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QUOTE OF THE WEEK

"When we do the best that we can, we never know what miracle is wrought in our life, or in the life of another."

Helen Keller

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INSURANCE TERM FOR THE WEEK

Premium Paying Term

Definition: Premium paying term is the total number of years for the policy holder to pay the premium.

Definition: Policy term is normally equal to the premium paying term. However, some insurance policies give the insured the autonomy to choose a premium paying term lower than the policy term. For instance, insurers allow the insured to get the insurance benefits even if they stop the premium payments after a stipulated period of time by converting the normal insurance policy into a paid up policy.

Here the sum assured will be calculated by using the formula.

(Total number of premiums paid/Total number of premiums payable) X Sum Assured + vested bonus (if any)

Source

INSURANCE INDUSTRY

RBI tells banks to cap stake in insurance companies at 30% - Mint – 27th December 2019

The Reserve Bank of India has asked lenders to cut their stakes in insurers to 30%, as the banking regulator attempts to shield banks from risks arising out of their non-banking businesses and steer focus to boosting credit growth in a slowing economy, four people with direct knowledge of the matter said.

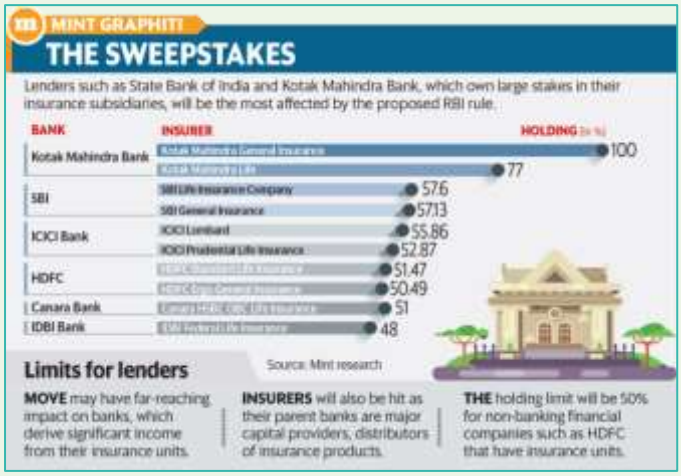
RBI informed the bankers in a meeting last week that it will soon introduce rules to cap their holdings in an insurance company to 30%, the people said, requesting anonymity as the matter is confidential. The holding limit will be 50% for non-banking financial companies such as Housing Development Finance Corp. that have insurance units, they said. Banks have been told to await RBI's official communication on the new rules.

The move is likely to have far-reaching impact not only on banks, which derive significant income from their insurance units, but also on the insurers themselves as their parent banks are major capital providers and distributors of insurance products. State Bank of India, ICICI Bank Ltd and Kotak Mahindra Bank will be among the lenders to be affected by the decision.

"The 30% capping rule is meant to safeguard banks from capital risks arising from non-core businesses. But the new RBI rule, which is likely to come into effect some time in fiscal 2021, will create a huge supply of equities in the market when the banks slash their stakes. It is to be seen if the market has an appetite to absorb such large amount of liquidity," said the first of the four people. The rule is likely to be implemented in a phased manner, the person added.

"RBI is asking us to rather use the money for credit growth. RBI is suggesting banks to increase Tier 1 networth," said the second person. "There should not be much of a problem as some of the insurance firms are listed. We (as a bank) have to give a roadmap to RBI as in when we will bring down stake to 30%. We have asked for five years but they (RBI) will not give five years. They may say three."

Current regulatory norms mandate that a bank can hold a maximum of 50% in an insurance venture but the regulator may allow them to hold more on a case-to-case basis.



In the life insurance space, ICICI Bank owns 52.87% in ICICI Prudential Life Insurance Co. Ltd; Kotak Mahindra Bank holds a 77% stake in Kotak Mahindra Life Insurance Co. Ltd; and State Bank of India owns 57.6% in SBI Life Insurance Co. Ltd. Home financier HDFC holds 51.47% in HDFC Standard Life Insurance Co. Ltd.

Among general insurers, HDFC holds 50.49% in HDFC Ergo General Insurance Co.; ICICI Bank holds a 55.86% stake in ICICI Lombard General Insurance Co. Ltd; Kotak Mahindra Bank holds 100% in Kotak Mahindra General Insurance; and State Bank of India holds 57.13% in SBI General Insurance Co. Ltd.

“Banks are the major distributors of financial products especially life insurance. Any reduction of stake by sponsor banks in these institutions may have negative impact on the distribution capabilities as well as general public perception about these institutions they enjoy because of parentage. This issue may impact the prospective investor sentiment also," said Ashutosh Mishra, head of research, Ashika Stock Broking.

In any insurance business, whenever capital infusion takes place, all promoters need to put in money as per the proportion of their shareholding. If even one of the promoters is unable to put in money as per their shareholding, the capital infusion process fails. This can stifle the growth of the insurer.

“RBI is concerned that such capital contributions commitments may hurt the bank and exposes it to higher risks. This is why RBI wants to cap bank’s holding in insurance firms," said the first person.

The second person said RBI doesn’t want banks to own insurance, asset management and NBFC businesses.

“Over a period of time, RBI wants to reduce the holding cap to 30% or below 10%," said the second person.

Insurance is a capital-guzzling business, which needs regular capital infusions as it grows. Mutual fund businesses also have been growing steadily but new norms related to penetration of AMCs into locations beyond top-15 cities, require additional growth capital.

The NBFC business has been shrinking after the IL&FS debacle last September and a subsequent liquidity crisis. Any turnaround in the NBFC business or even to keep the NBFC afloat, albeit with losses until the credit situation improves will require a lot of capital.

In all these businesses, wherever banks are parent companies, capital outflow will be from the bank’s books, which will weaken the bank’s own core business.

While RBI plans to limit the holding of banks in insurance at 30%, in order to ensure that insurance companies do not face growth constraint due to the ceiling on bank’s holding, the Insurance Regulatory and Development Authority of India, or Irdai, last week proposed an increase in FDI in insurance from 49% to 74%. If this proposal is enacted in the Parliament, foreign joint venture partners in insurance will be able to infuse more capital in the company whenever growth plans are drafted.

To be sure, RBI has been attempting to recalibrate banks’ holding norms to safeguard them from external risks for some time. In May 2011, an RBI working group recommended a holding company structure for

banks. It said all new banks and insurance companies will mandatorily need to operate under the financial holding company (FHC) framework and intermediate holding companies within the FHC should not be permitted. Under the holdco norms, a bank had to unwind its shareholding in subsidiaries and the existing shareholding of the bank in its units were to be transferred to the holdco.

According to the working group, the holdco was supposed to be regulated either by RBI itself or by a new regulator. The group had said it was necessary to put in place some limit on the expansion of non-banking businesses after the existing financial groups, dominated by banks, migrate to the holding company structure. However, the holdco proposal has now been scrapped due to its complexities, according to the three people cited above.

(The writers are Anirudh Laskar and Gopika Gopakumar.)

TOP

Source

Bar set high for insurance sandbox play - The Economic Times – 26th December 2019

Rejections await many of the 150-odd insurance and fintech applicants that are keen to participate in the sandbox project of India's insurance regulator, regional precedents show.

In Singapore, the rejection rate for the regulatory sandbox project was as high as 90%, and the Insurance Regulatory and Development Authority of India (Irdai) may have a similar rejection rate for these applications, sources aware of the scrutiny standards told ET.

"More than 150 applications have been submitted to IRDAI, with solutions ranging from distribution-side innovation to marketplace models," said a person with knowledge of the matter. "However, given the high-risk factor of testing these products on a live audience, the acceptance rates could be on the lower side."

The insurance sandbox project will allow insurers and technology companies to collaboratively experiment with new products and technology on a live audience under supervision of the regulators. The exercise has been designed primarily to help the regulator gauge real-life implications of the commercial use of new technologies before giving them the regulatory nod for commercial launch.

"If you look at the Monetary Authority of Singapore's sandbox, the rejection rates were almost 90%; just 7 of the 67 applications that were submitted to them made the cut," said the source cited above. "There are several matters to consider before applications are accepted."

These applications are currently being reviewed by an eight member panel headed by IIIT Bangalore director S Sadagopan, the insurance regulator had said in a statement in October. Irdai didn't respond to ET's mailed queries. The Reserve Bank of India (RBI) and the Securities and Exchange Board of India (Sebi) also announced working guidelines for their respective sandbox programmes.

The three sandboxes are aimed at creating an environment of easier regulations for testing new product-based and technology-based innovations. IRDAI had said earlier that it was keen to test out ideas based on both product and technology, such as mobile application services, data analytics, blockchain, API integrations, artificial intelligence, digital KYC, smart contracts, cybersecurity products and online market places.

The writer is Ashwin Manikandan.

TOP

Source

LIFE INSURANCE

Life insurance companies embraced technology and launched creative online products in 2019 - Industry Global News24 – 25th December 2019

Life insurance companies concentrated on security strategies embraced technology and launched creative online products in 2019. The regulator has also concentrated on the welfare of policyholders, which has helped both consumers and industry.

New Business Premium— the industry's lifeline — has risen to Rs 1.7 lakh crore 37 percent year-on-year by November this year. Financial savings in households also changed in favour of financial savings. This year until November, the Individual Annualized Premium Equivalent (APE) rose by 17 per cent.

Insurance is an important tool for long-term savings as insurance is distributed about 17 per cent of total financial savings in households. India's Insurance Regulatory and Development Authority (Irdai) has introduced changes for lapsed policies in the filing of new or modified products, increased surrender values and relaxed survival periods. Innovative solutions can be analyzed and reviewed by the regulatory sandbox initiative.

The use of technology has influenced the design of the product and has contributed to sales and claims performance. Online sales make up an estimated 16 per cent of the total premiums. A study by JM Financial says about 35% of total renewal premiums are charged online in life insurance, while the offline mode is the most used during the first premium payment.

Digital insurance has made buying a life insurance policy easy, allowing for quicker policy delivery and efficient settlement of claims. Because life insurance is price-sensitive in India, a potential policy buyer finds price to be an important factor as online products are cheaper than offline ones.

Here are some of the regulator's main initiatives this year.

Surrender, annuity standards: There will be guaranteed surrender interest for all protection-oriented non-linked goods. If the fee is charged for two consecutive years, a fixed surrender interest will be received by the program.

When lost during the policy's second year, it will be 30 per cent of the total premium paid less any survival benefits already received. It will be 35 per cent of the total premium paid, less any protection incentives, if the policy is abandoned during the third year. If surrendered between the fourth and seventh year, the cumulative premium paid will be 50%. If it is lost during the policy's last two years, so 90% of the premium paid will be returned to the policyholder.

Faster claims process: Irdai provided a circular request to insurers to notify policyholders at different stages of processing of claim settlement status and to provide policyholders with an opportunity to receive payment of claims in instalments under certain plans, such as personal accident and benefit-based health insurance cover.

In the case of health insurance, where the third-party administrator is engaged in the provision of claims services, insurers must ensure that claim status is reported to the claimant at each claim time.

Plain-vanilla policies: a master circular for point of sale goods and life insurance persons was issued by the regulator. (LI-POSP). The plans will be plain-vanilla life insurance policies where, at the time of sale itself, each benefit is pre-defined and reported in advance and is easy to understand. Only term insurance

policies with or without premium return will be the type of products offered by POS-Life. We will sell with fixed benefits non-linked non-participating endowment policy, immediate annuity products, and non-linked non-par insurance products.

TOP

Source

Life insurance: Customer-friendly norms, better products in 2019 - Financial Express – 24th November 2019

The year 2019 saw life insurance companies focusing on protection solutions, embracing technology and launching innovative online products. The regulator, too focused on policyholders' interest which benefitted both customers and the industry.

New Business Premium—the lifeline of the industry—has grown 37% year-on-year to Rs 1.7 lakh crore till November this year. Household financial savings has been shifting in favour of financial savings. Individual Annualised Premium Equivalent (APE) has grown 17% this year till November.

Insurance is an important instrument for long-term savings as around 17% of incremental household financial savings are allocated to insurance. The insurance regulator has taken a steps to make products focused on policyholders' interest. The Insurance Regulatory and Development Authority of India (Irdai) has introduced changes in filing new or modified products, enhanced surrender values and relaxed survival period for lapsed policies. The regulatory sandbox initiative enables insurers to evaluate and test innovative solutions.

Digital in focus

The use of technology has impacted product design and has led to efficiency in sales and claims. Online sales contribute an estimated 16% of the overall premiums. A report by JM Financial says that in life insurance, while offline mode is the most used during the first premium payment, around 35% of total renewal premiums are paid online.

Digital insurance has made the purchase of a life insurance policy simple, enabling faster processing of policies and efficient claim settlements. As life insurance in India is price-sensitive, a potential policy buyer does consider price to be an important factor as online products are cheaper than the offline ones.

Here are some of the key initiatives taken by the regulator this year.

Surrender, annuity norms

All protection-oriented non-linked products will have guaranteed surrender value. If the premium has been paid for two consecutive years, the policy will acquire a guaranteed surrender value. It will be 30% of the total premium paid less any survival benefits already paid, if surrendered during the second year of the policy. In case the policy is surrendered during third year, it will be 35% of the total premium paid, less any survival benefits. If surrendered between the fourth and the seventh year, then it will be 50% of the total premium paid. In case it is surrendered during the last two years of the policy, then the policyholder will get back 90% of the premium paid.

Faster claims process

Irdai has issued circular asking insurers to inform claim settlement status to policyholders at various stages of processing and give policyholders an option to receive payment of claims in installments under certain policies such as personal accident and benefit-based health insurance covers.

In case of health insurance, where third-party administrator are engaged for rendering claims services, insurers have to ensure that status of claim is notified to the claimant at every stage of claim.

Plain-vanilla policies

The regulator has issued a master circular for point of sales products and persons for life insurance. (POSP-LI). The products will be plain-vanilla life insurance policies where each benefit is predefined and disclosed upfront at the time of sale itself and is easy to understand. The category of products that will be offered by POS-Life will be pure term insurance products with or without return of premium. They can sell non-linked non-participating endowment product, immediate annuity products and non-linked non-par health insurance products with fixed benefits.

Regulatory sandbox

In order to experiment with innovative approaches including fintech solutions, Irdai has created a regulatory sandbox. It will provide flexibility in dealing with regulatory requirements and focus on the core issue of policyholder protection. The sandbox approach will also help to strike a balance between development of the insurance sector and protecting the interest of policyholders. An applicant wanting to promote any innovation in insurance will have to demonstrate to Irdai that it will help increase insurance penetration and provide enhanced services to the policyholders. Irdai may consider granting limited regulatory relaxation to the proposal that promotes innovation in insurance.

