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QUOTE OF THE WEEK

"Change will not come if we wait for some other person or some other time. We are the ones we've been waiting for. We are the change that we seek."

Barack Obama

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INSURANCE TERM FOR THE WEEK

Reinsurance Risk

Definition: Reinsurance risk refers to the inability of the ceding company or the primary insurer to obtain insurance from a reinsurer at the right time and at an appropriate cost. The inability may emanate from a variety of reasons like unfavorable market conditions, etc. Default risk by a reinsurer also affects the ceding insurance company in an adverse manner as it may affect their profitability.

Description: Insurers transfer a part of their portfolio to a reinsurer in exchange for a premium. However, the unavailability of reinsurance at the right time and cost has ramifications for the ceding company. A default on the part of the reinsurer can lead to adverse impacts on the profitability and solvency of the ceding insurer. It may also lead to an adverse affect on the underwriting abilities of the insurer as the default by the reinsurer will augment the risk of the insurer. The ceding company has the onus of meeting the insured's claims in the event of a default by the reinsurer.

Source

INSURANCE INDUSTRY

Indian insurance firms build own tech teams as focus turns to data - The Economic Times – 8th January 2019

Indian insurance firms, which depend on technology services vendors to man their IT processes, are increasingly building in-house technology teams, eyeing data and analytics as core to their business strategy. The insurers have stepped up hiring from premier institutes, including the Indian Institutes of Technology and Indian Statistical Institute. Some are also expected to increase the number of freshers hired to more than a couple of hundred.

Apart from coders, freshers with data analytics skills are the most sought-after, senior executives at the insurance companies said. "Most of the software services and development work was provided by the outsourcing companies. There was no IP (intellectual property) advantage," said Girish Nayak, chief of customer service, technology and operations, at ICICI Lombard Life. "We do see a growth in campus and lateral hiring of technology professionals. We are increasing the number of internal hires as they not only understand the products and processes better, but also handle internal people dynamics better to complete projects on time," she said.

Own technology teams with new age skills become a must-have as the insurance sector looks to transform digitally. "Our reorientation journey began two years ago and one of the projects within this was upgrading our tech and digital capabilities to be future-ready," said Goutam Datta, chief information and digital officer, Bajaj Allianz Life Insurance.

(The writer is Ayan Pramanik.)

TOP

Source

Budget 2020: Will you benefit if FM raises FDI limit in insurance to 74 per cent? – Financial Express – 8th January 2020

Budget 2020 Insurance: The life insurance industry is looking forward to the Budget 2020 with high expectations. Several industry experts expect the cap on foreign ownership in insurance companies to be raised in the upcoming Budget. Currently, the foreign direct investment (FDI) in insurance is capped at 49 per cent which according to many industry observers may be raised to 74 per cent.

Earlier, the relaxation was provided only to the insurance intermediaries where the FDI can be up to 100 per cent. "Yes, there could be an increase in FDI in the upcoming budget 2020 as the insurance sector has seen the benefit of relaxation in FDI from 26 per cent to 49 per cent in 2015. So, the government is likely to increase the FDI in life insurance, which will enable other private players to go public," says Rakesh Goyal, Director, Probus Insurance Broker.

With an increase in FDI limit, will there be any corresponding impact on the policyholders? The benefit rolling down to the policyholders may not be immediate and upfront. Capital inflow from abroad helps in technological advances and making the distribution channels more robust. "Increase in FDI means insurance companies will have more funds to come up with new products and enhance operations to provide a seamless experience. The policyholder will benefit in the form of new products and better customer experience. Ultimately, this increase in FDI, will help in securing more heads, propelling the goal of increasing insurance penetration in India," says Goyal.

Insurance is a capital intensive business and companies need to pump-in huge funds over several years before the returns start flowing for them. Innovative products require equally longer periods to generate optimum results for the entire stakeholder including policyholders.

The industry also expects an increase in the limit of Section 80C of Income Tax Act, 1961 so as to give impetus to the insurance sector. Currently, under Section 80C, the limit of Rs 1.5 lakh a year includes insurance premium and investments made into PPF, NSC, and ELSS etc. Further, the impact of tax especially on pure term insurance policies is seen as a dampener in popularizing them as low-cost, high cover plans. "The other expectations are reduction of GST in term life products and increase in the limits of 80C, which will attract more people to opt life insurance products," adds Goyal.

(The writer is Sunil Dhawan.)

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Source

India and digital insurance – Industry Global News24 – 8th January 2020

In the last couple of years, the insurance industry has went through a modification that has considerably altered the industry's course and traditional objectives. Due to a couple of dynamic external characteristics ranging from technology to socioeconomic ones to government policies, the insurance industry is going to witness a continuous change in these macro trends.

Since when it first came into formation, the insurance industry has gotten sturdier as it becomes increasingly more aware, innovative products come into being, and channels of distribution increase in number.

Even though there has been an increase in premiums at the market's level, India's degree of insurance penetration is still small relative to other nations around the globe, giving all insurers ample opportunity to prosper.

After China, India is the largest online market. India has internet users amounting to nearly 460 million. It is estimated that India will have internet users amounting to nearly 635.8 million by 2021. Most of the wireless population in India is made up of internet users.

Consequently, individuals using increased digital media for communications, along with the insurance industry, are fully accepting digital technologies because of how the government is backing the digital India movement.

New features have been added to the transmission of data by the use of web-based tech as a delivery medium for insurance providers. Enhancement in self-service technologies has given clients numerous options for making use of the facilities delivered by insurers. Insurers prioritize the online service 'convenience' and 'ease of use' when opting for web-based facilities.

Insurers in India are increasingly embracing digital media for provision of their facilities keeping in mind the rural and millennial incorporation. Contrary to direct marketing, the utilization of digital media is very much more feasible when intending to reach users and enhance insurance coverage.

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INSURANCE REGULATION

Health insurance guidelines modified by IRDAI: Check your rights as a policyholder – Financial Express – 4th January 2020

The Insurance Regulatory and Development Authority of India (IRDAI) has recently come out with a circular on modifications in the Health insurance guidelines. In fact, the modifications relate to the insertion of two new definitions in the list of Standard Definitions for 42 commonly used terms in health insurance that IRDAI had issued earlier.

The two definitions included in the list are – Migration and Portability. Both Migration and Portability are important when a policyholder seeks to migrate from one insurance plan to another or from a group insurance cover to an individual cover of the same insurer or another insurer.

Importantly, the guidelines remain the same but the applicability of Migration and Portability has now been clearly defined. With the introduction of the two definitions, it has been made clear that switching a plan with the same insurer will be referred to as Migration, while a switch to another insurer will be referred to as Portability.

What is migration in health insurance policy?
Migration means the right accorded to health insurance policyholders including all members under family cover and members of group health insurance policy, to transfer the credit gained for pre-existing conditions and time-bound exclusions, with the same insurer.

What it means: It means if one holds a health insurance policy as an individual policy, Family Floater or as a group cover, the policyholder has the right to get the credit for pre-existing conditions and time-bound exclusions while switching to a new health insurance policy of the same insurer.

What is portability in health insurance policy?
Portability means the right accorded to an individual health insurance policyholder including family cover, to transfer the credit gained for pre-existing conditions and time-bound exclusions, from one insurer to another insurer.

What it means: It means if one holds a health insurance policy as an individual policy, Family Floater or as a group cover, the policyholder has the right to get the credit for pre-existing conditions and time-bound exclusions while switching to a new health insurance policy to another insurer.

The need for Migration of health insurance policy arises typically health covers specific to age groups such as maternity covers, children under family floater policies, students etc. Health insurance guidelines are clear that the insurer will have to offer an option to migrate to a suitable alternative available health insurance policy at the end of the specific exit age or at the time of withdrawal of the policy. In the process, due credit for all previous years also needs to be provided to the policyholders. The need to port a health insurance policy may arise anytime and the policyholder is allowed to get the credit for pre-existing conditions and time-bound exclusions while porting to another insurer.

So, if you want to switch from one plan to another of the same insurer, it will be Migration while a switch to another insurer will be called Portability. As a policyholder, now that you know your rights, making optimum use of the health cover is possible now.

(The writer is Sunil Dhawan.)

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After standardising health insurance, Irdai looks at rating of hospitals – Business Standard – 4th January 2020

After standardisation of basic health insurance products, Insurance Regulatory Development Authority of India (Irdai), is planning the standardisation of health services through rating of hospitals for insurance claims.

According to a senior official at Irdai, the regulator is consulting National Accreditation Board for Hospitals & Healthcare Providers (NABH) for rating the hospitals.

Under the rating mechanism, insurers can charge on the basis of grades based on facilities like number of doctors or equipment in the hospital. For example, charges applicable in a three-star hospital would be different from a five-star hospital.

The regulator is already in discussions with insurance firms for the rating mechanism.

"At present, an insurer doesn't have any control over the hospital ecosystem. To a large extent, rating will be an indication of the quality of its services. The idea is still at a discussions stage, and details on what parameters the rating will be based upon needs to be seen," said Mayank Bathwal, CEO, Aditya Birla Health Insurance.

"We had some discussions with the regulator on rating of hospitals. It will be quite beneficial for the sector" said Sanjay Datta, Chief, Underwriting, Claims, Reinsurance & Actuary, and ICICI Lombard.

Irdai already has a registry of hospitals and medical day-care centres, in the health insurers and Third Party Administrators (TPAs) network, called Registry of Hospitals in Network of Insurers (ROHINI). The database lists approximately 33,000 unique hospitals and medical day-care centres.

IRDAI has been moving towards standardisation of health insurance products for quite some time to make them more accessible to the common man. In September this year, it came out with guidelines on standardisation of exclusions in health insurance contracts.

On Thursday, it issued guidelines on standard individual health insurance, asking the general and health insurers to offer products that can take care of basic health needs of customers with maximum sum insured of Rs 5 lakh and a minimum of Rs 1 lakh. The standard product should have the basic mandatory covers, no add-ons or optional covers are allowed to be offered along with the standard product and the insurer may determine the price keeping in view the covers proposed to be offered subject to complying with Irdai guidelines.

The health insurance market will open up a lot after this. There is going to be a lot of awareness that will be created around health insurance with this product," said Amit Chhabra, Business Head, Health Insurance, Policybazaar.com. During FY20, general and health insurance companies collected Rs 44,873 crore as health insurance premium, registering a growth of about 21 per cent over the previous year.

"At present there are too many products in the market, which is confusing for the customer. Now with a base product, the penetration of health insurance will increase," said, Anand Roy, Managing Director, Star Health and Allied Insurance."We had discussions on the issue of ratings of hospitals with the insurer," he added.

The health insurance sector has been growing annually at the rate of over 20 per cent. Last year, more than 20 million health policies were issued covering close to 472 million people. "This will lead to deeper penetration of health insurance, and will also lead to more automation. The rating of hospitals will be a huge positive for the industry," said Priya Gilbile, chief operating officer, Manipal Cigna Health Insurance.

"Ultimately we want the awareness of health insurance to grow. And, the standardised approach helps a lot of people to get convinced about the product. This is a kind of financial inclusion. The main aim is to make people participate in health insurance. When there are too many variances, people get confused. And when health is seemingly not a priority, you want a simpler approach for people to buy it. it is a good start and this will also create a minimum standard for healthcare in this country. And, then insurers will innovate and come up with better products on top of this. So, this has a dual advantage," said Rakesh Jain, Executive Director and CEO, Reliance General Insurance.

(The writers are Namrata Acharya & Subrata Panda.)

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Insurance intermediaries with majority foreign stake can't repatriate over 75 percent as dividend: IRDAI – The Economic Times – 3rd January 2020

Insurance intermediaries having majority foreign holding cannot repatriate dividend more than 75 per cent of the net profit and if there is any extra-ordinary profits or income, the dividend payout ratio should be calculated after excluding that, regulator IRDAI said on Friday.

Issuing guidelines on 'repatriation of dividends by insurance intermediaries having majority by foreign investors', Irdai said such entities should seek prior approval from the Authority for the payout.

On the quantum of dividend payable, it said: "The dividend payout ratio shall not exceed 75 per cent. Dividend payout ratio shall be calculated as a percentage of 'dividends payable in a year' (excluding dividend tax) to 'profit after tax during the year'.

"In case the profit for the relevant period includes any extra-ordinary profits/ income, the payout ratio shall be computed after excluding such extra-ordinary items for reckoning compliance with prudential payout ratio".

Besides, the financial statements pertaining to the financial year for which the insurance intermediary is declaring a dividend should be free of any qualifications by the statutory auditors, which have an adverse bearing on the profit during that year.

"In case of any qualification to that effect, the net profit should be suitably adjusted while computing the dividend payout ratio."

The Insurance Regulatory and Development Authority of India (Irdai) also said that it will take into account the factor that the intermediary should have a net-worth of 1.5 times of the statutory required minimum paid-up capital after the proposed payout, when the request for dividend payout comes to the Authority.

The insurance intermediary should not have made any payments (other than dividends) beyond 10 per cent of the total expenses of the company in the financial year to its related parties taken as a whole, it said.

It will also consider factors such as latest technological, managerial and other skills brought by the insurance intermediary and that no restrictions have been placed on the company for declaring dividends.

IRDAI (insurance intermediaries) (Amendment) Regulations, 2019 allows 100 per cent foreign direct investment (FDI) in insurance intermediaries.

One of the conditions specified in the regulation is that the insurance intermediary that has majority shareholding of foreign investors should take prior permission of the Authority for repatriating dividend.

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LIFE INSURANCE

Is it possible for NRIs to acquire life insurance while in India? – Industry Global News24 – 9th January 2020

When referring to the lives of Indians, life insurance is among the most renowned and established financial facilities that individuals partake in. It is important to notice that it is not only Indian residents who can see the significance if investments in life insurance. Non-resident Indians often comprehend the significance of life insurance to safeguard their financial requirements as well as their families'.

Even though non-resident Indians are permitted to invest in Indian insurance plans, it is vital to initially recognize the procedure of registering such strategies and why it is a fine idea for them to opt for such a move.

There are some frequently asked questions when choosing an adequate insurance plan:

Does the non-resident Indian have to be within India during the purchase of the insurance?

This does not have to be the case, but that depends on the insurance firm you opt for. The simplest method of purchasing life insurance for the non-resident India is going online. By doing so, you will go over all the options present to find the finest plan and buy it as soon as you do from wherever you are situated.

As we have already pointed out that Indian individuals working abroad usually have their families still residing in their home country, it can be said that the respective families will manage the smooth continuation of the insurance scheme. We have already established bank accounts locally and bonds with insures, in case the policyholder is situated abroad.

What are the respective laws in case of demise and maturity?
If the non-resident India has purchased a life insurance scheme from an India-based insurer, the plan is needed to make up for the death of the insured individual, irrespective of the country where the demise takes place.

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Source

Life agents see mass culling – The Asian Age – 8th January 2020

The poor success rate of agents in selling life insurance products has led to high termination levels of agents in 2018-19. The industry continued to grapple with the problem of large agency termination during the year.

Sample this; during 2018-19, the total number of agents appointed by the life insurers were 6.46 lakh and the number of agents terminated were a whopping 5.34 lakh.

While the private insurers appointed 3.82 lakh agents, they terminated 3 lakh agents. Similarly LIC of India appointed 2.64 lakh agents and terminated 2.33 lakh according to the recent annual report 2018-19 released by the Insurance Regulatory and Development Authority of India (Irdai).

Reduction in the number of agents adversely affects the life insurers' business, persistency and public perception of the agency channel as a stable career. It is, therefore, in the interest of the stakeholders to work on reducing the turnover of agents and build a stable and growing agency force.

"Termination problem is due to poor productivity of agents. Acceptance of protection products is low among people and therefore the success rate of agents is low," said the head of a large private life insurer.

The number of individual agents as on March 31, 2019 were 21.95 lakh as against 20.83 lakh in the previous year. At the end of the year 2018-19, while the number of agents with LIC stood at 11.79 lakh, the number for the private sector insurers was 10.16 lakh.

Large agent termination has continued over the years despite the insurance regulator lowering the pass percentage for a person to qualify as an agent to 35 per cent from 50 per cent earlier, making the syllabus easier and allowing life insurance companies to have their own board-approved policy for classifying their agents as active. Therefore, each insurer has a different norm for terminating an agent.
The writer is Falaknaaz Syed.

TOP

Source

Life insurance for NRI: Could non-resident Indians obtain life insurance in India? – Industry Global News24 – 7th January 2020

In the sense of Indian lives, life insurance remains one of the most popular and prevalent financial services that people participate in. And the best part is that it's not just Indians residing in India who see the need to invest in life insurance. Indians well established in foreign lands often understand the importance of life insurance to protect the financial needs of their family members.

