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QUOTE OF THE WEEK

"Human behavior flows from three main sources: desire, emotion, and knowledge."

Plato

INSIDE THE ISSUE

INSURANCE TERM FOR THE WEEK

Unearned Premiums

Definition: Unearned premium is that part of the overall premium which is collected by the insurance companies beforehand, but for which protection is not provided.

Description: The premium is collected in advance by the insurer, but the insurer needs to pay back the premium to the insured in the event of cancellation of the policy. As this is an unearned income, the same is treated as a liability in the balance sheet of an insurance company.

Source

INSURANCE INDUSTRY

Insurance sector liberalisation to lift India's ease-of-doing-business ranking - CNBC – 11th February 2020

Insurance -- The spontaneous reaction to that word is 'get coverage to secure your life, health, and property'. The Indian insurance industry comprises approximately 57 insurance companies - 24 in the life insurance space and 33 in the non-life. Among the life insurers, Life Insurance Corporation (LIC) is the sole public sector company, which is currently preparing for an IPO. In the world's second-most populous country, statistics show that only about 4 in 100 Indians have life insurance coverage – a huge potential market for companies and investors.

Given the sensitivities of this sector, the industry is highly regulated by the Insurance Regulatory and Development Authority of India (Irdai) acting as its watchdog. This sector has opened up to foreign direct investment (FDI) after much deliberation over several years. From an initial FDI limit of 26 percent under the automatic route and 26 percent to 49 percent under the approval route, the Insurance Law (Amendment) Act, 2015 increased the FDI limit in the insurance sector to 49 percent under the automatic route, resulting in many successful insurance joint ventures such as Tata AIG General Insurance Company Limited and Bajaj Allianz General Insurance Company Limited.

Pursuant to the Insurance Law (Amendment) Act, 2015, the Indian Insurance Companies (Foreign Investment) Rules, 2015 (Foreign Investment Rules) were ratified. Under these rules, in addition to insurers, foreign investment in insurance intermediaries, was also to be capped at 49 percent. The cap was considered unfair, because insurance intermediaries, unlike insurers, are not custodians of policyholders' money. As a result, the Union government ratified the Indian Insurance Companies (Foreign Investment) Amendment Rules, 2019, on September 2, 2019, increasing the FDI limit for insurance intermediaries to 100 percent.

Raising FDI limit

In addition to the Foreign Investment Rules, insurers and insurance intermediaries are also required to comply with Irdai's guidelines on the Indian owned and controlled of October 19, 2015 (IOC guidelines). The IOC guidelines mandate insurers and insurance intermediaries to be Indian owned and controlled, by ensuring: (i) the majority of the Board of Directors, excluding independent directors, be nominated by Indian investors/promoters; (ii) key management persons, including the CEO and principal officer, be

appointed by the Board of Directors or the Indian investors/promoters; (iii) control over 'significant policies' be exercised by an appropriately constituted (as per (i) above) Board of Directors; (iv) in cases where the chair of the Board of Directors has a casting vote, they are nominated by the Indian investors/promoters; and (v) the quorum for a board meeting is a majority of the Indian directors.

A circular in November 2019 and the Irdai (Insurance Intermediaries) (Amendment) Regulations 2019 relaxed these compliances vis-a-vis insurance intermediaries, making the IOC guidelines inapplicable to insurance intermediaries.

The government is looking at further liberalisation of this sector, as indicated by the finance minister in her budget speech. A further increase of the FDI limit in this sector, from the existing 49 percent to a proposed 74 percent under the automatic route, is on the cards. To facilitate this increased investment limit, the government will have to amend the Insurance Act, 1938, the Foreign Investment Rules, and other allied legislations. In addition, the government will have to alter the provisions pertaining to the IOC guidelines. Other factors that will have to be considered are solvency of firms owned by foreign promoters, the exercise of long-term liability contracts on overseas owners, and securing the rights of policyholders in case the insurer is foreign owned. The extent to which the applicability of the IOC guidelines are withdrawn/altered for insurers is yet to be seen, especially in light of the fact that though the IOC guidelines are withdrawn for insurance intermediaries, insurance intermediaries with majority foreign shareholding are still required to ensure that the majority of their key management persons and Board of Directors are resident Indian citizens.

IPO of LIC a sure-shot success

Such liberalisations will definitely help India further improve its ranking in the Ease of Doing Business Index. India jumped from rank 142 in 2014 to rank 63 in 2020 on the World Bank Ease of Doing Business Index. With 16 percent surge in FDI inflows in 2019, India drove the FDI growth in South Asia. Per the Global Investment Trend Monitor Report of the United Nations Conference on Trade and Development (UNCTAD), India attracted $49 billion FDI inflows in 2019, compared with $42 billion in 2018.

As far as the LIC IPO is concerned, if the precedent set by the IPO of Indian Railway Catering and Tourism Corporation (IRCTC) is anything to go by, the IPO of LIC is a sure-shot success for the government and will improve product transparency and efficiency across the entire life insurance sector. LIC is likely to become the nation's largest company by market value on the day of the listing, given that it is the largest company based on assets under management (AUM). The insurance sector is sure to get a boost with all these measures in the government's plan of action.

(The writers are Pallavi Puri and Pooja Thomas.)

TOP

Source

Hike in deposit insurance cover welcome, but more deep-rooted reforms are needed – The Hindu Business Line – 10th February 2020

The decision by the Centre/RBI to substantially hike the insurance cover for depositors in scheduled banks from ₹1 lakh to ₹5 lakh is a welcome move that is likely to mend bruised public confidence in banks, lift financial savings and level the unequal playing field between State-owned banks and their private counterparts in their access to CASA deposits.

With the ₹1 lakh deposit insurance limit set way back in May 1993, the impact of inflation and rising income levels had ensured that nearly 72 per cent of bank deposits by value remained unprotected by end-March 2019. The five-fold hike in insurance limit now ensures that the lion's share of retail deposits by value are shielded from bank failures.

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Source

INSURANCE REGULATION

New Definition of Pre-Existing Diseases by the IRDAI – Moneycontrol – 14th February 2020

Health insurance is a significant investment. You need insurance so that you can seek the necessary treatment without bearing the enormous costs associated with hospitalisation, surgery, treatment, and so on. However, every insurance policy comes it its own set of terms and conditions. The coverage you get depends upon the sum assured and the deductibles you choose.

Health Insurance for Pre-existing Conditions:
Health insurance companies also provide policies for individuals suffering from pre-existing diseases. However, such individuals cannot seek treatment for those diseases and cannot encash the policy until they've ridden out long waiting periods lasting 2-4 years. However, all of this is set to change as the Insurance Regulatory and Development Authority of India (IRDAI) has recently amended the definition of pre-existing diseases. Here's the original definition of pre-existing diseases, the new definition amended by the IRDAI and what this change could mean for policyholders.

Pre-Existing Diseases – Meaning and Original Definition
A pre-existing disease is an insurance term used to refer to a condition, injury or ailment, which already exists when a policyholder purchases a health insurance policy. Often abbreviated as PEDs, the insurance provider generally excludes these conditions from the policy coverage until the policyholder rides out what is known as an 'initial waiting period'. Typically, the minimum and maximum waiting periods on such pre-existing diseases is anywhere between two and four years, respectively.

Pre-Existing Diseases – The Two Amendments made by the IRDAI
In September 2019, the IRDAI modified the definition of pre-existing diseases. The IRDAI issued a regulation stating that insurance companies were mandated to include certain illnesses and diseases if they were diagnosed (in the policyholder) within three months of buying the insurance policy. The amended definition was included in the standardisation guidelines in health insurance that the IRDAI released on 27th September 2019.

However, the IRDAI issued another circulator on 10th February 2020, in which it once again amended the definition of pre-existing diseases. As per the new circular, the IRDAI has now deleted the 'additional/modified clause'. Thus, as per the new definition, no such disease or illness will be treated as pre-existing even if it is diagnosed within a period of three months, or later, after one has purchased the health insurance policy.

The New Definition of Pre-Existing Diseases as mentioned in the IRDAI circular
The new description of pre-existing diseases comprises of three clauses. It is as under:

As per IRDAI, a Pre-existing Disease is any condition, injury, ailment, or disease, which is/are diagnosed by a doctor within 48 months (2 years) before the effective date of the insurance policy issued by the health insurance provider

It is a condition for which medical treatment or advice was recommended or provided by the doctor within 48 months (2 years) before the effective date of the insurance policy issued by the health insurance provider.

The IRDAI also states that (Life insurance providers may define the norms for the applicability of pre-existing diseases when a policy is reinstated.

As per the new definition, the IRDAI has removed or deleted the following clause
A Pre-existing Disease is any condition, injury, ailment, or disease for which any signs or symptoms, leading to an illness or medical condition are presented and have resulted within less than three months of the time the policy is issued. Note that the amended definition of pre-existing diseases does not apply to overseas travel insurance.

How the Amended definition can help policyholders
Owing to the original definition of pre-existing diseases, health insurance companies had the leverage to reject insurance claims and increase the waiting period, even if one was diagnosed of a condition within a few days of purchasing the health insurance policy. As a result, the policyholders could not file a claim despite pay high insurance premiums. However, due to the IRDAI's interference, policyholders do not have to worry about filing claims. The move by the IRDAI could undoubtedly lead to reduced instances of claim rejection rates in the health insurance sector.

The IRDAI has mandated all insurance providers, including third-party administrators (insurance agents and brokers), wherever applicable, to make the necessary changes and ensure complete compliance with the new directive stated in IRDAI's circular, with immediate effect.

List of Diseases regarded as Pre-Existing:
Health insurance providers typically enlist certain, specific diseases as pre-existing in the policy document. Here's a list featuring some of the most common types of diseases or conditions that are generally regarded as pre-existing in all insurance policies

- Asthma
- Diabetes
- High blood pressure
- Thyroid
- Sleep apnoea
- Lupus
- COPD
- Cancer
- Atherosclerosis

Things to remember

- While purchasing a health insurance policy, you must truthfully disclose your medical history to your insurance provider
- You must inform them if you are suffering from any pre-existing diseases
- Failure to notify the insurer about pre-existing conditions can result in your claim being rejected
- The insurer may also refuse to renew your policy
- The insurer may levy a higher insurance premium if you're suffering from pre-existing conditions

Final word: Before buying a health insurance policy for pre-existing conditions, make sure that you compare the different insurance providers. Check the premiums charged and the waiting period. Remember to read the terms and conditions and the inclusions and exclusions in the policy before you pay the insurance premium.

TOP

Source

New Irdai guidelines unlikely to impact insurance premium rates for now – Business Standard – 13th February 2020

The Insurance Regulatory and Development Authority of India's (IRDAI) February 10, 2020 circular is likely to cause more than a flutter in the general insurance industry. The amendment in the definition of pre-existing disease (PED) allowing claims to be made within three months of buying a policy may result in a higher number of claims.

But experts say insurers are unlikely to hike their premium rates immediately and will in all probability absorb the impact, for now. In insurance parlance, claims made soon after the purchase of a policy are referred to as 'early claims. And such claims tend to be prone to frauds.

The three-month barrier served as a safeguard against fraudulent claims. "If you remove this barrier, there is the possibility of a rise in the number of fraudulent claims. That could, in turn, result in insurers raising their premiums, which would not be in the interest of good customers.

To prevent harassment of genuine customers, may be specific steps can be prescribed for these first three months, but a blanket removal may not be advisable," says Joydeep K Roy, Partner & Leader India Insurance Practice & Global Leader for Insurance Digital Assets, PwC.

(The writer is Sanjay Kumar Singh.)

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Source

Good news for health insurance policyholders! IRDAI revises definition of pre-existing diseases – Financial Express – 10th February 2020

The Insurance Regulator and Development Authority of India (IRDAI) has brought in changes to the definition of pre-existing diseases. Through a circular dated February 10, 2020, IRDAI has deleted 'the additional/modified clause' in its current definition of pre-existing diseases. Experts say this move could bring in a reduction in the claim rejection rates in health insurance policies.

The regulator had modified the definition of pre-existing diseases last year. IRDAI had included certain illnesses if they were diagnosed within 3 months after purchasing the health insurance policy. However, as per the new definition, now no such disease will be treated as a pre-existing disease even if diagnosed within 3 months, or later, of buying the health insurance policy.

Definition of Pre-existing Diseases as per IRDAI
The existing definition of Pre-Existing Disease sates that (not applicable for Overseas Travel Insurance) pre-existing disease means any condition, ailment, injury or disease:

i) Old definition: That is diagnosed by any physician within 48 months, preceding the effective date of the policy issued by the insurer.
New definition: That is diagnosed by a physician within 48 months preceding the effective date of the policy issued by the insurer or its reinstatement.

ii) Old definition: For which medical advice or treatment was received from a physician within 48 months preceding the effective date of the policy or its reinstatement.
New definition: Any illness for which medical advice or treatment was recommended, or received from, a physician within 48 months preceding to the effective date of the policy issued by the insurer or its reinstatement.

iii) Old definition: Any condition for which symptoms or signs if presented and have resulted within 3 months of the issuance of the policy in a diagnostic illness or medical condition.
New definition: Deleted

What is pre-existing condition?
Insurance companies consider medical illness or injury that have occurred to the policyholder before he/she started a new health plan as a pre-existing condition.

Examples of pre-existing health conditions
Conditions like diabetes, COPD, cancer, lupus, epilepsy, depression, anxiety, sleep apnea, etc. fall under pre-existing health conditions, mostly which tend to be chronic or long term.

(The writer is Priyadarshini Maji.)

TOP

Source

IRDAI new rules on ULIP, Non-Linked insurance products: Check what has changed – Financial Express – 10th February 2020

On 8th July 2019, the Insurance Regulatory and Development Authority of India (IRDAI) issued guidelines for both unit-linked and non-linked insurance products with the proposition to make them more customer-centric. The issued notification broadly talks about the rules for pension products, traditional plans and Unit Linked Insurance Plans (ULIP) by easing the surrender and annuity process. The reason for the issuance was to improve the current product regulations in order to be in line with dynamic needs of the present and to ensure that insurers follow prudent practices to protect the interests of policyholders.

In order to implement it right on time, IRDAI has made it mandatory for all insurance companies to get these guidelines with effect from February 2020 superseding the earlier circulars on the subject. The move is a strong effort to increase transparency and curbing mis-selling of life insurance policies while also ensuring that policyholders are provided with all the correct information related to the product.

As per the rules, a policy lapses when the policyholder skips paying premium which is not just on the due date but even within the grace period. According to the new guidelines, IRDAI has asked the insurance companies to increase the revival period of non-linked policies to 5 years from the current 2 years. To comply with this provision, LIC of India has decided to increase the revival period of 32 of its products to 5 years and that of its ULIP plan, New Endowment Plus, to 3 years from the date of the first unpaid premium. This is the best change that has been brought keeping insured's interest and their financial conditions.

There have also been some changes in the minimum sum assured of linked and non-linked products. For regular premium and limited premium paying policy, death benefit is reduced to seven times the annualised premiums, irrespective of your age when you purchase the policy. For single premium policy, the sum assured is 125% of single premium, again irrespective of your entry age. After its implementation, the policyholder will be able to invest in market more resulting in building higher corpus rather than getting deducted for the mortality charges. However, to avail tax benefit under section 80C, death benefit is still required to be 10 times of the annual premium. Also, the new regulations will now allow the insurers to charge an extra premium from policyholders who wish to buy riders with unit-linked insurance plans. Previously, insurers used to deduct units from ULIPs in case a policyholder buys riders with it.

People these days, while investing money in a specific product, invest with certain goals and tenure in mind. However, as they pass through different stages of life and experience different aspects, the goals tend to change. On traditional policy front, if for some reason the policyholder plans to discontinue his policy now, one doesn't have to wait three years for their policy to acquire guaranteed surrender value.

Which means, if a policy is discontinued after 2 years from its commencement, then a fixed sum of up to 30% will be given to the policyholder. The draft had proposed 35% payback if you surrender after 3 years and for the 4th to 7th year it will increase to 50%.

Moreover, rules have also been tweaked for premature part withdrawals. To make the life insurance pension products comparable with NPS, it will now allow partial withdrawal in case of linked pension plans in situations of critical illness, permanent disability because of an accident, or any other major health issue wherein the insured needs to withdraw some amount for survival.

Previously, one could draw only 1/3rd as the lump sum amount and 2/3rd of the amount was annuitized. But now, once the five-year lock-in ends, the maximum withdrawal allowed at maturity has been increased from one third to 60% of the corpus. Around 25 per cent of the insured value can also be withdrawn by the policyholders during an emergency situation that includes a serious illness, marriage and the education of their children. This is no doubt a very effective and efficient move as it will provide flexibility to customers to use their resources as whenever required.

Conclusion

IRDAI further underlines the reason for imposing these conditions by saying: Considering that life insurance is essentially a long-term financial instrument, a fair and transparent sales process with meaningful, timely and relevant disclosures is very important to ensure good customer outcomes and protect the interests of insuring public. It has also been made clear that existing products also will have to be modified within a reasonable period of time to comply with the new regulations. The move will prove very beneficial for the sector in the long run.

(The writer is Santosh Agarwal.)

TOP

Source

IRDAI revises stewardship policy for monitoring investee companies - The Hindu Business Line – 10th February 2020

Following the recent troubles at a number of non-banking finance companies (NBFCs) and housing finance companies (HFCs), the insurance regulator Insurance Regulatory and Development Authority of India (IRDAI) has issued a revised set of stewardship guidelines for insurance companies to closely monitor the companies they invest in, intervene if required and also coordinate with other institutional investors for these investee companies.

"Insurance companies are significant institutional investors in listed companies and the investments are held by them as custodians of policyholders' funds. The state of governance of the investee companies is an important aspect and insurance companies must ensure that investee companies maintain corporate governance standards at high level," the IRDAI has noted in its recent circular, adding that insurance companies should play an active role in the general meetings of investee companies and engage with the managements at a greater level to improve their governance. Stewardship activities are aimed at monitoring and engaging with investee companies on matters such as strategy, performance of risk, capital structure, and corporate governance, including culture and remuneration. The IRDAI had initially issued guidelines on stewardship activities in March 2017.

Under the revised guidelines, the IRDAI has asked insurers to decide on the responsibilities they would undertake as part of their stewardship policy and work out clear guidelines on them. It has also said that insurers should have a clear policy on how to manage conflict of interests in fulfilling their stewardship responsibilities and publicly disclose it. It has also stressed that insurance companies must monitor their

investee firms and can also nominate a member on the Board of these companies. "Areas of monitoring which shall include company strategy and performance - operational and financial, industry level monitoring and possible impact on the investee companies, quality of company management and Board, leadership, corporate governance including remuneration, structure of the Board (including Board diversity and independent directors) and related party transactions, risks including Environmental, Social and Governance (ESG) risks and shareholder rights and their grievances," the IRDAI said, adding that insurers may also identify situations which may trigger communication of insider information.

