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QUOTE OF THE WEEK

"The function of education is to teach one to think intensively and to think critically. Intelligence plus character - that is the goal of true education."
– George S. Patton

INSIDE THE ISSUE

INSURANCE INDUSTRY

Insurers looking to pare investments in Tata Sons - The Hindu Business Line – 6th December 2018

Insurance companies are looking at how best to exit from their investments in Tata Sons after it turned into a private limited company. The Insurance Regulatory and Development Authority of India (IRDAI) has sought data on the exposure of each insurance company to Tata Sons, and wants them to sell it off.

"Section 27 of the Insurance Act 1938, bars insurance companies from investing in shares and debentures of private limited companies, as it is essentially public money that they are dealing with," noted an insurer, who did not wish to be named, adding that some insurers have already started to pare down their holdings.

Industry bodies – General Insurance Council and Life Insurance Council – are understood to be collecting the data on behalf of the regulator, but many insurers are also in discussions on a possible roadmap to bring down their investments in Tata Sons.

"Tata Sons is a good and credible company, which is why insurers invested. But most of us were taken unaware by its decision to turn into a private limited company, and it is not advisable – and in many cases – even possible, to exit all investments at once," noted an executive with an insurance company, adding that IRDAI has periodically sought data on their holdings in the company since it turned private.

LIC is already in talks with IRDAI on how to lower its exposure to Tata Sons in a time-bound manner. Another insurer said this is a "passive breach" of investment norms, as the company turned private after the investment was made. "In such cases, there is usually at least a three-day period given to exit the investments, but all companies can't sell at one go," he noted.

Tata Sons declined to comment on the issue. In August this year, Tata Sons received permission from the Registrar of Companies to convert to a private limited company. It had sought approval from shareholders to become a private company from a deemed public company in September last year, in the wake of the legal battle with Cyrus Mistry.

TOP

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Mutual Funds: Your insurance agent may now sell MF, pension products, FDs - Financial Express – 5th December 2018

In order to increase insurance penetration in the country, the regulator has proposed to widened the ambit of insurance marketing firms (IMFs). They can now sell group insurance products for micro small and medium enterprises (MSMEs), crop insurance for non-loanee farmers and combination products. A particular insurance marketing firm can operate in only three districts within a state.

A panel constituted by Insurance Regulatory and Development Authority of India (Irdai) had recommended that individuals be allowed to shift from being insurance agents to insurance service providers (ISP). Insurance agents may sell products of two life, general and health insurance companies. Apart from that, a financial service executive can also market products of mutual fund companies regulated by SEBI, pension products regulated by PFRDA, banking/ financial products of banks/ NBFC regulated by RBI and non-insurance products offered by Department of Posts and the government.

Insurance marketing firms have been operating since 2015. For general insurance, insurance marketing firms are allowed to sell retail insurance products which are under file and use guidelines, namely, motor, health, personal accident and householders. The firms sell insurance products of only those insurers with whom they have an agreement for soliciting insurance products.

Registration of IMFs

In order to register as an IMF, the firm has to submit an application to the insurance regulator and remit non-refundable application fees of `5,000. It has to submit a copy of the IMF exam pass certificate of the principal officer and the ISPs proposed to be engaged by the IMF. It also has to submit copy of the licences or authorisation or registration issued by Sebi, RBI, PFRDA, etc., obtained by the financial service executive (FSE) proposed to be employed by the IMF.

Most importantly, the IMF will have to submit an undertaking stating that telemarketers will not be engaged for solicitation/ lead generation of insurance business. The applicant will have to have a net worth of at least `5 lakh if it is opting for only one district. The IMF will have to ensure that the net worth is maintained at all times and it will have to submit a certificate duly certified by a chartered accountant to this effect annually within three months from the close of the financial year.

The registration will be valid for a period of three years, unless it is suspended or cancelled by the authority. Every IMF will have to take a professional indemnity insurance cover throughout the validity of the period of the registration granted to it by the regulator. The limit of indemnity shall be two times the total remuneration of the insurance marketing firm subject to a minimum amount equaling the net worth of the IMF. The total remuneration includes remuneration from their insurance procuring, servicing activities and marketing of other financial products.

Insurers will have to handhold the IMFs for completing the registration process, take measures for capacity building through imparting continuous training and education and share information to service the policyholders of the policies issued through IMFs such as status of proposal, status of policy, change request, grievance or claims, etc.

Maintenance of records

An IMF will have to keep records of the mandate received from the customer (policyholder), Know Your Client (KYC) records of the customer as required under the regulator's guidelines and provisions of Prevention of Money Laundering Act, copy of the proposal form duly signed by the customer and submitted to him. The IMF will have to maintain a register containing list of the clients, details of policy, premium amount, date of issue of the policy and charges or fees received.

The register will also contain details of complaints received, name of the complainant, nature of complaints and action taken and any other record as may be specified by the regulator. Every insurer company will have to submit to the regulator a copy of the policy to be sold by IMFs for increasing insurance. Insurers will also have to give an annual report on the number of IMFs promoted by them and the business generated through them under various segments. The report will have to be prepared state-wise number of policies sold and the amount.

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Source

How to ensure a special child is cared for life – Mint – 5th December 2018

For Delhi-based Madhusudan Srinivas, 57, making it home early from work every day is a priority. He wants to ensure his son Abhimanyu, 25, who is on the autism spectrum, gets all the time and care that he needs. "Spending quality time with my child is my priority and with the support of my colleagues, I am able to manage early shifts," said Srinivas. Abhimanyu has all the love and help he needs, but his care doesn't come cheap.

Like the parents of many special needs children, Srinivas and his wife Shubhra Gupta, both media professionals, have struggled to balance paying for their son's immediate needs and planning for his future. "Financial planning by a special needs child family is planning for two generations. Parents have to plan for lifetime care of the child within their lifetime and after them," said Jitendra P.S. Solanki, author of 'Financial planning for the families having children with special needs' and a Sebi-registered investment advisor.

If you are a parent or guardian to a child with special needs, here are a few things you need to take into account when planning for your child's future.

Sea of concerns

On 3 December, India celebrated International Day of Persons with Disabilities, but for the millions of people with disabilities in India it means little. While Census 2011 put the number of people with disabilities in India at around 26.8 million, other estimates say the figure is much higher; for instance, the National Centre for Promotion of Employment for Disabled People pegs it at 70 million. Government aid and social infrastructure is all but absent in the country. For instance, the reimbursement provided by the government for the tuition fees for children with disabilities ranges from a paltry Rs20 to Rs50 per month, which may not even pay for admission to most schools, let alone a school that caters to children with special needs.

It is natural for parents, therefore, to worry about who will care for their child after they are gone. "A special needs child may not be in a situation to take his own decision even after attaining majority. Parents have to consider how the child will be provided for and maintain the standard of living after their death and who will manage the affairs without any self-interest," said Solanki.

It becomes crucial because most of these children don't even understand money matters. "It depends on the degree of challenge of the child. Autism is a spectrum disorder, and even those who are high functioning and integrated into the school system may not be able to make financial decisions," said Srinivas.

The other important question to ask is how much help and care your child will require in the long term. "If your child has the potential and agency to eventually make financial decisions for himself, you might not have to worry about having a guardian handle their finances. But the bulk of children with mental disabilities will need to be cared for life," said Srinivas.

If lifetime care is what your child needs, you will have to provision for hiring caregivers or placing them in a care facility after you are gone. Therapies and hiring caregivers can be quite expensive.

"When my son went for speech therapy sessions, they would charge Rs750 for each 45-minute session. How many sessions can you afford?" asked Indu Singh, 40, who is a financial advisor and parent to a child with special needs. But two major future goals have to be factored in when you spend or save. "I tell my clients that their retirement comes before the higher education of their child. But in the case of a child with special needs, both retirement and the child's future are equally critical. If the corpus falls short, the parents need to be open to working longer, finding a parallel source of income or cutting corners to save more," said Deepali Sen, a certified financial planner and founder of Srujan Financial Advisors.

Another challenge is creating a safety net, since many insurers are reluctant to provide coverage for people with disabilities. "It's extremely important to have health insurance cover, because kids with disabilities are often more prone to injuries and hospitalisation," said Singh. "Insurers are reluctant to cover those with disabilities because it is something they don't understand very well and, therefore, can't assess the risks associated with it," said Abhishek Bondia, principal officer and managing director, SecureNow.in.

Finding a way

While every parent wants to give their child the best of everything, parents of a child with special needs might have to make some hard choices.

"Prioritise what is best for the kid within the limits of the income you have," said Sandeep Sharan, 50, director of Asia Pacific and Japan, Dell, who is parent to a child with special needs. "The key thing is to plan a future for your child, ensuring all the comforts that he enjoys now, in a sustainable way," he said.

