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INSUNEWS

- Weekly e-Newsletter

29th July – 4th Aug 2016

• Quote for the Week •

"The best way to be missed when you are gone is to stand for something when you are here."

Seth Godin, Author

INSIDE THE ISSUE

Insurance Industry

GST to make insurance costlier by 300 bps - The Economic Times – 3rd August 2016

Your insurance policies- life, health and motor will begin to cost more from April 2017 as you would end up paying up to 300 basis points more in taxes. This could pinch the middle class more as they continued to depend more on insurance for savings than other investments like stock markets. Indeed, the pure protection may cost more than the unit-linked insurance plans.

There are two parts of insurance and service tax is levied on the protection part and not the investment part. Term plans will be the most hit which will become costlier by 300 basis points. A basis point is one-hundredth of a percentage point. Service tax of 15% is levied on term plans, which are pure protection. This will go up to 18% in the new regime.

At present, service tax of 3.5% is levied on protection part of endowment and unit-linked life insurance policy in the first year and 1.75% from second year onwards. This would go up to 4.5% in the first year and 2.25% from second year onwards.

"Insurance premium rates will go up by 50-300 basis points when GST is passed," said Naresh Makhijani head of financial services KPMG. "There is greater challenge in complying with the GST laws, deciding on where to pay tax. If the proposal is accepted in one state but the policy is issued from another, where does one pay premium?"

The industry believes that higher tax rate will have a negative impact on the insurance industry. Life insurance penetration has shown negative growth over the last few years. It has dropped from 4.6% in 2009 to 2.6% in 2016.

Also, you will have to pay 300 basis points more for motor, health and other general insurance products. Service tax of 15% is levied on general insurance products. This will go up to 18%. "Apart from policies becoming costlier by 300 basis points, processes will become cumbersome and we will have to see if we need to register in each state," said Ritesh Kumar managing director and CEO HDFC Ergo.

The life insurance council- representative body of life insurance companies- has asked the finance ministry that GST be levied only on the premium collected by the insurance companies only for their life insurance services, excluding the investment portion where the insurance companies act purely in a fiduciary capacity.

Source

Back

Insurance companies holding on to stash of unclaimed Rs 11,668 crore - The Economic Times – 29th July 2016

Unclaimed amount of policyholders with insurance companies (both life and non-life) has reached around Rs 11,668 crore as on March 31, 2016, Parliament was informed today.

"There are unclaimed amounts of policyholders with various insurance companies in India. The approximate unclaimed amount with insurance companies as on March 31, 2016 is Rs 11,668 crore," Minister of State for Finance Santosh Kumar Gangwar said in a written reply to the Lok Sabha.

The approximate unclaimed amount with Life Insurance Corporation (LIC) of India as on March 31, 2016, was Rs 5,934 crore. The minister said unclaimed amount is common in insurance sector and over a period of time amounts have accumulated as unclaimed which is a cause of concern. "It has been noticed by the Authority that the quantum of amount lying unclaimed by the policyholders is accumulating on year on year basis," Gangwar said.

Source

Unclaimed amount includes any amount payable to policyholder as death claim, maturity claim, survival benefit, premium due for refund etc remained unclaimed beyond six months from the due date for settlement of the claim amount.

Back

IRDAI Regulation

Irdai asks banks/FIs not to sell insurance policies forcibly - The Financial Express – 1st August 2016

Irdai has directed banking and financial institutions, who act as bancassurance agents for insurance companies, not to forcibly sell policies to their customers or even without their consent.

The Insurance Regulatory and Development Authority (Irdai) said it was receiving plaints from policyholders on being mis-sold insurance policies by banks and NBFCs.

Most of the plaints where cases of misselling and unfair business practices took place included: Compulsory bundling of insurance products with bank's products despite expressing unwillingness when customers approach for housing loans; insist to buy insurance or make it a condition, at times, to get locker and issuance of policies without consent.

In other cases, customers were also forcibly sold single premium insurance policies in lieu of fixed deposit receipts stating that "this will give better benefits than fixed deposits," Irdai said in its list of types of complaints.

Customers were also issued regular premium policies in place of single premium policies and renewal premiums were debited from their bank account without any intimation, assuring they will get double payment after a select period.

Regulations under 'Registration of Corporate Agents' expressly forbids compelling the customers to buy insurance, Irdai said, adding there is a specific code of conduct to be aboded by corporate agents.

"Regulation 22 (5) of Irdai (Registration of Corporate Agents) Regulations, 2015 states that the corporate agent has to disclose to the Authority the details of specified persons (SP) along with their certificate number issued by the Authority."

"This will help to ascertain the name of the SP who was responsible for such misselling," the regulator said. When such cases were referred to the insurers, they said banks had taken necessary action against the erring employee.

In good number of cases it was informed that the employee has already left service and in many cases premium amount collected by insurer was refunded to the customer or he is allowed to change the mode of payment/type of plan, it added.

"It is emphasised that refunding the money or allowing the customer to change the mode of payment or plan is not the solution for this vexatious issue. Instead the banks/NBFCs should have a system which should proactively detect and discourage such kinds of misselling/forced selling/wrong selling," it said.

Source

Irdai directed: "You (Banks/NBFCs) are hereby advised to follow the regulations cited herein scrupulously and bring it to the notice of Specified Persons/concerned officials that such complaints are being viewed seriously by Irdai."

Life Insurance

Health insurance: Life insurers can no longer offer indemnity based products - The Financial Express – 2ndAugust 2016

Insurers will have to ensure that the premium for a health insurance policy is based on age and other relevant risk factors and standard declarations in the proposal form for a health insurance policy are not required. This will mean flexibility to insurers to have own set of declarations for the customer which will help in better investigation.

The Insurance Regulatory and Development Authority of India (Irdai) has issued new Health Insurance Regulations, which will replace the 2013 rules. It will be applicable to all registered life insurers, general insurers and health insurers conducting health insurance business.

Life insurers can no longer offer indemnity-based health insurance products either as an individual or a group policy. Insurers also cannot offer single premium health insurance product under unit-linked platform. General and health insurers can offer individual health products with a minimum tenure of one year and a maximum tenure of three years, provided that the premium remains unchanged for the tenure. In fact, the new regulations have helped differentiate the product offerings by life and health insurers for the first time. While life insurers will offer financial protection plans, comprehensive health plans will only be offered by health insurers.