The IRDAI also added that the insurers must have a clear policy of intervention in their investee companies, which could include meetings and discussions with the management for constructive resolution of the issue and in case of escalation, meetings with the Boards, collaboration with other investors and voting against decisions. For issues that require larger engagement, insurers should have a clear policy for collaboration with other institutional investors, the revised guidelines have said, adding that insurers should have a clear policy on voting and disclosure of voting activity. Insurers with assets under management of up to Rs 2.5 lakh crore and holding three percent or more of the paid-up capital in an investee company or insurers with AUM of over Rs 2.5 lakh crore and more than 5 percent of paid-up capital in an investee company should compulsorily vote, the IRDAI has said.

(The writer is Surabhi.)

TOP

Source

IRDAI asks LIC, GIC Re, other insurers to ensure high level of corporate governance in investee firms – Financial Express – 9th February 2020

At a time when defaults, fund diversions and mismanagements have rocked the corporate sector, the Insurance Regulatory and Development Authority of India (IRDAI) asked insurers to play an active role in ensuring high level of corporate governance standards in listed companies in which they have investments.

Insurance companies, especially Life Insurance Corporation (LIC), are significant institutional investors in listed companies and the investments are held by them as custodians of policyholders' funds. "The state of governance of the investee companies is an important aspect and insurance companies must ensure that investee companies maintain corporate governance standards at high level," IRDAI said in its revised guidelines on stewardship code for insurers in India.

"Insurance companies should play an active role in the general meetings of investee companies and engage with the managements at a greater level to improve their governance," it said. "This will result in informed decisions by the parties and improve the return on investments of insurers, which will ultimately benefit policyholders," IRDAI said. LIC alone invests around Rs 50,000 crore in listed companies every year. Four public sector general insurers, GIC Re and private insurers are also major investors in listed companies.

The regulator's new guidelines follow mismanagement and poor corporate governance standards in several listed companies, especially in the financial sector, even though insurers hold significant stakes in such firms. The collapse of IL&FS and DHFL are two examples of institutional neglect. Institutions have either remained mute spectators or supported shady and weak promoters at annual general meetings where resolutions come up for shareholders' nod.

IRDAI had conducted a special training programme for independent directors in insurance companies at the National Insurance Academy, Pune.

As per the code for stewardship of the IRDAI, an insurer should have a board-approved stewardship policy, which should identify and define the stewardship responsibilities that the insurer wishes to undertake and how the policy intends to fulfill the responsibilities to enhance the wealth of its policyholders who are ultimate beneficiaries.

In its revised guidelines, IRDAI said all the insurers need to review and update their existing stewardship policy within three months from the date of issue of the same and the updated stewardship policy needs to be approved by the board of directors. "The updated policy should be disclosed on the website within 30 days of approval by the board by all insurers, alongside the public disclosures," it said.

The IRDAI code says insurers may decide their own engagement strategy and the stewardship policy should clearly set out the criteria/circumstances in which they will actively intervene. "The policy should provide for regular assessment of the outcomes of intervention by the insurer. Intervention should be considered regardless of whether an active or a passive investment policy is followed," it said.

The regulator said compulsory voting is required if the insurer's holding of the paid-up capital of investee company (in percentage) is 3 per cent or above in the case of insurers with assets under management of up to Rs 2.5 lakh crore and 5 per cent and above for insurers with AUM above Rs 2.50 lakh crore. Circumstances for intervention may include, but not limited to, poor financial performance of the company, corporate governance related practices, remuneration, strategy, environmental, social and governance risks, leadership issues and litigations.

"The mechanisms for intervention may include meetings, discussions with the management for constructive resolution of the issue and in case of escalation thereof, meetings with the boards, collaboration with other investors and voting against decisions," it said.

Various levels of intervention and circumstances in which escalation is required may be identified and disclosed in the stewardship policy. This may also include interaction with the companies through the insurance councils in case of any industry-level issues. Investment committee of the insurer has to consider which mechanism to be opted and escalation of matters in specified cases, the code says.

As per the revised code, insurers should exercise their independent judgement with regard to voting decisions on resolutions and should not automatically support the proposals of the board of the investee firm.

IRDAI said insurers should have mechanisms for regular monitoring of their investee firms in respect of their performance, leadership effectiveness, succession planning, corporate governance, reporting and other parameters they consider important. "Insurers may or may not wish to have more participation through nominations on the board for active involvement with the investee companies.

An insurer who may be willing to have nominations on the board of an investee company should indicate in its stewardship statement the willingness to do so and the mechanism by which this could be done," it said.

It said stewardship activities include monitoring and engaging with investee companies on matters such as strategy, performance of risk, capital structure, and corporate governance, including culture and remuneration. The policy should address all the aspects relating to stewardship activity like managing conflict of interest, training of personnel, monitoring of investee companies, intervention in investee companies, collaboration with other institutional investors and voting activities.

(The writer is George Mathew.)

TOP

Source

Digital Drive: Irdai to soon okay insurance products under sandbox technology – Financial Express – 8th February 2020

Insurance Regulatory and Development Authority of India (Irdai) will soon approve products of life insurance industry under the sandbox technology. Recently, the insurance regulator had approved 33 products under the regulatory sandbox in the non-life and distribution category.

Irdai chairman SubhashKhuntia speaking at an "Digital Disruption: Embracing digital innovation in (Re) Insurance Business in Mumbai said, "Fintech solutions are also going to transform financial services in a big way. We in Irdai have already allowed a regulatory sandbox because we do not know whether the (existing) regulations will be adequate for the new processes that the technologies will ascertain. This is an experiment we we'll allow for six months and up to one year. If we find that these are old processes which will help transactions and make life easier for the insurer as well as the insured without compromising on the policy holders protection, we will think of tweaking the regulations to make it happen."

Regulatory sandbox will allow insurance companies to test products in particular geography or among a set of few policyholders before they are available in the market. Regulator also said that in the months to come they would again open the application under sandbox technology.

Speaking on the lines of the new tax regime which allows investors to forgo certain deduction and exemptions, Khuntia said, "Section 80C of the I-T (Income Come) Act remains as of now, it has not been removed. Different option has been given but I am sure people would understand the need for protection. So, those who need protection will go for it. I do not think so that it will impact collections. It is not only for tax exemption that people are going for insurance."

He also added the government itself has said they will remove exemptions gradually, it will not be abruptly removed. "By that time I would like the insurance industry to create such awareness that people understand the need for protection."

Irdai chief also added a total of about Rs 9,500 crore has been provided for three non-life insurance companies such as Oriental Insurance, United India Insurance and National Insurance. For the next fiscal it is Rs 6,950 crore, while it is Rs 2,500 crore for this financial year. This move could improve the solvency margins of the insurers.

TOP

Source

LIFE INSURANCE

Life insurers report 18% premium collection growth in January – Financial Express – 12th February 2020

The domestic life insurance industry registered strong growth in January, led by strong performance in both individual as well as group categories. The industry achieved first-year premium collections worth Rs 20,623.01 crore in January compared to Rs 17,419.76 crore in the same month in the previous financial year, a growth of 18.39%, data from Insurance Regulatory Development Authority of India (Irdai) showed.

Total annualised premium equivalent (APE) for the industry stood at Rs 10,285.3 crore in January, a year-on-year increase of 41%, according to data from Kotak Institutional Equities.

The growth in January was led by Life Insurance Corporation of India (LIC) which saw its APE at Rs 5,826.1 crore, a y-o-y growth of 79%, while private players saw their APE at Rs 4,459.2 crore, a surge of 11% y-o-y.

"LIC gained significant market share with 99% y-o-y growth in individual APE as compared to muted (10% y-o-y) growth reported by the private sector in January 2020. Strong agency push to sell select products, prior to reprising in February, was the likely reason," said Kotak Institutional Equities in its report. APE is the sum of annualised first year premiums on regular premium policies, and 10% of single premiums, written by insurance companies during any period from both retail and group policyholders.

Between April and January, total APE of the industry increased 24% y-o-y to Rs 74,367.6 crore, while y-o-y growth of total APE for LIC and private insurers was at 34% and 16% respectively. According to the Kotak Institutional Equities, their channel checks suggest that LIC's agents seem to have pushed some of its flagship products like 'Jeevan Umang' and 'Jeevan Labh' as sunset-period offerings. Notably, even in the month of November, LIC reported 104% growth in individual APE due to the sunset period of a couple of its products.

Deadline given by insurance regulator was till January end when all the life insurance companies had to comply with new products guidelines which had bought regulation changes in life insurance products. In January, new business premium for individual non-single insurance stood at Rs 9,136.66 crore compared to Rs 6,144.71 crore in January 2019, a growth of 48.69%. While new business premium for both group single and non-single premium stood at Rs 8,146.56 crore in January this year as against Rs 7,805.42 crore in previous financial year.

Rushabh Gandhi, deputy chief executive officer of IndiaFirst Life says, "While individual non-single premium continued to grow, however, large part of the group business in fuelled by this overall growth in protection business. A large part of the group business which is growing is because of the enhanced focus on protection business by most of the organisations."

TOP

Source

Is India short-selling the family silver? - The Hindu Business Line – 12th February 2020

The public sector in India is a picture of contradictions. Often, it elicits derision and ridicule in market circles. The government is apologetic about it, analysts are baying for its dismantling, and academics are divided over its relevance.

At the same time, when markets are on a free fall, investors look at public sector entities like LIC to bail them out. When Indians are stranded abroad and in distress, people expect Air India to airlift them. And when the government runs short of revenues, often public sector units are put up for sale to raise money.

Despite the privatisation wave across the world, the reach and influence of state-owned enterprises (SOEs) keeps growing.

According to OECD (a September 2017 presentation on size and sectoral distribution of state-owned enterprises), there are about 40 countries in the developed and developing world (excluding China) having SOEs valued at $2.5 trillion and employing nearly 10 million people.

In addition, governments hold minority shareholdings valued at $912 billion, employing 2.8 million people. Finance (26 per cent), electricity and gas (21) and transport (18) are the major sectors in which SOEs have a significant presence in value terms.

The presence of SOEs is strongest in China, India, Brazil and Eastern Europe.

China's financial SOEs together hold $34 trillion of assets compared to non-financial SOEs' $26 trillion. They employ millions and form a large part of global GDP (Asia Society Policy Institute, China Dashboard, Winter 2019).

China has also been extensively using SOEs categorised into key industries (defence, electricity, oil, aviation, rail, shipping, etc), pillar industries (autos, chemicals, construction, electronics) and normal industries (tourism, pharma, investment) for garnering revenues for the government to maintain economic stability.

SOEs have a strong presence in markets too, accounting for 26 per cent of MSCI EM Index and over 40 per cent of the market cap — with large weights in utilities (74.7 per cent), energy (59.1 per cent), financials (44.4 per cent) and industrials (40.2 per cent) — and 25 per cent of Schwab Fundamental EM Large Company ETF (Callan.com: SOEs in emerging market indices).

Large IPOs

Divestment of public sector is not something unusual in emerging markets.

A host of big SOEs with large IPOs like Agriculture Bank of China ($22 billion), ICBC ($22 billion), Bank of China ($11 billion), Rosneft ($11 billion), China Construction ($9 billion), Electricit de France ($9 billion), VTB Group ($8 billion) and China State Construction Engineering ($7 billion) are inspirations for many emerging economies.

Even General Motors of the US, which pulled off the biggest IPO in 2010 at $23 billion, was 61 per cent owned by the US government then; this fell to 33 per cent after the share issue. So there is no dispute about putting public sector units on the block, but the question is about how and when — selling them for meeting immediate needs or after making them strong enough to attract global interest. Large IPOs of SOEs in India such as Coal India ($3.3 billion), ONGC (2.2 billion) and GIC (1.6 billion) may look suboptimal compared to companies of similar stature and significance in other countries. The concern thus is whether India is able to realise the full value these companies hold or is it too hasty in cashing out.

The case of LIC

The plan to divest LIC too raises this concern; whether to sell it when apprehensions over its asset quality and slower pace of premium growth remain to be addressed or to make it strong before the sale.

While analysts in India and abroad will be number crunching to make some good money from its listing, a few points on how it is placed against its global peers may be pertinent.

On the net premiums written, LIC, with $48.9 billion (December 2018), is placed 17 among the 25 top global insurers and 21st on the basis of non-banking assets (Global Insurance Market Trends, OECD 2019).

On premiums written, LIC's is $100 billion less than top ranked UnitedHealth Group of the US ($156 billion), and about $50 billion less than Ping An of China (4th rank). And in terms of non-banking assets, LIC's $438 billion is less than half of Allianz's $1 trillion.

When it comes to growth, direct gross premiums in life in India was a meagre 0.5 per cent with non-life better at 7.2 per cent. Growth in life insurance has been negative in 20 of the top 50 companies in 2017. On the other hand, gross claims paid by India's insurance sector at 17.2 per cent in life and 15.9 per cent in non-life are on the higher side when compared with those in the US (2.8/4.6 per cent) and Korea (6.9/12.3 per cent).

Asset allocation of 77 per cent for bills and bonds is on a par with many markets, though with regard to equity, allocation in India is fairly high at 18 per cent — perhaps due to frequent calls to support the stock market and rescue sick companies — compared to 5.2 per cent in the UK, 11.7 per cent in the US, 13.9 per cent in Brazil, 12.4 per cent in Singapore, and 6.4 per cent in Russia.

While enthusiasts could look at LIC as another Aramco, evidence from the past is worth considering. China has listed all its four major insurance companies. China Life, the country's biggest insurer raised $3 billion in 2003 when the market was down; Ping An made $5 billion in 2007 at its peak; China Pacific garnered $3.1 billion in 2009; and New China Life, $1.9 billion in 2011s. Premium written by Ping An is double of LIC's, and the markets today look dicey. Add to this, the post listing prices of many PSUs have been less than inspiring (www.insurancebusinessmag.com).

Can be made productive

Public sector entities will be found wanting if they do not adapt to and learn from the changes happening around it. If directed properly and structured without too much bureaucratic interventions, the public sector too can become more productive. If listing is a sole solution, then why have many public sector banks with great listing history two decades back been merged to save the banking industry? How much growth and stability are the regions of Africa, Latin America and Eastern Europe showing after rampant privatisation compared to Asia, which largely thrives on growth driven by a large public sector?

It is the active support of the state that enabled Chinese financial firms to mop up most of the new capital issuance in the world. A sell-off to raise quick cash won't be such an effective way in the long run for an economy in pursuit of global leadership. Selling family silver is easy, but creating heirlooms that a family can take pride in is difficult.

(The writer is Bandi Ram Prasad.)

TOP

Source

Is employer-provided life insurance coverage enough? – India Post – 12th February 2020

To attract and retain the best talent, firms offer additional benefits to their employees. One of these benefits is life insurance coverage. Employer-sponsored insurance plans can be low-cost, or sometimes even free. They are always easier to procure – the employer often takes care of the technicalities. However, employer-provided life insurance plans are only sufficient for a small subsection of the population. If you are young and single, then an employer-provided plan may be enough. But if you have a partner, old parents, and especially if you have children, then your safety net needs to be a lot stronger.

TOP

Source

Tax savings: How sales of life policies surge in the last quarter of a fiscal - The Hindu Business Line – 11th February 2020

Tax saving continues to be a big pull factor for people buying life insurance policies, especially in the last few months of the financial year. Insurers, however, remain upbeat about sales even in the light of the recent Budget proposal under which income-tax assesses may give up deductions for a lower I-T rate.

Industry data reveal a sharp jump in the sales of life insurance policies in March, compared to December. Last fiscal, the premium collected by life insurance companies more than doubled in March 2019 to Rs 37,459.36 crore, compared to Rs 18,237.84 crore in December 2018. The number of policies and schemes bought also more than doubled in March 2019 to 55.39 lakh, against 25.15 lakh in December 2018.

Data for the previous financial years also reveal a similar surge in life insurance policies towards the end of the financial year, especially in March, as many people suddenly decide to save tax through long-term investments in the Section 80 C window.

(The writer is Surabhi.)

TOP

Source

Protection business drives growth of life insurers - Financial Express – 11th February 2020

The top four life insurance companies delivered 4% to 18% annualised premium equivalent (APE) growth in 3QFY20. While October was a weak month on APE, most companies bounced back in November and December 2019. HDFC Life's year-on-year (y-o-y) growth was driven by par (likely its new product) and ongoing traction in the non-par business, though down quarter-on-quarter (q-o-q). Limited pay, return of premium protection policies and non-par policies with regular income were key drivers for Max Life.

Thus, despite the absence of any significant catalyst (like high Ulips or falling interest rates), large players were able to use various strategies to deliver healthy growth. The above trends highlight the ability of life insurance companies to manage growth through a combination of products and channels. These provide some comfort on the ability of the top players to sail through potential near-term challenges like losing the 80C sales pitch in FY2021E.

Is protection losing sheen?

Most life insurers have reported a moderate pace of growth in the protection business led by competition on pricing in individual business, muted growth in the credit life business, either due to high distribution costs or slowdown at NBFCs and transitioning towards increasing share of limited pay policies. Market sources suggest that reinsurers are planning to hike reinsurance rates on term policies.

Two likely reasons adverse mortality experience due to aggressive pricing – this has, however, not yet been reflected in the operating variance reported by large players in FY2019 and secondly, expansion into interiors/newer customer segments, with adverse mortality experience. In case of the latter, the ability of insurance companies to differentiate and underwrite customers will be crucial to drive profitability.

Are insurers assuming higher risks?

Strong value of new business (VNB) growth during the quarter was mostly driven by higher APE growth. In fact, VNB margin expansion was about 60 to 250 bps y-o-y. This compares with significantly higher risk on balance sheet, the share of non-par savings policies increased by 500 to 1,700 bps y-o-y. Following strong growth in HDFC Life's non-par business in Q1FY20, other players seems to be catching on. The share of non-par protection has increased albeit moderately. It appears that incremental margins are lower due to ROP and LP products. Solvency has reduced y-o-y for ICICI Prudential and Max Life.

APE growth shows diverse trends

Life insurers (except ICICI Prudential Life) reported APE growth in the range of 16-18% y-o-y in Q3FY20. We don't see any common trend or growth driver. First, SBI Life and Max Life picked up in ULIPs (18-19%) while HDFC Life and ICICI Prudential Life slowed down (-11% to -35%). Second, growth rate in protection APE was strong for Max Life (1.4X) and ICICI Prudential (34%) but moderated (10-15%) for HDFC Life and SBI Life. Three, non-par business moderated for HDFC Life to 1.9X from 5.7X in 1HFY20, while it was stable/picked up for the rest – ICICI Prudential Life (other segment) was up 1.9X (stable q-o-q), Max (1.9X from 4X) and SBI Life (18X). The focus for most players was on non-core channels, digital and strategic partnerships coupled with higher volumes from the agency business.