It is crucial to create a support system of trusted family and friends to help with the care of your special needs child, especially in your absence. A number of Srinivas's family members are willing to fill in as guardians, depending on ability and availability, whenever it's required.

Having caregivers is one aspect, the other major concern is building enough corpus to sustain the care of the child through his lifetime. “We had a trust formed of family and friends, into which members of the family contributed and built up a corpus, which can be banked and invested for his future,” said Srinivas.

Sharan, who does his own financial planning, recommends investing aggressively. “You have to decide at what stage you want to take up risky investments like equity and when you will switch to fixed income,” he said. He also suggests buying property that could yield a rental income to keep income flows steady even after retirement.

In all this, inflation poses the biggest threat to a long-term savings plan and can devalue your corpus significantly if you don’t plan right. One way to counter it is to start early. “Parents should start planning as soon as the disability is identified. Through proper budgeting, they should monitor the child's expenses so that they are aware about the financial requirement,” said Solanki.

Singh seconds this. She has calculated how much her child might need for monthly expenses in the future and adjusts the amount for inflation every few years. The final corpus will be available for her child’s expenses, which can be drawn upon through a systematic withdrawal plan.

As for health insurance, according to Bondia, while the industry is opening up to the idea of insuring people with disabilities, there is still a long way to go. But there are a couple of ways around this.

“If parents have the choice to opt for group insurance through their employer, they should go for it and enhance the coverage through top-up insurance. This would cover the child as well. They can also buy a personal accident cover which would take care of medical expenses for the child in case of accidents and injuries,” he said.

Taking life insurance for parents is critical. Since most children with special needs are partially or completely financially reliant on their parents, the sudden passing of a parent might spell disaster for the child if there isn’t enough saved up already. An insurance payout can boost the corpus for the child’s care in such a scenario.

It’s not an easy road for parents of children with disabilities. There are many considerations to be taken into account and a lot of planning and safeguards to be put in place to secure their future. But, perhaps, the most crucial part is to ensure your child lives a fulfilling life. Abhimanyu, who has inherited a love of music from his parents, is safe and happy, and for now that’s enough for Srinivas.

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Source

INSURANCE REGULATION

Irdai proposes changes in registration norms for insurance firms - Financial Chronicle – 4th December 2018

The regulator Irdai on Monday proposed to relax norms for registration of insurance marketing firms with an aim to improve penetration of insurance products in the country. Insurance marketing firms (IMFs) are registered by the insurance regulatory and development authority of India (Irdai) to solicit or procure insurance products.

Earlier this year, the regulator had constituted a committee for review of IMF regulations. Based on the recommendations of the panel, Irdai has proposed several changes in the existing framework governing IMFs.

As part of the proposed changes, Irdai is considering to reduce the net worth requirement to Rs 5 lakh for applicants opting for an aspirational district. The NitiAayog has designated 117 districts in 28 states as aspirational districts.

The current capital requirement for registration as an insurance marketing firm is minimum Rs 10 lakh. Irdai has also proposed expansion of the basket of products which can be solicited or procured by an IMF to include group insurance products for Micro Small and Medium Enterprises (MSMEs), crop insurance for non-loanee farmers and combi products.

Simplification of process of resignation of insurance sales person and expansion of the scope of work of Principal Officer are some of the other key changes proposed in the current regulations. Irdai has sought comments from stakeholders on the proposed changes by December 15.

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SJM urge PM to intervene in 'Brokers Regulations' by IRDA - The Hindu Business Line – 30th November 2018

Asserting that IRDA's January 2018 'Brokers Regulations' are discriminatory against domestic investors, the Swadeshi JagaranManch (SJM) has urged Prime Minister Narendra Modi to intervene in the matter and correct the situation.

The insurance regulator IRDA has in its 'Brokers Regulations' clearly favoured foreign investors and they are tilted in favour of multinational brokerage houses with much deeper pockets, said Ashwani Mahajan, National Co-convenor, SJM, in a letter to Modi.

"We are seeking your (Prime Minister) direct intervention in this and seeking a level playing field for the domestic and indigenous players",the letter said.

The main point of anguish is that a domestic investor cannot hold more than 25 per cent stake in an insurance broker, but a foreign investor can go upto 49 per cent. A reading of the regulations clearly points out that the intent of the regulator IRDA is to only promote the interests of foreign investors, said the letter.

"The matter was represented to the regulator, but nothing moved. We hereby request you to intervene and bring resolution to the hardship and unfair business practice faced by the domestic players", the letter added.

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LIFE INSURANCE

Make most of your life insurance cover, add these Term insurance riders - Financial Express – 1st December 2018

When you plan to buy a life insurance policy, you must always consider buying a term insurance plan. This is no doubt one of the simplest and most cost-effective insurance products available in the market today. Term insurance plans are designed and customised in such a manner that in the event of the sudden death of the policyholder, the beneficiaries receive the sum assured as a lump sum or monthly income, whichever the dependents choose.

Under the term plan, the insured pays the premium to the insurer until the policy tenure against which the insurer provides insurance cover to the policyholder. Under a term insurance policy, the policyholder also enjoys the prerogative of choosing different options along with the policy in order to get enhanced and overall protection. These options are better known as riders.

What are Term Insurance Riders?
Based on specific needs and requirements of the policyholders, insurers give an option to policyholders of customising their term insurance cover with add-ons, also known as 'riders'. Riders are basically like accessories which can be attached to the main insurance cover to enhance its overall value and

policyholder, it is very important for you to choose the right rider with the term insurance to enjoy the required benefits.

1. Accidental Death Rider
Not all would know the fact that India continues to be the accident capital of the world with over 150,000 people being killed each year in just road accidents. The numbers are even higher than most developed auto markets across the globe including the US. However, roads are just another example as accidents often happen at construction sites, home, and many other potentially safer places as well. While a simple term insurance plan gives you normal death benefit, an accidental death rider offers a supplementary sum assured if the policyholder passes away due to an accident. This rider is very important for people with high-risk jobs as it provides the dependents with extra financial help.

2. Waiver of Premium Rider
A very popular rider among the policyholders, the waiver of premium rider keeps the term insurance plan active even if the policyholder is not able to pay the premium due to some unavoidable circumstances. The rider mostly comes into action when the policyholder losses on the monthly income due to a certain unexpected event like partial or complete disability due to an accident. The rider can also be availed during a critical illness when the policyholder losses on the monthly income and fails to pay the premium amount. During such an event, the rider takes the financial burden off the shoulder of the insured by waiving the premium till the term plan tenure.

3. Critical Illness Rider
Some major critical illnesses like cancer, heart attack, kidney failure, coronary artery bypass, and paralysis are some of the diseases that can surely dry out a person's finances if there is no adequate cover in place. For all such situations, it is best to have a term plan with a critical illness benefit as a rider. It is a rider that helps to cover the cost of critical illness during both, hospitalisation and non-hospitalisation expenses. Critical Illness rider provides much-required cash flow during the recovery period as well. On diagnoses of the illness, the rider provides the policyholder with a lump sum benefit. If unfortunately, the policyholder dies during the critical illness, the term insurance plan benefit is paid to the nominees.

4. Income Benefit Rider
In case of sudden death of the sole breadwinner of the family, it becomes very difficult for the dependents to replace the income. With the help of income benefit rider in a term insurance plan, the family receives a regular income for a fixed number of years. The income benefit rider is an addition to the existing life insurance policy as it provides the beneficiaries with an amount equal to the policyholder's monthly income. The dependents get additional income for approximately 5-10 years along with the total sum assured. The rider is best suited for salaried people who are also the sole breadwinners of the family.

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Source

HEALTH INSURANCE

ESIC allows people other than subscribers to avail its services - The Hindu Business Line – 6th December 2018

The Employees' State Insurance Corporation (ESIC) has allowed public other than its subscribers to avail medical services at its under-utilised hospitals. The decision was taken during the ESIC's 176th meeting held on December 5 under the chairmanship of Labour Minister Santosh Kumar Gangwar, a labour ministry statement said.

The decision will immensely help common people avail quality medical care at low cost and ensure full utilisation of ESIC hospital resources, it added. In the meeting, it was decided to allow non-insured persons to avail medical services at under-utilised ESIC Hospitals after levying user charges at a subsidised rate of Rs 10 for outpatient department (OPD) consultation and at 25 per cent of Central Government Health Services' package rates for in-patients, the statement said. Also, the ESIC will provide

medicines on actual rate initially for one year on a pilot basis. The ESIC has over 150 hospitals and around 17,000 beds for patients across the country.

Recruitment
It has also approved hiring of full-time contractual staff in various departments to meet the shortage of specialist/super-specialist doctors in some of its hospitals.

The recruitment to 5,200 posts such as social security officer, insurance medical officer Grade-II, junior engineers, teaching faculty, paramedical & nursing cadre, upper division clerks and stenographers, among others, in the ESIC is under process, it said.