General and health insurers will have to devise mechanism or incentives to reward policyholders for early entry, continued renewals, favourable claims experience, preventive and wellness habits and disclose upfront the incentives in the prospectus and the policy document. Insurers will have to ensure that the premium for a health insurance policy will be based on the age for both individual and group policies. For cover under family floater, the multiple incidence of rates of all family members proposed will be considered.

The new regulations allow general and health insurers to come out with pilot products for a policy tenure of one year but not over five years for providing innovative insurance covers. This will help insurers overcome the fear of launching new schemes, as they would now not be stuck with the policy because of the lifelong renewability clause. After five years of the launch of the pilot products, it needs to be converted into a regular product or withdrawn based on valid reason. In that case, the insured will be given an option to migrate to another product. An Insurer cannot resort to fresh underwriting by calling for medical examination, fresh proposal form, etc. at the renewal stage where there is no change in the sum insured offered.

An insurer cannot deny the renewal of a health insurance policy on the ground that the insured had made a claim or claims in the preceding policy years, except for benefit-based policies where the policy terminates following the payment of the benefit covered under the policy like critical illness policy. All new individual health insurance policies will have 15 days of free-look period from the date of receipt of the policy to review the terms and conditions of the policy and to return it if not acceptable.

The cost of any pre-insurance medical examination will form part of the expenses in arriving at the premium. However, in case of products with term of one year and less, if such cost is to be incurred by the insured, not less than 50% of such cost shall be borne by the insurer once the proposal is accepted. Cumulative bonuses offered under policies will be stated explicitly in the prospectus and the policy document and if a claim is made in any particular year, the cumulative bonus accrued will be reduced at the same rate at which it has accrued.

General and health insurers will provide coverage for one or more systems covered under Ayush treatment, provided the treatment has been undergone in a government hospital or in any institute recognised by government or accredited by the Quality Council of India.

Ashish Mehrotra, MD & CEO, Max Bupa, says, the overall regulatory sentiments are in the best interests of customers and insurers. “Incentivising healthy behaviours of customers, ability to launch pilot products, promoting combi-health and life insurance products, and credit-linked, long-term products, will all help boost penetration of holistic health insurance products, tailored to the evolving needs of customers.”

As a part of product design for insurers, the new regulations have encouraged wellness and preventive aspects. Exports say this will enable health insurers to reward customers on healthy wellness habits, early entry and continued renewal, which will have a positive impact on the quality of portfolio.

Source

Settling death claims to become faster - Business Standard – 30th July 2016

Insurers are trying to settle death claims in less than half the stipulated time. They are also doing away with the need for documents, including death certificates, so as not to inconvenience claimants. A life insurance company is required, to settle a death claim without investigation within 30 days. Those requiring investigation will have to be settled within six months.

Section 45 of the Insurance Laws (Amendment) Act, 2015, says no claim can be repudiated after three years of a policy being in force. These claims have to be paid, even if a fraud has been committed in making them. Claims guarantees are being introduced by insurers, to make sure families receive some benefits if claims are delayed.

Amitabh Verma, chief operating officer, Tata AIA Life Insurance, said his company provided a guarantee for settling claims within eight working days of receiving all the documents for policies in force, for over three years.

"There is a significant focus on the ease of transaction. We closed the last financial year with a claims settlement ratio of 96.8 per cent," he said.

LIFE AFTER DEATH

Individual death claims of life insurers during 2014-15

Life insurer	Total claims	Claims paid	Claims repudiated/ rejected	Claims written back	Claims pending at year-end
Private total	100	89.4	7.78	0.02	2.8
LIC	100	98.19	1.15	0.17	0.48
Sector total	100	96.97	2.08	0.15	0.8

Source: Irdai annual report 2014-15 Note: Figures in per cent of policies

"We also have a claims tracker on our website and send regular SMS alerts to keep claimants updated," Verma added.

IDBI Federal Life Insurance also has an eight-day claim settlement guarantee. If the company fails to honour the guarantee it pays interest of eight per cent a year on claim amount for each day of delay. IDBI Federal said since the guarantee was introduced in July 2014, it had not paid any penal interest.

The Insurance Regulatory and Development Authority of India (Irdai) is ensuring claim settlement guarantees are part of insurance policies. Irdai has informed insurers they can promote these guarantees, if they are filed along with the product.

Having a bank partner makes settling claims easier, because processing can start from branches. Mohit Rochlani, director, operations and information technology, IndiaFirst Life Insurance, said the money was transferred directly to the claimant's bank account.

"When we receive a claim, a common mail is floated to the claims heads of all life insurance companies asking whether any claim has been made to them," he said. The fraud repository being set up by the Life Insurance Council would ensure genuine claims would be separated from the fraudulent ones, Rochlani added.

Similar processes are being followed for government insurance schemes. Rochlani said a portal was created by the Credit Information Bureau of India for the Pradhan Mantri Jeevan Jyoti Bima Yojana for use by banks to register claims at branches, and for insurers to update the claim status.

Fast-tracking of death claims is also being done. A Reliance Nippon Life Insurance spokesperson, said based on intensive analysis of historic trends, they have arrived at a pre-defined criteria to ensure fast-track processing of claims. This involves having an assured claim settlement within 12 days for claims meeting the service

guarantee criteria, and promises to pay interest at 6.5 per cent per annum for the number of days exceeding the 12-day guarantee.

The key, according to insurers, was to keep the communication going with those insured at all points, so that relevant information was captured at regular intervals. Vijaya Nene, director, operations and services, PNB MetLife India, said claims could be intimated either at Punjab National Bank branches or at their branch offices. "We process claims at the earliest and ensure that we communicate with the claimants at every point via email and SMS," she said.

"We have a committee to look into critical claims. The benefit of the doubt goes to the claimant to ensure genuine claims are passed," Nene added. The Irdai annual report for 2014-15 stated insurance companies had settled 851,000 claims on individual policies with a total payout of Rs 11,788.67 crore in 2014-15. The number of claims repudiated or rejected was 18,231, for an amount of Rs 701.69 crore.

Source

The sector's settlement ratio increased slightly to 96.97 per cent in 2014-15 from 96.75 per cent in 2013-14 and the repudiation ratio remained static at 2.08 per cent.

