



# Insurance Institute of India

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## INSUNEWS

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### • Quote for the Week •

“What we really are matters more than what other people think of us.”

Jawaharlal Nehru

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### Insurance Industry

#### **India: Govt to review state-run insurance companies – Asia Insurance Review**

The Finance Ministry will soon hold a performance review meeting of all state-run insurance companies, including the Life Insurance Corporation.

The review of general insurance companies will set the pace for consolidation, said a Finance Ministry official. The underwriting losses of state-run general insurance firms increased by 43.89% to INR155.91 billion (US\$2.41 billion) for the financial year ended 31 March 2017, from INR108.35 billion for the previous year, reported *The Economic Times*.

Referring to the three unlisted government owned non-life insurers—National Insurance, United India Insurance, and Oriental Insurance—that are to be merged, he said: “We are hopeful that the firms will improve their performance, and we will be able to merge these companies in the next six months and after that we will look at listing.” All the three insurers have already been directed to align their operations in preparation for their merger.

“The Finance Ministry review will also be an opportunity for the three insurers to undertake together a preparatory exercise for the reorganisation of offices and manpower,” said the official.

The government wants the general insurers to contain their underwriting losses. As per the latest report available from the IRDAI, Oriental Insurance and United India Insurance reported a solvency ratio of 1.11 and 1.15, respectively, below the stipulated minimum solvency ratio of 1.50 at 31 March 2017.

“We are evaluating all options as to how the combined entity can be strengthened given that the losses of public sector firms have not come down significantly,” said the Finance Ministry official.

The merger would result in the largest general insurer in India, with a market share of 30%.

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### IRDAI Regulation

#### **Irdai takes segment-wise approach for revising motor TP premiums - Financial Chronicle – 30th March 2018**

Irdai has revised third party motor insurance premium rates for the next fiscal by taking a segment-wise approach. It has lowered the rates for vehicles in some segments, retained some and has increased some taking the claims experience into account.

In case of two-wheelers, Irdai has brought down the premium rates for vehicles with less than 75 cc by 24 per cent, from Rs 569 this year to Rs 427 next fiscal. There is no change in rates of two-wheelers between 75 cc and 150 cc.

However, those with less than 350 cc will have to pay 11 per cent more premium, from Rs 887 to Rs 985. The rise in premium is 128 per cent when it comes to two-wheelers above 350 cc from Rs 1019 to Rs 2323.

For private cars, small segment ones with less than 1,000 cc will see 10 per cent dip in premium rates, from Rs 2055 to Rs 1850. For other cars, there is no change in premiums.

For goods carrying public carriers with gross vehicle weight (GVW) less than 7,500 kg, the premium will remain same.

Rates will go up by 23 per cent for vehicles less than 12,000 kg. There will be 12 per cent rise in those with GVW less than 2,00,000 kg, 26 per cent for carriers with GVW less than 4,00,000 kg and 16 per cent for those above it.

In case of goods carrying private vehicles, the rates have come down for vehicles with GVW less than 7,500 kg but will remain same for those with GVW less than 2,00,000 kg and 4,00,000 kg. The rates have gone up for all carriers with GVW less than 12,000 kg, and those with less than 4,00,000 kg but higher than 2,00,000 kg.

“Irdai is taking an analytical approach for revising the rates. A few years back the rates were increased across the board. But now the regulator is looking at different segments in detail, evaluating the claims experience and taking into account the predictions for the next year before deciding the rates. This is a welcome move by the regulator and the system has now started functioning well,” said Sanjay Datta, chief (underwriting claims & reinsurance), ICICI Lombard.

The rates will be applicable from April 1. In the notification, Irdai said: “After examining the comments received from various stakeholders, the authority has now revisited the premium rates of a few categories vis-a-vis the exposure draft and has smoothened some rates”.

Irdai has also advised insurers to be mindful of the concerns expressed by vehicle owners about the availability of insurance. “Considering the mandatory nature of Motor Third Party Liability Insurance, insurers are advised to ensure that it is made available at their underwriting offices and through all available channels of distribution. The authority will treat any complaint of non-availability of insurance or use of methods to deny/delay the insurance cover, seriously”, it said. Further, insurers are not permitted to cancel the current insurance policies and issue fresh policies to effect new premium rates, it added.

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## Life Insurance

### *A pension plan that guarantees future returns now – Mint – 28th March 2018*

HDFC Standard Life Insurance Co. Ltd has launched an annuity product called HDFC Life Pension Guaranteed Plan. Annuities are pension products that offer a fixed sum every year. You can buy this product in two ways: deferred and immediate. A deferred annuity requires you to first build a corpus, and then use it to buy an annuity. For an immediate annuity, you don't have to accumulate a corpus; just take your money and buy an annuity from any insurer. The plan by HDFC Life offers both options, and goes a step further.

The plan allows you to lock in your annuity rate at the time of buying the deferred annuity option. In a typical deferred annuity plan, you invest first and then use this money to buy an annuity at the then prevailing interest rate. In that sense, the plan by HDFC Life takes care of the interest rate risk. But is that enough?

#### **Immediate annuity**

The immediate annuity plan offers two options—annuity for life; and annuity for life with return of purchase price. The first option pays annuity for life. On death of the annuitant, the benefits stop. In the second option, the plan returns the purchase price to the nominee. You can take it on an individual basis or on a joint life basis (annuity will continue as long as one of the annuitants is alive, and return the purchase price on death of both annuitants under the second option).

Annuity rates are guaranteed for life. Typically, the older you are the higher is the annuity rate.

#### **Deferred annuity**

Under this option, you buy the annuity upfront and lock in to the current annuity rate; pay-outs happen later. This option comes with a return of purchase price variant with single and joint life options. The maximum deferment period is 10 years.

The annuity pay-out rate depends on factors such as age and deferment period: the older you are and higher the deferment period, the more is the annuity pay-out. On annuitant's death, the return of purchase price option pays a minimum of 110% of the purchase price as death benefit.

“This policy offers better liquidity options than other annuity instruments. It offers a loan facility during the deferment period and also surrender at any point for the return of purchase price options. The surrender amount will be the present value of all future benefits discounted at the prevailing interest rate plus 2%,” said Srinivasan Parthasarathy, senior executive vice president, chief actuary and appointed actuary, HDFC Standard Life Insurance Co. Ltd.

#### **How does it work?**

Under the immediate annuity option for a sum of Rs50 lakh, a 60-year-old will get life annuity at a rate of 8.12% and the return of purchase price option will come at 6.57%. (You could instead consider the insurer’s new immediate annuity plan that offers a better rate.) For deferred annuity pay-out, advertised annuity rates are up to 13%. But this is not how you should look at this product.

The higher interest rate is due to the fact that you commit a big corpus in advance. You forgo an opportunity to get returns on this. So, the time value of money actually erodes the value of money. It’s on this eroded value that the annuity rates apply. Say, a 50-year-old buys deferred annuity with a deferment period of 10 years, with a purchase price of Rs50 lakh. The product offers a guaranteed pay-out of Rs6.27 lakh per annum or an annuity rate of about 12.54%. But this can be misleading as this is the rate at which the payouts happen. What you need to know is the rate of return, for which you need to factor in the time value of money. If you consider that, the actual return will be about 6.3%, assuming the person lives till 90 years of age.

#### **What should you do?**

Annuities make sense for those who want guaranteed pay-outs. But retirement is also about managing longevity risks and so one needs to ensure that investments beat inflation. We suggest you have only a portion on your money in annuities.

The deferred annuity variant of this plan takes away the interest rate risk, but at a cost. One needs to be mindful of the economic scenario when taking a call on the deferred annuity option, said Shyam Sunder, managing director, Peak Alpha Investment Services Pvt. Ltd. “We are likely to move into an upward interest rate cycle, so locking into a rate at the lowest point in the cycle may not be advisable. Further, if a person has 10 years to retirement, then I recommend a more aggressive approach by investing in equities so that a person is able to achieve higher returns instead of keeping the money in an annuity that yields low returns of 2.3-7.1%,” he added.

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### ***Life Insurance: Buying a policy? Must understand these important things - Financial Express – 28th March 2018***

Research conducted in India and in the developed market has revealed that purchase of a life insurance policy is dependent mostly on milestone events in one’s life. People decide to buy life insurance when they get a job or when they get married or even when a couple gets the first or the second child. Such events in life generate a unique sense of responsibility and people look for instruments of protection for their loved ones. Such sales normally account for around 55% of total policy sales by the life insurers. The remaining sales, however, is motivated or triggered by factors other than the need to provide financial security to the family. The most dominant among such factors is the motivation to choose life insurance for saving for the future.

Traditionally, the sellers of life insurance have been promoting their products as the finest instrument for systematic and long-term saving. The market has also accepted the endowment and money back type policies as a safe and a relatively compulsory saving instrument. The perception of more than 40% of the policyholders has been substantially removed from the core function of life insurance as a financial instrument

#### **Spurt in sale of Ulips**

The spurt in sale of unit-linked insurance policies (Ulips) after foreign insurers entered the market in 2001 has strengthened the perception that for accumulating fund for long-term needs such as higher education for children or their marriage insurance policies provide attractive options. Many people have purchased and many are still purchasing Ulips plans on a very large scale. The handsome growth of annualised equivalent premium for the current financial year by the life insurers has been driven mostly by Ulips. Even LIC has achieved Rs 99,783 crore of new business premium in FY18 (till December 2017) with the largest contribution coming from Ulips and that too, through single premium mode.