(The writer is Saikat Neogi.)

TOP

Source

Insurance cover, regularization, PF lined up: Sops for Safai Karamcharis in Kashmir - The Kashmir Monitor – 22nd December 2019

Safai Karamcharis have a reason to rejoice as Jammu and Kashmir government is all set to implement National Commission for Safai Karamcharis Act in the Union Territory in a bid regularize the unsung heroes of cleanliness and bring them under insurance cover.

Official figures reveal that there are 3300 Safai Karamcharis in Srinagar alone, of whom only 1600 are regular employees while rest are daily wagers.

"For the first time, there will be an organization that will work for the welfare of Safai Karamcharis of Jammu and Kashmir," said an official of Srinagar Municipal Corporation (SMC).

Chairman, Safai Karamcharis Union, Ghulam Mohammad Solina said they have been facing step motherly treatment from the government for years. "Government has always neglected us. There is not a single scheme for the welfare of Safai Karamcharis in J&K," he said.

Solina said Safai Karamcharis work 365 days without taking day off. "We face acute manpower crunch. We are overburdened with work. Plus we receive meager salaries. Our daily wagers receive their salaries after four months delay," he said.

Solina however pinned hope on National Commission to redress their grievances. "The Commission will work for the betterment of Safai Karamcharis," he said.

National Commission for Safai Karamcharis Act has recommended specific programmes of action towards the elimination of inequalities in status, facilities and opportunities for Safai Karamcharis under a time-bound plan.

"Study and evaluate the implementation of the programmes and schemes relating to the social and economic rehabilitation of Safai Karamcharis and make recommendations to the Central, State and UT

Government for better co-ordination and implementation of such programmes and schemes," the Act reads.

Chairman, National Commission for Safai Karamcharis, Manhar ValjibhaiZala told The Kashmir Monitor that they are planning to visit Srinagar in the first week of February to conduct a survey in the Union Territory.

"We will pass the direction to constitute Commission in the new UT. Due to Article 370, the Act was not implemented in J&K and with the result Safai Karamcharis faced many problems", he said.

During a visit to Srinagar in June this year, a team of National Commission for Safai Karamcharis found that certain laws pertaining to Safai Karamcharis were being violated with impunity.

Zala, who was heading the team, found that the provident fund of Safai Karamcharis is not deducted from the salaries, which is a violation of labour laws.

The Commission also learned that there is no life insurance policy specifically meant for Safai Karamcharis. Plus there was no departmental medical check-up conducted on Safai Karamcharis.

(The writer is Bisma Bhat.)

TOP

Source

One size does not fit all in life insurance – The Hindu – 22nd December 2019

How most people come to the conclusion that Rs1 crore cover is enough, is by calculating that if the family deposits Rs1 crore in a bank account that earns 7 percent interest, it will fetch them a monthly income of rs58,333. To them, the amount is enough to sustain the expenses of an average middle-class Indian household. Calculations of most industry experts suggest that if the policyholder has a loan and is also parent to two kids, the Rs1 crore received on the death of the policyholder will not sustain the family for more than 10-12 years.

Unfortunately, most Indians buying life insurance policy are under-insured! No doubt, despite the demand for pure protection term plans having increased considerably in the last few years, the disparity in life protection in India is still as high as 92 percent. Attributing low awareness around adequate coverage for this massive disparity would not be wrong. Technically, an individual's life cover should be strictly based on his/her stage of life.

(The writer is Santosh Agarwal.)

TOP

Source

Different GST rates are applicable to different life insurance plans – Mint – 22nd December 2019

When buying an insurance policy, it's important to look at the various costs. Apart from the costs specific to insurance such as mortality cost, you also need to pay goods and services tax (GST). However, you may not find this information displayed prominently in advertisements.

Keep in mind that this will be an added cost at the time of buying a policy.

Different rates
Different rates of GST are applicable to different types of life insurance policies.

GST of 18% is charged on term policies, which are the cheapest form of insurance as they only carry the mortality cost. So, if your annual premium for a term plan is ₹5,000, know that ₹900 of this is going towards GST. If you have opted for an add-on such as an accidental death benefit (for additional payout in case of death due to an accident), you will have to pay GST of 18% on the additional premium charged for the rider.

The GST rate for unit-linked insurance plans (Ulips) is 18% as well and it applies on all the cost heads, including the premium and fund management charges. Your Ulip premium partly goes towards insurance and partly towards investment. GST is not charged on the money invested net of costs.

In the case of traditional policies, which bundle insurance and investment, GST is levied at 4.5% on the first-year premium and 2.25% on premiums for subsequent years. So, out of an annual premium of ₹10,000, ₹450 will go towards GST in the first year and ₹225 in subsequent years.

In case of insurance pension plans or annuities, where you pay a lump sum and receive an annual income in return, GST of 1.8% is applicable. In this case, if you pay a lump sum of ₹10 lakh to get an annual income of ₹80,000, the GST component of the purchase cost will be ₹18,000.

How this compares
With mutual funds: Though mutual funds also charge GST, it comes under the overall cap of expense ratios stipulated by the Securities and Exchange Board of India. For instance, the cap for equity funds is 2.25%. Also, MFs' lower-cost structure reduces the cascading effect of GST—since the tax is a percentage of the costs, the lower the costs, lower is the GST.

With National Pension System (NPS): NPS also charges GST but given the extremely low caps (fund manager fees is at 0.01%), the effect is marginal. Also, if you buy annuity under NPS, which is typically done after maturity, there is no GST deduction, unlike in insurance plans.

You must consider GST costs, particularly in policies that have an investment component. Remember, this cost will weigh down your returns.

(The writer is Neil Borate.)

TOP

Source

Telling numbers | Snapshots of the insurance sector: little change in a year – The Indian Express – 21st December 2019

The insurance density of the life insurance sector in 2018 was $55, unchanged from the life insurance density of the previous year, the annual report of the Insurance Regulatory and Development Authority of India (IRDAI) for 2018-19 released this week, shows. Life insurance penetration for 2018 was 2.74%, slightly lower than the 2.76% of 2017.

Insurance density is measured as the ratio of premium (in US dollars) to the total population; insurance penetration is measured as the ratio of premium (in US$) to GDP (in US$). Insurance density and insurance penetration indicate the level of development of the insurance sector.

INSURANCE PENETRATION AND DENSITY IN INDIA

	Life		Non-life	
Year	Density (US$)	Penetration (%)	Density (US$)	Penetration (%)
2001	9.10	2.15	2.40	0.56
2002	11.70	2.59	3.00	0.67
2003	12.90	2.26	3.50	0.62
2004	15.70	2.53	4.00	0.64
2005	18.30	2.53	4.40	0.61
2006	33.20	4.10	5.20	0.60
2007	40.40	4.00	6.20	0.60
2008	41.20	4.00	6.20	0.60
2009	47.70	4.60	6.70	0.60
2010	55.70	4.40	8.70	0.71
2011	49.00	3.40	10.00	0.70
2012	42.70	3.17	10.50	0.78
2013	41.00	3.10	11.00	0.80
2014	44.00	2.60	11.00	0.70
2015	43.20	2.72	11.50	0.72
2016	46.50	2.72	13.20	0.77
2017	55.00	2.76	18.00	0.93
2018	55.00	2.74	19.00	0.97

Source: Swiss Re, Sigma, Various Issues via IRDAI Annual Report 2018-19

The IRDAI report notes that the insurance density of the life insurance sector rose steadily from $9.1 in 2001 to $55.70 in 2010, and thereafter fell for three years to reach $41 in 2013 before rising again. Life insurance penetration increased from 2.15% in 2001 to 4.60% in 2009, and has thereafter showed a generally decreasing trend.

There was a slight increase to 2.72% in 2015 from 2.60% in the previous year, and penetration, after holding steady at 2.72% in 2016, increased in 2017.

LIFE, NON-LIFE INSURANCE PREMIUM, 2018

(In $ billion)

Region/Country	Life	Non-life	Total
Advanced markets	2,231.35 (54.61%)	1,854.79 (45.39%)	4,086.14
Emerging markets	588.82 (53.19%)	518.27 (46.81%)	1,107.09
Asia Pacific	1,092.85 (64.95%)	589.66 (35.05%)	1,682.51
India	73.74 (73.86%)	26.10 (26.14%)	99.84
World	2,820.18 (54.30%)	2,373.05 (45.70%)	5,193.23

Figures in parentheses are share of the segment.

Source: Swiss Re, Sigma 3/2019 via IRDAI Annual Report 2018-19

NEW INDIVIDUAL POLICIES ISSUED BY LIFE INSURERS, FY2018-19

(In lakh)

Insurer	2017-18	2018-19
LIC	213.38 (5.99%)	214.04 (0.31)
Private sector	68.59 (8.47%)	72.44 (5.61%)
Total	281.97 (6.58%)	286.48 (1.70%)

Figures in parentheses are growth over the previous year

Source: IRDAI Annual Report 2018-19

The insurance density of the non-life insurance sector has risen from $2.4 in 2001 to $18 in 2017 and to $19 in 2018. The non-life insurance penetration has risen from 0.56% in 2001 to 0.97% in 2018, shows the report.

Source

TOP

Guaranteed Investment Plan: Is it wise to pay Rs 1 lakh for 5 years to get Rs 1.5 lakh annually? - Financial Express – 20th December 2019

Who will not wish for a fixed and a guaranteed income by investing some money? As an investor, if one is asked to invest today and get the returns or guaranteed benefits at a later date, the offer seems to be very tempting. Generally, life insurance companies offer such guaranteed return plans that come with a guaranteed flow of income in the later years after paying a certain amount in the initial few years. Sample this – Pay Rs 1 lakh for 5 years and after five years start getting Rs 1.5 lakh for another 5 years! Or this – Pay Rs 1 lakh for 5 years and get Rs 10 lakh at the end of 15 years! There are several guaranteed return life insurance plans with a varying structure providing a guaranteed income to the policyholder.

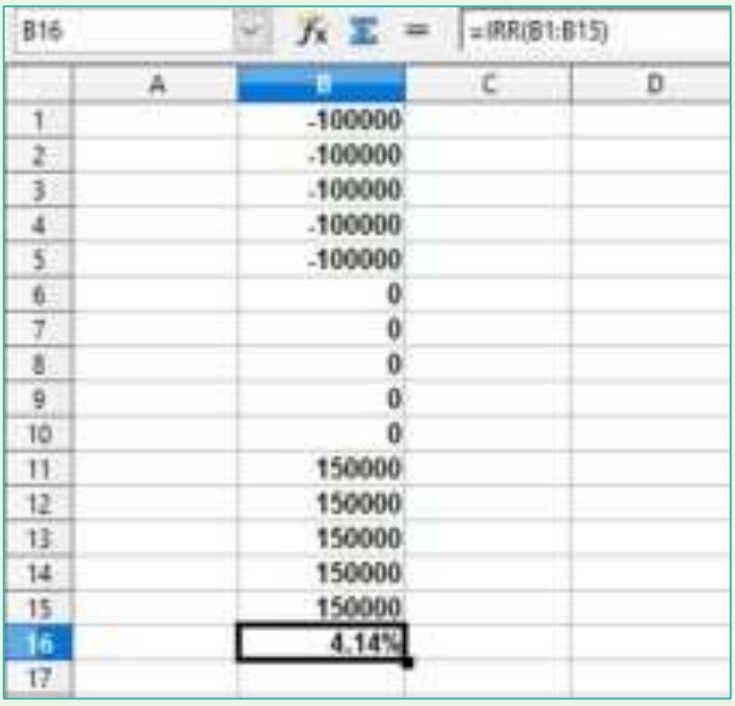
Without getting into the calculation part, for most investors, these are high return plans. For some, these plans are at least helping them to save for their long term needs and assuring them of a regular income. Nothing wrong in such plans, however, as an investor one needs to be aware of the effective returns or the in-hand returns or the annualised returns on the premium paid each year. Even the best guaranteed income plan will not have returns higher than 7 per cent over a long duration.

The returns in a life insurance policy can be calculated by using the formula of Internal Rate of Return (IRR). As the inflows or the survival benefits are not regular while the outflows a premium may not be for every year, IRR helps in arriving at an annualised return giving a rough estimate of the return to the policyholder.

One can use the excel sheet to calculate the return in a life insurance policy.

Here, we take a simple example of an endowment plan in which one has to pay Rs 1 lakh for 5 years and will get Rs 1.5 lakh from the 10th to the 15th year.

- Open a excel sheet
- Enter the premium figures as a negative figure as premium is an outflow. In the table below, Rs 100000 is shown as a negative figure for 5 years. (B1 to B5)
- Enter the amount that you will receive (Rs 150000) as a positive figure from the cell. (B11 to B15)
- In the cell below, enter the formula for IRR
- =IRR (B1:B15)
- On pressing Enter Key, the result will be shown.



	A	B	C	D
1		-100000		
2		-100000		
3		-100000		
4		-100000		
5		-100000		
6		0		
7		0		
8		0		
9		0		
10		0		
11		150000		
12		150000		
13		150000		
14		150000		
15		150000		
16		4.14%		
17				

Being insurance plans, there is a death benefit in them in which the sum assured and the bonuses or guaranteed additions are paid to the nominee.

The returns from the life insurance plan either in a bonus based plan or a guaranteed plan are around 6 per cent. In the case of guaranteed plans, there is a cost of providing a guarantee and hence returns may even be lower. For younger age, the return is more than returns for older age. The returns are, however, tax-free in nature. Such plans suit those who need a fixed and assured amount on maturity and will not want to take any risk with their savings. And once purchased, make sure to run them till maturity as any exit before maturity will be very costly in life insurance plans.

(The writer is Sunil Dhawan.)

TOP

Source

Life Insurance: What has changed during the year and how it affects you - The Economic Times- 20th December 2019?

The Insurance Regulatory and Development Authority of India's (IRDAI) primary aim is to prevent the mis-selling of products. Keeping up with its objective this year, IRDAI has announced a slew of changes to the non-linked as well as linked products offered by the Life Insurance Companies in India. Let's have a look at how these changes would affect the policyholders and prospective buyers.

Life insurance products are often the most mis-sold ones in the entire bouquet of investment products. The products, if not properly understood, can sound complicated. This further adds to the risk of mis-selling. To keep this risk in check, the insurance regulator has been introducing various guidelines and changes during the year.

Recently, the Insurance Regulatory and Development Authority of India (IRDAI) has further simplified both traditional and unit-linked insurance products (ULIP) products offered by life insurers. These changes are going to impact life insurance products like term, endowment, ULIP and pension plans, and will end up becoming more beneficial to the customers at large.

These changes can be broken down into three parts: *suitability information, product structure and pension plans.* Let's take a look at the changes that have taken place.