While the NRI is legally allowed to invest in Indian term insurance plans, it is important to first understand the process of enrolling such plans and why it is a good idea for you to make such a move.

Here are some of the considerations worth studying when deciding: **does the NRI have to be present in India at the time of the policy purchase?**

Not really, although it may vary from company to company. The easiest way to buy life insurance for the NRI is going online. That way, you will analyze all the choices available to find the best plan and purchase it immediately from the convenience of your current residence.

How do I pay premiums for the policy?
Since we have already identified that people working outside India usually have their families (maybe just a spouse or parents) already residing in India, it is fair to say that their families will handle the continuation of the insurance plan smoothly. We have already developed local bank accounts and bonds with insurers, while the main policyholder will reside internationally.

What are the laws for the benefits of death and maturity?
If the NRI has bought a life insurance policy from an insurer in India, the scheme is required to compensate for the demise of the insured, regardless of the nation in which the event occurs. The death benefit paid to the beneficiaries of the policyholder shall be in the currency specified in the policy document, i.e. either the Indian Rupee or any other foreign currency. To make a death claim, the nominee must submit all the documents as set out in the policy terms. One has to understand that the list of documents required can differ from one insurer to another.

Is the NRI supposed to buy life insurance in India?
Having seen the rules and regulations regulating the purchasing of life insurance in India, it is relevant for NRIs to decide whether they should purchase life insurance in India. There are a few things to consider here: stable families in India–In general, millennials are looking for new job opportunities to get international exposure to work when their families are in India handling their savings locally and continuing their lives. With this pattern, it has become more important for NRIs to safeguard their families in India through a local life insurance plan that can protect their families from unplanned demands.

We can all accept that life insurance has arisen as one of the main assets to protect the safety of one's family members and dependents. There are multiple high-cost thresholds in each individual's life to save their money, and in the case of a sudden loss of the family's bread earner, the savings plan can be derailed, thus causing uncertainty about the future. Therefore, the best way to prepare for this possibility is through a term life insurance policy.

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Three scenarios in which buying annuity plans may make sense – Mint – 7th January 2020

Annuities are pension products that provide regular payout and have always been sold as an attractive option to retirees by insurance companies. With interest rates on fixed deposits (FDs) and small savings schemes falling, your agent may be pushing harder to sell annuities to you. The sales pitch is straightforward: those annuities can help you lock in the rates for life in a falling interest rate scenario.

But before you fall for a similar sales pitch, remember that annuity products, typically, provide low returns compared to other fixed-income products and are not tax-efficient. In fact, financial planners recommend this product only in certain scenarios. Read on to know when it makes sense to buy this product and in what scenario you should stay clear of it.

What are annuities?

Historically, interest rates have been falling in India. For instance, Public Provident Fund, which offered 11-12% per annum in the 1990s, gives 7.9% currently.

An annuity plans lets a retiree lock into the existing interest rates. Say, a 60-year-old buys an annuity plan where the annual payout comes to 6% of the corpus. After a decade or two, if the interest rates decline to, say, 4-5%, the investor will continue to receive 6%. Remember that the converse is also true: if interest rates happen to rise, the retiree will continue to get the lower rate he signed up for.

Annuity plans also reduce the longevity risk as they guarantee a fixed income for life. They also tackle reinvestment risk. A retiree faces the risks of outliving his corpus or finding a drop in interest rates upon reinvestments. Annuities can handle these, though at a cost—the monthly payout is even lower than a public sector bank's FD rates of 10 years at present.

What doesn't work?

Low returns: Annuity plans have never been popular with retirees as they offer lower interest rates than other fixed-income options available.

The interest rates on annuities differ depending on the variant you choose to invest in. One of the popular options—life annuity with return of purchase price—works like an FD. The investor earns an income for life, and the nominee gets the entire money on the death of the depositor. The annual payout on this variant typically works out to 5.7-6.4% of the purchase price for someone who is 60. Another popular option is lifetime annuity, without the return of the initial investment. The rate of interest—7.6-8.1% per annum—in this option is the highest among all variants as the insurer doesn't need to return the funds to a nominee.

On the other hand, the Senior Citizen Savings Scheme gives an interest rate of 8.6% per annum. The biggest non-banking finance companies, considered as safe as a large private bank, offer rates up to 7.75-8.35% for senior citizens on their FDs. The return on Pradhan MantriVayaVandanaYojana comes to around 8%.

Tax inefficiency: What further reduces the returns is the fact that the pension income is subjected to tax. The payout is added to the income of the receiver and taxed at marginal rates.

In comparison, senior citizens enjoy a tax advantage when they invest in FDs or small savings schemes. They get a tax deduction of up to ₹50,000 on the income from these two instruments. In Budget 2018, the finance minister had introduced a new Section 80TTB that allows individuals above 60 to claim income-tax deduction on interest income from specified products.

Lack of liquidity: Once a person buys an annuity plan, the money is locked away permanently. Under no circumstances can the investor touch this money. “For us, this is one of the key reasons for not recommending annuities. A senior cannot access his funds in an annuity plan even in emergencies," said Malhar Majumder, a Kolkata-based financial planner and partner, Positive Vibes Consulting and Advisory.

When should you buy?

Despite the aspects that don’t work for annuities, retirees can look at them in small doses, according to financial planners. “If a retiree has a surplus corpus, only then he should invest in an annuity plan. Annuities would be the last option after the senior has taken care of his living expenses and has exhausted other options," said Suresh Sadagopan, founder, Ladder7 Financial Advisories, a Mumbai-based financial planning firm.

Scenario 1: Lack of liquidity in an annuity product can be a blessing for some. Financial planners point out that it is common for retirees to make emotional decisions that can compromise their retirement corpus. They may give a portion to their children to buy a house or bail them out from financial difficulties. “If a retiree doesn’t have enough savings and can take an emotional decision of helping children, we would suggest putting a part of the retirement savings in annuities. In the retirement years, a person cannot afford to be dependent on anyone, not even their children," said Sadagopan.

Scenario 2: Annuities should also be considered depending on your tax slab. Financial planners recommend annuities only to those who do not have a taxable income or those who are in the lowest tax bracket. For such investors, the tax won’t eat into their returns like it would in case of those who are in the 20% and 30% tax slabs.

Scenario 3: Buying annuities may make sense for someone in their 70s who may have saved only in fixed-income instruments whose income is not inflation-efficient. Remember that the payout increases as a person grows older. “One of the options for such retirees is to look at annuities when they are in their 70s. The payout for someone in his 70s would be about 11-12% of the purchase price for life annuity variant, where the nominee doesn’t get any money," said Deepesh Raghaw, a Sebi-registered investment adviser based in Mumbai. If a 75-year-old puts a corpus of, say, ₹30 lakh in an FD at 8% interest rate, he will earn ₹2.4 lakh a year. If he invests ₹20 lakh in a life annuity plan, he will receive a similar payout, while he can invest the remaining ₹10 lakh in other instruments.

Investment advisers had expected that annuities will see a transformation after they became an essential part of the National Pension System, under which 40% of the corpus has to be annuitized on maturity. “There were expectations that with an increase in competition, the segment may start witnessing better returns and more flexible variants, which hasn’t happened," said Majumder. The product continues to have limitations. So don’t let the agent convince you into buying an annuity plan. There are enough options available for seniors that offer higher returns, liquidity and are more tax efficient.

(The writer is Tinesh Bhasin.)

TOP

Source

Expanding the horizons of insurance marketing - Outlook – 6th January 2020

In a country where life insurance penetration is just 2.76 per cent (ratio of premium to GDP the immediate need is to amplify the reach and enable people to be adequately economically protected and help them also build disciplined saving habits.

In pursuance of increasing the insurance outreach in the country and make it a part of comprehensive financial planning, insurance regulator IRDAI approved the formation of a new distribution channel - Insurance Marketing Firm (IMF). This move is resultant of the NM Govardhan Committee’s report, which suggested that a group of agencies be set up to improve the market penetration of the insurance business and to enable selling of mutual funds, pension plans, stocks, and other financial services by merchandisers under one umbrella.

Tracing the IMF trajectory

IMFs have been designed to function on the 'distribution model', having tie-ups with multiple insurers and other financial services providers, a model akin to Independent Financial Advisors (IFA). Expected to be the missing link that helps increase insurance penetration, an IMF is a progressive step towards making the country insurance aware and build a business model that takes the insurance sector forward.

There remain gaps in terms of taking insurance penetration to the masses. The gap as identified is on two levels – **a)** deficient knowledge of insurance instruments and how insurance helps households being financially protected, and **b)** Individual insurance agents being allowed to sell products of only one insurer each in life, general and health, and hence the consumer needs to reach out to multiple agents for product choices.

To address these gaps, IRDAI as per Registration of Insurance Marketing Firm Regulations, 2015 (IMF Regulation) was stipulated that offered IMFs the freedom to sell insurance products from two life, two general and two health insurance companies at any point of time.

Conducive regulations to pave the path for progress

Since its inception, Insurance Marketing Firms have seen a gradual increase in their reach across the country. As per a recent report by the Insurance Regulatory and Development Authority of India (IRDAI), there are more than 280 Insurance Marketing Firms active across the country having the option to work with 2 life insurers each. However, at present, 175 IMFs have opted to start their journey with one life insurer each. Of the total number of active IMF's around 60 plus IMF's are associated with the Life Insurance Corporation (LIC), around 30 plus with PNB MetLife, around 40 with HDFC Life, around 40 plus associated with Aviva Life Insurance; while more than 150 IMF's are associated with Max Life Insurance. These exponential numbers go to show the growing acceptance of IMFs in the country, and augur well for a rapid growth of the sector.

Recent amendment to the IMF Regulations allows IMF's to function in maximum three districts within a state as compared to only one district earlier, of which one has to be an aspirational district (district designated as such by the NITI Aayog, Government of India or any other economically backward district, as may be recognized by the Authority), will surely encourage more IMF's to enter the fold. With this amendment, IMFs can now take layered risks where they could spread their business outreach across these three districts and offer larger insurance outreach to the consumers.

Another major amendment that comes in force allows IMFs applying to launch operations to have a net worth of only Rs 5 lakh, which earlier was Rs10 lakh. This will allow for more IMF's to reach to economical backward areas and bring a larger customer base into the protection net. The net worth of Rs10 lakh norm was high for tier-II and III cities and this move to reduce net worth requirement will certainly attract more players to opt for IMF license in these districts and thus help in making residents more insurance aware and get into the fold.

Regulatory changes now also allow IMFs to engage with Agriculture Insurance Company of India Ltd. (AIC) and Export Credit Guarantee Corporation Ltd. (ECGC), which is in addition to existing norms allowing them to solicit business for two life, two general and two health insurers. This move allows the IMF's to now sell crop insurance for non-loaned farmers and combo products along with property, group personal accident, group health, Group Savings Linked Insurance and term insurance policies for Micro, Small and Medium Enterprises (MSME), helping them widen their product gamut and offer relevant products to the customer base.

In line with the umbrella aim of increasing the spread of insurance, the amendment has also allowed for relaxation in the work experience requirement of the IMF's Principal Officer where if the person has undergone training and examination required for Principal Officer of an insurance broker company / corporate agent / web aggregator, then they shall be exempted from training and examination requirement (if undertaken within a period of five years preceding the date of application) to become the Principal Officer of the Insurance Marketing Firm, thus easing the upskill. This shall help in bringing adept officers with granular insurance expertise to come into the fray and create their own IMF business that will help take insurance penetration across the deeper delves of the country.

The amendment also allows that a life insurance agent with some experience may seamlessly transition into building an IMF business; this move ensures next-level career opportunity for the Principal Officer, agents and the industry at large. Further, subject to Board approved policy of the respective insurers, an agent may also be allowed to continually receive renewal commission benefits despite migrating to or joining an insurance marketing firm. Earlier, an agent had to surrender his insurance agency on upgrading to an IMF, which meant cancellation of renewal commissions; the new regulations now do away with the stipulation thus allowing an IMF partner to increase his delta of earnings and building a larger insurance business.

With the end-user customer being the net-net winner in terms of greater insurance awareness, these positive regulations shall lead towards a larger insurance penetration in the country. Thanks to the advent of Insurance Marketing Firms, the day looks not too distant when the country would improve its protection quotient and be risk-free and prosper in its rightful spirit.

(The writer is V. Viswanand.)

TOP

Source

GENERAL INSURANCE

Govt set to form GoM on merger of 3 non-life insurance companies - CNBC – 10th January 2020

There could be a further delay in the Narendra Modi government's proposal to merge the three state-owned non-life insurance companies - Oriental Insurance, National Insurance and United India Insurance, according to sources.

The reason: the Centre is looking to set up a group of ministers (GoM) to chart an action plan to go ahead with the merger, the sources said.

Not rushing onto the decision, the government aims to better understand the fallout from such a major exercise as well as possibly understand the business model, the sources added.

Former Finance Minister Arun Jaitley had announced the merger plan in his February 2018 budget speech. The merged entity would eventually be listed on the stock exchanges, as per the plan.

The July amendments to the insurance laws clearly show that there is a clear intent to move forward, but there could be possibly some delay in this particular proposal in terms of the timelines.

The development comes three weeks after reports that the three state-owned non-life insurance firms have sought a capital infusion of Rs 12,000 crore from the Centre, to stay afloat and conduct business.

The idea to merge the three insurers was to create a stronger and larger insurance company sustainable in the long run. The other two state-owned entities, New India Assurance and General Insurance Corporation of India are listed on the exchanges.

TOP

Source

Insurers stay on sidelines as Mutual Funds step up purchase of shares – Business Standard – 9th January 2020

Domestic insurers have largely remained on the sidelines even as mutual funds (MFs) stepped up their purchase of shares in the past few years.

In 2019, mutual funds shopped for equities worth about Rs 53,000 crore, while domestic institutional investors (DIIs) bought shares worth Rs 42,000 crore, implying net selling by insurance companies. A similar trend has played out in the past eight years. MFs, on the other hand, have significantly ramped up their buying since 2015 driven by the surge in flows through systematic investment plans (SIPs), ploughing in Rs 4.1 trillion.

"Within the industry, there is increased focus on protection, which typically means less equity exposure. In our estimate, overall insurance companies have been flat to negative on equities flows in 2019," said Mihir Vora, Director & CIO, Max Life Insurance.

According to market observers, insurers are long term investors in the market and tend to get stable flows. MFs, on the other hand, are much more driven by cyclical flows, especially in times of sustained market upsurge. "With a long-term perspective and stable flows, insurers have the ability to sell at expensive valuations and wait for the right time to buy on corrections," said Aneesha Srivastava, CIO, IDBI Federal Life Insurance.

Ulip investors have a tendency to withdraw their money once their lock-in period is over, especially if the market is at a high, said experts. In 2019, India's benchmark Sensex gained 14 per cent.

The asset allocation in Ulip products varies from customer to customer, but typically about 75 per cent is invested in stocks. Traditional products such as term, endowment, and whole-life policies are more long term, and have 5-20 per cent invested in stocks. These products are driven more by fund managers than by investors.

"Whenever the markets heat up, in ULIPs by and large, to improve the performance of the funds the fund managers may ease out their position with a hope that they might be able to rebuild it at a later stage," said Ashvin Parekh, CEO, Ashvin Parekh Advisory Services. "Insurers might have liquidated their gains from equity and may be deploying some of that money in the debt market owing to the favourable interest rate scenario and RBI's accommodative stance," he added.

The RBI slashed rates by 135 basis points in 2019, boosting debt portfolios. Bond prices and interest rates move inversely.

Insurers are one of the largest drivers of Indian stocks. In the past, insurance firms such as the Life Insurance Corporation of India (LIC), the country's largest insurer, have helped prop up the market against steep falls.

According to market observers, LIC may have liquidated some of its holdings in the secondary market to participate in the government's disinvestment programme. The insurance behemoth, which reportedly invested about Rs 68,000 crore in stocks in FY19, typically looks to increase its stock investments by 10-15 per cent every year.

Historically, foreign portfolio investors have been the dominant market price-setters, given their size and trading patterns in India. The past couple of years have indicated a change, with domestic flows increasingly being the primary driver of market direction.

(The writers are Ashley Coutinho & Subrata Panda.)

