, the company took more than a year to refund the premium. "We didn't receive insurance details for that amount [Rs 16,62,856.57] from the Satlana Primary Agricultural Credit Society (PACS) as per the format prescribed in the PMFBY notification. Rs 16,60,196.71 of this amount were refunded on September 28, 2017 and Rs 2,659.8 on March 20, 2018," AIC said in its reply to the court.

To explain the delay, the insurance company said it was waiting for proper details to come. "We didn't want the famers to suffer just because the insurance details were not given in the prescribed format, so we waited for some time and that is why the refund process got delayed," Pushkar Priyadarshi, regional manager of AIC, told The Wire.

The mess doesn't end here

The Jodhpur Central Co-operative Committee Bank, which received the refund from AIC, told the court that it couldn't have "assumed" that the amount refunded was the farmers' premium. "When we received an amount of Rs 16,62,856.57 from AIC, we asked for clarification of the amount but it [AIC] didn't reply. There was no reason for us to assume that the amount was a refund of farmers' premium," the bank said in its reply.

The bank further claimed that the premium, along with requisite particulars of farmers, was provided to the AIC on October 5, 2016, which it had received without any objection.

"AIC started disbursing the insurance claims of Kharif 2016 on December 13, 2016. If there were any lapses in the particulars of the farmers, then that should have been intimated before the disbursal of the claims. We never received any communication from the insurance company in this regard," the bank claimed.

As per farmer Satya Narayan's pass book, seen by The Wire, insurance premium worth Rs 1,207 was debited on June 3, 2016 and Rs 1,380 on September 12, 2017, but there was no entry for an insurance claim. "Each season there is no delay in debiting our premium, but when it comes to paying claims, there is a long list of excuses and conditions. Even for kharif 2018, we are yet to receive the claim despite crop yield losses," said Satya Narayan.

Issues in disbursal of claims from kharif 2017

For kharif 2017, AIC admitted that it had received insurance details of 1,151 farmers from Satlana through the state PMFBY portal in the desired format, but paid insurance claims to only 25 farmers. "It is

not necessary that all the farmers who are insured are entitled to receive the insurance claims. There are a lot of factors that need to be seen," said Priyadarshi.

However, the remaining farmers claim that they were also insured for the same notified crop for which a few farmers had received claims. "When the crop sown is same, then how is it possible that we are not entitled to insurance claim?" a farmer in Satlana asked The Wire.

The insurance company has rejected the crop loss assessment of these villages, stating, "As per the provisions of the PMFBY, the village-wise Jinswar report or any other report prepared by government has no relevance."

This is in contrast with the Rajasthan government's PMFBY notification, which states, "If more than 25% of the total insured area in a patwar circle has suffered crop yield loss, then all the insured farmers producing the insured crop in that patwar circle, who would have informed to the implementing agency within the stipulated time period, would be entitled to insurance claim."

"In such a situation, the percentage of crop damage will be determined on the basis of a survey of the area with the joint consent of the local farmers and the officer of the revenue department," the notification reads.

The farmers' counsel in the PIL believes that the insurance company is making absurd excuses for having denied insurance claims of eligible farmers. "When the guidelines clearly mention that the damages in a patwar circle on a certain threshold make all the insured farmers in that circle eligible to seek claim, there is no point in discarding village-wise crop loss assessment reports of the village," Moti Singh Rajpurohit, counsel for the petitioners, told The Wire.

There is also a discrepancy in the insurance company's and bank's versions on the number of Satlana farmers who benefited under the PMFBY in kharif 2017. The insurance company claimed that it had paid claims to 25 farmers, while the bank details submitted to the court brings down the number to just seven. "In the season Kharif 2017, a total of 1,521 farmers in Satlana were insured under the PMFBY, however, insurance claim amounting to Rs 40,992.14 was paid only to 7 farmers," the bank said in its reply to the high court.

(The writer is Shruti Jain.)

TOP

Source

PM's crop insurance scheme needs tweaking to make it work better on the ground – Financial Express – 21st November 2019

Since the launch of the Pradhan Mantri Fasal Bima Yojana (PMFBY) in kharif 2016, there have been mixed reactions to the Narendra Modi government's flagship crop insurance scheme from different stakeholders. While each of them — insurance and reinsurance companies, farmers, state governments, agricultural scientists, economists and media — have their own perception about the scheme, what is not in doubt, however, is the fact that it is very ambitious and probably an 'ideal one' any country should have. Also, the government has been very forthcoming in using technology, right from the process of registration of farmers to the settlement of claims and transferring of money to beneficiaries.

The whole infrastructure for making this process a success may not have been in place from the start, but the individual pillars are being strengthened with each passing crop season and issues resolved through consensus approach. And this isn't easy, given the vast differences within the country in terms of last-mile penetration of technology, crop types, seed varieties, agronomic practices, landholding sizes,

microclimate and soil-moisture regimes, etc. In addition to these major constraints is the small time window available for farmer enrolment, monitoring of crop through the season, conducting crop cutting experiments (CCE) for quantitative assessment of losses, if any, and settling claims — not to speak of the 'human factor' operating at every level of undertaking these exercises.

Taking into account the above realities, here are some suggestions that may be worth considering for improving the implementation of a fundamentally well-conceived scheme:

* Historic Yield data: For calculation of threshold yields, against which crop loss assessment is made, PMFBY relies on data aggregated at district or, at best, sub-district level. This is problematic when field or plot-level insurance is what should be a desirable aim. Any benchmark based on historic long-term data also needs relooking, as the field that gave 'x' quintals of produce in the past may currently yield more, thanks to availability of better seeds, irrigation or better crop management practices. To arrive at threshold yields, it would be best to take the past three-years data and exclude drought/flood years to decide threshold yields, while giving more weight to the latest year. In the past few years, yield data is being collected through digitisation of CCEs involving geo-tagging, date-timing and photographs of the plots where these are being conducted. Such data, which correlates better with local conditions than area averages, should be used for determination of threshold yields as well.

* Selection of Insurance Units (IUs) for CCEs: Sowing acreages aren't uniform across any district or even block. While some IUs in a district or block may have significant area sown under a particular notified crop, this wouldn't be the case with others. It makes sense, therefore, to merge IUs having less sown area under that crop with the nearest significant ones. Alternatively, a number of IUs, whose individual sown area under the crop is below a pre-decided level, can be merged to form a bigger IU. All this will reduce the total number of IUs in which CCEs are required to be conducted. A further reduction can be achieved through smart site selection of IUs using satellite-mapping tools such as normalised difference vegetation, water or leaf area indices (which would help identify sites where more or less CCEs may be required, depending on the crop health status revealed by these values).

* Selection of fields: CCEs are now done on random plot selection basis, independent of whether a farmer's crop is insured or not. Insurance is sought primarily by farmers whose yields are generally low and prone to fluctuations. That being so, it would be unfair to decide the fate of insured farmers based on data collected from uninsured farmers' plots. To be fair to insured farmers, yields from only their plots ought to be considered, as opposed to taking all farmers for computing the average yield of an IU. One way to do this to simply take the list of all insured plots in the IU and picking randomly (even a digital lottery system isn't bad).

* Adopting Satellite Remote-Sensing Technology (RST): Ideally, RST should be employed at all stages in the crop season, whether for tracking progress of sowing area or estimation of yields and determining sites for CCEs. One reason for RST solutions not being adopted for crop insurance is the lack of standardisation in the approaches towards their use. Secondly, optical remote-sensing images in the red, green, blue, and near infrared electromagnetic spectrum bands are not available during the major part of the kharif (monsoon) season, when they are needed the most. Now that we have satellite technology using microwaves, which can penetrate through cloud cover, light rain and haze, its utility for determination of crop-wise sown area and yields is beyond doubt. RST can, in fact, today be widely and more effectively deployed to simplify many aspects of PMFBY implementation.

* Weather-based insurance: In an ideal world, crop yield loss at the individual farm should be the basis for compensation. But from a simplicity and scalability point of view, weather-based crop insurance is the best and fastest solution. Automated weather stations that measure simple parameters such as rainfall, temperature, relative humidity and wind speed — which correlate well with crop growth performance — can help supplement or even be an alternative to CCEs. Below-normal rain during July-August is bad for most kharif crops (when they are in sowing or vegetative growth stage), just as we know from this year's experience how too much rainfall in September-October (when they are in grain formation or near-harvesting stage) isn't also good. It should further be possible to offer insurance

products based on crop yield proxies from satellite datasets such as normalised difference vegetation index. These should preferably be microwave satellite datasets, which are all-season.

