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INSUNEWS

- Weekly e-Newsletter

16th – 22nd December 2016

• Quote for the Week •

The real art of conversation is not only to say the right thing at the right place, but to leave unsaid the wrong thing at the tempting moment.

– Dorothy Nevill

INSIDE THE ISSUE

Source

Insurance Industry

Premiums may Go North for 'East' Indians – The Economic Times – 16th December, 2016

With three years of consecutive claims from cyclones, insurance firms consider bringing in differential premium rates

Insurers may have to bring in differential pricing on insurance premiums in India as there have been an increase in claims, especially from low-lying areas in the eastern part of India which have been deluged by cyclones over the past three consecutive years.

At present, insurers charge one common premium for risks across the country. However, with three years of consecutive claims from cyclones in Andhra Pradesh, Orissa and Tamil Naidu, insurance companies are looking at increasing premium for properties located in low-lying areas, especially on the east coast.

"Claims in the past two consecutive years from one place is unprecedented", said G Srinivasan, chairman and managing director, New India Assurance. "We may look at charging higher premium from factories located in the East and those in low-lying areas as the severity of claims is high."

"We will have to do the modelling of risk based on regions and accumulation of risks to charge differentiated premium", said Sanjay Datta head of underwriting, ICICI Lombard. "We have not done that 1,000 yet." Insurers expect around crore claims from damage caused by Cyclone Vardah. However, this is much lower than last year's Chennai flood claims of 5,000 crore. This in fact exceeded earlier claims made during the Jammu & Kashmir and Uttrakhand floods, when the industry took a 2,000 crore hit.

Insured losses from Chennai floods at around $755 million, was the second costliest insurance event in India on sigma records, according to the latest sigma study by Swiss Re. India's total economic losses from all disasters, including natural and man-made events exceeded $6.2 billion in 2015, according to the study.

Total insured losses were $1 billion, up from $971 million the year before. The severe flash floods in Chennai in November were the largest disaster, causing estimated economic losses of $2.2 billion. Insurance companies were working on setting up a natural catastrophe pool to pay for damages due to cyclones, floods or earthquakes. In India, uninsured losses from all catastrophes and man-made disasters were 84% of the total losses in 2015. Most of the claims after floods are from motor and fire policies. These claims highlight the vulnerability of growing urban areas to floods caused by heavy rains.

Back

Govt. woos staff with insurance, easy credit – The Tribune – 18th December, 2016

With uncertainty looming large over the regularisation of employees — a major vote garnering sop for lakhs of state government employees – the Punjab government today announced a slew of incentives to woo its staff and their families.

The government announced personal accidental insurance up to 15 lakh, air accident insurance up to 25 lakh and permanent disability insurance up to Rs 5 lakh for all salary account holders of the government employees, apart from several banking services and facilities.

Chief Secretary Sarvesh Kaushal said the incentives were finalised after working out detailed modalities with senior management of the State Bank of India.

The employees can get free international gold/platinum debit cards for international travel without annual maintenance charges. Employees can also get a free add-on card for spouse. Credit/loan related facilities have also been provided to the employees at zero processing charges and competitive home loan rate of 9.4 per cent, car loans at 9.75 per cent, gold loan at 11.2 per cent and express credit at 12.6 per cent to 15.2 per cent. NPS and Sukanaya Samridhi schemes are also available for all employees who can avail overdraft facility up to two months' salary at very competitive rates.

Source

All employees can take credit cards as per their eligibility from the bank branches concerned. Various facilities extended to employees on internet banking include fixed deposits, utility bill payments, online payment of taxes etc.

Kaushal said all these facilities had been tailor made for the government staff.

Back

Govt's online insurance discounts not on renewals – The Times of India - 17th December, 2016

Buyers of motor and health insurance from state-owned companies will get 10% discount only if they switch companies. This is because the online discounts announced by the finance minister are available only for new policies, and not renewals. The online discount offered by the Life Insurance Corporation (LIC) is even more limited as it applies only to online term policies.