Source

TOP

Make insurance GST exempt, increase income tax benefits on health insurance – Financial Express – 9th January 2020

The Indian insurance industry is at an inflection point. Having shown a considerable improvement in almost all areas over the last few years, the industry is all set to play a major role in bridging the vast "protection gap" of that exists in the country today. A workforce that is increasingly getting younger, higher life expectancy, greater awareness, better disposable income and savings will drive demand for almost all insurance products, especially motor and health insurance.

Amid this, the insurance sector – growing at a healthy pace – is also bustling with activity; higher growth rate, new product launches, newer distribution models, increase in capital infusion, and new players entering the market. The most notable achievement in recent times has been the launch of mass insurance plans like PMJSBY, PMSBY and PMFBY. Ayushman Bharat has also helped raised awareness on the crucial need to cover the risks of working class and under privileged categories.

Having paved the way for growth so far, we hope the government will utilize the forthcoming Union Budget to incentivize the end users for enhanced insurance awareness and penetration. These steps are critical as it falls within the purview of legislature and administration. First of all, the industry is hoping the Tax Rebate cap for medical insurance Under Sec. 80D to be increased further from Rs 25,000 to Rs 50,000 for self, and from Rs 50,000 to Rs 75,000 for dependent parents. This will be a huge relief for those who are struggling to meet rising healthcare costs.

Second incentive will be the abolition or at least a substantial reduction in the GST on all Personal Lines of Products – from the existing 18% to 5%. Alternatively, the government may consider making all personal lines – Health, Accident and Home – GST exempted to make the insurance affordable and available to a larger populace. While the GST remains outside the purview of the Budget, the government may find some innovative steps to improve the penetration of the personal lines.

Third incentive is highly critical given the recent incidents of building collapses and fire. The FM must bring in regulations making insurance mandatory for housing societies (with just 1% home insurance penetration, the gap is alarming), AOG insurance by municipal corporations, townships, etc.

Considering the growing incidences of Nat Cat across the country, the government could consider a universal CAT cover which is funded by the government for the BPL category from the National Disaster Relief Funds while for all others, the premium could be built into their property taxes. This will seed 'social insurances' which will help achieve a reduction in uninsured losses, making available capital for the reconstruction and free the government from footing relief bills during natural disasters. This would help in minimizing the protection gap and increase the overall insurance penetration.

(The writer is Pushan Mahapatra.)

TOP

Source

MNRE shares list of insurance providers for solar power plants – Saurenergy – 8th January 2020

With an aim to provide some relief to solar energy industry stakeholders, the Ministry of New and Renewable Energy (MNRE) has shared a list of those insurers who are currently offering products covering various risks associated with the solar power plants.

The MNRE said in a statement that it had taken up with the Department of Financial Services, Ministry of Finance and Insurance Regulatory and Development Authority of India (IRDAI) for the availability of insurance products regarding domestic modules.

As per the information provided by the Financial Services Department and IRDAI, Iffco Tokio GICL, HDFC Ergo GICL, The New India Assurance Co. Ltd., ICICI Lombard GICL and Cholamandalam MS GICL were among the insurance providers offering various products for the solar plants.

Further, the various products offered by these insurers include – photovoltaic sales policy, photovoltaic buyers policy, solar panel warranty insurance, new India solar energy insurance policy, solar panel warranty insurance, solar energy shortfall insurance policy, and Chola solar plant protect policy among others.

Moreover, these insurance products covers various risks associated with the life cycle of a solar energy plant such as – covers contractual liabilities of PV module manufacturers' arising out of the performance and product warranty offered to buyers; these products also indemnify insured against costs and expenses necessary to fulfil its obligation under the warranty; providers cover to PV module buyers' if manufacturer becomes insolvent; covers underperformance of solar modules on account of performance degradation of panel insured below the performance warranty due to – faulty manufacturing, material defects and material ageing beyond normal wear & tear and degradation; covers energy shortfall due to – unintentional error in calculation of target production, defect in insured energy installation etc.; and covers shortfall in deemed energy production due to lack of adequate solar irradiation among others.

(The writer is Manu Tayal.)

TOP

Source

Builder questions inadequate insurance cover – The Times of India – 8th January 2020

A builder, whose project is adjacent to one of the apartment complexes scheduled to be demolished at Maradu, has approached the high court, alleging that the insurance availed by state government for possible damages is inadequate. While the policy availed by the government is for Rs 50 crore, the builder said a policy of Rs125 crore is required to cover their property alone.

The petition was filed by Heera Construction Company Pvt Ltd regarding possible damage to their apartment complex named Heera Windfaire, which is adjacent to Golden Kayaloram.

In the petition, it is alleged by the builder that the authorities have not taken proper steps to cover the risk to their building, which is situated very near to Golden Kayaloram. The sub collector, who inspected the buildings several times, is not divulging the steps taken to provide compensation in case of damage, the builder has alleged. Authorities are duty bound to take sufficient insurance coverage for their property, the builder has contended.

According to the petition, there are 95 apartment units in Heera Windfaire and the builder has already spent around Rs 95 crore. A total of 80% of the apartments have been sold, the petition said.

The nearest distance between Heera Windfaire and Golden Kayaloram is 6m whereas the highest distance is 11m. While authorities are liable to take insurance policy for Rs 125 crore to compensate for possible damage to Windfaire, they have only taken a policy for Rs 50 crore to compensate for the damage to all buildings in the vicinity, the builder has alleged while stating that the extent of insurance cover is grossly inadequate. A court directive to the government to either avail insurance for Rs125 crore to compensate damage to Windfaire or given an undertaking in writing to compensate for the damage from demolition is being sought by the builder.

TOP

Source

Benefits of insurance while studying abroad - Orissa Post – 6th January 2020

Studying abroad is typically well-researched when considering the financial investment it requires. Students going abroad for higher studies take up the challenges and become responsible for their own well-being without much external support despite the excitement surrounding it. But what happens when you are left to deal with unknown unpleasant events like losing your passport, missing your flight or some emergency medical expense? One factor to consider consciously as part of your to-do list when moving abroad for studying abroad is Student Travel Insurance. As a student, it is not only important for you to have good insurance cover while you are away, but in most countries which are popular study destinations, it is also mandatory. Some thumb rules to compare the features that can help you zero in on a good insurance plan for yourself are as below.

What is student travel insurance?
Student travel insurance is tailor made specifically for providing financial security to students studying abroad. This insurance product is designed exclusively while keeping in mind the risks associated with students who choose to travel abroad for academic purposes. This product covers health and travel related risks while the student is in a foreign country. It also provides additional cover for the student's family in case of certain unavoidable situations involving the insured.

How is it different from travel insurance?
Travel insurance is generally for a shorter stipulated amount of time whereas student travel insurance will be spread across months or years together. One of the most prominent difference between travel insurance and student travel insurance is that the former solely covers travel related risks while the latter covers travel as well as academic related risks like paying tuition fees in case of the discontinuation of schooling due to unavoidable circumstances, paying for stay of one family member when the policy holder requires hospitalisation for more than a week, pays for medical and dental treatments etc.

Why is it important?
Everyone knows that studying abroad is expensive, but what is even more expensive than that is, medical treatment, which is a certainty when you are in an unfamiliar area for prolonged time. While an average visit to the doctor would cost anything between `150 to 300 in India, abroad it would cost nothing less than $250-300. In such a case, having an insurance cover that helps as an active backup plan is always a good idea. A student insurance cover like this can help ease the financial burden on you and your family. Besides that, most universities overseas have made it mandatory for foreign students to have an insurance cover.

How do I select a good insurance plan?
Most universities abroad have their own set of regulations and guidelines regarding insurance. Make sure that you pick an insurance plan in coherence with those suggested guidelines. Apart from that, also look

at getting insured from a company that offers you a product which is designed to suit all your needs. With regard to features, any good insurance plan should ideally cover the following:

Medical expenses, evacuation, and repatriation, accident to sponsor, personal accident, tuition fee, AD & D common carrier, Loss of checked baggage, Bail bond insurance, and Family visit.

How are claims settled?
The procedure followed for settling claims under student travel policies is normally simple and quite hassle free, subject to prompt intimation of claim. Claims can be considered for settlement directly to the hospital (Cashless settlement), in case expenses are over USD 500 and subject to all other policy terms. Insured may also submit all claim documents to the insurer after settlement of the bills to the hospital either during his stay abroad or on his return to India. Claims are settled within 7 working days from submission of complete set of documents and the payment is transferred to the insured account through a NEFT transfer.

(The writer is SasikumarAdidamu.)

TOP

Source

Merging insurance companies: Yet another Air India in the making? - Money life – 6th January 2020

If you do not know where you are going, it does not matter which road you take. Well, this is not exactly what the cat said to Alice in the famous parable, but it captures succinctly the conundrum currently surrounding the merger of general insurance companies in the public sector, namely, Oriental Insurance (Oriental), National Insurance (National) and United India Insurance (UI).

The department of financial services has now taken the first step towards going down the rabbit hole by announcing that two of these, namely, National and UI, will be merged with Oriental by 31 March 2020. The merged entity will start functioning with effect from 1 April 2020 with its head office in Delhi.

According to rough estimates, the capital infusion needed is at least Rs2, 000 crore-Rs3, 000 crore in each of the companies, and the total collective requirement is close to Rs12, 000 crore-Rs13,000 crore. What is perhaps left unasked is: Will this merger, accompanied by the fund infusion, act as a silver bullet, that is, will it make the merged entity viable both in terms of capital adequacy and the return on investment to the principal shareholder, the Indian taxpayer?

The question that arises while making such an open-ended commitment of taxpayers' money is: whether there has been a robust and transparent debate to evaluate the decision, the process and the likely outcomes?

Let us start by asking a basic question—what is the objective behind the proposal? Is it to cut costs? Is it to create synergies? Is it to provide for a government owned counterweight to the private sector in the general insurance space, something like the Life Insurance Corporation (LIC) in the life insurance space? The government probably assumes that consolidation will lead to cost rationalization, marketing synergy, avoidance of wasteful competition and better leveraging of the balance sheet, thereby restoring the profitability of the merged businesses.

The one likely objective—cost cutting - seems reasonably straightforward at first sight and possibly that is what is driving this whole exercise. Merging the companies will eliminate the wasteful expense of these three companies having an office each in the same locality, sometimes in the same building, thus saving on rent and other fixed costs. This will also eliminate the parallel pyramids of staff and officers in the three companies.

However, if the government promises that jobs will be protected, and in the current scenario this is a given, then any attrition of manpower will only happen gradually, by way retirement. The financial strain of a realistic voluntary retirement scheme (VRS) may break the balance sheets of these companies.

The second objective might be to create synergy. This is easier said than done.

Integrating the information technology (IT) systems or migrating to a standardised one will be a logistical and financial nightmare. Business operations of these companies will be paralysed while integration is taking place. Although outwardly similar, these three companies have different cultures and practices and integrating them will be a long and painful grind. Even if the elusive goal of synergy is somehow accomplished, what would it achieve? If the market doesn't really need you, synergy of any kind is a false objective.

Creating a counterweight to private sector? One large company, New India Assurance, already exists. This is a listed entity and perhaps this factor gets in the way of integrating the four public sector insurance companies, instead of the three unlisted ones, which would have been the most sensible course to take. Yet another giant public sector insurer is unlikely to stand on its own in the market, given the strong presence of private sector companies in almost all nooks and corners of the country. The only thing that is bound to happen is that the business of the three public sector companies will move to the private sector or to New India while the transition is taking place. By the time the merger is fully accomplished, the merged company would have turned into an insignificant entity, presumably a dumping place for unwanted business or to administer government-sponsored schemes.

Here it may be pertinent to examine the seemingly parallel merger of public sector banks. While the drivers may be similar, the operational consequences are different. Bank customers are unlikely to move their banking relationships in a hurry—be it savings or current accounts, or loans. Juxtapose this with the fact that insurance policies are generally 12-month contracts. Customers always do forum shopping at the time of renewal. There is every incentive to move one's policy to another insurer either for a lower premium or for better service. The other parallel that might be drawn is the merger of Mahanagar Telephone Nigam Ltd (MTNL) and Bharat Sanchar Nigam ltd (BSNL). This is a false analogy simply because while ownership of telecommunication assets can be justified as a strategic imperative for the government, there are no such imperatives as regards the non-life insurance space. In any case, hopefully, the one listed insurer, New India, can serve the purpose, if any, behind government presence in the market.

Will the merged entity generate returns for the government? A cursory look at the financial performance of each of these three companies will provide the answer—none of them have made an underwriting profit for the past couple of decades and some of these companies have actually incurred losses even after considering the investment income. The harsh fact is that insurance financial statements, given the reporting standards currently prevalent in our country, are notoriously opaque. The real state of their financials might be far more alarming than the published figures.

Would the merged entity provide a choice to the insuring public? Given that there are already 27 companies in the market, competing for a customer base, the argument of offering customer choice sounds preposterous.

Will the merged entity have a strategic rationale for its existence? Is there a gap in the market which a second public sector insurer will fulfill or will it end up as a drag on the other remaining public sector company, New India? It is obvious that the merged entity will act as a direct competitor to New India rather than to other private sector insurance companies.

The reality is that non-life market is overcrowded and fiercely competitive. Regardless of the projected growth of the economy, the market is unlikely to make room for a new insurer. Make no mistake; the merged entity will be a new entrant given that consumer loyalty is rather flaky. Share of the non-life premium in the gross domestic product (GDP) has barely moved over the years, and with the economy being near-stagnant now, the size of the pie is unlikely to grow at the same pace as was the case in the past couple of decades. The size of the pie and its constituents are probably the subject matter for another article.

Is the merger a prelude to eventual disinvestment? Drawing a parallel with Air India privatization is possibly not very apt. Air India has international flying rights and airport slots which make it attractive to a potential investor. It is difficult to imagine why any eventual disinvestment or listing of the merged entity will attract any interest from private investors. The best course for the government would be to put the three companies into 'run-off' and give a golden handshake to its employees. This is a common practice in all insurance markets where a general insurance company is in terminal decline and is not an attractive proposition for merger or acquisition.

If the merger exercise goes ahead in its present shape and form, the owners, i.e., the government, will have 'another fine mess' on its hands sooner rather than later. The principal reason is that there is no business case or other strategic rationale for the merger. Our experience shows that government ownership simply does not allow the management to run a business like a business. And it is our money which will be spent time and again.

The additional capitalisation requirement mentioned in the earlier part of this article is merely the starting point; it is very likely that, given the total absence of a business case for the existence of the merged entity, periodic top-ups become inevitable. This is where one worries about 'another Air India' inasmuch as this will amount to throwing good money down the rabbit hole.

(The writer is Shrirang Samant.)

Source

TOP

Cyber Insurance: How Lloyd's India is closing the gaps – Moneycontrol – 8th January 2020

India was the third worst hit nation during the 2017 WannaCry ransom ware attack, affecting over 40,000 computers. However, Shankar Garigiparthy, Lloyd's India's CEO and Country Manager believes the real number was over quarter of a million.

India suffered numerous cyber attacks recently. The Indian Computer Emergency Team recorded 50,362 attacks in 2016, which rose to 3,13,649 in 2019. These attacks comprised phishing, hacking, and business interruption.

These growing incidences have prompted Lloyd's India to consider cyber insurance products as a pertinent offering in its current portfolio. Its CyRiMBashe Attack Report 2019 highlighted that less than 14 percent companies are covered by cyber insurance. "The economic losses due to lack of insurance in case of cyber attacks is in the region of USD 160 billion," Garigiparthy noted.

Most of the cyber insurance earlier focused on digital assets like customer data. But growing instances, frequency and impact of attacks have seen insurers and reinsurers include components like physical assets, business interruption, brand reputation and IPR (intellectual property rights). A KPMG report states that the faster the insurers unravel the complexity of modeling and pricing these risks, the quicker they can seize a share of this market, valued at over USD 10 billion of global premiums by 2020.

Keen to grab a major pie of India's cyber insurance market, Lloyd's, a specialist in the insurance and reinsurance market, will concentrate on business interruption and ransom ware, including first party payments. This is when an insured company, or the first party, is paid by their insurer, or the second party, in case of the events covered under the policy.

Garigiparthy explained, "If companies want their first party losses to be protected, then the reinsurance price will be quite high. Most insurers would typically want to retain up to a certain level and purchase reinsurance for losses above their threshold appetite level."

Quantifying cyber risk exposure is a challenging task, since a single data breach affects multiple geographies. In such scenarios, Lloyd's extrapolates its global experience for the Indian region after extensive consultations with brokers, insurance companies and risk managers.