No doubt, a lot of tweaking still needs to be done to PMFBY. Addressing the issues highlighted above should result in reduction of CCEs and more standardisation in procedures. These would ultimately help distressed farmers, who are looking for immediate relief in case of crop loss from natural factors beyond their control. They will benefit from a crop insurance scheme that expeditiously settles claims.

(The writer is Sudhakar Manda.)

Source

TOP

Fixing crop insurance - Business Standard – 21st November 2019

The decision by four private insurance companies to opt out of the government's flagship crop insurance programme — the Pradhan Mantri Fasal Bima Yojana (PMFBY) — is least surprising. The scheme, though better than most farm insurance instruments tried out with little success since the early 1970s, suffers from several inherent flaws which undermine its appeal to both insurers and farmers. While the insurance companies find it a loss-making business despite the hefty 90 percent subsidy by the government, the farmers complain that the compensation is too meagre and comes with an inordinate time lag. The common impression that the subsidy is being cornered unfairly by insurance firms seems true but only partly. In the initial years after the launch of the scheme in 2016, salubrious weather had kept the crop damages and, hence, the reimbursement claims, low, thus, allowing the insurers to make good profits. But the situation has since changed with the aberrant monsoon rainfall — 9 percent deficient in 2018 and 10 percent excess in 2019 — inflicting heavy crop losses in several states. As a result, the compensation claims have exceeded the collected premium, thereby, eroding the insurance companies' profits and making crop insurance an unattractive proposition for them.

TOP

Source

Crop insurance flaws fuel farm distress – Mint – 19th November 2019

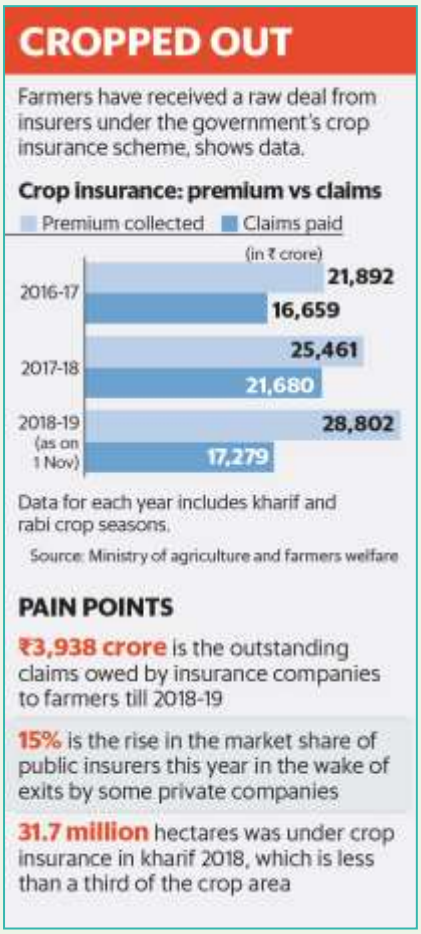
Santosh Kumar's first brush with insurance left a bitter aftertaste. A farmer's son, 26-year-old Kumar from Bihar's Araria district felt betrayed when hundreds of farmers from his village, including his own father, were denied what was due to them. In August 2017, Kumar's village in Palasi block of Araria was flooded by an overflowing Kosi river. Much of the paddy crop got washed away.

Thankfully, for the first time—without even knowing about it—around 250 farmers had gotten themselves covered under the Prime Minister's flagship crop insurance scheme. Premiums had been automatically deducted from their crop loan accounts held by a public sector bank without their consent. However, after the floods, it seemed like a blessing.

A month after the water receded, the flood-hit farmers visited the bank as the insurer did not have a local office. They were told matter-of-factly: your claims will be settled, but it may take more than a year. "Such delays are normal".

So, they waited. By February 2019, their patience had worn off. They made a list of insured farmers and pressed for a settlement of the claim. The bank advised them to get in touch with the insurer, a private firm. The response of the insurer's customer service executive came as a rude shock: "You were supposed to intimate us within 48 hours of crop damage, which you didn't. Besides, according to our records, your crop did not suffer any significant loss."

“We felt cheated. How could we inform the company when our homes were under water?" asks Kumar. “We were living on the highway...on the roofs of concrete houses. During the first 48 hours of the flood, some took shelter on top of trees," added Kumar, who still harbours a faint hope that the money will reach him someday.



Experiences like Kumar’s have become fairly common. And it is starting to make farmers view the flagship central government crop insurance scheme with suspicion. When the Pradhan Mantri Fasal Bima Yojana (PMFBY) was launched in June 2016, the idea was fairly simple: any farmer who avails a loan will simultaneously sign up for insurance; any crop damage will be evaluated by state government officials; and the insurer would eventually pay out a compensation amount commensurate to the degree of yield loss. That was the theory.

In practise, few farmers get compensation on time. As on 1 November, insurance companies owe farmers ₹2,511 crore from the kharif 2018 crop season (16% of estimated claims). That amounts to a delay of more than a year from the date of harvest. For winter crops harvested in April-May of 2019, farmers are waiting for another ₹1,269 crore (26% of estimated claims), revealed an agriculture ministry official on condition of anonymity.

Naturally, farmers are losing interest. Enrolment under PMFBY fell from 40.5 million farmers in kharif 2016 to 34 million in 2018, a 16% drop within two years.

So, what really came out of the government-led programme to mitigate the risks faced by the farmers which has cost nearly ₹1 trillion in premiums since 2016? What will happen to those who suffered serious crop damage this year due to an erratic monsoon, which has, most visibly, resulted in soaring onion prices?

Inside this esoteric world of premiums and compensation claims and the fates of individual farmers lies a larger economic puzzle: how can there be a revival in rural incomes when the only remaining fallback fails?

Private exit

Farmer distrust regarding the scheme has only gained strength after four private insurers—ICICI Lombard General Insurance Co. Ltd, Tata AIG General Insurance Co. Ltd, Cholamandalam MS General Insurance Co. Ltd, and Shriram General Insurance Co. Ltd—did not bid for insurance clusters in the kharif 2019 crop season.

“After making money for two years, private insurers are running away when adverse weather is hitting us in more and more states," said Raju Shetty, a former member of Parliament and farmer leader from Maharashtra.

Insurance industry insiders point to a slew of problems which forced some to leave the business. High costs of reinsurance due to erratic weather, a spike in claims and political interference in crop loss estimation are significant reasons, they claim.

The decision to stay away is not final and was driven by extreme weather conditions, said S. S. Gopalarathnam, managing director at Cholamandalam MS, which is expecting an adverse 165% loss ratio (claims as a % of premiums) in 2018-19. Both ICICI Lombard and Tata AIG declined to respond to queries from Mint.

However, Bhargav Dasgupta, MD and CEO of ICICI Lombard, in an earnings call in July this year, said: “We don’t believe that the crop business, given the terms, can be viable. At the end of the day, it is social insurance."

Suddenly, three years and seven crop seasons after PMFBY was launched with much fanfare, no one seems to be happy. The farmer is troubled, the insurer is running for cover and state governments, who spend a significant amount of their agriculture budget on the scheme, appear reluctant to pay their share of premium on time (under the scheme, farmers pay only 2% of the premium while the rest is borne equally by the Centre and state governments).

“The claims for kharif 2019 are expected to cross 90% of the premium collected," predicted a senior official at the agriculture ministry who did not want to be named. “With an average 10% in reinsurance costs and 5% in administrative charges, this season is likely to bleed insurers."

To fill the gap left behind by private firms, public sector insurers now account for 65% of the crop insurance market, up from around 50% a year ago. The largest among them, the Agriculture Insurance Company of India Ltd, is now staring at heavy payouts due to erratic rains in at five states—Maharashtra, Madhya Pradesh, Gujarat, Chhattisgarh and West Bengal.

The ministry official cautioned that it should not shock anybody if public insurers, too, express an intent to exit, unless the government makes good their losses.

This wasn’t the case till last year (2018-19). In the six crop seasons between kharif 2016 and rabi (winter harvest) 2019, insurance companies collected a total of ₹76,155 crore in premiums and settled ₹55,618 crore in claims. On balance, that implies decent profit margins, given the unique nature of the scheme—since costs are kept low by selling policies through the banking network and crop loss assessments are mostly carried out by state governments.

