भारतीय बीमा संस्थान
INSURANCE INSTITUTE OF INDIA

INSUNEWS

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QUOTE OF THE WEEK

"We must teach science in the mother tongue. Otherwise, science will become a highbrow activity. It will not be an activity in which all people can participate."

C. V. Raman

INSIDE THE ISSUE

INSURANCE TERM FOR THE WEEK

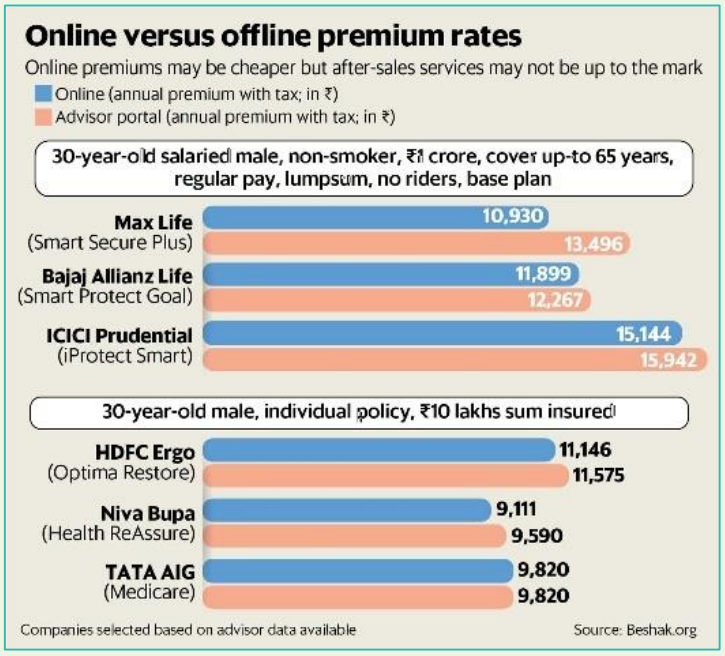
Replacement Cost Clause

A replacement cost clause can drastically affect the amount of money paid out in the event of a claim, especially an auto insurance claim. Because cars lose value through wear and tear and depreciation faster than many other assets, the difference between its replacement value and its actual cash value can be substantial. If you total your car after four years of driving it and your insurance policy doesn't have a replacement cost clause, you may only be reimbursed for 50% of the initial purchase price. However, if your policy had a replacement cost clause, then you would get the full initial purchase price reimbursed even if your car's actual value was much lower.

INSURANCE INDUSTRY

The hidden advantages of humble insurance agents – Live Mint – 24th February 2022

Anushka Prasad wanted to buy both life and health insurance policies. One of her friends connected her with an insurance agent who gave her quotes for both policies. When she compared the premium rates quoted with what was displayed on a web aggregator's platform, she found the latter to be much cheaper. She chose the web aggregator platform. Such incidents are not uncommon. Many people prefer buying insurance online if it is available at lower rates. Data from insurance regulator Insurance Regulatory and Development Authority of India (IRDAI) shows that the contribution of individual insurance agents to individual new business premium is decreasing. It fell to 58.14 percent in 2020- 21 compared to 60.09 percent in 2019-20 in the life insurance business. In the case of health insurance, it slipped to 73.90 percent in 2020-21 from 75.21 percent in 2019-20. Instead, online direct selling and web aggregators saw an uptick in sales— from 1.72 percent in 2019-20 to 1.92 percent in 2020-21 in life insurance new business premium and from 4.56 percent in 2019-20 to 5.95 percent in 2020-21 in health insurance. Interestingly, the share of banks in new business premium in life insurance increased from 26.7 percent in 2019-20 to 29 percent in 2020-21. However, it decreased from 8.06 percent to 7.84 percent in case of health insurance. The data trend aside, what you must care about is the distribution channel through which you are buying the policy.



Focus on source more than the premium: There is a casual approach to buying insurance. People lay emphasis on the premium amount or a specific insurance company. However, the first step should be to search for a favourable distribution channel, be it individual, corporate agents or web-aggregators. Take into account factors such as expertise in the industry, the agent's commission structure, and the pre and post sales services. Skin in the game: Not all distribution channels earn the same amount on selling a policy. You must understand to what extent you matter to a specific distribution channel. Ask the agent how much upfront or renewable commission they earn from the premium you pay. "Agents' remuneration includes first year as well as renewal commission whereas alternate channels get only first year commission which is higher than the commission given to agents. Hence an agent would be service-oriented because their future commissions

are linked," said Shailesh Kumar, co-founder and insurance head at Insurance Samadhan, a grievance redressal platform.

Mahavir Chopra, founder, Beshak.org agrees with this. “Customer executives on toll-free numbers have goals that may not be aligned to customer’s long-term interest. For instance, if a claim gets rejected due to something amiss in the proposal form or even information that is incorrectly understood, there is hardly any impact on the reputation or earnings of the advisor," says Chopra. So far as banks are concerned, they have the least skin in the game. The online web-aggregator platforms do have a separate team that looks into claims resolution, but banks do not have any such mechanism. Advice jaroori hai: Insurance is not a one-size-fits-all product. Experts can guide you about the product that better suits your needs. The distributor involved should be incisive enough to ask the right questions. “Just as there are family doctors who stay involved with your family for generations, you need a similar connection when buying insurance," said Kumar. Most importantly, when the time comes to file a claim or make changes in the policy, dealing with customer care executives or bank officials is the last thing you want.

“In an imperfect world of insurance where post-sales services are still not seamless, you need a human by your side. Accept it or not, insurers have a certain conflict of interest in settling claims. We have seen cases where they would rather err on the side of not paying it over settling a claim. If you have a reputable agent by your side, they will fight for you to get your rightful claims settled," said Chopra. Choose the advisor wisely: It is not that all individual agents are equally good. “95 percent agents leave the business in two-three years. You should buy policies online than going to such agents. At least you will have some support in the former," said Avdhesh Mishra, founder and CEO of Caterpillar Insurance. Do your research well. Some websites like Beshak.org are building an alternative business model. “We have curated a list of professional financial advisors on our platform. Customers can explore the list and get a video consultation with anyone whom they prefer, without paying any fees or charges," said Chopra. “The industry has been working aggressively over the last few years to minimize the difference between what an agent charges and direct sales. In our case, the difference has been coming down year-on-year and is now about 5-7 percent," said Prashant Tripathy, MD & CEO, Max Life Insurance Co.

Mishra of Caterpillar Insurance confirms that he can now match the online prices against the physical services he offers for a couple of life insurance policies. A welcome trend, indeed. Mint Take: Insurance misselling occurs across the board, whether the agent is a bank, aggregator, or individual. However, individual agents with whom you have a direct relationship may provide you with better after-sales service even if they quote a higher premium. Take this into account, while buying an insurance policy.

(The writer is Aprajita Sharma.)

TOP

INSURANCE REGULATION

Irdai wants insurers at par with banks on legal recourse for surety bonds – Business Standard – 25th February 2022

The insurance regulatory and development authority of India (Irdai) has taken up the issue of insurers being treated at par with banks when it comes to recovery recourse available to them for the surety bond business and the government has reacted positively to the concerns of the industry, said TL Almelu, member, Non-Life, Irdai.

Speaking at a seminar organised by National Insurance Academy, Alamelu said, “Recently we had come with surety bond guidelines for which there is huge demand. However, we do understand the concerns raised by the insurers that they should have a recourse to recovery on par with the banks. This aspect has been taken up with the government and I can tell you that they have reacted extremely positively on the issue of trying to keep insurers at par with banks in the IBC code."

The general insurance companies are seeking changes in Indian Contract Act and Insolvency and Bankruptcy Code (IBC) to bring surety bonds at par with bank guarantees when it comes to recourse available to them in case of a default.

The finance minister in her Budget speech this year had said that surety bonds can be used as a substitute for bank guarantees for government procurement in order to reduce the indirect cost for suppliers and work contractors. The insurance industry had hailed this as a very positive move as this will give a big boost to project financing with overall improvement in project viability.

However, insurers are seeking legal recourse against defaulting contractors to whom the surety bonds are issued. Interestingly, the working group, which the insurance regulator had formed to study the viability of the surety bonds business, had recommended a robust legislation for surety bonds and other non-fund-based guarantees as a necessary condition for them to be introduced.