TOP

Source

Is Employer-Provided Life Insurance Coverage Enough? - India Post – 11th February 2020

To attract and retain the best talent, firms offer additional benefits to their employees. One of these benefits is life insurance coverage. Employer-sponsored insurance plans can be low-cost, or sometimes even free.

They are always easier to procure – the employer often takes care of the technicalities. However, employer-provided life insurance plans are only sufficient for a small subsection of the population.

If you are young and single, then an employer-provided plan may be enough. But if you have a partner, old parents, and especially if you have children, then your safety net needs to be a lot stronger. Here are some reasons why one must obtain insurance beyond their workplace-sponsored plan:

One may lose their job – or want to quit. There are two scenarios here – either one gets booted or decide that their current company isn't the best fit. In the former scenario, if one only has an Employer-Provided Life Insurance plan, then they will not only lose their job, but also lose their safety net. Let's consider the second scenario.

Even if the employee feels that they are unable to reach their full potential in their current job, the prospect of losing their life insurance coverage might keep the employee stuck in an unfulfilling position. Therefore, an individual life insurance policy provides protection regardless of the employee's career moves.

The firm might pull back the coverage. Most firms go through a purse-tightening phase at one point. They either lay off some employees – for instance, Zomato recently automated its customer support system and cut out 540 manual jobs – or they cut back on employee benefits. This is where one's life insurance plan might come under the axe.

A change in management – or a shuffling of the Board – might result in one's insurance not getting renewed at the end of the year. Life Insurance must be consistent and reliable – and employer-based plans are dependent on too many variables.

Life Insurance gets more expensive as you age. You may have decided to buy life insurance for yourself later in life, once your employer-sponsored coverage subsides. However, life insurance gets more expensive for older people, owing to the increased risk of mortality. The value-to-cost ratio for life insurance is more feasible if you buy it sooner.

Thus, employees should build their own safety net today. NBC has reported than "job-hopping is on the rise," and Monster has written than changing jobs regularly – though not too often – can help you bump up your salary significantly. Therefore, untie your insurance from workplace turbulence and career mobility today.

One can easily explore AEGON Life's Term Insurance plan for a policy that suits their needs perfectly. The iTerm plan provided by AEGON Life provides comprehensive coverage up to 100 years of age. The iTerm Insurance plan also offers three different plan variants: Life Protect, Protect Plus, and Dual Protect. Dual Protect offers a monthly income to policyholders while Protect Plus raises the life cover by 5% every year – while the premiums stay the same! The iTerm plan also offers lower premiums for females and non-smokers.

TOP

Source

Why term life insurance premiums may see a correction in the near future – Mint – 10th February 2020

In the classic book, Against the Gods: the Remarkable Story of Risk, American economist Peter L. Bernstein iterates that the revolutionary aspect which delineates the boundary between modern times and the past is the mastery of risk. Insurance and reinsurance help in the mastering of risk of any sort by the modern societies.

From managing financial losses in the aftermath of natural catastrophes such as earthquakes to protecting industries against man-made catastrophes such as terrorism, reinsurance helps insurers by providing the financial capacity for sharing of risks, and plays a pivotal role in global risk management. Almost 80% of the insurance cover is backed by the reinsurer; hence, they have the right to determine the price along with the insurer.

Mechanism of Life Insurance

As any other form of insurance, life insurance is based on three concepts: pooling many exposures into a group, accumulating a fund through premiums and paying from this fund for the losses of those who die each year. That is, life insurance involves the group sharing of individual losses. To set premium rates, it is important for an insurer to be able to calculate the probability of death at various ages among its insured, based on pooling. But in India, mortality rates still work on an assumption.

Today's term insurance prices work on a key assumption that the rate of mortality of the pool of customers, which can be enrolled under the current term insurance plans, will be approximately one-fourth of the death experienced for the average Indian population. However, if we go one level deeper, the online prices are cheaper as they are built on the mortality assumption of one-fifth or 20% of the average Indian customer. This is because online caters to a more affluent segment of customers and, hence, better life expectancy. Offline prices which are higher than online are built on the back of mortality assumption being roughly one-third or 33% of the mortality rate of the average Indian population.

The current prices are an outcome of this base assumption, which is now getting challenged as there has been a consistent rise in incidences of claims. This has led to both Indian and global reinsurers taking a cautious stance as far as providing covers is concerned. There is a vivid difference between the early trends and the actual mortality experience, which is a clear indication of why term prices will get expensive. At an individual insurance company level, this trend may not be credible yet, but when reinsurers look at the results for all the companies together, they seem more credible. If reinsurers revise the rates for life insurers, the insurance companies may be forced to revise the end price for the term plan customer.

Price Comparison

Insurance runs on the principles of risk and probability. Both risk and probability can be ascertained by information and experience that is available to insurers about the target masses. The more accurate the available information is, the lower is the risk and more accurate the estimation of expected deaths.

Over the last decade, term prices in India have come down. If we were to compare these prices with developed countries like the US, Dubai and Singapore, they are actually lower. Competition in the Indian insurance marketplace is a key reason for lowering of prices and this is perhaps the best time for customers to buy term insurance. On an average, the premium rates of term policies are about 30% higher in the US and Singapore, according to data from Quotacy.com, a US-based insurance aggregator, and Singlife.com, a Singapore-based insurance company.

A comparison of term insurance premiums offered by three prominent insurers in India, the US and Singapore for a 30-year-old non-smoker male, with a total sum assured of ₹2 crore over a term of 35 years, will give you an idea. For India, Edelweiss Tokio Life Insurance charges an annual premium of ₹14,042 (the cheapest in India); in the US, US Life charges $311 or ₹22,177; and in Singapore, Singlife charges a premium of $415 or ₹29,591.

The current term insurance prices in India are actually unsustainable. As reinsurers increase their cost price, life insurers will take strategic calls on term insurance pricing through trade-offs between profitability and price. Since life insurance companies depend on term insurance—they are a major source of profitability in the long run—the likely outcome is price increase for customers. We should see some degree of premium rate correction in the near future with all key brands adjusting to the new reality over the next three to 12 months.

(The writer is Santosh Agarwal.)

TOP

Source

Insurance schemes need retooling: Modi – Hyderus Cyf – 10th February 2020

Two Government-sponsored insurance schemes need retooling, Prime Minister Narendra Modi has directed.

The two initiatives in question are the Pradhan Mantri Jeevan Jyoti Bima Yojana (PMJJBY) and Pradhan Mantri Suraksha Bima Yojana (PMSBY). As reported in The Economic Times, Modi has urged that these schemes be looked at to improve the experiences of policyholders following complaints.

The PMJJBY is a life insurance scheme, for which those aged eighteen to fifty are eligible. The scheme offers cover of Rs 2 lakh for one year between June 1st and May 31st, which is renewable. The PMSBY is an accident insurance scheme available to those aged eighteen to seventy. It has the same coverage period as the PMJJBY and offers risk coverage of Rs 2 lakh for accidental death and Rs 1 lakh for partial disability.

The Prime Minister addressed these insurance schemes during a meeting held on January 22nd, The Economic Times reported in recent days. According to the minutes of the meeting obtained by the publication, Modi directed that "the Department of Financial Services, states and UTs [union territories], banks and insurance companies should develop a mechanism to make automatic, hassle-free and timely payment to policyholders."

The Prime Minister also said that the "Department of Financial Services and banks should sensitise their officers to increase efficiency and effectiveness for dealing with grievances" and that efforts should be undertaken to increase coverage under the two schemes.

The PMSBY and the PMJJBY were formally launched by Prime Minister Modi on May 9, 2015 in Kolkata, West Bengal, in addition to a third insurance scheme – the Atal Pension Yojana (APY). The insurance schemes were announced by then-Union Finance Minister, the late Arun Jaitley, in that year's Union Budget.

The Union Finance Ministry announced that the time that the schemes would represent "a path breaking initiative towards providing affordable universal access to essential social security protection in a convenient manner linked to auto-debit facility from the bank account of the subscriber."

In December last year, it was reported that the PMJJBY and the PMSBY had enrolled 5.91 crore and 15.47 crore respectively according to incumbent Union Finance Minister Nirmala Sitharaman.

(The writer is Kerean Watts.)

TOP

Source

ULIPs: Is it Best for Achieving Long Term Financial Goals? – Goodreturns – 8th February 2020

The dwindling increase in expenses added with a rise in inflation rates has forced the investors to look for a kind of investment which helps them to maximize returns on their invested money. The traditional form of investment tools like the fixed deposits (FD) are giving a meagre interest rate and the one like public provident funds (PPF) has a longer maturity period. Most of the investors in today's era look for smart yet higher returns on their funds, within short to medium tenure.

Saving your income from tax also has to be borne in mind while making an investment decision as this will help you to boost your income and helps you to achieve your desired investment goal. The Unit Linked Insurance Plans (ULIPs) comes in handy for investors over other forms of investment as they will be invested in stock markets through a mix of equity, growth and balanced schemes. Let's take a sneak peek as to how it works and how it helps investors to achieve long term financial goals.

What is ULIP?

A ULIP, the full form of ULIP is a unit-linked insurance plan. It is a form of investment tool which provides for insurance payout benefits. It is one of the most popular forms of investment instruments in India which can be used as a tax savings instrument as well as for insurance coverage. It provides dual benefits - protection and wealth creation.

An investor can choose funds under a ULIP plan based on their financial goals for the long term and accordingly allocate money in equity and or debt funds respectively. Investors will receive the benefit of life coverage throughout policy by investing in ULIPs. If one is looking out for a long term goal be it children's education or retirement planning or for house construction or purchase of a new car and so on one can go for ULIPs as it offers best returns on long term investment.

How do ULIPs work?

Once you start investing in ULIP, the insurance provider will invest a part of the premium amount in equities or debts and so on and the balance amount will be utilized to provide insurance cover to the investor. The fund managers in insurance companies will handle the investments and hence investor need not have to worry about tracking their investments.

The ULIPs provides an opportunity for its holders to switch between equity and debt-based investments (based on your risk-taking ability). Benefits of the flexibility of switching will boost the popularity of these investment instruments.

Please Note: There will be switching charges which an insurer will levy on investors for switching and some insurers may offer it for free.

Lock-in Period of ULIP

The Insurance Regulatory and Development Authority of India (IRDAI) during 2010 increased the lock-in period of ULIPs to 5 years from 3 years. The mantra which holds good for insurance policies applies to unit-linked insurance plans as well, the longer you hold the policy higher the yield it fetches.

ULIPs fetches better returns if held for a longer period and hence it is better to hold it for the entire tenure of the policy which ranges between 10 - 15 years.

Benefits of ULIPs

Investing in ULIPs has its share of benefits as it provides protection and helps individuals to plan for long term savings. Let's understand the benefits of investing in ULIPs.

Flexible Investment Options
Investing in ULIPs offers its investors with low, medium and high-risk investment options and all this will be available under the same policy. All you have to do is to pick a policy based on your risk-taking ability. The policy will provide the user to switch between the fund options without charging any additional expenses (differs with each insurer) in a year.

ULIP's provides you with the flexibility to either opt for a premium amount or sum assured, and this will entirely be based on your financial needs and requirements. You will also get an option for top-ups to increase the flexibility of your investment portfolio and to make the best and most of the investment opportunities amidst uncertain external environmental factors or due to fluctuation in your income flows.

Liquidity Factor
ULIPs offers partial withdrawal option for investors after a lock-in period of 5 years. In case of any financial emergency, the investor can go for partial withdrawal only,
If the policyholder has paid premiums on time till date.
The policy is in force to withdraw the premiums.

Life Cover
With ULIPs one will get a life cover along with investment. It offers security to the holders family as they can depend on it when emergencies knock the door (death of the taxpayer, major health issue, and so on).

Income Tax Benefits
Investing in ULIPs offers rebate under Section 80C of the Income Tax Act of 1961. In addition to this, returns on the matured policy of ULIP are exempt from Income Tax under Section 10(10D) of the Income Tax Act. This dual benefit drives the investor to go for ULIPs.

Choice of Funds
The ULIP offers a variety of market-linked investment funds to its investors which suits their risk appetite and financial needs. Hence it gives an option for individuals to invest in their choice of funds be it in stocks or balanced funds or fixed-income security.

The following factors will help us to determine whether investing in ULIPs is better for achieving long term financial goals?

Better Returns
Investors will get better returns from ULIPs compared to any other insurance product due to its equity advantage. The premium amount paid by you will be invested in various asset classes through different funds. So far, the tax savings funds have given double-digit returns, but the catch here is one has to look out for a new fund every year if it is a one-time investment.

Maturity amount usually depends on the performance of the stock markets during the tenure of the policy and in addition to this endowment plans are designed in such a way that you will be receiving your lump sum amount after the completion of specific tenure.

When it comes to tax efficiency, the entire maturity amount arising from ULIPs are tax-free and this makes it the best option amongst the other forms of investment options. Though 5-year tax savings fixed deposits also have a five-year lock-in period, the interest amount earned on it is taxable.

Dual Advantage
ULIPs offers insurance and wealth creation for investors in a single product. On one hand, you can invest funds as per your choice be it in stock markets or balanced growth funds or debt funds and on the other hand you will get life insurance protection on the premium amount.

ULIPs provides a wide choice of investment options for its investor based on risk appetite. For example:
If you are a high-risk taker then you can opt for equity funds
If you are a moderate risk taker then you can go for balanced funds
If you are a low-risk taker then you can opt for debt-based funds

Flexibility
During the tenure of the policy, the holder has an option to switch funds. You can either pick growth, income, equity, balanced funds based on your financial goals and risk-taking capability. Usually, four switches are allowed per year free of cost.

Unlike investing in equities, you need not have to track their performance in stock markets daily. All you have to do is to choose the policy and you can change the fund allocation anytime during the tenure of the policy and run it till maturity to earn benefits in the long term.

Lock-in Period
The unit-linked insurance plans have a lock-in period of five years and this will induce a disciplined savings habit amongst the investors. As ULIP is a long term insurance contract, the lock-in will be calculated from the date of the issue of policy. Investors can pay the premium amount either monthly or annually or as a lump sum as per their preference.

(The writer is Archana L.)

TOP

Source

GENERAL INSURANCE

Directors feel heat, seek cover against legal action – The Times of India – 14th February 2020

The directors & officers' (D&Os') insurance policy, which compensates key management personnel of a company against legal actions, is seeing a surge in demand. The cover, which was earlier being purchased by businesses with a global exposure, is now being bought by companies with only domestic stakeholders as well.

The trigger for the renewed demand for this cover has been the amendment to the Companies Act last year. Under this, the government can ask the National Company Law Tribunal to hold directors and key management personnel responsible without any limit to liability in the event of fraud.

Besides this, there have been several actions by enforcement authorities against directors in recent times, particularly in the financial sector. Insurers say that the regulator's action against directors of a large private bank have triggered claims under the policy. The regulatory action against IL&FS is also believed to have triggered a claim by the erstwhile management.

"Another significant cause for a spike in claims has been in the employment practices coverage afforded to some large IT companies. Many of them have employees in the US, which is a highly litigious geography in this area and the industry has seen many claims coming from this exposure. It has an impact on the pricing of the policy," said IFFCO Tokio General Insurance EVP (underwriting) Subrata Mondal.

According to Praveen Vashista of Howden India Insurance Brokers, there has been a big surge in demand for D&O policies. "We are seeing lots of demand for D&O, which is part of the liabilities business. Because of increased demand, we have enhanced the size of our liability team and now have 55 people," said Vashista. Insurers say that before joining, directors are asking companies whether they have a policy that will protect them from liability claims.

According to Mondal, rates for D&O cover are firming up in sectors like finance, IT and real estate where the industry has seen a spike in regulatory action, financial downturn and consequent claims under D&O.

"The claim payouts always start with defence costs and often involve out-of-court settlements. Given the length of the judicial process in many countries and long-tail nature of liability claims, the defence costs are high, and settlement is mostly out of court," he said.

D&O policies cover key officials against legal action from regulators, shareholders or employees. Besides covering the cost of legal fees for the defence, it also pays penalties. If there is a regulatory fine on an individual, which is civil in nature, the D&O cover will get triggered, provided coverage for civil fines and penalties have been granted. If the fine or penalty is criminal in nature or has criminal undertones, the policy will not cover it, but it will allow the insured to defend the imposition of the same.

Promoters are also facing regulatory action because of the insolvency process during which violations come to light. The D&O cover can be extended for directors for past actions even after the board is dismissed, provided it has been purchased in advance.

"When we underwrite a D&O policy, an important underwriting criterion is the financial health of the company. Most insurers generally frown upon granting a D&O to a company whose finances are distressed or already in the red. Higher claims activity will often see a higher demand for the insurance product from the industry," said Mondal.

(The writer is Mayur Shetty.)

TOP

Source

Non-life insurers see 14.52% growth in gross premium underwritten in January – Mint – 13th February 2020

Gross direct premiums underwritten by non-life insurers rose 14.52% in the 10 months up to January from a year-ago period, according to the data released by Insurance Regulatory and Development Authority of India.

In absolute terms, the total premiums underwritten by the non-life insurers stood at Rs1.59 trillion up during April-January against Rs1.39 trillion in the corresponding period a year ago. This includes underwritings by state-owned general insurers, private general insurance companies, specalised public sector insurers and standalone health insurers.

Among the private non-life insurers, Acko General Insurance Limited's gross direct premiums underwritten in the April 2019 to January 2020 period surged over 200% to Rs311.2 crore from Rs102.87 crore in a year-ago period.

HDFC Ergo, ICICI Lombard and Reliance General Insurance reported a positive growth of 5.12%, 7.16% and 23.44% respectively in the gross premiums underwritten in April-January period of the current financial year.

Among state-owned insurance companies, SBI General Insurance reported a 49% year-on-year growth, Oriental Insurance 4.69% and United India insurance 6.84% growth in the gross direct premiums underwritten till January.

The New India Assurance Company, which holds the largest market share (14.28%) reported a positive growth of nearly 15%.

Standalone health insurers, seven in total, saw a 31.69% growth in the gross premiums underwritten in the April-January period of FY 2020 to ₹11,207.13 crore from ₹8,510.31 crore in the same period last year.

Specialized PSU insurers reported a 35.83% increase in gross premiums underwritten by them to ₹9,622.98 crore in April-January of the current financial year from ₹7,249.32 crore in year-ago period.

(The writer is Devansh Sharma.)

TOP

Source

Could entry of Dental Insurance Provider solve the problem of oral awareness & accessibility in India: Ken Research – Openpr – 13th February 2020

There is a dire need for upgrading dental infrastructure to improve accessibility and affordability by the poor in India looking at the statistics released by National Health Profile 2019 and WHO through various publications.