“The heavily subsidized scheme unlocked a lot of value for insurers. Now that the market is mature, farmers are aware, and the government is eager to make insurance work for farmers, companies are running away," said an insurance consultant to a state government who did not want to be named.

Insurance companies have used every trick in the book, the consultant said, “from choosing low-risk profitable clusters to forming cartels in order to quote higher premiums during bidding". In the end, when nothing else works, there is always the option of an exit.

“The government needs to go back to the drawing board and fix this," said the state government official. “Insurance companies cannot be entrusted with the scheme where so much public money is flowing (close to ₹1 trillion in seven crop seasons to kharif 2019) and when farmers are running from pillar to post to get claims."

A mess across states

At its heart, a well-functioning insurance is meant to bail out a person when the need is dire. That is why the idea of crop insurance itself has its origins in depression-era 1930s US. But India’s farmers have little hope that PMFBY will come to their aid this year.

In Maharashtra alone, an estimated 10 million farmers are affected. Farmer organizations are now demanding that the state be declared hit by a “wet-drought". Drought, for the lack of rainfall in the early months of monsoon (June-July), and wet since crops like soya bean, cotton and onion were washed away by three weeks of continuous rains in October.

“Poor claim settlement cannot be justified (this year) since the rainfall data is proof of how extreme it was," said Prakash Popre, a farmer and professor of agriculture from Nanded.

If poor compensation payouts was not worrying enough, in July this year, Madhya Pradesh government went a step ahead to limit the maximum payout. To lower its financial outgo due to premiums, the state government reduced the sum assured by 25%. For instance, in Harda district, farmers were entitled to a

claim of ₹35,000 for 100% damage to their soya bean crop per hectare in 2018, which has now fallen to ₹26,250 this year.

“Back in 2017, the claim payout was as low as ₹131 in some cases. We are unsure this year," said Ram Inaniya, a farmer from Harda, Madhya Pradesh.

There is an evident conflict of interest, admits the official from the agriculture ministry quoted earlier. “We are running PMFBY as a social sector scheme for farmers. For insurers, it is a business. Still, the beauty of the scheme is that insurance companies cannot decide everything, including the extent of crop loss," said the official.

Saga of distrust

But that element of protection built into the scheme, which mandates state governments to determine the extent of damage, may be one of the main reasons for the long delays in compensation payouts.

In cases where crop damage is reported, state governments usually undertake crop cutting experiments (CCEs) in the presence of officials from insurance firms. The challenge lies in the sheer number of CCEs which needs to be completed within a short window—currently estimated at more than seven million every year. “The possibility of dispute is high since the process is manual and farmers are (often) unhappy about the choice of plots to estimate yields. Moving away from yield-based insurance to a weather-based products could offer a solution," said Yogesh Patil, CEO of Skymet, a private weather services company.

The way ahead could also lie in extensive use of technology, such as satellite imagery and drones to estimate losses—which PMFBY promised but has been slow to implement. Data on a host of parameters like the groundwater situation, soil moisture, irrigation, weather and remote sensing can be used to estimate yields, said Anuj Kumbhat, director at Weather Risk Management Services. “The idea is to use CCE’s as a corroboration tool and minimize the number of CCEs. But states have been slow to adopt new technology."

With limited use of technology and gaping challenges in implementation, crop insurance seems to be on the verge of getting caught up in a web of distrust fuelled by limited evidence. Even farmers sometimes exploit these weaknesses, says Siraj Hussain, a former agriculture secretary. That begins with enrolment, which has a cut-off date of end-July, when the actual arrival of the monsoon is in early June.

“Insurance is a cover for uncertainty… one cannot allow enrolment when signs of a drought or flood is evident," said Hussain. “A scheme where so much of public money is involved needs integrity at all levels." He added that by November, more than 2.5 million claim intimations have already been filed by farmers in Maharashtra for post-harvest losses due to excess rains, and some of these may be dubious.

Meanwhile, Suresh Ediga, a volunteer with the non-profit run helpline Kisan Mitra, has been grappling with a spike in distress calls from farmers in several districts of Telangana, who are genuinely in a fix due to irredeemable crop damage. The helpline, originally meant to be a suicide hotline, is quickly learning about the intricacies of insurance.

Most insured farmers, a shocked Ediga found out, had no knowledge about whom to report their losses. They did not have any details about the insurance policy, which crop was insured, or the amount of coverage (sum insured). The helpline of the private insurer did not work most of the time, and when it did, the customer executive could not follow the local language, Telugu.

But the state of India’s response to remedy the risks inherent in farming became most evident, Adiga says, by one instance in which a private bank sold a mortgage insurance to a Telangana farmer who was made to believe it was crop insurance. This year, like many other farmers in India’s hinterland, he will get no relief.

(The writer is Sayantan Bera.)

Source

TOP

Insurance sector beset with its own problems - The Hindu Business Line – 19th November 2019

Undoubtedly 2019 will be a testing year for Pradhan Mantri Fasal Bima Yojana (PMFBY), the flagship crop insurance scheme launched by Narendra Modi-led NDA government in 2016. After a run of three relatively good years, insurance firms are staring at a bad year — in fact, a situation where claims can far exceed premiums collected.

The heavy rains in the last leg of the monsoon season were extremely unkind, leading to floods, particularly in the central and western parts of the country, resulting in huge crop losses. Many kharif crops in Gujarat, Maharashtra and Madhya Pradesh suffered massive losses. “A month back we had been expecting a profitable situation, but it has all gone now,” says Rajeshwari Singh, GM, State-owned Agricultural Insurance Corporation of India, which accounts for nearly half of the PMFBY pie.

Insurance firms that operate clusters in these States are particularly hit hard. With the increasing frequency of weather events such as droughts, floods and hailstorms, crop insurance is no longer a profitable venture, says an industry insider.

A public-private partnership scheme, PMFBY was rather different from the crop insurance schemes that India had gone for in the past. Under the scheme, a farmer has to pay only 1.5 to 5 per cent of policy amount as premium, with the State and Central governments equally sharing the rest. As per cent provisional figures released by the government, in 2018-19, the total premium collected was Rs. 29,035 crore, with farmers contributing Rs. 4,889 crore. As many as 5.64 crore enrolled for the scheme, covering the gross cropped area of 30 per cent. According to a senior government official, in the 2019 kharif season, the number of farmers enrolling for PMFBY is expected to be 3.7 crore, a sizeable number of them non-loanee farmers.

Since its inception, the scheme has had its share of controversies. While a number of farmer organisations argued that it has been designed to benefit private insurance companies, the insurance firms have had their own set of grouses. The farmers have been suspicious of intentions of the private companies and arguing that they have been making a windfall at the behest of farmers. They point out that while gross premium collected in 2016-17 was Rs. 22,008 crore, the claims payout was Rs. 16,617 crore and in 2017-18 as against premium collection of Rs. 25,481 crore, the insurance firms paid out Rs. 21,705 crore. In 2018-19, they collected Rs. 29,035 crore and Rs. 14,246 crore has been paid in claims so far. But these numbers are not final as there are a large number of outstanding claims, whose payouts are pending mostly because a number of State governments have to pay their share of premium subsidy.

Singh of AIC says the non-receipt of premium subsidy from the State government was a double whammy for the firms. “Only if the State government did, the Centre would release the matching subsidy. We were supposed to get 50 per cent subsidy upfront, but hardly receive the funds in time,” she says, adding that this often delays the claim settlements. In October 2018, the Centre decided to revise PMFBY operational guidelines, bringing in, among other things, a provision to impose penalties on delayed financial translations by any of the stakeholders.

According to Ashish Bhutani, CEO of PMFBY, and Joint Secretary at the Ministry of Agriculture and Farmers’ Welfare, the percentage of farmers enrolled for PMFBY through non-loanee route has gone up from 5 per cent at the inception to a good 42 per cent now.

The compulsory enrolment of all farmers availing crop loans for PMFBY, as is the practice currently in most States barring a few like Maharashtra which has made it voluntary for farmers to decide, has been a

sore point among farmers. The Central government has been holding consultations with the State governments to make the scheme voluntary. "Maharashtra is a classic case. The maximum number of non-loanee farmers enrolled for PMFBY was from Maharashtra, where the scheme is voluntary. The farmers still enrolled because of their risk perception," says an industry insider.