“Surety bonds may also be included in other Acts such as Insolvency and Bankruptcy code, 2016 and given equivalent status as bank guarantees to ensure speedy and effective resolution and enforcement of indemnity by surety providers”, it had said.

A surety bond is a three-party contract by which one party (the surety) guarantees the performance or obligations of a second party (the principal) to a third party (the obligee).

The insurance regulator in January this year had come out with a framework for development of surety insurance business in the country, which will come into effect from April 1, 2022, that allows Indian general insurers to commence surety insurance business, if they have 1.25 times the solvency margin they are required to keep. The insurance regulator mandates insurance companies to maintain solvency of 1.5x at all times.

(The writer is Subrata Panda.)

TOP

IRDAI Proposes Policyholders Less Accountable Porting Health Policy – Live Mint – 23rd February 2022

Soon, insures could be solely responsible for gathering claims information of a policyholder from existing insurer following the porting of a health policy. As a result, insures will not be able to repudiate claims on the grounds of non-disclosure. Also, insurers will have to seek necessary medical and claims history of a policyholder from existing insurer within five working days of receipt of portability form.

The proposed changes by the Insurance Regulatory and Development Authority of India (Irdai) aim to make policyholders less accountable while porting their health insurance policy.

Nikhil Kamdar, appointed actuary, Digit Insurance, said as per the proposed guidelines, insurers will be responsible for obtaining previous claims history from the existing insurer of the policyholder. Earlier, it was the insured's responsibility to disclose these details to the new insurer, and future claims could be rejected if such details were not shared explicitly at the time of porting.

"Further, insurers have been advised to publish on their websites all information on the sequence of steps that need to be followed in addition to the responsibilities of the policyholder while porting their policy. The proposed changes could make policyholders less accountable while porting and increase the responsibility on insurers as they would have to carry out enhanced due diligence," said Kamdar.

The guidelines have also prescribed a five-day period from receiving the portability form for the port-in insurer to seek all necessary information from existing insurer.

Naval Goel, Founder and CEO, PolicyX.com, said by making portability a time-bound process, Irdai aims to ensure that policyholders will not have their requests pending for an undefined period.

"Since portability is quite a common trend in health insurance and it was primarily done manually, which you used to consume at least 15 days, or more, this mandate was quite essential. During this course, the policyholders were never sure whether they would get the new policy or not and if they didn't get the health insurance from the new insurer, that would put them in a difficult situation. However, this won't be the case with these new draft amendments," said Goel.

Besides, Irdai has also proposed that insurers arrange an adequate number of public and private sector network providers across geographies to provide cashless facility. Goel said, "The prime focus of health insurance is to provide cashless facilities to the policyholders during a dire situation. However, policyholders have to suffer due to the non-availability of the network hospitals. Hence, this mandate will further signify the importance of health insurance and ensure higher reliability on customers' insurance policies."

Irdai, in consultation with the Insurance Advisory Committee, has proposed these amendments in regulation. The draft is under review, and Irdai has asked stakeholders to share their feedback.

(The writer is Navneet Dubey.)

TOP

Irdai proposes lifelong renewability of personal accident insurance, time bound porting of policy – The Economic Times – 19th February 2022

The Irdai is planning to amend insurance rules so that insurers cannot deny lifelong renewal of a personal accident policy provided the policy has been earlier renewed without a break. . As per an exposure draft issued by the Insurance Regulatory and Development Authority of India (Irdai) on February 16, 2022, an insurer will not be able to deny lifelong renewal of a personal accident insurance policy on the grounds of age of policyholder. This is one of the changes proposed in insurance regulations in the exposure draft.

Similarly, if a policyholder wishes to port his insurance policy from one insurer to another then, once the portability form is received, then within 5 days the insurance company shall seek necessary details from the existing insurance company. The amendment is proposed in order to make the portability of insurance policy a time-bound exercise. Further, insurer companies are encouraged to offer discounts where there is an improvement in the risk profile of policyholder, as per the Irdai draft.

Kapil Mehta, Co-founder, Secure Now says, "The amendments proposed to the IRDA Health Insurance Regulations are of different types. From a policyholder perspective the most important proposals are that personal accident be renewable lifelong, in portability the onus to pull out prior claim information is the insurers' and insurers are encouraged to give discounts on renewals if a policyholder's health or other circumstances improve. Currently most personal accident plans have an upper age cap and senior citizens are largely uncovered. This issue will be addressed. Also, ported health insurances have a relatively larger number of claim rejections where the insurer says that prior claims were not correctly disclosed. This will now reduce because insurers will need to speak with other insurers to get claims information and cannot lay the blame on policyholders."

Changes proposed regarding personal accident policy
"Personal Accident products are also proposed to be brought under the ambit of lifelong renewability in the interest of the policyholders," said the Irdai in the exposure draft. As per the existing regulation, "Except travel insurance products, personal accident products and Pilot Products referred to in Regulation 2(i) (l) herein, once a proposal is accepted and a policy is issued which is thereafter renewed periodically without any break, further renewal shall not be denied on grounds of the age of the insured."

The words 'personal accident products' are proposed to be deleted from this clause as per the Irdai draft.

Discounts on improvement in risk profile
Similarly, existing regulation is proposed to be modified to encourage insurers to offer discounts where there is an improvement in the risk profile. Currently, in case of improvement of risk profile of customer, only removal of loading is allowed at the time of renewal. Loading is an additional amount added to the insurance premium amount to provide coverage to high-risk customers.

As per the existing regulation, "No Insurer shall resort to fresh underwriting by calling for medical examination, fresh proposal form etc. at renewal stage where there is no change in Sum Insured offered. Provided that where there is an improvement in the risk profile, the Insurer may endeavour to recognise that for removal of loadings at the point of renewal."

The draft proposes to add the word 'discount' in the regulations as follows: No Insurer shall resort to fresh underwriting by calling for medical examination, fresh proposal form at renewal stage where there is no change in Sum Insured offered. Provided that where there is an improvement in the risk profile,

The Insurer may endeavour to recognise that for removal of loadings or offering discount at the point of renewal.

Making insurance portability time bound
In order to make insurance policy portability a time bound exercise, timelines have been prescribed for calling for claim details from the existing insurer. Proposed regulation will require the insurance company to collect necessary details such as medical history and claim history of the policyholder from the existing insurance company within 5 days of receipt of portability form.

As per the existing regulation, "On receipt of the Portability Form, the insurance company shall seek the necessary details of medical history and claim history of the concerned policyholder from the existing insurance company. This shall be done through the web portal of the IRDAI." The current regulation does not provide any timeline for insurance companies to seek details from existing insurance companies of a policy holder in case of portability of policy.

The Irdai has issued the above draft to seek comments from stakeholders in the insurance industry before notifying the proposed changes in the rules.

(The writer is Preeti Motiani.)

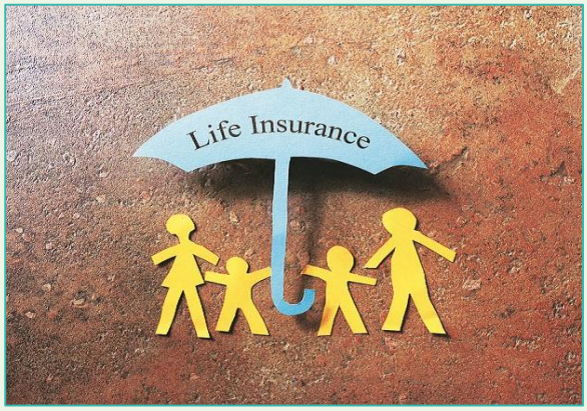
TOP

LIFE INSURANCE

Allowing your life insurance policy to lapse carries a very high cost – Business Standard – 20th February 2022

The persistency ratio within the life insurance industry continues to be low, according to data published in the Handbook on Indian Insurance Statistics for financial year 2020-21. The median 61-month persistency figure for the industry for FY2020-21 stood at 39.4 percent. This figure has remained in the thirties since 2016-17. Persistency ratio tells us what percentage of an insurer's policies are still in force after a certain period of time, say, one, three, four or five years. This figure should be looked up before selecting an insurer. Satisfied customers tend to stay with an insurer for a longer time. Several factors are

responsible for the life insurance industry's low persistency numbers. One is that insurance is a fairly complex product. "A large part of the persistency challenge comes in because people buy a product without a clear understanding of their expectations from it. Do they want a pure term cover, or do they want an insurance cover cum investment plan, say, to plan for their kid's future?" says Manu Lavanya, director and chief operations officer, Max Life Insurance. When products are purchased without understanding their objective, or the financial need they are supposed to fulfil, it leads to disappointment later. Customers then allow such policies to lapse.