At ground level, an inadequate number of doctors per population (1:10,926) and no standardization of dental treatment prices across cities have been restricting the penetration of dental care.

Why there is no Standalone Dental Insurance Company in India?
In 2015, Ocare, a Mumbai based company, was the first-ever company to launch dental insurance products in association with ICICI Lombard & New India Assurance. However, owing to scalability challenges & regulations by IRDA, the partnership couldn't succeed and Ocare decided to pause its operations. In December 2017, Ocare applied for a license as a Standalone Health Insurance Provider and to date (Jan 2020), is awaiting the same.

Lack of data collection by dentists, fragmented nature of dentistry practice and lack of financial inclusion was the common challenges faced by us back in 2016', said Dr. Neeraj Sheth, Founder and Group Director at Ocare talking to Ken Research, India. He further emphasized on the bureaucratic challenges being currently faced by the company to obtain necessary licenses before launching their products.

Where does India stand today?
With marketing efforts from Chain clinics coming up in top cities of India, the population is becoming aware of the need to maintain oral care and undergo preventive treatment on a regular basis. Introduction of government schemes such as Ayushman Bharat Yojana, eDantSeva, etc. are welcoming steps aimed at affordable and accessible healthcare. Yet, there is still a long way to meet the standards set by developed regions.

Is it the right time to enter Dental Insurance in India?
"Mismatch between demand and supply of dental services and non-existence of such product to date paves the way for the entry of Dental Insurance because demand is there", said Dr. Sheth. During its operations in 2016-17, Ocare received tremendous response from dentists and sold more than 100,000 policies. In popular health insurance plans such as Apollo Munich Maxima Plan, Bharti AXA Smart Health, dental treatments find limited coverage and do not cover routine treatment charges.

It is expected that the existence of dental insurance products would prompt customers from top cities of Bangalore, Chennai, Delhi NCR and Mumbai to pursue preventive treatment over sick treatment. Higher adoption rates could also bring in the innovative technology and dental medical equipment capable of detecting fatal diseases such as Oral Cancer at early stages.

(The writer is Ken Research.)

TOP

Source

ESIC proposes amendments to ensure better implementation of scheme – The Economic Times – 13th February 2020

The Employees' State Insurance Corporation, under the labour ministry, has proposed draft amendments to the Employees' State Insurance (General) Regulations, 1950, paving way for appointment of a local committee with representatives of Centre, state government, employers and employees in each notified district under the existing regional board to facilitate devolution of powers at the grass root level for better implementation of the scheme.

The draft amendments have been notified in the gazette for stakeholder consultation and will be finalised in a month's time.

Employees' State Insurance Corporation of India, is a multidimensional social system tailored to provide socio-economic protection to worker population and immediate dependent or family covered under the scheme.

The ESI scheme is applicable to all factories and other establishments as defined in the Act with 10 or more persons employed in such establishment and the beneficiaries' monthly wage does not exceed Rs 21,000 are covered under the scheme. The scheme currently covers nearly 3.5 crore insured persons and have 13.3 crore beneficiaries.

Besides full medical care for self and dependents, that is admissible from day one of insurable employment, the insured persons are also entitled to a variety of case benefits in times of physical distress due to sickness, temporary or permanent disablement etc. resulting in loss of earning capacity, the confinement in respect of insured women, dependents of insured persons who die in industrial accidents or because of employment injury or occupational hazard are entitled to a monthly pension called the dependents benefit.

(The writer is Yogima Seth Sharma.)

TOP

Source

Deposit Insurance: DICGC to Increase Premium by 20 percent from 1st April – MoneyLife – 13th February 2020

While some bank depositors were feeling happy about increase in deposit insurance to Rs5 lakh from Rs1 lakh, the Deposit Insurance and Credit Guarantee Corporation (DICGC) has announced a 20 percent increase its premium on deposit insurance. Given the five time increase in insurance cover on deposits, the increase in premium is insignificant; banks have been told to pay the premium themselves.

The DICGC requires that banks cannot recover the premium from depositors and one assumes this will continue even if there is a major bank failure in the future. Remember, DICGC collects insurance premium on overall deposits in banks, but provides cover only for assessable deposits of up to Rs5 lakh (up from Rs1 lakh until recently).

DICGC, in a circular (DICGC.RPIC.No.2676/02.01.003/2019-20 dtd 5 February 2020) sent to chiefs of all banks, says, "The premium will be raised to 12 paise per Rs100 of assessable deposits per annum from the half year beginning 1 April 2020 onwards...it is imperative to maintain the adequate level of deposit insurance fund by the DICGC, for settlement of claims in case of failure of banks."

As per DICGC, the deposit insurance premium on assessable deposits of Rs100 was 10 paise since April 2005. In 2018-19, DICGC collected a premium on Rs120 lakh crore of deposits, although only 28% of them (Rs33.70 lakh crore) were insured.

As on 31 March 2019, the deposit insurance fund at DICGC is Rs97,350 crore, including a surplus of Rs87,890 crore. The claims settled by DICGC so far since 1962 are only Rs5, 120 crore and that too for the cooperative banks.

Out of 2,098 banks covered by the DICGC, 1,941 banks are cooperative banks. Only these banks are facing problems of closure and liquidation and the deposits of these banks need to be covered by DICGC.

In FY18-19, commercial banks, including public sector banks (PSBs), paid a deposit insurance of Rs11,190 crore while cooperative banks paid Rs 850 crore, taking the total premium paid to DICGC at Rs12,040 crore. During the same year, DICGC received claims worth Rs37 crore from cooperative banks. However, none of the claims was settled.

While there was no clarity on who will pay for the increase in premium for the five times higher risk coverage, another circular issued by DICGC says, the banks will pay the premium. "The rate of premium payable by the insured banks will be raised from 10paise per Rs100 of assessable deposits to 12paise per Rs100 assessable deposits per annum."

Over the past 25 years, only one private lender, Global Trust Bank (GTB) has failed. At the same time, cooperative banks fail regularly. The flawed deposit insurance guarantee scheme is viable only because of the hefty premium collected from PSBs and successful private banks.

DICGC has been almost entirely settling dues of cooperative banks. Most cooperative banks are not only under dual regulation (Reserve Bank of India and the Registrar of Cooperatives), but are regularly controlled and exploited by politicians.

Even the All Indian Bank Depositors Association (AIBEA) had called the move to increase deposit insurance five times as unwarranted.

In a statement, CH Venkatachalam, general secretary of AIBEA had said, “Already, under the provisions of the Banking Regulations Act, the deposits of our banks enjoy the guarantee and no bank can be closed down. By increasing the insurance cover, the cost will go up for banks, which in turn will be put on the shoulders of the banking public through hike in service charges. Increase in insurance cover on bank deposits is warranted only for urban cooperative banks, which are vulnerable. The government should withdraw this proposal.”

AIBEA says the aggregate deposits of PSBs are Rs72 lakh crore, of which only Rs22 lakh crore are covered by insurance, but premium is collected on the entire amount.

"While the entire amount of deposit is taken as assessable deposit and premium is collected on the total deposits, the scheme covers insurance only up to Rs1 lakh. Thus Banks are paying premium even for the deposits which are not insured. For example, premium paid for FY2018-19 was on deposits worth Rs120 lakh crore but deposits covered by insurance were only for Rs33.70 lakh crore or just 28% of the total deposits," the bank employee union says.

TOP

Source

How much deposit cover can you get? – Mint – 13th February 2020

Budget 2020 met depositors’ demand to hike deposit insurance, which is now up at ₹5 lakh from ₹1 lakh, in the wake of the Punjab and Maharashtra Cooperative Bank crisis. However, there is confusion about its implementation—several people have voiced their concerns on social media about when the cover would kick in and what will happen if a depositor holds multiple accounts with a bank. We answer some of the common questions related to deposit insurance.

When do you get it?
Deposit insurance comes into play under two situations. One, if your bank goes into liquidation and two, if your bank is reconstructed or merged with another bank.

"The Deposit Insurance and Credit Guarantee Corp. (DICGC) do not directly deal with the depositors of failed banks. In the event of a bank's liquidation, a depositor-wise claim list is prepared and sent to DICGC for scrutiny and payment by the liquidator," said Adhil Shetty, CEO, Bank Bazaar, an online financial services marketplace. DICGC then pays the money to the liquidator who is liable to pay the depositors.

In case of merger of banks, the amount due to each depositor is paid to the transferee bank. However, this is applicable only when a stressed bank is merged with another.

How it plays out

Deposit insurance covers the principal and interest up to ₹5 lakh. For example, if your principal deposit was ₹95,000 and you accrued an interest of ₹4,000 on it, the total amount insured would be ₹99,000. On the other hand, if the principal was ₹5 lakh, then the accrued interest will not be insured.

However, how the cover works will also depend on the number of accounts you have in the same bank or multiple banks.

When you have multiple accounts: Suppose you have three accounts with the same bank—savings, fixed deposit and recurring accounts—in the same or three different branches, you will get an overall cover of ₹5 lakh only. "In such a situation, the deposits kept in different branches of a bank are aggregated for the purpose of insurance cover and the maximum you would be eligible for is ₹5 lakh in all," said Shetty.

When you have a joint account: A joint account is considered a single entity and irrespective of the number of holders, it gets a ₹5 lakh cover. Even when you hold two or more joint accounts with the same person and with the first and second holders in the same order, then you will get ₹5 lakh in total for the two joint accounts, said Shetty.

When you have accounts in different banks: If you have accounts in two different banks and both go bust one after another, then the funds from both banks will be eligible for a cover of ₹5 lakh each. However, Shetty said, this is a far-fetched thought because practically no scheduled commercial bank in India has collapsed since 1960.

Note that DICGC is a subsidiary of the Reserve Bank of India. All scheduled commercial banks, including branches of foreign banks functioning in India, regional rural banks, and co-operative banks are insured by DICGC. However, the premiums for deposit insurance is borne entirely by the insured bank.

(The writer is Disha Sanghvi.)

TOP

Source

Govt okays proposal to infuse Rs 2,500 cr into 3 PSU general insurers for improving financial health - The Economic Times – 12th February 2020

The Union Cabinet on Wednesday gave an in-principle approval to pump in Rs 2,500-crore capital into three public sector general insurance companies.

These three insurers are Oriental Insurance Company Limited (OICL), National Insurance Company Limited (NICL) and United India Insurance Company Limited (UIICL).

The Cabinet has allowed "immediate release of Rs 2,500 crore in the light of the critical financial position and breach of regulatory solvency requirements" of these general insurers", an official statement said.

Briefing reporters here, Union Minister Prakash Javadekar said the capital has been infused in the light of the critical financial position and breach of regulatory solvency requirements of the general insurers. The capital infusion in these companies comes ahead of their proposed merger by the end of March 2020.

Earlier in January, the finance ministry had said that the merger of PSU general insurers was at an advanced stage and that could happen soon as the matter was pending before the Cabinet. In his Budget speech 2018-19, the then finance minister Arun Jaitley had announced that the three companies would be merged into a single insurance entity.

However, the merger process could not be completed due to various reasons, including poor financial health of these companies. As on March 31, 2017, the three companies together had more than 200 insurance products with a total premium of Rs 41,461 crore and a market share of around 35 per cent.

TOP

Source

Cabinet may approve merger of 3 state-owned general insurers – Mint – 12th February 2020

The Union Cabinet is likely to approve the merger of three state-owned general insurers -- Oriental Insurance Company, National Insurance Company and United India Insurance Company --on Wednesday, a government official in the know of the matter told Mint.

"The Cabinet will discuss merger of the three insurers, as well as capital infusion into them," the official said.

The merger of the three entities is expected to improve their operational efficiency, solvency ratio and profitability.

In 2018-19, former finance minister Arun Jaitley had proposed a merger of the three insurance companies, and listing of the single entity on domestic bourses.

"Three public sector general insurance companies National Insurance Company Ltd., United India Assurance Company Limited and Oriental India Insurance Company Limited will be merged into a single insurance entity and will be subsequently listed," Jaitley had said in his Budget speech.

However, there has been a delay in the merger process as finances of these companies are not strong.

The idea is to make these companies stronger, before they are listed, the official said, adding "The final call will be taken by the Cabinet."

The Centre has already infused ₹2,500 crore into the three state-owned insurance companies via supplementary demands for grant earlier this year. Besides, ₹6,950 crore will be infused in these three companies next year, according to the budget document.

(The writer is Shreya Nandi.)

TOP

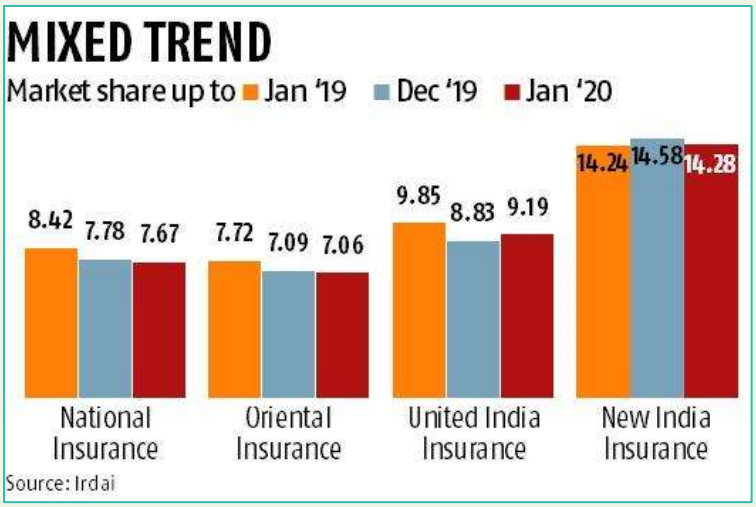
Source

PSU general insurers continue to lose market share, merger plan stuck - Business Standard – 12th February 2020

Public sector general insurance companies continue to lose market share to their private peers. As of January, the collective market share of the four PSU general insurance companies stood at 38.2 per cent, against 40.23 per cent in January 2019, according to the data released by the Insurance Regulatory and Development Authority of India (Irdai).

National Insurance, Oriental Insurance, United India Insurance and New India Assurance are the four PSU insurers, and barring New India Assurance, the others have been losing market share for some time now.

However, compared to December 2019, United India Insurance has marginally gained market share in January.



New India Assurance continues to have the highest market share in the general insurance space at 14.28 per cent, followed by United India Insurance at 9.19 per cent, National Insurance at 7.67 per cent, and ICICI Lombard at 7.22 per cent.

In the February 2018 Budget, the government had announced a plan to merge National Insurance, United India Insurance and Oriental Insurance, and list the merged entity on the stock exchanges.

However, there has little progress on the merger since, even as the financial health of the firms deteriorated in terms of losses, falling market share and poor solvency ratios.

National Insurance's solvency ratio, a key measure of financial strength, stood at 1.04 at the end of FY19, against the regulatory requirement of 1.5, according to the data.

It was 1.05 for United India in the second quarter (Q2) of FY20. The company posted pre-tax loss of Rs 1,091 crore in Q2FY20, according to the data from the General Insurance Council. Oriental Insurance's solvency ratio was 1.56 in Q1FY20. The company had posted net loss before tax of Rs 330 crore in Q2FY20.

The three insurers, under the aegis of GIPSA (General Insurance Public Sector Association), earlier appointed consultant EY to draw a blueprint for the merger plan.

(The writer is Namrata Acharya.)

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Source

Just raising deposit cover to Rs 5 lakh won't help – The Economic Times – 11th February 2020

Finally, the Government of India has woken up to the problems faced by Indian bank depositors. And to regain their confidence, finance minister Nirmala Sitharaman announced in her Budget speech on February 1 that "Deposit Insurance and Credit Guarantee Corporation (DICGC) is permitted to increase deposit insurance coverage from Rs 1 lakh to Rs 5 lakh".

DICGC, a wholly owned subsidiary of the Reserve Bank of India, also acted fast and increased the deposit insurance limit to Rs 5 lakh with effect from February 4.

Deposit insurance limit, which was languishing at Rs 1 lakh since 1993, always used to come into discussion when any bank got into trouble. Naturally, it was the talk of the town recently because of the crisis at Punjab and Maharashtra Co-operative (PMC) Bank, which is one of the biggest co-operative commercial banks with lakhs of customers.

With fears spreading, people were shifting their FDs to nationalised banks or very big private sector banks. The deposit insurance limit increase will stem this tide, and therefore, will be a positive for small private sector banks and small finance banks. Most of the banking sector stress now is in the co-operative banking space. Since DICGC covers co-operative banks also, they will be the biggest beneficiary of this move. Please note that primary co-operative societies are not covered by DICGC.

This deposit insurance increase is a welcome move, but is it enough? No, because this will address only half the problem. Two problems still plague Indian depositors. First one is the low deposit insurance limit and the same is addressed now, at least partially. Non implementation of the earlier Rs 1 lakh limit by the DICGC was the other problem and the situation continues like that even now. This is because the DICGC is liable to pay only when a bank goes into 'liquidation' and not when a bank is left under 'suspension'.

For example, RBI placed restrictions on CKP Co-operative Bank in May 2014. It has been over five years since then, but the depositors have not been able to make use of the deposit insurance scheme. Because the RBI only 'suspended' its banking activities, (i.e., deposit-taking and lending), and not 'terminated' its banking licence. Situation is similar with the recent PMC Bank crisis – the RBI only suspended its operations and did not terminate its licence. That means DICGC will not pay the depositors. What is the purpose of increasing the limit from Rs 1 lakh to Rs 5 lakh when the previous limit of Rs 1 lakh is not getting implemented?

To win back investor confidence, the RBI needs to be more proactive with defaults happening at cooperative banks. Because according to DICGC annual report, of the 2,098 insured banks, 1,941 are co-operative. Claim settlement is done through the Deposit Insurance Fund (DIF), a corpus generated out of the premium received from banks and the returns generated on its investments in government securities.

As on March 31, 2019, the size of DIF was Rs 93,750 crore. Compared to the premium income of Rs 915 crore and income on investments of Rs 827 crore, total claims settled during 2018-19 were only Rs 37 crore paid against claims from 15 cooperative banks.

The operation of DICGC also needs to be streamlined to make the payment directly to depositors. As per the current rules, DICGC will not directly pay the depositors when a bank goes for liquidation. Instead, the amount will be paid through the liquidator and that too only within two months of receiving receipt of claim list from the liquidator. The payment will be to the transferee bank in case the failing bank is forced to merge with another bank.

(The writer is Narendra Nathan.)

Source

TOP

Days after hiking deposit insurance, FM Sitharaman says working on contentious FRDI Bill – Financial Express – 7th February 2020

Within days of hiking the deposit insurance five-folds to Rs 5 lakh per account, Finance Minister Nirmala Sitharaman on Friday said her ministry is working on the controversial Financial Resolution & Deposit Insurance (FRDI) Bill, but added she is not sure when it will be tabled in the House. The government was forced to withdraw the FRDI Bill from the House after Opposition members objected to it, especially the bail-in clause to banks, which many fear is detrimental to depositors.