Back

Health Insurance

Centre plans to lower ESI contribution rate to 4% - The Hindu – 3rd August 2016

The Centre has proposed a reduced rate of contribution from companies towards the health insurance scheme for workers in areas where it plans to set up a dispensary or a hospital for the first time.

393 districts

The ministry has proposed that employers contribute four per cent, instead of 6.5 per cent of a worker's income towards the Employees' State Insurance (ESI) scheme, as per the draft rules dated July 25, reviewed by The Hindu. At present, the ESI Corporation has a presence in certain parts of 393 districts of the country.

The corporation has plans to cover all the states and expand the scheme to India's 683 districts by March next year. ESIC is present in all states, except the north-eastern states of Manipur, Sikkim, Arunachal Pradesh and Mizoram.

Workers drawing salary up to Rs.15,000 per month are entitled to medical benefits for treatment during incidences of sickness, maternity, disability and death due to injury during work.

The ESI Act applies to factories with 10 or more workers and it is also applicable to shops, hotels, restaurants, cinemas and road transport undertakings.

While 4.75 per cent of a worker's salary goes towards ESI as employer's contribution, 1.75 per cent of the income goes as the employee's share. This is proposed to be decreased to three per cent and one per cent for two years, respectively.

"Our plan is to expand ESI to all parts of the country. Since the medical facilities at places where we want to open a new dispensary or hospital will not be at par with our established units, we have decided to take less contribution from companies for a period of two years," said a senior ESIC official, on condition of anonymity.

March 2017

The official said it would cover all parts of 393 districts by September-end this year and the entire country by March next year. Trade unions suggested that ESI Corporation collaborate with private hospitals in the new areas to provide full medical treatment to workers.

"We welcome the expansion of ESI services to all the districts," said AITUC Secretary DL Sachdev, "But taking less contribution means workers would not be provided full medical facilities that are otherwise available in the 393 districts.

Source

They should provide full facilities by tying up with private hospitals to ensure all medical treatments are available."

Hepatitis claims show decline in FY16 - Financial Chronicle – 2nd August 2016

Hepatitis claims, which have been steadily increasing for the past few years, witnessed a decline in the last financial year. The insurance industry finds that increased awareness is helping in bringing the disease under control.

ICICI Lombard has witnessed a five per cent drop in hepatitis claims in FY16 over the previous two financial years. The company received 1,065 claims in FY14, while the number of claims it got in FY15 was 1,045. By FY16, the number of claims came down to 892. The share of hepatitis-related claims in the total number of health claims has accordingly dipped from 35.48 per cent in FY13 and 34.81 per cent in FY14 to 29.71 per cent in FY16.

As far as Star Health is concerned, the insurer notes that growth in hepatitis claims has slowed down from 31.78 per cent in FY15 to 14.18 per cent in FY16. This percentage has come down in all the zones except the south zone. In the central zone, it declined from 121 per cent to 24 per cent. The growth moderated from 71.50 per cent to 10 per cent in the west zone, from 47 per cent to 6 per cent in the east zone and from 31 per cent to 5 per cent in the northern zone. In the south zone, however, the claims saw a 27 per cent growth against a 20 per cent de-growth in FY15.

"We cannot say that the incidence has come down, but the disease is getting tackled increasingly at the OPD level before it worsens and the person is hospitalised. The insurance cover comes into the picture at the time of hospitalisation and, probably, that's why we are seeing a slowdown in the growth,' said Dr S Prakash, executive director, Star Health and Allied Insurance.

"The company data does not show an increase in the hepatitis claims received in the past few years, which could be attributed to better awareness, people opting for preventive measures such as vaccination against the disease and healthy lifestyle choices.

"Along with preventive care, it is essential that people avail a health insurance policy to tide over the high medical expenses associated with the disease," said Abhijeet Ghosh, head of health administration team, Bajaj Allianz General Insurance.

As per industry estimates, viral hepatitis has been posing a significant threat to the health of the average Indian. Approximately, 40 million people are infected with hepatitis B while 6-12 million people are affected by hepatitis C. Out of the five types of hepatitis, hepatitis A and E are typically caused by contaminated food or water, the cases for which rise during monsoon. Hepatitis B, C and D usually are blood-borne types. Most people infected with hepatitis are unaware of the symptoms and, therefore, succumb to liver cirrhosis or liver cancer.

"Different agencies including government departments, hospitals and insurance companies have been actively conducting awareness campaigns," added Prakash. Cities in Gujarat are among the top cities that have witnessed a high number of claims. ICICI Lombard saw the highest number of hepatitis claims from Surat (51 per cent) in FY16, followed by Bhopal (45 per cent), Vadodara (39 per cent) and Mumbai (35 per cent). In case of Bajaj Allianz General Insurance, the top five cities from where the company received hepatitis claims included Mumbai (15 per cent), Surat (10 per cent), Ahmedabad (9 per cent), New Delhi (6 per cent) and Pune (6 per cent).

The average claim size with regard to hepatitis at Bajaj Allianz General Insurance ranged between Rs 35,000 and Rs 38,000.

Source

There has been a five per cent rise in the average claim value for hepatitis, compared to the previous year.

Back

Health insurance scheme to bring 12.5 lakh people uneder its umbrella - The Times of India – 2nd August 2016

Chief minister Harish Rawat on Monday launched the second phase of the Mukhyamantri Swasthya Beema Yojna (MSBY) which aims to cover 12.5 lakh people in the state. The health insurance scheme provides cashless health benefits for its holders in case of hospitalisation in public as well as private hospitals. The scheme aims to cover all those in the state who are not tax payers, pensioners or government employees.

In the second phase, the limit of the cashless benefits has been raised from Rs 50, 000 to Rs. 1.75 lakh. The scheme will now cover 1,206 'common' diseases like dengue, fever and 459 'critical' diseases like cancer and kidney ailments. The scheme will be available in over 60 hospitals in Garhwal and Kumaon.

Speaking on the occasion, the CM said, "Phase one of MSBY was a trial project and we had thought that even if it is 50% successful we will extend it further."

Rawat also directed health minister Surinder Singh Negi to ensure that each hospital associated with the scheme has an MSBY facilitator to help patients avail themselves of the benefits.

The government has also started a campaign to create awareness about the scheme. Asha workers have been roped in to provide door-to-door information in the hills about the policy.