All the four public sector companies — National Insurance, New India Assurance, Oriental Insurance and United India Insurance — have filed for new discounted online policies. These discounts will be available only on those policies sold through the customer portal. At present, companies offer motor, health, personal accident and travel insurance online. Although online renewals have started picking up, new sales are still small.

Last week, the finance minister announced a host of measures to promote online payments. These were in the form of discounts offered by public sector companies. Oil companies and railways will offer a 0.75% and 0.5% discount, respectively, on payments made via debit card. Public sector insurers will provide incentive, by way of discount or credit, up to 10% of the premium in general insurance policies and 8% in new life policies of LIC sold through the customer portals.

"Our premium from online sales is around Rs 150 crore. It is roughly 1% of our gross premium," said G Srinivasan, chairman, New India Assurance. New India has already started offering 2% discount on private car, two wheeler, personal accident, householder and individual personal accident. The maximum discount on an individual policy is capped at Rs 2,000. However, the discount is not applicable on renewals.

According to K Sanath Kumar, chairman, National Insurance, any new customer who comes to the insurance company online would be eligible for the discount even if he earlier had a policy with another company. This is because all policies are one-year contracts and, if a policyholder moves to another company at the end of one year, it is treated as a new policy.

Source

LIC has obtained the regulator's nod for offering 8% discount on its online term plan. However, industry officials say that even after the discount, LIC's online policy is much more expensive than those offered by private life insurance companies.

Back

Profits of insurers dip in FY16 – Business Line – 16th December, 2016

Profits of life and non-life insurers declined in 2015-16, and so did the total number of agents.

The life insurance industry posted a net profit of Rs. 7,415 crore in FY16 as against Rs. 7,611 crore in the year-ago period (FY15).

The premium income of life insurers, however, grew 11.84 per cent to Rs. 3,66,943 crore (Rs. 3,28,102 crore in FY15).

Of the 24 life insurers in operation, 19 reported profits, according to the annual report of the Insurance Regulatory and Development Authority of India (IRDAI) for 2015-16. The total net profit of the non-life insurance industry too fell to Rs. 3,238 crore from Rs. 4,639 crore in the previous year.

All public sector insurance companies posted profits. Among the 18 private general insurance companies, 12 posted net profit and remaining incurred losses.

The companies which posted losses were Bharti AXA, Future Generali, L&T General, Magma HDI, Kotak Mahindra, Liberty Videocon and SBI General.

Standalone health insurers reported Rs. 177 crore net loss during the year. Of these, only Apollo Munich reported a net profit of Rs. 7.46 crore.

Agents on the decline

In FY16, the number of individual insurance agents fell 2.48 per cent — from 20.68 lakh as on March 31, 2015, to 20.17 lakh in March this year.

The pattern of decline, however, was not the same. While the private life insurers recorded a growth of 5.61 per cent, Life Insurance Corporation showed an 8.77 per cent decline in agents.

LIC has the higher number of individual agents, more than all private life insurers put together.

As on March 2016, it had 10.62 lakh agents, compared to 9.55 lakh for private sector insurers.

However, the trend of falling number of life insurance offices has halted — the number climbed marginally to 11,071 from 11,033.

Source

As on March 2016, there were 54 insurers in the country — 24 life insurers, 24 general insurers and five health insurers.

In addition, GIC is the sole national re-insurer.

Back

Life Insurance

Life insurance penetration turns the corner, up a tad in 2015 – Business Line – 16th December, 2016

After showing a decelerating trend since 2009, life insurance penetration in India reported a marginal increase in 2015 over 2014.

India's life insurance penetration surged to 4.6 per cent in 2009 from 2.53 per cent in 2005. In the years following that, it exhibited a declining trend. However, the trend changed in 2015, when a slight increase was registered, as penetration reached 2.72 per cent compared to 2.6 per cent in 2014, Insurance Regulatory and Development Authority of India (IRDAI) data show.

"In the recent past, the life insurance sector went through structural changes as various companies re-aligned their business models in view of the regulatory changes in 2010. This led to a drop in premiums and decline in life insurance penetration from 4.6 per cent of GDP in fiscal 2010 to 3.1 per cent in fiscal 2014," according to ICICI Prudential Life Insurance.