Exemption limit enhancement
In a major move, the labour ministry has decided to enhance the exemption limit for payment of employees' share of contribution from Rs 137 to Rs 176. This comes in the wake of rise in the national floor-level minimum wages to Rs 176.

Among the officials present at the meeting were Labour and Employment Secretary HeeralalSamariya, ESIC Director General Raj Kumar and senior officers of the ministry.

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Source

Ayushman Bharat will increase penetration – Mint – 4th December 2018

Health insurance's contribution to total healthcare expenditure is quite low. How can Ayushman Bharat change this? Currently, around 28-30% of the country's population has some form of health cover. About 3-4% have a retail health plan and the rest is government sponsored schemes.

Even before Ayushman Bharat, government schemes have been there. Ayushman Bharat will now take this to a higher level of about 45%. This will result in an overall healthy population and will have a positive effect on productivity and the economy.

The second issue is that India has a lesser overall ecosystem like hospitals and beds. Even a majority of these are in urban areas. Beyond that, centres, including primary healthcare centres, are not regis- tered. Ayushman Bharat will create this ecosystem in rural India.

Moreover, the cost of treatment will get standardised. As the ecosystem will get developed, chances are that private health insurers will be able to go and sell retail health insurance in these markets, at a price which could be much cheaper. Will it happen tomorrow? No. But will this happen in the next 5 years? Definitely yes.

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Source

What you get under restore, recharge benefits for health insurance plan - Financial Chronicle – 3rd December 2018

With the increase in the number of lifestyle diseases, Health Insurance has now become a very serious requirement and people are very much warmed up to this idea. Presently, many Insurers have come up with features such as Recharge of Sum Assured along with Restore of Sum Assured. The name of these features (Restore Benefits and Recharge Benefits) sound alike and hence creates confusion in the mind of the policy seekers. The features of these policies are very different and come with distinct terms and conditions as well. Here, we have tried to clear your confusion by drawing out the difference between the both.

As the term restore defines "storing back to its former condition". Similarly, if your sum insured gets exhausted towards the treatment of any illness then the insurance company will restore your sum insured in case of the restore benefits. However, the restored sum insured could be used for the treatments other than the one for which the claim was already disbursed by the insurer. Moreover, this

restore benefit can be availed only once in a year and can be used only during the policy period it was brought in and cannot be carried forward to the subsequent policy period.

While talking about the Recharge Benefit, it automatically reinstates up to 100 per cent of the sum insured amount when the sum insured gets reduced owing to the former claim that has been paid out. This benefit is available immediately during the next hospitalisation in a situation that the reminder of the basic sum insured fails to meet the cost of the treatment. However, this is done regardless of whether or not the basic Sum Insured has got exhausted.

For Instance, in case of restore benefits if the basic sum insured of policyholder's insurance plan is Rs 5 lakh and he/she gets hospitalised for Typhoid and undergoes treatment for the same, which exhausts the sum insured of Rs 5 lakh completely. And if the policyholder has the restore benefit active under his/her policy, the insurer will reinstate the basic sum insured amount for that particular policy period.

However, this sum insured amount cannot be used by the policyholder for any other treatment except Typhoid as the claim is already made for it. In addition, if the policyholder exhausts the restored amount, he/she will not be eligible for any restoration thereafter for that policy year.

In case of recharge benefit, the scenario is quite different. Suppose, if the policyholder has been hospitalised for Malaria and exhausted Rs 4 lakh against the sum insured amount of Rs 5 lakh and if he/she is hospitalised again for some other ailment and incurred Rs 2 lakh as hospitalisation expenses, the insurer will automatically recharge the sum insured with Rs 1 lakh to reimburse the second hospitalisation expenses.

It is clear from the above detail that the restore benefits reinstate the sum insured only when the complete sum insured amount gets exhausted while the recharge benefit reinstates the required amount automatically during the next hospitalisation event (up to 100 per cent of the basic sum insured amount) when the basic sum insured amount gets reduced. The reinstatement in the recharge benefits take place regardless of whether or not the basic Sum Insured amount has got completely exhausted.

Simplifying the fact that, Both Restore as well as Recharge Benefits means reinstatement of the complete sum assured in the policy year but with different conditions.

Keep in mind

Individuals must research well before they opt for the medical insurance from any insurers. There can be cases wherein the policyholder exhausts Rs 3.5 lakh against the sum insured amount of Rs 5 lakh. Now, during the next hospitalisation the expense goes to Rs 2 lakh, the insurer should provide protection for Rs 1.5 lakh while the remaining Rs 50,000 has to be borne by the policyholder in this case. However, there are insurers who could deny paying the Rs 1.5 lakh saying that the entire sum insured is not exhausted. Hence, it is highly recommended to be vigilant enough from such stratagem done from the company's end.

There are multiple factors that need to be considered while deciding your health insurance policy. But when it comes to deciding between the two, Recharge seems to be the optimum choice. Also, the main difference between Restore and Recharge benefits is that Restore option can be availed only once your Basic Sum Insured has been completely exhausted. Whereas on the other hand, the recharge option is available even if the claim amount made by the insured exceeds the basic sum assured.

However, make sure that you are holding a considerable amount of medical cover while you are opting for restore options since these plans works best along with a floater policy. Your choices depend on your immediate and future medical needs.

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Source

Central health schemes will go long way in reaching out to poor: Fadnavis - The Hindu Business Line – 2nd December 2018

The Maharashtra government will be able to take health benefits to the poor and tribals in every corner of the state through 'Atal Aarogya' camps, Chief Minister DevendraFadnavis said in Nashik district on Sunday.

He said the poor people who cannot afford medical treatment and thus remain out of the healthcare system will be benefitted by the Pradhan Mantri Jan ArogyaYojana (PMJAY) and the Ayshman Bharat scheme of the Central government. The PMJAY aims to provide cashless health treatment to its beneficiaries.

"The prime minister has started a major health scheme 'Ayushman Bharat' which will cover 50 crore people," the chief minister said while inaugurating the Atal Arogya health camp at Nanduri, located 70 km from here. At the camp, a team of 1,700 doctors examined people at 100 separate wards that were set up under a big tent at the camp site.

TOP

Source

In govt's health scheme, most claims so far are for cataract surgery and root canal – The Indian Express – 2nd December 2018

The Pradhan Mantri Jan ArogyaYojana (PMJAY), launched as protection against large expenses arising out of serious illnesses, has seen the most claims for relatively minor procedures like cataract surgery and root canal treatment, available data from several states for the first two months of the scheme show.

Advertising

The data, from greenfield states, also show a high incidence of claims for enteric fever or typhoid. The data are yet to be fully integrated, and the final picture could, therefore, be somewhat different. Greenfield states are those that had no health insurance scheme before PMJAY. They include some of India's poorest and most populous states, including Uttar Pradesh, Bihar and Madhya Pradesh, apart from Chhattisgarh, Himachal Pradesh, Haryana, Jharkhand, Uttarakhand, Jammu & Kashmir, and all of the Northeast.

Between September 23, when the scheme was officially launched, and November 24, 6,900 claims were made for cataract surgery, and 4,900 for root canal treatment, official data show. A total 3,400 claims were made for the typhoid package during this period.

PMJAY is the tertiary care arm of the government's flagship Ayushman Bharat scheme, under which 10.74 crore families will be provided an annual health cover of Rs 5 lakh. The other part of the scheme is the setting up of 1,53,000 health and wellness centres, the first of which was inaugurated in April in Bijapur in Chhattisgarh. All states except Telangana, Odisha and Delhi have signed the Memorandum of Understanding with the newly created National Health Agency (NHA), the implementing authority for the PMJAY. Rajasthan has signed the MoU, but is yet to implement the scheme.

The PMJAY, billed as the most ambitious health scheme in the world, is one of Prime Minister Narendra Modi's flagship social welfare initiatives. The NHA has been filing a report of its progress to the Prime Minister's Office at 5 pm every day since the launch of the scheme, including on weekends, holidays, and festival days.

The daily report includes updates on the numbers of health cards issued, beneficiaries admitted, and claims raised, and even the numbers of calls answered and letters despatched to beneficiaries. The health scheme has made an occasional appearance in Modi's campaign speeches in the ongoing Assembly elections. The process of automatic integration of data from the states is not complete yet. Once that is done, the PMJAY dashboard will be made public.

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Source

Tamil Nadu hikes health insurance cover to Rs 5 lakh - The Hindu Business Line – 30th November 2018

Tamil Nadu government on Friday announced the hike of health insurance coverage from Rs2 lakh to Rs5 lakh which will benefit 1.58 crore families.

The increase in coverage will benefit over 1.58 crore families registered under the government's health scheme, who can now avail no-cost treatment uptoRs5 lakh per year, a government release stated. The Chief Minister said following the requests made by the beneficiaries, he issued orders to increase the insurance cover to Rs5 lakh from the existing Rs2 lakh.