Recently, a friend called me to find out how the insurance company had paid him maturity amount of just Rs 48,000 for a single premium of Rs 40,000 ULIP taken eight years ago. The salesman had assured him of 100% growth in the fund value. I tried to rationalise the lower return due to yearly cancellation of certain amount of units for mortality charges and fund management charges by the insurer. But he was not convinced and regretted his decision to buy Ulip. It's a classic example of mismatch between one's needs, age and expectations from a life insurance policy.

Not much of thought was involved in the buying process which resulted in setback to my friend's financial planning. The lesson is that one must spend time to understand the terms and conditions of the plans and then sign the proposal form.

#### **Last quarter sales**

During the last quarter of a financial year, the financial world woos potential customers desperate to save for income tax benefits under Section 80C. Traditionally, insurance has been on the forefront for such investments. Agents step up their market mobility and succeed in selling almost 55% of their yearly productivity in the last 90 days. Customers buy insurance policies in haste and regret later. Life insurance is not bought every year and life insurance binds the policyholder to a fairly long-term contract from which exit is either not possible or is possible with heavy cost. Customers must spend some time to understand the features of the products being offered and then decide regarding the plan, sum assured and mode of payment.

Life insurance is not a plain-vanilla product. It provides for variety of options regarding benefits and also add-on value through rider benefits. Once a policy is issued rider benefits may not be included later on. Hence decision regarding riders must be taken at the time of signing the proposal. Mostly the terms agreed upon on the basis of declarations in the proposal form are irreversible in the contract of life insurance. Those who are pushed by circumstances or by ignorance to the year-end selling and saving pressure must avoid haste if they decide to go for a life insurance product for their family's long-term benefit.

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#### ***Passive euthanasia: Rethink insurance death claim settlement - Financial Express - 27th March 2018***

The recent landmark judgment of the Supreme Court, allowing passive euthanasia to ease the dying process of terminally ill patients or a person in a persistent vegetative state, has evoked strong criticism across the country. While many welcomed the judgment, many others, particularly religious groups, expressed unhappiness, stating that the right to life is in the hands of God. Will passive euthanasia have an impact on death claim settlement in case the customer had taken a life insurance policy earlier? One would be surprised to know the statistics pertaining to suicide cases in India. As per the National Crime Records Bureau data on accidental deaths and suicides in India, there were 1, 33,623 suicide cases in 2015. Maharashtra recorded the maximum number of suicide cases, accounting for 12.7% of the cases, followed by Tamil Nadu (11.8%) and West Bengal (10.9%).

Illness, bankruptcy or indebtedness, marriage-related issues (non settlement of marriage, dowry-related issues, extra-marital affairs, divorce, etc), failure in examination, impotency/infertility, drug abuse/alcoholic addiction, fall in social reputation, love affairs, poverty, unemployment, property dispute, illegitimate pregnancy, physical abuse, rape, professional/career problems, etc, are some of the major causes of suicides. The report further mentions the means adopted for committing suicide that include consuming sleeping pills, drowning, fire/self-immolation, using fire arms, hanging, consuming poison, jumping into the well, coming under running vehicle/train, touching the electric wires, etc. Sadly, the Insurance Regulatory and Development Authority of India (IRDAI) annual reports are silent about the life insurance claims settled under suicide cases.

It is indeed surprising to note that "illness" accounted for 17.2% (3,379 out of 19,665 victims) of the suicide cases. Illness includes AIDS/STD, cancer, paralysis, insanity/mental illness and other prolonged illness. Thus, even without legislation, if the percentage of suicide cases pertaining to illness was 17.2%, then one can imagine that with the legalisation of "passive euthanasia", the death figure due to illness may rise exponentially in the near future. Now, the question is, would death due to passive euthanasia be treated as natural death or should it be treated as unnatural death? If it is treated as unnatural death, then what would be the cause of death? Would it be treated as suicide or assisted suicide? As per the definition of "suicide" as mentioned in the National Crime Records Bureau, it includes, "deliberate termination of life.

The essential ingredients of a suicide are: (i) It should be an unnatural death, (ii) The desire to die should originate within him/her, (iii) There should be a reason for ending the life.” Thus, going by this definition, can the death due to passive euthanasia be construed as equivalent to suicide? If not, then how would it be treated? This is important since if the customer had taken a life insurance policy earlier, then, while claiming the death benefit, the nominee is required to mention the cause of death. Even if passive euthanasia is treated as suicide or assisted suicide, it would hardly have any impact on the death claim from an insurer in case the customer had taken a life insurance policy earlier. This is because even for suicide cases, claims under a life insurance policy are settled by the insurers, subject to certain conditions as mentioned in the clause. The suicide clause states that, “if the life assured commits suicide within one year from the date of commencement of risk or date of revival if revived, whether sane or insane at that time, the policy will be void and no claim will be payable”. This is applicable for policies issued before January 1, 2014.

This implies that if the policy holder commits suicide after one year from the date of commencement of the policy, then the policy qualifies for death benefit. However, in case the policy holder commits suicide before the completion of 12 months, then no claim would be paid by the insurer and the policy would become void. This clause has undergone some changes, and as per the new regulation that became effective for life insurance policies issued after January 1, 2014, “in case of linked plans, if the policyholder commits suicide even within 12 months from the commencement of the policy during the policy term, then the nominee is entitled to receive 100% of the policy fund value. Whereas in case of non-linked plans, the nominee is entitled to receive 80% of the premium paid in case of death claim due to suicide even within 12 months from the commencement of the policy during the policy term”.

It is important to note that life insurance is governed by a principle called “utmost good faith”, also known as “Uberrimae Fidei”, which means that there should not be any suppression of material facts while purchasing a life insurance policy. It is high time that the IRDAI captured the data pertaining to claim settlement under suicide cases in its annual reports. This would provide a trend of claim settlement over the year, enabling the policymakers to make necessary amendments to the suicide clause. This is important because there may be a possibility of intentional suicide by the policyholder in order to enable its beneficiaries or its creditors to receive the proceeds from the life insurance policy. Utmost care needs to be taken by the regulator to ensure that suicide clause should not encourage commercially planned suicide since no one should profit from one’s own crime.

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### *It’s still early death for most life policies – Mint – 27th March 2018*

The Indian life insurance industry continues to manufacture and sell products that die early. According to the Handbook of Statistics published by the insurance regulator, in FY17, the life insurance industry was able to retain an average of 65% of its policies after the first policy year and 34% after the fifth policy year. This means that one in three policies sold don’t survive 5 years. These numbers compare poorly with the global average, where life policies retain close to 90% of their customers after a year of sale and about 65% after 5 years.

In insurance parlance, policy retention is known as ‘persistency’ and ‘persistency ratio’ measures how long customers stay with their policies, by looking at the number of policy renewals year after year.

These numbers don’t bode well as life insurance is in the business of selling long-term products, of 10 years or more, and so it benefits if customers renew their policies year after year. Poor persistency doesn’t just hurt the insurer; you as a customer stand to lose much more largely because of the way life insurance policies are designed. Tracking persistency is, therefore, important, but the way persistency ratios are disclosed at present is not precise enough to give a true picture.

#### **Indian life insurance plans still collapse early**

Persistency numbers are still improving but are still far below global averages of 90% after one year and 65% after 5 years.

#### **The report card**

Although still a long way to go, persistency numbers are slowly improving. In FY16, the average persistency ratio in the 13th month was 61%; in FY17, this number has improved to 65%. For the 61st month (the

regulator doesn't publish persistency beyond 5 years), persistency in FY16 was just 29% which improved to 34%.

“Increase in ticket size by selling policies to more affluent customer segments is perhaps the main reason behind improvement in the 13th month persistency. In the case of 61st month persistency, new Ulips (unit-linked insurance plans), where most customers continue to pay premiums even after 5-year lock-in period, is the main reason,” said V. Viswanand, senior director and chief operating officer, Max Life Insurance Co. Ltd.

But the industry has a long journey ahead as actuarial experts say persistency of less than 80% can impact profitability over the long run since fixed costs get spread over a smaller base, keeping the expense ratio high. According to Kapil Mehta, co-founder, SecureNow.in, changing products and distribution can bring about improvement faster. “Persistency will improve if traditional plans undergo reform similar to unit-linked insurance, or if a higher proportion of products is sold through direct channels like the online medium. Systemic changes like training agents to sell in a need-based manner takes place relatively slowly,” he said.