Speaking with the media, Negi, said, "We are trying to ensure that patients do not succumb to disease due to lack of money. MSBY aims to improve the health situation in Uttarakhand."

He also said that the Centre had blocked Rs 800 crore that were part of the $125 million sanctioned by the World Bank to improve health facilities in the state.

Source

Negi added that the health department will also start screening camps from September 1 in various areas of the state to check for diseases. Medical aid would be provided to people on the spot, he said.

Back

Phase-II of health insurance launched - The Tribune – 2nd August 2016

The second phase of the health insurance scheme, in which the total treatment coverage for BPL and APL patients is Rs 1.75 lakh, was inaugurated today by Chief Minister Harish Rawat.

In the second phase, around 1,206 diseases and 459 serious diseases will be covered and around 151 private and government hospitals have been empanelled. Further, an agreement has been worked out with two insurance companies Bajaj Alliance and General Insurance for the scheme.

The beneficiaries Rashtriya Swasthya Bima Yojana will also be linked with the scheme. Further a registration camp, to be held from August 1- 15, will look into the complaints of the beneficiaries who were left out during the first phase of the scheme or want the details in their cards rectified.

While inaugurating the scheme, Rawat said, “The patients requiring more assistance (beyond Rs 1.75 lakh) for serious illnesses can also apply for assistance under the Vyadi Nidhi and the Chief Minister’s Relief Fund,” said Rawat.

For proper implementation of the scheme, a toll-free number 18001801200 has been activated and chief medical officers in all districts have been nominated as the nodal officers for the scheme. The scheme will also be monitored by the District Magistrates.

Source

The government is banking on ASHA workers to identify the beneficiaries and help in the successful implementation of the scheme. The government has also hiked their honorarium to Rs 5,000 per month.

Back

Rly insurance not to cover terror attacks on station premises - Financial Chronicle – 31st July 2016

While the government has announced a railway insurance cover of Rs 10 lakh at 92 paise that will insure you against accidents during your train journey, there are several exclusions that you need to be aware of.

For instance, you will not be covered for any terror attack or accident on the railway station nor will you be compensated if you board the train without a confirmed ticket. Your coverage will start with the departure of train from the originating station to its arrival at the destination station, including the process of entraining and de-training the train.

As per the fine print, claim intimation should be immediate but not later than four months after the event has taken place. Train accident will be defined as per definition under Section 123 read with Sections 124 and 124A of the Railways Act, 1989.

Here are some of the general exclusions — You won't be paid if the accident happens while crossing the railway tracks, accident due to breach of law with criminal intent, accidents due to mental disorders or disturbances of consciousness, strokes, fits or convulsions which affect the entire body and pathological disturbances caused by the mental reaction to the same.

Similarly, damage of health caused by curative measures, radiations, infection, poisoning, except which arise from the accident, intentional self-injury, suicide or attempted suicide, engaging in any form of adventurous sport, influence of intoxication, liquor or drugs, directly or indirectly caused or contributed by congenital anomaly, venereal diseases, sexually-transmitted diseases, AIDS, insanity caused by, contributed to or aggravated or prolonged by child birth or from pregnancy, war, nuclear energy and radiation.

What will the policy cover?

The insurance cover offers the same terms, conditions and premium rates irrespective of the class of travel and duration of the journey.

The scheme offers compensations up to Rs 10 lakh in the event of death or permanent disability, Rs 7.5 lakh for permanent partial disability, up to Rs 2 lakh for hospitalisation expenses and Rs 10,000 for transportation of mortal remains in the event of death or injury suffered in a train accident or other untoward incidents, including terrorist attacks, dacoity, rioting, shootout or arson as well as for short termination, diverted route and Vikalp trains.

How to buy?

Railway passengers booking their tickets on the Indian railway catering and tourism corporation (IRCTC) website will be able to opt for travel insurance cover from September 1. The payment gateway transaction charges and taxes will be added to it.

The new facility will be available for all passengers who book e-ticket, excluding suburban trains, through its official website, irrespective of the class of the ticket, on a trial basis. The coverage shall be for each passenger under the PNR in case of death, permanent total disability, permanent partial disability and hospitalisation expenses for injury and transportation of mortal remains following a rail accident.

The insurance cover will be available through a checkbox at the time of e-ticket booking. The premium amount will be automatically added to the ticket fare if the passenger opts for insurance. After the ticket booking and payment of the premium, a message shall be displayed to complete the nomination details, which are necessary for settling claims on the timely basis. Users wanting coverage for children below the age five years will need to furnish details of the child at the time of booking. Accordingly, travel insurance premium will be added to the total amount payable.

The passenger will have to provide her/his email-id mandatorily for receiving an e-copy of the insurance policy. They will also receive confirmation in form of a text message from the insurance company on a real-time basis. A senior official of an insurance company selected to provide the cover told FC, "Around 13.4 lakh tickets are booked online every day, out of which 67 per cent is for sleeper class, 20 per cent is for AC and chair car, 12 per cent is for AC-II, while the remaining one per cent is for AC Tier-I. These numbers increase during the festival season." "Railways pays awards/compensation of Rs 18-20 crore annually. Yatra has around 3-5 per cent of the customers buying insurance for airlines and, therefore, we expect at least 10 per cent of the online railway customers to buy insurance," the official added.

The three insurance companies, namely Shriram General Insurance, ICICI Lombard General Insurance and Royal Sundaram, will share business PNR-wise and will have a share of 33.33 per cent in the premium earned. Around 19 companies had participated in the bidding process from which two insurers were disqualified. "Since the duration is short, the probability of a high number of accidents is low. We don't expect to make losses," added another official.

Tatkal scheme

While booking tickets via Tatkal, a few seconds can prove to be the difference between a confirmed ticket and a waiting list. Therefore, time taken while buying an insurance cover may lead to loss of a confirmed ticket.

Source

In case of cancellation of ticket, IRCTC will make an automatic refund of the premium amount, after deducting the administrative charges, to the passenger on the same account that was used to book the ticket.

General Insurance

Centre extends cut-off for crop insurance to Aug 10 - The Hindu Business Line – 3rd August 2013

The Agriculture Ministry has extended the cut-off date for enrollment under the Prime Minister's crop insurance scheme for kharif crops to August 10 for all crops where the original cut-off was July 31 (subsequently extended to August 2), to give more time to states to sell it to farmers and improve coverage.