"There is constant discussion with risk managers and brokers to understand how much of that exposure we are asked, or are willing to take, since often there is no precedence for such attacks. After all, if we always rely on past experiences, we cannot innovate. Lloyd's has a strong history of innovation, and was amongst the first to issue a cyber risk policy. We still have approximately 40 percent share of the cyber market globally," he added.

Lloyd's believes it has cracked the code for a sustainable insurance product portfolio by ensuring its underwriters are present in the country, and constantly engage with brokers and clients. This helps them understand risk exposure before deciding how to best protect clients.

(The writer is V Bhatia.)

Source

TOP

Should you insure your dream wedding? - The Hindu Business Line – 6th January 2020

Indian weddings are flamboyant affairs. So much so that the celebration often goes on for a week or more. Destination weddings at exotic locations are quite the rage, too, but they can cost you dearly if the event runs into rough weather — quite literally. Wedding insurance can come to the rescue, covering your expenses in case certain events mar the D-day for you. But the policies come with several strings attached, and not all expenses are covered by insurers.

Here is a lowdown on such policies. Wedding insurance provides cover for events such as burglary and theft, fire, loss or damage to the props, sets or equipment and so on. While Future Generali offers a separate wedding cover named Vivah Suraksha, other players including Bajaj Allianz General and ICICI Lombard offer wedding cover as part of their event insurance policies. The scope of coverage varies across insurers. Broadly, there are five coverages.

(The writer is Bavadharini KS.)

Source

TOP

HEALTH INSURANCE

Millions of gig workers set to get health cover, other sops with labour law tweak – The Times of India 10th January 2020

The inclusion of "gig workers" in new labour laws, offering millions of informal workers like Uber drivers and Swiggy riders benefits like health insurance and other schemes, is set to be okayed by Parliament's standing committee on labour which concluded its discussions on Thursday.

In its brief to the committee, headed by BJD MP Bhartruhari Mahtab, the government said that new definitions have been included to cater to emerging forms of employment like aggregator, gig worker and platform worker.

"For these workers, schemes can be formulated by the central government with regard to disability cover, health and maternity benefits," it said. The code on social security, one of four codes that are intended to refashion 43 labour laws, seeks to extend coverage of employees state insurance corporation act across India and to all establishments employing 10 or more employees.

Earlier the ESIC Act's applicability was based on the concept of notification for each district or a part of it and the law can be specific to hazardous occupations. "In such (hazardous) classes of establishment, the threshold can be even one worker," the government has said, adding that an employer of a plantation may opt for the ESIC by willingly joining the corporation.

The committee seems in agreement with the view that these measures will go a long way in extending social security for medical services, sickness and maternity benefits as also dependent pension and employee compensation. Thresholds for provident fund, ESIC, gratuity, maternity benefits and social security can be set or changed through notifications rather than amendments of specific acts.

At present, under the unorganized workers social security act, 2008, there is no provision of electronic registration of workers. It has been proposed that an unorganized worker will submit a self declaration electronically or otherwise in a form to an authority prescribed by government. A registered unorganized worker will be assigned a unique number based on Aadhaar. Stiff fines have been proposed, with increases of as much as 10-fold, as earlier the fines were last revised in 1998.

At the same time there is a provision of prior warning for improvement and for complying with the new code. The news codes are likely to be discussed and voted on in the second half of the budget session.

TOP

Source

Ayushman for all: Bringing informal non-poor under its fold to increase pool size – Financial Express – 10th January 2020

In its recent decision, IRDAI has made it mandatory for health and non-life insurance companies to offer to the general public a standard basic health insurance product with well-defined features. This customer-friendly product is targeted mainly at the lower-middle and middle-middle income households who can afford to pay a premium, but not the hospitalisation expenses that can potentially push them in financial stress.

This decision is consistent with the recommendations made in NitiAayog's recent report. One of its recommendations calls for "harnessing the power of commercial and private health insurance" as a short-term action for improving risk pooling in the health sector.

While the report gets the diagnosis right to assess the problems facing India's current health system in selected areas, some recommendations are a little worrying. In the field of risk-pooling, for example, the report is spot-on in making contextual observations of severe fiscal constraints, high level of labour informality and high level of out-of-pocket (OOP) spending. It is right in suggesting that growth in risk pooling will need to come from pooling OOP spending from the informal non-poor. However, where the report falls short is in not giving convincing reasons as to why the informal non-poor cannot be brought under Pradhan Mantri Jan Arogya Yojana (PM-JAY)—a scheme that offers free hospitalisation benefits to nearly 110 million poor and vulnerable households. And why this pathway cannot feed into whatever long term risk-pooling strategy the country may choose to achieve Universal Health Coverage.

It's not difficult to understand why the report recommends commercial insurance instead of PM-JAY for the informal non-poor. One, healthcare being a state responsibility, it is states' prerogative (and, not of the centre) to decide whether or not to extend PM-JAY to the informal non-poor. Two, difficult fiscal situation will constrain the government's ability to contribute towards bringing the informal non-poor under PM-JAY. Three, the inclusion of the informal non-poor in PM-JAY would lead to fragmentation of risk pool by states. To see how significant these reasons are, let's examine each of these in some detail.

Centre's role in extending PM-JAY to the non-poor? Healthcare being a state subject, the centre can partake in it by contributing financially (and technically) through centrally sponsored schemes such as PM-JAY. In the absence of any financial contribution, the only way the centre can promote risk pooling among the informal non-poor is through a national level policy decision. And the centre has two options in the shorter-term: to promote a standard basic insurance product offered by commercial insurers (recommended option in the report) or expanding Employees' State Insurance which is also contributory social insurance. However, given the voluntary nature of enrolment in both the options, the government will need to give some financial incentives to ensure its significant uptake. If the government is to get involved in providing financial incentives, it may as well cover them through PM-JAY rather than through commercial insurance. This leads to the question of how much government funding would it entail, and how burdensome would it be, given in the current fiscal situation.

How much fiscal space is needed to extend PM-JAY? The government indeed has limited fiscal space, especially during the current phase of the economic slowdown. However, a small financial contribution by the centre and states could help expand PM-JAY to the informal non-poor as a bulk of the funding would come as contributions by the insured themselves. Back-of-the-envelope calculations suggest that government contributions need not be burdensome. To demonstrate this, supposing PM-JAY is thrown open to the general public, and it succeeds in covering 200 million (non-poor) individuals. With an average claims amount of Rs20,000 (it is nearly Rs14,600 under PM-JAY as per government data) and a hospitalisation rate of 5%, total claims bill would come to Rs20,000 crores. If 70% (or Rs14,000 crores) of this is contributed by the insured themselves, the balance 30% could be shared equally by the centre and the states. This would require the centre to provide Rs3,000 crores (less than 5% of the health ministry's budget!) and remaining Rs3,000 crores will be shared collectively by the 33 states/UTs that have rolled out PM-JAY. And the contribution per insured per annum would be Rs700 only or Rs3,500 for a family of five, which is three to five times lower than the premium currently charged by commercial insurers for a shallow cover of Rs500,000. Indeed, low average claims are one of the hallmarks of PM-JAY, and the non-poor too should benefit from it.

Some states, such as Karnataka and Uttarakhand, have already extended insurance to their entire population using funds from their budgets. Other states, notably Himachal, Kerala, Maharashtra and Punjab, have covered populations beyond those included in the 2011 Socio-Economic Caste Census survey.

Will it lead to serious fragmentation? The fragmentation issue is not a matter of real concern as risk pools under PM-JAY are already fragmented by states. Bringing the informal non-poor under its fold will only increase the size of this pool. Further, many states have large enough population to derive benefits of large risk pools. On the other hand, if commercial insurers cover the informal non-poor, some fragmentation of risk pools by insurers will still happen.

The informal non-poor would stand to benefit from all the advantages that PM-JAY is known for: cost containment due to larger pool and affordable package rates improved access as a result of a larger network of care providers, the advantage of portability, strong IT system and so forth. In order to make it attractive for people who will pay to join the scheme, it should be possible to introduce superior non-clinical facilities to create differentiation. Inclusion of the informal non-poor would strengthen PM-JAY.

Does this mean that commercial health insurers will play a limited role? PM-JAY only covers standard hospital care. Although some states have used commercial insurers, the real "meat" is in providing additional cover and tapping the higher end market.

To conclude, it is imperative to improve the pooling of health risks in the country. Growth in risk pooling will need to come from the pooling of OOP spending by the informal non-poor. The pathway chosen for improving risk pooling is no less critical as it will create dependencies over time, and will have serious cost implications. There are apparent advantages of expanding PM-JAY to include the informal non-poor.

(The writer is Rajeev Ahuja.)

Source

[TOP]

Why taking OPD health cover is a smart idea – Financial Express – 10th January 2020

Lately, based on the changing consumer expectations, health insurance policies are getting designed which include OPD (Out Patient) cover. Investing in a health insurance policy at a young age ensures that one will have greater coverage. Many latest health plans offer wide coverage for young customers that include daycare procedures and treatment for vector-borne diseases to maternity benefits and cover for OPD expenses among others.

OPD treatment refers to the one in which an individual visits a clinic or a hospital or an associated facility for diagnosis and treatment based on the advice of a medical practitioner and does not have to be admitted as daycare or in-patient. Health insurance plans that offer OPD cover assists the insured to claim expenses other than that incurred during hospitalisation.

Who should take OPD cover?

OPD cover is for anybody who might incur healthcare costs which does not require in-patient hospitalisation. This covers minor medications like viral fever and in cases of some chronic conditions like diabetes, arthritis, or back pain. For any other chronic condition that requires regular visits to the doctor, OPD insurance is a suggested cover.

OPD cover allows one to make claims for expenses incurred, not including hospitalisation. The cost of medicines, along with diagnostics or minor procedures, is also covered under this policy. One can also claim tax exemption on the premium paid. However, it should be noted that the OPD treatments is considered only in network clinics and hospitals. One can claim OPD expenses without an extensive wait. It is usually within 90 days of availing the policy if one is claiming for a pre-existing disease or even from day one if it is not related to any pre-existing condition. One can make multiple claims within the same year until the limit is done in.

Inclusions

The OPD benefits come in several shapes and sizes. It includes fees for medically necessary consultation and examination by medical practitioners to assess one's health for any illness. It also covers the medically necessary out-patient diagnostic procedures such as x-rays, brain and body scans, and pathology and so on used to make a diagnosis for treatment from a diagnostic centre along with prescribed medicines. In addition to this, minor surgical procedure such as POP, suturing, dressings for accidents and animal bite-related OPD procedures carried out by a doctor are also covered.

Note that OPD covers might not include all daycare procedures. So, it is always wise to check with the health insurer on what procedures one can claim this benefit for. Also, this cover typically excludes expenses incurred towards spectacles, contact lenses, cosmetic procedures, physiotherapy, and ambulatory devices like walkers, BP monitors, glucometers, thermometers, dietician fees, vitamins and supplements.

Often health insurers offer the OPD cover as an add-on with the base policy. Usually, since an OPD expense is much more likely to be utilised by the insured, this coverage comes at a higher cost. One must analyse whether the efficacy justifies the cost, keeping their health requirements and age in mind. This might look insignificant and expensive but can actually save the day when one is in a difficult situation.

(The writer is Anand Roy.)

TOP

Source

Why first-time health insurance buyers should go for Arogya Sanjeevani – Business Standard – 8th January 2020

With medical inflation ranging between 12 and 14 percent annually, buying health insurance should be high on buyers' priority list. Yet surveys show that 75-80 percent of hospitalisation expenses are borne by customers out of their own pockets.

One factor that deters many from purchasing health insurance is lack of faith. Buyers are not sure whether their insurer will reimburse a claim when it arises. It is this mistrust that the Insurance Regulatory and Development Authority of India (IRDAI) has tried to address with, a standard health insurance product that all health and general insurers must offer from April 1.

Sometimes, customers do not understand the terms and conditions of their cover. When their claim is rejected, even on legitimate grounds, they feel aggrieved. "The standard product will have the same features irrespective of which insurer you buy it from. Policy wordings will be the same. The features have been decided by the regulator. Hence, it will reduce expectation mismatch and distrust," says Amit Chhabra, business head, health insurance.

(The writer is Sanjay Kumar Singh.)

TOP

Source

What the standard health insurance product offers – Mint – 7th January 2020

With a host of health insurance policies available in the market, buyers often get confused and do not know how to compare them. To curb this confusion and to encourage more people to buy health insurance, the Insurance Regulatory and Development Authority of India (Irdai) has mandated all general and health insurers to offer a standard individual health insurance product with a maximum sum insured of up to ₹5 lakh. Find the circular, which was issued last week.

The product will be named Arogya Sanjeevani followed by the insurer's name. It will have to be made available starting 1 April 2020. "Standardization of a product offering will help customers get a parity-based understanding of product benefits, simplifying the purchase decision. It leaves no room for ambiguity for the customer in terms of product comparison, since they are assured of the fact that other insurers do not offer a different coverage," said Anuj Gulati, managing director and chief executive officer, Religare Health Insurance Co. Ltd.

While a standard product will surely simplify health insurance for you, do keep in mind that this may not be the best product in the market. We give you the features and details of the new standard plan.

Main features

Like a typical health insurance plan, Arogya Sanjeevani will be an annual policy renewable for life and will pay for hospitalization expenses. This means costs incurred on the surgeon, anesthetist, consultants, specialist fees, operation theatre charges, oxygen, surgical equipment, costs towards diagnostics and so on are covered too. Further, expenses incurred on hospitalization under the Ayush system of medicine will also be covered without any sub-limits. Pre-hospitalization (from 30 days prior to the date of admission) and post-hospitalization expenses (60 days from the date of discharge) will be included too.

IN A NUTSHELL

Irdai has mandated insurers to offer a standard health plan with a maximum sum insured of ₹5 lakh. Here are the main features

Policy name

AROGYA SANJEEVANI*

Entry age (years) 18-65	Sum insured (₹) 1 lakh-5 lakh
Premium As per insurer's discretion	Tenure One year with lifetime renewal
Add-ons Not allowed	Co-pay 5% of sum insured
Room expenses Capped at 2% of sum insured	Modern treatments 50% of the sum insured
Cumula-tive bonus 5% for each claim-free year	Sub-limits 25% for cataract treatment

*Along with the insurer's name

SANTOSH SHARMA/MINT Source: Irdai

The policy will also cover dental treatment and plastic surgery necessitated due to a disease or injury, all day-care treatments and expenses incurred on road ambulance. The ambulance expenses will be capped at ₹2,000 a day.

Anyone between 18 and 65 years can buy this product, but it can't be customized to your needs.

However, there are some important caveats to consider. The policy will cover room, boarding and nursing expenses but only up to 2% of the sum insured, subject to a maximum of ₹5,000 a day.

Gurdeep Singh Batra, head, retail underwriting, Bajaj Allianz General Insurance Co. Ltd, said the intention of the policy is to insure the non-insured population of the country, particularly in tier-2 and tier-3 cities, which is why the sum insured is capped at ₹5 lakh. "Room rent makes for a large chunk of the hospitalization expense and not having a cap would push the premiums. Instead of a 1% cap, they've capped it at 2% or ₹5,000, which is reasonable because in tier-2 and tier-3 cities, most nursing homes and hospitals offer good rooms within ₹5,000," said Batra.

The policy also covers expenses on intensive care unit (ICU) and intensive cardiac care unit (ICCU) facilities up to 5% of the sum insured, up to ₹10,000 a day.

"The mandatory covers prescribed by Irdai are inclusive enough for a standard product but this could have been enhanced by increasing some of the limits restricting the coverage such as cap on room rent, pre- and post-hospitalization expenses, and restricting ambulance charges up to ₹2,000 per hospitalization. Existing products offered by insurers offer flexibility and superior covers with no capping on room rent or a cover for more number of pre- and post-hospitalization days along with higher limits for ambulance," said Biresh Giri, appointed actuary, head of product development and chief risk officer, Acko General Insurance Ltd.

The product will come with a fixed co-pay of 5%, across all age groups. A 5% co-payment clause would mean that you will pay 5% of the claim amount and the insurer will pay the rest.

There's also a limit on how much the policyholder can claim for cataract surgery. Irdai said, for each eye, expenses incurred on the treatment of cataract will be covered only up to 25% of the sum insured or ₹40,000, whichever is lower. Irdai has also listed the conditions that insurers shall cover after a prescribed waiting period.

What is positive about this policy is that it takes into account the ever-evolving healthcare ecosystem. The policy will cover modern treatments like stem cell therapy and balloon sinuplasty up to 50% of the sum insured. "This (including modern treatments) is a good proposition from an insured viewpoint. Currently, other products are also being re-looked for such extended coverage in line with guidelines issued on standardization of exclusions in health insurance," said Batra.