Life insurance policies alive after 5 years of sale (61st month persistency)						Percentage of life insurance policies continuing after one year of sale (13th month persistency)					
Insurer	FY13	FY14	FY15	FY16	FY17	Insurer	FY13	FY14	FY15	FY16	FY17
1 IDBI Federal Life	NA	43.22	54.47	58.11	51.62	1 ICICI Prudential Life	67.00	66.20	73.40	78.70	80.58
2 HDFC Standard Life	23.00	24.87	31.78	41.36	50.00	2 Kotak Mahindra Life	64.00	70.90	71.79	76.82	79.00
3 ICICI Prudential Life	10.00	10.70	16.70	35.20	49.12	3 Max Life	70.00	76.00	78.00	74.00	77.00
4 Max Life	26.00	23.00	23.00	37.00	46.00	4 Sahara India Life	57.00	76.22	62.62	75.21	74.84
5 Kotak Mahindra Life	33.00	14.12	25.75	37.39	45.00	5 Aviva Life	59.00	56.10	56.50	62.49	70.87
6 Life Insurance Corp. of India	43.00	44.00	44.00	44.00	44.00	6 PNB MetLife India Ins.	71.22	50.24	58.00	63.30	69.31
7 Aviva Life	NA	11.90	18.10	31.53	37.50	7 Edelweiss Tokio Life	46.00	41.60	49.50	63.92	69.16
8 SBI Life	17.02	11.43	16.00	23.44	37.19	8 Canara HSBC Oriental Bank of Comm. Life	65.00	58.20	53.47	59.25	68.97
9 IndiaFirst Life	NA	NA	37.30	26.01	35.78	9 SBI Life	67.34	67.98	69.00	69.25	68.81
10 Canara HSBC Oriental Bank of Comm. Life	NA	80.50	36.96	31.04	34.54	10 HDFC Standard Life	69.00	67.61	68.19	71.33	67.00
11 Tata AIA Life	18.00	16.06	16.39	24.02	33.22	11 IndiaFirst Life	64.00	65.29	60.10	60.53	65.56
12 Sahara Life	24.00	38.88	22.09	40.05	32.38	12 Angon Life	49.00	69.74	73.00	62.07	65.00
13 Reliance Life	21.09	7.33	6.42	16.17	31.40	13 DHFL Pramerica Life	43.64	40.62	43.21	50.08	64.76
14 Exide Life	24.00	23.80	29.00	30.10	31.13	14 Life Insurance Corp. of India	70.00	59.00	66.00	63.00	64.00
15 Angon Life	NA	15.05	20.00	27.31	31.00	15 IDBI Federal Life	70.00	70.70	70.07	61.89	62.41
16 Birla Sun Life	40.00	44.38	19.00	28.00	27.00	16 Star Union Dai-ichi Life	45.00	43.45	48.84	52.89	60.45
17 Edelweiss Tokio Life	NA	NA	NA	NA	25.96	17 Reliance Nippon Life	61.52	51.59	54.48	55.80	60.30
18 Shriram Life	4.00	80.63	7.00	28.03	24.53	18 Bajaj Allianz Life	48.89	61.57	52.72	53.95	59.56
19 Bharti Axa Life	32.00	30.22	33.30	16.53	24.52	19 Exide Life	56.00	55.90	59.00	58.80	58.68
20 PNB MetLife India Ins.	61.36	13.41	14.00	17.10	24.45	20 Bharti Axa Life	45.00	54.28	52.10	49.73	58.19
21 Bajaj Allianz Life	4.02	3.98	6.88	14.86	24.34	21 Tata AIA Life	49.00	46.85	51.43	56.84	56.58
22 Star Union Dai-ichi Life	NA	47.43	19.01	21.40	22.50	22 Birla Sun Life	49.00	43.37	50.00	54.00	56.00
23 DHFL Pramerica Life	NA	NA	10.16	15.66	22.18	23 Future Generali India Life	39.82	42.44	38.73	35.23	51.31
24 Future Generali Life	6.81	14.69	8.88	16.61	20.46	24 Shriram Life	30.00	48.93	45.00	47.19	44.42

Currently, only five insurers from a total of 24 have upwards of 70% in the 13th month persistency ratio. Eighteen have improved their numbers from FY16 while six insurers have seen a drop in this bucket. The sharpest drop was witnessed by HDFC Standard Life Insurance Co. Ltd, which got listed last year. Its 13th month persistency fell from 71% in FY16 to 67% in FY17. As per its red herring prospectus, the drop is largely due to the poor persistency of its health insurance portfolio. In the 61st month ratio, HDFC Life was able to retain at least half the policies, which is more than what we can say about most insurers.

#### What does it mean for you?

A poor persistency means that you are losing money by way of exit penalties. Most of what the insurance industry sells now is traditional plans, which have high exit penalties—100% of the premium in the first couple of years. So, when you decide to opt out of a policy, you actually end up forgoing your premiums.

To give you an idea of the magnitude of loss to customers, here are some rough calculations. In FY17, the industry sold 26.4 million policies. Given an average persistency rate of 65% after a year of sale, only 17.2 million policies were renewed. This means 9.26 million policies dropped out, and since the industry is

dominated by traditional policies, it means that a large part of these policies didn't give any money back to the customers.

"Persistency has not shown a marked improvement and if the insurers are not able to retain even 50% of their customers after 5 years, then the products being sold are really not long-term products," said K.S. Gopalakrishnan, chief executive officer, RGA Life Reinsurance Company of Canada (India Branch).

### **The way forward**

This brings us to an important point: how insurers currently report persistency figures. According to insurers we spoke to, some insurers include group policies (that are largely single-premium policies) and single-premium retail policies in their persistency calculation. Including this inflates the persistency reported as these are one-time payment policies and don't lapse. Reporting persistency on the basis of retail regular premium policies will reflect true customer retention, and that needs to be standardised.

What's also required at this point is further slicing of this number. It's important to break persistency numbers by policy type and channel of distribution. "Term plans have a retention rate of more than 90%, and even if you lapse, you don't lose anything in them because you are only paying the cost of insurance. Even in Ulips, the exit load is minimal, but it's very high in non-linked plans. So there is a lot of merit in slicing the persistency numbers across product categories because insurers still manage to make profits through policy lapses in non-linked plans but customers lose the entire capital," added Gopalakrishnan.

Mehta said slicing the number product-wise will also bring about important product changes. "Persistency in Ulips has improved a lot owing to a better product construct. Charges are capped and exit penalties are minimal. There is no motivation to surrender the policy, but the same is not true for traditional plans where policyholders sometimes prefer to lapse than continue with a plan they don't understand," he added.

Persistency ratios need to get cleaner and sharper as they are a commentary on the selling practices of an insurance company. For you, this is what poor persistency indicates. Majority of the plans are investment plans and a poor persistency indicates that people end up buying products they don't need or understand. Stick to a term plan for now.

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### ***MNC bank in India offers same-sex partners of staffers medical cover – The Times of India – 27th March 2018***

Taking a big step towards creating an inclusive workplace, the Royal Bank of Scotland (RBS) in India has extended medical hospitalisation benefits to same-sex partners of its employees.

In India, since Section 377 of the penal code criminalises homosexuality, lesbian, gay, bisexual & transgender partners are not covered under any insurance scheme. So, RBS India has decided to bear the cost of its liberal move from its profit and loss account.

The policy comes into effect from this April 1, making RBS one of the first companies to take the progressive step. L'Oreal India too offers benefits such as adoption leave or maternity/paternity leave irrespective of the gender of its employees or their partners.

The company recently introduced surrogacy leave, again given irrespective of the partner's gender.

Companies usually do not extend medical hospitalisation benefits to same-sex partners, but progressive corporate organisations have strongly expressed their intent towards having inclusive workplace policies.

Some organisations have extended spousal benefits like adoption leave, paternity leave and relocation to same-sex partners of their employees.

The challenge, however, is to ensure such initiatives are well within the ambit of the Indian law, which does not recognise same-sex marriage. In 2009, the Delhi high court had decriminalised same-sex relationships.

In 2013, that ruling was overturned by the Supreme Court. Spousal benefits like insurance are thus restricted to opposite-sex spouses.

However, there are UN standards on LGBT which prod companies to extend the same benefits to partners, spouses, children or other dependants of staff members, regardless of sexual orientation, gender identity and

expression, or sex characteristics. So, while Google has an LGBT community of employees called Gayglers, RBS has established the RBS Rainbow Network India.

Salesforce India recently launched Outforce, which brings together employees who are allies of equality in sexual orientation and gender identity.

According to Vikas Goel, lead (diversity & inclusion LGBT stream) and head of engineering transformation, core banking & payments, RBS India, the objective behind their move is to mainstream the LGBT community and to protect them from the various challenges they face in society. More such initiatives are in the pipeline, he added.

“We are all aware of the social issues that the LGBT community faces. The attempt is to make them inclusive. We want to encourage our employees to come out freely on their orientation with no reason for fear, judgment or reservation.

At the same time, we will ensure that privacy and confidentiality is maintained. Our endeavour is to ensure that we do the right thing and that all our policies treat all our employees equally and give them a fair opportunity to grow,” said Goel.

Employees at RBS India get a health insurance of Rs 8 lakh, which covers his/her spouse, children and aged parents.

The new policy expands the definition of family to cover the partners of LGBT employees as well.

Jnanesh Kumar, director employee success, Salesforce India, said: “We promote open and inclusive culture that empowers employees to bring their whole, authentic selves to work. Along with all our Ohana Groups, Outforce also educates our Salesforce ecosystem on how diversity and inclusion create business success.”

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### ***Jivan Jyoti Yojana: Insurers lose 10-20% in PM's life scheme - Financial Express - 26th March 2018***

Life Insurance companies have made losses of around 10% in the Pradhan Mantri Jeevan Jyoti Bima Yojana (PMJJBY) this year. Compared to the premium of around Rs 1,756 crore collected so far in FY18, insurance firms have received claims for Rs 1,931 crore.

A total of 5.3 crore persons have insured themselves under the scheme that charges Rs 330 per year for a life cover of Rs 2 lakh. LIC charges Rs 1,529 for a Rs 6 lakh cover for a 20-year-old, going up to Rs 6,273 for a 45-year-old.

Insurers are likely to ask the government for a rate revision from the current Rs 330 to Rs 350-400, say top industry officials.

Till March 19, a total of 96,550 claims were received and, of these, 87,412 were settled which amounts to Rs 1,748 crore — launched in 2015, the insurance scheme gives a one year term life cover of Rs 2 lakh for death due to any cause, including suicide and murder.

In its first year, in FY17, compared to a premium of Rs 1,028 crore for the life policies, the claims were for Rs 1,249 crore, giving it a claims ratio of over 120%.