Expressing concern on the slow roll-out of the scheme in the on-going kharif cropping season, the Centre has also asked States to start the tendering process for insuring the rabi crop, to be sown starting October, in August itself, an Agriculture Ministry official told Business Line.

"This extension is valid only for crops where cut-off date earlier was 31st July, 2016. This is a one-time extension only and should not to be quoted as precedent in future," an official release said.

A number of States had requested the Centre to extend the cut-off date as they had notified the crop insurance scheme late and did not have enough time to sell it to farmers.

"To prevent such a situation from arising again, directions have gone from the Agriculture Ministry to states to start the bids for selecting insurance companies for coverage in the rabi season in August. Insurance companies, too, need to be given time to set up infrastructure," he said.

If the bidding process for insuring the rabi crop takes place this month, insurance companies would have ample time to sell insurance to farmers as the cut-off date is December 31.

The lower than expected response to the ambitious crop insurance scheme that seeks to insure farmers right from pre-sowing to the post-harvest stage at a uniform rate of just 2 per cent (for kharif crop) and 1.5 per cent (for rabi crop) of insured value, has left the Centre disappointed. The scheme has a Central budget of Rs. 17,600 crore and the subsidy involved is to be shared equally by Centre and States.

"The delay by most states in starting the tendering process was the main reason behind the lower than expected coverage so far. But this was the first time that they were dealing with a new scheme. Hopefully the extenstion will give them more time to make up for the delay," the official said.

There are a few kharif crops such as the paddy crop in Bihar that have deadlines of August 15 or later. These deadlines have not been extended.

Source

"Insurance companies cannot agree to insure crops beyond a date when it becomes clear to a farmer if he/she would be suffering a loss or not. So we cannot blame the companies if they refuse to oblige," the official said.

Back

'State-run insurers' new scheme lacks focus on profitability' - The Financial Express – 2nd August 2016

In an attempt mainly to protect its topline regardless of profitability, the four public sector general insurance companies are considering re-appointing retiring development officers and marketing executives on contractual basis, said officials. But the move has evoked a mixed response, including heart burns. The proposed scheme would allow development officers retiring on or after March 31, 2016, to be re-appointed as business associates provided they procured a premium ranging between Rs 1 crore and Rs 2 crore based on their place of posting.

The business associates will be paid a remuneration of their last drawn basic pay, subject to achieving the business target. If the targets are not achieved, the remuneration will be reduced accordingly. However, a minimum remuneration of 40 per cent of their last drawn basic pay will be paid.They will also be paid volume allowance, conveyance allowance and profit incentive. The scheme, however, does not talk about the profitability of the existing business and whether it is prudent to retain them at all.

Currently the business channels for the National Insurance Company, New India Assurance, Oriental Insurance and United India Insurance are development officers, agents, brokers, micro-offices and direct sales people. "It is a welcome move by the companies. At an average each development officer will do a business of Rs 2 crore per annum. Each company may have a minimum of around 1,000 such officers. So the potential business

to be retained within the fold is around Rs 2,000 crore per company," S. Vasudevan, Secretary General, All India General Insurance Field Workers' Association (AIGIFWA), told IANS. On the other hand, some of the officials manning the micro-offices/one man offices are upset at the development. The micro-offices are manned by administrative staff-clerical/officers having an aptitude for marketing and also by development officers and those promoted from the development officer cadre.

"A development officer is serviced by a full-fledged branch. On the other hand we have to procure business and complete the documentation. Our remuneration is only our salary. Many of us do business equivalent or better than a serving marketing executive," a clerk at a micro-office of a government insurer told IANS, preferring anonymity. "The companies should also shift us to the Development Officer's cadre. We are willing to abide by the terms and conditions governing that cadre," he added.

"When the insurance brokers were allowed it was expected they would add value to the policy-holders and for the industry. However, a majority of them were like a glorified agent focusing on cutting the premium down by pitting one company against another," a senior official of a government-owned non-life insurer, not wanting to be named, told IANS.

"The data provided by some of the brokers about a risk to be underwritten were at variance with the actual," he said. The economics of the business associates scheme has to be worked out in detail with the focus on profitability of the business sought to be retained, he said. "There is a need for another round of VRS (voluntary retirement scheme) in the four companies to bring down employee cost. New recruitment across the cadres can be made to bring down the management expense ratio," he added.

Industry officials pointed out the need to do the profitability analysis of each distribution channel and to wind up unviable ones. "More marketing feet on the road are needed. The business associates scheme should be made open to all the retiring employees. There are many administrative staff who are now doing handsome business and have good contacts," a long time employee of a government insurer told IANS.

"The scheme in the current format is like giving a chicken to a tiger that is already devouring a goat. Now the retired development officers are placing profitable business with private insurers and earn handsome commission while giving loss making business with the government insurers," he added. "The reported scheme seems to be basically for protecting the volume of business. Though there is an additional 'profit incentive' in the reported scheme, there seems to be no built-in control for rejecting bad business," K.K. Srinivasan, former Member of the Insurance Regulatory and Development Authority of India (IRDAI), told IANS.

The scheme clearly shows that the branch/divisional/regional managers have failed to develop the necessary rapport with their corporate clients so that they are serviced directly even after the retirement of the development officers. "So what happens to the business when the business associates attain the age of 65 when his/her appointment will be terminated," Srinivasan wondered. "That is for the then chairman-cum-managing director to manage. Perhaps there will be a business surrogate scheme. By that time those who are responsible now would have retired," an official quipped.

Source

Back

Group Personal Accident Insurance Scheme for small tea growers receives good response - The Economic Times – 2nd August 2016

The Group Personal Accident Insurance Scheme for small tea growers launched by Tea Board has received good response among the small tea growers of Assam and other northeastern states, West Bengal, Tamil Nadu, Kerala, Himachal Pradesh and many other regions of India. Tea garden workers throughout India within the age group of 18 to 70 years, and falling under the ambit of small tea growers are eligible for the Scheme.

The sum insured per person is Rs 2 lakh and the cover will be effective for a period of one year, from the date of receipt of premium by the insurance company selected for this purpose. The Oriental Insurance Company has been identified to administer the group insurance scheme.