Till date 26.96 lakh people to the tune of Rs5,133 crore have been benefitted from Chief Minister's Comprehensive Health Insurance Scheme, the release added.

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Source

CROP INSURANCE

Crop insurance scheme: Farmers at the helm of benefits – The Times of India – 3rd December 2018

Of the various crop insurance schemes at the national level since 1985, the Pradhan MantriFasalBimaYojana (PMFBY) is the most ambitious risk mitigation programme for farmers. The yield-based National Agriculture Insurance Scheme (NAIS) was the most widely implemented scheme. The present government held a comprehensive review and extensive consultations to close loopholes before a national level rollout in April 2016.

The scheme has been implemented over five seasons now and the scale of finance in each district for each crop forms the basis of calculation of sum insured. This roughly corresponds to cost incurred and gives farmers adequate financial protection without any reduction due to capping in earlier scheme. This sum insured has doubled. The average sum insured, which was Rs 22,000 per hectare, is now Rs 40,000.

The earlier NAIS was based on the trust model where government collected a token premium from farmers but bore liability for payment of claims beyond premium collected. PMFBY is an actuarial model based scheme where token premium is charged and government pays the balance premium quoted by insurance companies selected by states through transparent bidding — full liability of payment of claims is with companies.

Reports suggesting 350% increase in premiums conveniently suppress that government liability was unlimited in the earlier scheme. The 2015-16 type drought, had it happened in 2016-17 or 2017-18 with nearly double sum insured, would have resulted in a huge payout than premium subsidy in PMFBY.

PMFBY has seen a quantum jump in voluntary enrolment of farmers. It has two categories — loanee farmers (those who avail agriculture loan) are compulsorily covered automatical by banks and non-loanee farmers (those who do not take loan) enrol voluntarily. In 2015-16, the year before PMFBY was launched, only 28 lakh farmers opted voluntarily, rising to an additional 1.36 crore farmers in 2016-17. This number stayed constant in 2017-18. Increase in voluntary enrolment, particularly in rain-fed areas, implies its utility as a safety net.

Since launch of PMFBY, India has had two consecutive bumper crop years. Yet, during 2016-17, more than 5.72 crore farmers were insured, with a claim ratio of 75%. And 4.99 crore farmers were insured in 2017-18, with claim ratio of 87% for Kharif 2017. More than Rs 33,000 crore was paid in the first three seasons against farmer premium share of Rs 7,272 crore.

In context of criticism that insurance firms made windfall gains, calamity-hit areas saw high settlements. More than 100% of premium collected in Kerala (210%) and Karnataka (132%) during Kharif 2016, in Tamil Nadu (287%) and Andhra Pradesh (159%) during Rabi 2016-17, and in Chhattisgarh (425%),

Odisha (204%), Haryana (201%), and Madhya Pradesh (135%) during Kharif 2017. Administrative costs for firms can range from 10%-12% of gross premium.

During 2017-18, there was a drop in total farmers insured to 4.99 crore from 5.72 crore in 2016-17. This drop is in the compulsory loanee category. Two largest states, Maharashtra and Uttar Pradesh, announced loan waivers, making more than 69 lakh farmers ineligible.

Direct benefit transfer with Aadhaar introduced in April 2017 to deliver claims directly in bank accounts erased ghost beneficiaries. This also decreased loanee farmers though voluntary coverage was unaffected.

Technology has sped up claim settlement. The National Crop Insurance Portal seamlessly links more than 5.5 crore farmers and data entry from more than 1.5 lakh banks and financial institutions is done every season. Government is keen to improve the scheme.

Timely claim settlement is the key focus. There are penal provisions on agencies which cause delays — 12% penal interest by insurance companies farmers for delays beyond 10 days. And 12% penal interest by states to insurance companies if more than three months delay in releasing share of subsidy.

PMFBY has a higher basket of risk coverage — from pre-sowing calamities to post harvest losses — and provides uniform benefits to farmers across India.

Insurance is all about spreading the risk. It is premature and unfair to compare claims in relatively good years of 2016-17 and 2017-18 with premium collected, even though this is as high as 80%. The scheme has passed the test in states hit by major losses.

TOP

Source

Crop insurance: State gets 15 days' time – The Hindu – 2nd December 2018

With uncertainty continuing on the issue of deadline for enrolment of paddy farmers under the new crop insurance scheme, the Central authorities have conveyed to the State government that insurance companies can make use of the existing norm, which allows a time of 15 days for uploading data in respect of those farmers, for whom premium has been paid.

This communication, conveyed orally, provides partial relief to the State authorities who have been anxiously waiting for the announcement on the extension of the deadline.

Chief Minister Edappadi K. Palaniswami, about 10 days ago, wrote to Prime Minister Narendra Modi seeking extension of the deadline by a month. The officials here have made it clear that the extension is required not for paying the premium but for the submission of relevant documents by farmers, who, in turn, have to depend on officials of the Revenue and Agriculture departments.

As the officials are busy with the restoration works in areas hit by the Gaja cyclone, the farmers find it difficult to get the documents.

Samba crop

Around 9.5 lakh farmers have registered themselves with the insurance companies for the Samba cultivation season and this was about two lakhs more than the previous year.

Meanwhile, P. Shanmugam, general secretary of the **Tamil Nadu** VivasayigalSangam [affiliated to the Communist Part of India (Marxist)], called upon the Union and State governments to secure the consent of the insurance companies and ensure that the deadline should be extended at least by 10 days.

TOP

Source

MOTOR INSURANCE

Good news! Motor insurance premium may come down from FY20-21 - Financial Express – 7th December 2018

As per a recent indication by the Insurance Regulatory and Development Authority of India (IRDAI), the insurance premiums of two-wheelers and four-wheelers may soon come down. All thanks to the latest indication by IRDAI which states that starting from the financial year 2020-21, it may discontinue the regular practice of fixing the annual premium for third party (TP) insurance for motor vehicles.

As of now, it is the IRDAI which decides and fixes the premium for third party insurance cover that remains same across all insurers. With IRDAI discontinuing the practice, it will certainly make way for insurance companies to quote their own premiums at discounted rates in order to attract more and more customers.

Over the past few months, numerous transporters from all across the country have been continuously demanding that the IRDAI must start fixing the cap for premiums and even allow the insurers to offer a discount on insurance premiums so that policy seekers have better options.

Talking about motor insurance, currently, there is no capping on the "own damage" component and thus most of the insurance companies offer great discounts on the premium amount of "own damage" cover.

According to a recent report by the Insurance Information Bureau of India, in the financial year 2016-17 the insurance companies collectively accumulated about Rs 50,000 crore premiums for motor vehicle insurance.

As per the Indian Road Safety Act and Indian Motor Vehicles Act, third party insurance is mandatory for every vehicle running on the Indian roads. Moreover, with the implementation of a new rule, the third-party insurance cover for all new cars has been made mandatory for a period of three years.

However, as per several media reports, the matter did come up for discussion with the PMO for meeting the demand of the truckers to roll back the steep increase in premium. In order to support their demand, the truckers even went on a strike. The regulator then assured to bring the hike from 28 per cent to 10 – 15 per cent in the next financial year.

The only reason why the IRDAI is so firm in implementing the indication as soon as possible is that it wants to benefit the customers by reducing the third-party insurance. Once the insurers get the right to decide on the third-party insurance premium, the customers will have more options and they can select the insurer by deciding on the best prices offered.

Most of the car and two-wheeler dealers offer third party and comprehensive motor policy and the premium is generally added to the vehicle purchase price (only in case of new vehicles). However, the prices are relatively higher than the insurance policies being sold online at insurance aggregator's website.

People looking for affordable motor insurance cover are always advised to check for the best available quotes online. While zeroing on a comprehensive motor cover, it is important to make sure if 'voluntary deductible' is added by the dealer in the policy or not.

By adding the 'voluntary deductible' element, you can significantly lower your car insurance premium. Also, by buying car insurance online, you get the option of comparing insurance covers by multiple insurers.

TOP

Source

Should vehicle drivers or owners pay for third-party compensation in accidents? - The Economic Times – 3rd December 2018

Insurers want vehicle owners or drivers to pay stiffer fines or buy additional third-party covers. Not all agree. Can making them pay a part of the compensation be a solution? ET Wealth speaks to experts.

JehangirGai, Consumer Activist, says NO
"The law makes it mandatory to have third party insurance coverage for all vehicles. This does not burden the insurer as the compensation is funded by the premium collected."

Drivers, even in metros, earn about Rs 15,000 a month. The working condition of truck drivers, who mostly belong to the lower strata of society and hail from remote villages, is worse. Consequently, they do not have much savings. So, it would be impractical to expect a professional driver to bear a part of the compensation payable to an accident victim. Judicial delays also make it difficult to trace a driver and execute the order several years down the line.