The major pain point of the PMFBY scheme is crop cutting experiments (CCEs). As many as 70 lakh CCEs need to be carried out in a short span of 2 to 3 weeks across the country to assess the crop yield, which is then used to calculate insurance claims. "It is a logistical nightmare," said Bhutani, while addressing a seminar at FICCI about two months ago. Disputes relating to not conducting CCEs in a proper manner has been one of the major reasons for inordinate delays in claim settlements.

Charge of data fudging

Bhutani maintains that local officials often collude with farmers to inform them about the plots chosen for CCEs 50-60 days in advance. The farmers then deliberately avoid taking care of the field, leading to a poor crop. "It is commonly seen that while the plot where CCE is conducted has a poor crop, all surrounding fields are lush green," he says.

But such fudging of data is not helping anybody. "With the increase in claim payouts, premium rates are going up," says an agriculture ministry official. There are a number of districts where several crops have a premium rate of around 50 per cent and above. Cotton crop in Porbandar and groundnut in Rajkot in Gujarat and bajra in Barmer district of Rajasthan are examples.

Says Vijoo Krishnan, a farmer leader affiliated to the All India Kisan Sabha: "Farmers in most States are unhappy with the fact that the governments have made PMFBY compulsory for availing crop loans. As a result, they have been forced to take an insurance policy even when they do not want it."

Farmers' activist Devinder Sharma argues: "The process of awarding a cluster to an insurance company on the basis of bids does not lead to competition driving down the premium. On the contrary, cartelisation across clusters leads to high premiums even as threshold yields are manipulated."

The Centre has identified around 40 districts around the country that account for nearly 50 per cent of the total claims in the country. The Centre is exploring the possibility of taking the high premium crops out of PMFBY and putting them under other crop insurance schemes. However, Singh of AIC feels that the high claim rates in these districts are quite explainable as most of these districts fall in arid zones.

(The writer is TV Jayan.)

Source

TOP

MOTOR INSURANCE

Three tips for choosing the right motor insurance - Financial Express – 22nd November 2019

The excitement around buying a new vehicle—be it a two-wheeler or a four-wheeler—for the first time in your life remains etched in your memory.

You check out various models, compare features and prices, and then choose the one which is best for you. However, most people forget to follow the same process while buying motor insurance for the vehicle.

As per the Motor Vehicles Bill 2019 in place, driving a vehicle without valid motor insurance draws a penalty of Rs 2,000 and/or imprisonment up to three months for the

first offence and a subsequent penalty of Rs 4,000 on the second offence.

When buying a new vehicle, it is good to do a detailed research and compare various motor insurance policies available online. Dealers usually sell bundled motor insurance policies that mostly provide vanilla coverage and lack the features that may be required to cover the risk for your vehicle in a comprehensive manner. For the overall protection of your vehicle, it is important that you buy a comprehensive policy that gives adequate cover to your vehicle at all times. Here are few tips to consider while buying a motor insurance policy for your brand new vehicle.

See what the dealer has to offer

While buying a new vehicle, people are tempted to buy insurance from the dealer itself as they do not want to spend time researching the various options available. Moreover, dealers give heavy discounts on the premium to a few customers only. However, there are far more disadvantages of buying insurance from the dealer as they only sell policies of those insurers who have a commission-based tie-up with the dealer. Also, the extent of coverage offered in the bundled insurance products is very limited and while taking a claim, the consumers may have to face many a challenge.

Understand types of policies

A motor insurance policy has two-basic components—third-party liability (TP) that covers damage done to others and Own Damage (OD) that covers damage to the owner's vehicle. While TP cover is mandatory, the OD cover is optional. After the implementation of the new guidelines issued by the Supreme Court, it is mandatory to buy a long-term insurance cover. The Insurance Regulatory and Development Authority of India has directed all the general insurers to offer a three-year long-term third-party insurance cover for all brand new cars while it is mandatory for new two-wheelers to have a five-year cover.

Choose the right add-ons

A basic comprehensive motor insurance policy provides coverage to your vehicle against accidental damages and damages to the vehicle caused due to natural calamities. However, there are various other elements as well that can cause severe damage to the vehicle. To provide adequate coverage to your vehicle against all such damages, buy add-ons such as zero depreciation, engine protection cover, return to invoice, roadside assistance covers and consumable coveralong with the regular cover to make the policy much more comprehensive. Buying such add-ons may increase the premium by 15-20%, but the coverage is way more useful and cost-saving during an emergency situation. Also, consider the inclusions and exclusions when buying add-ons.

(The writer is Sajja Praveen Chowdary.)

TOP

Source

Not insuring your car keys can cost you heavily now - The Economic Times – 19th November 2019

While most people insure their cars, insuring the keys is not a common practice because of the belief that replacing lost car keys is not expensive. However, this is where most people err. While cost of replacing keys of manual locking cars is comparatively reasonable, the cost of a new set of keys for remote or keyless locking cars can cost between Rs 8,000 for high-end cars like Hyundai Verna, Volkswagen Polo and up to Rs 1 lakh for premium cars like Fortuner.

This is why those buying cars with remote locking or feature-laden locking systems should seriously consider insuring their car keys.

Additionally, if you think that you can avoid replacing a lost car key be aware that incase of your car is stolen you insurance claim for the same is can be rejected by the insurer if you don't posses all the keys to the car.

You should be aware that most car policies do not cover loss of keys. In order to insure the keys, one has to buy an add-on rider wherever offered. Generally, the cost of this rider varies between Rs 100 and Rs 300 depending on the car model/variant.

Why has car key insurance become important?
With advancements in technology, several high-end cars are coming up with remote key lock system or a keyless Frequency Operated Button (FOB).

FOB is a keyless remote system based on a new technology which completely controls the car's lock and unlock functionality through a keyless remote. You do not require a key to start the car, the vehicle starts with a push-button instead. Such advanced technology is the reason why high-end car keys are expensive.

So, if your high-end car's remote key/keyless FOB gets damaged/misplaced and you want to get it replaced from the authorised Original Equipment Manufacturer (OEM) service center, it can be a costly affair as not only is the product is expensive, it also requires a more skilled mechanic to replace your car key lockset.

Why replacement of remote key/keyless FOB is expensive?
For safety concerns, if your remote-key/keyless FOB gets stolen, damaged or lost then you should completely replace the remote-lock system of your car as it is an integral part of the remote-lock system.

Amit Bhasin, Co-founder, GoMechanic, an automobile repair and service solution firm, said, "The remote-key/keyless FOB and remote-lock system work on the principle of radio transmitter because of which you can easily lock and unlock, operate other functions like the closing of windows and roof when remotely locking the car, from a distance." He said, "The radio transmitter of the car works within a general range of 10-20 meters."

Every remote-key/keyless FOB has a unique computer-code which is matched with the code present in the remote-lock system of the car. Thus, your car cannot be unlocked by another remote-key/keyless FOB. If you try to open the car manually with a different key, the remote-lock system will detect the code error and your car alarm will be set off.

Some remote-keys/keyless FOBs also have separate buttons to set off the car alarm, unlock the boot of the car, help your car to move back and forth when parked in a congested area. Bhasin said, "Many safety and convenience features incorporated in the car can be controlled via remote-key when you are away from your car at a certain distance. However, these features vary across brands and models of cars hence. Due to this the cost of keys vary accordingly."

So, the more features are enabled in your remote-lock system and remote-key/keyless FOB, the more will be its cost of replacement.

What car-owners should do
If you have a car with remote-key/keyless FOB, taking insurance cover for your car keys becomes important. A car key insurance or a key and lock replacement insurance add-on in your motor policy covers the cost of replacing your complete key lockset in a situation where you have lost your car keys or the same has been stolen or where the lock has been damaged due to accident/theft.

Cost of key insurance
What you must know is that the 'key and lock replacement insurance add-on' premium cost in a motor insurance policy is relatively much lower than the cost of replacing of the damaged car lockset.

Sajja Praveen Chowdary, Head- Motor Insurance, Policybazaar.com, said that in case of theft or loss of computer-coded or encrypted keys, one needs to get the replacement done by an authorised OEM service

center which may cost you Rs 4,000-10,000 or even more depending on the car, make, brand and model of the car. "But, the 'key and lock replacement insurance cover' will only cost you around an additional premium of Rs 100-300 in your motor insurance policy. The cost of add-on premium varies depending on the car make variant," he said.

So, paying a small amount of add-on premium cost in your motor insurance policy can cover the huge replacement cost of your car keys. However, reimbursement of the replacement cost is subject to the maximum sum insured you have purchased under the car key protection add-on cover.