These schemes, launched in May 2015, were projected as path-breaking steps to provide affordable, universal access to essential social security protection.

The premium amount has to be paid by May-end every year for renewal and the policies are linked to the beneficiary bank accounts.

While several private players provide cover under PMJJBY, but state-owned general insurers like Life Insurance Corporation of India (LIC) has a market share of 65-70%.

Even for the Pradhan Mantri Suraksha Bima Yojana (PMSBY), the prime minister's accident insurance scheme, insurance companies have asked for a revision in premium rates.

Source

In this scheme, insurers have witnessed a claims ratio in the range of 180-200% and are planning to ask for doubling the premium from Rs 12 per annum to around Rs 20-30.

## Health Insurance

### ***Modicare will expand private healthcare market: NITI Aayog VC – Mint – 30th March 2018***

Hundred million families coming under the National Health Protection Mission (NHPM) could lure more investments into private healthcare market and drive down cost of treatment at private hospitals in near future.

NHPM, often called Modicare, is set to significantly lower the cost of healthcare at private hospitals by scaling up the healthcare market, estimate NITI Aayog, country's apex policy think tank and industry bodies.

"NHPM will bring a huge supply side response. The fact that the scheme will be available across the country will bring private sector healthcare providers to Tier-3 and Tier- 4 towns and expand operations there. The healthcare market will expand hugely and it will have the potential to bring prices down because of its scale," said Rajiv Kumar, vice-chairman, NITI Aayog in an interview.

"Also, the protocols that will be signed between health insurance companies and healthcare providers will become benchmarks for other private providers. That will also help in bringing prices down. One will also see a shift towards use of generics from costly branded drugs. The whole healthcare paradigm will radically transform," he said.

The NHPM, labelled the world's largest health assurance cover, aims to provide health insurance to nearly 40% of the population—i.e. more than 100 million poor and vulnerable families—with the premium paid by the government. The finance ministry in February had initially announced an outlay of Rs2,000 crore. The Union health ministry last week announced an allocation of Rs10,000 crore to Modicare for next two years with Union health minister J.P. Nadda saying more funds will be provided accordingly.

"With NHPM, it is very likely that investment in mid-size hospitals with more than 50 beds and more will increase. This may cut the costs of the health services considerably," said Arup Mitra, professor, Health Policy Research Unit (HPRU) at the Institute of Economic Growth, New Delhi.

NHPM will be an entitlement-based scheme based on data from the deprivation criteria in the Socio-Economic Caste Census (SECC). Beneficiaries under NHPM can avail of benefits in both public and empanelled private facilities. Health policy experts claim that the scheme will prove to be a game changer with poor families benefiting the most.

"Poor people will not fall back into utter poverty due to a health emergency and they can be assured that the scheme will take care of their health needs. The scheme is a game changer in the health sector and it should be rolled out in a manner that ensures the best possible coverage," said Kumar.

Private health and insurance industry experts also expect new jobs to be created. "The scheme will also create lakhs new jobs in the country as new healthcare facilities will come up in smaller districts and villages," said Antony Jacob, CEO, Apollo Munich Health Insurance.

The government also has a provision of extending free treatment to the poor by reserving some beds in private hospitals. However, most private hospitals claim they don't get enough poor and underprivileged patients for free beds.

Source

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### ***Newborns may get more health insurance benefits in Bengaluru – The Times of India – 28th March 2018***

In a move that increases hope for newborns battling for life in neonatal ICUs, the Insurance Regulatory and Development Authority of India (IRDA) has defined a newborn as a "baby born during the policy period and aged up to 90 days". It has communicated the definition to the Newborn Medical Insurance Committee of National Neonatology Forum (NNF), which has been fighting for insurance coverage for newborns.

The IRDA move seems to be a blessing for parents who have to shell out anywhere between Rs 17,000 and Rs 25,000 a day to save their newborns placed on ventilators due to various complications. The regulator wrote to the committee in January 2018.

With an increase in the incidence of neonatal complications, paediatricians and neonatologists have been worrying about the lack of insurance cover for newborns. “Every newborn should be covered by medical insurance since birth. Parents should be educated and encouraged to take insurance cover for babies during antenatal visits. IRDA has defined ‘newborn’ following the NNF initiative. At present, seven companies provide medical insurance to newborns. It can be used as an effective tool to reduce the neonatal mortality rate,” said Dr Prashant S Urs, co-chairman, Newborn Medical Insurance Committee and a Bengaluru-based neonatologist.

Insurance schemes tailor-made for newborns covering all minor and major disorders are yet to be a reality. Until then, expecting parents can rely on family floater and maternity plans that mention newborn care. In the absence of a definition of ‘newborn’ by IRDA, insurance schemes that mention newborn coverage were restricting it to vaccinations in the first 90 days of the child’s birth. According to Dr Urs, infants were being extended benefits of family health insurance schemes only after they were 90 days old.

One insurance company, as part of its maternity section, offers Rs 1 lakh cover for newborns but neonatologists say the amount is too small when the child is in the neonatal ICU (NICU).

Docs take crowdfunding route to save premie.

A boy weighing only 700gm at his birth in a private hospital near Cambridge Layout on December 31, 2017 was brought to Manipal Hospital and is still in the NICU. “The baby’s lungs had not fully developed as he was born in the 26th week of pregnancy. The mother who conceived through IVF faced many complications and the delivery was done to save them both. The baby has been in the NICU for the past 85 days and the treatment cost has run up to nearly Rs 15 lakh despite the hospital giving concession. We are currently raising funds through crowdfunding to help the couple as they have no insurance. Neonatal insurance is the need of the hour as these babies are the future of the country,” says Dr Karthik Nagesh, chief neonatology, Manipal Hospital. The infant now weighs 1.1kg. Dr Nagesh is raising funds through his trust, Foundation for Newborns.

Source

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### ***Get a preventive medical test done, enjoy good health and tax benefits too - Financial Express – 28th March 2018***

With drastically changing lifestyles and annually rising medical costs, do not overlook life and health insurance policies which also help you maximise tax saving benefits. Over the last decade, with medical inflation having risen in double-digits annually, it is important to have adequate medical coverage because the cost of medical treatment without any health insurance policy may wipe out your savings completely. According to the 2017 ‘Cigna 360° Well-being Score – India Report’, a whopping 62 % of Indians burnt a hole in their pockets by paying for their own medical expenses.

It further underscored that Indians primarily depend on their own savings when it comes to funding health emergencies. Therefore, investing in a health insurance policy holds a dual objective. While you are rest assured of financial support in times of unforeseen medical and health-related exigencies, you also receive tax benefits on your net taxable income in the process.

#### **Preventive health check-ups**

While health insurance is a smart financial safety net for you and your family, there are also ways to ensure that you don’t end up unnecessarily paying higher premiums. The best way to save your premium outgo is by regularly doing preventive health check-ups. The preventive health check-ups is one way to ensure that you don’t end up spending lakhs for an illness. A health insurance policy allows you to avail tax deduction for any expenses incurred for preventive health check-up, however most people end up spending money for the check-up but miss out on claiming the tax benefits.

Based on expenses incurred, you can save on income tax for preventive health check-ups during the policy term. However, you need to keep in mind the following conditions for claiming this tax deductions:

You need to incur an expenditure on preventive health check-up in a particular financial year. It can only be for self, spouse, parents and dependent children. You cannot claim deductions for payment made on behalf of in-laws, siblings and children who are not financially dependent on you. Expenses can be in cash or in a mode other than cash. If all the above conditions are satisfied, the amount that will qualify for deduction is the amount spent in the financial year or Rs 5,000, whichever is less. This limit of Rs 5,000 is included within the

overall limit of Rs 25,000 for mediclaim insurance premium. Unlike mediclaim insurance premium, there is no additional deduction in case a senior/super senior citizen undergoes the check-up.

While there is no requirement of submitting any document/receipt to the income tax department, it would be advisable to keep the same as proof as it may come in handy on a later date.

There are many places where the preventive check-ups can be conducted and this need not be in the form of cheque payment and in such a situation this will not keep away the tax benefit. Last, but not the least, invest for yourself, stay healthy, save enough to indulge and buy what you desire. Invest smart and continuously learn about the nuances of investing. It is your money and you deserve the very best.

Source

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### ***Funding shortfall may hit National Health Mission's key programmes – Mint – 26th March 2018***

Several significant programmes under the National Health Mission (NHM) are likely to be impacted because of a shortfall of funds in 2018-19.

The ministry of health and family welfare got an allocation of only Rs30,129.61 crore for 2018-19 against a projected plan outlay of Rs 34,882.32 crore under NHM for the current year. The deficit of around Rs 4,752.71 crore may affect a range of activities under the mission such as upgradation of hospitals, expansion of the vaccines programme and implementing interventions for non-communicable diseases.

The ministry of health and family welfare recently expressed concerns before a parliamentary standing committee on health and family welfare that the shortfall in allocations for NHM for 2018-19 vis-à-vis its projected demand for funds will adversely impact the major health initiatives.

While the revised estimates (RE) allocation for NHM programmes for 2017-18 was Rs 30,786.56 crore, the parliamentary committee said the current year's allocation, i.e. Rs 30,129.61 crore for 2018-19, is abysmally less.

A few of the initiatives under the NHM are upscaling of existing initiatives such as strengthening of health facilities to Indian Public Health Standards (IPHS), establishing sub-centres, primary health centres (PHCs) and community health centres (CHCs), expansion of new pneumococcal vaccines, measles-rubella and rotavirus vaccines to all states, and implementation of new interventions particularly those relating to non-communicable diseases and strengthening of district hospitals.