Similar difficulties could arise in affixing liability on the owner of a vehicle. Law is uniformly applicable—it cannot discriminate between affluent and poor vehicle owners. There are several people without much money who buy a vehicle on hire purchase to ply it for gainful employment. Such persons will not be able to afford payment of any compensation. Moreover, an owner may sell off his vehicle, change residence, migrate, or even be dead by the time the case gets decided. This would make it difficult for the decree holder to execute the award for compensation.

Keeping all these factors in mind, the law makes it mandatory to have third party insurance coverage for all vehicles. This methodology does not even put a burden on the insurer, as the compensation payable is funded through the premium which is collected. Another advantage is that insurance companies have a presence throughout the country. So recovery of compensation from the insurer is much simpler.

Hence, payment of the entire compensation by the insurer is in the best interests of all concerned.

ShailajaLall Partner, ShardulAmarchandMangaldas says NO
"For victims, there is no recourse to compensation if the owner or the driver can't pay it."

The idea of the insured driver/owner sharing a portion of the third-party compensation is flawed. For the insured driver or owner, this defeats the purpose of obtaining third party cover, as the insured will still have to pay out of his pocket and will remain exposed to such liability.

For the victim, there is no recourse to compensation if the owner or the driver has no means to pay it, and in several cases, this will lead to protracted litigation. As per existing laws, interim compensation for death or permanent disablement of a victim works on a no-fault principle. The efficacy of this principle will be impacted if compensation is to be contributed by the owner or driver. The purpose of the no-fault principle is to bring faster relief to victims.

If the insured drivers and owners are made to share a portion of the compensation, then it will open up a lengthy process of investigation to determine fault and the relevance of third party insurance cover can be questioned. The core issue to be addressed in third party motor insurance segment is enforcement of mandatory third party insurance cover rule.

Rakesh Jain Executive Director and CEO, Reliance General Insurance says Yes but...
"Owners/drivers can contribute by buying an optional add-on cover."

Getting the insured to directly share the compensation payout is not practical. Claims are filed by the accident victims after a lag. The hearings at the tribunal could also go on for a few years. So, the claimant could receive the compensation only after several years. At that stage, it is not always easy to trace the owner or driver. Thus, it is the poor victim who will have to suffer.

In some parts of the world, there is a minimum mandatory insurance specified under third-party covers. For example, in the US, it is $1,00,000 in most states. It is optional for the driver to buy the additional

cover. If a driver chooses to buy protection till $5,00,000, another $4,00,000-cover will be required to be bought.

At the moment, in India, it is an open-ended model for insurers and the whole liability is passed to the insurers. The claims can come in after many years and there is no cap on the likely compensation. My view is that the owners/drivers should participate in compensation sharing by buying an optional add-on cover that insures them against claims exceeding the minimum amount—say Rs 15 lakh—prescribed by law.

Kamesh Goyal Chairman, Digit General Insurance Co says Yes but...
"The driver of a vehicle should be fined Rs 10,000 for injury cases and Rs 25,000 for deaths and the vehicle owner should be fined double this. This, in a way would be their contribution."

India has the highest number of road accidents in the world compared to the number of vehicles. The reasons are many. Overloading of vehicles, poorly maintained vehicles, drivers who are untrained or driving on bogus licences, as well as over worked drivers, etc.

Another contributing factor is the way our judicial system is structured. Cases for compensation go on forever and the courts over a period of time have adopted a philosophy that insurance companies should pay more and more compensation while letting go the vehicle owner and driver.This, coupled with the fact that motor third party premium in India has no concept of no claim bonus, has meant vehicle owners and drivers have no incentive or disincentive to reduce road accidents.

Since there is no time limit to file a MACT claim, the concept of NCB will not work as intimations of accident come after 1-2 years also. The only way this will work is if the driver of the vehicle is fined a minimum of Rs 10,000 for injury cases and Rs 25,000 for deaths and the vehicle owner is fined double this amount. This, in a way would be their contribution. The cases can take years, so getting them to pay will be difficult. So, the amount should be deposited in the court as soon achargesheet is filed.

If the driver is not traceable, then the owner becomes liable for the driver's fine as well. Unless people whose vehicles are involved in road accidents are penalised, society will continue to pay a heavy social and economic price for the road accidents.

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Source

After Irdai overhaul, what's in store for motor insurance space? – Mint – 3rd December 2018

Motor insurance has seen major changes over the past few months, such as change in policy tenure and sum insured for private vehicles. We asked experts about the overhaul and the way forward for the space

Raj Khosla, Founder and Managing Director, MyMoneyMantra
Market ready for product innovation

It was in 2007 that the pricing of motor own damage was detariffed, and it is only in November 2018 that the insurance regulator has established a working group to further examine the issue. I think we now need to free up basic product structures, which were earlier left untouched. The market has evolved considerably and is ready for significant product innovation in own damage, including usage-based pricing (which is common overseas), break-up of coverage by peril and higher deductible-based motor insurance.

The online ecosystem is now large and current motor insurance products need to be modified to effectively reach online customers, as well as need to be suitably buttressed with attractive offers like lower premiums. The information and processes needed to purchase a policy online should be rationalised and made less cumbersome. For instance, the number of fields in the proposal form should not exceed 10.

To protect the consumer, Irdai should keep a check on exclusions. The list of exclusions should be specified and clearly defined, in line with the recent steps taken in the health insurance space.

Tapan Singhel, Managing Director and CEO, Bajaj Allianz General Insurance
Greater insurance penetration needed

With the recent Irdai regulations, motor insurance in India is undergoing significant transformation. Despite motor third-party insurance being mandatory by law, a majority of vehicles plying on Indian roads are uninsured, mainly because of lack of awareness.

While long-term motor third-party insurance will ensure that vehicles stay insured for a longer duration, increase in the sum insured of compulsory personal accident cover to Rs15 lakh will provide additional cover to drivers in case of an accident.

There is concern over low penetration of motor insurance. A simple way to address this is to map the registered vehicles' database from regional transport offices (RTOs) and insured vehicles' database from insurance companies and send this data to the Insurance Information Bureau.

RTOs can send a notice to vehicle owners based on this record. For on-ground implementation, the traffic police should develop a mobile application to identify uninsured vehicles.

Tarun Mathur Chief Business Officer - general insurance, Policybazaar.com
New Irdai rules are customer-friendly

All the recent changes have been positive. For instance, the mandatory term for the third-party liability component of these policies has been increased to three years, which will eliminate the concept of customers being uninsured. The second major change that we saw is that the minimum premium is now Rs750. Most people were unhappy with that, which I find quite shocking. All it means is that if an accident happens, the insured would get Rs15 lakh, rather than the paltry Rs1-2 lakh earlier. To my mind, that is the right regulation because you are protecting the policyholder.

The erstwhile regulations were very distributor-friendly, and now they are becoming more customer friendly.

With the committee being formed for innovation, I think we will see "pay as you go" come into play. It'll allow people to put a telematics device in their car to measure how they drive, so that they can get an insurance cover tailored to their needs. I foresee those kinds of experiments taking shape in the coming six months.

Animesh Das Head of product strategy, ACKO General Insurance
Motor cover sector needs major facelift

The current motor insurance products in India were drafted back in 2001-2002. Over the years, there have been so many innovations in different markets. Motor insurance products need a major facelift from their current version, especially in terms of the application of technology for customisation of offerings, pricing and services for vehicle owners.

One of the gaps in motor insurance is that every customer is paying a similar premium, and the pricing is not done taking an individual's vehicle usage into account. Why should two car owners with daily usage of 2km and 20km respectively pay the same premium? The current products need to see the introduction of premium as per usage. Also, the product should be enhanced keeping the current vehicle owners in mind, where they expect cashbacks, referral bonus and other benefits, on the basis of their better driving behaviour.

Customers are getting used to the service levels offered by e-commerce companies. The insurance sector also needs to match up to the expectation of new-age customers. Products and services should be powered by technology advancements to benefit both insurers and customers.