If only car locking system is damaged

What happens if the key is not lost but only the car's lockset gets damaged, will it be covered under insurance?

Rakesh Goyal, Director, Probus Insurance, a Mumbai-based insurtech, said, "The comprehensive insurance policy doesn't cover the repair cost of the car lockset if the car's lockset gets damaged due to an unfortunate accident. Most insurers neither cover the repair nor the replacement cost for the lockset damages even if it is caused due to the accidental damages under the motor insurance policy."

Hence, you must understand that not insuring your car keys can cost you heavily, that is, without a key replacement add on cover.

What if you don't replace the lost key and run the car using the spare

What if you lose one of your high-end car keys and because of high replacement cost do not get the lockset replaced from the authorised OEM service center or general car repair workshop to get back two new car keys? In such a scenario if your car gets stolen, you can be in big trouble as the insurer may ask you to show the two car keys before processing the claim. If you do not do so, your claim can get rejected.

Cost of replacing keys from authorised dealer or local garage

When your high-end car key gets damaged or stolen, due to security concerns, you generally need to replace the complete remote-lock system of your car along with the new set of keys, because the keys are actually a part of the remote-lock system.

The cost of the new remote-lock system along with the new set of remote-keys vary if you get it replaced from the authorised OEM's service center or general car repair workshop. However, if your high-end car's keys are covered under a motor insurance policy, then it will not be a problem. You can get it replaced from any workshop and claim a reimbursement from the insurer.

Animesh Das, Head of Product Strategy, Acko General Insurance said that claim settlement process will not be different whether you get your lock set replaced from authorised OEM service center or a general car repair workshop. "Once your lockset is replaced, you need to submit the bill of the replaced remote-lock system to the insurer for reimbursement claim." He said, "The settlement will, however, depend on the cost of replacement subject to the maximum sum insured purchased by you under the car key protection cover," he explained.

He further said, "There are few companies who may offer you cashless settlement but, in that case, you need to visit the nearest network garage to get your car key lockset replaced.

The following tables (1,2 and 3) show the cost of replacing keys and lockset by authorised OEM cost and at local garage for keyless FOB lockset, remote-key lockset, manual key lockset of five different brands.

1. Keyless FOB lockset* replacement

S.No.	Brand	Make- (Top variant model)	Authorised OEM service center (Keyless Fob) (Rs)	Car repair workshop (Keyless Fob) (Rs)
1	Maruti	DZire	3,500-4,000	N.A.
2	Volkswagen	Polo	12,000-14,000	8,000
3	Hyundai	Verna	16,000	8,000
4	Toyota	Fortuner	80,000 – 1 lakh (including immobilizer)	8,000
5	Mahindra	XUV 500	12,000	8,000

2. Remote-key lockset* replacement

S.No.	Brand	Make- (Mid variant model)	Authorised OEM service center (Remote-key) (Rs)	Car repair workshop (Remote-key) (Rs)
1	Maruti	DZire	7000-8000	5500-6000
2	Volkswagen	Polo	18,000 - 20,000	8000-8500
3	Hyundai	Verna	25,000	8500-9000
4	Toyota	Fortuner	80,000 – 1 Lakh (including immobilizer)	22,500 - 23,000
5	Mahindra	XUV 500	14,000 - 15,000	11,000 - 11,500

3. Manual key lockset* replacement

S.No.	Brand	Make- (Base variant model)	Authorised OEM service center (Manual-key) (Rs)	Car repair workshop (Manual-key) (Rs)
1	Maruti	DZire	2,500-3,000	2,500-3,000
2	VW	Polo	3,000-3,500	3,000-3,500
3	Hyundai	Verna	3,000-3,500	3,000-3,500
4	Toyota	Fortuner	4,000-4,500	4,000-4,500
5	Mahindra	XUV 500	4,000-4,500	4,000-4,500

*Note: You need to submit a copy of your RC, Vehicle Booklet, FIR documents at authorised OEM service center in the case of a keyless FOB lockset replacement. Also, these prices are indicative only, they may vary from model to model. The cost of replacement of keys is taken from authorised OEM service and a workshop located in Delhi. *The lockset includes two new keys. Data as on 31-October-2019| Source: Carpathy.com*

Broadly, these lock systems differ according to the three types of car variants. The top variant of cars come with a keyless FOB remote-lock system. The mid-variant of cars come up with the remote-key lock system and the base variant of cars come up with a manual-key lock system.

Bhasin said, "You must keep your remote-keys/FOB safe when buying a high-end car - especially top variant car. It poses an additional risk of the car being stolen as the lost keyless FOB would still work unless it is deactivated by especially reaching out to the manufacturer." He said, "For luxury cars like BMW, Audi, Mercedes, etc., the replacement cost of keyless FOB lock set at authorised OEM generally cost around Rs 40,000 to Rs 50,000, and at the general car repair workshop (located in Delhi) it will cost you around Rs 20,000 to 25,000, depending on the car variant."

Are duplicate car keys an option?

What if you do not want to replace the complete manual-lock/remote-lock system of your car instead you only want a duplicate manual key/remote-key/keyless FOB to be made from car repair workshop?

Akshat Lavania, Co-founder, Carpathy, an automobile repair and service solution firm, said, "You must know that authorised OEM service centers generally do not provide you with a duplicate key. However, if you want duplicate car keys made, you can get it made from a general car workshop. These car keys are not secure as code of your remote-lock system is known by the car repair workshop who is not an authorised person." He said, "A car key, however, can only be made if you have another original car key present with you."

You can get duplicate car keys made from a general car repair shop which will cost much less than replacing the complete lock set, except in case of keyless FOB, but you run several risks when you go for this option.

Firstly, the local garage would know the secret code of your new key. Further, your lost keys may also fall into wrong hands and be used to steal your car. Therefore, the safer option is to get the entire lockset replaced at the authorised OEM dealer or standardised multi-brand workshop. As this option is normally expensive, car key insurance for high end cars can be of help.

"For security purposes, we would always recommend you change/replace the complete remote-lock system of your car with a new lockset when your car keys are stolen or damaged," Lavania said.

Point to note
If you are getting a duplicate key made, you need to report it to the police and get the copy of FIR (First Information Report). Also, inform the insurer about the loss of key(s).

(The writer is Navneet Dubey.)

Source

TOP

REINSURANCE

Reinsurance terms, a challenge for the industry - The Hindu Business Line – 19th November 2019

When Pradhan Mantri Fasal Bima Yojana was rolled out three years ago, insurers were excited and made a beeline to offer it.

But now, most private insurers are going back to the drawing board as stress under the portfolio has been mounting.

According to industry sources, at least two players have lined up their exit from the segment while more are in wait and watch mode for any intervention from the Government or Insurance Regulatory and Development Authority of India (IRDAI).

Basic concerns
Many fundamental issues have not been addressed since the beginning. Even in the pre-PMFBY era, delay in providing data of Crop Cutting Experiments (CCE) by States to insurance companies was a serious problem which delayed claim settlements. This has not been addressed adequately after the launch of PMFBY, say insurers.

Pricing
Increasing issues with monsoon and steadily expanding reach of the scheme where distress is more is making pricing untenable. “If the scheme is not expanding in areas where there is less distress and fast spreading in those districts where distress is regular, then offering crop insurance is not viable because it it bound to result in losses,” says the Chief of Underwriting and claim settlement of a private insurer.

Bhargav Dasgupta, MD and CEO of ICICI Lombard, recently ascribed the trouble to pricing of reinsurance. “Reinsurance terms have turned adverse for insurance companies, so it doesn’t make sense. Rates on the ground are more aggressive,” he pointed out. “With foreign players taking a big pie of reinsurance of crop cover, we have no control on pricing of re-insurance which is calculated on changing data and perceptions of risk,” he said.

In a way, the situation is similar to heavy losses incurred by the insurers on motor pool which became a major concern during 2011-13. IRDAI chipped in by ending the commercial third party motor pool and brought in a declined pool in 2013.

“While one cannot straightaway compare declined pool with crop insurance modalities today, various options are being examined to come out with a viable solution,” said a senior official. PMFBY is market-led when it comes to discovery of premium rates.