Premiums and bonus

The regulator has allowed insurers to determine the price of the policy keeping in view the mandatory covers they would need to offer. Insurers, however, will have to comply with Irdai norms while doing so. Pricing for any insurer is a factor of risk assessment, estimated claims, consumer behaviour and long-term sustainability of the product.

The range of pricing should largely be similar for most insurers but it's too soon to be sure, said Gulati. While insurers are not allowed to offer any add-ons or optional covers with this product, they can package it in the form of a family floater plan where the premium is decided based on the age of the oldest member of the family. Giri said the premiums could start from ₹5,000 for an individual policy with a sum insured of ₹5 lakh and ₹15,000 for a family floater plan with a sum insured of ₹5 lakh.

Note that a cover of ₹5 lakh may not be sufficient for a whole family but is still better than having no insurance at all. "For a floater policy, ₹5 lakh may not be adequate. Nevertheless, we have a huge untapped market where most people don't have any insurance and are paying out of their own pockets or not getting properly treated," said Prasun Sikdar, MD and CEO, ManipalCigna Health Insurance Co Ltd. Like other health products, policyholders will get the option of paying premiums on a monthly, quarterly, half-yearly and annual basis. The cumulative bonus on this product, according to Irdai, shall increase by 5% in respect of each claim-free year, subject to a maximum of 50% of the sum insured but only if the policy is renewed without a break. If a claim is made in any particular year, the bonus will decrease at the same rate at which it was accrued: 5%. Also, no deductibles are allowed.

Mint take

Sikar said it is difficult to say whether premiums will drive this product or awareness campaigns by Irdai, or the brand name of the insurers. "But this will definitely benefit the industry and increase penetration," he added. Batra said this product is specifically targeted towards the lower middle-income group where medical expenses, especially the cost of hospitalization is still lower than metro cities.

Experts also said that this may impact the retail health insurance business in the long run as it will bring more uniformity and standardized policy wordings, making it easier for customers to choose.

However, keep in mind that this policy suffers from two major setbacks: room rent capping and co-payment. While this may make the policy affordable, in case of a claim, you will have to shell out a part of the claim from your pocket. Given the low sum insured, this policy comes with restrictive clauses that also make it more affordable. Before you buy the new standard product, compare the premiums and choose the least restrictive option. If you haven't bought a policy due to high premiums, this can be a good entry point. Whether the product will enhance the adoption of health insurance remains to be seen.

(The writer is Disha Sanghvi.)

Source

TOP

Health Insurance: More wellness products, use digital solutions in year 2020 – Financial Express – 7th January 2020

Since the last few decades, healthcare delivery and financing in India has shared key landmarks with general insurance. Despite constant progress, the current state of India's healthcare outcome leaves much to be desired. A strong synergy between private and public players, complementing each other is a major objective. Insurers need to carefully design and implement their strategies and products in a 1.3 billion-strong population segmented in various divisions.

Gap in healthcare delivery

There is a wide gap in healthcare delivery for the insured and for the total population. Health insurance is majorly dominated by government schemes. The private health insurers have expanded rapidly in tier-1 and tier-2 cities with products centredaround 'in-patient reimbursements' and 'cashless payments'. New business models of delivering care are evolving via the virtualization of processes and business models, with consumer-centric mobility paradigms gaining ground. It is no longer a tactic but is core to business success. Medical diagnostics, Artificial Intelligence and Big Data are sparking disruptive innovations that are redefining care paradigms.

With data explosion, digitalisation and the emergence of Internet of Things (IoT), primarily the connected human, nowhere in the world are the prospects of integrating technology and data higher than in the Indian health insurance sector, with a large transformation opportunity presented by a largely underinsured population, increasing health consciousness, and the availability of data and digital advancements. Insurance companies will be able to leverage data and digital solutions to engage more with their customers, moving away from simple products to solutions, and from being just a payer to a partner. This will include health insurers leveraging data analytics and partnerships to encourage customers to eat healthy, exercise appropriately, and perform regular check-ups by nudging their customers at the right time.

Customer experience

Technology will be a key enabler and will serve support differentiation among various players. Disruptive emerging technologies such as cloud computing, mobility solutions, telemedicine, and social computing are poised to enter mainstream operations. Experts also believe that next year will be dedicated to wellness wherein most insurers will try to promote wellness by introducing new and customer-centric wellness products.

Insurers are expected to come up with new-age health insurance plans that increase fitness levels amongst the masses. An important objective of these wellness plans will be to focus on building an outcome-based preventive structure in order to promote a healthy lifestyle. Another important focus area will be developing new products that help consumers stay prepared for any kind of specific illness. The year 2020 will also witness a significant rise in products that cater to the diagnostic needs of the customers. Also, the ultimate focus of the health insurance will be middle-class families as the industry will develop affordable plans to bring health insurance within their reach.

Even the standard health insurance plan proposed by the Irdai is expected to go live. It will cover both pre and post hospitalisation expenses and will definitely change how the health insurance market behaves. The future is all about data. Digital technology is evolving rapidly and becoming so affordable that insurers will figure out different ways to innovate and engage with their customers.

(The writer is Amit Chhabra.)

Source

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Insurance regulator alters health cover rules, makes it more customer-friendly – The Indian Express – 7th January 2020

The Insurance Regulatory and Development Authority of India (IRDAI) last week made significant changes benefiting health insurance policyholders. From allowing them to pay premiums in installments to porting from one plan to another within the same insurer, the regulator hopes to make health insurance customer-friendly.

For the first time ever, IRDAI has allowed policyholders to pay health insurance premiums in installments — be it monthly, quarterly or once every half year. But the catch is the free-look period for monthly or quarterly premiums will be lower than annual premiums.
Interestingly, insurers can increase the maximum age limit filed for insurance policies from the widely followed limit of up to 65 years, though insurers are given an option to decrease the minimum age for insurance policies. Importantly, the guidelines remain the same but the applicability of 'migration' and 'portability' has now been clearly defined.

Migration allows policyholders, including all members under family cover and members of group health insurance policy, to transfer the credit gained for pre-existing conditions and time-bound exclusions with the same insurer. Portability allows policyholders to transfer from one insurer to another.

For policyholders with existing health conditions, the deal is sweetened as insurers have to specify a period of not more than four years to cover pre-existing diseases. Also, customers can declare any disease contracted up to three months after taking the policy.

According to Prasun Sikdar, MD & CEO, Manipal Cigna Health Insurance, the standardisation of health insurance will bring uniformity in interpretation as well as simplification, and ease of understanding of policies and go a long way in reducing industry grievances.

There's more. The regulator made it clear that several critical illnesses such as mental problems, genetic diseases, and even psychological disorders shouldn't be included in the exclusions list of the policy. The move is immensely beneficial to customers.

Insurers can increase or decrease premiums by 15 per cent, caused due to the modifications based on the loss-ratio numbers of the last three financial years. "Change of premium rates resulting in the increase shall be only after expiry of three years from the date of launch of approved or modified individual product," said IRDAI.

To reach out to customers, insurers can explore additional distribution channels for particular products without having to wait for the regulator's approval and must provide a list of third-party administrators to policy holders before on-boarding customers. However, customers can change TPAs only at the time of renewal. Moreover, insurers can even make minor modifications in approved individual insurance products on a certification basis.

What's new?

- Insurers can pay insurance premiums in installments
- They can increase the maximum age limit for insurance policies
- Applicability of 'migration' and 'portability' is clearly defined
- Insurers have to specify a period of not more than four years to cover pre-existing diseases
- Several critical illnesses such as mental problems, genetic diseases, and even psychological disorders shouldn't be included in the exclusion list of policies

Source

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10 things to know about the standard health insurance policy an insurer has to offer – The Economic Times – 4th January 2020

The Insurance Regulatory and Development Authority of India (IRDAI), on January 2, issued a circular mandating health and general insurance companies to offer a standardised product that will take care of the basic requirements of policyholders.

According to IRDAI, the policy will be named as Arogya Sanjeevani Policy, succeeded by the name of the insurance company. The regulator said, no other name is allowed in any of the documents. Insurers will have to start offering the policy from April 1, 2020.

"It is a welcome move to increase penetration in the lower-middle-income segment as this will come with a facility of paying a premium in installments. Thus, making it an attractive avenue for people as it will not only be easy on their pocket but will also give them enhanced coverage. Moreover, since all the insurers have been directed to have the same coverage and exclusions, it will be simpler for the customer to understand," said Gurdeep Singh Batra, Head – Retail Underwriting, Bajaj Allianz General Insurance.

According to IRDAI's guidelines, issued on January 2, these are the key features of the ArogyaSanjeevani Policy.

- Health insurance policy to take care of basic health needs of insuring public
- To have a standard product with common policy wordings across the industry
- To facilitate seamless portability among insurers

The health insurance plan will have the basic mandatory covers as specified under the guidelines which will be uniform across the health insurance sector. The following health insurance plan will be offered on indemnity basis, as a standalone product. It will not be combined with defined benefit-based insurance covers such as critical illness covers and so on.

Here are 10 things you should know about the health insurance plan, as per IRDAI:

1. Minimum and maximum sum insured: The minimum sum insured under the health insurance plan will be Rs 1 lakh and the maximum sum insured limit should be Rs 5 lakh (in multiples of 50,000). In the case of individual health policy, the sum insured will apply to each individual family member and in the case of the floater health insurance plan, the sum insured will apply to the entire family.

2. Eligibility: Minimum entry age is 18 years and the maximum age at entry is 65. However, there is no exit age. The policy is subject to lifelong renewability. Biresh Giri, Appointed Actuary, Head of Product Development & CRO, Acko General Insurance said that a proposer with higher age can obtain a policy for the family without covering one's self." The policy can be availed for self and the following family members:

- Legally wedded spouse
- Parents and parents-in-laws
- Dependent children (i.e., natural or legally adopted) between the age of 3 months and 25 years. If the child is above 18 years of age and is financially independent, he or she will not be eligible for coverage in the subsequent renewals.

3. Policy period: The health insurance plan should be offered with a policy term of one year.

4. Modes of premium payment: All the premium payment modes are available, that is, you can pay the insurance premium either annually, half-yearly, quarterly or in monthly mode. There will be uniformity in premium pricing. Also, the premium under this health insurance plan will be pan India basis. No geographic location/ zone-based pricing is allowed.

5. Grace period for premium payments: For yearly premium payment mode, a fixed period of 30 days is to be allowed as Grace Period. However, for all other modes of payment, a fixed period of 15 days grace period will be allowed.

6. Expenses to be covered: The expenses incurred on treatment of cataract will be covered up to 25 percent of the sum insured or Rs 40,000 whichever is lower, per eye. Dental treatment necessitated due to disease or injury. Plastic surgery necessitated due to disease or injury, all daycare treatments and expenses incurred on road whereby ambulance cost subject to a maximum of Rs 2,000 per hospitalisation.

7. Free look period: The insured will be allowed a period of at least 15 days from the date of receipt of the policy to review the terms and conditions of the policy and to cancel the policy if not acceptable.

8. Co-pay: Fixed co-pay of 5 percent on all claims will be applicable across all the ages.

9. Cumulative bonus (CB): Sum insured (excluding CB) will be increased by 5 percent in respect of each claim-free policy year, provided the policy is renewed without a break subject to maximum of 50 percent of the sum insured. If a claim is made in any particular year, the cumulative bonus accrued may be reduced at the same rate at which it has accrued.

10. Specific waiting period for certain disease: According to the guidelines issued in a circular: A. "D *isease which will have a waiting period of 24 months*. Benign ENT disorders, Tonsillectomy, Adenoidectomy, Mastoidectomy, Tympanoplasty, Hysterectomy, All internal and external benign tumours, cysts, polyps of any kind, including benign breast lumps, Benign prostate hypertrophy, Cataract and age-related eye ailments, Gastric/ Duodenal Ulcer, Gout and Rheumatism, Hernia of all types, Hydrocele, Non-Infective Arthritis, Piles, Fissures and Fistula in anus, Pilonidal sinus, Sinusitis and related disorders, Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident, Calculi in the urinary system, Gall Bladder and Bile duct(excluding malignancy), Varicose Veins and Varicose Ulcers and Internal Congenital Anomalies."

B. Disease which will have a waiting period of 48 months: "Treatment for joint replacement unless arising from an accident and age-related Osteoarthritis & Osteoporosis," as per the guidelines issued in the circular.

Apart from the factors mentioned above, the health insurance policy also includes expense incurred on hospitalisation under AYUSH treatment; any medical expenses incurred for inpatient care treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines shall be covered up to sum insured, during each policy year as specified in the policy schedule, are reimbursed under AYUSH.

The plan covers pre-hospitalisation expenses incurred for a period of 30 days prior to the date of hospitalisation, post-hospitalisation expenses for a period of 60 days from the date of discharge from the hospital.

Sub-limit for doctors/room rent, boarding, nursing expenses all inclusive as provided by the hospital up to 2 percent of the sum insured subject to maximum of Rs 5000 per day. For intensive care unit (ICU) charges/intensive cardiac care unit (ICCU) charges all inclusive as provided by the hospital up to 5 percent of the sum insured subject to maximum of Rs 10,000 per day.

What you should do

Insurance experts believe that such a policy is a good entry-level product. "The proposed range of Rs 5 lakh and below works well because the product caters to entry-level health insurance. This product sets a floor for the kind of benefits that insurers are likely to offer. They will, for example, offer much higher sum assured as well. The standardised product is an addition to the current portfolio of health insurance products. Benchmarking the standardised product across insurers is relatively easier because the only variable will be price," said Kapil Mehta, CEO, Secure Now.in

However, some believe that the insurance coverage of Rs 5 lakh is not enough. "A Sum Insured of Rs 5 lakh may not be sufficient to address medical expenses especially in tier-1 markets but it definitely is a good entry point for individuals to enroll," said Anuj Gulati, MD & CEO, Religare Health Insurance.

(The writer is Navneet Dubey.)

Source

TOP

Buying health cover will now be a breeze – The Hindu Business Line – 4th January 2020

Buying health insurance has been made simple now. Saving you from the hassles of choosing a policy, the insurance regulator has mandated insurers to come up with a standard health cover product at an affordable price. As per the guidelines issued by the Insurance Regulatory and Development Authority of India (IRDAI), all general insurers and standalone health insurance companies will have to offer a mandatory health cover product, Arogya Sanjeevani, from April 1, 2020. "The standard health product will also supplement the PMJAY which is meant for people below poverty line. Hopefully, middle-class and senior citizens will find this product useful,'' Subhash C Khuntia, Chairman, IRDAI, said. It will also complement efforts under the Ayushman Bharat initiative for a healthy India, he added.

(The writer is G. Naga Sridhar.)

Source

TOP

Why Arogya Sanjeevani has the potential to be a game-changer in health insurance sector – The Hindu Business Line – 4th January 2020

The most baffling aspects a customer faces while buying health cover are the nature of disorders covered, lack of clarity and high premium. What makes Arogya Sanjeevani significant is the solution it provides to these key challenges.

The IRDAI, on Friday, issued guidelines for a standard health cover policy to be offered by all general insurers and standalone health insurers from April 1. As observed by Prasun Sikdar, Managing Director and Chief Executive Officer, ManipalCigna Health Insurance Company, Arogya Sanjeevani will offer a health cover that is likely to address the basic health needs of consumers.

(The writer is G. Naga. Sridhar.)

Source

TOP

Ayushman Bharat: 171 hospitals de-empanelled, ₹4.5 cr fine imposed for fraud – Mint – 3rd January 2020

A total 171 hospitals have been de-empanelled and penalties to the tune of ₹4.5 crore have been imposed on hospitals for allegedly committed fraud and indulging in malpractices under the Ayushman Bharat health insurance scheme, the apex body implementing it said on Friday.

FIRs have been lodged against six hospitals in Uttarakhand and Jharkhand, the National Health Authority said.

The NHA said the National Anti-Fraud Unit has detected suspect e-cards on the basis of algorithms developed internally by it and shared with states for due diligence and action.

It ruled out any possibility of a fake e-card being generated automatically by the system, saying the process requires a go-ahead by authorised persons based on supporting documents and final approval of the state health agency officials to not just create an e-card but also to add any additional family member.

"171 are already de-empanelled and the list of these hospitals is posted on PMJAY website. Penalties to the tune of more than INR 4.5 crore have also been levied on hospitals indulging in malpractices," the NHA said in a statement.