1. Changes in the pre-application process requiring suitability information: Under this directive, life insurance companies, agents, and intermediaries are to collect suitability information like age, income, family status, life stage, financial goals and insurance plans already bought. This information has to be collected from every prospective buyer and then only can a product recommendation be made. This directive will not apply to pure term and pure health insurance products.

For ULIPs, there should be a clear indication of how the premium paid is utilised towards charges or from the fund balance, and the balance fund at the end of the first year and subsequent years.

This is an important step because if the customer's background, goals and expectations are not understood, the perfect plan and right fund allocation cannot be advised by agents or intermediaries. The regulator has made the right decision in making it mandatory for insurers and intermediaries to first understand the customer's profile, and his needs and goals, before advising any specific investment plan to them.

2. Changes in life insurance product structure

Reduction in Life Cover: The minimum life cover amount has now been reduced from the current 10 times the annual premium till the age of 45 years and seven times the annual premium for age above 45

years, to seven times the annual premium across all ages for regular and limited premium payment plans. The sum assured to be offered under single premium products would continue to be 1.25 times the single premium.

People, who already have adequate term insurance cover and are now looking at life insurance products as an investment option, can now get better returns from their investments. The benefit of reduction in the sum assured would be more visible as a benefit in ULIP products, as the mortality charges would come down and more amount would be available for utilization towards their chosen funds.

It is also important to know that it's not mandatory to buy a policy with the minimum sum assured of seven times. You can go for a higher sum assured, thereby, you would not be worried about the tax benefits going away as the tax benefits outweigh the mortality rates.

Direct ULIP rider premium payment: Previously, the rider cover expenses were recovered by cancelling units from the policyholder's unit balance. Insurers can now collect the premium towards the rider attached to ULIP either as a rider charge or directly through a level rider premium. This will help policyholders get better visibility on their investment.

Smaller waiting period for acquiring surrender value: Policyholders can now surrender non-linked traditional insurance plans in a time-frame of two years instead of three. This change will help people drop out from plans prematurely in case they have second thoughts or need the money urgently. However, you must be careful and understand whether such plans meet your financial goals before investing.

Higher revival period: The revival period available under a life insurance plan has also been increased. Before the new regulations came into effect, policyholders could revive their policies within a period of 2 years from the date of the last unpaid premium. Now, as per the new guidelines, ULIP can be revived within a period of three years, while non-linked insurance (traditional) plan can be revived within a period of five years from the date of the first unpaid premium.

Option of paying reduced premium: While taking life insurance plans is a long-term financial commitment to invest, there can be an instance when an investor is unable to make the payment due to a financial crunch. Earlier, the policy holder had to either pay the entire amount committed or lapse the policy till the money is available.

This had resulted in huge losses of hard money to policyholders. The regulator has now introduced the flexibility to reduce their premiums after five years of term. Through this flexibility, a policyholder can reduce their premiums by 50 percent after the fifth policy year and keep themselves covered at the same time.

3. Changes in pension plans:

Choice in buying annuities: Pension policyholders now have an option of buying an annuity plan from the maturity proceeds of their pension plan, from any of the life insurers. With this liberty, policyholders are now free to choose a good annuity plan that provides better returns to them from the open market.

Higher equity investment for ULIPs: Policyholders now have an option to forgo the assured benefit offered on the pension products, and invest more in equity funds, to generate more returns by the time they retire. This change will help revive the demand for pension plans that have seen a great slump in the past years.

Increased commutation value: In older pension plans, the policyholder could commute only up to one-third of the policy proceeds, while the remaining amount had to be compulsorily utilised for buying an annuity plan. The new changes will now provide a policyholder with 60 percent of their maturity benefit for commutation.

Along with these changes, the regulator has also stressed on providing agents and intermediaries proper training, so that they have a sound understanding of equity markets, including the risks involved before

they advise policyholders. This will greatly improve the customer experience as all the pieces of information, doubts, queries would be solved before buying a life insurance plan.

(The writer is Mahavir Chopra.)

Source

TOP

GENERAL INSURANCE

For non-life insurers, year 2020 is going to be year of digital – Moneycontrol – 26th December 2019

It has been an exciting 2019 for the general insurance sector in India. Our country, being one of the most under-penetrated markets globally (at 0.97 percent in FY19 as per Swiss Re sigma report), presents a massive opportunity for the general insurance industry. We estimate an average 15-18 percent growth year-on-year for the next decade or two. This year we saw a major regulatory push to ease access and strengthen innovation.

Regulatory Sandbox: IRDAI's regulatory Sandbox is one of the most significant steps towards innovation and maturity for the industry. A secured test environment to execute new ideas will lead to improved coverage, eased accessibility, faster processing and lesser rejection of claims for consumers.

Motor Vehicles Act (2019): Enforced since September 1 this year, the new Motor Vehicles Act has introduced hikes in traffic violation penalties, mandatory third-party liability and helmet cover. This has led to a stark growth (~38 percent) rise as of September 2019 for the motor portfolio as well as positive changes in driving behaviour and compliance.

Natural calamities: Climate change did and will continue to affect India with unpredictable natural calamities. In light of the rise of floods incidents in several states, home and property insurance have the opportunity to offer robust financial protection and resilience for the masses. General awareness however, remains low as evidenced by the Kerala floods, where out of 70,000 impacted homes, only 5 percent were insured.

Healthcare coverage: The National Health Protection Mission (PMJAY - Ayushman Bharat) was a momentous announcement for the health insurance sector during Union Budget (2018-19). This move is set to enable a health infrastructure push across the country and continue to expand coverage for the deprived population. As of October 2019, under the scheme, 50 lakh beneficiaries have availed free secondary and tertiary treatment costing about Rs 8,000 crore in 32 states and Union Territories. There are 9 hospital admissions every minute using Pradhan Mantri Jan ArogyaYojna. The numbers are a clear evidence of progress and growth in the health care and insurance sector in India.

New age risks: Persistent cyber threats continue to rise in India. The growth of digitization will create new forms of security risks to critical infrastructure.

Conversational commerce: By 2020, every three in four policy purchases is estimated to be influenced by digital channels. This has led to a paradigm shift for insurers who are now addressing the needs of the tech-savvy generation with 24X7 AI-chat bots.

Emergence of New Age products: The year saw a slew of innovative products in the form of bite-sized insurance policies also called as Sachet products with low premiums. This new model will continue to see

innovations in pricing flexibility, value for money, convenience and awareness for customers in the long run.

With all eyes towards 2020, the future of General Insurance industry looks extremely promising aided with favourable regulatory framework, deeper personalization of products and growing digital customer-centricity.

(The writer is Rakesh Jain.)

TOP

Source

General insurers want FDI raised to 74%, valuation remains a concern - Business Standard – 23rd December 2019

General insurance firms are in favour of raising foreign direct investment (FDI) limit in the sector to 74 per cent.

Last week, the General Insurance Council (GIC), the representative body of general insurance, health insurance and reinsurance companies in India, met to discuss the view of insurance companies in raising the FDI. All the companies agreed on raising FDI limit to at least 74 per cent.

"Prima facie no company had reservations in increasing the FDI limit to 74 per cent," said sources. Also several companies are in favour of 100 per cent FDI in the sector.

"The government is also considering the option of 100 per cent FDI in insurance. Insurance companies had several meetings on the matter with the government," according to a source close to the development.

However, a few insurance firms, especially private ones who have foreign partners, raised concerns over issues such as valuations, although in-principal they agreed on raising FDI limit.

"Some joint venture partners may see change in positions in case FDI limit is raised to 74 per cent. That is why some companies had some concerns about safeguards, although no company opposed FDI," said a person familiar with the development.

Notably, the Insurance Regulatory Development Authority of India (IRDAI) recently sought suggestions from various stakeholders on raising FDI to 74 per cent.

In September this year, IRDAI raised FDI limit in insurance intermediaries to 100 per cent. This is likely to bring in much needed capital in the sector, and increase the use of technology in the sector.

At present, FDI up to 49 per cent is allowed in the insurance sector through the automatic rout. Earlier, the approval for investment up to 49 per cent required approval by the Foreign Investment Promotion Board (FIPB), which was disbanded two years ago.

Finance minister Nirmala Sitharaman, in the Union Budget for fiscal 2020 had said the government will examine proposals for opening up FDI further in insurance in consultation with all stakeholders.

"Insurance companies sought more clarity in terms of ease in doing business and lesser restrictions. At present, frequently the laws keep changing, which has been a major concern for foreign insurance partners in India," according to a source present in the meeting.

(The writer is Namrata Acharya.)

TOP

Source

Ailing General Insurance – With Regulator as Onlooker I - The Times of India – 22nd December 2019

In line with govt decision to merge three PSU General Insurance Companies (National Insurance, Oriental Insurance, and United India Insurance), preparations are on for the merger and soon we may have the merged entity, which experts say, would be the largest general insurer of the country. Experts also say that the company will be able to grow and sustain in the market successfully with more net worth, more risk-taking capacity, more expertise and strength, and a more focused market strategy.

General Insurance Industry, as a whole, of late, has come to a very bad phase. Though the volume of income – premium income – has been ever-increasing, the losses are also ever mounting. While the total premium income as at the close of 2018 – 19 stood at over 169 thousand Crores with moderate growth of around 12%, the losses sustained were as high as over 22 thousand Crores up over 45% against last year. The PSU insurers had a premium share of over 68 thousand Crores growing dismally at less than 2%, the private players could have an income of over 81 thousand Crores growing at a remarkable rate of over 24%, rest around 20 thousand Crores being of standalone health and specialized insurers. The industry sustained a loss of over 22 thousand Crores, the share of PSUs was at over 18 thousand Crores with a loss ratio of over 33%, with private insurers' share being over 2 thousand Crores at a loss ratio of over 6%, with another around 2 thousand Crores being standalone health and specialized insurers' share.

The market share of PSUs has been falling steadily over last few years – this year it fell to 40% against last year's 45% with private players having a share of around 48 against last year's around 43%, with another 12% market share of standalone health and specialized insurers.

The figures, as above, have been taken from the regulator's (IRDAI) report. The position, evidently, is too alarming for the entire industry and quite more so for the PSU insurers. While the merger of the three PSUs may be one of the positive initiatives, the regulator has to wake up and take special measures to save and sustain the industry.

The crisis, therefore, is twofold – one, the general, affecting the entire industry and the other, typical to PSUs. PSUs, in general, have their common handicaps – organizational as well as functional. The PSU insurers are no exception – with casual corporate managements, working always on ad hoc initiatives changing too often with changing guards, having no long term vision.

While it is expected that all the relevant factors must have been taken into account, certain facts emanate from some insiders and other stakeholders including regular customers. Why the PSU general insurers started doing so badly in all aspects, to the extent of going much below the solvency ratio fixed by the regulator? What external/internal factors affected them adversely and how come merger and money (capital infusion by the govt) would eventually make them viable? Are the size and net worth of these companies responsible for their failure? How the three worse doing entities clubbed together will start making profits and how a very big or the largest insurer would overcome all the ills?

After all, the deterioration did not happen suddenly. If we analyse honestly it would reveal that the very birth, nourishment and bringing up of these PSU general insurers were hugely faulted and apparently neither the management nor the govt cared about their health and a beaming sector was allowed to proceed towards a path of a slow and painful death like situation.

As a background, let us go back and take two facts from the history – Firstly, nationalization of General Insurance companies was part of at least two other such decisions – abolition of privy purse and

nationalization of Banks. These were done in hurry in quick successions by Indira ji, just like that, without much of studies put into it. 1969 Bank nationalization, 1971 management takeover of General Insurance Companies (followed by nationalization in 1973) and 1971 abolition of privy purse too. Indira ji became Prime Minister in Jan 1966, termed as 'Gungi Gudia' and was too fragile, rather weak, in front of old guards like K Kamraj, Morarji Desai etc in the party and in govt too. She was too uncomfortable and was desperate to establish herself in the party and govt by whatever means. These were some actions, which were aimed at, solely, establishing herself as a progressive and socialist leader, getting rid of old guards in her party and her govt. These initiatives, coupled with some other political strokes (like supporting V V Giri as presidential candidate) by her, triggering resignations and later a vertical split in the party, proved to be on her side, got her desired public support and established her as undisputed leader of Congress. Since decisions were political and were taken in too haste, personally by her (she took over finance ministry post Morarji Desai's resignation) with couple of bureaucrats only, not much of professional expertise went into the exercise.

Secondly, right from the day the four General Insurance Companies (National Insurance headquartered at Kolkata, Oriental Insurance headquartered at Delhi, The New India Assurance headquartered at Mumbai and United India insurance headquartered at Chennai) came into being as PSU insurers, with another one as the holding and supervising corporation for the four (General Insurance Corporation of India headquartered at Mumbai), professional experts as well as insiders – trade unions and associations – felt the futility of four entities selling same products at same prices by same type of people but incurring repetitive input, infra costs and unnecessary quintuple management expenses. Having already an excellent experience of LIC of India, there was no sense of having five organizations dealing with one aspect. There were always demand of a single monolithic Corporation of General Insurance in line with LIC of India. But those were the days of PSUs doing 'service to the Nation' at whatever costs, hence no heed to anything otherwise by anyone who mattered! Thus, though very lately, but merger and consolidation of banks into few entities and merging of three PSU general insurers into one and eventually making all the four as one entity taking The New India Assurance also is not only desirable but a necessity too.

With the merger, with remarkable infusion of capital from the govt to begin with and possibly lessening the govt holding at a later stage, the organizational need of the hour would be fulfilled but this only would not be a guarantee of successful operation of the organization. After all only capital is not the issue. Even the private players started with 26% of foreign partnership, increased to 49% subsequently and now recommended to 74% by the regulator. But if the losses and chaos in the industry is not arrested immediately, any amount of capital will always be insufficient. Therefore, if the reasons of the failure of General Insurance industry in the country in general and PSU companies in particular are not properly analyzed and fixed, in no time the so called biggest entity of the country may also bite the dust. For, had the bigger organizations been guarantee of success, there would not have been so much of closures, mergers and accusations of many big organizations in corporate world.

(The writer is Purushottam Jha.)

TOP

Source

Do You Need Wedding Insurance? – Good returns – 20th December 2019

Indians are known to spend a significant part of their wealth on wedding ceremonies. In a country where the guest lists are long and hospitality is important, a huge amount is spent on wedding preparations, including customary expenses on gold jewellery.

With trends of destination weddings and grandeur experience picking up, Indian general insurance companies including National Insurance, ICICI Lombard, Future Generali, Oriental Insurance, Bajaj Allianz, have formulated covers for unexpected events at these big-budget ceremonies.