The premium is Rs. 14/- per person per annum, out of which 75% will be borne by the Tea Board while the rest 25% i.e. Rs. 3.50/- will be the workers' contribution. The Insurance scheme provides compensation in the event of the insured sustaining bodily injuries resulting solely and directly from accident caused by external, violent and visible means resulting in death or disablement.

Source

Tea Board has launched this insurance scheme as per the XII Plan scheme guidelines under the component Small Tea Growers Development for extending support for the welfare of the tea garden workers.

Back

Farmers to get 3% premium relief in crop insurance scheme – The Times of India – 2nd August 2016

Just before she offered to step down on Monday, Chief Minister Anandiben Patel made an important pro-farmer decision to provide the maximum benefit of crop insurance scheme to farmers. Accordingly, farmers will have to pay only 2% premium instead of 5% premium as decided earlier.

Under Prime Minister Crop Insurance Scheme, it was decided that farmers will have to pay 5% premium for yearly commercial and yearly horticulture crops and 2% premium for yearly food crops and oil-seeds including pulses growers. And state and central government's share for assistance will be equally on further premium.

Moreover, for kharif season cotton (irrigated & Non-irrigated) and banana crop, total 5.14 lakh farmer occupants will be paid total Rs. 317.71 crore premium assistance (including additional 3% assistance) by state government for approximately 10.42 lakh hectare insured area. As many as 7.80 lakh farmers who are growing food crops including pulses and oil-seeds crops will get Rs. 908.88 crore premium assistance for approximately 28.00 lakh hectare area. This assistance is over and above the 2% premium on the part of farmers.

According to the proposal for insurance premium assistance of Rs 884 crore to 6.76 lakh groundnut farmers in 14.34 lakh hectares area, premium assistance of Rs 317.70 crore to 5.13 lakh cotton farmers in 10.41 lakh hectares area, premium assistance of Rs 12.98 crore to 1.01 lakh paddy farmers in 1.37 lakh hectares area, premium assistance of Rs 7.57 crore to 0.42 lakh millet farmers in 1.02 lakh hectares area and premium assistance of Rs 2.62 crore to 0.35 lakh castor farmer in 1.02 lakh hectares area will be provided by the state government.

Source

Thus so far, as per insurance proposal, the state government will assist total Rs 1226.68 crore premium for cotton and crops, a maximum of 3% premium assistance worth Rs. 147.42 crore including insurance proposal for 28.00 lakh hectare crops estimated by 12.94 lakh farmers.

Back

State set to miss date with crop insurance scheme - The Tribune – 2nd August 2016

There will be no crop insurance under the Pradhan Manti Fasal Bima Yojana in Punjab this year.

The last date for the states to enrol under this yojana is tomorrow. However, the state government is not inclined to adopt it. Reason: it does not suit the farmers of the state. The plan, which has been rejected by the state due to what it describes as non-suitability factor, is a politically significant programme of the Modi government.

Taking the plea that the yojana is not acceptable to the state in its existing form, the Centre was approached to make amendments to it. CM Parkash Singh Badal had personally taken up the matter with the PM. Officials of the state also held meetings with their counterparts in the Union Agriculture Ministry. However, the Centre refused to concede to the points raised by the state. Only an assurance was given by the Centre was that it would improve the parameters of the scheme in due course.

Financial Commissioner (Dev) NS Kalsi said, “We again wrote to the Centre last week to address the issues raised by us. But there is no response so far.” He said that the insurance scheme in its existing format was not suitable for farmers of the state. “Owing to this reason, we asked for amendments to it,” he added. As an alternative to the scheme, the state had proposed the creation of a crop compensation fund of the premium, which was to be about Rs 250 crore per annum supposed to be paid by the Centre for crop insurance in the state. However, the Centre did not yield to this plea of the state.

The state government had offered to contribute an equal amount to the compensation fund.

The state had urged that farmers should be asked to give Rs 100 per acre only while remaining amount of premium should be paid by the Centre and a part of it by the state government.

In the existing format, farmers will have to pay Rs 420 per annum for wheat and paddy crops and much more for cash crops such as cotton, sugarcane and vegetables. Other major issue, on which the Centre did not agree, was that the calculation of the damage to the crops should be made taking into count the production of the crop concerned previous year and not on the basis of the average of past seven years.

Source

Another was raising the indemnity cover to 95 per cent also to cover the damage caused to the crops by pest and insect attack under the scheme. In fact, most of the damage to the cotton crop was caused by an insect attack last year. The state had to pay Rs 644 crore as compensation to farmers on this count.

Back

Online platform in non-life insurance puts customers first – Mint – 1st August 2016

Parallel existence and conduct of business in the online space is a contextual requirement and the order of the day for any business. Though small in volumes, online business has started taking shape in general and non-life insurance as well. But the segment, in addition to the normal regulations, would need a special code of conduct, considering the peculiarity of the absence of personal interaction in the entire gamut of transactions—except in rare cases where personal intervention is warranted.

In this respect, the Exposure Draft Insurance Regulatory and Development Authority of India (Insurance e-commerce) Regulations, 2016, and the insurance self-network platform, seek to provide a structure to this segment as also the rules of conduct for vendors, which will infuse transparency and customer centricity. The stipulation that only those market participants who are registered with the regulator can operate in the online space, will go a long way in instilling confidence in customers' minds.

Further, the regulatory provisions regarding audit of information technology (IT) systems and networks, particularly the insistence on review of controls by an external information system auditor, and compliance to information security management standards of organisations like International Organization for Standardization (ISO) or the International Electrotechnical Commission or their equivalent, will help enhance the reliability and credibility of the entire model. The goal of these provisions is to ensure, apart from robust performance, high levels of system integrity and data privacy.

Also, the fact that insurers can go ahead with marketing the products that have already been approved by the insurance regulator, will quicken the implementation.

Pricing the products

The insurance regulator has proposed differential pricing. This would enable insurers to offer policies at cheaper rates, compared to what are sold offline. But this may not happen if the policy is sold through online platforms of brokers or aggregators. Enabling differential pricing for products sold through self-network platform is aimed at incentivising sales in this infant channel.