The cover provided under PM-JAY is ₹5 lakh per family and not ₹5 lakh per e-card. There is no package under PM-JAY scheme which is free for government. There are certain packages, especially abuse-prone packages, which are reserved for government hospitals by the state authorities, it said.

It was detected that private hospitals were performing these government reserved procedures and blocking/submitting the same under a different package name or as unspecified package.

According to the statement, cases of fraud were detected by NAFU in August 2019 and shared with Gujarat State Health agency which has disabled the cards and an FIR was lodged on November 8.

In Chhattisgarh, such cases were detected initially in May 2019 and the cards have been disabled.

In Madhya Pradesh, cases were detected in August 2019 and shared with state which has disabled the cards and the concerned hospital has been issued show-cause notice. Penalty has also been levied on TPA.

The cases in Punjab were detected in Oct 2019 and shared with state which has disabled the cards.

[TOP](#)

Source

CROP INSURANCE

Insurance scheme on anvil for JK's agriculture, horticulture sectors - Brighter Kashmir – 10th January 2020

Administrative Secretary APD, Manzoor Ahmad Lone and Joint Secretary, Credits, CEO, Pradhan Mantri Fasal Bima Yojana (PMFBY), Ashish Kumar Bhutani convened an Interactive and Pre-bid meeting regarding Pradhan Mantri Fasal Bima Yojana (PMFBY) and Restructured Weather Based Crop Insurance Scheme (RWBCIS) in New Delhi.

The representatives of empanelled insurance agencies, Scientists from Indian Metrological Department, Officers of Agriculture, Horticulture Departments and SKUAST, J&K, UT participated in the meeting.

The Secretary APD said that the Government of J&K is committed to provide all necessary logistic support to the empanelled insurance companies for the successful implementation of the crop insurance schemes so that the farmers of J&K UT are benefited who otherwise suffer losses due to inclement weather conditions during crop cycle.

Joint Secretary DAC&FW asked the implementing agencies to formulate a strategy so that they can be the part of bidding process for the notified crops in J&K UT and requested all empanelled insurance agencies to be in direct touch with Mission Director PMFBY and RWBCIS regarding any issue which may be an impediment in submission of bids for any notified crops.

Director Agriculture Kashmir, Altaf Aijaz Andrabi who is also Mission Director PMFBY and RWBCIS informed the meeting that bids were re-invited on 19th December for implementation of the schemes in J&K for three years from Kharif 2020 to Rabi 2022-23 as only one insurance companies participated in the bidding process.

Director IMD J&K Sonam Lotus informed the meeting that the Doppler Weather Radar has already been installed which will enable insurance companies to have access to accurate and authenticated weather data. During the meeting some key decisions were taken with regard to contract period extension in cut-off date for submission of bids.

Director Indian Metrological Department was directed to submit a proposal for installation of automatic weather stations at the block level along with their catchment areas to the Government of J&K and to the Department of Agriculture Cooperatives and Farmers Welfare, Government of India for back up weather data. IMD will continue to be the proxy weather data provider as mandated under PMFBY and RWBCIS guidelines.

It was also decided in the meeting that the agriculture production department will work out the possibility of out sourcing the installation of AWS for better and accurate assessment of weather parameters responsible for the losses at block level so that the interest of farming community is taken care off.

TOP

Source

Insurers brace for highest ever claim ratio in FY20 for Govt's crop scheme - Business Standard – 7th January 2020

The year 2019-20 could see the highest claims ever under the government's crop insurance scheme, the Pradhan Mantri FasalBimaYojana (PMFBY). According to sources, insurers are expecting the claim ratio to be as high as 120 percent this year. This is because unseasonal rains and natural calamities led to high crop damage, they said.

This year, at least three private insurers, ICICI Lombard General Insurance, Tata AIG and Cholamandalam MS General Insurance, did not participate in the scheme. The claim data for 2018-19 is yet to be released by the government. Together, these companies accounted for about Rs 3,000 crore of premium. According to sources, last year, in many areas, the insurers had to pay very high amount of claims, leading to reluctance in bidding for the scheme this year.

(The writer is Namrata Acharya.)

TOP

Source

India's crop insurance scheme loses sheen - Down to Earth Magazine – 7th January 2020

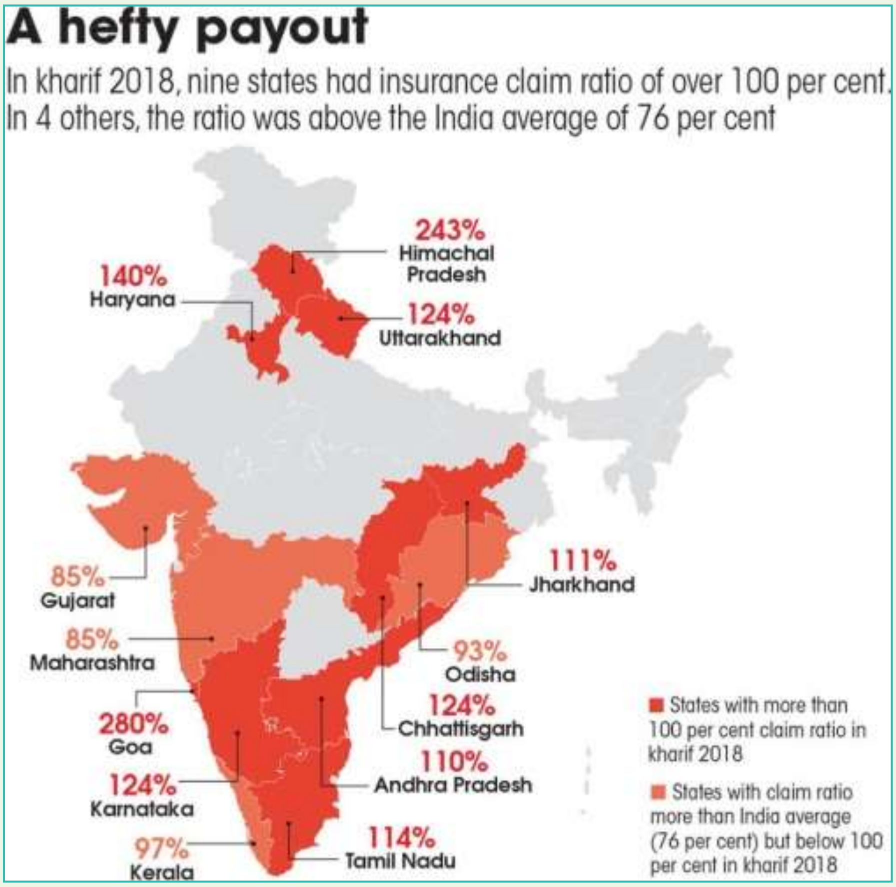
Three years and seven crop seasons after it was rolled out, nobody seems to be happy with the Centre's flagship farm insurance scheme, Pradhan MantriFasalBimaYojana. While the number of farmers enrolling under the scheme has gone down, insurance companies too are pulling out of it.

Ahead of the 2019-20 crop season, three private companies — ICICI Lombard, Tata AIG and Cholamandalam MS — did not bid for the rabi (mid-November to May) and kharif (June to October) seasons due to heavy losses in the 2018 kharif season.

This is a worrying trend as the scheme, rolled out during the 2016 kharif season, is largely spearheaded by private players. It started with 10 private insurance companies and just one public insurance company.

During rabi 2016-17, five more companies were empanelled, four of which were government-run. This was the season private player Shriram General Insurance exited from the scheme due to losses. In kharif 2017, two additional private companies joined the scheme taking the total list of empanelled companies to 17. Now, the scheme is left with 14 companies, nine of which are private-run.

While the companies are tight lipped over the reasons for the exit, data clearly tell the story. Profit of an insurance company depends on the claim ratio — the percentage of amount paid as claims in relation to the premium earned.



ICICI Lombard and Cholamandalam had made some profits in the first year of the scheme as their claim ratio was 79 per cent and 61 per cent respectively; but they made heavy losses thereafter. Tata AIG made losses in all the three years with over 100 per cent claim ratio.

In fact, most of the insurance companies incurred losses in 2018 kharif season, with nine states — which include Haryana and Maharashtra — recording over 100 per cent claim ratios.

In another four states, claim ratios were lower than 100 per cent but higher than the India average of 76 per cent, according to the Union Ministry of Agriculture and Farmers' Welfare.

In Goa, which had the highest claim ratio, insurance companies had to pay out Rs 2.8 for every rupee they collected as premium. In Haryana, it was Rs 1.4. The assessment of rabi 2018-19 is still underway, but companies say a large number of claims have already been filed.

There are two distinct reasons behind the high claim ratio: Surge in extreme weather events and alleged political interference in crop loss estimation.

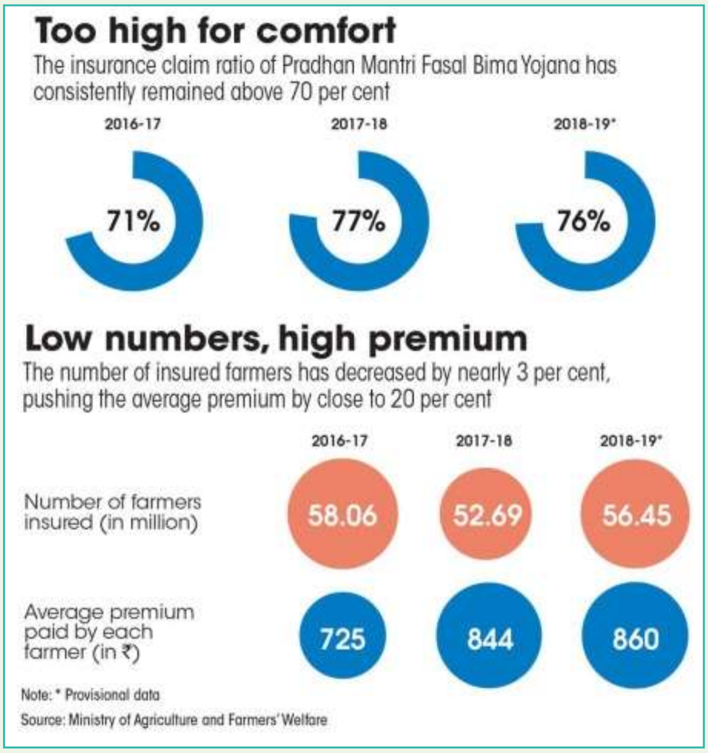
The data of 2016-17, updated till December 2017, shows extreme weather events affected 2.6 million hectares of cropped area in the country. In 2017-18, updated till December 2018, the share nearly doubled to 4.7 million hectares, suggests Envi Stats India 2019, released by the Ministry of Statistics and Programme Implementation.

Rajeev Chawdhary, chairperson and managing director of government-run Agriculture Insurance Company Ltd (AICL), says traditionally insurance companies would incur losses during the rabi season, which is associated with freak weather events, and earn profits during the kharif season. “So, we would make a profit of 10-15 per cent every year. This is no longer true,” says he.

What adds to the companies’ losses is the fact that the scheme covers farmers in the pre-sowing as well as the post-harvest periods, unlike traditional insurance schemes that cover just standing crops.

“Most farmers now apply for post-harvest losses, and no insurance company has the infrastructure to verify them,” says Chawdhary. He estimates the claims in 2019 kharif season will be the highest ever due to prolonged rainfall in Maharashtra, Karnataka and Madhya Pradesh that damaged key crops such as pulses and cotton.

A senior AICL officer, on conditions of anonymity, says in Maharashtra more than 2.5 million farmers had already applied for 100 per cent insurance money till the first week of November. “The insurance companies in the state will go bankrupt if they honour all the claims,” he adds.



Most insurance agents *Down to Earth* spoke to also allege that local politicians and state governments inflate the loss estimation under the crop cutting experiment, which is carried out to ascertain the extent of crop damage.

“In a way, private insurance companies are pitted against state governments who are blindly approving claims without site visits and then asking us to pay up,” says a private insurance agent in Gujarat. Media reports suggest that the Rajasthan government asked Tata AIG to pay 100 per cent insurance money to farmers in Barmer district for damages to groundnut crops in 2018 kharif season, even when the company claimed that groundnut was not even sown in the area.

“Because of the political influence, farmers do not cooperate with us,” says the private insurance agent. Even Chawdhary admits that the crop cutting experiment is not in favour of the insurance companies. He suggests the scheme should have the provision of hiring independent agencies that both government and insurance companies have faith in to carry out the crop cutting experiments.

The economic slump and its impact on the reinsurance market have also marred the scheme. “The commission that insurance companies receive when they reinsure the risk cover has gone down from 10 per cent to just 3 per cent in the past five years. The commission amount itself runs into crores of rupees and this dip has impacted the companies,” says an insurance market expert on anonymity.

Company officials say their risk has also increased because the number of farmers covered under the scheme has not increased over the years. In 2016-17, more than 58 million farmers were covered under the scheme, which dropped to around 56 million in 2018-19. This has pushed the scheme’s premium, which is shared by farmers, the Centre and states. A farmer in 2016-17 paid on an average premium of Rs 725 under the scheme, which increased to Rs 860 in 2018.

The losing interest of private players can seriously weaken the scheme. For starters, it will increase the risk burden of the government companies. Already, the five government-run companies under the scheme cover over 50 per cent of the disaster-prone areas. This is the reason the overall claim ratio of the government companies in the past three years have been substantially higher (86 per cent) than the private players (77 per cent). The remaining players are also expected to increase the premium amount to compensate for the higher risk. This will make farmers more unsure of the scheme.

Chawdhary believes the only way this logjam can be broken is if the Centre intervenes and increases the number of farmers under the scheme and ensures that it covers the entire country. “Currently, only 25 per cent of districts contribute the bulk of the premium. If the farmer base spreads to new places, companies can earn enough to remain in the scheme,” he says.

(The writer is Jitendra.)

TOP

Source

INSURANCE CASES

IRDAI slaps ₹1 cr. penalty on Cholamandalam MS – The Hindu – 9th January 2020

IRDAI has imposed a penalty of ₹1 crore on Cholamandalam MS General Insurance Company (Chola MS) holding that the firm had violated certain provisions of corporate governance guidelines for insurers.

The trigger for the action was an analysis of 2016-17 financial statements and specifically, advance payments of about ₹115 crore made by the insurer to four entities who, IRDAI said, were corporate agents, related parties and auto original equipment manufacturers (OEM).

Chola MS said that the advances were paid towards advertisements, manpower supply and risk assessment services.

In the order, the Insurance Regulatory and Development Authority of India Chairman Subhash C. Khuntia said three of the payments — ₹22.98 crore to Ashok Leyland; ₹9.39 crore to Chola MS Risk Services and ₹40.96 crore to DHFL Sales and Services — raise concerns on whether they were genuine business transactions.

On the ₹42.47 crore paid to Chola Insurance Distribution Services Pvt. Ltd. (CIDSPL) for branding services, IRDAI observed that CIDSPL was a group company of the insurer and also a corporate agent.

Chola MS had not submitted the entity’s memorandum/articles of association.

“By making these payments… the general insurer had contravened the provisions of Paragraph 6 of Guidelines for Corporate Governance for Insurers in India, through improper use of funds from the policyholders’ account and having inadequate control over the administration of funds. In view of the violation observed, the Authority… imposes a penalty of ₹1 crore,” the order, issued on January 7, said.

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Source

Curbing frauds in the insurance industry – IIFL – 8TH January 2020

India’s insurance industry is growing rapidly but the menace of frauds is draining some of these efforts. As per a PwC report, the insurance industry is the 15th largest in the world with written gross premiums of Rs 494.8bn in FY18. The insurance penetration measured by premiums as a percentage of the GDP has steadily risen to 3.69% in 2017 from 2.71% in 2001. However, fraud losses of Rs 40,000 cr across the sector leads to a bleed of about 8.5% of the revenue that the industry generates.

A fraudulent claim is usually composed of misrepresentation of facts coupled with an intent to avail a claim that is wrongful and invalid. While there is a bucket of invalid claims leading to fraud, there is an equally big problem at the front-end where misrepresentation or complete withholding of critical information can become the basis of an insurance policy being issued which could be claimed later leading to fraud.

In a recent survey by EY, more than 56% of life insurers noted that frauds have risen by 30%. The alarming rate of rise in frauds is detrimental to the health and credibility of the industry while it also reduces consumer trust and tampers their overall experience. Bad experiences make companies cautious and that cautiousness mars the customer experiences leading to potential customers having to think twice before writing that cheque leading to loss of revenue for the industry and so on. The problem is exacerbated when one considers the vicious cycle frauds tend to perpetuate. For instance, companies tend to do meticulous checks and verification of information while insuring someone if they suspect a high probability of fraud. Even if more than 90% of the customers are genuine, the whole bucket has to go through the strict checks and endure a longer process because of a few rotten apples.