New regulation-induced structural changes to unit-linked products are cited as the key reason for the fall in life insurance penetration levels in recent years.

In addition to the impact of regulatory changes, shift from financial savings to physical savings, slower economic growth, and high inflation were also reasons for the decline.

According to the latest Economic Survey , life insurance penetration continues to be low in India. Against the global average of 3.5 per cent, the figure in India stood at 2.7 per cent in 2015.

Source

The level of insurance density (measured as a ratio of premium to total population) had increased from $11.7 in 2002 to $55.7 in 2010. However, it started decelerating thereafter, standing at $43.2 in 2015. This is low vis-a-vis other developed and emerging market economies.

Meanwhile, the penetration of non-life insurance sector in the country has remained steady at 0.5-0.8 per cent over the past 10 years. However, its density has gone up from $2.4 in 2001 to $11.5 in 2015.

Back

General Insurance

General insurers' gross direct premium up 29% in Nov – The Financial Express – 16th December, 2016

General insurance companies continued their positive performance in November and posted 29% growth (year-on-year) in gross direct premium. Private-sector insurers registered higher growth compared with public-sector insurers, largely due to strong growth in the crop insurance segment.

According to senior officials, the general insurance sector has already received R12,000 crore from crop insurance and premiums are likely to touch R16,000-18,000 crore by the end of the current financial year. Data from the General Insurance Council shows that specialised players like ECGC and AIC saw their growth slowing in November. In November, the general insurance industry saw gross premium income at R9,146.96 crore against R7,104.10 crore in November last year. While private insurers registered gross premium income at R4,277.24 crore, up 44.7% compared with last year, public-sector insurance companies saw a growth of 18.9% at 4,192.29 crore in November, 2016.

The General insurance sector in the last few months has seen sustained growth and higher participation from private players as against public-sector insurers. "In the last few months, private players had seen higher growth compared to public sector insurers. Growth has been be very positive from marine, motor and fire insurance as well in the last few months," said a top insurance player.

The data from the General Insurance Council also shows that up to November, gross direct premium underwritten by the industry was R81,772.88 crore compared with R62,097.91 crore last November, a growth of 31.7%.

Apart from general insurance, standalone health insurance companies also saw a surge in their premium income by 39.9% in the month of November. Two specialised players like ECGC and AIC saw combined growth of -12.7% in November.

Source

"In the months to come, public-sector insurers are likely to post better growth after the government announced 10% discount on premiums paid online by customers. This year, we might end up touching more than R1.2 lakh crore in new business premiums," said a senior official from a leading public sector insurance company.

Back

Pradhan Mantri Fasal Bima Yojana insurance scheme to cover higher number of farmers in Kharif 2016 – The Financial Express – 17th December, 2016

More farmers, mostly in states such as Andhra Pradesh, Chhattisgarh, Gujarat, West Bengal, Karnataka, Maharashtra, Madhya Pradesh and Uttar Pradesh, have been covered under the NDA's government's flagship Pradhan Mantri Fasal Bima Yojana (PMFBY) in Kharif 2016, as compared with crop insurance coverage provided in the previous year.

Sources told FE that more than 3.66 crore farmers of the estimated 14 crore in the country were enrolled under PMFBY in kharif, 2016 against 3.09 crore farmers enrolled with the crop insurance scheme in kharif, 2015. However in states including Bihar, Odisha, Telangana, Rajasthan and Tamil Nadu, a lower number of farmers have been covered under PMFBY in Kharif 2016 compared with previous year.

"The scheme has provided coverage to 3.66 crore farmers (26.50%) and at this rate it is likely to exceeding the target of 30% coverage for both kharif and rabi seasons in 2016-17," an official statement recently stated.

According to an agriculture ministry note, the performance in the kharif season was better despite the fact that there were teething issues to begin with. "For instance, many states did the bidding process for selection of the insurance companies for concerned clusters for the first time and consequently, the notification of the scheme was delayed in a number of states," the note stated.