TOP

Source

56% Indians still don't have a health cover – Mint – 4th December 2018

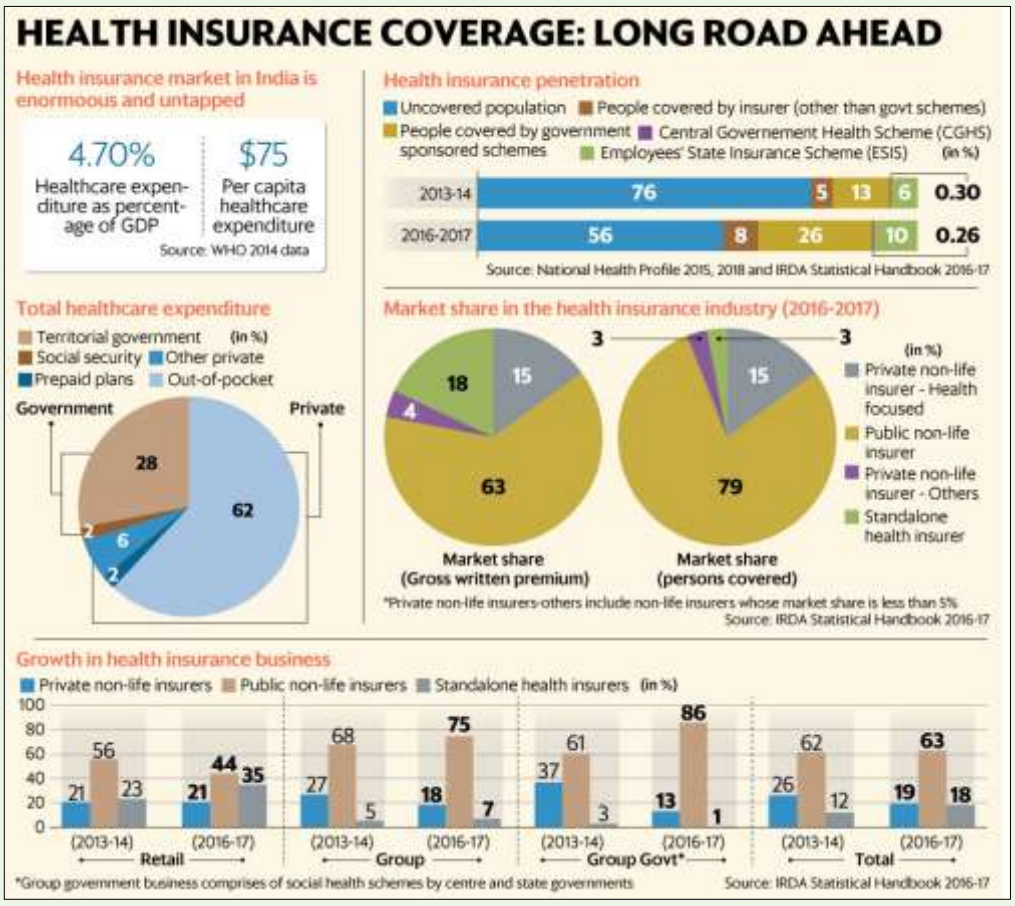
Only 44% of the 1.3 billion people in India have a health insurance policy as of 2017, according to a report by actuarial and consulting firm Milliman, titled 'Indian Life and Health Insurance Sectors'.

Healthcare expenditure as a percentage of GDP is just 4.7% in India, while the US, according to Statista.com, spends about 18% of its GDP. Of the total expenditure on healthcare in India, 70% comes from the private sector, whereas the government spends only 30%, said the Milliman report. In the US, the federal and state governments contribute as much as 45%.

Also, the schemes offered by the government have many limitations. "A majority of insured population is covered under Employees' State Insurance Scheme (ESIS) or government-sponsored schemes. Such schemes have significant coverage limitations. For example, RashtriyaSwasthyaBimaYojana (RSBY) provides a cover of only Rs30,000 for a family. ESIS provides an unlimited coverage but offers only 5 hospitals for whole of Delhi," said Abhishek Bondia, principal officer and managing director, SecureNow.in.

PENETRATION

In 2013-14, 76% of the population did not have any significant health coverage. However, the number dropped to 56% during 2016-17. The report calculated the number of uncovered population by subtracting all the covered persons from the population estimate provided in the National Health Profile. Of the population with health insurance, 8% are covered by insurers other than government schemes and RSBY, 26% are covered under RSBY and other government schemes, 10% under ESIS and 0.26% under the central government health scheme (CGHS).



"Government should remove disincentives on health insurance. For example, indirect taxes on individual health insurance have increased from 12.5% to 18% over the last few years. GST on individual health insurance should be reduced. This will have a direct impact on an individual's ability to buy cover," added Bondia.

The market share, in terms of the number of people covered, of public non-life insurer increased to 63% in 2017 and that of private insurers was 18%. "Public sector non-life insurers had a first mover advantage.

They carry a legacy book. Also, PSU insurers take the lead in participation in large programs such as government sponsored schemes and group insurances of other PSU units," said Bondia.

According to the report, between 2013 and 2017, standalone health insurers gained substantial presence in the retail segment. "Stand-alone health insurers are specialists and hence are able to innovate on the product as well as servicing side. With increasing and directed focus towards health products alone, stand-alone insurers are able to provide solutions for fulfilling customer needs which were considered difficult to meet earlier," said Ashish Mehrotra, managing director and chief executive officer, Max Bupa Health Insurance.

AYUSHMAN BHARAT

According to the report, Ayushman Bharat will upgrade over 150,000 sub-centres to health and wellness centres by 2022. Until now, all public sector hospitals and more than 9,000 private hospitals have been empanelled and more than 38,000 patients were hospitalised in the first two weeks of the launch. For people who are not eligible for government schemes, Ayushman Bharat will encourage them to buy private insurance, said Bondia.

Ayushman Bharat will help increase health insurance penetration, said Mehrotra. "Also, since the basic cover would now be available through Ayushman Bharat, the focus of insurers would be towards developing solutions for meeting other out-of-pocket expenses like OPD, pharmacy, diagnostics etc. which are currently at about 65% of the overall healthcare spends," he added.

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Source

OPINION

Opinion: Problems of moral hazard in insurance – Mint – 6th December 2018

Readers of A House for Mr Biswas by V.S. Naipaul will be familiar with the term insuranburn. It appears to have been standard practice in Trinidad for failing businessmen to take up insurance, burn their property and then file a claim. Insurance can drive such behaviour. In cases of outright fraud, as in insuranburn, this is called out and addressed. However, there are many situations when the influence on how we behave is subtler and difficult to quantify.

In insurance language, moral hazard is when insurance encourages behaviour that is harmful or riskier than what the person would have done without insurance. The outcome is always an increased financial loss to the insurer. I learnt about this concept many years ago when a product idea I had proposed—to insure the lives of small children—was dismissed by an experienced appointed actuary. "Moral hazard", he concluded and patiently explained that the insurance would encourage parents to kill their children. I was horrified by the thought and never brought up this idea again. Moral hazard is also one of the arguments to restrict the amount of insurance given to housewives.

The implications have been discussed extensively in other markets. Some US states allow an insured person in financial need to sell their insurance to a third party. This unrelated person pays future premiums and gets the sum assured on maturity or if the insured person dies. Effectively, this stranger-owned life insurance creates an incentive for the third party if the insured person dies prematurely. Not a pleasant thought.

Our focus in the industry is always to increase cover. We will look at uninsured risks and push to include those, for example in cyber liability and title insurance, where previously uninsured risks such as cyber crime or faulty land ownership titles are now covered. In existing products, our focus is to reduce exclusions. I have done that most frequently in health insurance by questioning new exclusions and claims decisions. This is the right approach given significant insurance under-penetration. Occasionally, however, one must pause and think about the behaviour that this product design encourages.

The most obvious questions are does health insurance make people take less care of their health? Does liability insurance encourage businesses and professionals to be less concerned about what their clients think? Does fire insurance make us ignore poor safety standards at home and in the workplace? There is limited research on these topics but they should be understood. A young friend recently diagnosed with diabetes has taken the disease in her stride because she is well insured. I would have preferred she panicked and got onto an emergency weight loss plan but that did not happen.

Over the years, we have made many insurance covers extremely suited to the Indian context. The Workmen Compensation Act specifies an unlimited liability for a company if their worker dies or is injured on the shop floor. I was not there in 1923 when this law was written but I suspect the legislators wanted to keep factory owners on their toes with the threat of unlimited liability. Today, at a small cost, the workman compensation insurance removes this risk by paying any damages identified by worker courts. This is excellent from a business standpoint because it removes the uncertainty but it may make the factory owner care less about workers' welfare.

For some age groups and personality types, the moral hazard issues can be addressed by introducing a co-pay or large deductible into the insurance. A 20% co-pay implies that 20% of any claim will need to be paid by the insured. The fact that you need to pay Rs20 lakh in a fire damage of Rs1 crore is a sure shot way to make you think about fire safety. A deductible of Rs1 lakh implies that losses over Rs1 lakh will be paid by an insurer. This can be effective, for cost-conscious persons, if deductible levels are set high enough to pinch the insured. This concept is used in health insurance top-up plans. However, the effectiveness there is limited because most buy a separate health insurance to match the deductible amount.

I am not making a case that adding restrictions, exclusions, co-pays or deductibles to insurance are the only solution though they do reduce moral hazard but I do advocate that we, particularly the larger insurers and research agencies, invest in understanding the impact of product design on behaviour. Perhaps, I can still get my friend to lose weight.