Late finance minister Arun Jaitley in August 2017 introduced the FRDI Bill in the Lok Sabha, which had proposed a comprehensive resolution framework for revival/closure of financial institutions, including banks, insurers, NBFCs, and cooperative banks. But could not go ahead with the same. A year later in August 2018, the then finance minister Piyush Goyal was forced to withdraw the Bill, following concerns raised by the public on the 'bail-in' clause and also due to conflict of opinions with various regulators, including the Reserve Bank.

The government then proposed to set up an independent resolution corporation to carry out a speedy and efficient resolution of financial firms in distress. The Bill was then referred to a joint House committee. According to the bail-in clause, proposed for the first time in the country, customers of a failing financial institution would bear a part of the cost of resolution by reducing their claims.

Despite government clarifying that the bail-in clause will be sparingly used, concerns persisted among the public, and the government believed that it was one the main reasons for the spurt in cash withdrawals seen that year. The finance minister's comments assume importance given the massive five-

fold hike in deposit insurance and the recent changes in the insolvency laws to include insolvency provisions for financial institutions, following which leading mortgage player DHLF was sent to NCLT last November.

"We are working on the FRDI Bill; but not sure when it can get through the House," the minister told reporters here without elaborating. The minister's comment also comes a day after the Reserve Bank had clarified that the spike in deposit insurance will not hit the balance-sheets of banks as the insurance premium will go up by just 2 paise from 10 paise now.

The move also comes at a time when many financial institutions, especially NBFCs and cooperative banks, are showing signs of deep stress. The bankruptcy code takes care of resolution for ailing non-financial firms, but doesn't cover deposit-taking financial companies. While DHFL became the first NBFC to be sent to NCLT last November, IL&FS, much larger than the former was been taken over by the government in October 2018.

There were string failures among the cooperative banks with the largest being the bankruptcy of PMC Bank with over Rs 11,800 crore of public deposits. Those apart more than two dozen cooperative bank managements were superseded by the RBI in 2019 from Maharashtra alone. Many analysts argue that financial sector companies need a special resolution regime as the main purpose is to safeguard the interests of depositors and prevent prudential risks from spilling over into a systematic concern.

Commenting on the impact of the deposit insurance hike on banks' bottom-line, Reserve Bank deputy governor B P Kanungo on Thursday said the five-fold hike would not have much impact on bank balance-sheets. The budget had permitted the Deposit Insurance and Credit Guarantee Corporation (DICGC) to raise deposit insurance coverage to Rs 5 lakh from Rs 1 lakh.

The DICGC, a wholly-owned subsidiary of the Reserve Bank of India, provides insurance cover on bank deposits. At present, the DICGC provides Rs 1 lakh insurance to a depositor regardless of the deposit amount, in case the lender fails or gets liquidated.

"The premium is something, which we consider, will increase from 10 paise to 12 paise per Rs 100 for the time being. So, the impact on bank balance sheets is not likely to be much," Kanungo told reporters. According to analysts, the premium burden on banks following the insurance cover hike will go up by 20 per cent.

TOP

Source

HEALTH INSURANCE

Coronavirus effect on health insurance – Moneycontrol – 14th February 2020

We're living in an increasingly scary world. In the last five year alone, we've heard of outbreaks of increasingly dreadful viruses like Zika, Ebola, MERS (Middle East Respiratory Syndrome) and Nipah. And now there is this new virus called the coronavirus that is causing fear and panic. The dreaded virus, which originated in Wuhan, China, has already affected thousands of people globally and claimed several lives too.

At last count, three new cases of coronavirus have been reported in India too. And, although these are isolated incidents, many people are confused whether their health insurance covers them against this monstrous disease that is spreading like wild-fire. Let's understand what coronavirus is and whether you can seek treatment for the same under your existing general health insurance plan.

What is Coronavirus? What are its Symptoms?
Said to have originated in Wuhan, China, the coronavirus has come from animals. Many people who were initially infected with the virus either worked or frequently shopped in the Huanan Seafood Wholesale market in Wuhan, China. The market also sold newly slaughtered and live animals.

According to doctors, coronavirus is akin to a common cold. The infection typically affects the patient's upper respiratory tract and can even cause pneumonia. Sore throat, cough and flu, mild headache and fever are some of the most common symptoms of the infection. Fever caused due to the infection can last for two days or more. In case one is severely infected, they may need medical attention, including hospitalisation. But the question remains; can one seek health insurance coverage for the treatment of coronavirus? The answer is yes, you can!

Your health insurance policy covers you against treatment for coronavirus
Typically, most health insurance policies are general policies. This means that you can avail coverage against all kinds of illnesses or treatments; including diseases that aren't yet discovered. General health insurance policies, which are the most common types of health policies, are not disease-specific. As such, you can avail coverage against hospitalisation as well as OPD (out-patient department) expenses, irrespective of the disease you're suffering from. General health policies offer coverage against all kinds of infections, and since coronavirus is a type of infection; you can avail coverage from the first day of your insurance policy.

Coronavirus is not considered a pre-existing disease
Coronavirus is not considered a pre-existing illness. It is the kind of illness that can affect one without any prior warning. Insurance providers, therefore, have no reason to reject coverage for the disease, and you can file an insurance claim if you need treatment for the same. As such, you can claim coverage against all expenses – be pre-hospitalisation, in-patient treatment, ambulance cover, OPD charges, and post hospitalisation, and so on; depending upon the coverage you are entitled to, under your policy.

Filing an insurance claim for coronavirus treatment
You can file health insurance claims for treatment against coronavirus in two ways

You can seek cashless treatment
You can seek cashless treatment in one of your insurance provider's network hospitals. You just need to inform your insurance provider about the hospital where you'll be seeking treatment. Remember to take your policy documents and health insurance card provided by your insurer. If you opt for the cashless facility, you do not have to pay the hospital bills upfront. A representative of the insurance company directly settles the bills with the hospital. However, the insurer will only cover you up to the sum assured amount. You may also need to bear the costs associated with any non-medical expenses, such as soaps, shampoos, medical masks and other apparatus you need to use to prevent the virus from spreading.

You can file the claim and seek reimbursement later
If you wish to seek treatment in a hospital not listed in the insurance provider's network; you can do so and file for reimbursement of expenses. However, you need to intimate the insurer about your intention to seek treatment and file an insurance claim, before you seek admission in the hospital. Once the treatment is completed, you can file a reimbursement claim. You must submit all the documents – reports, hospital and medical bills, and so on and then file the reimbursement claim. Typically, most insurance providers reimburse claims within 21 days. However, before filing a claim, you must check what is and isn't covered.

Preventive measures
Although the number of coronavirus cases reported in India are very few; it does not hurt to take certain, preventive measures. Here are the precautions you can take:

Follow good respiratory hygiene
Use tissue papers or handkerchiefs to cover your cold and sneezes. If you're using tissues, make sure to discard them appropriately, without fail.

Wash your hands properly
You must wash your hands as frequently as possible, especially if you have a cold or cough. Choose a liquid soap as opposed to a soap bar and follow up with a hand sanitiser.

Maintain distance
It is better to maintain your distance from people if your cough or cold is mild or severe. Take an off-day or two from work or school, to avoid infecting others.

See a doctor
If you've been coughing, sneezing or feeling unwell for more than a day, make sure to visit your doctor and seek treatment immediately. Immediate treatment prevents the infection from becoming severe, wherein you may need hospitalisation.

Avoid animal products
It is recommended to avoid consuming meat products or even animal products like dairy for the time being, especially if you're getting your provisions from wet markets. Consider using vegan products (almond milk, for instance) to fulfil your dietary needs.

Final word: There is no reason for your insurance provider to deny your insurance claim for coronavirus treatment. However, if you have any confusion about whether or not are eligible for treatment, you can always call on your insurance provider's customer care helpline and get all the details you need.

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Source

National health registry of hospitals is the need of the hour: R Raghavan - The Economic Times – 12th February 2019

Shahid Akhter, editor, ETHealthworld spoke to R Raghavan, Former GM, GIC of India and also Founder CEO of IIB to know more about the need for a unique thirteen digit id, ROHINI, which could be supportive in identification of hospitals and also help in promoting medical tourism in India. Edited excerpts:

Hospital identification: The need
We have hospitals in various segments in health care industry in India. Firstly, is obviously the government run hospitals, both at the primary level, health care level, then your secondary level, at district headquarter hospitals, and thirdly you have a specialist like AIIMS etc. Secondly, you have corporate run kind of chain of hospitals like Apollo Indraprastha and also medium -sized hospitals like for example, the Ganga Ram Hospital in Delhi. You also have super-speciality hospitals in India like the cancer institutes, TB institutes etc. No one has an exact number on number of hospitals in the country basically because the regulatory system for infrastructure framework for hospital upto an establishment is scattered between the central government and the various state governments. Each state government has its own law because health is still a concurrent subject.

With the reserve what happens is, there is no single better ways from where we can locate all of the city as to which hospital is located in which place. So, this leads to not only confusion in the minds of the general patient public those who seek health care but when it comes to the back of its requirements like analytics or even control of certain diseases like endemics and epidemics, it leads to a huge yawning gap. Therefore, the lack of a single, National health registry of hospitals on the road is a huge deterrent to the analytics of the country.The problem of the health insurance companies can also be added to it as they basically recur proper documentation from patients which are normally supplied by what are called as the third party administrators who are the link between the hospitals providing treatment and the insurance companies who finally pick up the bill.

Those capturing data also create a lot of distortions so with the result what happens is in the Insurance Information Bureau, it has a very robust data base, dating on health insurance claims, dating from 2005 onwards, But all that huge volume of data base cannot be constructively utilized for analytics for a simple reason that the data input is coming in a deficient way. This is exactly where some kind of identification of hospitals on a unique basis was meant as necessary. The comparable example is perhaps the IFSC code for the banks, today if you want to send money from one bank to another bank, between the banks electronically or from one individual to another individual in another bank, you use the simple IFSC code, from the particular branch from where the money goes and also for the particular branch which receives

the money on bare from the payee.That kind of absence of a single code was the biggest nightmare of any analytics to be carried of and more importantly this is also a great detriment for fraud detection and fraud control as far as insurance claims are concerned. So, there is Ram Chandra hospital which can be perhaps in one location, let say in Dhaulakuan but since there is a fraud detriment in Ram Chandra Hospital, they can change their name to Chandra Ram Hospital and continue in the same location in the same building, so this was again great handicap for the insurance company thus,unfortunately in health insurance, insurers are not making money.They are paying more than 152-180 rupees as claims and out of these 180, may be 30-40 rupees is because of fraud only, so the purpose of having a National Registry is to insure the information linkage between various stakeholders in the health care industry.

Hospital identification: Way forward

So, to sought out the problems which I just now highlighted we needed a role model. What I tried to do was, like ours is a unique id for every citizen of India (proof of id), similarly we wanted to make sure that each hospital which is in the insurance provision network has a unique id and all are clearing the kind of role model which we will follow. Therefore, we want warders called as the National Registry of Hospitals for the insurance provider network which is designated as ROHINI- Register of Hospitals in the Insurance Network.

ROHINI: Journey

ROHINI is basically a 13 digit unique id allocated to each hospital which is in the insurance provider network. With this 13 digit id, the proper name of the hospital, the exact geo location- the longitude, the latitude, pin code, exact address etc, is also provided. The important thing is, this is not done unilaterally by Insurance Information Bureau, it is the hospital which wants to participate in the insurance network, they voluntarily apply to ROHINI for allocation of unique id, and a 13 digit id is allocated to them after a particular waiting process.

ROHINI: Future Plans

ROHINI, now that almost 33,000 hospitals have enrolled in the ROHINI National Register, there are lot of additional benefits which can come out of it, One clear example is known as the "Bharat Ayushman Scheme", which is proposing to enroll almost 50 crore families. Now the same hospitals which are there in the insurance network may also participate in the Bharat Ayushman and therefore rather than having independent course,the hospitals which have ROHINI can find it easy to find place in the Bharat Ayushman enrollment of hospitals also. Second thing is, what future can do is, if hospitals voluntarily furnish information about the facilities available, doctors available and possibly the rates, the charges for various procedures and critical illness procedures and if that can appear in ROHINI, then even patients who are seeking treatment in India from foreign countries, for example middle east or union territories etc can also do a easy search on ROHINI, under-locate which hospital, which doctor, which date and possibly even the level of comfort. So, the ultimate possibility in ROHINI is to enhance medical tourism in India.

(The writer is Shahid Akhter.)

TOP

Source

₹15 lakh aid for treatments out of Ayushman cover – Hindustan Times – 11th February 2020

Poor patients in need of expensive treatment not covered by packages under the Ayushman Bharat insurance scheme will now again be able to get financial assistance of up to Rs 15 lakh under the Rashtriya Arogya Nidhi (RAN) scheme, an official statement said.

The beneficiaries of Ayushman Bharat scheme in need of expensive surgeries like organ and bone marrow transplants, spine surgeries, and revision surgeries for faulty joints became ineligible for assistance under RAN after the guidelines were revised in February last year.

"If as per medical advice, the suggested treatment is not covered under any of the approved listed packages of AB-PMJAY, financial assistance up to Rs 15 lakh can be provided to AB-PMJAY beneficiaries out of umbrella scheme of RAN," states the office memorandum with the revised guidelines.

An official from the health ministry confirmed the same, on condition of anonymity.

Financial assistance is provided to patients living below the poverty line suffering from life-threatening diseases and rare diseases at 14 central government hospitals, including four hospitals in Delhi – All India Institute of Medical Sciences (AIIMS), Dr Ram Manohar Lohia hospital, Safdarjung hospital and Lady Hardinge Medical College and associated hospitals. In addition, the scheme also has a Health Minister's Cancer Patient Fund at 27 regional cancer centres.

In 2017-18, Rs 40 crores were used from the Rashtriya Arogya Nidhi funds at AIIMS, Delhi for providing free treatment to 926 people, approximately 4.31 lakhs per patient, according to the latest annual report from the hospital.

In January, the Delhi high court had directed AIIMS to treat a poor 11-year-old boy with aplastic anaemia for free, with the central government reimbursing the cost of treatment, as the disease is not covered under the central government's flagship Ayushman Bharat scheme.

"This had opened up the way for other patients to approach the court to get financial aid. However, the change in guidelines is a big win," said Gaurav Bansal, a city based advocate who had filed the case for the 11-year-old.

TOP

Source

Want to cover outpatient expenses? You may try this new plan of Star Health – Financial Express – 11th February 2020

Traditionally, health insurance plans pay policyholders in case of hospitalisation for over 24 hours for treatment of any disease or accidental injury and expenses made in association to hospitalisation including pre- and post-hospitalisation expenses on checkups and tests.

However, hospitalisation is very rare in comparison to visiting doctors in outpatient (OP) facilities. So, there has been a long-standing demand of policyholders that OP expenses should also been covered under health insurance policies.

Moreover, during policy a policy year, a healthy person is more likely to visit a doctor for medical conditions, which are not serious enough for hospitalisation than actually get hospitalised. So, OP cover would be more appealing for a healthy person to take health cover.

Although, the Insurance Regulatory and Development Authority of India (IRDAI) is also in favour of providing OP cover to health insurance policyholders, stakeholders of health insurance industry fear major payouts due to frauds.

"OPD fraud is very easy in India. Unless proper network of doctors is in place, it will be difficult to provide OPD cover," said Rajesh Dalmia, Partner, Ernst& Young LLP during Annual Insurance Brokers Summit in New Delhi.

However, to meet the expectations, leading health insurance company Star Health, has decided to launch a standalone plan specific only for outpatient procedures (OP), instead of providing the cover in traditional health insurance policies.

The all-new standalone product Star Outpatient Care policy would pay for all outpatient consultation, which starts with doctor fees and covers Diagnostic tests, Pharmacy Bills, Physiotherapy, Non-Allopathic Treatments, Dental Treatments and other therapeutic procedures.

Explaining the product, Star Health and Allied Insurance Co Ltd Managing Director Anand Roy said, "There are ailments that don't require in- patient hospitalisation and these come under outpatient care. In India, mostly, costs incurred for treating such ailments are paid by the people from their own pocket. Since such costs can be substantial at times, we, at Star Health, have introduced Star Outpatient Care Insurance Policy, which is one of its kind in the market."

This plan would cover customers in age group of 18-50 years and dependent children up to 25 years age, who are economically dependent on their parents.

Maximum six members of a family may apply for the policy, which is available in individual plan as well as family floater plan with a policy term of one year duration. The maximum sum insured under the policy is Rs 1 lakh and applicants may opt for variants like – Platinum, Gold, and Silver.

The OP plan provides coverage for all outpatient consultation expenses, incurred at Star Health network registered medical facility in India, as well as in non-allopathic facilities, such as Ayurveda, Yoga and Naturopathy, Unani Sidha and Homeopathy systems of medicines in any institute recognised by the Indian government and/or accredited by the quality Council of India/National Accreditation Board on Health.

Apart from outpatient consultation expenses, the new policy also covers diagnostics, physiotherapy and pharmacy expenses as well as ophthalmic treatment expenses arising out of accidental injuries incurred by an outpatient at any Star Health-registered medical facility in India.

(The writer is Amitava Chakrabarty.)

TOP

Source

How is lack of health insurance affecting the poorest in India? – Elets – 10th February 2020

No doubt, health insurance has become a necessity, but still, a lot of Indians do not understand this and keep playing with their health. According to the recent survey conducted by 'Largest National Survey' on consumption, only one-fifth of the Indians are insured under health insurance. Rest is still unaware of its importance. There are multiple reasons behind the lack of health insurance which affect the poorest.

●Low-Income Groups- To invest in any kind of health insurance, the low-income group is forced to pull out money from their savings or borrow from someone else. As many of them can't afford, they choose to remain uninsured and receive poor quality health care services. As per the survey, one-fifth of India's population usually spends more than 15% of their income on healthcare expenses. The survey confirms that in recent years, poverty has grown by 5% and more than 40 million people are below the poverty line. They are still not insured and don't have enough funds to get the required coverage.

●The extreme poor groups-Because of the lack of health insurance, roughly 79% of people from rural areas pay for the required healthcare services from their small savings. Still, the extremely needy groups are not able to get this. Hence, it leaves the majority of Indians uninsured. If we check further, you will realise that average medical expenses for hospitalisation in a private hospital are seven times of a government hospital. With this figure, it is clear that extremely poor people are still not getting the required assistance in the hour of need.