During last year's rabi season, 167.47 lakh farmers were covered under crop insurance. In the ongoing rabi season, 15 states and UTs have issued notification for providing crop insurance to farmers, the last date for opting for crop insurance is December 31.

For PMFBY, finance minister Arun Jaitley had allocated R5,501 crore in the 2016-17 Budget against R2,995 crore allocated for various crop insurance schemes in the last financial year. However, under the revised Budget estimate, the centre would provide R13, 396 crore for the implementation of PMFBY in the current financial year.

Launched by the Modi government this January, PMFBY stipulates a uniform premium of 2% to be paid by farmers for kharif crops, and 1.5% for rabi crops. The premium for annual commercial and horticultural crops will be capped at 5%.

The major subsidy burden for rolling out crop insurance would be borne by both the states and the Centre. Subsidy from the government would now be 'unlimited' and grow a steep 183% to R8,800 crore by FY19.

The Centre had earlier named state-owned Agriculture Insurance Company of India (AIC) and 10 private companies, including ICICI-Lombard General Insurance, HDFC-ERGO General Insurance, IFFCO-Tokio General Insurance and SBI General Insurance, for the implementation of the mega scheme.

Source

Only 20 million of an estimated 140 million farmers in the country — earning for a population four-five times as many — had crop insurance cover in 2014-15, even as the facility was just against the cost of cultivation and barely provided any income protection.

Back

How to choose between a term plan and a return of premium term plan – Mint – 22nd December, 2016

If you want to insure your life, there is no better product than a term insurance policy. A term plan only charges you for the cost of insurance, so when the term of the policy is over, you don't get anything back.

For those who buy insurance with savings or investment returns in mind, if the policyholder outlives the policy term, insurers offer a variant of the term plan that returns the premiums paid at the end of the policy term. So what should you go for? We see the pros and cons.

Benefits

A term policy charges you for insuring your life. This means you only pay for the cost of insurance and nothing else. So if you survive the policy term, you don't get anything back.

On death during the policy term, the beneficiary gets the sum assured (insurance money) and the policy terminates. Term plan with return of premium (ROP), on the other hand, returns the premium paid at the end of the policy term if the policyholder survives the term. On death the sum assured is paid and the policy terminates.

Costs

A pure term plan is the cheapest form of life insurance as it only charges you for the insurance cover. The ROP term plans are more expensive as they promise to pay the premiums back at the end of the policy term.

The insurer also charges you for the guarantee and will need a surplus for investment.

For example, a 35-year-old man who buys a term insurance policy for a policy term of 20 years for a sum assured of Rs1 crore will only pay about Rs8,000 as premium whereas for the same sum assured the ROP term plan will cost about Rs29,000.

Returns

A pure term plan does not return your premium at the end of the policy term as it is not a savings or investment product. However, since it charges less, you can put more money in investment products.

In the case of an ROP term plan, even though you get the premiums back, you do not get any returns on your money and since these plans are expensive, you have less left for investment purposes.

Surrender value

If you decide to surrender a policy midway, a term plan doesn't return anything back, but a ROP term plan does.

It acquires a surrender value only after the first couple of years, but the surrender charges are high.

So, not only do you pay more, but also pay a big charge if you decide to quit midway. In the case of a term plan, even though you get nothing back, you have more to invest.

Policy term

Although this may depend on the insurance companies, an ROP term plan is generally available for a policy term of 20-25 years. Term plans are usually available for a policy term of 40-45 years.

Source

For instance, we took the previous example from an insurance company's website and the maximum policy term available for its ROP term plan was 20 years.

Do keep in mind that even though a term plan is available for a larger policy term, you typically do not need life insurance after retirement.

Back

Health Insurance

Three-month window for employers to register under ESIC – The Economic Times – 15th December, 2016

Bandaru Dattatreya-led labour ministry has open up a three-month window for employers/enterprises to register themselves and their employees under the Employee State Insurance Corporation to avail of medical facilities of the government.

"To extend the coverage to the entire workforce a new employer friendly scheme has been approved at the 170th meeting of EISC, chaired by labour minister," a statement from ESIC said.