Mis-selling is another key reason. Often customers are sold policies without explaining their payment obligations properly. "The customer may think he has purchased a single-premium policy. When he realises he has to pay a premium every year, he abandons the policy," says Kapil Mehta, co-founder and managing director, Secure Now Insurance Broker. Sometimes, customers have incorrect return expectations. They compare the returns from an insurance-cum-investment product with a pure investment product, such as a mutual fund. But returns from the two can't be similar because a part of the premium goes towards meeting the mortality charge (paying for the insurance coverage). In case of unit-linked insurance plans (Ulips), customers at times take short-term calls based on the state of the market. When the markets are up, they decide to cash out. Such tactical calls may not always be in their best interests over the long term. Many people carry a bias that "bad things won't happen to me". Whenever they become financially stressed, payment of insurance premiums is a commitment such customers don't mind breaking.

In the case of some insurers and products, only the annual payment mode is available. Half-yearly, quarterly and monthly modes are not available. "In cases where these options are not available, insurers witness low persistency due to the unavailability of funds in the policyholder's account," says Sanjay Radhakrishnan, chief executive officer (CEO) and principal officer, Hero Insurance Broking. Customers often buy life insurance policies at the last-minute (before the March 31 deadline) for tax saving. When they do so, they don't pay adequate attention to the policy features. Later they realise they have purchased an unsuitable policy and hence abandon it. One operational cause is that customers change the bank account from which they paid their premiums. "But they don't change the NACH forms. This results in non-approval of renewal premiums," says Radhakrishnan.

The cost of customer acquisition is high in life insurance. It is only when premiums come in for many years that this cost gets recovered. A low persistency ratio also erodes an insurer's embedded value (the present value of future cash flows). So, insurers too are taking several steps to ensure customers don't abandon their policies prematurely. Insurers nowadays try to select the right customers. "Insurance companies, with the help of data analytics, work on selecting people with the right financial profile for their products, so that these customers can meet this long-term financial commitment," says Lavanya. They also try to ensure that the customer understands the terms and conditions of the policy at the time of purchase. They use simplified benefit illustrations with graphics that are easy to understand.

Companies also conduct a pre-insurance verification call to ensure that customers understand aspects like the premium they have to pay, the period for which they have to pay it, and the benefits of the product. "Only if the customer fully understands what he has purchased will he be able to answer the questions that are asked in this call. If he has been mis-sold a product, he will fail to answer the questions," says Lavanya. When the premium payment is due, insurers remind customers and ask them to make sure that the bank account from which the payment will happen is funded. In the past two years, when customers failed to pay the premium on time owing to Covid, many insurers waived the late payment charge. To make it easier for customers to meet their commitments, insurers also give them an opportunity to convert annual premiums into quarterly or monthly premiums. In some policies, the

customer can surrender the paid-up additions to adjust against the premium payment. In others, they can opt for premium offset feature which allows them to offset the bonus against the premium payment.

The key fallout of discontinuing a policy is that you lose out on the insurance cover. This can have serious consequences, especially amid a pandemic. According to Ashish Rao, chief customer experience and operations, ICICI Prudential Life Insurance, "Allowing a policy to lapse adversely impacts the purpose and goals for which it has been purchased, like income replacement in case of an eventuality." If you surrender a policy, the insurer levies a surrender charge. "These costs tend to be considerable," says Mehta. If the policy has not acquired a surrender value, you lose out on all the premiums paid until then. "Customers lose out on benefits like sum assured amount and any bonus pay-outs," says Lavanya. In case of term plans, when the customer goes to buy a new policy after allowing the older one to lapse, he will typically face a revised premium which is higher (since he would be older now). "In case of investment and guaranteed income plans the returns are impacted adversely and the risk cover may reduce substantially," says Radhakrishnan.

The key prerequisite for not allowing a policy to lapse is that you buy a policy well suited to your needs. You will then be motivated to pay your premiums and stick to the policy for the long term. This requires that you do a lot of due diligence at the time of purchase. Do your research and compare the policies available in the market. Nowadays you can do a lot of research online, either at the websites of insurers or using aggregator platforms. "Our digital platform facilitates matching products with the needs of customers," says Rao. Research will enhance your understanding of insurance products and enable you to make the right purchase. Make sure the insurer you buy from scores highly on key parameters. "Evaluate the claim settlement ratio and the average time taken to settle claims before finally making the commitment," says Rao.

Don't be in a hurry while making the purchase decision. Sit with the seller and understand the benefit illustration properly: What benefits will you get and at what intervals? Also understand your obligations: How much premium do you have to pay and for how many years? Before deciding to discontinue payment of premiums, speak to the company representatives. They will explain the costs of discontinuing the policy and suggest better alternatives.

Persistency ratios: Slow improvement

	Median persistency ratio (%)				
Year	13-month	25-month	37-month	49-month	61-month
2014-15	57.3	46.0	42.5	38.0	19.0
2015-16	61.2	47.4	41.8	38.1	28.0
2016-17	64.9	53.1	43.9	38.3	31.9
2017-18	69.0	58.2	49.5	41.8	33.8
2018-19	71.8	61.4	52.6	45.0	37.8
2019-20	70.5	62.3	53.3	46.4	37.6
2020-21	72.4	62.9	55.8	51.0	39.4

Persistency figures are for life insurance policies based on number of policies. Data as on March 31, 2021

(The writer is Sanjay Kumar Singh.)

TOP

GENERAL INSURANCE

Huge market available for surety bonds in India: NHAI member Manoj Kumar – Business Standard – 24th February 2022

National Highways Authority of India (NHAI) member Manoj Kumar on Thursday said a huge market is available for surety bonds in the country and now, the onus is on the insurance fraternity to come out with products quickly. Addressing an event organised by industry body Assocham, Kumar further said

the NHAI is working to expand the construction market because "as a country, we had a certain level of construction capability in a strategic manner by having contracts of various sizes".

"A huge market is available for surety bonds in-country and now the onus is on the insurance fraternity to come out with products quickly. We have already initiated at authority level discussions with the insurance agencies and companies," he said.

The member (project) noted that it is important for the industry to come out with the right kind of insurance products.

He pointed out that three years ago, the country had 6-7 players who were doing public-private partnership (PPP) and hybrid annuity model (HAM) projects.
"Today, in the current financial year, we have 25 players. We are now awarding nearly 50 per cent contracts to new players, which in turn has resulted in competitive bids and faster constructions," Kumar said.

He, however, added that it poses another challenge as new players often find it difficult to get bank guarantees and that's where the roles of surety bonds come in.

Surety bonds are different from corporate bonds and financial guarantees.

While surety bonds refer to the performance or delivery obligation to complete the insured project, the corporate bonds refer to financial obligation to repay the debts or loans.

TOP

Standard home insurance policy at affordable premiums: All you need to know – The Economic Times – 21st February 2022

Bharat Griha Raksha (BGR) insurance cover
Many home buyers have bought their dream houses but not a home insurance policy to go along with their homes. The primary reason for this has been costly insurance premia. This led insurance regulator IRDAI to issue guidelines for the issuance of a standard house insurance policy called Bharat Griha Raksha (BGR) meant to cover residential properties at affordable premiums. The regulator mandated all general insurance companies to offer this standard policy and as a result, most insurers have started offering the cover from April 1, 2021. Here is a look at the features of the Bharat Griha Raksha insurance cover and whether you should get it.

Key features of the policy as per IRDAI
Higher sum insured coverage: Rather than the market value, the coverage under this policy takes into account the cost which will be incurred in reinstating or replacing the covered items. The sum insured can be higher than this value but not lower. Affordable premium: Under BGR many insurers are offering the coverage at affordable rates. For instance, you can get Rs 1 crore sum insured at an annual premium of Rs 2,466 from Digit, which effective means an annual premium Rs 247 for each Rs 1 lakh of sum insured. Over the period of 10 years you spend Rs 24,660 to for a protection of Rs 1 crore.

Advantage of no underinsurance
A special feature of this policy is that underinsurance does not apply. Here's an example to understand: Say the area of your home is 100 sq.m and the rate of cost of construction for the city is Rs 15,000 per sq.m. By mistake, you have declared the area as 90 sq.m., and your home building is insured for Rs 13.5

lakh instead of Rs 15 lakh. If there is a loss that requires repairs that costs you Rs 5 lakh, then the insurance company will pay you Rs 5 lakh.