Paying regularly for their healthcare needs from their pocket increases their poverty level. Since it becomes hard for them to afford quality healthcare service, they delay seeking the treatment which results in major diseases. Many lose their lives in the bargain. Growing healthcare costs keep people poor and below the poverty line. To deal with the same, the government has designed multiple health

insurance policies for the poor section of the society. Such policies are available for free or at a nominal cost.

Government health insurance program

Before Pradhan Mantri Jan Arogya Yojana (PMJAY) which is also known as Prime Minister's Health Protection Scheme comes into the picture, only 13% of people from the rural section of the society were covered under the central government insurance scheme. Since the cover was not sufficient, the government of India launched PMJAY in September 2019. After the launch of PMJAY, the rest of the 45% of the population is now covered under health insurance. It is a big jump towards Universal Health Coverage. Just insurance alone is not enough; all needy sections are not aware of the scheme. Not all can get the required cover and not all have access to quality healthcare services.

In India, health insurance is weak, it is still at the embryonic stage. That who can and want to invest in insurance is still quite low and on the other hand, the insurance premiums are rising daily.

Furthermore, as Indians especially those in rural India], have limited access to quality healthcare services, they are less likely to invest in health insurance.

To assist the underprivileged section of the society with full medical care, the government is running many awareness programs. Even insurance companies are providing health insurance plans at really affordable prices.

To conclude….

Every person needs to get insured under the adequate health insurance plan. It will help them in dealing with unwanted medical emergencies. It allows the person to avail quality healthcare services easily without spending any money from their pocket. For a secure and healthy future, it is vital to insure yourself and family under adequate health insurance.

(The writer is Naval Goel.)

TOP

Source

Poor workers insured with ESIC left in lurch - The Pioneer – 10th February 2020

The sudden decision of Employees' State Insurance Corporation (ESIC) authorities to ban the secondary care referral of the insured persons to other hospitals has shocked and irked the insured persons dependent on ESIC.

With thousands of industrial workers getting affected with this sudden withdrawal of secondary care referral, trade union, CITU State secretary in a statement here threatened for a mass agitation demanding immediate lifting of the ban.

Sources said ESIC, a Government of India body, takes care of the health issues, mainly of the private sector employees. Accordingly, ESIC runs dispensary, model hospitals and the insured persons and their family were earlier being referred to by ESIC Model Hospital, Rourkela, for secondary care treatment and in some cases, when super speciality treatment was required, patients under ESIC, were being referred to super speciality hospitals for their treatment.

The secondary care referred was stopped by ESIC from February 1. Significantly, the employee's contribution rate (from July 1, 2019) is 0.75 percent of the wages and that of employer is 3.25 per cent of the wages but before that, the employee's contribution rate was 1.75 per cent and employer's contribution was 4.75 per cent.

Although there has been a ESIC model hospital at Rourkela, the hospital doesn't not have facilities like ultrasound, ECG and other essential facilities, for which it refers the patients to other tie-up hospitals of the city.

The patients were getting treatment there without making any payment, as a secondary care measure but after the secondary care referral facility has been stopped by ESIC, the insured persons, particularly workers with meager salary, are left in the lurch.

"It is really painful to know that secondary care referral has been stopped by ESIC. ESIC Model Hospital at Rourkela does not have required facilities for patients and now a worker with very small salary like me, have to run to local hospitals and testing centres that I can ill afford to," said B Majhi, a worker of an industry.

Deputy Superintendent, ESIC Model Hospital, Rourkela, Jayanti Behera said, "We have informed the difficulty faced by the patients to our higher authority." CITU State general secretary BC Mohanty warned of a mass agitation unless the decision was rolled back.

TOP

Source

Know why health insurers reject claims – Financial Express – 10th February 2020

Every insurance—be it health, life, motor or travel—is basically a contract between the insurer and policyholder based on principles of utmost good faith. If the policyholder fails to exercise complete honesty and accuracy while providing the information to the insurer, the insurer has every right to reject the claim stating it as the reason for its rejection.

According to a recent finding, the number of customer complaints against health insurers has significantly gone up primarily on account of dissatisfaction with the claim settlement process. However, after proper investigation and examination, it has been found that it is the policyholder who is at fault and responsible for rejection of health insurance claim. Some of the prominent reasons for rejection of claims are not declaring pre-existing diseases (PED), less or no knowledge about room-rent capping, extent of coverage of OPD expenses, day-care procedures covered and not filling the claim process completely.

Stringent underwriting process

As a policyholder, it is important to understand that your job does not end at selecting the insurer with the highest claims ratio. It's much more than that! Health insurers these days are exercising extreme caution. The underwriting processes have become much more stringent, resulting in increased proposal rejections. This is the reason why policy seekers while buying a health insurance policy need to be extra careful. This has made it very important to pre-disclose all your medical conditions, including both current and past medical history.

The most important thing is to be mindful of detailing pre-existing disease —any ailment a customer had either as symptoms or was diagnosed with and received medical treatment for the same throughout the 24 months prior to the policy being issued by the insurer. If any ailment not declared earlier and found later, may restrict you from getting the claim proceeds.

As per a recent survey by ICICI Lombard, over 50% of the policyholders are not sure whether they should disclose their pre-existing ailments at policy inception. Moreover, over 27% policyholders say they would rather not declare any PED while purchasing the policy while around 30% feel they do not need to disclose pre-existing lifestyle diseases like diabetes and hypertension if they are under control. The fact is it is very important to disclose any PED while buying a health insurance policy to avoid claim rejection.

Inclusions and exclusions

Know the various inclusions and exclusions under your health insurance policy. Often people assume that their health insurance policy covers the OPD expenses incurred including doctor consultation fees

and cost of medicines. Before filling a claim that includes OPD expenses, be sure if your insurer covers you for the same and if buying a new policy, do buy a policy that even covers OPD expenses along with day-care procedures.

Talking about rejection of claim due to exceeding room-rent limit, the sub-limit on room-rent is the most important. In most policies with sub limits, the cap on reimbursement of claim is linked to the room-rent limit. To avoid rejection of claim, it is always better to stick to the room-rent limit. If the sum insured mentioned in your policy is Rs 5 lakh, it is advisable to choose a hospital room with rent equal to 1% of the sum insured, i.e., Rs 5,000 or lower.

(The writer is Amit Chhabra.)

TOP

Source

Even a cashless health insurance claim may require you to pay; Here's why – Financial Express – 9th February 2020

While making a health insurance claim, in case of a health insurance policy with the medical reimbursement option, the policyholder needs to show the hospital bill to the insurer and the amount is reimbursed. However, in the case of a cashless claim, the insured does not have to pay the hospital bills as the insurance company reimburses the same directly to the hospital.

Though this is how it should work, that is not the case always.

In fact, with the cashless claim option, most policyholders think they are not liable to pay anything against treatment if they are pre-authorized for the cashless option. However, that's not the case, as the insurance company makes a few deductions.

Be it is a cashless claim or a reimbursement claim; know the benefits that you are entitled to. Read the terms and conditions carefully, so that a deduction does not come as a disappointment later.

Find out what you are required to pay in a cashless claim option:
Exclusions: Every medical expense is not covered by insurance policies. Hence, there are deductions due to non-admissible items or services when making a claim. For instance, services such as registration charges, medical record fees, admission fees, insurance processing fees, etc. are also not covered.

Room rent limit: Room rents are capped with most insurance policies. With this, upper-limit is applied on the room rent beyond which the insurance company is not liable to pay for the policyholder. Hence, if during hospitalization you choose a room whose rent exceeds this upper-limit, a proportionate charge will be applied to all the treatment-related services.

For instance, Aparna is eligible for a semi-private room with rent up to Rs 3,000. Now if she chooses to stay in a deluxe room with rent Rs 6,000, she will end up bearing 50 per cent of the total cost because of the proportionate deduction in the final claim settlement. This is because the insurance company will not cover the increase in the bill due to the room selection.

Co-pay: Co-payment is an insurance policy decreases the premium out pay. With the Co-pay option, the policyholder is liable to pay a certain percentage of the total claim amount. This is applied to the dependents of the policyholder such as spouse, children, and parents. Also, for a senior citizen policyholder co-pay is also applied to every claim he/she makes.

Sub-limit on treatments: A common misconception that most policyholders believe is that if their total treatment cost is less than the sum insured, it will be covered by the insurer. What they don't understand

is that under a policy almost every treatment has a limit applied to it. Hence, if the treatment cost exceeds the limit, the policyholder will have to pay the difference.

For instance, if Aparna is insured under a policy with a sum insured of Rs 5 lakhs, usually under a policy normal delivery charges and C-section delivery charges up to Rs 30,000 and Rs 50,000 respectively are covered. Hence, if the maternity expenses exceed the specific amount, Aparna will have to pay the difference out of her pocket. This is applicable despite having a sum insured for up to Rs 5 lakhs.

(The writer is Priyadarshini Maji.)

TOP

Source

CROP INSURANCE

Coverage under PM crop insurance scheme has increased: Central Government – The Hindu Business Line – 11th February 2020

The Centre has claimed that coverage under Pradhan Mantri Fasal Bima Yojana (PMFBY) has increased to 30 per cent of the gross cropped area (GCA) from 23 per cent in 2015-16 under the earlier schemes. The Ministry of Agriculture and Farmers Welfare told the Rajya Sabha last week that it was incorrect to say that private insurance companies had made windfall gains under the scheme.

The Ministry added that the rise in coverage was because of the improved features of the scheme. "Participation of non-loanee farmers, for whom the scheme is voluntary, have also increased from 5 per cent under erstwhile schemes to 42 per cent (Kharif 2019) under PMFBY, showing the voluntary acceptability of the scheme," the Ministry added.

Reinsurance costs

The difference between premium collected and claims paid is not the margin/profit for the insurance companies, the Ministry said. "The cost of reinsurance and administrative cost totalling 10 to 12 per cent of gross premium also have to be borne by the insurance companies. Further, out of the total crop insurance business under the scheme, more than 50 per cent is shared by the five public sector insurance companies, including Agriculture Insurance Company of India Ltd."

Under the provisions of the scheme, premium from farmers along with central and State government share in premium subsidy is paid to the concerned insurance company for acceptance of risk and payment of claims as per the provision of the scheme. Insurers save premium in good seasons/years and pay high claims, if any, in bad years from the savings made in the good years, the Ministry added.

Claim ratio

The Ministry said that in spite of overall good monsoon during the first three years of the implementation of PMFBY, the claim ratio during 2016-17, 2017-18 and 2018-19 was about 77 per cent, 86 per cent and 80 per cent (provisional) respectively. Overall claim ratio for the three years combined (2016-17, 2017-18 and 2018-19) comes to about 81 per cent.

But the farmers in most affected areas/States received higher claims and the claim ratio was higher in Kerala (209%) and Karnataka (136%) during Kharif 2016, Tamil Nadu (298%) and Andhra Pradesh (179%) during Rabi 2016-17.

During Kharif 2017, the higher claim ratio was in Chhattisgarh (452%), Haryana (270%), Madhya Pradesh (161%) and Odisha (217%). During Rabi 2017-18 high claim ratio States were Odisha (226%), Tamil Nadu (148%) and Chhattisgarh (109%). Though complete data for Kharif 2018 season is not available, high claims ratio has been reported in States of Haryana (140%), Uttarakhand (115%) and Chhattisgarh (124%), the Ministry informed the House.

Coverage under Pradhan Mantri Fasal Bima Yojana (in ₹ crore)

Year	Farmer applications insured (in lakh)	Area insured (in lakh ha)	Premium paid				Claims reported
			Farmers	State Govt	Central Govt	Gross premium	
2016-17	583.71	570.84	4,216.42	8,923.29	8,735.21	21,874.92	16,774.35
2017-18	527.96	514.99	4,395.60	10,511.84	10,442.17	25,349.61	21,925.59
2018-19*	568.12	519.25	4,918.77	12,152.51	12,034.70	29,105.98	23,175.99*

*Claims of some crops/areas for Rabi 2018-19 are not finalised (Source: Rajya Sabha question answers dated 7/2/2020)

(The writer is Radheshyam Jadhav.)

TOP

Source

Crop insurance scheme likely to give more flexibility to states and farmers – The Economic Times – 10th February 2020

The government is planning to revamp its flagship crop insurance scheme - Pradhan Mantri Fasal Bima Yojana (PMFBY) - by giving more flexibility and freedom to states and farmers in choosing insurance products for risk hedging as per the proneness of the particular state to the specific weather vagary. Currently, farmers across the country don't have any choice. There is one single comprehensive insurance product, which covers risks right from pre-sowing to post harvesting.

"Every farmer who wants crop insurance has to take this comprehensive product without any customisation. This leads to payment of a higher premium. We want to break up this single product and give farmers multiple options in a bouquet of insurance products so that they can take their pick based on their need," said a senior agriculture ministry official.

He said that in the current scheme, suppose a farmer in Bihar doesn't want to take risk coverage for drought or a farmer in Rajasthan wants to opt out from flood coverage, there is no provision.

"We are planning to roll out separate products for pre sowing losses, post-harvest losses due to cyclonic rains and losses due to unseasonal rainfall. State government in consultation with farmers may decide on products they want to buy and the risk they want to cover," the official said.

The PMFBY has replaced the existing two crop insurance schemes -- the National Agricultural Insurance Scheme (NAIS) and the Modified NAIS. It provides comprehensive crop insurance from pre-sowing to post-harvest period against non-preventable natural risks at extremely low premium rates a farmer has to pay - 2% for kharif crops, 1.5% for rabi crops and 5% for horticulture and commercial crops. The balance amount of premium is equally shared by central and the respective state governments.

The penetration of crop insurance scheme has increased to 30% of gross cropped area in the country from 23% in previous crop insurance schemes in 2015-16. The coverage of non-loanee farmers, for whom the coverage is voluntary, has increased from 5% in 2015-16 to 42% during Kharif 2019, which shows the acceptability and progress of the scheme on voluntary basis.

"We are also considering to make this insurance voluntary for loanee farmers also for whom this is mandatory now. We expect that after knowing the importance of this scheme, farmers would voluntarily participate in this scheme," the official said.

The government is also planning to involve compulsorily use of technology and mobile applications for monitoring of crop health and Crop Cutting Experiments (CCEs) in coordination with concerned states.

"We would be adopting technology, such as satellite and UAV remote sensing, for various applications such as crop area estimation and yield disputes and also promote the use of remote sensing and other related technology for CCE planning, yield estimation, loss assessment, assessment of prevented sowing and clustering of districts. This will help in reaching to a scientific and more accurate conclusion on yield and losses estimations," the official said.

(The writer is Rituraj Tiwari.)

TOP

Source

Crop insurance payout of Rs 321cr is pending to AP farmers on want of state govt share: Centre – Business Standard – 7th February 2020

Crop insurance claims of Rs 321.23 crore for the 2018-19 crop year have not been paid to farmers in Andhra Pradesh for want of state share of premium subsidy to insurance companies, Parliament was informed on Friday.

Union Agriculture Minister Narendra Singh Tomar in a written reply to the Rajya Sabha said total claims reported from the state were Rs 1,179.23 crore for the 2018-19 crop year (July-June). Of this, Rs 858 crore of claims have been paid to farmers.

"The balance claims (Rs 321.23 crore) pertaining to Kharif 2018-19 and Rabi 2018-19 pending for want of state share of premium subsidy to the insurance companies," the minister said.

HDFC-ERGO GIC Ltd, Oriental Insurance Company, AIC of India, National Insurance Company and SBI General Insurance Company were implementing the crop insurance schemes in Andhra Pradesh during 2018-19.

The government is implementing two crop insurance schemes of Pradhan Mantri Fasal Bima Yojana (PMFBY) and Restructured Weather Based Crop Insurance Scheme (RWBCIS).

Of the total pending claims, Rs 224.35 crore belongs to kharif crops while Rs 96.88 crore of Rabi seasons of 2018-19, the minister said while placing the data before the Upper House.

The minister further said a tentative claim of Rs 465 crore and necessary bill of Rabi 2018-19 will be presented in 2-3 days for release of state share of premium subsidy.

"Admissible claims for the year 2016-17 and 2017-18 have been settled," he added.

To ensure timely payment of claim, Tomar said the concerned state governments including Andhra Pradesh have been asked to take action including imposing of penalty against defaulting insurance companies as per the revised operational guidelines of the scheme.

In the revised guidelines, there is a provision for timely release of state government share in three installments and settlement of claims by insurance companies without waiting for final or third installment of premium subsidy by the states and advancement of 15 days in seasonality discipline for early settlement of claims.

Penalty provisions for late settlement of claims by insurance companies and late release of funds by state governments have also been stipulated under these guidelines.

These provisions include payment of 12 per cent interest rate per annum by the insurance company to farmers for delay in settlement claims beyond 10 days of prescribed cut off date for settlement of claims.

TOP

Source

MOTOR INSURANCE

Regulatory independence shouldn't be diluted; government shouldn't be fixing the premium for third-party motor insurance – The Times of India – 8th February 2020

For the past few months the amendments to the Motor Vehicles Act have been in the news for significantly raising penalties for traffic violations. Not surprisingly, several state governments have responded by siding with the violators and lowered the fines, triggering a debate on whether they have over-stepped their jurisdiction.

Hidden deep inside the amended law is a clause that can do far more damage but has probably skipped the attention of most lawmakers, who backed the legislation in Parliament. The provision inserted by an officer sitting in Delhi's Transport Bhawan has taken over the powers of the Insurance Regulatory Development Authority (Irda) in fixing the premium for third-party motor insurance.

Overriding the provisions in all other laws, the transport ministry has now assumed powers to "prescribe" (read fix) the base premium and the insurer's liability "in consultation with" with Irda.

This is akin to the finance ministry taking over the Reserve Bank of India's powers to decide on the interest rate that your savings bank deposits will earn. Unlike savings bank rate, which was de-regulated by RBI a few years ago, third party premiums are fixed by the insurance regulator to ensure that vehicle owners are not over-burdened with what is a mandatory insurance cover.

Your motor insurance has two components – "own damage" to deal with risk such as theft or damage to your vehicle, while third-party cover insures you against claims arising due to an injury or death of a "third party" (other than the vehicle owner or the insurance company) in an accident.

Among all the segments, motor insurance sees the highest claims with the ratio estimated at 90.6% in 2018-19, according to the Irda annual report. For the public sector companies, the ratio was close to 108%. This means the four state-run general insurers lost Rs 8 on every Rs 100 of premium they earned. For the system as a whole, there was a profit of a little under Rs 10, but that is excluding the operating costs.

By all accounts, third-party insurance leaves a bigger hole on the balance sheet of insurers, especially given the long tail as cases are often decided almost a decade after a person is injured or killed in a road accident.

Given the claims, insurance companies always pitch for an increase in premium to cover the risk. And, they usually take the safer option of an across-the-board increase in premium instead of rewarding a vehicle owner with a clean record or disincentivising someone with a poor claims history. The regulator too hasn't moved on the plan to actually deregulate premium, something that has been the stated agenda.