“The National Health Policy (NHP) 2017 has envisaged a target of 2.5% of GDP as health expenditure by the government both Centre and states by 2025.

However, keeping in view the scaling down of various activities due to reduced budgetary allocations, and the central share in health funding stagnating at 0.3% of GDP, the achievement of targets set for 2025 would remain a pipe dream,” the parliamentary panel said in its report that was tabled in Rajya Sabha last week.

“The allocations provided for 2018-19 is not in line with the pious vision set in NHP 2017 and is opposite to the vision envisaged.

The Committee therefore strongly recommends that the department should approach the ministry of finance to provide enhanced allocations for NHM in right proportion which helps actualize the health schemes under NHM and also facilitate the reaching of the targets of 2.5% of GDP by 2025,” it said.

NHM aims to provide universal access to equitable, affordable and quality health care services, accountable and responsive to people's needs, with effective inter-sectoral convergent action to address the wider social determinants of health.

“It is apparent that the overall funding for NHM has reduced. Currently, there is no shortage of funds for vaccine programmes. There may be shortfall in the budget which may hamper some programmes, but during the financial process, the Union health ministry will demand more funds in revised budget estimates,” said Pradeep Halder, deputy commissioner, immunization division, Union health ministry.

“We are hopeful that the finance ministry will provide an additional budget for the NHM under which most of the important programmes fall, which will cope up the shortage of funds.”

Source

### ***Health insurance for all can be a reality - Mint – 26th March 2018***

In Budget 2018, the government had made a few announcements. (a) On a National Health Protection Scheme (NHPS) providing insurance cover of Rs5 lakh per family; (b) Having an initiative to establish new government medical colleges and hospitals, and upgrading existing district hospitals under the programme; and (c) Setting up of over 1,50,000 health and wellness centres throughout the country.

In March, the Cabinet cleared the Ayushman Bharat National Health Protection Mission, dubbed Modicare.

An integrated approach in implementation of all the three initiatives can steer the country towards having universal healthcare. The success of the flagship NHPS, aimed at making available secondary and tertiary care to the needy could largely depend upon how successfully the other two initiatives are implemented. The two major concern areas identifiable in the existing government health insurance schemes are enrolment and abuse or overtreatment or unnecessary hospitalizations. We have situations of fictitious enrolments, unnecessary hospitalizations or unnecessary hysterectomies, and other such instances.

#### **Steps to implementation**

Studies indicate that 65% of the healthcare expenditure in the country is for outpatient care, which are primarily out of pocket expenses. If comprehensive healthcare is the goal, effective financing and delivery of primary healthcare is vital. Setting up of 1,50,000 health and wellness centres is a big initiative and it has to be primarily implemented effectively. There is a strong case for public private partnership in establishing and running these health centres with specific measurable goals. Private participation could be further encouraged by means of tax benefits or subsidies.

Every NHPS beneficiary should mandatorily register with one of the wellness and health centres, which can function on capitation basis. To avoid unnecessary usage, a nominal co-payment can be collected from beneficiaries when such facilities are used. Medicines and diagnostics can be provided at subsidized prices or free to those who cannot afford it. These centres—manned by Primary Care Physicians (PCPs)—will provide outpatient care, including diagnostic facilities and medicines, and also act as gatekeepers for NHPS. Polyclinics with specialists and higher level of diagnostic facilities should also be established for referrals from the primary centres.

Every beneficiary of NHPS should consult a PCP in the health and wellness centre, and treatment in polyclinic by a specialist would be only on referral from the primary centre. Existing as well as the new district hospitals should be equipped to be on par with corporate tertiary care hospitals. Existing as well as new medical college hospitals should be equipped to be on par with corporate super specialty hospitals.

Admissions of any NHPS member to a hospital should be only on referral from the PCP or the specialist, except in emergencies such as accidents. The PCPs and the specialists will act as gatekeepers for hospitalizations and would be responsible for preventing unnecessary hospitalizations and surgeries. Suitable mechanisms have to be built to prevent collusion of PCPs and specialists with hospitals.

Hospitals that are empaneled under the health protection scheme should be graded according to their infrastructure available and quality of care provided, and then continuously monitored also. The government must set up a National Health Regulatory Authority and insist on all state governments to set up similar authorities. All the heads of such regulatory authorities should become members of the National Health Regulatory Authority. This would bring in uniformity in the healthcare sector in the country.

An integrated approach to implementing all the three initiatives would have far-reaching effects on the country's healthcare scenario, and we could see a healthier India. Rationalizing treatment or surgical procedures, and use of medicines and diagnostics will bring in reduction in healthcare costs. This would also lead to stabilizing the premiums of NHPS and ensuring continuous improvements in terms of coverage.

India has the problem of big numbers. Just launching NHPS without integrating the wellness centres as well as the government infrastructure may not yield the desired result in the long run. We must realize that implementation of such schemes requires strong planning, strong regulations, simple and efficient processes, and continuous monitoring through the use of advanced technological platforms. Implementation failures can not only result in an exponential rise in costs of such schemes, but also put a strain on future allocations as well towards the healthcare sector.

**Source**

***Almost 70% policyholders are thrifty with information - Financial Chronicle – 26th March 2018***

Omission of information or providing incorrect information while making health insurance claims is widely prevalent among policyholders. Almost 70 per cent of policyholders and 90 per cent of young policyholders find it acceptable, according to a survey.

Conducted by LexisNexis Risk Solutions, a leading provider of data and analytics solutions to insurance providers, the survey found that nearly seven in 10 consumers find it acceptable to consciously omit or incorrectly report information during claims submission and have most likely reported incorrect information in the past year.

The phenomenon was more pronounced among the young consumers or those in the age group of 25 to 44 years. The survey found that nine out of 10 young respondents felt it acceptable to misstate information while filing a claim. Eight out of 10 have probably reported incorrect information regarding test/treatments and their medical condition in the past 12 months. An equally strong number of customers were open to omitting/misreporting information, such as income, marital status, gender, age, family medical history, employment status, and health claims history, while filling their health insurance application forms.

Around 52 per cent of the respondents were reluctant to share information as they were concerned about how the information may be used by the insurance company and its negative impact. Thirty four per cent perceived that it was just a formality and the insurer may not use the information in the decision making process. They also feared that providing correct information might turn into further medical tests or increase the premium.

Further, only very few people understood the importance providing complete information. Less than half (47 per cent) of the respondents perceive the application form to be easy to fill, and an even fewer respondents (39 per cent) believe that the forms ask for the right amount of information. Most importantly, only 5 to 10 per cent respondents found that purchasing their current policy has been 'very easy'.

"The statistics reveal that insurance providers must take additional steps to engage more effectively with their policyholders during the purchase and claims processes in order to ensure complete data sharing for faster processes and positive outcomes for both parties," Shivakumar Shankar, managing director, LexisNexis Risk Solutions India said.

Source

[Back](#)**General Insurance*****Good driving may not mean less premium – Mint – 28th March 2018***

When people buy insurance for their private cars, most are unaware of the break-up of the cost. A motor insurance policy has two main components—third-party liability and own damage. In India, it is mandatory for all registered motor vehicles to have insurance for third-party liability. The premium for this is fixed by the insurance regulator and is announced every year. Premium paid towards this only covers liability from damage caused to a third party, including injury, death of an individual or damage to property in case of an accident.

The own-damage part of motor insurance is optional and it covers damage to the insured vehicle in case of an accident, and theft. Insurers can price the premium for this as they see fit, although there are guidelines.

"Insurance zones are created by insurers according to a vehicle's vulnerability to damage or loss. Due to higher rates of vandalism, theft and accidents, urban drivers pay more for car insurance than those in small towns or rural areas. This zonal bifurcation generally comprises metro cities and rest of India," said Rakesh Jain, chief executive officer, Reliance General Insurance.

A recent study by insurance web-aggregator Policybazaar shows how users in different states behave when it comes to own-damage premiums. The study was conducted on 3,00,000 policies sold through the platform in 2015-16 and 2016-17. While there is a marked difference in the data from states, we tried to see if insurance companies take note of this difference to price own-damage premiums.

**Track record**

Nine states were part of the study (they make up about 80% of the platform's business)—Andhra Pradesh, Delhi, Gujarat, Haryana, Karnataka, Maharashtra, Rajasthan, Tamil Nadu and Uttar Pradesh. Of these,

Karnataka and Andhra Pradesh appear to be the most profitable for insurers as they have the lowest loss ratio (59%); and Haryana is the least profitable with the highest loss ratio (84%). Loss ratio is the percentage of total premium collected that goes out in claims. So, lower the loss ratio, higher the profitability. When loss ratio is high, insurers increase the premium to cut losses.