Benefits of sum insured escalation
Annual escalation in long-term policy: The cost of replacing re-construction and re-building material rises with time due to inflation which means that the cost of constructing the house 10 years later would be a multiple of what it is today. To address this, BGR policy comes with an auto escalation feature under which the sum insured amount is raised annually. Being an inbuilt feature this will not cost extra premium for the policyholders in future.

Daily escalation for annual policy: Price rise not only happens annually but also gradually. To give an identical benefit within one policy year, BGR offers daily escalation of sum insured. For an annual policy, the sum insured is automatically increased each day by an amount representing 1/365th of 10% of sum insured at the Policy Commencement Date.

What the plan includes/covers: Types of damages
According to the IRDAI guidelines, the common damages that are covered under the Bharat Griha Raksha include fire, explosion or implosion, lightning, earthquake, volcanic eruption, or other convulsions of nature, storm, cyclone, typhoon, tempest, hurricane, tornado, tsunami, flood and Inundation, landslide, rockslide, bush fire, forest fire and jungle fire. The policy also covers damage caused by impact of or collision caused by any external physical objects such as vehicles, falling trees, aircraft, walls etc. Additionally, the policy covers any physical loss or damage, or destruction caused to the insured property by theft within 7 days from the occurrence of and proximately caused by any of the insured events.

Associated costs and man-made disasters
Besides the actual damage, the policy covers many associated costs which often occur in case of a major damage. It pays up to 2% of the claim amount for reasonable costs of removing debris from the site. Some man-made disasters are also covered under this policy which includes riots, strikes, malicious damages, acts of terrorism and missile testing operations.

Default coverage of home contents unless opted out
In many cases, any damage to the house mostly results in damage to the contents inside it. For this, BGR offers automatic coverage. The sum insured for general home contents is automatically taken as 20% of the sum insured of the home building which is capped at Rs 10 lakh if the home building is covered. If a policyholder does not want this feature, he/she can opt out as recorded choice.

What is excluded?
Certain damages are not covered such as loss, damage or destruction to any electrical/electronic machine, apparatus, fixture, or fitting by over-running, excessive pressure, short circuiting, arcing, self-heating or leakage of electricity from whatever cause (lightning included). This exclusion applies only to the particular machine so lost, damaged or destroyed.

(The writer is Sambhavi Mehrotra.)

TOP

HEALTH INSURANCE

Insurers expand health insurance covers to include LGBTQ persons – Outlook – 24th February 2022

FMCG major Procter & Gamble India on Tuesday announced that it will extend all company-offered financial and medical benefits to the partners of its LGBTQ+ employees. From April 1, 2022, partners of LGBTQ+ employees would be covered under the company's medical plan, which includes hospitalisation coverage. Companies widening their support, which includes healthcare, to all types of employees is a big step forward. Those who identify as LGBTQ find it a struggle to access healthcare professionals who understand their specific needs.

The Transgender Persons (Protection of Rights) Bill (2019) was introduced in Lok Sabha on July 19, 2019, which proposed steps to provide health facilities to transgender persons, including separate HIV surveillance centres and sex reassignment surgeries. The government shall review medical curriculum to address health issues of transgender persons, and provide comprehensive medical insurance schemes for them.

Many companies such as such as Citibank, RBS, Capgemini and Tata Group companies already extend medical cover/family health insurance cover to transgender employees. Recently, Plum, an employee health insurance company, incorporated LGBTQ cover within their employee benefits policy and now offers this to customers as well. "Gender reassignment surgeries were previously considered cosmetic (and hence not normally covered), but we have now been able to include them as part of the standard group medical cover. What this means is that we can offer these policies to all our clients, even by default," says Abhishek Poddar, co-founder and CEO, Plum.

Inclusion doesn't necessarily mean having to create new policies or standards. "All we needed to do was simply widen the scope of what is possible so that they can be included in the same benefits as heterosexual people. After all, that's what equity is; being impartial and just towards everyone. So, essentially, it is the same standard group medical insurance policy, with the important distinction that it is now more inclusive," says Poddar. In April 2019, the insurance regulator had issued advisories to all insurers to ensure that there is no discrimination towards the LGBTQ section of the society in providing health insurance.

Demand and Growth of LGBTQ Health Insurance

Legislative support along with that of social media and corporate initiatives, representation of LGBTQ community has increased in past few years. According to a recent report, LGBTQ persons form close to 15 per cent of the Indian population.

"We see a few proposals received from the LGBTQ community, mainly from urban areas, and they are being processed at par, with no discrimination. Definitely, the numbers did grow during the pandemic period as Covid-19 also did not discriminate in spreading infection. Secondly, as this section of society is small and spread out among so many insurers, the awareness for health and personal accident insurance has been on the rise and we see more proposals coming now," says Gurdeep Singh Batra, head-retail underwriting, Bajaj Allianz General Insurance.

What To Keep In Mind While Availing LGBTQ Health Insurance Policy

Anyone looking to buy health insurance should analyse the healthcare requirements and the cost of medical treatment or procedures in order to arrive at an appropriate sum insured. "Understand the policy coverage and see if it fits with what you're looking for. It's also crucial to understand the claim process, exclusions under the policy and network hospitals of your insurer as it helps have a seamless experience at the time of making a claim," says Batra. It's important to address specific health needs and risks while availing LGBTQ health insurance as every individual may have different needs. For some, the primary need may be for hormone therapy and surgery while other may be more focused on mental well-being. "Due to the pressures of society, the LGBTQ community may experience higher instances of substance abuse, depression and anxiety than the general population. Including them in standard policies is just the start. We need to have more and deeper conversations about these aspects, so that we can continue to make progress," says Poddar.

(The writer is Meghna Maiti.)

TOP

Corporate hospitals cash in on govt health insurance plans; reach hinterland sans branches – Money control – 22nd February 2022

A patient who has had a heart attack or is in need of urgent specialist medical care in Malda, a district 325 km north of Kolkata, has little choice but to travel to the West Bengal capital for treatment. The journey takes eight hours. The poorly equipped and thinly staffed government medical college and hospital in Malda doesn't inspire confidence in local residents so they make the arduous journey by road to Kolkata. In many cases, they don't make it alive to a tertiary care hospital.

People lack sufficient paying capacity and specialist doctors are reluctant to serve in small-town India, which in turn means that timely secondary and tertiary healthcare is inaccessible to the majority of the residents across the country. So how do millions of people living in districts like Malda access quality healthcare in the most vulnerable moments of their lives? An option that did not seem even remotely possible some years ago has appeared on the horizon.

Big corporate healthcare providers are turning their attention towards small towns, forging alliances with local partners through innovative models—teleconsultation for specialist care and by setting up virtually run critical and emergency care facilities -- without the need to build brick and mortar structures.

Private-private partnerships

In September 2018, the Narendra Modi government launched its flagship health insurance programme Ayushman Bharat- Pradhan Mantri Jan Arogya Yojana (AB-PMJAY), billed as the largest such public initiative in the world. Its aim was to cover 100 million poor and vulnerable families in the country with cashless hospitalisation insurance of up to Rs 5 lakh.

In the past, the government's focus was on providing services, building hospitals, staffing them with human resources and installing equipment. Under PMJAY, the approach has changed. Now, it has started paying healthcare providers based on service delivery to the people who needed advanced care. Of the 25,000 hospitals empanelled under the scheme, nearly 10,500 are private facilities, many of them small ones with 20-50 beds each.

Several of these small hospitals have joined hands with major multi-speciality chains from the big cities and are catering to people needing secondary and tertiary care through facilities like e-ICUs and teleconsultation, a concept that has existed for two decades but has been popularised only over the last few years. While there has been no dearth of demand for quality healthcare services in the country, the problem has always been lack of funds, said Ayanabh DebGupta, member of the health services committee at the Federation of Indian Chambers of Commerce and Industry (FICCI).

"Earlier in small towns and rural areas, people were not able to afford the specialized medical care, but now schemes like AB-PMJAY, Swasthya Sathi in West Bengal and other state health insurance schemes are taking care of financing," said DebGupta, co-founder and joint managing director of the Medica group of hospitals. Swasthya Sathi, a health scheme that guarantees cashless secondary and tertiary care treatment of up to Rs 5 lakh at empanelled hospitals every year—similar to AB-PMJAY-- was launched in West Bengal in 2016.