While the insurance companies charge the Actuarial Priced Premium Rate (APR), a farmer has to pay a maximum of 2 per cent for Kharif, 1.5 per cent for Rabi and 5 per cent for commercial and horticultural crops. The difference between APR and what is being paid by the farmers is treated as Rate of Normal

Premium Subsidy, which shall be equally borne by the Centre and States. The problem here is delay in payments as well as 'aggressive' pricing by insurers initially.

(The writer is G Naga Sridhar.)

Source

TOP

SURVEY & REPORT

More women now buying health insurance, shows Policybazaar study – CNBC – 21st November 2019

The number of women in India buying health insurance policies for themselves has risen significantly over the last two years. In FY2017 only 9 percent women bought health security for themselves but it rose to nearly 19 percent in FY19, a study by insurance marketplace Policybazaar has revealed.

Of the women buying policies, nearly six out of ten are opting for a sum upwards of Rs 5 lakh.

The survey saw 10,000 participants and was conducted in 15 Indian states.

The study further showed that the share of bookings made with women as the proposers for health insurance policies has grown by 57 percent in FY19, as compared to FY18.

"The findings indicate most women are purchasing health plans with a bigger cover, aware of the need to protect against the rising medical costs. Health plans with sum insured of Rs 5 to 10 lakhs witnessed a growth of almost 80 percent in FY19, compared to last fiscal year. On the other hand, the bookings for policies with sum insured of Rs 10 lacs and above saw a jump of 61 percent for the same period," said Policybazaar in a release.

"This upward trend of women policyholders becoming proactive financial decision-makers establishes changing social dynamics wherein insurance has now become an integral part of their financial planning process," it added.

Of the policy buyers, nearly 75 percent fall in the 25 to 45 years age category, indicating the tendency for the women to insure health early in their careers.

Commenting on the findings of the study, Amit Chhabra, head of health insurance, Policybazaar.com said: "The average lifespan for women in India is 69 years, which clearly tells us why it's crucial for women to be adequately covered by an apt health insurance plan early in their lives. A health plan is important to women across all age groups, young girls can opt for health insurance with their parents while working or married women must opt for an individual policy."

"Cases of cardiovascular diseases, diabetes, thyroid, infertility and breast cancer among women are increasing each year. The data mentioned above is indicative of the changing trend of women investing in health plans that benefit them in more ways than one and provides financial protection against such emergencies in life," he added.

TOP

Source

Focus on risk pooling to provide healthcare: NITI Aayog to govt - Financial Express – 19th November 2019

Drawing from global findings on healthcare financing, a NITI Aayog report has proposed that the government should focus on risk pooling, strategic purchasing, health-service provisioning and digital health to make services affordable and reduce out-of-pocket (OOP) spending by vulnerable sections of society.

"A transition for integrating fragmented risk pools, and benefits packages, is essential at the state-level, building basic support systems, reducing transaction costs and dispersion of scarce state talent and capabilities," the think-tank said in the report titled 'Health Systems for a New India: Building Blocks—Potential Pathways to Reforms'.

The report recommended that all healthcare schemes should be brought initially under a common co-ordination arrangement managed by the government, including PM-JAY and NHM. "Transition to establish single strategic purchasing rules for all of them, eventually having a single strategic purchaser even if pools continue to be separated financially," it noted.

Finally, the government could merge functionally and financially all similar risk pools previously organisationally aggregated. Incrementally homogenise and equalise contributions (from beneficiaries, state and Union, if available) across all merged schemes so that household contributions in contributory schemes are the same for the same package and the subsidised per capita fiscal contributions are also the same for the standard (basic) benefits package.

In collaboration with states, the Centre launched the Pradhan Mantri Jan Arogya Yojana (PMJAY) last year, which offers Rs 5-lakh-a-year free health cover to 10.7 crore households or bottom 40% of the pyramid. Fragmentation and lack of risk pooling explain India's very high and slow-to-decrease levels of OOP financing from households which accounts for more than 64% of total health expenses in the country, the report said.

In most emerging markets, health shocks account for between 1-10% of new poor households annually. In India it is 9% (2010).

TOP

Source

For millennial parents, concern for kids' financial future key trigger to buying term insurance: Survey - The Economic Times – 18th November 2019

India is an under-insured country, however, more and more young people are becoming aware of the importance of insurance. A recent survey conducted by Max Life Insurance in association with Kantar IMRB found that that while getting lump sum at a future date for their child's education was a term insurance buying trigger for about 44 percent urban Indians, at 48 percent it was the biggest trigger for millennials with kids.

It also found that as compared to the national average of 47 percent, awareness of term products is a comparatively higher at 50 percent among millennials parents, a press release by Max Life Insurance stated.

The survey
The survey had a sample size of 4,566 respondents and was administered to respondents of different demographics and age groups across 15 metropolitan and tier 1 cities in India. The survey primarily measured their level of knowledge and ownership of various life insurance products, degree of term insurance preference and penetration, primary fears and triggers to life insurance purchase, preferred channel of policy purchase, and roadblocks to owning life insurance.

Here are more findings from the survey.

Awareness of term insurance products
"There are several key milestones in parents' life that they go through which children's are growing, right from nurturing values, to a good quality education in the early days and then to supporting their higher education and matrimonial plans. To achieve such milestones without any hassles, it is important to undertake financial planning judiciously. It is reassuring to see that young India understands the need for owning term insurance to secure their family's future. Birth of child is the biggest trigger for millennials to buy term insurance, which confirms that children continues to be the fulcrum of financial planning for Indian households," Aalok Bhan, Director and Chief Marketing Officer, Max Life.

Families with children consider term insurance their first preference
About 36 percent families with children consider term insurance as their first choice when it comes to buying life insurance. "This indicates that millennial parents understand the risks of life and the need to protect against those risks by buying term plan," the release stated.

At 52 percent, term insurance awareness among families with children is almost twice as compared to the awareness levels of 29 percent, among families without children. Understandably then families with children have a higher term insurance ownership of 24 percent, while only 12 percent families without children own term insurance.

Millennial parents' priorities
The survey found that while nearly half of urban Indian millennials in the age group of 25 - 35 years believe in spending more on travel/ luxury and are not even thinking about financially protecting their families, millennials with kids are far more conscious of creating corpus to support life stage goals related to their children. It found that 79 percent millennial parents save for their kid's education while 55 percent save for their kids' marriage.

With regards to their own retirement planning, almost 54 percent India saves for old age security and retirement, millennials with kids prioritise savings for goals related to their children over their own selves with 50 percent of them saving for old age security.

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Source

INSURANCE CASES

Kochi: Consumer forum hits out at 'unholy alliance' between hospital and insurance firms - The Economic Times – 22nd November 2019

The Consumer Disputes Redressal Forum, Ernakulam, came down heavily on the “unholy alliance” between hospital establishments and medical insurance companies to deny legitimate and genuine claims of consumers for reimbursement of hospital bills covered by valid insurance policy.

Pointing out that instances of unjustified repudiation of insurance claim by insurance companies is on an increase, going by the statistics of the cases of such nature, being filed before it, the Forum headed by Cherian K Kuriakose noted, “…from proved evidence, a doctor who belongs to the noble profession has become a prey at the hands of dishonest employees of corporate, by stage-managing a per se forged

document, presumably with dishonest intention to gain undeserved enrichment at the cost of denying a merited and genuine claim of the complainant".

The Forum was hearing the case of a 11-year-old boy, who underwent treatment at a private hospital in Kochi from October 22 to 29, 2014 for acute bronchial asthma. The total cost of the treatment was Rs 41,414.39 and the same was covered by a medical insurance policy. The boy's father paid the said amount and then submitted documents to the insurance company for settlement.

But after keeping the claim on hold for long, the insurance company informed that they were ineligible for settlement stating that the treating doctor had certified that the patient was wheezing since five months of age. It was also alleged in the repudiation letter that the existence of asthma ailment was known to the child's father and he did not declare it at the time of entering into the insurance contract.

After going into the details of the case and hearing both parties, the Forum in its order said that private hospital doctor had issued the medical certificate detrimental to the patient without referring to the patient's previous history or medical record available at the hospital, purely on the basis of hearsay information and without supporting documents. "The opposite parties have committed unfair trade practice and deficiency in service against the complainant," the forum in its order observed.

To keep a check on such professional misconduct and unethical medical practices, the Forum has referred the matter to TCMC for taking appropriate necessary action against the erring doctor. A copy of the order shall be sent to the state principal secretary and IMA, Ethics Committee, for appropriate action after due enquiry. The private hospital has been directed to pay Rs 10,000 towards the unfair trade practice committed against the complainant.