Fraud losses were particularly prominent in India at a reported 65 per cent and lowest in Hong Kong at 34 per cent. The U.S. has the highest incidence of insurance fraud in the world at 80 per cent, as reported by the Annual Fraud Report of India published by Experian 2018-19. However, commendable efforts are being made by the industry to check the incidence of frauds across products. For instance, there's now a fraud registry with the Insurance Information Bureau of India which is proving to be very useful for insurers to conduct validations at the time of customer on-boarding or at claim payouts.

Increased focus on fraud mitigation is necessitated in part on account of the amendment to Section 45 of the Insurance Act, which now says that a policy claim cannot be called into question on any ground (including fraud) after expiry of three years from of issuance. This has provided a three-year window for insurers to make sure that their policy buckets are healthy and based on accurate information as they can't reject the claims later.

Insurers have always taken a strong stand against frauds and have bought into play both physical and digital assets to check frauds. By augmenting its process of physical live verification with data analytics using Artificial Intelligence, and automating work flows, insurers are aiming to bring down the fraud rate.

One such initiative run in-house is akin to a fraud-o-meter which ranks applications/policies basis certain risk scores assigned to them. Policy ranked as high risk are thereafter subject to higher due diligence either before or after policy issuance using physical and digital verification systems. Such rankings are an outcome of insurers' actual experience, fine-tuned using data analytics augmented with industry learnings. Data and technology are key contributors to insurers' efforts to fight against frauds, by helping obtain more information from potentially risky buckets to digitally verifying all the documents before creating the insurance contract so that the future risks can be mitigated. At the same time, it is important for the industry as a whole to adopt more digital practices to standardise workflows and improve the customer experience for genuine insurance buyers.

The risk from rising fraud has to be converted into a golden chance for the ecosystem to evolve to the next level where mitigation is not an afterthought but a core value of the business. As India's growth story continues, insurance penetration is set to rise on the back of digital proliferation as well as increased awareness. Fraud prevention has to be a cornerstone of the industry in order to promote ethical practices and maintain consumer trust. The rising sophistication of fraud across the world is a wake-up call to all of us that complacence has to give way to proactive vigilance if we are to develop India's insurance sector as one of the best in the world.

TOP

Source

NPS subscribers don't need to pay STT, DDT on stock investments through the vehicle – Mint – 9th January 2020

If you invest in stocks, directly or through mutual funds, you need to pay securities transaction tax (STT) as well as dividend distribution tax (DDT) whenever the company or stock distributes dividends. However, when you invest in stocks through the National Pension System (NPS), no such tax is levied.

NPS, in its private sector avatar called the All Citizen Model, allows up to 75% investment in equity for persons below the age of 50. Even after the age of 50, this limit is only gradually tapered off by 2.5% each year to finally reach 50% at the age of 60 when the account matures. Even government employees in NPS can invest up to 50% of their corpus in equities under the new rules announced in December 2018.

NPS investments in equity are made through pension funds, but it is the NPS Trust that invests on behalf of the subscribers. The NPS trust is exempt from paying both STT and DDT and that benefits the subscribers. Although mutual funds are also structured as trusts, they don't enjoy such exemption.

STT is charged at 0.1% of the transaction value. Hence, every time you buy or sell shares worth ₹5 lakh, you have to pay STT of ₹500. When your mutual fund buys and sells shares, the money is deducted from the net asset value (NAV). This doesn't happen in the case of NPS.

DDT is charged at 20.56% (including surcharge and cess) when a company pays a dividend. For example, if a company pays a dividend of ₹10,000, a sum of ₹2,035 will be deducted towards DDT and you will only get ₹7,965. If you have invested in the company through a mutual fund, the latter will get this reduced amount of ₹7,965 and your NAV will rise by a corresponding lower amount. However, there's no tax to pay in case of NPS and the full dividend of ₹10,000 will get credited to your account.

Note that if you opt for the dividend option on your mutual fund, you will be subject to a second layer of DDT. This amounts to 11.648% (including surcharge and cess) on equity-oriented funds and 29.12% (including surcharge and cess) on debt funds.

You can make up to three partial withdrawals, which are tax-free, from NPS on specific grounds up to 25% of your contributions, before the account matures.

Finally, if you directly hold stocks and receive dividends of more than ₹10 lakh in a year, you have to pay another layer of tax at 10% on the amount received. This is once again not applicable if the same amount of dividend gets added to your NPS corpus.

The STT and DDT exemptions may seem small, but their effect can compound over time. Consider these costs when choosing a retirement product. Funds and stocks can also help build a retirement corpus, but they do not have as many tax advantages as NPS.

(The writer is Neil Borate.)

Source

TOP

Public Provident Fund Act, 1968 stands repealed: Will it impact PPF investors? – Financial Express – 8th January 2020

The government has recently brought about a significant change in the management of post office small savings schemes. The Government Savings Certificates Act, 1959 and the Public Provident Fund Act, 1968 have been merged with the Government Savings Banks Act, 1873, and all of them will now come under the Government Savings Promotion Act. This means, your investments in PPF will not be as per the PPF Act anymore. The Government Savings Certificates Act, 1959 and the Public Provident Fund Act, 1968 stand repealed.

Back in February 2018, the government had proposed about this and stated that relevant provisions of the Government Savings Banks Act, 1873, Government Savings Certificates (NSC) Act, 1959 and the Public Provident Fund Act, 1968 would stand subsumed in the new amended Act without compromising on any of the functional provisions of the existing Act.

A big change will be that instead of PPF Act, it will now be Public Provident Fund Scheme, 2019 that will

determine the rules determining the operation of the PPF scheme. The PPF rules are kept the same and there is no major change in any of the features of the PPF scheme. All deposits made in the accounts or certificate shall be deemed to be made under the relevant provisions of the Government Savings Promotion Act, 1873. There have been a few cosmetic changes, however, that does not mean anything functionally will change for PPF depositors. The government has retained all existing protections while consolidating PPF Act under the Government Savings Banks Act, 1873.

As per the government of India notification dated December 12, 2019, it is also made clear that "Amount standing to the credit of any account holder shall not be liable to attachment under any order or decree of any court in respect of any debt or liability incurred by the account holder." Therefore, in PPF, the Protection of credit balance from attachment will continue to be there.

Some of the cosmetic changes in the PPF scheme include the minimum initial deposit of Rs 500 instead of Rs 100 earlier, making any number of monthly deposits as against 12 in one year earlier. Further, the nomenclature of relevant Forms have been changed. For opening PPF account instead of Form A, it will now be Form 1.

In addition to Public Provident Fund Scheme, 2019, the government has notified the following schemes:

- Sukanya Samriddhi Account Scheme, 2019
- Senior Citizens' Savings Scheme (SCSS), 2019
- National Savings (Monthly Income Account) Scheme, 2019
- National Savings Recurring Deposit Scheme, 2019
- National Savings Certificates (VIII Issue) Scheme, 2019
- KisanVikas Patra Scheme, 2019
- National Savings Time Deposit Scheme, 2019

Importantly, PPF will continue to enjoy the exempt-exempt-exempt (E-E-E) tax benefit status as earlier. PPF subscribers or depositors of MIS, Time Deposits, SCSS, SukanyaSamriddhi Account Scheme or holders of NSC, KVP certificates need not be concerned about their money. The investments continue to be governed by the government and carry a sovereign guarantee.

(The writer is Sunil Dhawan.)

Source

TOP

EPF likely to fetch lower returns – Mint – 06th January 2020

Millions of salaried workers may soon get lower returns on their mandatory investment for the fiscal ending 31 March. The Employees' Provident Fund Organisation (EPFO) is likely to reduce the interest rate offered to its subscribers by 15-25 basis points for this fiscal, two government officials said on condition of anonymity. A basis point is one-hundredth of a percentage point. This comes in the wake of EPFO offering its subscribers an interest of 8.65% in the 2018-19 fiscal after taking seven months to convince the finance ministry of the viability of its proposal.

The decision also comes against the backdrop of the economic downturn, lower yields for debt market instruments, including government securities, and fixed deposits and lower interest rates on similar products such as public provident fund and government provident fund that are likely to be factored in when EPFO announces its 2019-20 rate of interest, said one of the two officials cited earlier. The retirement fund manager is expected to announce the annual rate of interest by the end of January after a series of meetings of its investment officials, executive committee members and the central board of trustees (CBT), the other official said.

"The economic downturn was visible this year. The falling returns on debt instruments will force the EPFO to tinker its 2019-20 payout downwards," the first official said. "The long-term fixed deposits and some bond yields have gone down by between 50 and 90 basis points in the last one year and you cannot ignore those indicators." "The 10-year benchmark government securities or G-Secs went down between 85 and 90 basis points between January 2019 and January 2020" and that would be a drag on EPFO's earnings, said the second official.

A 100-basis point fall in interest rates in the market has the potential to impact the EPF payout by between 55 and 70 basis points, the official said. As such, EPFO will find it difficult to offer 8.65% interest this fiscal, especially as it invests 85% of its annual accruals in the debt market and 15% in equities through exchange-traded funds. "Thus, a 15-25 basis point cut in EPF interest rate this fiscal should not come as a surprise," said the second official.

Two more developments could force a rate cut, according to the first official. First, investments made in small savings instruments such as public provident fund and government provident fund are at present earning only 7.9% interest. Second, EPFO this year has found it hard to recover some of its previous investments in crisis-ridden shadow lender Infrastructure Leasing and Financial Services Ltd and troubled mortgage lender Dewan Housing Finance Corp. Ltd. Despite attempts, about ₹1,300 crore of workers' money, invested directly by the retirement fund manager, is stuck with the two firms, Mint reported on 14 August. Employees' representatives in CBT confirmed that 2019-20 is likely to be a tough year, but said they would push EPFO to maintain the 8.65% rate of return for the current fiscal. "Yes, we know it's a tough year, but we shall push for maintaining 8.65% EPF payout," said Prabhakar Banasure, a CBT member representing employees. "We are waiting to see what the labour ministry and EPFO bring to the table in terms of their income this year when we meet."

A labour ministry spokesperson chose not to comment. CBT, led by the labour minister, is the apex decision-making body of EPFO, which manages a corpus of over ₹12 trillion and has an active subscriber base of more than 60 million. CBT, comprising representatives of the government, employers and employees, discusses the retirement fund manager's earnings for the year before deciding the provident fund interest rate that needs to be approved by the finance ministry. The finance ministry had kept on hold the EPFO payout of 8.65% in 2018-19 for almost seven months. One of the contentions last year was that after an 8.65% payout, EPFO was left with a surplus of ₹151 crore in 2018-19, much less than the surplus of ₹586 crore in 2017-18.

(The writer is Prashant k. Nanda.)

Source

TOP

National Pension Scheme for traders fails to gain traction – The Hindu Business Line – 5th January 2020

The National Pension Scheme for Traders and Self-Employed Persons has failed to gain traction as only about 25,000 persons have opted for the scheme as against the government's target to enrol 50 lakh by March-end.

As per government data, only 84 traders and self-employed persons from Delhi have registered for the scheme so far, while 59 persons from Kerala, 54 from Himachal Pradesh, 29 from Jammu and Kashmir and two from Goa have registered. No one has registered for the scheme in Lakshadweep and Mizoram.

Uttar Pradesh has the highest number of registrations with 6,765 persons, followed by Andhra Pradesh (4,781), Gujarat (2,915), Maharashtra (632), Bihar (583), Rajasthan (549), Tamil Nadu (309), Madhya Pradesh (305) and West Bengal (234).

The National Pension Scheme for Traders and Self Employed Persons (Pradhan Mantri Laghu Vyapari Maan-dhan Yojana) is a voluntary and contribution based central sector scheme. The government launched the scheme, entailing monthly minimum assured pension of Rs 3,000 for the entry age group of 18-40 years after attaining the age of 60 years, with effect from July 22, 2019.

Under the scheme, the government makes matching contribution in the subscribers' account. Commenting on the lukewarm response to the scheme, Confederation of All India Traders (CAIT) Secretary General Praveen Khandelwal said the entry age and the premium for the scheme should be raised to encourage more traders to join the scheme.

"Rs 3,000 to be given after 30 years of paying premium will hardly have any value. Why have traders aged between 40 and 55 years been kept out of the scheme? The government can increase premium for this age group (40-55) instead of depriving them of the scheme's benefits. These are two big drawbacks," Khandelwal told PTI.

He said the traders' body had suggested to the government that a provident fund like provision be made whereby a fund is created out of the total tax paid by a trader throughout his/her life, out of which every trader can be paid monthly pension upon attaining the age of 60.

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Source

IRDAI CIRCULARS

Gross direct premium underwritten for and up to the month of December, 2019 is available on IRDAI website.

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IRDAI issued guidelines on Standardization of General Clauses in Health Insurance Policy Contracts.

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List of Valid Insurance Brokers as on 31st December, 2019 is available on IRDAI website.

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List of corporate agents registered with the authority as on 31 Dec 2019 is available on IRDAI website.

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GLOBAL NEWS

Global insured losses fell to $50bn in 2019 – Punch – 6th January 2020

Insured losses from natural catastrophes fell to $50bn in 2019 from $84bn in 2018. The Swiss Re Group disclosed this in its report on the 2019 global catastrophe. Insured losses from man-made disasters declined to $6bn from $9bn.

Total economic losses from natural and man-made catastrophes fell to around $140bn in 2019 from $176bn in 2018, according to preliminary sigma estimates from Swiss Re Institute.

Global insured losses were estimated to be around $56bn, down from $93bn in 2018 and below the annual average ($75bn) of the previous 10 years. Tropical cyclone activity in the second half of 2019 pushed overall insurance losses higher after a benign first-half of the year.

As in recent years, a number of smaller and mid-sized loss-generating disaster events (so-called secondary perils) accounted for more than 50 per cent of the insured losses. Globally, more than 11,000 people died or went missing in disaster events in 2019. Natural catastrophes accounted for $133bn of the year's around $140bn in global economic losses.

The report said the remaining $7bn came from man-made disasters. Tropical cyclones inflicted devastation in different parts of the world. In the first half of the year, cyclones Idai and Kenneth in Mozambique and neighboring countries, and Cyclone Fani in India, left trails of destruction and suffering to local communities.

The events claimed around 1 400 victims. Insured claims were very low given the low insurance penetration in the impacted regions. It stated that in the second half of 2019, the Bahamas and North Carolina in the US were hit by Hurricane Dorian, which caused insured losses of about $4.5bn. Japan was hit by two devastating typhoons within a short period. In mid-September, Typhoon Faxai hit the Kanto region that includes the Greater Tokyo Area, with associated insured losses estimated to be approximately $7bn.

Soon after, in early October, Typhoon Hagibis struck the same region, causing further widespread damage across Japan. Total insured losses from Hagibis were estimated to be around $8bn, Swiss Re stated. After some years of relative calm, the experience of the last two years reaffirms that typhoon risk remained a major vulnerability for Japan. Faxai and Hagibis followed Typhoon Jebi in 2018, which resulted in substantial insurance losses of close to $13bn. The 2019's typhoons further underscored the high exposure of urban regions in Japan to both typhoon wind and flood risks, in spite of the presence of mitigation infrastructure.

While climate change could not be ruled out as an amplifying risk factor, it was certain that the last three events confirmed the historical pattern of devastating Japanese typhoons in the middle of the 20th century. Last year also saw heat waves and dry spells, with new temperature highs recorded in several locations around the world, from Europe to Australia.

Devastating wildfires affected Australia, Indonesia, the United States, Canada, the Amazon region and Siberia, among others. There were devastating floods in many regions in 2019. Severe monsoon rains led to extensive flooding in India, Bangladesh and Nepal, and there were repeated flood events in other regions, such as China, the US, Europe, Canada and Australia.

TOP

Source

Vietnam: Insurance market sees premium revenue soar by 20% in 2019 – Asia Insurance Review

The insurance industry posted revenue of VND160.18tn ($6.9bn) in 2019, up 20.54% against the previous year, according to the Ministry of Finance's Insurance Supervisory Authority (ISA).

This marked the sixth year in a row that the Vietnam insurance market has achieved a premium growth rate of over 20%. In 2018, total premium revenue surged by 24%.

Of the total insurance premiums in 2019, non-life insurance premiums stood at nearly VND52.39tn while life insurance premiums amounted to VND107.79tn.