DebGupta chain of hospitals, which has 10 branches in Bihar and Jharkhand apart from West Bengal in cities like Patna, Kolkata, Ranchi and Siliguri, is now seeking a footprint in every district of these states through local partners.

"It's like a supply chain concept and people recall your name," he explains. "How COVID-19 pandemic has helped is that tele-consultation has become a reality. Earlier, seeing a doctor in front of you was a very important thing, but a lot of people have started using teleconsultation; that has helped bridge a barrier," DebGupta adds.

The Manipal hospital group, for instance, was remotely monitoring the health of COVID-19 patients, including Intensive Care Unit inmates, in 16 districts of Karnataka during the pandemic's first wave in 2020. It was an initiative formally approved by the state government.

Hub and spoke model

Healing Touch hospital in Bhagalpur, Bihar, was established in 2001 by Dr Sanjay Kumar Singh, a surgeon trained in Dubai, UK and Singapore, and his wife, obstetrician-gynaecologist Dr Pratibha Singh. "I come from a family of doctors and wanted to serve back my society and people and set up the hospital to offer services and facilities that were not here earlier," he said.

Always aspiring to do something better and bigger, he tied up with Medica in 2018 to set up a nine-bed e-ICU. The hospital group has entered into such collaborations with several local hospitals in towns like Munger, Gaya and Deoghar in Bihar alone. Similar collaborations are being undertaken by other healthcare groups such as Narayana, Apollo and Manipal, said DebGupta, adding that more than 100 such tie-ups would have taken place over the last 3-4 years.

Mutual benefits

Such collaborations work this way. A hospital with basic facilities ties up with a major hospital chain from the cities and sends its MBBS doctors to the latter for a training programme of nearly three months. At Manipal, these professionals are then called "master medics". These doctors, on their return, know what basic protocols to follow for patients in need of critical and emergency care and then hook up with specialists in the cities for real-time monitoring using technology and virtual treatment methods.

What's more, the big hospital chains are also helping their local partners in improving basic hygiene and health standards—which in a few cases has led to them receiving accreditation by the National Accreditation Board for Hospitals & Healthcare Providers (NABH).

"That's bringing a phenomenal amount of change in bringing tertiary care to people in small cities," said a Confederation of Indian Industry (CII) member who is associated with a leading hospital chain in North India. Karthik Rajagopal, the co-chair of the FICCI Health services committee and chief operating officer of Manipal Hospitals, said the group was working on innovative methods to take its medical capabilities to small towns.

"We are partnering with hospitals in secondary cities to offer outpatient consultations, like in oncology, cardiac or orthopaedics," he told Money control. Dr Singh explained that for every patient so treated and managed, the larger group-in his case Medica-receives a fixed sum. It also gets the advantage of strengthening the group's brand and recall value in the hinterland.

Infrastructure, innovation but is it benefitting the last man in the line?

Dr Shankar Narang, COO of Paras Healthcare, stresses that it is critical to put in place a strong medical infrastructure and to be innovative to ensure that quality healthcare reaches the masses at an affordable cost. He has a point- given that rural India gets just one-third of total hospital beds, or, in other words, 28 per cent of the population in urban parts gets 75 per cent of the medical infrastructure available in the country.

But can the task of taking medical expertise and quality and timely healthcare beyond the big cities be left entirely to the private sector alone?

Antony Kollanur, a public health activist who is also an independent monitor of the Centre's National Health Mission, says that if Five Star hospitals run collaborative nursing homes in Tier-3 towns, that could be a financially efficient model of extending tertiary care, especially e-ICUs and coronary care units; they will mainly benefit the upper-middle class and the rich.

"But what about the poor who cannot afford it? Will the government upgrade the services in the district hospitals for a matching quality of services," he asks, adding that if not, it was akin to abdicating its core responsibility to common citizens. "On the other hand, if you purchase such services through empanelment under the AB-PMJAY scheme of newly mushroomed private hospitals, it is a hidden sale. It is akin to siphoning out of public funds for the betterment of the private sector, not aimed at the welfare of the common man."

(The writer is Sumi Sukanya Dutta.)

TOP

Can 'Ayushman Bharat' become a Game Changer for India? - The Times of India – 22nd February2022

Good health policies of the country make a significant impact on its economy through building good health status of the population. The latest Economic survey states that India ranks 179 out of 189 countries in prioritisation accorded to healthcare in its government budget. Indian Government is committed to increase public spending from current 1.35 percent to 2.5 percent of GDP in the near future. Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (PM-JAY) is one such initiative to achieve this goal. It is expected to be a game changer in India. As Prime Minister Narendra Modi mentions "It is a holistic solution for a healthy India". It strives to give free access to medical services to nearly 40 percent of the population which covers around 50 crore people along with free primary, secondary and tertiary level medical care by providing a health insurance of Rs 5 lakh per family per year. The current budget has a higher allocation for Ayushman Bharat Digital Mission through building national digital health ecosystem.

The latest figures on Ayushman Bharat portal show that 17.35 crores person till date received Ayushman Bharat cards and 2.61 crores person availed the facility of hospital admissions. It is only a humble start. We need to see how effectively we can reach the vulnerable population in order to make it more effective. It can be argued that the effectiveness of the Ayushman Bharat programme depends on overcoming many other challenges besides an increase in budget allocation. One needs to see how the interests of different stakeholders are synergized together. Let's look into some of them.

Central and state governments are some of the key stakeholders. It is important to notice that though Ayushman Bharat is rolled out by the central government, its implementation responsibility lies with the state governments. Many state governments such as Karnataka, Andhra Pradesh, Maharashtra, etc. have already launched their flagship health programmes. The states can either join this programme by subsuming their existing plans or run their own health programmes. Many state governments such as Karnataka, Andhra Pradesh, Maharashtra, etc. have already launched their flagship health programmes. The states can either join this programme by subsuming their existing plans or run their own health programmes. Many state governments are still sceptical about joining hands with the central governments due to fear of losing autonomy.

The role of public healthcare in providing primary healthcare is very crucial for creating the nexus between primary and secondary healthcare. Inadequate availability of public healthcare infrastructure in terms of number of primary healthcare centres, sub-centres, and other infrastructure has been a chronic problem in our country since independence. Though the programme has an ambitious plan to build 1,50,000 Health and Wellness Centres (HWCs) by transforming the existing centres, it is difficult to implement it on the ground. It means the success of the programme depends on voluntary participation of private healthcare sector, especially private hospitals. The programme may benefit the private

hospitals in boosting the demand for many special or super specialised treatments and scaling up their operations. Approximately 23,000 private hospitals have empanelled in this scheme. They are facing many challenges such as low fixed rates per surgery, prevalence of fraudulent cases and complicated reimbursement processes.

Private health insurance sector acts as a major pillar of the programme. The state governments ask for a competitive bidding from the insurance companies for accessibility of health insurance to masses. This might help insurance companies to scale-up very fast and reduce their average cost of customer acquisition. At the same time, they may run a high risk of reducing the premium charges to a low level where they may become unviable.

It is expected that firms operating in pharmaceuticals, diagnostics medical device and digital healthcare will act as a support system to the entire health eco-system. MedTech companies using technologies such as virtual reality, artificial intelligence, wireless sensors, 3D printing, digital healthcare can be used to collate and analyse data, bring down the costs and reach the bottom of the pyramid section effectively. In a nutshell, we can say that the success of this programme depends on the development of skilled manpower. Healthcare workers require additional skills such as empathy, trustworthiness and communication skills along with technical and managerial skills. They are hard to develop in the short-run. India needs to have good quality healthcare education institutes to create such skillsets. Successful implementation of this programme will not only take India ahead on the global front in improving the health status but also in creating a strong base for future economic growth. The key of successful implementation depends on i) creating a mechanism to see that all the stakeholders are benefitting, ii) bringing coordination between different stakeholders, and iii) creating vigilant monitoring system to control the quality.

TOP

Long-term Health Insurance: One-stop solution to reduce the burden of yearly renewal – Financial Express – 21st February 2022

To avoid crowding at the limited numbers of government-run hospitals and to get quick medical attention, many people have no option but to visit private hospitals. However, treatments in private hospitals are generally very costly and the rate of inflation in treatment costs are also very high.