E-commerce account

Mandatory e-KYC (know-your-customer) and e-insurance accounts for online businesses are welcome moves and will go a long way to put the business of insurance on strong technical and commercial foundations. These should be made mandatory across other modes of business sourcing as well. If e-KYC and e-insurance accounts are mandatory only for online customers, prospective online customers may perceive other modes of purchase easier on this count. Dispensing with the hard copy of the proposal form and the physical, or wet, signature is a well thought out enabler. Authentication through one-time password (OTP), Permanent Account Number (PAN) or date of birth makes the whole process easier. The attempt has been to have transparency even in the area of post-purchase servicing, as the participant is required to provide process and turnaround time for each type of service, online. The draft regulation aims at laying a strong foundation for the incubation and growth of the online channel.

Premium payment

Electronic payments are becoming increasingly popular due to their widespread use in online shopping and banking. Their bigger advantage is the instant gratification in policy issuance that enables customers to transact 24x7. This will also bring about greater transparency in premium breakups and taxes that are applicable.

Outlook for growth of online business

Insurers need to invest more on technology platforms and customer analytics, which will result in: reduced transaction costs, increase in need-based products, expanded market opportunities leading to growth of business and more qualified leads. E-commerce is emerging as an effective medium to increase insurance penetration, lower administration cost, improve efficiency and enrich managerial data. Insurers now need to invest in better technology and analytics to deliver the right solution for customers. It will also enable customers to transact with more than one product in a single shopping cart transaction. More importantly, the key differentiator will be moving to need-based selling in the online platform with a clear intent of customer-first approach.

E-commerce in insurance will also be a new paradigm, which will come with a lot of attendant benefits to both insurers and customers. Policies can be issued instantly and directly to the customer so the question of delay in issuance or non-receipt of policy will not arise. It will also come with a cost advantage. Data confidentiality will be yet another value-add. With policies being available in a demat account, the customer will not have any difficulty in retrieving policy details while lodging a claim. But the greatest advantage that the entire system would see is that the introduction of e-KYC will result in creation of a reliable and comprehensive database, complete with the customer's insurance history and claim details. This will contribute to evolving a granular rating model, apart from helping mitigation of frauds.

Source

Back

India: Insurance mis-selling & forced selling, draw IRDAI's ire – Asia Insurance Review

The insurance regulator has notified banking and financial institutions, which act as bancassurance agents for insurance companies, not to mis-sell or forcibly sell insurance policies to their customers, or do so without the latter's consent. IRDAI said that it had received complaints from the public about being mis-sold insurance policies as well as unfair business practices by banks and non-banking financial companies (NBFCs), reported Press Trust of India. The regulator warned that it viewed transgressions seriously.

The complaints centred on: compulsory bundling of insurance products with bank products in spite of customers expressing their unwillingness to purchase the products when they approach the bank or financial entitiy for housing loans; insistence on customers buying insurance or make the insurance purchase a condition of other services (at times, to get a locker); and issuance of insurance policies without customer consent.

In other cases, customers were forcibly sold single-premium insurance policies when they had wanted to place their money in fixed deposits. Customers were also issued regular-premium policies in place of single-premium policies, and renewal premiums were debited from their bank account without any intimation, or with the bank or NBFC promising that customers would receive payment of double the sum they paid after a certain period.

IRDAI said that regulations governing corporate agents expressly forbid compelling customers to buy insurance, adding that there is a specific code of conduct to be observed by corporate agents. When IRDAI followed up on complaints with insurers, the response from the latter would be that the banks or NBFCs had taken the necessary action against the erring employee.

In a good number of cases, IRDAI was informed that the employee had already left the service of the institution, and in many cases, the premium amount collected by insurer was refunded to the customer or the latter was allowed to change the mode of payment/type of plan, the insurance regulator said. "It is emphasised that refunding the money or allowing the customer to change the mode of payment or plan is not the solution to this vexatious issue. Instead the banks/NBFCs should have a system which should proactively detect and discourage such kinds of mis-selling/forced selling/wrong selling," IRDAI said.

Source

Back

IRDAI Circular

Insurance Regulatory and Development Authority of India (Registration of Indian Insurance Companies) (Eighth Amendment) Regulations, 2016 is available on IRDAI website.

Source

Source — Status of Insurance Brokers (As on 31st July, 2016) is uploaded on IRDAI website.

Source — List of Products/Add-ons noted during FY-2014-15 is available on IRDAI website.

Source — List of Products/Add-ons Noted during FY- 2015-16 is available on IRDAI website.

Source — Terms and Conditions of Life Products for F.Y. 2016-17 are available on IRDAI website.

Source — IRDAI uploaded guidelines regarding complaints of Misselling /Unfair Business Practices by Banks/NBFCs to All Banks/NBFCs registered as Corporate Agents Under IRDAI (Regn. of CA) Regulations, 2015 and All Life Insurers.

Source — Insurance Regulatory and Development Authority of India (Health Insurance) Regulations, 2016 is available on IRDAI website.

Source — Guidelines on Standardization in Health Insurance To all Insurers and TPAs is available on IRDAI website.

Source — Guidelines on Product Filing in Health Insurance Business To all Life, General and Health insurers carrying on health insurance business is available on IRDAI website.

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Global News

China: Insurers ordered to audit risks in vast sweep of functions – Asia Insurance Review

The insurance regulator has directed insurance companies to carry out an internal audit into 10 main areas of risk and to make improvements, where necessary.

CIRC warned that it would send its team of inspectors to any insurer found wanting in this exercise and might prohibit them from conducting new business, reported the online financial publication, *Caixin*.

The areas which insurers are to carry out a self-audit on are: governance risk, product risk, operating capital risk, solvency risk, asset-liability mismatch risk, cross-sector business risk, reputation and consumer protection risk, fraud risk, compliance risk in major lines of business, and internal control risk including cyber security.

Given the low interest rate environment and intense competition, several insurers had made aggressive equity investments with leveraged trading, moves which could endanger their ability to meet financial obligations. Several insurers are aggressively marketing “universal insurance” policies that are wealth management products promising high returns, in a bid to attract more cash flow to finance their investment acquisitions.

Last December, CIRC said that it would tighten regulations for insurers to reduce the risks from equity investments. Mr Xiang Junbo, CIRC Chairman, warned then of the "emerging risks along with the rising number of market players and the expansion of their investment channels". Last month, he warned the shareholders of insurers against treating the insurance companies as “ATMs” and that insurance companies should undertake insurance business.

Source

Back

Bangladesh: Regulator to crack down on excess management expenses - Asia Insurance Review

The insurance regulator has found that 40 non-life insurers have breached their limits on management expenses for the last seven years, and plans to take tougher action against them.