Meanwhile, the insurance company has been directed to reconsider the claim application within a month. The forum added that the complainant is entitled to get Rs 1 lakh towards the mental agony and uncertainty in a genuine claim.

(The writer is Preetu Nair.)

TOP

Source

Vehicle Fire Insurance Claim: How this man won Rs 13.5 lakh with interest, 10 years after incident – Financial Express – 22nd November 2019

Vehicle Fire Insurance Claim: It took 10 years to Kamlesh to finally win against an insurance company, which had denied him insurance claim after his truck was damaged in fire in June 2009. The incident took place in the intervening night of 1st and 2nd June 2009 in which his truck was damaged.

His insurance claim of Rs 13.5 lakh was, however, denied by the insurer on the basis of a report of a surveyor, which claimed the "fire was not natural." Kamlesh appealed against the insurer's decision in State Consumer Disputes Redressal Commission, Lucknow. The insurance company – namely Shriram General Insurance Company Ltd – told the State Commission that its investigator had

reported the incident of accident and fire to be "doubtful". The State Commission, however, rejected the insurer's claim and concluded in its order dated 11.8.2015:

"It is established from the evidence produced by the opponent insurance company that the truck of the complainant was found in burnt condition at the place of accident on the next day of alleged incident. In these circumstances, we are of the view that the opponent insurance company is deficient in services by repudiating the insurance claim of the complainant. The insured value of the Truck in question is admittedly Rs.13 Lakh 50 Thousand. Therefore, we are of the view that the complainant is entitled to this amount with interest from the opponent insurance company."

The State Commission directed the insurance company to pay Rs 13,50,000 with 9% interest from the date of institution of the complaint till its payment within one month. It also told the insurer pay Rs 10,000 to Kamlesh as litigation expenses. The State Commission further said that if the amount was not paid within the time fixed then the insurer will be liable to pay interest at the rate of 12% on the entire amount to the complainant.

Appeal in NCDRC

The insurance company appealed against the State Commission in National Consumer Disputes Redressal Commission (NCDRC), which observed that the intimation to the respondent was given late (on 3.6.2009). It rejected the claim of the insurer that the truck was deliberately put on fire. However, it reduced the claim amount to 69 per cent on grounds of delay in intimation to the insurer and failure to inform the police in time. The National Commission said to have relied upon the SC decision in Amalendu Sahu vs. Oriental Insurance Co. Ltd. [(2010) 4 SCC 536].

SC Order on 19-11-2019

The matter finally reached the Supreme Court, where Kamlesh's counsel submitted that there was no delay in intimating the insurance company about the fire incident. The insurer's advocate, however, opposed the claim, saying there was a delay in intimating the insurance company and the National Commission was justified in reducing the amount.

The apex court went through "Conditions" of the Policy, which had two important points:
– *"Notice shall be given in writing to the Company immediately upon the occurrence of any accidental loss or damage; and*
– *"In case of theft or criminal act which may be the subject of a claim under this Policy, the Insured shall give immediate notice to the police."*

The top court observed that as per conditions of the policy, the appellant (Kamlesh) had not violated any rule by not immediately informing the police. Secondly, the incident happened during the night of 1st and 2nd June, 2009 and the intimation was given to the insurance company on 3rd of June, 2009. Hence, "the notice was not delayed on any count and did satisfy the requirements contemplated by the conditions in the policy."

The top court also held that NCDRC was wrong in relying on Amalendu Sahu judgement. In this case, the apex court had "dealt with fact situation where, in violation of the terms of the policy, the vehicle in question was being used for hire." Hence, the top court said, "the principle on the basis of which the admissible claim could be reduced, does not apply."

SC finally set aside the view taken by the National Commission and restored the order of the State Commission. "In our view, there was thus no reason for the National Commission to hold that there was any violation of the requisite conditions on part of the appellant and there was no justification to reduce the claim to the extent of 60% of the IDV of the vehicle. The conclusions drawn and the directions issued by the State Commission, in our view, were quite correct and did not call for any interference," Supreme Court concluded.

(The writer is Rajeev Kumar.)

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Source

Divide insurance money equally among wife, son, mother: Consumer forum to firm - Hindustan Times – 22nd November 2019

Observing that amount assured in policies should be distributed equally among the mother, wife and child of the deceased, the district consumer disputes redressal forum-I directed an insurance company to refund ₹10 lakhs, the amount insured towards their deceased client to a Panchkula resident and her son.

Deepika Dahiya from Sector 19, Panchkula and her two-year-old son Navdeep Singh (through his mother Deepika) filed a complaint against Life Insurance Corporation of India, Sector 17-B, Chandigarh and her mother-in-law Kamla Devi resident of Jind (Haryana).

In her complaint, Deepika mentioned that her husband Amardeep Singh died on January 4, 2018. Before the wedding, he had bought three life insurance policies from the firm. In these policies, he had nominated his mother, Kamla Devi as his nominee to receive the amount in the event of his death.

After her husband's death, Deepika asked the firm to not disburse the sum assured in favour of Devi as she being the widow and her minor son are the legal heirs of the deceased man. However, the insurance firm disbursed the total amount of the policies amounting to ₹15,09,180 to her mother-in-law.

Describing it as deficiency in service and unfair trade practice, Deepika filed a complaint in the consumer court , asking it to direct the opposition party to refund the amount along with compensation and costs of litigation.

The insurance firm mentioned that since Kamla Devi was the nominee of the deceased, therefore as per provision of the relevant Act, the amount was disbursed to his nominee.Kamla Devi also claimed that since she was the nominee, so she was entitled to the sum assured.

The forum observed: "Keeping in view the factual and legal position, the sum assured in the three policies was to be apportioned amongst complainants No1 & 2 and OP-2 proportionately in equal shares. As such, OP-1 has also committed a deficiency in service and the liability of OPs would be joint as well as several as it tantamounts to deficiency in service and unfair trade practice."

The consumer forum directed the insurance firm to refund ₹5,03,060 each to Deepika and her minor son (i.e. 1/3 share of the total disbursed amount of ₹15,09,180) along with interest @ 9% per annum from the date of disbursal.

It also directed the firm to pay ₹20,000 in compensation for causing mental agony and harassment to them, and also to pay ₹10,000 as costs of litigation.

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Source

Doctor makes insurance company pay more than his cover of Rs 6 lakh - Ahmedabad Mirror – 19th November 2019

Denied full settlement of their medical bills despite having adequate mediclam cover, most people let it go and don't pursue the matter with insurance companies. But not a city-based doctor who fought a two-year legal battle and made the medical insurance company settle his dues. In the end, the insurance company ended up paying more than the Rs 6 lakh cover the doctor had taken.

After fighting a lone battle for two years, 58-year-old Dr Prayag Shah (name changed), who had a medical cover of 6 lakh, made his insurance company pay Rs 6.3 lakh for not settling his full claim for a treatment he underwent in 2017.

A resident of Navrangpura, Shah was diagnosed with carcinoma of prostrate and was admitted to a Mumbai hospital for treatment in May 2017. After the discharge, Shah put forth a total claim of Rs 6.34 lakh with United India Insurance Company, which had him insured since 1996 on an annual renewal basis.

The insurance company, however, passed only 1.28 lakh in August 2017 and repudiated the remaining amount of Rs 4.72 lakh, stating that the settled amount was arrived at by the third-party aggregator (TPA) for cashless treatment. The company further stated that the insured is entitled to receive only Rs 2.92 lakh against claim of 4.72 lakh.

Mohit Patel, Shah's lawyer, claimed than an amount of Rs 4.35 lakh had been wrongly rejected by the insurance company, depriving Shah of the treatment expenses.

Following a long hearing, the court ordered the insurance company to pay the remaining claim amount of Rs 4.35 lakh at an interest rate of 8 per cent per annum from the date of the complaint, which was filed in January this year.

The court also observed that Shah was made to wait in distraught condition for more than two years despite his busy schedule. It ordered the insurance company to pay Rs 25,000 as compensation for the trouble Shah was put in to fight for his right, and an additional Rs 10,000 as the cost of complaint, taking the total amount payable by the insurance company to Rs 6.3 lakh.

Talking to Mirror, Shah said, "I had faith in the judiciary, and my lawyer Mohit Patel played a key role in getting the verdict in my favour. The past two years have been painful; first, to be diagnosed with such a critical disease and then fighting it out with the insurance company even as the illness always kept bothering.