If you are planning a wedding ceremony for yourself or for a family member, you can decide whether or not you need to get insured after considering the following aspects:

What is a wedding insurance policy? Wedding insurance policies are customised plans to include specific risks associated with the ceremony.

Marriage ceremonies hold the risk of disruption from natural calamity, fire, theft or even an accidental injury of a family member. If for one of the reasons, the event has to be postponed, the biggest problem is the no-refund policy followed by venue providers and caterers.

Especially in weddings involving big budgets and a large crowd, cancellation, postponement or an accident could cause a massive hit on one's finances and plans.

An insurance plan covers these risks.

What does it include? While the insurance cover will generally include losses from a natural disaster, fire, terror attacks, riots, curfew and theft, the plan can be customised based on the risks associated with the venue.

Losses from unforeseen injury or death of a family member can be sought as an add-on. Additional cover for damages to property or life of guests, burglary of jewellery or cash at home, can be opted for.

Note:
The wedding insurance cover will kick-in only 24-hours prior to the start of the wedding-associated ceremonies, irrespective of when you choose to purchase one. These will range for close to 7 days to include all the events of the marriage (like Mehendi and Sangeet) and ends on the next day of the wedding.

The insurance will, however, not include financial damages caused if the bride or groom calls off the wedding.

A claim can also be rejected if any information that could consequently lead to losses of any kind, was known by the insured but not disclosed to the company before the commencement of the policy.

Premium charged
The premium charged on these insurance covers varies on a case-to-case basis.

It will depend on the information related to the parties involved, the number of people attending, venue (place and whether indoor or outdoor), cost of decoration, cost of event management, cost of catering, etc.

The premium will depend on the sum assured for each associated risk. Ideally, wedding insurance premiums are a cheap affair; ranging between 0.5 and 2 percent of the sum assured.

How to purchase one?
Generally, wedding insurance covers are included in the expenses by the event planner. The family can also choose to directly purchase one from general insurance companies.

National Insurance, ICICI Lombard, Future Generali, Oriental Insurance and Bajaj Allianz provide wedding insurance covers in India.

(The writer is Olga Robert.)

Source

TOP

HEALTH INSURANCE

Planning to buy health insurance? Take a look at key norms that changed in 2019 - Financial Express – 27th December 2019

The Insurance Regulatory and Development Authority of India (Irdai) introduced various health insurance regulations that brought in many developments in the health insurance industry. Here are some of the key changes in the health insurance industry in India in 2019.

Guidelines for a standard product

In February this year, Irdai issued draft guidelines for a vanilla standard health insurance product common to all non-life insurance companies – both general and health. The standard health product will cover both pre- and post-hospitalisation expenses and the consumers will also have the option of taking treatment under AYUSH scheme, subject to sub-limits. While the minimum sum insured in the standard policy will be Rs 50,000, the maximum limit will be `10 lakh. Insurers are allowed to follow differential pricing and charge a lower premium from an old customer against a new customer regardless of their age. The proposed plan will remain a basic insurance product and customers will not be allowed any add-ons or riders.

Standardisation of exclusions

Irdai issued guidelines for standardisation or pre-defined format for the exclusions in a standard health insurance policy. A list of exclusions will be prepared and moving forward, only the listed ailments will be excluded from the health insurance policy. This means that now health insurance policy will be an all-inclusive product covering you for all possible health risks. Age-related ailments like knee-cap replacements, mental illness, cataract surgery, Alzheimer's and Parkinson's, etc., which were earlier excluded will now be covered by the insurance company.

As per the guidelines, any disease/s or ailment/s that is/are diagnosed by a physician 48 months prior to the issuance of the health cover will now be classified under pre-existing disease. Moreover, any disease/s or ailment/s for which any type of medical advice or treatment was recommended by a qualified doctor 48 months prior to the issuance of the policy will also qualify under pre-existing diseases (PED). Any other condition whose symptoms or signs have resulted in a serious disease within three months of the issuance of the policy will also be classified under PED.

With the aim of making mental healthcare available to all, Irdai has made it mandatory to include mental illnesses and several other health issues in all regular health insurance coverage. In the exposure draft, Irdai made it clear that insurers cannot deny coverage to policyholders who have used opioids or anti-depressants in the past. Insurers can't deny coverage to people with a history of clinical depression, personality or neurodegenerative disorders, sociopathy and psychopathy.

Ability to choose TPA

The regulator has allowed policyholders to choose third-party administrator (TPA) at the time of buying a health insurance policy or at the time of renewal, thus providing more flexibility and encouraging the entire health insurance ecosystem to constantly ensure that customers get the best service experience.

(The writer is Amit Chhabra.)

TOP

Source

NHRC seeks report over Ayushman Bharat beneficiaries not able to avail high-cost treatment under RAN - The Economic Times – 26th December 2019

The National Human Rights Commission has sought a report from the Health Ministry over a complaint about poor patients suffering from life-threatening diseases not able to avail treatment under the Rashtriya Arogya Nidhi (RAN) if they are Ayushman Bharat beneficiaries.

According to NHRC, it has received a complaint stating patients holding BPL cards are not getting RAN benefits if they availed benefits of AB-PMJAY even if they are suffering from life-threatening diseases - whose expenditure is much more than Rs 5 lakh, the maximum permissible limit under Ayushman Bharat health scheme.

The Commission has asked the ministry to take appropriate action and sent an action-taken report to it within six weeks.

"The complainant has further stated that due to such discrepancies people belonging to the most marginalized section of society are forced to sell their houses, land and to take loan on higher interest rates to cover the cost of treatment.

"He has requested the Commission to ask the government to take immediate necessary action so that poor patients get the benefit of the RAN scheme and Ayushman Bharat health scheme in case of life-threatening diseases, when the expenditure exceeds Rs 5 lakh permitted under the PMJAY scheme," the commission said in its letter to the Health Ministry secretary.

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

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

They had written to the Health Ministry, asking if the patients deprived treatment under AB-PMJAY could be covered under the RAN umbrella.

They drew the ministry's attention to the patients who were refused treatment 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 RAN umbrella since they are AB-PMJAY card holders. 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 writer is Payal Banerjee.)

TOP

Source

Income Tax Saving: How health insurance can help you save tax - Financial Express – 26th December 2019

As we head into the New Year, it can pay big dividends to spend a little time seeing if any year-end move can help you save a lot on taxes or improve your financial situation. One of the most prominent ways to save yearly tax is by investing your money in risk control investment product – Health Insurance. Health insurance, apart from saving you from the massive cost of medical expenses in case of an adversity, even helps you enjoy tax rebate. As per the Finance Act (India), premium paid towards medical insurance offers tax benefits under Section 80D of the Income Tax Act. Here are the different ways to save income tax with health insurance.

Health Insurance for Self
You as an individual or Hindu Undivided Family can claim a deduction up to Rs 25,000 under the Section 80D when buying health insurance for self, spouse and children.

For instance, if Ajay's age is 38, his wife Preeti's age is 34 and their son Krishiv's age is 4 years, the maximum deduction that Ajay can claim for his family's health insurance is Rs 25,000.

Health Insurance for Self and Parents (Below 60)
If you have a family as well as dependent parents, you can avail an additional deduction of Rs 25,000 for buying health insurance for your parents. In total, the overall deduction that can be claimed is Rs 50,000.

For instance, apart from his family, Ajay has dependent parents – father (59) and mother (57), Ajay can avail an additional benefit of Rs 25,000 for buying health insurance for parents. The total benefit Ajay can avail becomes Rs 50,000, i.e. Rs 25,000 (self) and Rs 25,000 (parents).

Health Insurance for Self and Parents (Above 60)
If you have dependent parents and the age of any of the parents is above 60, you are allowed for a tax benefit of up to Rs 50,000. Here, the total tax benefit goes to Rs 75,000.

For instance, apart from your family, you have dependent parents — father aged 71 and mother aged 68, you can avail an additional benefit of Rs 50,000 for buying health insurance for your parents. The total benefit that you can avail is Rs 75,000 i.e. Rs. 25,000 (self) and Rs 50,000 (senior citizen parents).

Health Insurance for Self (Above 60) and Parents (60)
Where one family member— self, spouse or children— is over 60, one can claim up to Rs 50,000 in tax benefit on medical insurance. Additionally, for parents over 60, medical insurance paid can fetch up to Rs 50,000 in tax benefit. So, the total deduction in this case can be up to Rs 1 lakh a year.

For instance, your age is 65 and your father's age is 90. In this case, the maximum deduction you can claim under section 80D is Rs 1 lakh i.e. Rs 50,000 (senior citizen self) and Rs 50,000 (senior citizen parents).

Deduction on Preventive Health Check-up
Apart from regular health insurance, any payments made towards preventive health check-ups also entitle you to a tax deduction of up to Rs 5,000, which though fall within the overall limit of Rs 25,000/ Rs 30,000 as the case may be. The deduction can be claimed either by you, spouse, dependent children or even parents.

For Instance, Abhay paid a health insurance premium of Rs 22,000 towards the insurance policy he bought for himself, his wife and his dependent kid. Further, he even got a health check-up done for himself and his wife for which he paid Rs 5,000.

Now, Abhay can claim a maximum deduction of Rs 25,000 under Section 80D of the Income Tax Act. While Rs 22,000 has been allowed towards insurance premium paid, Rs 3,000 has been allowed for the health check-up. The deduction towards preventive health check-up has been restricted to Rs 3,000 as the overall deduction cannot exceed Rs 25,000 in this case.

(The writer is Amit Chhabra.)

TOP

Source

Innovative collaborations to make Maharashtra a safer place for childbirth - Express Healthcare – 26th December 2019

Dr Nandita Palshetkar, President, Federation of Obstetricians and Gynecological Societies of India emphasises on the importance to prevent maternal mortality rate with private and government initiatives

A lot has been said and written about the role of the government in delivering universal healthcare coverage for maternal health. However, I believe that there many ways in which private healthcare providers can step up to plays a greater role in ensuring better health coverage. The private sector forms a critical part of India's maternal healthcare ecosystem, accounting for 30 per cent of babies delivered in an institution in rural India and more than half of institutional deliveries in urban areas.

The overwhelming concern is that in spite of unprecedentedly high levels of women opting to have their babies under institutional care (78 per cent as per the last National Family Health Survey), this has not led to India achieving desirable improvements in maternal health care indicators. For instance, while India — and Maharashtra in particular — has made tremendous progress in reducing the maternal mortality rate (MMR), it still remains high compared to developed nations.

The key factor contributing to low performance in maternal care is the lack of a strong regulatory framework for quality standards. Private maternity care in India is largely unorganized and unregulated as service providers do not have adequate opportunities to improve their care s maternal mortality rate services. There is no body or authority to ensure that private clinics or hospitals follow the norms for safety, hygiene, clinical care, equipment, etc. so that mothers can deliver safely.

It is well past time for the private sector to step up and self-regulate to achieve higher standards for maternal care. Globally, health reforms are driven by Professional Medical Associations (PMAs). Since these organisations represent medical professionals — nurses, pharmacists, physicians, mid-wives, etc. — they have the resources to drive education and training and the capabilities to set much-needed standards and guidelines.

Thankfully, India is seeing a similar trend. FOGSI (Federation of Obstetricians and Gynecological Societies of India) is one of India's premier PMAs, with about 35,000 obgyns under its umbrella. Three years ago, FOGSI took a major step towards quality enhancement and capacity building at private maternal care facilities. It started driving Manyata, which is a quality care certification programme for clinical and facility standards in maternal health. Manyata has been quite a success story. Rolled out in five states (Uttar Pradesh, Jharkhand, Rajasthan, Karnataka and recently launched in Maharashtra), Manyata has impacted over 250,000 deliveries in 475 hospitals and trained over 3,000 service providers in adhering to clinical standards.

The accreditation programme, which is supported by MSD for Mothers, Jhpiego and MacArthur Foundation, enables registered facilities to train their doctors and nursing staff to comply with 26 quality standards, which include both clinical and facility standards. Thus, it can help smaller facilities even in

remote areas to strengthen their service delivery and offer better conditions of care. Moreover, the quality accreditation improves the chances of such facilities coming under the private insurance umbrella. This will not only support their business viability, but also allow more patients to receive financial support via medical insurance. The partnership will especially help in reaching the last mile and thus in improving universal healthcare coverage. A win-win situation all around.

Government partnership is key to delivering scale and ensuring sustainability in quality enhancement initiatives. Recognizing the vital role played by the state in driving healthcare coverage, FOGSI has joined hands with the Maharashtra state government to launch 'LaQshya-Manyata'. The aim is to improve access to quality care, particularly for women living in rural and semi-urban areas, and thus drive an upswing in maternal health indicators. It has been thrown open to all the districts in Maharashtra and will help overcome the inherent bottlenecks in the state's healthcare system.

LaQshya Manyata is a shining example of what can be achieved through strong public-private partnerships and collaborative solutions — a more robust healthcare system that will offer equitable access to all communities across economic strata and the rural-urban divide.

TOP

Source

In 2-3 years, 'every Indian may get public health cover' - The Hindu Business Line – 25th December 2019

In the next two-three years, government health cover will become a reality for every Indian.

According to National Health Authority (NHA) officials, the Pradhan Mantri Jan Arogya Yojana (PM-JAY), popularly known as Ayushman Bharat, which currently covers 40 per cent of the population, is likely to be extended to all citizens.

NITI Aayog, in its latest report, has rued duplication of government health schemes. It wants multiple health schemes brought under one umbrella scheme.

"Taking a cue from the NITI Aayog report, universal health coverage in India will become a reality in the next two-three years. Implementation authority will most likely be the NHA, as it makes little sense to create a separate authority as we already run PM-JAY," PM-JAY CEO Indu Bhushan told *Business Line.*

Currently, PM-JAY provides cover worth ₹5 lakh annually for 10 crore families, or 50 crore individuals, for treatment in a public or private hospital.

According to officials, while 50 crore persons are under PM-JAY, another 20 crore persons get the benefit of State schemes, with 100 per cent cover, and 13-odd crore persons come under Employment State Insurance Corporation (ESIC) scheme. And then there is Central Government Health Scheme (CGHS).

"All in all up to 70 per cent of the population is already covered; the rest 30 per cent that are excluded are tax-paying citizens and those working in the private sector," said a senior NHA official.

The official added that the NHA had already started inching towards bringing different schemes under one umbrella, by making PM-JAY available in ESIC hospitals. "In two to four months we will make sure that PM-JAY is extended to all CGHS claimants," the official said.

The NHA is waiting for a political nod to extend PM-JAY across the country; the officials said and indicated that the model for the taxpaying citizen may be slightly different, with a modest premium deducted for extending the cover.

"This may or may not be the case... at this stage as we await orders, all possibilities are conjectural," said the officials.