So, in case of hospitalisation in a private hospital, the medical bill may run into several lakhs of rupees, exhausting even the lifetime savings of a patient and his/her family. Therefore, to reduce the uncertainty of treatment costs, taking an adequate health insurance cover has become a necessity, where the premium to be paid is known, which makes the money outgo in case of hospitalisation quite predictable.

So, before you start investing, you should first take insurance covers – health insurance, life insurance and other necessary insurance covers – to reduce financial uncertainty, which in turn would ensure that the investment plans don't get derailed in case of any eventuality. Once a good health insurance plan – that suits your requirements – is selected, you have to decide whether to take the cover for 1 year or for a longer period.

While the insurance benefits remain the same for both short-term and long-term policies, by taking cover for a longer period, you may get saved from paying higher premium during renewal in case of upward revision of the premium in between the policy period.

"Customers have the choice to buy an annual or a multi-year cover for health insurance. Multi-year cover provides a host of benefits to consumers. The premium of a 3-year policy will not change even if the insurer decides to revise the premium during the period. As an example, if the premium is revised by 10 per cent at the end of year one, the customer will continue to get the benefit of lower premiums for the rest of the multi-year cover and in this case would save on 10 per cent for another two years. The policy once booked will continue to cost the same in subsequent years, making it immune to market volatility," said Mayank Bathwal, CEO, Aditya Birla Health Insurance Co. Ltd. By opting for long-period cover, a policyholder also gets some discounts on the premium amount.

"Additionally, policyholders are also eligible to receive a discount of 10 per cent for a 3-year policy & 7.5 per cent discount for a 2-year policy including the first year premium payable which will further increase their savings. A longer policy also ensures protection in a seamless manner for the entire family and the customer can avail tax benefit for the premium in an apportioned manner in respective years as applicable as well," said Bathwal.

(The writer is Amitava Chakrabarty.)

TOP

Buy health insurance within 7 days of being diagnosed with covid – Outlook – 21st February 2022

You may now be able to buy a health insurance cover after a maximum of seven days after being diagnosed with Covid, irrespective of whether you are vaccinated or not. Some insurers, including Niva Bupa Health Insurance, Care Health Insurance and Digit General Insurance, have reduced the cooling off period to zero to seven days from the day you get diagnosed with Covid.

All Niva Bupa plans that cover Covid have a zero-day cooling-off period, while all Care Health insurance plans and health plans from Digit General Insurance offer a seven-day cooling off period.

What is cooling off period?

The cooling off period is the time during which a person affected by a certain disease may not be able to buy health cover. This may vary from a few days to a few months.

The cooling off period is considered as an essential tool for health insurers to ensure the customer's health is evaluated fairly and accurately. For instance, in case of Covid, a person may be asymptomatic and won't know that he is suffering from the infection. However, the person may get diagnosed or the symptoms might start to show in a few days.

The cooling off period applied to health insurance policies even before the pandemic. Cooling off period is different for different diseases. It varies from condition to condition and insurer to insurer. It is, typically, two-four years for pre-existing conditions like diabetes or hypertension.

What happened after the covid outbreak?

The initial waves of infection plunged the world into a prolonged state of panic, resulting in a slew of restrictions imposed around the world. The insurance industry was directly affected by the outbreak.

Initially, the cooling off period was longer for new health insurance plans but as the severity of Covid variants has reduced, this has come down. "Previously, the waiting period for some policies could have been as long as six months. This is especially true for the second wave, when both the number of claims and the severity of infection increased dramatically. This period was gradually reduced to 30 days. Insurers are now offering a waiting period of as low as seven to 15 days for Covid detection. Not only

that, but some insurance companies even offer a zero-day cooling-off period," says Amit Chhabra, head, health insurance, Policybazaar.com.

What should you do?
Ideally, you should buy health insurance before you get infected with Covid to be able to avail the policy benefits without any delay. You should make sure that you go through the policy terms and conditions and check if the policy covers Covid-related infections.

While the third wave may be slowing down for the time being, it is unclear when the next variant will hit and how severe it would be. "The bottom line is that we have no idea how long we will be fighting this pandemic or how severe the infection will become in the future. As a result, protecting yourself and your loved ones is a must," adds Chhabra.

Remember to disclose all the information at the time of policy issuance to avoid any discrepancies that can later lead to rejections. Existing policyholders should remember to renew their health insurance policy before it expires and check if the sum insured is adequate.

(The writer is Meghna Maiti.)

TOP

SURVEY & REPORTS

Financial security gains prominence post-COVID: Max Life survey – Financial Express – 23rd February 2022

India's awareness towards life insurance grew significantly over the last two years due to COVID, and the need for financial security has gained priority among people, according to Max Life's annual flagship survey.

Launching the 4th edition of the India Protection Quotient (IPQ) survey on Wednesday, the life insurer said the 'Protection Quotient' of urban India has moved up 3 points to 50, witnessing a gradual rise from previous IPQ editions.

The trend line reflects a steady growth in the country's overall financial protection that has led to prioritizing financial security over all other aspects. As per the survey, with the COVID fears receding now, the policyholders in urban India have re-aligned their long-term objectives of children's education and retirement planning.

The survey was conducted online during December 10, 2021 to January 14, 2022 with as many as 5,729 respondents across 25 Indian cities. Even as COVID-induced anxieties have reduced, wellbeing has become a key concern, as per the IPQ, and the rising security levels across all zones have led to an overall increase in Protection Quotient. The survey indicates a marginal increase in urban India's knowledge index from 68 to 69, while the security index increased by 5 points to 56.

The survey conducted by Max Life in partnership with Kantar, in a way is a compass to show how policyholders are behaving. This year, the survey revealed that the awareness towards life insurance has gone up compared to the previous year, Prashant Tripathy, Managing Director and CEO, Max Life Insurance said in an interaction. "I must say that when COVID happened, there was a drastic increase in awareness. I am very happy that higher levels of awareness are continuing. Despite COVID settling down, I think people are feeling more secure which is a good news. Awareness is translating to buying. If we look at the ownership of insurance buying at term level, saving level, unit linked level – across all of them, we have seen improvement," he said.

As per the survey, metros, as well as tier 1 and 2 cities witnessed an increase in the protection index. Tier 2 saw a significant rise in life insurance awareness from 61 to 68. This indicates a strong potential in tier 2 markets for life insurance adoption. Tripathy said that people are buying multiple policies now, they now have far more level of understanding, ownership and awareness across all levels of products.

"Term insurance witnessed an uptake in the last two years, with ownership rising to a significant 43 per cent from 39 per cent last year." The survey also reflects an increased ownership of other life-insurance products amongst urban Indians such as savings and market-linked plans. "The last two years have been indeed challenging due to the pandemic, but we also witnessed an upside with India developing financial resilience. This is evident from the insights in IPQ 4.0 that shows a strong sense of financial security amongst urban Indians," said Tripathy.

However, he also pointed towards challenges for the industry, as 1 in 4 urban Indians associate term plans with high premiums. "Despite the positive movement, the survey also indicates key challenges for the industry that need to be addressed. While India has realized the real value of term insurance, existing barriers are limiting efforts to drive increased awareness and adoption till the last mile.

"The IPQ study will help us create customer-centric measures to resolve these issues, while enabling collective responsibility to build a higher level of trust with customers," he added. There is a growing significance of sum assured while buying term insurance. More than half of urban Indians feel their term plan cover is insufficient and cover/sum assured, riders and customization have become key term purchase parameters, as per the study.

"People are now giving priority to the sum assured rather than to premium or the frequency of premium outgo," Tripathy said. The survey also noted that millennials were at par with non-millennials in term insurance buying, and also women were at par with men in protection index, as there has been a significant increase among women in security levels. Salaried segment noted improvement across all key indices, self-employed witnessed fall in term insurance ownership. Soumya Mohanty, Managing Director and CCO, Kantar Insights, South Asia said IPQ is an important financial signifier for the country, especially in the current times.

"With IPQ 4.0, we have administered a complete digital survey across a robust sample that has given us unique insights on how urban India has financially evolved. The one key outcome that emerges from the survey, is the significant increase in security levels of the urban milieu. Despite the unprecedented impact of Covid-19, this is an important indication of the growing financial consciousness in the country," Mohanty said.