But that certainly does not make a case for the government to step in and take control of a sector where over two decades ago, Parliament in its wisdom decided to set up an independent agency and entrust the regulator with the task of managing the insurance business.

Today the government argument is that it is trying to ensure that consumer interest is protected and there is some check on the influence of insurance firms to increase the premium for mandatory third-party insurance. Quite to the contrary, the move shows how the government was influenced by the powerful transport lobby, which has always resisted any increase in premium, despite rash driving by largely untrained bus and truck drivers.

Going forward, the premium will be decided by the transport lobby and will either bleed the insurance companies or increase the burden on the own-damage component, unless the government decides to reverse the clock and regulate tariffs in that segment too. Beyond the insurance sector, the move sends wrofng signals on the governance front and indicates that the government does not care about regulatory independence.

Over the years, a series of steps – from insisting on transferring funds available with the regulatory agencies to appointments – by successive government are seen to be an intrusion into the domain that was carved out for regulators. Barring the financial sector regulators – RBI, Irda, Sebi and Pension Fund Regulatory & Development Authority – several of the new agencies such as those for the petroleum or the aviation sector were in any case bereft of sufficient teeth, allowing the ministries concerned to dictate terms.

The latest amendment can set a dangerous precedent. Instead of taking over the powers of the regulator, the government should provide subsidy through the budget in case the premium is genuinely excessive, much like what is done by states in the power sector.

(The writer is Sidhartha.)

TOP

Source

REINSURANCE

India's reinsurance market is on path to liberalisation: Bruce Carnegie-Brown, Lloyd's of London - The Economic Times – 10th February 2020

Lloyd's is an over 200-year-old name in reinsurance. What risks have you covered so far? How do you go about doing business where a state-backed entity has the first right of refusal? Indian economy is no different from any other increasingly sophisticated economy. And as it gets more sophisticated, the trading patterns between it and other countries develop. So, you need more complex covers. Obvious examples are business interruption covers, cyber-risk cover — particularly for services industry… this is a huge and growing risk. India is about to become the second-largest nation in terms of domestic aviation and the capacity you need to cover those risks — a lot of that exists in Lloyd's. So, as the economy grows, the risks grow, and therefore, risk protection.

Ten new companies have set up base in India in the past year and have done business of Rs 6,000 crore which was with GIC earlier. What's holding them back from joining Lloyd's syndicate? I think this market is also on path to liberalisation. It has not got there yet, but the preference shown to GIC represents a point of friction in the journey... but it's better to have an opportunity to play with that restriction than not to have the opportunity.

It is the same issue on distribution side, with the opportunity to move up from 49% to 100% ownership of the businesses, and respectively, for underwriters to be able to take 74% ownership of the business. If we step back and look at the journey, it's moving in the right direction. Sometimes, it may move too slowly and sometimes move in an imperfect way, but governments have many stakeholders and they have many pressures. Would we like it to be fully liberalized? Sure.

Where does Lloyd's see itself in India in a decade or so?
I think it's the same as my vision for any other counterparty that we do deal with at Lloyd's. At Lloyd's we are privileged to have over 200 licences in countries and territories around the world. Our expertise is recognised around the world in a number of classes of business that complement the domestic market. We very seldom compete with the domestic market counterparties.

The biggest sector of insurance is motor insurance and we don't do it anywhere in the world; so it tends to be that we get pulled in either to help create more capacity in a market that could exist without us or to provide expertise on how to insure risks that are new in a marketplace.

Is the kind of underwriting losses the industry is seeing one of the reasons why new players are not entering the reinsurance market?
No, I don't think so. The challenges in the Indian market are not any different from around the world in terms of underwriting disciplines. I don't think there's a distinction. Our experience is good in terms of underwriting losses in India and the risk we already underwrite.

Which part of the $275 million that you're writing up the London office can move to India?
Pretty much all of it could move to India in due course. The question is, why it would move to India if it's more efficient to do it in London? I'm agnostic about the distribution. What I want is for it to come to Lloyd's. Do I care if it comes through Lloyd's India or Lloyd's Singapore or Lloyd's London? Not really. But I think there is a bigger opportunity for getting closer to our customers here in India by having capital here, and as you understand a market better, you get more engaged; your opportunities also begin to grow.

There's a feeling Lloyd's is not adapting to changing realities quick enough. Even Chubb CEO has said that.
The first thing we've been doing over the last two years is transforming the underlying performance of business — that is, the underwriting performance. For any insurance, underwriting makes for two-thirds of cost structure. So, being more disciplined in underwriting is what we've done. The second part of where we need to focus is the administration cost of underwriting and distributing our products. We're investing in technology to try and improve the quality of data we take into the marketplace and the services we can provide.

What about the inefficiencies?
Today Lloyd's is a 100% broker-driven market; I don't see that changing. But, in many cases, we have a number of intermediaries in the chain between the customer and ourselves, and a lot of that creates inefficiencies in the way we do things. So, there's an opportunity to do things more directly with brokers in countries bringing business into London. We need to facilitate that with the investment in technology.

(The writer is MC Govardhana Rangan and Ashwin Manikandan.)

TOP

Source

INSURANCE CASES

RFL case: Siphoned off money still with Malvinder's company RHC, police tells court - Business Standard – 12th February 2020

Delhi Police Wednesday disputed in a court the claim of former Fortis Healthcare promoter Malvinder Singh, arrested for alleged misappropriation of funds at Religare Finvest Ltd that he paid back the money to the entities concerned and said the money was still with RFL's holding company, RHC, controlled by him.

The submission was made before Chief Metropolitan Magistrate Gurmohina Kaur during arguments on the bail plea moved by Malvinder in the case lodged by the Economic Offences Wing (EOW) of Delhi Police.

The court has put up the matter for further hearing on February 14.

The counsel for the police claimed that loans were disbursed to shell companies known to the promoters and the ultimate beneficiary was Religare Holding Company (RHC), of which Malvinder Singh and his brother Shivinder are promoters.

The siphoned off money was still with RHC, though it may not be in Malvinder's bank accounts, the counsel said.

Advocate Mohit Mathur, appearing for complainant Manpreet Suri of RFL, said that Malvinder as one of the promoters of RHC had siphoned off money that came the company.

Malvinder had earlier told the court that he has paid back the money to the entities concerned.
Advocate Manu Sharma, appearing for Singh, had said that the EOW "cherry picked" him because of his affiliation with the family of spiritual head of the Radha Soami Satsang, Gurinder Singh Dhillon, who allegedly conspired with other co-accused in the case in carrying out financial fraud.

He said Singh, who is in judicial custody, claimed that he has paid back the alleged laundered money to 14 entities through which he had received it.

"Also the promoter does not have any direct shareholding with any of these entities. If these entities do not return the money to RFL, it is not his fault. The money has come back. The probe agency chose not to look into it," he said.

RFL owes money to RHC, Sharma said.

Malvinder (46); Shivinder, also a former Fortis Healthcare promoter; former CMD of Religare Enterprises Ltd (REL) Sunil Godhwani (58); former CEO of REL Kavi Arora (48) and former CFO of RFL Anil Saxena were arrested by the EOW for allegedly diverting RFL's money and investing in other companies.

Senior advocate Nidhesh Gupta, appearing for Suri, had earlier told the court that loans were disbursed to shell companies known to the promoters and the ultimate beneficiary was RHC Holding company.

He had further claimed that unsecured loans had been given to shell entities without any due diligence as they were known to the promoters.

Gupta had alleged that documents showed the involvement of Shivinder in disbursal of unsecured loans to the shell companies which were further diverted to other companies and other co-accused Malvinder resulting in huge amount of public money being mis-appropriated.

RFL is a group firm of REL - Religare Enterprises Ltd, which was earlier promoted by Malvinder and his brother Shivinder.

The EOW registered an FIR in March last year after it received a complaint from RFL's Manpreet Suri against Shivinder, Godhwani and others, alleging that loans were taken by them while managing the firm but the money was invested in other companies.

"They put RFL in a poor financial condition by disbursing loans to companies with no financial standing and controlled by them. The companies to which the loans were disbursed willfully defaulted in repayments and caused a loss to RFL to the tune of Rs 2,397 crore," the police had alleged.

TOP

Source

Insurance firm told to pay claim, Rs 5K within month – The Tribune – 9th February 2020

The District Consumer Disputes Redressal Commission has directed an insurance company to settle a claim within 30 days and pay a compensation of Rs 3,000 and give Rs 2,000 as litigation expenses for its failure to provide the claim within a stipulated time.

Manjit Singh, a resident of Sialka village, had filed a complaint against the Life Insurance Corporation stating that he was a nominee of the insurance scheme subscribed by his deceased son. The sum assured under the scheme was Rs 5 lakh, in addition to bonus.

He said his son died during the validity of the insurance cover in 2018. He approached the Life Insurance Corporation to claim the insurance but it kept delaying the case, he said. “I even served a legal notice to the company but it continued to put off the matter on one pretext or the other,” Manjit stated.

The company, in its reply before the forum, stated that the claim was still under consideration and it had been accepted nor rejected. The forum stated that the complainant had filed for the claim along with requisite documents and a period of more than one year had passed.

It stated that it was company's duty to settle the claim within 30 days from the date of receipt of request and requisite documents. The company faulted by not settling the claim within the period prescribed by the Insurance Regulatory and Development Authority, the forum stated.

TOP

Source

PENSION

Not many takers for this National Pension Scheme! Only 30,000 accounts opened; Goa has just one – Financial Express – 13th February 2020

There have been not many takers for the National Pension Scheme for Traders, Shopkeepers and Self-Employed Persons launched by the Central government in September 2019. According to data presented by Anurag Thakur, Minister of State for Finance, in a written reply to Lok Sabha, the highest number of people opting for the scheme in any state across the country is not more than 9,000 while a state like Goa has just one account under the scheme as on February 3, 2020.

The NPS for traders is a voluntary, contributory pension scheme where the government assures a minimum monthly pension of Rs 3000 to all the beneficiaries after they become 60 years old. In case the subscriber dies, the spouse of the beneficiary will receive 50 per cent of the pension as a family pension.

Anyone between 18 and 40 years who is a retail trader, a shopkeeper with an annual turnover equal to or below Rs 1.5 crore or any self-employed person (paying taxes) is eligible for enrolment in this scheme. People can self-enroll themselves via an online portal. Moreover, all the beneficiaries have to contribute 50 per cent of the subscription amount; the remaining 50 per cent is contributed by the government. As on February 3, 2020, around 30,000 accounts were opened under the scheme, said Thakur.

Uttar Pradesh witnessed the highest number of enrollments with 8,895 accounts under the scheme. Andhra Pradesh and Chhattisgarh are the states with second and third highest enrollments with 4,899 and 3,929 accounts opened, respectively. On the contrary, Dadra and Nagar Haveli, Nagaland and Manipur did not open more than 16 accounts.

The pension fund is managed by Life Insurance Corporation (LIC) of India. It is also acting as a central recordkeeping agency and is responsible for pension payout, Thakur said.

(The writer is Pratishta Nangia.)

TOP

Source

Public Provident Fund: You will be denied Section 80C tax benefit unless you do this - Financial Express – 12th February 2020

Public Provident Fund (PPF) is one of the several investment options eligible for tax benefit under Section 80C of the Income Tax Act, 1961. The PPF contributions made by self or on behalf of a minor child up to Rs 1.5 lakh per financial year qualifies for deduction in the hands of an individual. However, PPF deposits made during the year may not be allowed for tax benefit unless the PPF extension rules are

followed. As per the Public Provident Fund account rules, if the PPF subscriber after the expiry of 15 years of the PPF scheme fails to exercise the option for continuing the account with deposits, the tax benefit under Section 80C will not be allowed.

PPF is a 15-year scheme and any time after the expiry of fifteen years from the end of the year in which the account was opened, the account can be closed. To close the PPF account, the account holder will need to apply in Form 3. The closure can be done anytime after 15 years and entire balance along with due interest up to the last day of the month preceding the month in which the account is closed can be withdrawn.

However, if the account holder wishes to continue PPF account after 15-years, along with fresh deposits, the same has to be intimated to the accounts office within one year. To extend the PPF account in a block of 5-years, along with fresh deposits, the account holder has to fill Form 4.

According to the Public Provident Fund Scheme 2019 rules, "No deposits can be made in the account if the account holder fails to give his option to continue the account within one year from the date of maturity. Any deposit made in such account shall be treated as irregular and refunded by the accounts office immediately without any interest."

But, will such deposits be allowed Section 80C tax benefit? The matter was taken up with the Department of Revenue (Central Board of Direct Taxes). The CBDT had clarified that the benefits of Section 80-C of Income Tax Act will not be available on deposits made in PPF account after expiry of 15 years without exercising option for the continuance of the account.

As the PPF account, in such a case, has become irregular, the deposits will not earn tax benefit under Section 80-C of the Income Tax Act unless the account is regularized. For this purpose, the subscriber will have to write to the Ministry of Finance, (DEA) through the Accounts Office for regularizing the account which was continued by him without giving the option.

Therefore, after 15-years, when the PPF account matures make sure to submit Form 4 if you wish to extend the account in a block of 5-years. Failing to exercise this option may leave you without getting section 80C tax benefits on contributions.

(The writer is Sunil Dhawan.)

TOP

Source

How your retirement benefits may get impacted by Budget 2020 announcements - Financial Express – 12th February 2020

The Finance Minister of India presented the Budget 2020 in Parliament on 1st February 2020. The announcement included some significant amendments to income tax regulations for individuals, which could potentially have implications on retirement and other long-term savings.

In this update, Willis Towers Watson summarizes some key implications and considerations for employers and employees.

Announcement 1: Retirement contribution and interest for high-salaried employees subject to tax
With effect from April 1, 2021, the meaning of perquisite (a subset of salary) would be extended to include the aggregate of any employer-driven contribution to a recognized provident fund, the National Pension System (NPS) and an approved superannuation fund, in excess of Rs 750,000 in a given financial year. This excess amount, if any, would be subject to income-tax.

The fund growth or "annual accretion by way of interest" in relation to the aggregate contribution of any employer-driven contribution to a recognized provident fund, the NPS and an approved superannuation fund, in excess of Rs 750,000 in a given financial year would also be included within the meaning of perquisite (salary). This excess amount, if any, would be subject to income-tax, with effect from April 1, 2021.

The impact would be felt on high earners whose combined employer contributions exceed Rs 750,000 per annum.

Implications and recommendations

This could discourage employees to save for retirement. In particular, voluntary plans, like NPS and Superannuation, could be affected as high salaried employees, especially those who would have already exhausted the Rs 750,000 limit or are close to this limit by virtue of their PF contributions are unlikely to save further for retirement through additional voluntary vehicles.

 # These provisions are likely to cause tracking, accounting and administrative difficulties for employees, employers and retirement fund managers. In particular:

a) It would be extremely complicated for a tax-assessed individual and his / her employer to keep track of what is taxable income from each retirement fund to which the employee is a beneficiary and aggregate such income in order to arrive at his / her tax liability, accurately.

b) It is not clear how the "annual accretion by way of interest" will be calculated, especially on NAV based plans, e.g. NPS and unit-linked Superannuation plans. This can be complicated, and it will also be difficult to carve out the interest explicitly earned on the contributions above the threshold limit.

c) In order to determine the annual accretion for the portion in excess of the threshold limit, there will be an issue in determining the order in which the funds will be considered for the calculation, e.g. if the annual contribution to PF is Rs 500,000 and annual contribution to NPS is Rs 420,000, will the interest on the contribution of Rs 170,000 (920,000 – 750,000) be calculated on PF or NPS or both, in some pre-defined basis? The government needs to formulate clear guidelines on the computation mechanism to tax such annual accretion.

d) There could be further complications if funds are transferred between retirement vehicles during the year, e.g. from Superannuation to NPS.

Announcement 2: All individuals will now have an ability to choose between the 'New Regime' and the 'Old Regime' for income tax assessment

In order to 'simplify' the tax calculations for individuals, the government has introduced a 'New Regime' which, if chosen at an individual level, would apply from financial year commencing 1 April 2020. Under this arrangement, the individual would need to forego a significant number of exemptions and deductions in exchange for lower income tax rates.

The key changes to the income tax rates are for the Rs 5-10L and Rs 10-15L slabs where the tax rates have been revised from flat 20% and 30% to 10% gradually increasing to 25%. A flat rate of 30% continues to apply for all income exceeding Rs 15L.

However, in order to be eligible for the revised rates, an individual must give up several exemptions / deductions which, if utilised, would have otherwise reduced their net taxable income. Some of the keys ones include S. 10 (13A) – House Rent Allowance (HRA); S. 80C – life insurance premium, employee PF contribution; S. 80CCD(1B) – employee NPS contribution; S. 80D – medical insurance premium for self and family; Standard Deduction of INR 50,000; S. 80 TTA – interest income from savings accounts etc.

The deductions also include all employee contributions to retiral arrangements such as EPF (12% of Basic Salary) and NPS 80CCD (1B) capped at Rs 50,000. These are separate from the employer's contribution to these arrangements (i.e. EPF at 12% of Basic Salary, part of which is diverted to EPS; 80CCD (2) up to 10% of Basic Salary). Subject to Announcement 1 above, the employer's share of the contributions continue to be eligible for tax breaks under the New Regime.

Implications and recommendations

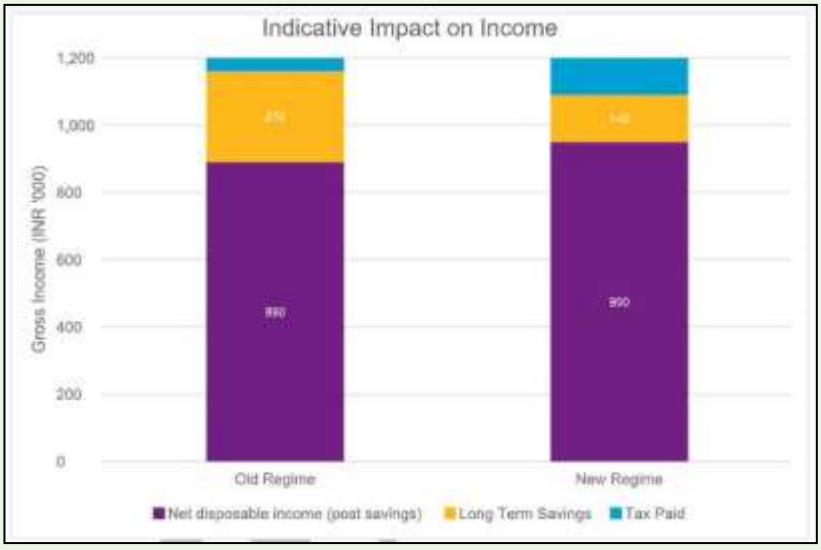
before choosing to move to the New Regime, all individuals should consider their personal circumstances as there may not be a clear winner. This is because some individuals may only wish to minimise their tax liability thereby increasing their net take home pay whereas others may choose to continue their long-term savings in order to defer consumption which may lead to a lower take home salary now but focus on building a corpus for their retirement, for example.