Currently, not all private hospitals especially the big chains are part of PM-JAY. Most upper-middle-class patients go to private healthcare providers because of overcrowding in government hospitals. Also, whether participation in the scheme will be voluntary or not has not yet been decided. "We will have to sort out the nitty-gritty of the scheme once we are directed to chart out a plan for universal health coverage," said the official.

(The writer is Maitri Porecha.)

TOP

Source

Choose an efficient TPA with a large network to ease claims – Mint – 24th December 2019

If you've ever been hospitalized and filed for an insurance claim, it's likely you'd have dealt with a third-party administrator (TPA). The involvement of a TPA, the intermediary between the insured person and the insurance company, can sometimes make the claim settlement process cumbersome, especially if the TPA isn't proactive or does not have modern systems in place.

Soon you may be able to choose a TPA you find more efficient than the others. In a bid to improve transparency and efficiency, the Insurance Regulatory and Development Authority of India (Irdai), in its guidelines issued earlier in December, said insurers will now have to give policyholders the option to choose a TPA. However, you will need to choose among the TPAs engaged by your insurer.

But will you be able to effectively exercise this choice? "The policyholder may not know which TPA is good. They could end up asking their insurance agent to suggest one. This means the decision can be influenced by the insurance agent," said Nayan Shah, Paramount Health Services and Insurance TPA Pvt. Ltd. If you want to make this choice independently, without getting influenced by an agent or intermediary, we tell you the things to consider, but first understand what TPAs do and the changes Irdai has brought in.

WHAT TPAs DO

Health insurers generally outsource the process of accepting intimations, approving cashless claims and settlement and disbursement of claims to TPAs, which issue identity cards to policyholders that are used at the time of hospitalization and filing of claims.

In case the need for hospitalization arises, you will have to inform your TPA, which will direct you to a hospital with which it has a tie- up. At the time of hospitalization, you will be required to show the identity card issued by the TPA. The hospital will then get an authorization letter from the TPA. Closer to discharge, the hospital will send all your bills to the TPA, who will forward the bills and other documents to the insurer for your claim to be processed.

THE CHANGES

Other than giving policyholders the option of choosing their TPA, Irdai has said that if the services of a TPA are terminated during the course of the health services rendered, then the policyholder should be allowed to pick another TPA.

You will have to choose a TPA at the time of buying the policy but in case you're dissatisfied with its services, you will get an option to change the TPA at the time of renewal. Remember that if you don't make a choice while buying the policy, then the insurer will allot a TPA of its choice.

More and more health insurers are now working on having an in-house facility. "This (in-house) facility makes the entire claims process convenient and seamless as the policyholder can directly coordinate with the insurer and the hospital, rather than having to coordinate with another external TPA," said Anurag Rastogi, president, accident and health, HDFC ERGO General Insurance Co.

Newer concepts introduced by private insurers such as wellness initiatives, health returns, policy benefits are better serviced by an in-house ecosystem compared to TPAs, said Mayank Bathwal, managing director and CEO, Aditya Birla Health Insurance.

THINGS TO CONSIDER

Network: Hospitals normally have contracts with a list of TPAs and insurance companies. This information is displayed in all hospitals. The first step is to figure out which hospitals you are likely to frequent. Next, find out the TPAs engaged with these hospitals. Then get a list of TPAs empanelled with your insurer. "Compare both these lists and see which TPA you'd want to go with," said Shah.

Find the TPAs common to both lists. But before you zero in on one, check the network hospital strength—the number of network hospitals across the country providing cashless claims facility— and the geographical spread of the TPA. A larger presence would mean not having to change your TPA in case you move from one city to another. "If the customer needs to change a TPA for any reason, the data of the customer is transferred from one TPA to the other. With regards to the TPA not having a presence in a city, the insurer normally provides an alternate arrangement," said Amitabh Jain, head, motor and health, underwriting and claims, ICICI Lombard General Insurance Co. Ltd.

Efficiency: More and more policyholders are complaining of delay in discharge due to negotiations between the hospital, TPA and the insurers There have been cases where patients have had to wait for 8-10 hours for settlement. This is where having an efficient and more organized TPA helps.

"Discharge is a two-step process. The doctor needs to approve the discharge after which the billing department submits the claim. This is usually a 3-6 hours process which can create a perception of delayed discharge. Also, the insurer and the TPA need to ensure that the claim is processed fairly by adjudicating them correctly against policy benefits and provider contracts, which can sometimes take more time than estimated, causing delays," said Jain.

Though the insurer takes the final decision on claim settlement, having a TPA that follows due process helps.

Digitization: Another aspect you should look at is the TPA's digital capabilities such as the availability of a mobile app. "Definitely the technologically advanced TPAs are able to offer better services," said Shah.

Cost: Note that you don't need to pay anything extra to your TPA who is paid by the insurance company out of the premiums you pay. But you may end up receiving quotations from different TPAs engaged by your insurer when you file a claim.

"It's possible to get rate cards from various TPAs and the costing also could be very different. This is because different TPAs negotiate differently with a hospital. This is a common phenomenon," said Abhishek Bondia, principal officer and managing director, SecureNow.in. Despite getting different rate cards, you will have to go with the TPA you picked while buying the policy.

TPA rates are dependent on multiple factors. Apart from the services offered, the rates are based on factors like the brand and the servicing capacity of the TPA and the service experience at the time of claims, said Rastogi.

TPA rates for individual policies do not vary a lot. This is because insurers fix the amount based on the percentage of premiums or on per life basis, said Shah. "A group policy as a category is very competitive

among TPAs which is why there could be a difference in the final quotations of different TPAs. If the costing is too low, then the quality of services may be questionable," he added.

Currently, there are about 26 TPAs in the country. Shah said the new guideline could result in the elimination of the less competent TPAs, leading to some consolidation in the industry.

(The writer is Disha Sanghvi.)

TOP

Source

Focus on cancer care for poor – The Telegraph – 23rd December 2019

The government should regulate insurance companies and quality of cancer drugs so that those undergoing treatment for the disease but finding it tough to bear the long-term cost can benefit, historian Sugata Bose said at a Bengal Oncology meet on Sunday.

The government should ensure that the insurance companies don't harass the patients while reimbursing treatment costs, Bose said.

"The government must come up with insurance schemes that cover everyone. Such schemes are available in southern states. We should learn lessons from them. But the insurance companies are always required to be regulated by the state. Because questions arise as to whether they will really reimburse the cost. The government should monitor this so that patients are not harassed," Bose said.

The former MP stressed the need for government intervention to ensure that the big pharmaceutical companies maintain the quality of generic drugs.

"In the US, branded medicines are too costly. They often make unconscionable profits. But in India the problem is perhaps of a different kind. The government must play the role of a regulator to see to it that quality is being maintained in generic drugs or their copied version," Bose said after his speech at the GD Birla auditorium.

While delivering the keynote address, Bose said it was crucial that early detection and cancer treatment facilities were available in the district hospitals so that people are spared the expense of coming to the city for detection and treatment.

"Cancer treatment facilities are mostly concentrated in cities. This problem is typical of Punjab and Bengal. The cost of travelling to cities leaves the families constrained financially," Bose said.

Bose also focussed on the need for early detection of cancer among the poor.

'There is a class-based inequity that I have pointed out in my speech where the poorest of the poor can only get palliative care because their cancer is detected so late and therefore we have to make it certain that screening for early detection of cancer is available to everyone," Bose said.

The secretary of the Bengal Oncology Foundation, oncologist Gautam Mukhopadhyay, said early detection was necessary to the extent that it made treatment affordable for the poor.

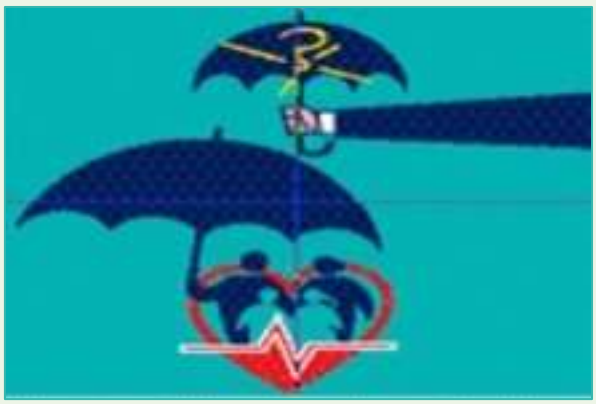
"The cost of cancer treatment is prohibitive. It's not a one-time treatment. The same patient undergoes surgery, radiotherapy, chemotherapy over several years.... If the cancer returns, treatment will recur. Early detection can ensure cure through one modality treatment," he said.

(The writer is Subhankar Chowdhury.)

TOP

Source

Why you need a top-up health insurance plan - Financial Express – 23rd December 2019



While employers do provide health cover to their employees, it is often not enough to meet medical expenses. Many avoid buying a health insurance plan throughout their lives because of high premiums.

So, if you are looking for a better way to manage the sum insured of your health plan and that too, without spending a lot of money, then opt for a top-up or super top-up plan.

Top-up plans

A top-up plan offers you additional coverage beyond the maximum limit of the existing health insurance policy. Most health plans offer automatic recharge of sum insured in a year after exhaustion during the tenure.

But, what if the medical bill goes over and above the sum insured during the policy period? In that case, having a top-up plan helps. A top-up plan will cover medical costs after a declared deductible or threshold is reached.

For instance, Ranjana holds an employer's health policy of Rs 4.5 lakh (also the threshold deductible) along with a top-up health cover of Rs 7 lakh. If she falls critically ill, and the claim goes to around Rs 7.5 lakh (which is higher than the threshold coverage of the plan), the medical bill up to Rs 4.5 lakh will be paid by the mediclaim policy and the remaining Rs 3 lakh will be paid by the top-up plan.

One of the key features of investing in the top-up plan is that the policyholder can get this plan from any company and not necessarily from the existing insurer.

It is available for both individual plan as well as family floater plan. It has an option to enhance the policy coverage at the time of renewing the policy. Children can be included in the same plan if both the parents are covered.

Super top-up plans

A super top-up insurance plan is a saviour when a single claim does not traverse the threshold limit of the regular plan, but multiple claims do. The super top-up plan helps you to enhance your base health plan's coverage. If the base plan is not sufficient enough to meet the actual medical expenses in a single claim or your sum insured is exhausted because of multiple claims in a year, then you can count on a super top-up plan.

For instance, Suresh has an existing health insurance plan of Rs 3 lakh and has bought a super top-up health cover of `9 lakh. Suppose, he gets hospitalised and if the medical expenditure is `8 lakh, his regular policy would pay `3 lakh and the super top-up insurance plan would pay Rs 5 lakh.

If another claim of Rs 4 lakh is made in the latter part of the year by him, the entire amount is paid by the super top-up plan since the regular policy cover is exhausted. The claim is settled if the overall bill amount exceeds the deductible limit.

It offers an additional benefit to the base plan which helps the insured if the medical expenses exceed the threshold value either due to a single claim or multiple claims in a year. A policyholder can make multiple claims in a year till the sum insured gets exhausted. It is advisable to have a base plan to cover the medical expenses up to declared deductibles. Keep these things in mind before opting for any additional cover.

(The writer is Rakesh Goyal.)

Source

TOP

CROP INSURANCE

Min reviews Prime Minister's Crop Insurance Scheme - The Pioneer – 24th December 2019

Farmer Welfare and Agriculture Development, Horticulture and Food Processing Minister Sachin Yadav reviewed the Prime Minister's Crop Insurance Scheme at the Mantralaya. He said that as per Insurance Clause the farmer must give information about crop loss within 72 hours to the concerned insurance company.

He said that the toll free numbers of companies are mostly out of order. To redress this problem he instructed the crop insurance companies to issue toll free numbers at tehsil level.

Minister Yadav instructed the crop insurance companies to give information about their employees appointed at the tehsil level and also about the farmers giving information about crop loss within two days.

He said that the receipt of the contribution of the crop insurance amount to the farmer should also be ensured. Yadav instructed to speed up payment of claim amount on crop loss as per rules.

It was told at the meeting that insurance of Rs 15,221.52 crore for Kharif-2019 of the crops of 27.64 lakh farmers of the state has been done under Prime Minister's Crop Insurance Scheme. This includes total 54 lakh 58 thousand 866 hectare agricultural land of farmers. For the insurance premium, the share of farmers is Rs 352.62 crore and State's share is Rs 509.60 crore. The claim of crop loss will be made available as per rules to the farmers soon.

TOP

Source

Maharashtra farmers still waiting for insurance payment for rain -damaged crops - The Hindu Business Line – 24th December 2019

Three months after untimely downpour in October damaged kharif crops on over 70 lakh hectare, farmers in Maharashtra continue to wait for compensation from insurance companies.

"Farmers have not received crop insurance compensation. In fact, we have lost faith in insurance companies as we have had a bad experience with them in the last three years," said Ankur Mane, a farmer from Satara.

Affected crops

Rains damaged soybean, cotton, banana, onion, potato and sugarcane crops. The government had ordered that insurance companies conduct damage assessment and offer compensation to farmers.

However, insurance companies have not responded to the order. Chief Minister Uddhav Thackeray has written to Union Agriculture Minister Narendra Singh Tomar to intervene in the matter. Thackeray has

demanded that the Centre direct the insurance companies to pay compensation to Maharashtra farmers as the companies are not responding to the State government's demand.

"The State has been implementing the Pradhan Mantri Fasal Bima Yojna effectively since 2016. Unseasonal rains in October-November have damaged crops in a big way and reports have been given to insurance companies. Till date, the insurance companies have not paid the insurance amount to farmers as per the guidelines. The Agriculture Minister must take a review of the same and direct the insurance companies to resolve the issue" Thackeray said in the letter.

Thackeray also said that the insurance companies have taken an 'apathetic' approach to 2019 rabbi season as well. Insurance companies have not participated in the tendering process in ten districts despite repeated efforts. Farmers in these districts will be deprived of insurance cover if the companies continue to play truant.

Paltry sums

Earlier, the insurance companies had provided compensation ranging from Rs. 1 to 5 to farmers in Maharashtra. But, instead of scrutinizing the companies' way of assessment, the Maharashtra government led by Devendra Fadnavis decided to shell out money from its coffers.

The government decided to pay Rs. 1,000 to farmers who received compensations of less than Rs. 1,000. The State issued a government resolution (GR) announcing that it would shoulder the burden of the amount paid to farmers.

(The writer is Radheshyam Jadhav.)

Source

TOP

Overdue claims on crop insurance hit all-time high level - Hindustan Times (Noida) – 23rd December 2019

When the Pradhan Mantri Fasal BimaYojana (PMFBY), the country's flagship crop insurance scheme was launched in June 2016, the idea was to replace complicated, multiple insurance schemes running simultaneously with one simple plan for the whole country. Any farmer with a crop loan gets enrolled automatically and pays between 1.5% and 2% of the premium, while the rest is shared 50:50 by the Centre and states.