According to the statement, this is a one-time opportunity to encourage the employers to register themselves, to register employees, if any, who have been left out of coverage including contractual, casual, temporary etc. "The proposed scheme will remain open for a period of three months from January 1, 2017 to March 31, 2017," it said.

Under the proposed scheme, the employers registering during the period will be treated as covered from the date of registration or as declared by them while the newly registered employees shall be treated as covered from the date of their registration. "This will not have any bearing on actions taken/required under ESI Act, if any, prior to 1st January, 2017," it said. Besides, the ESIC chairman may be authorized to remove difficulties, if any, in implementing the scheme.

Further, to improve the medical services under state run ESI facilities, the ESI Corporation has also decided to increase per capita ceiling of sharing expenditure with state governments from existing Rs 2150 to Rs 3000 with sub ceiling of Rs 1250 for "Administration" and Rs 1750 for "Others".

"With enhancement of this ceiling, the state governments may now further equip better their medical services to ESI beneficiaries in its ESI medical institutions. The enhanced ceiling of will be fixed from 2017-2018 to 2019-2020 and reviewed annually from 2020-21 on the basis of WPI and expenditure pattern of the states," it said.

Source

ESIC has been paying the cash benefits to its beneficiaries directly in their Bank Accounts. The Corporation spent a total of Rs.6819.47 crores in the year 2015-16 on medical, cash and other benefits to its over 2.5 crore subscribers.

Govt issues guidelines for insurance coverage of ayurvedic treatment – The Pioneer - 19th December, 2016

In a good news to the patients undergoing ayurvedic treatments, the Government has now issued much-awaited guidelines and benchmark rates for insurance coverage of such alternative traditional medicines.

The insurance cover will include treatment undertaken at Government hospitals, Ayurveda college hospitals, National Accreditation Board for Hospitals and Healthcare Providers (NABH) accredited hospitals and registered private clinics with 15 beds and minimum of five qualified and registered Ayurveda doctors.

As per the guidelines, 20 categories of diseases will get insurance coverage. These include Greevasthambha (cervical spondilitis, cervical spondilosis), Kateegraha (IVDP, sciatica, low back ache), Apabahuka (frozen shoulder), Pakshaghata (paralysis), Ardita (facial paralysis), Vataraktha (rheumatoid arthritis, gouti arthritis), Amavata (rheumatic fever), Sarvangavata (motor neuron diseases), Sandhigata vata (degenerative joint disorders), Twak vicara (skin diseases), Arbuda (benign and malignant growth).

Others are Arshas and bhagandhara (haemorrhoid, fistula, fissure), Moothraghata (renal dysfunction), Kashtarthava (amenorrhoea, PCOD), Mamsakshaya (muscular dystrophy), Drishti dosha (different eye diseases) and Sirasoola (headache, migraine).

The guidelines specify 20 categories of diseases for insurance coverage with its clinical conditions for hospitalization therapies, which can be performed in such diseases and the duration of hospitalisation, explained Dr D Induchoodan, treatment standardisation and accreditation committee convener of the Ayurveda Hospital Management Association (AHMA), who prepared the treatment protocol and costing, approved by Ayush, Idra and other stakeholders.

He further said that as per the benchmark costs for individual therapies/interventions, Abhyanga (Ayurvedic therapeutic massage) will cost Rs1,145 per session. If Abhyanga is added with Sweda (therapeutic steaming procedure), the cost will go up to Rs1,280, said.

Rates include procedure cost, medicine cost, price of accessories, HR expenses and cost for equipment maintenance, the guidelines have been laid out.

Room rent can be charged extra, as per insurance norms. If the treatment is taken at a NABH-accredited hospital or one situated in metro cities, 25 per cent hike in treatment costs can be considered. This also includes pre and post-procedure cost at Rs75 per day.

Stating that the move would revolutionise the Ayurvedic sector in the country, Dr Induchoodan said, AHMA was trying for this approval through the general insurance council, Irda and ministry of Ayush for several years. Induchoodan, who is also an NABH (Ayush) assessor of quality council of India, said standardisation and insurance coverage are essential for the survival of Ayurveda.