TOP

Pandemic effect: Indian consumers now more conscious of health, fitness and holistic nutrition, says survey – Financial Express – 18th February 2022

Indian consumers are willing to spend more on fitness classes and activities, consuming natural foods, health supplements, and following specialised diets with the COVID-19 pandemic creating 'the biggest seismic shift' taking health and immunity to the centre stage, according to a survey by consultancy firm EY India.

Around 94 per cent of Indians are worried about their family's health against 82 per cent globally, while 52 per cent of respondents think changes in their approach to mental wellbeing will persist beyond COVID-19, globally it is just 39 per cent as per EY India's report 'The Sunrise Consumer Health and Nutrition Sector'. "While some see this as a short-term phenomenon, we expect this phase to catalyse a larger acceleration in the propensity towards personal health, hygiene, fitness and holistic nutrition," EY India National Leader – Consumer Product & Retail Sector Angshuman Bhattacharya said in a statement. European and Asian nations have adopted functional foods and supplements, the Indian consumer is still predominantly showing a preference for "better for you" foods and home remedies, he added.

"Ayurveda and herbal are increasingly becoming 'back to roots' answers to modern problems," Bhattacharya noted. EY said Indian consumers have opened their wallets towards fitness classes and

activities, consuming natural foods, health supplements, and following specialised diets. According to the survey, 40 per cent of Indian respondents stated that they will pay a premium for products promoting health and wellness, which is higher than their global counterparts at 29 per cent. The survey numbers are based on EY Future Consumer Index (November 2021) with a total of 16,000 global respondents out of which 1,002 were from India.

The dietary supplements market, always considered to be high potential given the growing lifestyle diseases, has witnessed an accelerated adoption curve, post COVID-19, EY India said, adding over the last year, the demand for herbal supplements and vitamins and minerals have witnessed a growth of over 25 per cent. The growing interest in natural and ayurvedic products has encouraged companies, already active in this segment, to assert their credentials more strongly, while it has also attracted the attention of players from pharmaceuticals, the EY report said.

TOP

INSURANCE CASES

'Pay 75% of insured amount even if conditions breached' – The Times of India – 25th February 2022

Even if a consumer has breached the rules of an insurance policy, the insurer is entitled to 75 percent of the insurance amount. A consumer court in Banaskantha gave a judgement that would bring relief to many insured people in the state. Pratapji Vanzara, a resident of Palanpur, had filed a complaint in Banaskantha District Consumer Disputes Redressal Commission against The New India Assurance Company Ltd in August 2019 after his claim was rejected. Vanzara had purchased a tractor and insured it in April 2018. His tractor was stolen by some unidentified persons from Udaipur in Rajasthan in June 2018. A complaint of vehicle theft was filed in Rajasthan and Vanzara later filed a claim for the insurance amount. But his claim was rejected by the insurance firm by saying that he had used the vehicle for commercial purposes. According to the insurance firm, the tractor was to be used for private purposes only and hence Vanzara has breached the rules of the insurance policy.

He then approached the consumer forum through Jagrut Nagrik Grahak Suraksha Mandal in Banaskantha and sought Rs 2.50 lakh with 18% apart from Rs one lakh towards mental harassment and Rs 25,000 from the insurance firm. Vanzara said his vehicle was stolen and he had submitted the police complaint's copy. The plaintiff said that the insurance firm didn't do its private investigation about the theft and has incorrectly rejected the claim.

"The court observed that even if the insured person has breached some policy conditions, he or she is entitled to 75% of the insurance amount as per non-standard base. The court said that the national commission too has given such an order and hence Vanzara's claim was partly accepted," said P V Moorjhani of Jagrut Nagrik Grahak Suraksha Mandal.

The court ordered the insurance firm to pay Rs 1.87 lakh to Vanzara with 9% interest from the date when the complaint was filed. Also, the firm will have to pay Rs Rs 1, 500 towards legal fees and Rs 1,000 for mental harassment to Vanzara.

(The writer is Tushar Tere.)

TOP

Plea in HC alleges misappropriation of funds in Crop Insurance Policy – The Print – 23rd February 2022

The Uttarakhand High Court on Wednesday sought a reply from the state government on a PIL alleging irregularities in the Centre's crop insurance scheme. The matter was heard before a division bench of Acting Chief Justice Sanjay Kumar Mishra and Justice NS Dhanik.

It will now take up the matter on March 9. Ajit Singh, a resident of Nainital, had filed a PIL in the High Court claiming that 42,300 farmers of Nainital district had insured the Kharif crop in 2020 under Prime Minister's Crop Insurance from SBI General Insurance Company.

However, wrong figures were logged in by a Mumbai-based company responsible for data entry. Due to this, farmers received a negligible amount of money while many received no money at all for their insurance claims, he alleged.

When a complaint was made to the Prime Minister's Office, the matter was raised in Parliament. The PIL has been filed demanding action against SBI General Insurance Company, the Mumbai-based firm responsible for data entry and compensation to farmers for their losses.

TOP

Needn't pay insurance for death or injury when addl premium not collected: HC – The Times of India – 22nd February 2022

When an insurance policy is issued under Motor Vehicles (MV) Act, 1988, without collecting additional premium to cover the risk of inmates in a private car, there is no liability on the part of the company to pay compensation to them for personal injury or death due to accident. The high court made this observation in a recent judgment while upholding the contention raised by United India Insurance Company Limited.

Allowing the firm's petition and setting aside the award fixing the liability to pay compensation on the appellant company, justice P Krishna Bhat said occupants in a private car, which is not used for carrying passengers for hire or reward, are not third parties vis-a-vis the said vehicle.

Justice Bhat said in the New India Assurance Company Limited versus Mahadev Pandurang Patil case (2011), a division bench had already held that the legal obligation arising under section 147 of MV Act cannot be construed as third parties. The judge noted the insured vehicle was a private car and no additional premium was paid to cover the risk of passengers.

The deceased, Puttappa, and his wife Rathnamma were going from Bengaluru to Shikaripura on January 10, 2005 in Omni car owned by KM Neelakanthappa. At 3.30am, due to rash and negligent driving, the driver crashed into a tree in Arsikere, resulting in the death of Puttappa and injuring Rathnamma and several others.

Thereafter, Rathnamma and others filed a claim petition. On March 19, 2010, a Motor Accident Claims Tribunal in Shivamogga directed the insurance company to pay Rs 2.4 lakh with 6% interest to Rathnamma and other claimants. In addition, Rs 6,000 with 6% interest was awarded in favour of the car owner and driver.

The insurance company challenged the award stating it is not liable to reimburse the compensation awarded and the direction of the tribunal is illegal.

(The writer is Vasantha Kumar.)

TOP

Life insurance claim can't be rejected for mis-statement in proposal after 2 years – The Times of India – 21st February 2022

The National Consumer Commission has ruled that a life insurance claim cannot be rejected for misstatement in the policy proposal after a period of two years. The law now provides three years. The present complaint was filed by Nikhil Sharma through his father Ajay Sharma. The complainant was the nominee in the policy taken by his deceased grandfather. Gopal Dass had an account with Karnataka Bank, Varanasi Branch.

The bank's officials persuaded him to take life insurance policies from MetLife India Insurance. He took three policies with a coverage of Rs 30 lakh, Rs70 lakh and Rs 35 lakh, totalling Rs 1. 35 crore. The policies were issued after subjecting him to medical tests. His grandson, Nikhil Sharma, was a nominee under all the policies. Gopal Dass expired on October 25, 2011.

Nikhil, being a minor, lodged the claims through his father, Ajay Sharma. However, the claims were rejected through a common repudiation letter on the ground that Gopal Dass had suppressed material facts relating to his income. The insurer, however, issued demand drafts for Rs 4,43,941, Rs 54,137 and Rs 31,140 under each policy without giving any explanation.

Nikhil refused to accept the demand drafts, and approached the Insurance Ombudsman, but his complaints were rejected on technical grounds. So Nikhil filed a complaint before the National Consumer Commission. In its order of February 9, 2022, delivered by C. Viswanath and Justice Ram Surat Ram Maurya, the National Commission ordered the insurer to pay the entire claim, totalling Rs 1. 35 crore along with 9% interest.

(The writer is Jehangir Gai.)