Three years down the line, PMFBY has run into many of the old problems. The one most troubling issue for farmers is a continuous delay in payouts. The average delay in payment of claims, according to official data, is more than a year from the date of harvest.

Outstanding amounts owed by insurance companies to farmers have now reached nearly ₹3,000 crore until December 15, according to official data reviewed by HT. On October 31, the outstanding amount was ₹2,511 crore from the kharif, or summer-sown 2018 crop, season alone.

Delay in payouts can have domino effects. It leaves farmers short of funds to invest in their next sowing cycle. It also disrupts their ability to service their agricultural loans, pushing them closer to default.

(The writer is Zia Haq.)

TOP

Source

MOTOR INSURANCE

Even if driver is drunk, insurer is liable: Tribunal – The Times of India – 26th December 2019

A Motor Accident Claims Tribunal has held that an insurance company cannot absolve its responsibility of paying insurance if the driver of the offending vehicle is drunk.

The tribunal made the observation while awarding a compensation of around Rs 55 lakh (Rs 15 lakh interest) to the family of 53-year-old police sub inspector, Raja ram Desai, who died after a drunk car driver rammed into his bike at Vikhroli (East) in 2014.

The driver of the car, Ritesh Modi, a sales executive, was drunk. Desai was riding pillion with another cop who survived the accident.

The tribunal ordered the car owner, Shantilal Shah, and New India Assurance Co. Ltd to pay around Rs 40 lakh under various heads along with an annual interest of 7.5% from 2014-the year the complaint was submitted. Citing judgments of the Supreme Court and high court, the court said the defence of drunken driving by the driver of an offending vehicle is not available to the insurer.

"It can safely infer that even though a copy of the charge sheet along with chemical analysis report is produced on record, it doesn't mean the insurer is liable to be exonerated from the liability of paying compensation. The insurer has failed to prove the issue that the offending vehicle owner has committed breach of terms and conditions of insurance policy," the tribunal said.

The complaint was submitted to the tribunal in October 2014 by Desai's wife and two adult children. His 90-year-old mother, also party to the complaint, died last year. The accident took place on September 1, 2014 at 1.45 am. His family told the tribunal Desai was earning a monthly salary of Rs 40,000 at the time of the accident.

The car owner failed to appear before the tribunal. The insurance company submitted that the driver-Modi -was under the influence of liquor and, therefore, terms and conditions of policy had been breached by the car owner. The insurance company also blamed the cop riding the bike for the accident. The Motor Accident Claims Tribunal refuted the defence.

(The writer is Rebecca Samervel.)

TOP

Source

Growth in motor insurance business remains moderate – Financial Express – 25th December 2019

General Insurance companies reported 16% year-on-year (y-o-y) growth in premium in November 2019, up from 11% in October. Motor business continues to moderate on the back of weak OEM sales and moderating third-party (TP) business, while fire and health have helped offset the weakness.

Large private players, ICICI Lombard (down 6% y-o-y, up 7% ex-crop) and Bajaj (up 8% y-o-y) and HDFC ERGO (down 30% y-o-y, up 8% ex-crop) posted weaker-than-industry numbers. Chola MS (up 14% y-o-y) was in line while SBI (up 40% y-o-y ex-crop) maintained robust performance.

Motor TP moderation continues

Motor segment reported 6% y-o-y premium growth in November 2019, moderating from the 15-20% growth seen in the last two months. The immediate reaction to new traffic penalties on motor TP premiums seems to have almost faded.

Motor TP moderated sharply to 10% y-o-y (22% in October, 16% in YTD FY2020). OD business premiums were flat y-o-y in line with YTD run-rate after witnessing the first month of premium growth in October that was likely led by the festive season sales.

Private sector continued to gain market share registering 11% y-o-y growth while PSUs reported a decline of 4% y-o-y.

Own-damage (OD) business was back to flat growth in November after registering 8% y-o-y growth in October 2019, reflecting weak OEM sales. Higher business in October was likely reflecting festive season sales.

Among large private players, motor OD premium growth for Bajaj (15% y-o-y) and Chola MS (11% y-o-y) was better than the industry while ICICI Lombard posted 6% decline in premiums for the month-the reason for such a sharp decline for ICICI is unclear. Acko and Go Digit remained the fastest while SBI General maintained momentum at 60% y-o-y growth.

TP business moderated sharply to 10% y-o-y in November 2019 to levels well below YTD run rate of 16% y-o-y growth. Premiums had spiked in September (up 38% y-o-y) moderating to 22% in November. Private players posted 16% growth while growth for PSU players was muted (3% y-o-y).

Go Digit (up 3X y-o-y) continued to witness robust traction. Among top private players, Bajaj (up 24% y-o-y), HDFC ERGO (up 27% y-o-y) and Chola MS (up 12% y-o-y) posted better-than-industry growth rates (10% y-o-y) while ICICI Lombard saw premiums declining 14% y-o-y in November 2019.

Rebound in health insurance

Overall growth in health premium was robust at 28% y-o-y, compared to YTD run-rate of 17%. Retail heath growth improved registering 18% y-o-y growth in November 2019 (12% y-o-y in YTD FY2020). This may be due to a better pricing environment.

Industry trends were similar, with standalone insurers gaining market share (retail health premiums up 30% y-o-y) compared to single-digit growth at both PSU and private general insurers. In group health, standalone insurers registered 80% y-o-y growth while growth at private general insurers moderated to 23% y-o-y (40% in 2020 YTD). PSUs continued to post declines.

Fire business robust

Premium growth in fire insurance was robust in November 2019 at 58% y-o-y, better than YTD 2020 run rate of 45% y-o-y. All major players delivered strong growth, except Bajaj at 10% y-o-y. GIC had increased reinsurance rates (average rise of 2X) in eight occupancies (comprising 35% of industry volumes) which will likely drive higher volumes and profitability in FY2020E.

The run rate of 45% is higher, we would expect some moderation over the next few months.

TOP

Source

Reporter's Take - New third-party motor insurance formula – Moneycontrol – 23rd December 2019

To determine the third-party (TP) motor insurance cover, the General Insurance (GI) Council has proposed a new formula.

The Ministry of Road Transport and Highways has suggested that the general insurers' liability should be capped at Rs 10 lakh. Apart from that, the balance amount could be paid from the Motor Vehicle Accident Fund.

In this episode of Reporter's Take, Money control's Shraddha Sharma talks to M Saraswathy to understand the proposed rules and the timeline of its implementation.

TOP

Source

SURVEY & REPORT

Young adults consider investing important; 39% save a quarter of their salaries: Survey – The Economic Times -23rd December 2019

Young people and saving? Are they thinking of securing a financial future for themselves at such a young age? Well, according to a survey by Tata Capital, those in the 18-25 age group (or GenZ) believe in living in the moment, but are also extremely conscious about securing their future. That is right.

The survey found that 39 percent are saving a quarter of their salaries and 14 percent salt away more than half. GenZ is looking beyond bank deposits to invest money in.

The Tata Capital survey was conducted by Innovative Research Services (India), by interviewing 1,010 respondents. Here are more findings from the survey.

1. GenZ spends only a small portion of income on non-essentials like gadgets, entertainment and clothes

34% spend about 15% of their pay
33% spend up to 25%
22% of respondents spend only a tenth of their pay on non-essentials
9% spend half their salary on non-essentials
2% spend up to 60%

2. Saving and investing are important for this age group

39% are saving a quarter of their salaries
30% are saving up to 15%
17% are saving up to 10% of their earnings
9% are saving half their salaries
4% are saving 60% of their pay
1% is keeping away 80% of their pay

3. Family, friends and colleagues are those GenZ turns to the most for financial advice

40% of respondents turn to family for honest investment advice
26% approach friends and colleagues
9% listen to social media experts
8% heed other banks and advisers
8% turn to their banks and financial advisers
4% follow celebrity advice
4% listen to their social media friends

4. GenZ is looking beyond bank deposits to invest money in

Bank deposits: 34%
Mutual funds: 19%
Gold and real estate: 17%
Insurance policies: 17%
Equity shares: 8%
Company bonds: 6%

5. They mostly borrow money for higher education of self or a relative

25% borrow money for higher education
21% for vacations
19% to buy a new gadget
17% to build a house
10% borrow for the marriage of a family member
8% for emergencies

6. Banks and NBFCs are the preferred lenders

30% tend to borrow from family
29% borrow from banks
22% take money from friends and colleagues
10% opt for nonbanking financial institutions
10% turn to local money lenders

7. Most think it is a good idea to borrow from established lenders

31% say borrowing is a good way to build assets
31% think borrowing is ok in case of emergencies
20% say it's not wrong to borrow to lead a good lifestyle as long as one can pay back loan
18% find interest rates exorbitant and do not approve of borrowing

8. During festival sales and discounts, GenZ spends the most buying for family

70% buys gifts for family
44% buys for friends
42% purchases gifts for self
19% spends on colleagues
14% on business contacts

Source: Tata Capital. The research was conducted by Innovative Research Services (India), by interviewing 1,010 respondents.

TOP

INSURANCE CASES

Forum: Pay up for claim settlement delay – The Times of India – 27th December 2019

The Nashik District Consumer's Dispute Redressal Forum has asked an insurance company to compensate for the delay in settling claim in the case related to the death of a farmer's mother.

The three-member bench of the forum strongly objected to the "delay in compensation by the company for no valid reasons."

Though the claim has been settled, but it was not before the complainant filing the case with the forum for justice and, hence, the insurance company should also compensate for the unnecessary delay caused by paying interest for the period at the rate of 10% per annum," the forum observed.

The mother of the complainant – Kisan Dhula Aher — had died due to snake bite on October 23, 2017. On January 6, 2018, Aher had filed an insurance claim of Rs 2 lakh. Oriental Insurance had delayed the decision on Aher's application till January 11, 2019, following which, a complainant was lodged.

The insurance company, however, claimed that there were no clinical reports to prove that the woman died of snake bite and that the woman was more than 75 years old, which keeps her out of the purview of the agreement between the company and the government.

Nonetheless, the forum observed that the summary investigations by the police were also part of evidence to prove that the woman actually died of snake bite. Most importantly, the woman was aged 70 years as per documents submitted by Aher.

During the course of the hearing, the insurance company released a payment of Rs 2 lakh through bank transfer on January 28, 2019, — days after the complaint was filed with the forum. The company, therefore, drew the attention of the forum that since the claim had been settled, the case did not stand.

The judgment of the forum, headed by Milind Sonawane, pointed out that though the company had released the sum, it was not before the complaint was registered. The company is supposed to decide on the application within three months from the date of filing of the request. However, it failed to do so. Therefore, the company must now compensate the delay by paying 10% interest on the sum along with Rs 3,000 for mental and Rs 2,000 for physical harassment.

(The writer is Abhilash Botekar.)

TOP

Source

In Delhi, MACT orders insurance company to pay Rs 92 lakh to family of the deceased – Republic – 26th December 2019

Motor Accident of Claims Tribunal (MACT) of Delhi has ordered a health insurance company to pay over Rs 92 lakh compensation to the family of the person killed in a road accident.

On May 11, 2017, a motorcycle which was allegedly being driven in a rash and negligent manner hit Pradeep Kumar Srivastav from behind when he was taking an evening walk with his wife inside the NTPC township. He sustained serious injuries and died after a few days of the accident.

Hardeep Kaur, a judge MACT ordered IFFCO Tokio General Insurance Company Limited to pay Rs 92, 83,589 to Pradeep Kumar Srivastava's kin. He was employed as a senior manager with National Thermal Power Corporation Limited (NTPC) in Uttar Pradesh's Dadri district. Alakh Alok Srivastav, counsel of the petitioners told the MACT court that the deceased was earning Rs one lakh at the time of his demise and sought a total compensation of Rs 1, 39,22,487 for the disgruntled family member.

The wife of Pradeep of Kumar Srivastav told the tribunal court that it was the mistake of the truck driver because of which her husband died. The tribunal stated that "The factors are sufficient to conclude that preponderance of probability is made out showing negligence of respondent number two [accused] in causing the accident."

In a similar case, MACT Delhi had ordered an insurance company to pay 1.22 crore to the kin of a businessman who was killed in a road accident in Haryana.

Rajesh Jain, a businessman was killed in a road accident while returning to home from one of his factories on January 4, 2014.

The tribunal said," because of the discussion and the material and evidence which has come on record, it is held that the petitioners (family of Jain) have been able to prove based on preponderance of probabilities that the deceased (Jain) expired on above-mentioned date, time and place in a road accident caused due to rash and negligent driving of the offending vehicle's driver." Rajesh Jain was survived by his wife, two sons and his parents.

TOP

Source

Remarriage won't affect widow's compensation: Bombay High Court asks insurance firm to pay Rs 30 lakh to a woman - Mumbai Mirror – 23rd December 2019

The court asked insurance company to pay Rs 30 lakh to a woman who remarried within a year of losing her husband in a road accident in 2007.

Even if a widow remarries within a year of the husband's death in a road accident, she is still entitled to compensation, the Bombay High Court ruled recently.

The court held that such a widow continues to "represent the estate" of her husband and is thus entitled to make claims for compensation "irrespective of the change in her marital status".

Justice RD Dhanuka upheld the Motor Accident Claims Tribunal order and directed New India Assurance and one other responsible for the road accident, to pay the widow. The HC fixed the amount at Rs 29, 51,000, which includes an enhanced rate of interest, from 7 per cent to 9 per cent, for eight years.

Among its many arguments, the insurance company had contended that Mahindra Sonawane widow, Sushma, was not dependent on her husband's income at the time of filing the claim and, therefore, wasn't entitled for compensation.

Rejecting that contention, the court held that the status of the wife as a dependent has to be considered on the "date of death of Mahindra Sonawane and not on the date of filing an application for seeking compensation".

On February 21, 2007, at 6.30 am, Sonawane was headed for Nashik along with his mother via the Mumbai-Agra highway in a car when a truck coming from the opposite direction switched lanes and crashed into the vehicle.

While both mother and son died on the spot, their bodies could finally be removed after a crane was called to the spot.

His wife then approached the Motor Accident Claims Tribunal (MACT) along with their 10-year-old son. She had asserted that her husband was drawing a salary of over Rs 1.5 lakh as the director of a firm that exported flowers to the UK.

The Tribunal ruled in her favour and asked New India Assurance and the driver to pay compensation. Sushma, however, approached the high court for enhancement of compensation while the insurance company appealed against the order.

The company claimed that the driver should have been examined and that there was negligence on the part of Sonawane. The court, however, held that it was the insurance company's job to examine the driver.