Source

Welcoming the move, Viswanath Odatt, a well known Insurance experts said that apart from curative aspects, since Ayurveda has preventive benefits also, Insurance coverage will help the Insurance sector to decrease further claims for various diseases.

Back

Buy health insurance early, but carefully – Deccan Chronicle – 19th December, 2016

One needs to decide whether to avail of a fixed benefit plan or an indemnity-based plan. This is a question that often baffles policyholders

Rising medical costs can be financially draining, especially in times of need. A bypass surgery that was performed under Rs 2 lakh a few years ago now costs around Rs 5 lakh. And we can expect the cost of medical treatments to rise further. This increase in cost can be attributed to multiple factors, which include advent of speciality drugs, investment in super speciality equipment, emergence of new ailments and increase in incidents of severity of existing diseases.

The rising cost and increasing awareness for the need to protect oneself and family from medical and financial exigencies are convincing more and more people to buy health insurance policies. While deciding to purchase a health insurance at the right time that covers all members of the family is a critical aspect, there are other things that need to be addressed as well.

One of the key decisions that one needs to take is whether to avail of a fixed benefit or indemnity-based product. This is a question that often baffles policyholders.

Insurers across life and general insurance offer several health products, covering the insured against unforeseen and unfortunate hospitalisations, critical illnesses and disability. Although health benefits offered by them seem to be similar, there is a difference in terms of their coverage. Hence, to make an informed decision, you need to understand the types of health plans offered.

Health plans fall under two categories –indemnity and fixed benefit plans. In an indemnity plan, you receive compensation for your actual hospitalisation expenses up to a pre-defined limit, which is equal to the sum insured. These are reimbursement plans where your medical expenses are reimbursed up to the extent of coverage.

Fixed benefit plans, on the other hand, pay the sum insured on occurrence of a defined event like diagnosis of a critical illness, hospitalisation above a defined period and disability. These can also be referred to as compensation plans, which provide a fixed amount even if there are no immediate medical expenses. This amount may be higher or lower than the actual expenses incurred by the customer.

Let's understand this with a simple example. You have a health policy with a sum assured of Rs 5 lakh. You get hospitalised and his medical expenses come up to Rs 2 lakh. If the nature of his policy is indemnity-based, the insurer will reimburse you for Rs 2 lakh and the remaining balance can be used for further hospitalisation during the policy period.

Your neighbour has a fixed benefit health plan with a sum insured of Rs 10 lakh. He gets diagnosed with cancer and the treatment would last for months and cost him around Rs 8 lakh. Since his policy is fixed benefits-based, he will get the entire compensation of Rs 10 lakh and the policy terminates after that. Now, the onus is on him to spend the amount judiciously for his treatment.

Indemnity-based plans offer several benefits including cashless hospitalisation, outpatient treatment, pre-hospitalisation expense, inpatient hospitalisation costs and post-hospitalisation expense. Indemnity plans can also cover the entire family in one policy. To tackle multiple visits and severe illnesses with a high cost of hospitalisation, insurers also offer super topup indemnity plans. Super topups work over and above your base indemnity plan, increasing your sum assured and benefits.

Fixed benefit plans can act as a supplement to the indemnity-based health plans. The lump sum amount received from a fixed benefit plan can be used by the policyholder to pay off any outstanding loan amount. Your ill health may also lead to loss of job or discontinuance in earnings. The lump sum amount can also provide cushion in such a situation.

Life insurance companies primarily offer fixed benefit plans, whereas general insurance companies offer both indemnity and fixed benefits based plans. Apart from indemnity and benefit plans, one can also avail travel insurance where the insured is covered for emergency hospitalisation expenses overseas.

One should read the policy document for each plan to weigh in individual preferences as per the life stage and future requirements.

Last but not the least; we need to obtain cover not only for ourselves but also our family members. Do not wait! The younger you are the better, as the premium per annum is lesser for a healthier younger person than a middle-aged or older citizen. Visit the website of an insurance company to read about and understand the policies they offer, choose the ones that offer hospitalisation cover, daycare surgeries/treatments cover, pre and post hospitalisation expenses and domestic road emergency.