Shah's lawyer Mohit Patel said, "Many insurance companies repudiate the mediclaim amount by resorting to PPN (preferred private network) packages, which was the case with Dr Shah. Aggrieved customers must approach the consumer forum in such cases as the court not only clears the claim but also allows compensation in favour of the insured."

(The writer is Mihir Ved.)

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Source

IRDAI CIRCULARS

Brokers updated list as on 21st November, 2019 is available on IRDAI website.

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Exemption of classes of claims under sub-section (10) of Section 64UM of the Insurance Act, 1938.

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Withdrawal of Indian owned and controlled condition for insurance intermediaries

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Source

Bangladesh: Regulator lays down investment rules for non-life insurers – Asia Insurance Review

Non-life insurance companies must invest 7.5% of their assets in government securities, according to new regulations of the Bangladesh Insurance Development and Regulatory Authority (IDRA). Government securities include short-term and long-term securities such as treasury bills and treasury bonds.

The aim of the new regulations, titled "Insurance (Non-Life Insurers Asset Investment and Preservation) Regulations - 2019" is to strengthen the security of insurers' investments and protect the interests of policyholders, reported New Age.

Overall, general insurers are required to invest at least 10% of their premium income or a sum equivalent to their liabilities plus BDT10m ($118,000), whichever is higher, in Bangladesh, the regulations stipulate.

After making the required 7.5% investment in government securities, the insurers will be able to invest their remaining funds in certain specified sectors, including deposits with 'A' rated scheduled banks; infrastructure bonds; debentures and securities issued by city corporations; debentures, mutual funds and unit funds approved by Bangladesh Securities and Exchange Commission; shares listed on stock exchanges, and immovable assets located in city corporations and municipalities and in subsidiary companies.

Limits are also set for different investment categories. For example, the insurers will be able to keep deposits up to 80% of their assets with scheduled banks. The amount of deposits with a particular scheduled bank should not exceed 15% of assets. The amount of investments in infrastructure bonds, that are guaranteed by the government, is capped at 15% of assets. Insurers are also allowed to invest excess funds abroad, subject to IDRA approval. Currently, there are 48 non-life insurance companies operating in Bangladesh. The insurers maintain most of their funds as deposits with banks.

TOP

Source

Australia: Proportion of specialist life insurance advisers falls – Asia Insurance Review

The proportion of risk specialist advisers in Australia has shrunk by half, according to a study released by the research firm Investment Trends. Risk specialists are those who derive more than 50% of their total practice revenue from providing risk advice.

In its 2019 Planner Risk Report, Investment Trends notes that only 15% of planners derive over half of their total practice revenue from providing risk advice in life insurance, down from 34% five years ago.

Investment Trends senior analyst, Mr King Loong Choi, says that financial planners continue to regard life insurance advice as a key component of their proposition but many are diversifying their advice services.

He also noted that the top two challenges that prevent financial planners from growing their insurance advice services are:
The administrative burden of compliance and paperwork
An uncertain regulatory landscape

Mr Choi said more advisers are facing challenges posed by "inefficient processes" relating to underwriting, the application process and limited integration between systems.

Another key finding shown in the 2019 Planner Risk Report is the strong interest by advisers in new, less established insurers.

In addition, the report shows that overall adviser satisfaction with retail life insurers has improved markedly over the last 12 months, with 57% of financial planners rating their main insurer as 'very good', compared to 48% in 2018.

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Source

China: New health insurance regulations will promote product innovation - Asia Insurance Review

The CBIRC's new health insurance regulations, that will take effect from 1 December, will encourage differentiation and product innovation in the industry's health product offerings, says Moody's Investors Service in an article in the 18 November 2019 edition of "Moody's Credit Outlook".

On 12 November, the CBIRC released new guidelines for health insurance products. The guidelines cover medical reimbursement, critical illness, accident and health and long-term care products.

Moody's says that the guidelines are credit positive for insurers because they encourage the development of new products and other health management services outside current mainstream critical illness products, which are at risk of rising price competition. The new rules will also tighten scrutiny on distribution of health products for better customer protection.

The guidelines aim to encourage development of new product segments such as long-term care products and will allow insurers to include a premium-adjustment mechanism in their insurance contracts for these products, subject to regulatory approval. Such mechanisms will allow insurers to partly share the risks of these products with policyholders and encourage product development.

In addition, the new guidelines also raise the cap of the net premium covering the cost of providing the non-insurance health management services – such as health checks and risk assessments – to 20% from 12%. This will effectively expand the scope of health management services that insurers can provide along with health insurance products.

Products
While health insurance has been a key premium growth driver for the China insurance industry over the past three years, this growth has been concentrated on critical illness products. Critical illness products, like other health insurance products, usually carry a higher savings component than other insurance products and pay out a one-time fixed benefit when the insured is diagnosed with a critical illness.

Moody's notes that the industry has not made meaningful progress in health products that cover medical or rehabilitation expenses after diagnosis of chronic disease, such as long-term care and disability insurance. The underdevelopment of these health insurance segments are largely because of the lack of historical data and higher pricing risks from potential medical expense inflation and uncertainty on longevity trends.

The lack of product diversification has led to unhealthy competition in distribution incentives and premium discounts, which have started eroding product margins for some insurers.

By promoting a better mix in insurers' health product lineups, the guidelines will sustain continued growth in this business. Health insurance premiums grew strongly at 42% a year between 2015-18, compared with 16% for total premium income, and their share of total premiums has significantly expanded to 17.8% as of the end of June 2019 from 9.6% at the end of 2015.

The guidelines also tighten scrutiny on mis-selling practices of health insurance. The new guidelines will prohibit insurers from selling reimbursement products to customers who are already covered by products with similar coverage. It also bans insurers from selling health insurance products that are only sold bundled with other insurance products.

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Source

Australia: Insurers and govt to study cyclone reinsurance pool - Asia Insurance Review

The feasibility of a government-backed cyclone reinsurance pool will be examined as a possible measure to lower premiums in northern Australia, after insurers and Federal Assistant Treasurer Michael Sukkar held discussions in Townsville last week.

Treasury will work now with the industry on the design of a reinsurance pool before any next steps are announced, most likely by early next year, according to a report on the website insuranceNEWS.com.au.

The Insurance Council of Australia (ICA) says the industry agreed to work with the government to consider "a range of options" to reduce premium pressures and increase coverage.

"This includes developing a list of communities where priority physical mitigation projects might be effective, in consultation with local stakeholders," spokesman Campbell Fuller said.

"Insurers also agreed on preliminary work with Government and Treasury to explore the feasibility and potential effectiveness of a government-funded cyclone reinsurance pool."

The announcement came as a surprise because most players in the insurance industry until now have held that reinsurance pools are unviable, expensive, and don't solve underlying issues, except for Allianz which argues that a pool is needed.

A company spokesman said, "Allianz regards a government-backed reinsurance facility as the most efficient and effective mechanism to deal with the problem". But Allianz is no longer alone. IAG told the news website that it "sees merit" in investigating a government-funded pool.

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Source

Taiwan: Life insurance forecast to slow down in 2020 - Asia Insurance Review

Life insurers in Taiwan may see a slowdown in business next year, with total written premiums likely to grow a modest 2.5-3.0% following tightening requirements governing the sales of savings-type insurance policies, Taiwan Ratings Corp has said.

The forecast growth is significantly lower than the 5-10% increases seen between 2015 and 2017, says the credit rating agency which is Standard & Poor's Global Ratings' local unit.

Taiwan Ratings' projection followed the Financial Supervisory Commission's announcement that it would cut discount rates on savings-type insurance policies, making them more expensive to purchase, but less of a burden for insurers.

"The insurance industry has seen business momentum weakening since 2016 following stiffer regulatory controls on commission payouts and sales of savings-type insurance policies," reported TheTaipei Times quoting financial analyst Serene Hsieh.

Despite regulatory tightening, savings-type and unit-linked investment policies remain the mainstream products, underpinning sales, she said. Protection policies would prove a hard sell, as the low interest rate environment would raise their costs, she added.

Profitability at local insurers showed modest improvement in the first half of this year from the same period last year, attributable mainly to a recovery in the capital market and value increases in US dollar-based assets, but chances of investment gains would increasingly fall, as the US Federal Reserve lowered borrowing costs and other central banks adopted similar moves, Ms Hsieh said.

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Source