(The writer is Sharmeen Hakim.)

TOP

Source

Eligible for two schemes but these patients still can't get money for transplants - The Economic Times – 22nd December 2019

Eleven-year-old Sameer from Bihar's Muzaffarpur district is suffering from aplastic anaemia, and needs Rs 12 lakh for a bone marrow transplant. You would think that's not a big hurdle since his mother's name figures in the list of Ayushman Bharat beneficiaries but unfortunately his condition isn't covered by the scheme. What's even more unfortunate for the family, which is paying through its nose for weekly platelet transfusions, is that though Sameer is eligible for treatment under Rashtriya Arogya Nidhi (RAN), which provides up to Rs 15 lakh to poor patients suffering from life-threatening conditions, he can't be treated because a government order stipulates that anybody covered under Ayushman Bharat Pradhan Mantri Jan Aarogya Yojana (AB-PMJAY) cannot be provided funds under RAN.

Sameer's mother, who was initially happy when they got a letter at home saying they were Ayushman beneficiaries, is now angry and distraught. "Now we are told the condition is not among the list of treatments covered by Ayushman. Why did they make me run around for all the papers required to get the card made when my son's disease is not covered under it? I have a BPL card, but it is of no use. Why did they do this and make my son ineligible for the RAN scheme meant for BPL patients?" laments Shahjehan.

What Shahjehan is referring to is a perverse situation created by a bureaucratic attempt to prevent duplication between two schemes, AB-PMJAY and RAN.

Sameer is not alone. In August, the medical superintendent of AIIMS, Delhi informed the health ministry that many poor patients suffering from conditions requiring treatments not listed under AB-PMJAY were unable to get assistance due to the RAN guideline barring AB-PMJAY beneficiaries. The ministry

responded to AIIMS on October 4 in a letter stating that the suggestions of the National Health Authority (NHA) and AIIMS to let ABPMJAY beneficiaries get assistance under RAN "cannot be agreed to".

Instead it suggested that the NHA, which oversees PMJAY, should consider including these treatments under its scheme and enhancing the ceiling of PMJAY beyond Rs 5 lakh per family "so that patients eligible under PMJAY may avail facilities under PMJAY only". Given that the Rs 5-lakh ceiling is a decision taken at the highest levels, it's not surprising that this suggestion remains on paper.

One of the main grounds was that there could be "misuse" with one family member availing assistance for transplantation of organs beyond Rs 5 lakh under RAN and then availing benefits under PMJAY in a different hospital/state. The ministry letter added that RAN was "not a general health scheme to provide treatment to all patients whose treatment cost is beyond Rs 5 lakh". AIIMS had brought it to the notice of the ministry that many patients had died waiting for financial assistance, but the ministry reiterated its position in an office memo dated November 4.

While the ministry is attempting to prevent misuse, doctors want the rule to be amended so that hundreds of poor people needing life-saving treatment can get it. "With the fraud monitoring and digital health that ABPMJAY has in place, why can't they ensure that the sort of fraud or duplication they fear does not happen? Why punish the poor?" asked an AIIMS doctor. The AIIMS letter had stated that applications for assistance under RAN were being rejected by the ministry's central committee despite being approved by the AIIMS technical committee and pointed out that before ABPMJAY was launched, all BPL patients could avail assistance from RAN.

Attempts to get the ministry's and DGHS's response to TOI's queries elicited no response.

Four months ago, Sameer's brother was matched as a donor for a bone marrow transplant which could possibly cure Sameer. But it cannot happen without financial assistance. In the meantime, the only treatment is frequent platelet transfusion without which his platelet (a blood component crucial for clotting) count goes down to dangerous levels. The family is exhausted from the constant effort to find donors for the once-a-week transfusions. Shahjehan and her two sons have been in Delhi for almost two years now trying to get Sameer treated.

Pankaj Kumar, a 17-year-old from Bihar's Vaishali district, is in the same situation despite a Ayushman card. His eyes are bloodshot from blood leaking due to low platelet count. In December, he has so far had three platelet transfusions. Being far away from relatives and friends, the parents have struggled to find donors. "The transfusion is free, but we have to bring the donors. Many times, I paid people Rs3,500-4,500 to become donors. I do Mazdoor in Delhi to make ends meet and we have rented a room near Azadpur Mandi. I barely make enough for us to manage. My wife and two sons are with me. This Ayushman card has blocked the only hope we had as BPL patients," said Vishwanath Saini, Pankaj's father.

Three months ago, Pankaj's older brother Pappu was matched as a donor for the required bone marrow transplant but they cannot afford it. "We sold the only plot of land we had for his treatment. All that is left in the village is the hut in which my elderly in-laws stay," said Pankaj's mother Sonia Devi tearfully. "Why can't we return it (the Ayushman card) and get treated under RAN as we have a BPL card?" she asks.

Watching others with BPL cards getting treatment adds to their frustration. "We meet other patients and families who have got assistance under RAN. Why are we being punished just because the government decided to add our names to the Ayushman database? We didn't ask for it," says Shahjehan.

Meanwhile, a petition has been filed in the Delhi high court by advocate Gaurav Kumar Bansal on behalf of Sameer seeking directions to the health ministry to remove the lacunae which bars those in need of transplant treatment from RAN benefits. The court has issued notices to the ministry, director general of health services and AIIMS.

(The writer is Rema Nagarajan.)

Source

TOP

PENSION

National Pension System: These NPS subscribers have to pay TDS on annuity, PFRDA clarifies – Financial Express – 24th December 2019

National Pension System (NPS) TDS Deduction: The Pension Fund Regulatory Authority of India has said that the annuity payable by the Annuity Service Providers (ASPs) to NRIs and OCIs will be taxed at source in accordance with the rates applicable as per the Double Taxation Avoidance Agreement (DTAA) of the country where the NRI or OCI resides. This year, the regulator allowed Overseas Citizen of India (OCI) to enroll in the NPS at par with the Non-Resident Indians (NRI).

In a circular dated December 17, 2019, the PFRDA said: "Based on the communication received from Insurance Regulatory and Development Authority of India (IRDAI), it is hereby clarified that Annuity payable by ASPs to NRIs and OCIs will be taxed at source, at rates applicable as per the DTAA (Double Taxation Avoidance Agreements) of the country where the annuitant resides.

The PFRDA has directed the intermediaries including Annuity Service Providers to display/convey to the prospective and existing subscribers that "Annuitanties payable to NRI/OCI are subject to TDS' and repatriation of the corpus, if any will be subject to applicable laws and regulatory provisions of IRDAI/PFRDA/RBI" in their publicity materials including websites, brochures and communications.

NPS for OCIs

The PFRDA had allowed citizens of other countries, who at some point of time were Indian citizens, to invest in the NPS in October at par with NRIs. The any individual having an OCI card can open Tier I NPS account.

Both NRIs and OCIs are not allowed to open the Tier II NPS account.

In 2016, the NRIs were allowed to invest in NPS online through eNPS. Before this, they were allowed to join NPS only through offline mode.

NPS is a contributory pension system in which contributions by subscribers are collected, invested and accumulated in their accounts. The final return under the scheme is subject to the performance of the funds in which the money is invested by the fund managers.

This month the PFRDA recommended the government to allow systematic withdrawal plans by subscribers from the NPS instead of annuities. The regulator also said that it is in favour of increasing the deduction from Rs 50,000 to Rs 1 lakh under Section 80 CCD (1B) in the NPS.

(The writer is Rajeev Kumar.)

TOP

Source

Atal Pension may yield Rs 10,000 a month - The Economic Times (Delhi edition) – 24th December 2019

The Finance Ministry is considering a proposal to relax the maximum monthly pension paid under the Atal Pension Yojana (APY) to ₹10,000 and raise the maximum age limit for enrolling in the scheme to 50 years. Presently, the scheme benefiting unorganized sector workers allows enrolments for those aged between 18 and 40.

The scheme also provides minimum guaranteed monthly pension of ₹1,000 to ₹5,000 from the age of 60. "We have recommenced the finance ministry to increase the age limit and double the maximum guaranteed monthly pension payout. We have also shared the subscription rates and submitted the actuarial valuation report with the government," said Supratim Bandyopadhyay, member (Finance), PFRDA. "We have shared our submissions, but how much financial commitment the government would be able to make is its call."

The PFRDA proposed merging the pension schemes available separately for farmers and shopkeepers with APY to avoid confusion. The APY, a flagship pension scheme of the government to cover the workers in the unorganized sector, has now crossed the 19 million subscription mark, data until Novend showed. PFRDA aims to increase the subscriber base to 22.5 million by March 2020.

The pension regulator had indicated in the past that enrolment of the first 10 million subscribers had taken three years, while it took only 18 months thereafter to double the subscriber base. ET had recently reported that the finance ministry is considering a proposal to allow PFRDA to become the single regulatory authority for all pension products. An announcement to that effect is expected in the upcoming budget.

The government is considering doubling the tax benefits currently available under the national pension scheme (NPS) to ₹1lakh under Section 80CCD (1b) and making the annuity income tax-free. Currently, the annuity received is taxable in the year of receipt.

(The writer is Saloni Shukla.)

TOP

Source

Budget 2020: PFRDA wants govt to double tax benefit under NPS to Rs1 lakh – Mint – 23rd December 2019

Pension fund regulator PFRDA is pitching for doubling the tax benefit under the NPS to ₹1 lakh in the upcoming Budget, according to a whole-time member of the authority.

The Pension Fund Regulatory and Development Authority of India (PFRDA) has also urged the government to extend the facility of tax free contribution of 14 per cent by the central government to its employees under the NPS to all categories of subscribers.

The tax deduction under the NPS is ₹50,000 at present.

"For the Budget, we are trying to see that the ₹50,000 investment which is tax free under National Pension System (NPS), it should be raised to an amount of ₹1 lakh," PFRDA Whole Time Member Supratim Bandyopadhyay told PTI.

Employers' contribution of 14 per cent in pension for central government employees was made tax free from April 1, 2019.

"We have requested that this facility should be extended to state government employees as well as the autonomous bodies of both central and state government," he added.

For state government and autonomous bodies, as per the extant tax rules, up to 10 per cent of the employers' contribution is tax free and the rest 4 per cent is taxable at the hands of the employee.

Maharashtra, Bihar, Karnataka, Uttar Pradesh, Uttarakhand and Himachal Pradesh have enhanced the employers' contribution under NPS to 14 per cent from 10 per cent earlier. While Punjab recently announced to raise its contribution to 14 per cent.

"Apart from that we have been asking for increasing the age limit for subscription under Atal Pension Yojana (APY) from 40 to 60 years. And also to increase the pension limit from existing ₹5,000 a month to ₹10,000 per month under APY," Bandyopadhyay said.

APY, the pension scheme for the unorganized sector employees as well as self earners is sold to people under the age bracket of 18-40 years.

Further, keeping in view a UN report which says that globally the population aged 65 and above is growing faster than all other age groups, he said the PFRDA is focussing in a big way on the APY to increase pension penetration in India.

He said the pension regulator is conducting nationwide campaigns to bring more and more people in the informal sector to join the APY.

When asked about gender wise subscription under the APY, he said it is majorly dominated by male participants, however, states like Tamil Nadu and Kerala show more and more women joining the schemes.

"In places like Tamil Nadu and Kerala, we have seen that female participation is more because there our distribution channels are basically self-help groups (which are mainly run by women). One analysis is that when women subscribe to APY then their chances of staying with the system (APY) is more than male participants by 5 per cent," he said.

He said the PFRDA has set a rough target of adding 75 lakh subscribers under APY in the current fiscal of which 47 lakh have already been added so far.

"We have a very conservative target of 7.5 million under APY this year out of which we have already crossed 4.7 million and I believe that it is definitely possible (to reach the target) because the last three-four months like from December to March are the most productive months," he added.

As of November 9, 2019, the overall number of NPS and APY subscribers in the country crossed 3.12 crore with Asset under Management (AUM) of over ₹3.85 lakh crore , as per the PFRDA data.

The PFRDA administers these two pension schemes.

TOP

Source

Navigating the National Pension System – The Hindu – 22nd December 2019

The popularity of the National Pension System (NPS), the market-linked vehicle, has been soaring with investors desperately seeking retirement options. But for a newbie investor, investing in NPS can be very much like visiting a Starbucks outlet for the first time. The scheme offers so many choices that one is unsure where to start. With a little help though, you can use NPS's large menu to your advantage.

Tier I and Tier II

One of the first choices you'll need to make while opening an NPS account is whether you need just a Tier I account or want to add on a Tier II account as well. If retirement savings is your goal, a Tier I account should suffice.

The Tier II account is a voluntary investment vehicle where you can put in and withdraw money at any time. It is only under the Tier I account that your contributions earn tax breaks of up to ₹1.5 lakh a year under section 80C and the additional exemption of ₹50,000 a year under section 80CCD (1B). Tier II

contributions do not earn any tax breaks. While the NPS Tier II does offer advantages such as flexibility and low fees, there are alternative products such as mutual funds that you can consider too, for such voluntary investments.

Which fund manager

The NPS lets you choose who will manage your money.

The scheme currently has 7 pension fund managers (PFMs) on its menu – Birla Sun Life Pension Management, HDFC Pension Management Company, ICICI Prudential Pension Management Company, Kotak Mahindra Pension Fund, LIC Pension Fund, SBI Pension Funds and UTI Retirement Solutions.

Given that the NPS is market linked, there's no easy way to gauge which fund manager will deliver the best performance in future.

However, their past return record can be a useful guide. The NPS Trust publishes the last 1-,3-, 5-,7- and 10-year returns of all PFMs weekly at http://www.npstrust.org.in/return-of-nps-scheme. This table shows performance separately for equities, corporate bonds and government securities. However, as you can choose only a single PFM, it is best to go for one with a reasonable performance across all three.

In market-linked products, the true performance of a fund manager can be gauged only over a complete market cycle. Of the seven PFMs, only four have a 10-year track record. UTI Retirement Solutions, ICICI Pru Pension and SBI Pension have a good 10year record.

Which asset classes

The NPS allocates your accumulated contributions into four asset classes – Equity (E), Corporate bonds (C), Government Bonds (G) and Alternative Investment Funds such as private equity funds, REITs, Invits (A). Your allocation among these is critical to your final returns.

These assets carry varying risk profiles. Equities can get you to a double-digit return in the long run with a significant risk of capital losses.

Corporate bonds can get you to a high fixed return with some risk of defaults. Government bonds fetch you a moderate fixed return with complete safety of capital. Alternative investment funds, usually targeted at high net worth investors, target supernormal returns by investing in unlisted or exotic assets, but carry high risks.

For ordinary investors, allocations to E, C and G are sufficient to build a sound retirement portfolio. How you divide your money should be based on your risk appetite.