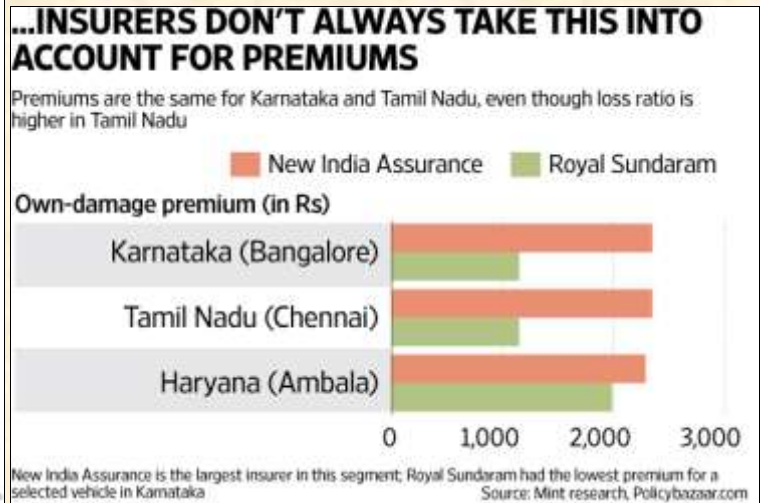
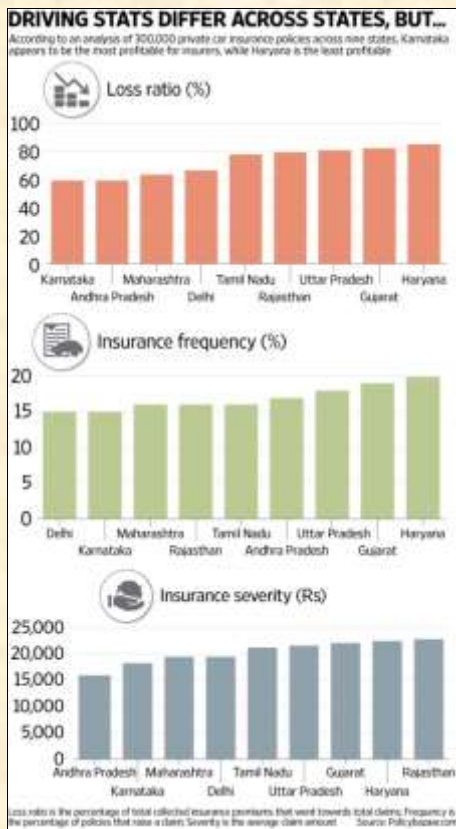
Patterns were observed for 16 cities. While cities in the ‘profitable’ states showed good performance, there were outliers. Mumbai had the lowest loss ratio at 48%, while Chandigarh was the highest at 110%. “Traffic in a city like Mumbai is a major factor as that impacts the top speed a vehicle can achieve. That (slow speed) reduces the severity of claims and the loss ratio.

Also, there are certain cities where fraudulent claims are high. Theft numbers also play a role. If public transport is good in a city, then the use of the vehicle and related risk to the insurer also goes down,” said Animesh Das, head, product strategy, Acko General Insurance.

**Change in premiums**

If there is a clear difference between how drivers in different cities and states drive, then do insurers take this behaviour into account when deciding premiums? Yes and no.

Here’s an example of mixed pricing. We looked at the own-damage premium for a popular hatchback from a public sector and a private sector insurer. In both cases, premium was the same for Karnataka and Tamil Nadu, even though loss ratio is higher in Tamil Nadu. And for Haryana, the public sector’s premium was in fact lower. (Renewal premium considered for Hyundai i10 Magna, petrol, bought in 2014 and policy expiring on 31 March 2018. No-claim bonus assumed at 45%.)



“The experience in Karnataka and Tamil Nadu are similar, so the pricing is in line. We must be having high losses in Haryana so the pricing is higher. Even within a single state, it is possible that two insurers have different experiences,” said S. Thirunavukkarasu, country head, underwriting and claims (motor), Royal Sundaram General Insurance Co. Ltd.

He added that all insurers use their own data and experience to price premiums. “The market has still not evolved a common theory. ‘Karnataka is good’ and ‘Haryana is not good’ may not be true in every case. Even

for a single insurer, one portion of motor insurance may be good in one place but the other may not be,” he said.

This may change in future. Just the way banks and e-commerce companies have evolved to an extent where they blacklist particular pincodes for certain services, insurance too may be priced similarly, said Das. Even within a geographical area, factors such as population density, vehicle density, road infrastructure, traffic conditions and behaviour of service centres are expected to play a role.

“With the advent of various techniques and statistical models, smallest of fractions can be priced as per the risk perspective of the geography,” said Jain. In developed markets, 85-90 data points on a policyholder are collected to arrive at pricing. In India, only 5-6 data points are collected, said Thirunavukkarasu. “It needs to become more granular. That is how matured markets operate: right risk, right pricing. The market is expecting these changes; it should start happening in the next 2 years,” he added.

### Source

Use of telematics to gather more data on user behaviour is being debated, but a more nuanced pricing of motor insurance is yet to happen. Till then, it is almost one size fits all.

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### ***Pradhan Mantri Suraksha Bima Yojana covers 13.41 cr subscribers: Government – Financial Express – 28th March 2018***

The number of subscribers under the Pradhan Mantri Suraksha Bima Yojana has gone up to 13.41 crore, Parliament was informed today. Number of enrolments in Pradhan Mantri Suraksha Bima Yojana (PMSBY) has increased from 8.85 crore in 2015-16 to 13.41 crore in 2017-18 through auto-debit under the scheme, Minister of State for Finance Shiv Pratap Shukla said in a written reply in the Rajya Sabha.

Launched in May 2015, PMSBY provides a cover of Rs 2 lakh for accidental death or total permanent disability and Rs 1 lakh in case of permanent partial disability. The cover period under this scheme is June 1 each year to May 31 of the subsequent year and the accidental insurance policies under implementation with different central government departments have been converged to PMSBY from June 1, 2017.

PMSBY is offered/administered through both public and private sector general insurance companies, in tie up with banks, regional rural banks and cooperative banks. It gives a renewable one year accidental death-cum-disability cover to all subscribing bank account holders in the age group of 18 to 70 years for a premium of Rs 12 per annum per subscriber to be auto debited from the subscriber’s bank account.

The minister said the scheme is meant for common people, especially poor and the under-privileged sections of the society. Shukla said government regularly monitors the progress of settlement of claims under the scheme and any complaints are dealt in coordination with banks and insurance companies in getting them resolved expeditiously.

### Source

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## Crop Insurance

### ***Narendra Modi government’s crop insurance scheme loses sheen as coverage area reduces – Financial Express – 25th March 2018***

The Narendra Modi government’s flagship crop insurance scheme, launched with much fanfare two years ago, has witnessed negative growth this year as the coverage has reduced to 24 per cent of gross cropped area (GCA) in 2017-18 from 30 per cent in 2016-17. This, when the actual target for the current year was 40 per cent. Similarly, the number of farmers insured during both the kharif and rabi seasons has gone down by 14 per cent this year. In 2017-18, the area insured under the Pradhan Mantri Fasal Bima Yojana (PMFBY) was 47.5 million hectares, as per the data accessed by IANS, which translates into 24 per cent of the GCA of 198.4 million hectares. After the PMFBY was launched in February 2016, the area under coverage had gone up to 30 per cent in 2016-17 from 23 per cent under the old schemes a year ago. As per the government’s targets, the coverage in 2017-18 should have increased to 40 per cent but has actually reduced to 24 per cent.

Thus, the government’s final target of bringing 50 per cent (98 million hectares) of the GCA under the PMFBY in 2018-19, which has been allocated Rs 13,000 crore in the Budget, appears to be an impractical goal. Under the scheme, farmers have to pay just two per cent of the total premium in case of the kharif crop, 1.5 per cent

for rabi and five per cent for horticulture. The remaining premium is equally shared by the Centre and the states. The central government has been citing poor implementation by the states for the lackadaisical response to the scheme. State officials say the bid of private insurance companies for more profit and delay in settlement of claims are crucial factors for the decline.

Interestingly, the scheme has performed poorly in the BJP-ruled states of Maharashtra, Gujarat, Chhattisgarh and Uttar Pradesh, while it has received a good response in non-BJP states like Telangana and Tamil Nadu.

The crop insurance scheme has also witnessed a 14 per cent drop in the number of farmers insured to 47.9 million in 2017-18 from 55.3 million in 2016-17. A state Agriculture Secretary said farmers had lost interest as the compensation was either denied or delayed, besides flaws with the crop-cutting experiment to obtain accurate estimates of crop output.

“The new scheme permits insurance company representatives to take part in the crop-cutting experiments. We have noticed that they lower the threshold level of the output than the ideal.

So farmers cannot claim even if their actual output is low since it will be above the threshold limit,” the official said, requesting anonymity.

According to farmers in Madhya Pradesh, they received their compensation six months after filing their claims. The government had allocated Rs 5,500 crore in the budget for 2016-17, which was increased to Rs 13,240 crore. In 2017-18, the allocation was Rs 9,000 crore.

For 2018-19, the government has provided Rs 13,000 crore with a target to bring 98 million hectares — close to 50 per cent of gross cropped area — under the scheme.

Source

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## Reinsurance

*GST Council okays exempting 24 insurance schemes for reinsurance – The Times of India – 28th March 2018*

Insurance sector regulator Irdai today said as many as 24 schemes will be exempt from goods and services tax (GST) for reinsurance and asked insurance firms to pass on the benefits to customers.

The proposal to exempt reinsurance schemes in respect of specified insurance plans has been approved by the GST Council in its 25th meeting held on January 18, 2018 on the condition that the benefit of reduction in the premium on such insurance schemes must be passed on to the beneficiaries and the state and central exchequers, Irdai said in a circular directed to all insurers.

The Insurance Regulatory and Development Authority of India (Irdai) has further directed all the insurance firms to avoid any undue enrichment arising out of this exemption.

"Insurers may note that if necessary benefit on account of reduction in premium is not passed on to the insured/ government, suitable action against the insurance companies may be initiated with National Anti-Profiteering Authority under Section 171 of the CGST Act," Irdai said.