Of the country's 45 non-life insurers, 40 overshot their management expenses by a combined BDT800 crore (US$102 million), reported *The Daily Star*citing the Insurance Development and Regulatory Authority or IDRA. Earlier, 30 life insurers were found to have breached expenditure limits by BDT2,064 crore in the seven years to 2015.

“We have failed to bring down the management expenses by moral persuasion. We will now take action

against the violators," said a senior IDRA official. He hinted that IDRA may impose restrictions on the insurers' management expenses until the overspending could be covered. No company is allowed to exceed the expenditure ceiling in any calendar year.

Corruption probe

Meanwhile, the Anti-Corruption Commission (ACC) has already taken up the case of the life insurers and launched an investigation into allegations that the companies embezzled more than BDT2,000 crore in the name of management expenses.

"We have started an inquiry into the allegation of excess expenses. We have taken information on these insurers from the IDRA recently," said an ACC official. Management expenses are all charges incurred, whether directly or indirectly, according to the insurance law. They include commission payments, as well as office management and branch expansion expenses.

Source

Back

New Zealand: Insurers unsure of full 2010-11 quake liabilities - Asia Insurance Review

Private insurers have no idea by which date they hope to know the full extent of their liability from the 2010-11 Canterbury earthquakes, the Insurance Council of New Zealand (ICNZ) has said. In early May, the government-run Earthquake Commission (EQC) gave itself six weeks to classify a final "bucket" of Canterbury earthquake claims. ICNZ Chief Executive Tim Grafton said then that EQC had advised insurers that it would confirm whether the 300 claims still to be classified were under or over the NZ$100,000 (US$72,000) damage cap by the end of June. He said once the claims were classified private insurers would theoretically know the full extent of their liability, reported the news site, stuff.co.nz. EQC must refer claims for damage over NZ$100,000 to private insurers.

An EQC spokesman said about 215 properties that reached cap were handed over to private insurers by the end of June. "As explained in May, the figure of 300 was an estimate. All properties identified as having reached cap up to this time were handed over to private insurers," he said. EQC was confident the total number of over-cap properties would only be slightly higher than the 25,000 forecast in 2013. "There is also a smaller number of claims yet to be settled outside of the Canterbury Home Repair Programme that may also go over-cap, such as claims involving multi-unit buildings or in cases where EQC has revisited a claim," the spokesman said. He said EQC kept in regular contact with private insurers about any likely over-cap claims.

Councillor Ali Jones, who has advocated on behalf of many earthquake-hit claimants, said it was "absolutely" taking too long for claims to be classified. She said that several deadlines for settling claims had been missed since the earthquakes. "In this situation, I believe there needs to be a change in legislation, so that there is a legislative requirement as to resolution of claims," she said. In May, the ICNZ announced that private insurers had settled 20,000 Canterbury earthquakes over cap residential property claims in its latest release of quarterly progress data. Mr Grafton had said then that "insurers have now fully settled 91% of all Canterbury earthquake residential properties. This represents 20,000 over cap and 63,000 out-of-scope properties. We have also settled 93% of commercial claims worth NZ$9.6 billion as at 31 March 2016". Including residential properties, the total claims payout stood at NZ$17.8 billion at 31 March 2016.

Source

Back

China: Major insurers issue 1H2016 profit warnings – Asia Insurance Review

Several Chinese insurers have issued profit warnings that their first-half earnings would plunge by more than 40% from a year earlier due to poor investment returns. The announcements followed a statement by CIRC last week that said that the insurance industry saw its first-half earnings slide by 54% to CNY105.6 billion (US$16 billion).

China Life Insurance, the nation's largest insurer, said last Friday that its first-half net profit would fall by between 65% and 70%, weighed down by lower investment income. "The estimated decrease in the results for the first half of 2016 is mainly attributable to the decrease in investment income and the impact of the update of discount rate assumption of reserves of traditional insurance contracts," China Life said in a filing to the Hong Kong stock exchange.

On the same day, China Taiping Insurance, China Pacific Insurance and China Reinsurance Group also issued

profit warnings. Hong Kong-based China Taiping has forecast its 1H net profit would fall by to 50% from the HK$5.86 billion (US$760 million) logged a year ago, attributing the slump to the relatively higher gains from the company's equity investments during the corresponding period in 2015.

Source

China Pacific warned investors of a possible 45% year-on-year fall in net profits for the first six months of this year from the CNY11.30 billion profits reported for 1H2015. China Re said it expected to see a 60% fall in 1H net profits from CNY6.58 billion reported for the first half last year.

Back

China: Tough mart conditions push insurers' profits down by 54% in 1H – Asia Insurance Review

The Chinese insurance industry reported a 54% plunge in net profits for the first half of this year to CNY105.6 billion (US$16 billion), the insurance regulator announced. The sharp decrease is attributed to lower investment returns because of stock market doldrums, lower interest rates and an economic slowdown. CIRC blamed the "complex and volatile market environment" for the 1H performance.

Source

Insurance companies' gains on investments declined to CNY294.5 billion, a fall of 42% compared to the first six months of last year, CIRC said. Non-life insurers saw their profit fall by 43% in 1H to CNY33.7 billion while life insurers' profits dived by 66% to CNY54.2 billion. Profits fell even as insurance premiums soared by 37% from January to June to CNY1.88 trillion, compared to the first half of last year.

Back

South Korea: Insurers' investments abroad hit record high in 1Q - Asia Insurance Review

South Korean insurance companies' overseas investments rose to a record high in the first quarter this year as the insurers turn to foreign assets that offer higher returns so as to counter falling yields at home.

The insurers committed US$49.4 billion to foreign assets from January to March, up by 15.9% from a quarter earlier or up by 50.9%, according to data from financial investment industry, reported *The Korea Herald*.

The Q1 figure shows that overseas investments have increased for the fourth consecutive quarter in a row since the second quarter last year. The Korean insurers' investments overseas stood at only KRW20 billion in 2011.

Investment managers at major private-sector insurers, are particularly focused on investing in foreign bonds as a safer option.

Source

They earmarked significant amounts of money -- as much as 10 times -- into bonds than equities. Foreign bonds accounted for 60.2% of the Korean insurers' total investment portfolio while equity-based investments took up a smaller portion of 5.9%.