TOP

PENSION

No need to prove criminal intent to fine employer for EPF delay: SC – The Times of India – 25th February 2022

The Supreme has held that in case of any default or delay in payment of Employees Provident Fund (EPF) contribution by employers, the authorities can impose penalty and damages without establishing if there was any criminal intent, reports Amit AnandChoudhary. A bench of Justices Ajay Rastogi and Abhay S Oka dismissed a plea of a company which had challenged imposition of damages of Rs 85,548 in addition to Rs 74,288 which it had not contributed towards EPF. It held that once default in payment of contribution is admitted, the damages are consequential and the employer is under an obligation to pay the damages for delay in payment of contribution of EPF. "We are of the considered view that any default or delay in payment of EPF contribution by the employer under the Act is a sine qua non for imposition of levy of damages under Section 14B of the Act 1952 and mens rea (criminal intent) or actus reus (criminal act) is not an essential element for imposing penalty for breach of civil obligations/liabilities," it said.

(The writer is Amit Anand Choudhary.)

TOP

National Pension System: Charges of these NPS services increased – Live Mint – 23rd February 2022

The Pension Fund Regulatory and Development Authority (PFRDA) has increased the service charges for Points of Presence (POPs) under the National Pension System (NPS) for all citizens as well as corporations. The charges of NPS-related services offered at POP outlets have been hiked with effect from February 1, 2022.

"With a view to incentivize the POPs to actively promote and distribute NPS and provide better customer service, applicable charges for POPs for the various services provided by them is being revised,"PFRDA said in its circular.

The revised charges structure for POPs under NPS (All citizens and corporates)
Initial subscriber registration: ₹200 – ₹400 (Negotiable with slab only; collected upfront)
Initial and subsequent transactions: Up to 0.50% of contribution (Minimum ₹30 Maximum ₹25000 (Negotiable with slab only; Non-Financial ₹30) (collected upfront)
Persistency: For more than 6 months in a FY and minimum contribution of ₹1000 to ₹2999: ₹50 per annum (Through cancellation of units only for NPS All Citizen)
For a minimum contribution of ₹3000 to ₹2999: ₹50 per annum
For a minimum contribution of ₹3000 to ₹6000: ₹75 per annum
For a minimum contribution of above ₹6000: ₹100 per annum
Subsequent contribution through eNPS: 0.20% of contribution (Minimum Rs15 Maximum Rs10,000) (collected upfront)

Processing of exit and withdrawal services. The charge of 0.125% of Corpus with a minimum of ₹125 and a maximum of ₹500 will be collected upfront.

Effective from February 15th, 2022, charges on all subsequent contributions through eNPS have been enhanced to 0.20 per cent of the contribution, subject to a minimum of ₹15 and a maximum charge of ₹10,000. This service charge will not be applicable for subscribers registered in eNPS.

NPS is a market-linked, defined-contribution product that needs you to invest regularly in the funds of your choice.

TOP

Employer obligated to pay damages for delay in payment of EPF contribution: Supreme Court – Financial Express – 23rd February 2022

An employer is under an obligation to pay the damages for delay in payment of the contribution of Employees' Provident Fund (EPF) of an employee, the Supreme Court said on Wednesday.

A bench of Justices Ajay Rastogi and Abhay S Oka said Employees Provident Fund & Miscellaneous Provisions Act is legislation for providing social security to the employees working in any establishment and engaging 20 or more persons.

The top court said that the Act casts an obligation upon the employer to make the compulsory deduction for provident fund and to deposit in the workers' account in the EPF office.

"We are of the considered view that any default or delay in the payment of EPF contribution by the employer under the Act is a sine qua non for the imposition of levy of damages under Section 14B of the Act 1952 and mens rea or actus reus is not an essential element for imposing penalty/damages for breach of civil obligations/liabilities," the bench said.

The top court was hearing an appeal filed against the judgement of the Karnataka high court which held that the employer is liable to pay damages if he has failed to deposit the contribution of EPF.

TOP

Don't bank just on EPS as its pension payouts are paltry, say analysts – Business Standard – 22nd February 2022

The Employees' Provident Fund Organisation (EPFO) is planning to bring out a new pension product for organised sector workers who get basic wages of more than Rs 15,000 per month and are not mandatorily covered under its Employees' Pension Scheme 1995 (EPS-95), according to media reports. At present, it is mandatory for employees who earn a basic salary plus dearness allowance (DA) of up to Rs 15,000 to enrol in EPS. The key drawback of the current scheme, and the reason a new scheme is being formulated, is that the pension is paltry. The employee and the employer each contribute 12 percent of the employee's basic salary and DA to EPF. Prashant Singh, vice-president and business head – compliance and payroll outsourcing, Team Lease Services, says: "While the employee's entire contribution goes to EPF, 8.33 percent of the employer's share goes to EPS." The formula for calculating the monthly pension from EPS is as follows: (Pensionable salary x number of years contribution to EPS)/70. If a person's monthly wage is Rs 15,000 and he has worked for 30 years, he will receive a monthly pension of (15,000 X 30)/70=Rs 6,428.

On retirement: Number of years served is important. Utsav Trivedi, partner, TAS Law, says, "If the employee is covered by the Act, then the employee receives a monthly pension from the age of 58, provided he has rendered service for a minimum 10 years." Less than 10 years' service: If a person has not completed 10 years of service before attaining the age of 58, he can withdraw the complete sum on turning 58. Disability: EPFO members who become permanently or totally disabled are eligible for a pension even if they don't complete the mandatory service period. Archit Gupta, chief executive officer (CEO), Clear, says, "The employer must, however, have deposited funds for at least one month in the employee's EPS account." Pension to family: In certain scenarios, the employee's family receives the pension. Sandeep Bajaj, managing partner, PSL Advocates & Solicitors, says, "The family gets a pension in case of an employee's death while in the employer's service, provided the employer has deposited funds in his EPS account for at least one month; in case the employee has completed 10 years of service but dies before 58; or in case the employee dies after he started receiving the pension." Singh says, "After that, the children receive the pension till the age of 25. A physically challenged child receives a pension for his entire lifetime."

If you are below 58 on the date of exit, you can opt for a scheme certificate under EPS instead of a lump sum withdrawal. Gupta says, "The scheme certificate allows you to retain EPFO membership in case you plan to join another job." The scheme certificate is given after 10 years of service which, however, need not be continuous. Gupta says, "If you hold a scheme certificate with service of 10 years or more, you get a monthly pension from the age of 58. You can also apply for an early pension at age 50." You can apply for complete withdrawal from EPF and EPS if you lose your job and are unemployed for two months or more, provided your number of years of service (in EPS) is less than 10.

(The writer is Bindisha Sarang.)

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IRDAI CIRCULARS

Topic	***Reference***
List of valid insurance brokers as on 22nd Feb 2022	https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo2120&flag=1

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GLOBAL NEWS

China: Govt promotes export credit insurance to increase foreign trade – Asia Insurance Review

China is stepping up support for export credit insurance as part of its efforts to spur the stable growth of foreign trade. Regulators should guide enterprises to make full use of export credit insurance policy tools and give full play to the role of export credit insurance in risk protection, according to a circular released jointly by the Ministry of Commerce and the state-run China Export &Credit Insurance Corporation, reported Xinhua News Agency.

The circular calls for support to be extended to enterprises to deepen traditional export destinations and tap diversified markets, with a focus on providing credit insurance services for exports to countries along the Belt and Road, emerging markets, and free-trade zone partners. Urging timely attention to the difficulties facing small and medium-sized trade firms, the circular stresses targeted efforts to expand insurance coverage and scale for them and to cut their insurance costs.

It also details efforts to encourage the growth of emerging foreign trade models such as cross-border e-commerce and overseas warehouses. Official data show that China's total foreign trade in goods exceeded $6tn for the first time, despite the COVID-19 pandemic continuing to weigh on global trade.

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Bangladesh: Guidelines drafted for introduction of bancassurance - Asia Insurance Review

Banking and insurance regulators are drafting two sets of guidelines on bancassurance. A Bangladesh Bank presentation indicates that bancassurance operations will lead to higher insurance penetration and improved risk coverage, according to a report by *The Financial Express.* "With bancassurance, the insurance and banking industries can make significant progress in implementing the SDGs (Sustainable Development Goals) for the insurance sector," the presentation states.

Bancassurance would help many more people have access to insurance products by tapping the nationwide reach of banks' branch networks. The Financial Institutions Division (FID) of the Ministry of Finance held a meeting earlier this month on the proposed guidelines with all key stakeholders. Present were representatives from the insurance regulator, Insurance Development and Regulatory Authority of Bangladesh (IDRA), Bangladesh Association of Banks (BAB), and Association of Bankers Bangladesh (ABB).

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