As many as 24 insurance schemes have been exempted from being taxed under GST including Janashree Bima Yojana, Aam Aadmi Bina Yojana, Varishtha Pension Bima Yojana, Pradhan Mantri Jeevan Jyoti Bima Yojana, Pradhan Mantri Jan Dhan Yojana, Pradhan Mantri Vaya Vandana Yojana, Hut Insurance Scheme, Pradhan Mantri Fasal Bima Yojana, Universal Health Insurance Scheme, Rashtriya Swasthya Bima Yojana, Pradhan Mantri Suraksha Bima Yojana and Niramaya Health Insurance Scheme, among others.

The exemption was sought for ease of living of senior citizens as well as for schemes relating to other insurance schemes of the government.

"Considering the fact that no GST is payable on insurance premium of such schemes and the GST paid on the re-insurance is included in the cost of insurance premium charged by the insurance companies from the beneficiaries and also shared between the centre and the state governments, the proposal to exempt reinsurance schemes in respect of specified insurance schemes has been approved by the GST Council...," the finance ministry said in a communication.

Source

### ***PolicyBazaar parent set to make its first acquisition; targets reinsurance sector - The Economic Times – 28th March 2018***

Etechaces Marketing and Consulting, which owns and operates online insurance policy aggregator Policy Bazaar, has begun discussions to make its first acquisition, believed to be in the reinsurance space, even as it continues negotiations to raise its next round of capital from Japanese telecom and internet giant Softbank.

Two persons aware of the development said the Gurgaon-based company has earmarked about Rs 500 crore to finance buyouts and other strategic initiatives, and has zeroed in on the reinsurance space, as it looks to expand its portfolio of products and services.

ET was unable to ascertain the name of the company PolicyBazaar has held talks with. The company's spokespersons declined to comment.

India's reinsurance sector, estimated at Rs 17,000-18,000 crore, has a relatively small pool of players, but which also include Berkshire Hathaway-backed General Re, Munich Re, Scor and Swiss Re, apart from local players, such as ITI Reinsurance and state-owned GIC Re.

Reinsurance, also known as insurance for insurers or stop-loss insurance, is defined as the practice of insurers transferring portions of risk portfolios to other parties by some form of agreement to reduce the likelihood of paying a large obligation resulting from an insurance claim.

The expansion of PolicyBazaar's portfolio of products and services comes at a time when the company, which is backed by the likes of Tiger Global Management, PremjiInvest--the personal investment arm of Wipro chairman Azim Premji-- and Temasek, is believed to be in the midst of negotiations with SoftBank for its next round of funding.

The development, first reported by Bloomberg, could see the Tokyo-based investor pump in an estimated \$500 million (Rs 3,246.25 crore) into the company, at a potential valuation of \$800 million (Rs 5,198.32 crore) and upwards, and which is likely to have a secondary sale of shares.

The company had last raised funds in October last year--which valued it at about \$500 million—in an investment round led by global asset management firm Wellington Management, private equity firm True North and IDG Ventures India. Till date, PolicyBazaar has raised about Rs 1,000 crore in equity financing.

SoftBank has also been in widely-reported discussions with Zurich-based Swiss Re for a potential \$10 billion-plus investment, which could see it pick up 20%-30% stake in the reinsurance major, and in the process become its anchor shareholder.

PolicyBazaar, too, has been branching out to other segments. Earlier this month, ET was the first to report that the company had entered the healthcare technology and services segment, which is likely to see it compete directly with the likes of Tencent-backed Practo and Sequoia Capital-backed 1mg Technologies.

The company has set aside about \$100 million (Rs 649.80 crore) towards the new venture, according to its chief executive, Yashish Dahiya.

"Indian healthcare system has a \$100 billion out-of-pocket expense market, one that is not covered by health insurance. This market is expected to grow to \$200 billion by fiscal 2020. We will enter into tie-ups with hospitals, and have PolicyBazaar advisors there to help consumers at the moment of truth — which is claims," Dahiya had told ET.

The company, which has also been mulling an initial public offering, swung to a net profit of Rs 12.9 crore for fiscal 2017, on revenue of Rs 213 crore, according to documents sourced from business intelligence platform Tofler.

Source

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### **IRDAI Circular**

Source

Premium Rates for Motor Third Party Liability Insurance Cover for FY 2018-19 is available on IRDAI website.

## Global News

### *China: New medical liability insurance cover launched for doctors - Asia Insurance Review*

The southern Chinese city of Shenzhen has launched a new medical insurance service to protect doctors from malpractice payouts, that is applicable to medical accidents across the Chinese mainland.

Doctors can buy the insurance voluntarily, reports China Daily.

Doctors' liability insurance is not a new thing in China, but it has never been fully implemented, said Wang Hui, general manager of Jiang Tai Insurance Brokers.

"Laws and regulations in other parts of the country did not differentiate the responsibility of medical institutions from that of doctors. Therefore, insurers were not able to judge doctors' share of liability, not to mention settlement claims," he said.

A regulation regarding medical services in Shenzhen, which took effect at the beginning of last year, makes it clear that medical institutions and doctors should bear different levels of responsibility for medical accidents.

#### **Insurers**

The insurance service is provided jointly by five insurance companies, including Ping An Insurance and China Pacific Life Insurance. The companies will share the profits as well as the cost of the insurance.

The total amount insured each year ranges from CNY300,000 to CNY4 million. The premium for doctors varies based on department and position.

Obstetrics, anesthesiology and plastic surgery are believed to have the highest risk in medical treatment, so premiums for doctors in those fields are higher than their counterparts in traditional Chinese medicine, nutrition or rehabilitation.

Meanwhile, premiums for directors of a department are also higher than those at lower ranks because normally the operations they perform are more difficult and therefore come with higher risks.

Mr Wang Tianxing, head of the Shenzhen Medical Doctor Association, said the insurance can help alleviate the financial burden of doctors and promote the development of the medical service industry.

The money that doctors pay for medical mishaps ranges from several thousand yuan to tens of thousands of yuan and could reach up to CNY100,000 (US\$15,930) in some cases. That places major financial pressure on doctors, he said.

To avoid risks, doctors are normally reluctant to try new technologies or therapies, so the insurance enables them to put more focus on technological improvement, Mr Wang said.

It can also play a role in easing tension between doctors and patients, he added.

"Disputes normally occur when the two parties cannot reach agreement on compensation. Now, medical accidents will be dealt with by a third-party organisation. It's like a buffer zone being set up between the two sides," he said.

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### *Australia: Private health insurers are less trusted than distrusted - Asia Insurance Review*

A new landmark survey shows that private health insurance is more distrusted than it is trusted by Australians.

In Net Trust Score (NTS)© surveys conducted by the Roy Morgan Research Institute between October 2017 and February 2018, the health insurance industry recorded a negative NTS of -2.6%. Net trust is the measure of trust minus the measure of distrust in a category or a brand. This is known as NTS or Net Trust Score.

The survey results show:

Trust Score	1.3%
Distrust Score	3.9%
Net Trust Score (NTS)	-2.6%

According to Roy Morgan CEO Michele Levine this level of systemic distrust is unexpected given the highly trusted health system it operates in.

The health ecosystem in which private health insurers operate comprise healthcare professions who consistently rank as the most respected in Australia and have done so since 1994, when Roy Morgan started measuring honesty and ethics.

Ms Levine said: “There is no doubt that when a patient has to pay an unexpected gap at a doctor’s surgery or hospital, they do not blame the health professionals, they blame their private health fund.

“The customer places their trust in the insurer; should they need to make a claim, they trust the insurer to fulfil its policy obligations. So, this level of industry distrust should be of concern to the funds.

“With trust at the heart of the health insurance relationship – current and potential – a fund’s degree of customer trust directly impacts so called brand stretch, pricing elasticity and member retention.

“Higher levels of trust feed a customer’s emotional belief that their fund will deliver on its policy promises, in turn reducing the customer’s price sensitivity. This is important to health insurance funds.

“In the current market in which private health insurance premiums continue to rise, it is a matter of survival that funds maintain high levels of net trust.”

Health Minister Greg Hunt has said that private health insurance premiums will increase by 3.95% on average wef 1 April.

The Roy Morgan Private Health Insurance Tracker survey reveals that when the distrust quotient is subtracted from that of trust, private health insurance funds with the highest net trust scores are HCF followed by Teachers Health and Medibank Private, said Ms Levine.

#### **Methodology**

Initially, at Roy Morgan asked 2,848 Australians which brands they trust and which they distrust. Three rounds were conducted in October 2017, January and February 2018. Then in March 2018, a survey of another 1,600 Australians was conducted asking which private health insurance brands they trust and distrust.

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### ***Shipping: Caution remains the watchword for global marine insurance, says IUMI - Asia Insurance Review***

Against the backdrop of encouraging global economic growth and an improved outlook for the shipping industry, concerns within the hull insurance market remain, says the International Union of Marine Insurance (IUMI), giving its expert opinion on the current state of the hull, cargo and offshore energy insurance markets.

"All hull markets acknowledge the severe volatility inherent in a typical international hull portfolio," said Mr Mark Edmondson, Chair of IUMI's Ocean Hull Committee at the association's Spring Conference in Hamburg on 18-19 March 2018.

"The global premium base has been eroding year-on-year as a result of reduced asset values, reduced activity in some sectors, and reduced premium rates. Although the financial impact of major casualties was modest recently, increasing values of single risks bear the potential risk of new record losses, and attritional losses are a growing concern."

Alongside risks inherent in operating ever larger vessels, IUMI is also concerned about advances in the digital applications involved with naval architecture and the operation of vessels – particularly crew training and their ability to manage cutting edge technology and large amounts of data. IUMI is seeing evidence that the frequency of collisions is increasing, possibly resulting from the introduction of modern technology.