Auto or Active choice

To implement an asset allocation, the NPS presents you with two possibilities — an Auto choice and an Active choice. The Auto choice helps you put your allocation in self-driving mode. The Active choice lets you to control how your contributions will be divided.

Earlier, opting for the Auto choice meant sticking to a single asset allocation plan. But today, the Auto choice has three readymade menus within it. So, there's the Aggressive Lifecycle Fund that starts with a 75% equity allocation, 10% in corporate bonds and 15% in government bonds.

There's the Moderate Lifecycle Fund which starts out with a 50% equity allocation, 30% in corporate bonds and 20% in government paper. There's the Conservative Lifecycle Fund with a 25% equity

allocation, 45% in corporate bonds and 30% in government bonds. Do note that these allocations are only the starting point and apply to NPS subscribers up to 35 years of age.

As you age, the Auto choice steadily trims your equities and raises your bond exposures. The automatic rejigs ensure that, by the time they turn 55, Auto choice subscribers have only 5-15% of their corpus invested in equities, with 85-95% in bonds.

In the Active choice, you get to decide how to mix and match E, C, G and A in any proportion, subject to just two conditions. One, the maximum you can invest in equities is 75% and that too up to 50 years of age. Beyond 50, your maximum equity limit gets reduced by 2.5% for every additional year. Two, you cannot park more than 5% in Alternative Investment Funds.

The Auto choice may certainly look appealing for folks to whom finance is Greek and Latin. But the flip side is that your returns at retirement may be sub-optimal. The Auto choice's propensity to cut back on your equity exposures right from the age of 35 can leave you with a very bond-heavy portfolio in your 40s and 50s, when your earnings are likely to be at their peak.

To maximise the retirement corpus you accumulate, it is desirable to opt for the Active choice. Peg your equity allocations at 60-75% to begin with, park 15% in corporate bonds and the rest in government bonds. You can sit tight on this allocation until you turn 55. That will be a good time to shift allocations to government bonds in order to reduce risks in the home run to retirement.

Finally, one of the most investor-friendly features of NPS is that it allows you to change your choice of PFMs and asset allocations once a year, without any costs or tax implications. Review the performance of your PFM at least twice a year and exercise the switch option if there's a big lag.

(The writer is Aarati Krishnan.)

TOP

Source

Govt to make PFRDA sole regulator for pension products, says official - Financial Express – 20th December 2019

The government is moving ahead to make Pension Fund Regulatory and Development Authority (PFRDA) as the sole watchdog for all pension products in the country, a senior official from the agency said on Friday.

In its pre-budget proposal, the body has sought for a doubling of the Income Tax exemptions for contributions towards pensions to Rs 1 lakh under Section 80CCD (1B), PFRDA's Member (Finance) Supratim Bandyopadhyay, told reporters here.

At present, pension's products are sold by both insurance companies as well mutual funds, which makes Irdai and Sebi, as the regulators for those products. "The in-principle approval has come from the Finance Ministry for the PFRDA Act amendment which will make PFRDA the single regulator for pension products," Bandyopadhyay said. He also said the authority expects the amendments to PFRDA Act to be passed by the Parliament during the Budget Session.
In order to encourage more people to join the New Pension Scheme (NPS), he said PFRDA has made the proposal for doubling of the tax deductions under the scheme. The body has also recommended that the government allow Systematic Withdrawal Plans (SWPs) for National Pension System (NPS) instead of buying annuities, he said.

TOP

Source

PFRDA would like to junk annuities and go flexi – Mint – 20th December 2019

PFRDA whole-time member Supratim Bandyopadhyay announced a slew of proposals for NPS at a media interaction on Friday. Three of these changes suggested by the PFRDA have received in-principle approval from the Finance Ministry, according to Bandyopadhyay.

They will be sent to an inter-ministerial body for a final decision. A decision on these issues is expected in time for the Budget session.

The first proposal is the setting up of a unified regulator for all pension products. At present pension products are governed by different regulators. Unit Linked Pension Plans (ULPPs) and annuities are governed by the Insurance Regulatory Development Authority of India (IRDAI).

Employees' Pension Scheme (EPS) is governed by Employees' Provident Fund Organisation EPFO and superannuation funds are managed by either employers or insurance companies, regulated by the IRDA. Retirement funds are managed by Mutual Fund houses regulated by SEBI. These products also have different costs for subscribers and incentives for distributors, creating confusion in the pension market in India.

"As far as a unified pension system is concerned, this is a necessity to avoid complexity and confusion," said Sumit Shukla, CEO, HDFC Pension Fund. "A good pension system will also make long term funds available for investment especially in infrastructure and economic growth," he added. However the proposal to allow subscribers to migrate between the EPF and NPS was dropped in the new Social Security Code. "Different regulators create distortions in the market. A single regulator will give a clear vision and direction to the Indian pensions landscape," said Amit Gopal, India business leader - investments, Mercer.

The second change proposed by the PFRDA is the introduction of a Systematic Withdrawal Plan (SWP) for NPS subscribers on maturity as an additional option. This option will be offered for the 40% component of the NPS corpus on maturity which has to be currently used to buy an annuity. An SWP withdraws a fixed amount every month from an accumulated corpus.

The remaining money continues to be invested. According to Bandyopadhyay, the taxation of the SWP may be akin to that of mutual fund SWPs but this is yet to be finalized. Alternatively, the PFRDA has suggested that pension fund managers be allowed to float annuities or cash management products rather than insurance companies as is currently the case. "With SWP, investors will get more freedom to withdraw as per their needs rather than being locked into an interest rate. However the taxation of the SWP needs to be seen before understanding how big a move this is," said Amol Joshi, founder, Plan Rupee Investment Services.

The third proposal is a separation of the NPS Trust and PFRDA, a proposal that was already floated in the Budget but has not yet been implemented. The NPS Trust plays a role in the operation of NPS schemes and hence should be distinct and separate from the regulator (PFRDA) which supervises them. "There absolutely should be a separation between the regulator and NPS trust, so there is no conflict of interest," said Shukla. Another reform suggested by the PFRDA for Budget 2019 is the hiking the tax deduction for NPS under Section 80 CCD (1B) from ₹50,000 per year to ₹1 lakh per year. For the Atal Pension Yojana, the PFRDA has proposed a hike in the maximum pension to ₹10,000 per month from the current ₹5,000 per month and a hike in the maximum age from 40 to 50 years.

Recent media reports have stated that the government is considering a hike in the FDI cap in insurance from 49% to 75% which is also likely to affect FDI in pension funds. Once these proposals are cleared, there will be another request for proposals (RFP) for Pension Fund Managers said Bandyopadhyay and

there could be a re-look at pension fund manager fees. These are currently capped at 0.01% which has made the business unviable for many players in the industry. Incentives for agents and distributors is also another area in which the PFRDA is considering changes. At present NPS Points-of-Presence (distributors) get a maximum of 0.25% of each contribution. However, this is far short of the roughly 1% that mutual fund distributors get and the far higher charges (8-10% of premiums) that insurance agents get.

(The writer is Neil Borate.)

TOP

Source

GLOBAL NEWS

Malaysia: Takaful shows steady penetration growth in last 10 years - Asia Insurance Review

Malaysia's takaful segment recorded double-digit penetration rate of 15.5% in the first half of this year compared to 9.3% a decade earlier in 2009, reported state-run news agency Bernama.

The penetration rate of family takaful had been steadily increasing with a double-digit growth of 15.5% as of the first half of this year from about 9.3% in 2009. The same scenario could also be seen in the general takaful segment which performed better than the conventional segment, according to MIDF Amanah Investment Bank insurance analyst Khoo Zhen Ye.

The takaful segment in Malaysia has registered higher growth than conventional insurance because of factors such as a lower base, stable domestic consumption, and increasing consumer awareness. The market has also driven partially by the central bank's target to increase the share of the Islamic financing mix to 40% by 2020.

"Overall in 2019, the life insurance segment performed better compared with general insurance segment as the latter is in the phased liberalisation of the motor and fire tariffs. The tariff liberalisation has started since last year but for fire insurance which was supposed to take effect this year had been postponed to next year to give some space to industry players," said Mr Khoo.

He also noted that the overall insurance penetration rate in Malaysia continued to remain stagnant at around 54% to 55 %for the past five years.

However, he still held a positive outlook for the industry amidst a strong domestic demand. The main driver of growth will come from the life and family takaful segment, he said as he foresees non-policy holders taking advantage of the new life and takaful tax relief of MYR3,000 ($725.45).

TOP

Source

Bangladesh: Non-life segment registers nearly 14% growth - Asia Insurance Review

Non-life insurers saw a 13.68% growth in gross premium income from BDT26.69bn ($315.56m) in 2017 to BDT30.34bn in 2018. At the same time, their total assets increased from BDT79.77m in 2018 from BDT75.5m the previous year.

However, total investment for the non-life sector dropped from BDT38.64bn in 2017 to BDT38.04bn in 2018 according to a report from local publication Financial Express citing Bangladesh Insurance Association (BIA)'s 2018 annual report.

Meanwhile, the report also showed an 8.78% rise in the total premium income of private sector life insurers from BDT77.32bn in 2017 to BDT84.76bn in 2018. The total assets of these insurers stood at BDT363.94bn in 2018 as against BDT346.52bn in 2017.

Earlier this week (24 December), the annual report was discussed by chairmen, directors and CEOs of insurance companies at BIA's 32nd annual general meeting which was presided over by BIA president Sheikh Kabir Hossain.

At 0.57%, Bangladesh has one of the lowest overall insurance penetration rates in emerging Asia according to Swiss Re data. There are currently 32 life and 46 non-life insurers operating in the country.

TOP

Source

South Korea: Insurance costs for panic disorder patients up by 61.5% - Asia Insurance Review

Health insurance costs for Koreans suffering from panic disorder, a common mental condition, jumped by 18.6% annually from KRW31.2bn ($26.87m) in 2014 to KRW61.6bn last year according to a Korea Bizwire report citing latest data analysis released by the National Health Insurance Service (NHIS).

This represented a significant 61.5% increase over the last five years.

At the same time, the number of patients visiting hospitals due to panic disorder has surged by 70.5% in the same time period with 159,428 patients last year.

Among them, women accounted for 86,010 which was 1.2 times higher than the number of men (73,418) and patients in their 40s comprised the largest age segment at 24.4% of the total.

Meanwhile, patients from their 30s to 50s accounted for about two-thirds of the total with 20.7% of them in their 50s and 18.5% of them in their 30s.

However, young patients saw the highest average annual growth rate from 2014 to last year. Patients in their 20s and teens grew by 24.5% and 18.1% respectively according to the NHIS report.

"The risk factors of panic disorder include a lack of socioeconomic resources, smoking, alcohol problems and stress-inducing incidents such as a recent divorce or separation," said NHIS Ilsan Hospital professor Park Sun-young.

Panic disorder includes symptoms such as repeated panic attacks and treatments such as counselling especially cognitive-behavioural therapy according to Cigna Insurance research.

TOP

Source

Taiwan: 61% jump in complaints on insurance policies - Asia Insurance Review

Disputes over compensation amounts and the definition of medically necessary treatment has led to a 61% year-on-year rise in complaints about insurance policies in Q32019, reported Taipei Times citing a Financial Ombudsman Institution report.

In the last quarter, there were a total of 1,721 complaints and in the first three quarters of the year, the number of insurance complaints amounted to 4,733. A majority of the complaints (71%) comprised disagreements over life insurance policies as the products which include injury and accident insurance are more complex than property insurance policies, said the report.

Out of the 665 complaints based on claims-related disputes reported last month, 37% concerned disagreements about the amount of compensation, the definition of medical necessity and which surgery a policy covers. These were followed by disputes over accident liability, delayed claims and pre-existing illnesses which made up 23% of complaints. Meanwhile, a majority of the 566 non-claims-related complaint were due to sales agents providing false information regarding policy coverage, the validity of policies and payment of premiums.

TOP

Source

Thailand looks to set up central claims centre for health insurance -Asia Insurance Review

The Thai Life Assurance Association (TLAA) aims to establish a central claim centre which will pool all health insurance claims. This will improve convenience for claimants and hospitals, reduce claim processing costs and help prevent insurers from inaccurate claims, said a report from the Bangkok Post.

Many life insurers in the country offer products through the digital channel. However, the industry still lacks sharing facilities unlike the banking industry which has ATM pools.

The incorporation of a central claim centre will therefore enable all health insurance policyholders to make claims at a single point regardless of their insurer according to TLAA president Nusara Banya tpiyaphod. A medical bill claim can then be shared in proportion or based on policies that are taken out first in the case of multiple health policies, she said.

A central claim centre helps insurance policyholders, hospitals and insurers not only cut costs, but also supports the ecosystem for digital insurance in the future. It will also allow hospitals to view a patient's health insurance benefits instead of manually checking from life insurers' websites. Making a claim for multiple health benefit policies is a time-consuming process because some insurers require an original receipt for hospital bill claims to prevent policyholders from 'over claiming', said Ms Banyatpiyaphod.

"It would be better if the association can create a central claim website for hospitals to let them know the overall health benefits of patients just by filling out the 13-digit ID number. Life insurers should provide better services for customers than we do now," she said.

TOP

Source

South Korea: Regulator calls for insurers to brace for IFRS 17 - Asia Insurance Review

South Korea's insurance regulator has urged the country's insurers to strengthen their capital base and align their assets and liabilities in preparation of IFRS 17's implementation on 1 January 2022.

Under the new rules, insurers' liabilities will be assessed on the basis of their market value rather than book value. This seeks to fairly assess an insurer's ability to have a larger capital base and reserves to cover potential losses. Therefore, the Financial Services Commission (FSC) has encouraged local insurers to increase their capital base gradually.

The change of global accounting rules comes at a time when the local insurance industry is struggling with lackluster growth. In 2018, local insurers saw their combined net profit decline 7.4% to KRW7.27tn ($6.2bn) as demand for insurance policies fell amid low interest rates and a slowing economy.

FSC Chairman Eun Sung-soo also said that insurers must bear a financial burden over sales of mismanaged insurance products such as indemnity medical insurance or reimbursement-backed private medical insurance.

Due to such heightened regulatory focus, industry capitalisation is expected to further improve according to EY in its '*2020 South Korea Insurance Outlook*' report.

EY states that a series of accounting scandals in the country has led to drastic, government-driven audit reforms that are designed to enhance accounting transparency fundamentally. For the next three years, approximately 660 companies are subject to mandatory auditor designations, with the biggest impact felt by top-tier life and non-life insurers and insurance affiliates of major financial groups.

However, analysts have warned that some insurers may face recapitalization pressure if the new accounting rules are adopted.

TOP

Source