Besides maintaining a high growth rate, insurance companies increased their total assets by 15.3% to VND454.38tn at the end of last year. According to experts, the domestic insurance market should continue to thrive thanks to rising living standards and GDP growth of more than 6% annually forecast for the next three years.

Thus, for 2020, the insurance market is forecast to see a growth rate of 18.42% in premium revenue which would total VND188.73tn. Insurers are also expected to increase their total assets by 13.3% to VND514.80tn by the end of this year.

To meet the forecast, Mr. Thu Phuong, deputy director of ISA, said the authority would continue to improve mechanisms and policies, focusing on restructuring to make the insurance market develop transparently, safely and efficiently as well as in line with international standards, reported Vietnam News Service.

“In particular, ISA will focus all resources to complete the revised Law on Insurance Business as well as regulations to guide the implementation of the law,” Mr Phuong said.

He added that in order to further develop the market and improve the quality of insurance services, the ISA would continue to consider and submit to the Ministry of Finance the applications of eligible foreign investors for licences in the insurance and reinsurance sectors in Vietnam.

Besides deploying agricultural products, the regulator will also coordinate with other related agencies to research and deploy other new insurance products in 2020. Vietnam has 66 insurance companies operating in it at present, offering more than 850 non-life insurance products and 450 life insurance products.

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Source

Australia: Regulators will need to decide nature of parametric products - Asia Insurance Review

Regulators will have to determine their approach towards parametric products as these have become established internationally as a significant product segment, according to the global law firm Clyde & Co.

Mr Dean Carrigan, partner, and Mr Johann Spies, special counsel, at Clyde & Co, in a blog which is part of the law firm's *Insurance Predictions 2020* series, say that with the growth of the market in parametric products, Australian regulators will need to grapple with the nature of such products in the same manner as regulators globally have had to. As parametric products do not react to loss in the same manner as traditional insurance products, these products can arguably constitute insurance products or capital markets products, namely derivatives, the authors say.

Given that parametric products by their nature contain certain marks of a derivative arrangement but nonetheless as a whole may have the provision of insurance as their principal objective, regulators are likely to have to assess each individual product to determine whether they are more appropriately categorised as insurance products or derivatives. Given the likely continued growth in this market, however, regulators will have to determine their approach sooner rather than later.

The authors also say that parametric insurance products may also be specifically attractive in the Australian market due to the nature of payments under these policies, which are generally structured as pre-agreed sums or calculated based on an index but informed by objective and measurable external data such as the speed of cyclone or hurricane winds.

As the criteria are objective and measurable, these products allow insurers to service remote locations and increase speed of claims payments compared to traditional insurance products in which the loss would have to be proved by the policyholder.

With the large geographic distribution of population and risks in Australia, and areas which are susceptible to increased risk consequent to climate change, the advantages of parametric insurance products will drive substantial growth for these products in Australia.

TOP

Source

China: Authorities to promote annuities and endowment insurance - Asia Insurance Review

China will encourage the development of annuities and endowment insurance to diversify people's investments, reported Reuters quoting an article in the government-backed Securities Times.

"The key consideration is to cultivate a multi-layer capital market," the newspaper reported, quoting Mr Xiao Yuanqi, spokesman of CBIRC.

"There'll be part of savings flows to the institutional investors for sure, then the professional investors can allocate those funds to bonds and equities investment," Mr Xiao had said in a media briefing earlier this week.

The briefing was held days after a statement from the banking and insurance regulator that it would promote the conversion of household savings into long-term funds in the capital markets.

"We didn't mean to encourage direct purchase of shares from household savings," Mr Xiao said.

TOP

Source

Taiwan: Revised life insurance product regulations are credit positive, says Moody's - Asia Insurance Review

Upcoming revisions to regulations on life insurance products in Taiwan will be credit positive for life insurers, said Moody's Investors Service's analysts. It is expected that revised regulations will reduce insurers' reliance on spread gains, widen their product margins and reduce incentives for further accumulation of asset risks

Effective from 1 July this year, these regulations stipulate that insurance products are must meet minimum death benefits or policy reserves ratios that are in accordance with a policyholder's age. They also prohibit the launch of products with negative contractual service margins, a profitability indicator introduced under IFRS17.

The new rules are also in line with the regulator's goal to promote life insurance as a preventive tool against mortality risk and reduce its role as an alternative to bank savings, said Moody's. They also reflect the regulator's emphasis on improving the industry's profitability and capital profile to prepare for the IFRS17 adoption.

Meeting minimum death benefits or policy reserves ratios

Currently, in the Taiwanese life insurance market, the most prevalent products are savings-oriented with low protection elements. The revised regulations will improve the coverage of such products as the requirements ensure that insurers include a certain degree of death coverage.

Moody's expects the revised rules to increase the proportion of benefits paid upon death in relation to savings and survival benefits. This will raise the contribution of mortality gains to insurers' profitability over spread gains.

The new rules are also expected to result in more balanced profit drivers and improve income stability as the industry's current reliance on spread gains has added volatility to its profitability.

Prohibiting products with negative contractual service margins

The product margins of insurers will be supported with the introduction of a contractual service margin test as it will discourage them from offering aggressive policy returns, said Moody's.

High guarantees on policy returns not only raise insurers' cost of liabilities but also put them at risk of incurring potential negative spreads especially amid the prolonged period of low interest rates.

The revisions are also credit positive for asset quality because they will reduce the incentives of insurers to increase their already sizable foreign-asset exposures that are offering higher returns than the fixed income instruments issued in Taiwan and in NT$. However, these exposures introduce significant foreign-exchange risk because they are only partly hedged or backed by foreign-currency policies.

One adjustment risk from the announced revisions is that life insurance policies could be perceived as more expensive by yield-sensitive customers which could trigger a drop in premium sales especially among those insurers mainly reliant on the bancassurance channel and savings products.

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Source

Taiwan: Regulatory chief outlines major challenges facing insurance industry - Asia Insurance Review

Taiwan's insurance industry currently faces major challenges, including long-term low interest rates, an aging population, the FinTech wave and requirements to comply with international standards such as IFRS 17, the chairman of the Financial Services Commission (FSC), Mr Wellington Koo, has said.

Speaking at an economic and insurance forum last month, Mr Koo said that in the current low interest-rate environment, consumers prefer savings products, and sales channels try to lure customers by promoting plans with high declared interest rates.

On the demographics side, according to the estimates by the National Development Council, the proportion of the elderly population in Taiwan will exceed 20% by 2026, making the island an ultra-aged society. Mr Koo said that the FSC is committed to promoting protection insurance to address this.

With effect from 1 July this year, life insurance companies are required to ensure that they provide enough death benefits for policyholders, the FSC says. Last month, it announced a minimum death benefits to policy account value ratio.

Insurance Bureau director Mr Tsai Huo-yen told The Taipei Times that the new rules state that new policies should offer death benefits of at least 1.9 times the account value for policyholders aged 16 to 30, the age bracket that has the lowest risk of accidental death. The minimum ratios are lower for older age brackets.

In the long run, the new rules would ease the intense competition among life insurers, which had to take the high risk of overseas investments to offer high returns for policyholders, he said. Explaining the new rules, he said, "While life insurance policies originally aimed to protect policyholders, they have become more of a wealth management tool, with many insurers promoting high survival benefits instead of death benefits."

In InsurTech, the FSC has been easing regulations covering online insurance business. The regulator has gradually relaxed the types and quanta of insurance plans, and has proposed the use of biometric technology in identity verification.

It hopes to build up a digital insurance market. Mr Koo added that the FSC is encouraging the insurance industry in Taiwan to comply with IFRS 17.

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Japan: Major insurers hike motor insurance premiums - Asia Insurance Review

The four companies are: Tokio Marine & Nichido Fire Insurance, Sompo Japan Nipponkoa Insurance, Mitsui Sumitomo Insurance, and AioiNissay Dowa Insurance.

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The reasons for the price hikes include a consumption tax hike in October last year and the implementation of the revised Civil Code next April, which will increase the levels of compensation required for accidents resulting in injury or death.

In the revised Civil Code, the statutory interest rate will be lowered from the current 5% to 3% in April. Compensation for people injured or killed in traffic accidents is calculated by discounting the victims' potential income by the statutory interest rate, meaning that the amount of compensation will increase when the rate is lowered, according to a report by JiJi Press.

In addition, there is a subdivision of the rate classification system, and insurance premiums differ depending on the class.

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Philippines: Insurance regulator to keep minimum capital requirement at current level - Asia Insurance Review

The Insurance Commission (IC) plans to limit the minimum capital requirement for local insurers at the current level of PHP900m ($17.6m).

This indicates that the insurance regulator would not press on to require insurers to raise their minimum capital to PHP1.3bn by 2022.

In a text message, Insurance Commissioner Dennis Funa said the IC would make a recommendation to Finance Secretary Carlos Dominguez to amend the Insurance Code, particularly in regards to the capitalisation requirement for insurance companies.

“I will recommend to Secretary Dominguez that we stop at PHP900m, meaning, I will suggest that we forego the 2022 increase to PHP1.3bn as stated in the amended Insurance Code,” he said.

Under the current Insurance Code, new players in the industry are required to have PHP1bn in paid-up capital. Existing insurers must have a net worth of at least PHP250m by 30 June 2013; PHP550m by 31 December 2016; PHP900m by 31 December 2019 and PHP1.3bn by 31 December 2022.

MrFuna said that proceeding with the PHP1.3bn required capital by 2022 would mean the Philippine insurance industry would then have the highest capital requirement for insurance companies within the Southeast Asian region.

The IC’s recommendation came after a review of its policies, that was prompted by lobbying by both life and non-life insurers, reported the Philippine Star.

The president of the Philippine Life Insurance Association, Mr Hans Looze koot, said that PHP900m should be enough to ensure that the insurance industry is well-capitalised, and that it is at par with other insurers in the region.

In an advisory, Mr.Funa reminded all insurance companies in the country to comply with the increase in minimum net worth requirement of PHP900m that took effect on 31 December 2019.

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Indonesia: Property premium rates unlikely to rise in short term despite flood losses - Asia Insurance Review

The executive director of the Indonesian General Insurance Association (AAUI) Dody Achmad Sudiyar Dalimunthe has said that the floods that struck Jakarta, Bogor, Depok, Tangerang, and Bekasi (Jabodetabek) in recent days have the potential to cause an increase general insurance claims.

However, he added that although the disaster that struck was quite large, it would not significantly affect the risk management of the general insurance industry.

At present, risk management from the industry is still relatively controlled. Separately, a senior insurance industry executive said that insurance premiums, especially those for motor and property, are unlikely to be increased in the near future despite increased risk due to the extreme weather.

Mr SahataLumbanTobing, the business development director of AsuransiJasa Indonesia, or Jasindo, told Bisnis that the higher risk from bad weather is still more or less covered by current premium rates.

In addition, "there will not be an increase in premiums because the nature of the loss [due to extreme weather] has not been calculated and the increase in premiums needs an industry agreement," MrSahata said. Any change in the amount of premiums will take into account changes in risk that need to be protected. Changes to rates and risk will be discussed by the insurance industry and then determined by the Financial Services Authority (OJK).

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Australia: Insurers can absorb bushfire claims - S&P - Asia Insurance Review

Australian insurers can absorb growing insurance claims arising from bushfires within the current ratings, S&P Global Ratings said yesterday. Industry wide loss estimates stemming from fires continue to rise and remain somewhat uncertain. Nevertheless, for individual insurers, the exposure is at a moderate level, and well covered by their natural peril allowances and extensive external reinsurance protection.

The bushfire events that began relatively early in September 2019 are vast and continuing across the south-eastern states of Australia. While weather-related natural peril events are a real and regular occurrence in Australia, the recent extremes in drought and climate conditions appear to have exacerbated the reach, longevity, and intensity of the current bushfire season.

Loss estimates expected to rise

In S&P Global Ratings' view, loss estimates are likely to be at the higher end of initial estimates. That's because the international credit rating agency believes insurers will be sympathetic and pragmatic in their assessment of claims, given the magnitude of events and the heightened focus on governance and behaviour in the banking and insurance sectors since the Royal Commission.

According to the Insurance Council of Australia, property casualty insurers' exposure to the bushfire events consists of over 5,000 claims totallingA$375m ($260m) as of 3 January 2020. These figures could easily double, in S&P Global Ratings' view as the season continues.

The agency sees the bushfire claims, along with the recent hailstorm claims, as likely to exceed insurers' usual natural peril allowances, leading to some moderation in profitability. In addition, the events could also pressure premium rates in future as insurers are forced to pass on likely higher reinsurance costs.

However, S&P Global Ratings notes that major insurers have strong stop-loss and aggregate reinsurance programmes to absorb losses at or around their natural peril allowances, as well as further extensive catastrophe reinsurance protection.

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Hong Kong: Insurer and healthcare provider tie-up supports patients facing critical illness - Asia Insurance Review

A newly-forged partnership between HSBC Life Hong Kong and US-based global healthcare provider Preferred Global Health (PGH) provides policyholders of the HSBC Health Goal Insurance Plan (HGIP) with access to 'Global Medical Care Services'. This refers to personalised care and consultation services to enable customers and their families to make informed decisions about their treatment plans and receive ongoing guidance and support.

"We understand customers are becoming more health conscious; that is why we have introduced various value-added solutions - from dementia screening to hereditary cancer genetic tests - that can truly help customers better understand their health, and proactively mitigate and prevent health risks. Our partnership with PGH is taking our commitment to our health proposition to the next level," said HSBC Life Hong Kong CEO Edward Moncrieff.

According to him, HGIP offers personal assistance for patients when diagnosed with critical illness and 'Global Medical Care Services' provides best-in-class bespoke medical advice, ensuring they have access to the best possible treatment.

Customers insured with HGIP can leverage 'Global Medical Care Services' to connect with leading hospitals and specialists in cancer, heart disease and stroke - the top three killer diseases in Hong Kong, to receive the optimal treatment plan available to them.

'Global Medical Care Services' will provide the following services:

'Diagnosis Verification and Treatment Plan' confirms or provides further diagnosis and helps develop an optimal treatment plan. Each medical case will be reviewed in-depth by multi-disciplinary teams of Harvard-level specialists in the US, enabling patients to make informed decisions about their course of treatment.

'Doctor-to-Doctor Dialogue' facilitates professional collaboration between the local doctor and medical experts via secure video conferencing, to discuss and develop an optimal treatment plan. Patients can choose to stay close to home to receive their treatment.

'US Care Management' arranges all the medical appointments on the patients' behalf with personalised concierge service, if they opt to be treated in the US. The all-round concierge service includes the arrangement of travel, accommodation, hospital, billing and after-care for patients.

"Global Medical Care Services are designed to remove the risk of preventable medical errors and will allow customers to make informed decisions not through the assistance of one single reviewing doctor but a team of specialists," said Preferred Global Health chairman and CEO David Fried.

There was over 1.5m preventable medical errors identified worldwide in 2018 resulting in avoidable hardships to patients' lives and a huge cost burden. The finding was revealed in a research article from the 'Health Affairs' journal. While Hong Kong's healthcare system is well-reputed for its quality and efficiency, receiving diagnosis verification and treatment plans from prominent multi-disciplinary teams of specialists can help ensure the best outcomes for patients. This allows patients to make informed decisions about their course of treatment.

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China: Regulator sets 2025 goal for high quality development of insurance industry - Asia Insurance Review

China's banking and insurance regulator has unveiled a guideline that aims for the high-quality development of the two sectors in the next few years.

By 2025, China expects the banking and insurance system to have a better financial structure with multiple layers, broad coverage and diversity, according to the Xinhua News Agency citing a statement issued by the CBIRC.

In the insurance arena, China expects insurance institutions to play a larger role in risk coverage, and hopes to see further development of foreign banking and insurance institutions and foster the unique advantages of non-banking financial institutions.

The regulator is also encouraging the greater development of corporate annuity and endowment insurance businesses. The CBIRC wants wealth management, insurance and trust products to be directly involved in financing and cultivate long-term value investment opportunities.

The financial regulator says that it will implement a series of measures to back the nation's troubled smaller banks and insurers while continuing a clampdown on shadow financing.

From now to 2025, the country hopes to establish a modern financial enterprise system with Chinese characteristics by improving corporate governance, as well as a financial product system that meets market demand with diverse and customised products.

The guideline particularly stressed the need to create financial products that support the real economy and improve people's lives, including those facilitating strategic emerging industries, advanced manufacturing, technological innovation and agricultural development.

Efforts should be made to prevent and dissolve risks in the banking and insurance industries, while banks and insurance institutions should prevent capital from illegally flowing into the property market, the guideline says.

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