On a brighter note, the past three years has seen the frequency of total losses within the global fleet stabilise at 0.13% by number (0.05% by tonnage). IUMI says that this is largely attributable to an improved safety climate, improvements in naval architecture and marine engineering; and more effective regulation. Total losses involving vessels younger than 15 years were significantly less during the 2013-17 period than the years 2008-2012. The frequency of serious casualties has increased since 2014 but appeared to be stable in 2016-17.

### Cargo insurance

The marine cargo insurance market is improving and stabilising but remains highly competitive with an abundance of capacity. Amongst the many challenges facing the line are larger and more complex risks, natural catastrophes (Nat CAT), vessel and port accumulations and larger outlier losses. The sector is facing a commoditisation of speciality lines, an increase in broker facilities with high commissions and rising expense ratios. Additionally, underwriters must comply with sanctions and requirements for globally compliant programmes including locally admitted policies where required.

Cargo underwriters are being stretched to evolve and improve their products, explains Mr Sean Dalton, Chair of IUMI's Cargo Committee. "The modern cargo policy has been significantly enhanced to include storage extensions, broad policy valuations and coverage provisions such as Control of Damaged Goods that provide for 'fear of loss' and 'brand protection'. As underwriters we are being challenged to improve our approach and utilise tools such as third-party data, sensor technology and predictive analytics."

"Cyber is also a concern", said Mr Dalton. "Most policies remain silent on cyber issues, but the recent Maersk NotPetya attack highlights potential exposures and consequences. Policies that raise the greatest potential risks include Freight Forward Liability cover such as NVOCC Legal Liability, Indirect Air Carrier Liability and Errors and Omissions."

### Cargo losses

2017 saw the worst Nat CAT losses in history for the property and casualty insurance sector – these were caused by hurricanes Harvey, Irma, Nate and Maria, the earthquake in Mexico, monsoons in Bangladesh, storms in Durban and wildfires in California. Since many marine insurers are part of larger P&C companies, they were also affected by these Nat CAT losses and now face increasing pressure to improve results. The losses come immediately after earlier, large outlier claims including the Amos 6 satellite, Tianjin port explosion and the insolvency of Hanjin.

### Offshore Energy

A 25% increase in the oil price has encouraged an upturn in offshore exploration activity which is starting to impact positively on the offshore energy insurance sector. Similarly, the oil price rally has increased the value of "loss of production" insurance purchased. However, Chair of IUMI's Offshore Energy Committee, Mr James McDonald, remains cautious, saying: "Capex growth is mainly confined to the US shale market where insured values are considerably less than those achieved offshore. That said, we expect to see an increase in premiums associated with mobile offshore drilling rigs as they come out of lay-up. But day rates for floaters and jack-ups remain well below their earlier peaks due to continued over-supply."

### Offshore losses

Loss activity offshore remains low. Hurricane Harvey bypassed the heavily populated Gulf of Mexico and large losses, in general, were minimal. A worrying trend for construction sector losses involving buoyancy devices seems to be developing, however. Attritional losses continued to track at a low rate due to reduced activity and improved health and safety practices. But this might reverse as rigs are reactivated.

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### *Australia: Govt introduces legislation for health insurance reforms - Asia Insurance Review*

A suite of private health insurance reforms will help Australia maintain a strong and competitive private sector and protect the health system, Health Minister Greg Hunt has said.

The government introduced a series of reforms to Parliament yesterday that includes allowing discounts for hospital coverage for people under 30, increasing the strength of the health insurance ombudsman and letting private health insurers cover travel and accommodation costs for rural and regional Australians attending health services, reports news.com.au.

"These reforms will therefore help strengthen the viability of the private health system by addressing concerns about affordability, complexity and lack of transparency of private health insurance," Mr Hunt said.

The legislation would also allow private health insurance providers to increase customer excesses in exchange for lowering premiums for the first time since 2001. The increased excess would be A\$750 (US\$575) for singles or A\$1,500 for couples and families.

Source

### ***Indonesia: General insurers optimistic of stable motor business this year - Asia Insurance Review***

The Indonesian General Insurance Association (AAUI) has predicted that motor vehicle insurance business can record positive performance this year with growth of 5%.

AAUI has said that unaudited results show that motor insurance premiums amounted to IDR17.2 trillion (US\$1.2 billion) in 2017. This represented growth of 4.5% over 2016 which saw motor premiums of IDR16.49 trillion.

Referring to data from the Indonesian Motorcycle Industry Association (AISI), motorcycle sales in February 2018 stood at 439,586 units, down 3.1% from the same month in 2017 which saw 453,763 units sold, according to a report by Kontan.

Meanwhile, data from the Association of Indonesian Automotive Industries (Gaikindo) showed that in February 2018, vehicle sales fell 1.5% year on year (yoy) nationwide. However, growth in the first two months of the year was 4.57% when compared to the end of 2017.

Encouraged by the growth of automobile sales in the first two months of this year, AAUI Executive Director Dody Achmad Sudiyar Dalimunthe said: "This will affect the big picture in the motor line because the total sum insured for four wheels is definitely bigger."

However, he added, the impact of motor vehicle sales on insurance premiums in the first quarter of this year should be studied further.

AISI expects motorcycle sales to be in the range of 5.8 million to 6.1 million units this year, higher than 2017's 5.8 million units. Meanwhile, Gaikindo targets sales of four-wheeled vehicles to reach 1.1 million this year, marginally higher than last year's sales of 1.08 million units.

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### ***Vietnam: Insurance market beckons with huge prospects – Asia Insurance Review***

The demand for health care and motor insurance has grown in the past few years in Vietnam, notes Willis Towers Watson in its recent "Asia Insurance Market Report 2018".

The global advisory, broking and solutions company says in a segment of the report that focuses on Vietnam that traditionally, motor insurance was mostly bought by corporates looking to insure their company vehicles; however, as people began to purchase more expensive cars, the demand for private motor insurance showed significant growth.

More insurance products have also started entering the Vietnamese market. In the past, a number of products were not sold due to limited market size. However, some lines such as trade credit insurance have started to see demand increase. Vietnamese insurance companies are trying to keep pace with continuous change in the market by offering more sophisticated products, catering to those who want to spend more on better coverage. In addition, regulations have widened the product range. For instance, in March 2017, a circular came into effect, mandating purchase of three types of compulsory insurance in construction: Construction Works Professional Liability, and Workmen Compensation.

The economy is still growing, and the expectation is that certain personal lines will continue to strengthen. Business Interruption insurance is expected to rise in demand as the transport and logistics industries develop – however, this growth is expected in the long term, possibly three years from now, unless there is a change in regulation to bring in more capacity to the market.

There are 18 life and 30 non-life carriers in the market. Due to high capital requirements, entry into the market is restricted to large foreign ventures. A number of regional insurance companies from Korea, Japan and China have started buying shares of Vietnamese insurers. For example, Dongbu has a 37% share of PTI, Sumitomo holds 18% shareholding of Bao Viet Holdings, and Samsung Fire and Marine (SFMI) has a 20% share of PJICO. With the deal, PJICO becomes the fifth non-life insurer in the market, along with Bao Viet, Bao Minh, PVI, and PTI, to enter into strategic partnerships with foreign shareholders.

In May 2017, the MOF issued regulations for the whole insurance industry including insurers, reinsurers, brokers, agents, that cover conditions to meet to apply for a licence to detailed rules governing operations. Cooperation between a licensed broker and overseas brokers has been accepted, provided that the overseas brokers meet the criteria to provide cross-border services into Vietnam, such as the maximum net retention by an insurer per individual risk.

### Questions

The remaining questions are how the market will grow and how the reinsurance market will develop, and whether this growth will be accessible to foreign brokers, especially in the oil, gas, and infrastructure sectors, says the report.

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## ***China: Merged banking & insurance regulator cites corporate governance as first priority – Asia Insurance Review***

The first task of China's newly formed banking and insurance regulator is to improve corporate governance at financial institutions it oversees while boosting their risk management and internal controls, reports Reuters citing a top regulatory official.

The China Banking and Insurance Regulatory Commission (CBIRC) will guide banks and insurers to return to their core businesses and support the real economy, CBIRC Vice Chairman Wang Zhaoxing said at the China Development Forum in Beijing at the weekend.

The regulator—formed after the recent merger of China's banking and insurance watchdogs—will also tell them to reduce unnecessary off-balance sheet business, Mr Wang said. The merger was approved by lawmakers on 17 March as part of an institutional restructuring plan of the State Council, the Cabinet.

In a related development, Mr Guo Shuqing, chairman of the China Banking Regulatory Commission, has been named Party Secretary of the CBIRC, the country's top banking regulator said in a post on its website last Thursday.

Mr Guo said at the appointment meeting that the formation of the CBIRC "is of great significance in terms of promoting the construction of a modern financial regulatory framework, improving the ability to regulate banking and insurance activities, and waging a tough war on financial risks", according to a report in *China Daily*.

He said the management team will push ahead in an orderly manner with the formation of the new agency and will continue to do a good job in regulation. In particular, he highlighted the importance of making sure that daily work such as financial regulation and major risk disposal will be carried out as normal during the process of institutional reform, according to the post on the CBIRC website.

Mr Wu Qing, chief economist of China Orient Asset Management, who has been a research fellow on the banking sector for many years, said: "After the merger of banking and insurance regulators, the new agency will be more effective at execution of upcoming rules and policy adjustments."

Source

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