(Kapil Mehta is co-founder, www.securenow.in)

TOP

Source

Taking a health insurance cover can protect your wealth – Mint – 4th December 2018

Adversities hit you without a warning. Especially if they are to do with a catastrophic illness. Most people have that one family member who has been diagnosed with a dreaded illness and finds it challenging to manage financially. It is surprising then to hear that almost 44% (according to a report by Vidal Healthcare Services Pvt. Ltd) of India's population is not covered by health insurance. Further the average insurance cover of Rs2 lakh is grossly inadequate to cover the expenses for any large illness. In such situations, people dip into their savings or take loans or sell assets to fund treatments. As per a report by EY, 70% of healthcare spending in 2016 was out of pocket and only 2% was through private insurance, the balance 28% being borne by the government.

With three-quarters of tertiary healthcare being provided by corporate hospitals, it becomes important to have a high health cover, given the high charges by these hospitals and medical inflation of 20% per annum in India. While a surgery costs Rs1.5-3 lakh, the cost of staying in ICU is Rs 50,000 to Rs1 lakh per day. A catastrophic illness (like a transplant) which requires long-term hospital stay, would set you back by Rs 15-20 lakh in a month. Common treatments like dialysis cost Rs 50,000 a month.

Most people are simply unprepared for lifelong treatments. A large hospital that I spoke with mentioned that 30-40% of the patients remain untreated due to financial constraints. Further, many diseases are manifesting early on and the incidence of lifestyle diseases like diabetes or heart-related issues is on the rise among people in their 30s and 40s. According to a report by Vidal Healthcare, all components of medical care costs are expected to grow rapidly with the highest increase in expensive treatments for conditions like cancer, joint disorders, cardiovascular diseases and respiratory disorders. Even people

who have some cover will have to end up dipping into their savings to pay for these expensive treatments.

Most salaried employees are covered by their employers for Rs 2-3 lakh. A common grouse, I hear from HR folks is the fact that employees look at paying insurance premium as a wasteful expense and top-up plans provided by the employer are not taken up. People also tend to drop their cover if they have not made any claims in the past. Unless they have a family member suffer a major illness, they do not consider taking large health covers.

You are never too young to fall ill and your body is your most precious asset, which you need to protect. So start thinking about securing this asset beyond the cover given by the employer. Remember, this is money spent on protecting you and hence it shouldn't be treated as an expense but as a must.

Taking into account the inflation on medical expenses, a large health cover will really help in protecting your wealth as it will pay for your expenses without you having to sell your assets or exhaust your savings. It can also help you pay for the best comfort during a harrowing illness. I have heard from so many people on how they had to choose sharing wards or scrounge on other things because they couldn't afford medical treatment. Finally, having adequate health cover is also part of retirement planning.

So what can you do to optimize your health cover? First, maximise the cover with the employer. If there is a top-up cover available, take that, as it will be cheaper than an individual cover and provides cover without exclusions and waiting periods. Second, take a separate cover for parents.

Third, choose a combination of at least Rs20 lakh health cover and Rs 20 lakh critical illness cover. The health policy will take care of hospitalisation expenses, pre- and post-hospitalisation medicine expenses and other related costs. The critical illness policy will give a lump sum on the diagnosis of a medical condition(there would be waiting period and other conditions applicable), which can be used for further treatment or to take care of expenses excluded in the medical cover. Critical illness policies cover catastrophic illness like cancer, kidney failure, organ transplant, paralysis, bypass, third degree burns, Alzheimer's, blindness and major trauma related to accidents.

Fourth, evaluate a policy on the basis of the premiums, the exclusions, waiting periods, deductibles or co-payment required. You would want to take a policy which has everything covered with a short waiting period (not more than 30 days). For example, some critical illness policies don't cover skin cancer. Fifth, the cost of a Rs 20 lakh family floater and critical illness may be Rs 60,000 per year and upwards. If you think it is a big expense, think of how much you spend every month on one weekend outing or on a shopping expedition or even at the salon.

While one cannot predict one's future health, one can certainly protect wealth to avail the best treatment and facilities.

(Mrin Agarwal is a financial educator, founder director of Finsafe India Pvt. Ltd and co-founder of Womantra)

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Source

INTERVIEW

If 'Mutual Funds Sahi Hai', then health insurance cover 'zaroorihai': Cigna TTK's PrasunSikdar – Mint – 4th December 2018

With exclusions getting standardised in the near term, health insurance is expected to become more inclusive and reduce claim rejection. But the industry faces many more challenges. Prasun Sikdar, managing director and CEO of Cigna TTK Health Insurance, gives an insight into the problems and possible solutions.

What challenges do you see for the health insurance sector in India?
The challenge according to me is how to make health insurance far more sustainable for the overall ecosystem and relevant for the customers.

In spite of making much progress in the last couple of decades, India is still behind the global benchmarks in healthcare. India is facing the threats of lifestyle diseases and existing communicable diseases and also infectious diseases like dengue and swine flu. If you put all this together, India is now holding an overall disease burden of close to 20% of the overall world disease burden. But our population share is around 18%. Therefore, a population of 1.3 billion makes it challenging to make health insurance far more universal. Moreover, our healthcare spend is 4.7-4.8% of GDP, while the world average is close to 9.9%. Then, compared to rest of the world, our out-of-pocket expenses for healthcare is around 65%.

Overall, healthcare expenditure, including spending by individuals in India, in the last year was around Rs7 trillion. During the same period, insurance companies would have paid a claim of Rs30-35,000 crore. So clearly, from a healthcare financing perspective, health insurance is providing around 4-5%. That highlights the relevance of health insurance in India. We need to focus on making it more relevant for a customer by ensuring that you can cover for more of the healthcare expenses of a customer and also making health insurance far more sustainable because insurance companies also want to make a profit.

As a standalone health insurance company, what are your views on the working group report on standardisation of exclusions in health insurance? Will this have a cost impact in terms of higher premiums?
The easy answer is that yes, it will have a cost impact. But insurance is ultimately pooling of risks and law of large numbers has to come into play. For instance, the kind of pricing that we have seen in Ayushman Bharat, whether it will make economic sense, only time will tell. But because the law of large number is playing, and the risk has been pooled, the prices have come down.

The good news is the standardisation of exclusions will make health insurance more relevant. A lot of people are reluctant to buy health insurance today because they are worried that even after paying a premium for 10 years, whether their claim will be paid or not. With exclusions getting standardised, price will not be a parameter to decide. As this trust gets developed, more people will buy more health insurance and, therefore, the law of large numbers will gradually come into play. So initially the prices may go up.

This will also help in making people understand that health insurance zaroorihai (it is necessary). If Mutual Funds Sahi Hai, then health insurance zaroorihai. I say this for three reasons. The first is that it gives you quality healthcare for years to come till the time you live. There is no upper limit of age. The second aspect is that health insurance helps you in protecting your life goals. It is a living benefit product. It prevents you from putting your hand in the bucket of savings that you had kept for a specific purpose like retirement or child's education. And the third aspect is that the regulator has asked health insurance companies to also address wellness and healthy living.

A lot of health insurers provide health insurance without a medical test, even till age 45-50 in some cases. How do you rate this underwriting practice vis-à-vis other markets?
India is different at some levels. In some other markets, you get the cover from day one. We have the waiting period and disease-specific waiting periods. The other issue is that medical tests are also a cost for the insurance company. So the industry, has through data analytics, seen that below or above a particular age the incidences of health claims are going up or down. As India is becoming more healthy, that age is going up. So I think it is good for a health insurance company to constantly look at the data and decide at what point to incur that cost.

The claims ratio, particularly for standalone health insurance companies, is much below 100. But in some developed markets, this might result in insurance companies being made to pay it back to the customers. That might not be the right way to look at it. There are two portfolios you have to look at, one is group and the other is retail. General insurance companies can focus on group business because they can cross-subsidise from other portfolios. But for standalone health companies, we cannot focus on group business because the pricing in the market is not economical. So we concentrate on retail and the claims ratio is

much lower in retail. The reason for this is the waiting period of 2-4 years. So for CignaTTK, we are in the fifth year of operations, a large part of our portfolio is still in that no-claim zone. As the portfolio matures, the loss ratio goes up. And this is true for any health insurance company across the world. So it is not about today's loss ratio, but about the projected loss ratio. Therefore, a standalone health insurance company that has been in business for 10 years, would have a retail claims ratio of around 65%. We are in our fifth year and are at 46%. We will also reach 65%.

While health insurance has become a life-long product, it hasn't been yet simplified to the extent that it becomes easy to explain it to everyone. Why?
One of the reasons why there are question marks on health insurance, apart from the claims experience of people, is the complexity of the products. So while health insurance is regulated, the provider network is not at all regulated. So it is always a battle for a health insurance company to get the right customer making the right claim. That's where Ayushman Bharat will help--in bringing simplicity to health insurance. Today if we do not have the exclusions and waiting period, chances are that a healthy customer will have to pay more premium. While it is pro-customer, it is complex. As the ecosystem gets developed, this simplification will also happen. Already some simplification has happened on the defined benefit critical illness products and personal accident products. But on the hospital side, the ecosystem has to emerge. Also, the standardisation of exclusions will simplify the product.