Things get even more complicated when you take into account the other deductions such as HRA / interest on home loan as these will apply differently to individuals. Some households may even consider a 'mix and match' type approach in order to meet their goals as a working couple.

Overall, the ability to move to a regime with a lower marginal tax rate may well confuse a large group of individuals who are likely to only focus on their net take home pay in exchange for the tax breaks they would have otherwise received in order to create long term savings. Below in an example of an individual who has an overall Gross Salary of Rs 12L per annum under both regimes.

Key assumptions for illustration:

Gross Salary = INR 12L;
Basic Salary = 50% of Gross Salary;
HRA = 50% of Basic Salary (actual rent paid = INR 25,000 per month);
Mandatory Employer and Employee contributions towards EPF contributions at 12% of Basic Salary each;
Under Old Regime investment in life insurance of INR 78,000 (total deduction under 80C = INR 150,000);
contribution in NPS under 80CCD(1B) of INR 50,000;
Standard Deduction of INR 50,000 applies under the Old Regime.



As can be seen from the table above, opting for the New Regime can have a significant impact on the composition of current and deferred income. While the New Regime may lead to higher disposable income, this is likely to come at a cost:

a) Potentially higher tax liability overall*;
b) Lack of any significant insurance cover due to the removal of tax breaks;
c) Only mandatory contributions being made towards long-term savings under the mandatory provisions of the EPF.
**subject to compensation levels and exemption options utilized by the individual*

Overall, while we understand that the objective of the New Regime is to drive higher consumption by increasing the disposable income in the hands of employees, there is a risk that this may also create a disincentive for employees to save for the long term. From a retirement perspective, 12% of statutory EPF contribution is not going to be enough – according to a study conducted by Willis Towers Watson; employees need to save at least 20% of gross salary to build a reasonable retirement corpus.

(The writer is Ritobrata Sarkar.)

TOP

Source

You can now contribute to NPS using UPI, but some hiccups remain – Mint – 11th February 2020

The National Pension System (NPS) has started allowing payments via the Unified Payments Interface (UPI). However, only payments up to ₹2,000 can be made in a single transaction if you contribute online through NSDL (eNPS).

How to contribute
You can contribute online through NSDL (enps.nsdl.com) or Karvy (enps.karvy.com). Some pension funds have also created links from their own websites to NSDL and Karvy. Go to either website and enter your Permanent Retirement Account Number (PRAN). An OTP will be sent to your phone number and email address. Next, select payment gateway SBI ePay and UPI as the payment option. A request will be sent to your UPI app—Google Pay, BHIM, PhonePe, MobiKwik or others. Approve the request by entering two PINs—the first for opening the UPI app and the second MPin for authorizing the payment.

However, be alert about the problem of failed transactions, which this Mint reporter faced. This may be reconciled eventually by NSDL or Karvy. If it's not done, lodge a complaint online.

Charges
If you've signed up for NPS through a Pop such as your bank, you'll pay 0.25% of every contribution. For example, on ₹50,000, you will be paying a charge of ₹125. If you contribute online through net banking, this percentage will fall to 0.1% or ₹50 in the above example. However, there is a minimum limit of ₹10 on Pop charges. This paradoxically increases the charges for UPI payments as the limit is just ₹2,000. As a result, the minimum PoP charge of ₹10 kicks in on every contribution rather than the percentage limit of 0.1% (which would be ₹2). This takes up the charge to a significant 0.5% of your contribution. There is an additional GST of 18% as well, pushing up the charge to ₹11.8.

Note that if you open your NPS account directly through a Central Recordkeeping Agency (NSDL or Karvy), the Pop charge won't apply.

Introduction of UPI is a welcome step in NPS. However, the tiny size of the contribution allowed makes the Pop charge higher. The limit of ₹2,000 (which also applies through payments via debit cards) should be revised at the earliest. You should also be careful of payment failures. For now, avoid UPI for NPS payments, if you are comfortable with net banking.

(The writer is Neil Borate.)

TOP

Source

EPS pension calculation formula: With maximum pension capped at Rs 7500, find out how much you will get – Financial Express – 7th February 2020

Employees working in the private sector have their provident fund to meet their post-retirement needs. On retirement, the employees get a lump sum amount from their employee provident fund (EPF). In addition, they may start getting a pension under the employees' pension scheme (EPS). Both EPF and EPS are part of the employee's contribution that happens during their working life. The minimum pension per month is fixed at Rs 1,000 while the maximum monthly pension amount is Rs 7,500. To know exactly how much monthly pension one will get under EPS, one need to do EPS calculation or use an EPS pension calculator.

How EPS pension works

Here, we first see how EPS works and then use the EPS formula to calculate the monthly pension.

Out of the 12 per cent contribution made by the employer towards employee PF, not the entire portion goes into the provident fund. With basic salary (for pension purpose) capped at Rs 15,000, 8.33 per cent of the salary is diverted or put into EPS. This means, irrespective of a higher basic salary (above Rs 15,000), each month Rs 1250 of employer's contribution is put into EPS. Earlier, as the basic salary was capped at Rs 6,500, only Rs 541 was put into EPS.

Here are a few EPS examples

If the monthly basic salary is Rs 15,000 – Rs 1250 is put into EPS
If the monthly basic salary is Rs 16,000 – Rs 1250 is put into EPS
If the monthly basic salary is Rs 35,000 – Rs 1250 is put into EPS
If the monthly basic salary is Rs 14,000 – Rs 1166 is put into EPS

Whatever goes into the EPS, the entire corpus stays with the government and the employee starts getting pension after retirement. The amount of monthly pension depends on the number of years of service and a fixed formula.

The balance of the employer's contribution is put into EPF along with employee's contribution of 12 per cent of actual basic salary.

EPS calculator

As the pensionable salary is capped at Rs 15,000, the maximum monthly pension is also capped as per the formula.

EPS formula:(Pensionable Salary * service period) / 70.

Here, Pensionable Salary is capped at Rs 15,000 and service period at 35 years. Therefore, irrespective of actual years that one has worked and the monthly basic salary, the maximum monthly pension would be Rs 7,500.

So, after 30 years of job, even if basic salary is higher than Rs 15,000 at the time of retirement, the maximum monthly pension comes to: = (15000 * 30) / 70 = Rs 6429.

To be eligible for EPS pension from age 58, one has to complete a service period of at least ten years. To ensure that one gets the credit for the number of years worked, make sure to opt for 'scheme certificate' which helps EPFO keeps a record of your service period.

(The writer is Suni Dhawan.)

Source

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IRDAI CIRCULARS

Monthly list of corporate agents registered with the authority as on 31 Jan 2020 is available on IRDAI website.

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Gross direct premium underwritten for and up to the month of January 2020 is available on IRDAI website.

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IRDAI issued amendments in respect of provisions of Guidelines on Standardization of Exclusions in Health Insurance Contracts and Modification Guidelines on Standardization in Health Insurance to all insurers and TPAs, wherever applicable.

TOP

Source

GLOBAL NEWS

Pakistan: Govt urged to drive insurance awareness campaigns in rural areas – Asia Insurance Review

The government should take the initiative to boost insurance awareness, particularly in rural areas which make up 60% of Pakistan, according to Mr Zeeshan Raza, CEO of UBL Insurers.

In an interview with *Golden Village Space*, he said that currently, insurers find no necessity to open branches in rural areas "because no one is willing to buy insurance there".

He added that this is because rural residents are unaware of insurance. For instance, they have no idea about livestock insurance, he said.

He noted that the government had made it compulsory for banks to operate their branches in all urban and rural areas, thus making banking more prominent in the countryside. He said, "The government can exert the same pressure in the case of insurance, urging insurance providers to conduct transactions across the country, but it is failing to do so."

Health insurance

He noted that health insurance has been promoted to a huge extent in the country through the efforts of Prime Minister Imran Khan in pushing the Sehat Sahulat Programme, a government-run health protection initiative that caters to those below the poverty line. The government is working to launch the programme nationwide.

Mr Raza said, referring to the Prime Minister, said, "If he promotes insurance other than health insurance, it can really facilitate the industry." He added that non-governmental organisations are contributing too, by buying health insurance for the villages they are helping.

Pakistan's insurance penetration is 0.85% and the insurance market is worth around PKR80bn ($516m) to PKR100bn a year, he said. Of this, the Pakistani insurance market pays approximately PKR60-70bn to the international market to buy reinsurance.

Mr Raza said that there are currently 29 insurers operating in Pakistan, among which UBL Insurers ranks fifth biggest with a market share of 5%.

TOP

Source

Indonesia: Regulator studies plans to increase minimum capital of insurers - Asia Insurance Review

To increase the strength of insurance companies in Indonesia, the Financial Services Authority (OJK) plans to increase the minimum capital of insurance companies.

OJK has not yet to decide on the new amount of minimum capital. Technical details are still being studied, reported *Kontan*. The current minimum capital of IDR150bn ($11m) is considered inadequate to accommodate risk. OJK chairman Wimboh Santoso said that the capital increase will be applied immediately to newcomers to the industry while it will be increased gradually for existing insurers.

The proposed change in minimum capital is part reforms aimed at non-bank financial industry supervision reform (IKNB). Mr Wimboh said that the reform, to be undertaken over the next two years, will be accelerated and focus on: regulatory and supervisory reforms, including enhancing prudential aspects; governance; risk management as well as increasing the effectiveness of risk-based supervision.

A senior official of the OJK Oversight Department, Mr Ahmad Nasrullah, said that there are investment risks in the insurance industry that need to be taken into account. He explained that the OJK will hold discussions with insurance associations soon about the proposed capital increase.

TOP

Source

Indonesia: General insurance business grows faster than the economy in 2019 -Asia Insurance Review

The general insurance industry in Indonesia posted premium income of IDR80.12tn ($5.85bn) in 2019. This represented a 14.62% increase over 2018, according to data from the Financial Services Authority (OJK).

Statistics Indonesia (BPS) has announced that Indonesia's economic growth rate in 2019 reached 5.02%, lower than the 5.17% achieved in 2018. This means that the general insurance business is still growing strongly in a slowing domestic economy, reported *Kontan*.

As for 2020, the Indonesian General Insurance Association (AAUI) is optimistic about the non-life market. AAUI executive director Dody Achmad Sudiyar Dalimunthe said, "We do estimate that total general insurance premiums grew by 14% during 2019. For 2020, we estimate they will grow by 17%." AAUI expects in 2020 the drivers of non-life business will be property, motor and credit insurance.

TOP

Source

Australia: Actuaries Institute says need for disability insurance sector reform is urgent - Asia Insurance Review

The Actuaries Institute has said that Australia's A$5bn ($3.3bn) disability income insurance (DII) sector needs urgent reform, noting that failure to implement significant changes will reduce consumer access to affordable disability cover in the future.

The Institute has established a taskforce to identify where critical reform is needed, the professional body says in a statement. It has drawn on the skills and experience of almost 50 actuaries to support the DII taskforce. It has started liaising with regulators, and hopes to engage with the director community, insurance company management, advisers, product ratings agencies and consumer groups to drive significant, long-term industry changes. It will also review the professional requirements for actuaries in the disability income insurance business.

The Institute commissioned international professional services firm KPMG to compile a comparative research report *Disability Income, An International Comparison*, to help start the debate about changes needed to bring about a sustainable long-term solution that supports consumers.

The KPMG report states that individual disability income insurance does not adequately support a policyholder's move back into work in Australia's modern economy. The report also acknowledges increased concerns by Australia's regulator about product sustainability.

The report says the sector needs simpler products, a reduction of 'bells and whistles', a change to definitions, and a review of the benefits to encourage those who can, to return to better health as soon as possible.

Mr Ian Laughlin, convenor of the Actuaries Institute's Disability Insurance Taskforce, said, "Australia has a very competitive market and customers have been offered a smorgasbord of product features. However, they have also been subjected to multiple unanticipated premium increases.

"A decline in insurance company profitability despite these steep premium hikes has called into question the sustainability of disability income insurance in its current form, and suggests the potential for market failure."

Mr Laughlin added, "That raises real concerns for consumers, and the broader community, about future access to affordable DII cover."

The Australian Prudential Regulation Authority announced in December 2019 that it had written to industry participants in response to ongoing heavy losses in the market. Life companies had collectively lost around A$3.4bn over the past five years through the sale of DII to individuals. APRA executive board member Geoff Summer ayes said life companies had kept premiums at unsustainably low levels and policy features were too generous.

The KPMG report found:
• Competitive pressure has resulted in DII products that are complex, making them difficult and expensive to administer;
• These products can be problematic to manage from a claims perspective;
• Guaranteed insurability has further aggravated sector problems by increasing the complexity of legacy business; and
• insurers have responded with increased premiums, perpetuating potential anti-selective lapses leading to worse claims experiences and falling profit margins.

Source

TOP

Maldives: Steady growth in insurance business in 2019 - Asia Insurance Review

The Maldives Monetary Authority (MMA) has revealed that the gross premiums of the insurance sector increased to MVR929.9m ($60.2m) during 2019, a 5% increase compared to 2018.

Gross claims amounted to MVR275m, a 15% increase compared to 2018, reported the news bulletin *Avas*.

According to statistics released by MMA, the insurance industry of Maldives consists of five insurance companies, eight insurance brokers and 40 insurance agents. The aggregate assets of these companies reached over MVR1.4bn.

TOP

Source

Cambodia: Insurance sector sees 14% growth in 1H2019 - Asia Insurance Review

The insurance industry in Cambodia saw premiums increase by more than 14% in the first half of last year.

Mr Huy Vatharo, chairman of the Insurance Association of Cambodia (IAC), says the market is growing rapidly and playing a bigger role every year in the country's economic development, according to a *Khmer Times* report.

In 1H2019, gross premiums in general insurance reached $49.3m, a surge of 14.7% compared with the same period in 2018, according to Mr Mey Vann, director-general of the Ministry of Economy and Finance.

Life insurance premiums hit $66.3m in 1H2019, an increase of 55.3%.

There are 13 general insurance companies, 11 life insurers, and 7 micro insurance companies operating in Cambodia.

TOP

Source

Singapore: General and life insurance bodies clarify medical coverage for coronavirus - Asia Insurance Review

The General Insurance Association of Singapore (GIA Singapore) and Life Insurance Association, Singapore (LIA Singapore) have clarified member companies' coverage for medical expenses relating to the 2019 Novel Coronavirus (2019-nCoV).

Integrated Shield Plans (IPs) and IP riders will provide coverage for hospitalisation expenses related to 2019-nCoV, say the two associations. IPs are optional medical insurance plans provided by private insurance companies, and are bought to supplement a mandatory health insurance scheme run by the government.

Many non-IP individual and group health insurance policies will also provide coverage for medical expenses related to 2019-nCoV.

Policyholders who wish to find out more about their insurance benefits, and terms and conditions in their policies can approach their financial advisor and / or insurer. Employers with Group policies are also advised to review their group policy documents and engage their insurers about the coverage.

Policyholders should continue to practise good personal hygiene and take precautionary measures as advised by the Ministry of Health (MOH). Policyholders are encouraged to practice frequent hand washing with soap, and seek medical attention promptly if they are feeling unwell.

TOP

Source

South Korea: Regulator acts to ease insurers' capital pressure from interest rate risk - Asia Insurance Review

The Financial Services Commission (FSC) has announced an amendment to the Insurance Business Act that would allow insurers to share or coinsure interest rate risk with reinsurance companies. The regulator expects to introduce the amendment in April.

The announcement on 31 January follows regulatory concerns over widening negative interest rate spreads for insurers amid a prolonged period of low interest rates, and is credit positive for Korean insurers, according to an article in the 6 February 2020 issue of *Moody's Sector Comment*. The article was written by Young Kim, analyst, Gil Jo, associate analyst, and Sally Yim, associate managing director, all from the Financial Institutions Group of Moody's Investors Service.

Coinsurance would reduce the capital insurers must hold against underwriting risk, easing pressure stemming from higher interest rate risk charges on required capital.

Insurers' solvency levels will improve amid a tighter local risk-based capital (RBC) regime and the introduction of the Korea Insurance Capital Standard in 2022 because they can partly transfer market risk to reinsurers, including interest rate risk associated with high legacy guaranteed reserves. Life insurance companies will benefit more than non-life insurers because interest rate risk is one of the largest components of their required capital.

Insurers significantly increased the issuance of hybrid or subordinated debt securities over the past three years to increase capital and strengthen their local RBC ratio (available capital divided by required capital), increasing leverage and interest rate burdens for some insurers and prompting regulatory concerns. By transferring some of the interest rate risk-related reserves, insurers will get relief to reduce the denominator (required capital) in the RBC calculation.

Ultimate effect

However, the ultimate effect of coinsurance on insurers' solvency will depend on the cost of reinsurance and whether ceding the risk of high legacy guaranteed reserves to reinsurers is cost-effective compared with the cost of issuing debt securities.

Details of the proposed amendment include broader coverage of premiums for reinsurers. The structure of coinsurance differs from traditional reinsurance because it allows insurers to transfer not only the risk premium, but also the savings premium and other loading charges (i.e., gross premium) to reinsurers.

Insurers were previously not allowed to share the negative interest rate spread risk with reinsurers because it was associated with the savings rather than the risk premium.

In addition, liability reserves currently valued at original cost will be valued at fair market cost before transferring the portion of ceded reserves to reinsurers. Insurers will recognise this difference as prepaid expenses on the asset side and a mortise throughout the contract period. Reinsurers will recognise the difference as unearned income under the liability.

The FSC also announced a review of other measures to alleviate insurers' widening negative interest rate spreads and its adverse impact on their solvency. including buying back existing high guaranteed interest rate policies from policyholders with additional charges, or transferring existing contracts to other insurers.

TOP

Source

China: Online insurance platform could raise over US$50m in IPO - Asia Insurance Review

Huize Holding, a Chinese online insurance platform, plans to raise $48m by offering 4.7m shares in an IPO at a price range of $9.40 to $11.40 each.

At the top of the price range, Shenzhen-based Huize would raise $53.6m, a third of what the company targeted to raise in earlier filings. Up to $50m may be acquired by corporate investors who have indicated interest, Huize said. The IPO is scheduled to take place on 12 February.

Huize intends to use the proceeds to invest in technology and analytics to boost its client acquisition and risk management capabilities. It also plans to use the funds raised on product design and development and general corporate purposes, it said.

Huize Holding was founded in 2014. and its platform connects users and insurers. In its prospectus, the company said it is not affiliated with any insurance company. Its target user base is China's younger generation.

TOP

Source