TOP

Source

INSURANCE CASES

Maternity benefits not just for live births, says consumer court - The Economic Times – 6th December 2018

A private insurance company's contention that maternity benefits are applicable only to live births came under criticism from a city consumer court recently. The judges slammed the firm's decision to deny a Bengaluru techie her policy claim after she had to abort her 23-week twin foetuses.

After a five-year battle by the victim, the court rapped the firm for acting unjustly and ordered full payment and compensation.

Maya (name changed), an employee of Wipro, was 23 weeks pregnant with twins in July 2013 when she went to a Chennai hospital for a check-up. Doctors established she was suffering from severe pre-eclampsia (a pregnant woman could slip into a coma triggered by hypertension) and acute renal failure. With her condition worsening, on July 9, 2013, doctors informed Maya's family that only a medical termination of pregnancy and removal of foetuses could save her life.

Child in its mother's womb is entitled to all rights: Court
With consent from the family, doctors performed the procedure.

A heartbroken Maya underwent treatment and was discharged on July 22, 2013 after paying hospital fee of over Rs 1.5 lakh. An ICICI Lombard General Insurance policy holder through Wipro, Maya submitted the bills to claim refund through the agent, Medi Assist India. To her shock, ICICI paid only Rs 24,313 and disallowed Rs 97,028, terming it "policy excess".

In her complaint to the Bangalore Urban District Consumer Disputes Redressal Forum, Maya said ICICI told her maternity benefits were applicable only to two live births; that she was not admitted to the hospital for delivering babies and her condition was failure of other organs; and that she was treated to save her life and it was for this reason the pregnancy was terminated.

Maya approached the consumer forum on January 29, 2014 against Medi Assist India, ICICI Lombard General Insurance and Wipro.

Medi Assist and Wipro remained ex-parte. ICICI Lombard appeared through its counsel who termed the complaint frivolous, vexatious and an attempt to obtain wrongful monetary gain. The lawyer argued that the complainant was enrolled in a maternity policy and abortions are not covered, even if it is medical termination of pregnancy.

After four years and 10 months, the consumer forum came down heavily on ICICI Lombard, stating childbirth doesn't indicate living or dead child. It is a settled proposition of law that a child in its mother's womb is entitled to all rights, including property. Therefore, repudiation of money in this case where foetuses were expelled is unjust, arbitrary and illegal, the judges said. The court on November 17 ruled ICICI Lombard, Medi Assist and Wipro are liable to pay pending medical expenses of Rs 97,028 with a compensation of Rs 5,000 to the woman within four weeks. They were ordered to pay Rs 3,000 towards her court expenses.

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Insurance firm penalised for refusing death claim - The Tribune – 6th December 2018

The District Consumer Disputes Redressal Forum has directed Life Insurance Corporation of India (LIC to pay Rs 9 lakh to the husband of KamleshKumari, who had purchased a life insurance policy from it but died in 2016. As per information, the wife of the complainant had obtained a life insurance policy (No.133960025) under Plan 'B' LIC's BimaBachat for a period of nine years for sum assured Rs 30,00,939 on January 30, 2013. But she died on November 26, 2016, due to a heart attack.

The complainant said he paid a single premium of Rs 30,00,939 to the insurance company and the maturity value on the expiry of the term or in the event of contingency of a pre-mature death before the term payable was Rs 40,00,3000.

Mehar Chand, the complainant, said he had submitted relevant documents to the company but it declined the death claim, stating that the deceased did not disclose in the proposal form about her ailment of HTN, DM Type-II and got the policy by misrepresentation.

The firm through its counsel argued that the deceased was suffering from the above said disease for the past 27 years and did not disclose her ailment at the time of taking the policy. The company in its reply to the forum also said the company had already paid an amount of Rs 30,00,939 as per the policy condition and the remaining allegations, as made in the complaint, are false and the complainant was not entitled for any claim.

The forum said the documents produced by the company to establish the previous ailment to the insured diseased, wherein no doubt, the diagnosis have been mentioned as HTN, DM Type-II, but the date these diseases were liquidated to the doctor was June 4, 2016, when the insured was admitted to the hospital and discharged on June 11, 2016, whereas the commencement of the policy was January 3, 2013.

Hence, the claims of the firm that the victim was suffering from HTN, DM Type-II, were declined as it failed to provide any valid document for the same. Meanwhile, KC Malhotra, advocate of the complainant, through valid certificates issued by Vasal Hospital proved that KamleshKumari was diagnosed with the disease in May 2014. However, the insurance firm, by presenting the facts of the discharge summary of the hospital, was trying to manipulate the facts and denied the claim on baseless grounds, he added.

The forum after verifying documents presented by both parties said: "The complainant has been wrongly and illegally repudiated by the insurance firm. Instead of repudiating the claim, it must have clarified all things from the hospital, hence, the company is directed to pay the remaining amount of Rs 9,00,061 with interest at 12 % and further directed to pay Rs 20, 000 compensation for mental and physical harassment and litigation expenses of Rs 10,000."

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IRDAI CIRCULAR

Report of Working Group on new standard on Insurance Contracts (equivalent to IFRS 17) alongwith Annexures is available on IRDAI website.

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Insurer wise list of life insurance products launched / modified in the financial year 2018 - 19 is available on IRDAI website.

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List of corporate agents registered with the authority as on 30th November 2018 is available on IRDAI website.

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IRDAI issued Exposure Draft on IRDAI (Registration of Insurance Marketing Firm) Regulations, 2018

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Gross direct premium underwritten – Non Life for and upto the month of October, 2018 is available on IRDAI website.

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GLOBAL NEWS

Global: Moody's says outlook stable for life market over next 12-18 months – Asia Insurance Review

The outlook for the global life insurance sector is stable, reflecting a favourable economic cycle and strong capital levels, says Moody's Investors Service in a report published yesterday.

Global life insurers have adapted to persistent low interest rates better than expected by exchanging sales of interest-sensitive products for fee-based retirement, savings and health products, says the report titled "*Life Insurance -- Global 2019 Outlook: Stable -- reflecting favourable economic cycle and strong capital*".

"Rising interest rates in some regions, such as the US and Canada, have been positive credit drivers," said ManojJethani, a Moody's vice president. "However, there is marginal re-risking of investment portfolios, with a gradual move towards lower quality and less liquid assets, such as private credit and alternatives."

Overall, the balance sheets of global life insurance companies are healthy and capital levels are expected to remain robust in 2019, although some challenges lie ahead. Specifically, RBC ratios are expected to decline in the US due to the impact of tax reform, although this should not affect the credit profile or ratings in the region. UK and Japanese capitalisation is expected to remain solid, although any financial market volatility in the UK as a result of Brexit remains an area of focus.

In China, the capitalisation of life insurers remain solid, while the refinement of C-ROSS will be beneficial for the insurance industry.

Moody's outlooks consider the forward-looking assessment of fundamental credit conditions that will affect the creditworthiness of the sector for the next 12-18 months.

The report highlights the following key themes for the global life sector:

- Continued favourable global economic growth should fuel more demand for life insurance products over the next 12-18 months
- Interest rates will likely rise gradually, but will still weigh on life insurers' profits; However, most are adapting through changes to product mix, but some regions, e.g. in Germany, will face solvency pressures
- Emphasis on risk management and rising equity markets have buoyed legacy blocks of business. Expect to see even more M&A activity in 2019.
- Asset risk is rising, with increasing exposure to late-cycle corporate debt risk and illiquid investments, such as alternatives and private credit
- Regulatory trends are mixed and create uncertainty, but are still manageable
- Technology and innovation is enabling insurers to reduce costs and improve efficiency while deepening customer relationships.

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Indonesia: Insurers cut non-life growth estimate – Asia Insurance Review

The Indonesian General Insurance Association (AAUI) has lowered its double-digit growth estimate for non-life insurance premiums for this year to single digit, that is, to less than 10%. Previously, AAUI had predicted that the total premium growth by the end of 2018 could be at least 10%. This expectation was due to seeing gross premium expand in the first semester by 11% compared to the corresponding period last year.

The correction is in line with Finance Minister Sri MulyaniIndrawati's forecast that the Indonesian economy would grow by 5.17% this year, sliding from the target of 5.4% set by the government in the 2018 state budget, reported *Bisnis*.

Based on general insurance industry audited reports, the sector last posted two-digit gross premium growth in 2014 when the sector expanded by 20.22%. After that, general insurance premiums increased 7.16% in 2015, 5.09% in 2016, and 2.27% in 2017.

The growth of the general insurance market is strongly influenced by growth in the property and motor business lines. Data for the third quarter of this year show that the two business lines contributed 54.2% to the total general insurance market.

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