Source

Diseases and accidents do not come with warning and can be a major threat to your health and savings as well. Just like a helmet protects one from an accident, health insurance is a protection from heavy medical bills and peace of mind, which is priceless. It is prudent to buy health insurance early, so that you can be rest assured and fulfill your promises to your loved ones.

Back

Indian households' healthcare woes – Mint – 20th December, 2016

The low penetration of health insurance and high health costs expose Indian households, especially those at the bottom of the pyramid, to severe financial shocks, according to fresh data from a large-scale nationally representative survey. The 'Household Survey on India's Citizen Environment & Consumer Economy' (ICE 360° survey) conducted this year shows that 3% of households in the top quintile (richest 20%) faced a health shock that wiped out more than a fifth of their annual income. The comparative figure for the bottom quintile (poorest 20%) was more than double at 6.8%.

The survey shows a similar divide between households living in metros and those living in underdeveloped rural areas. The ICE 360° survey 2016, covering 61,000 households, is among the largest consumer economy surveys in the country. The response period of the survey was April 2015 to March 2016.

The ICE 360° survey shows that 47% households consult a doctor at a public health facility when a family member falls ill while 38% households visit a private health facility; 14% consult an independent medical practitioner. The preferences of the bottom and top quintile households are roughly similar in this respect but the preferences of households belonging to the top percentile are very different. Among the top percentile, just 34% use a public health facility while the rest use a private facility or an independent medical practitioner when any family member falls ill.

The survey also shows that just 23% of households in the country are covered under any health insurance scheme. Less than a fifth of the bottom quintile has health insurance cover. The comparative figure is relatively higher for the top quintile at 36%. Among the top percentile, 42% have health insurance schemes.

The penetration of health insurance, especially among the poorer income classes is because of public health insurance schemes rather than private health insurance (or the so-called mediclaim) policies. Nationally, 10% of insured households reported having purchased private mediclaim policies. In the bottom quintile, only 5% insured households reported purchasing private health insurance. In the top quintile, 17% insured households reported purchasing private health insurance. 26% of the insured households in the top percentile have private health insurance cover.

The low penetration of private mediclaim policies in the country is largely because of lack of awareness and lack of affordability, the survey shows. The fact that many more people are covered under public insurance schemes than under private ones, especially at the bottom of the pyramid, also indicates that affordability could be a key factor limiting the penetration of health insurance products in the country. Health insurance schemes launched by state governments seem to be more popular than those launched by the central government, the survey shows; 68% of insured households reported being covered by state government insurance schemes while 28% reported being covered by central government insurance schemes.

The ICE 360° survey was conducted by the independent not-for-profit organization, People Research on India's Consumer Economy (PRICE), headed by two of India's best-known consumer economy experts, Rama Bijapurkar and Rajesh Shukla. The urban sample of the survey is comparable to that of the National Sample Survey Office (NSSO) consumer expenditure survey conducted in 2011-12. While the NSSO surveyed 101,651 households of which 41,968 (41.3%) were urban households, the ICE 360° survey covered 61,000 households of which 36,000 (59%) are urban households. The rural sample of the ICE 360° survey is less than half of the NSSO sample. Nonetheless, all the estimates of each region have been derived by adjusting for the respective population of those regions.

A notable feature of the ICE 360° survey is that it is representative at the level of economic clusters. Urban India has been divided into four clusters: metros (population more than 5 million), boom towns (2.5 to 5 million), niche cities (1 to 2.5 million) and other urban towns (less than 1 million). Based on a district development index, rural India has been sub-divided into three different clusters: 'developed rural', 'emerging rural', and 'underdeveloped rural'. The first category includes districts such as Bathinda (Punjab) and Kangra (Himachal Pradesh). The second category includes districts such as Latur (Maharashtra) and Kamrup (Assam) while the last category includes districts such as Kalahandi (Odisha) and Bastar (Chhattisgarh).

In metros, 3.3% households witnessed a health shock, which wiped out more than a fifth of their annual income. The comparative figure is double in underdeveloped rural India at 6.6%, the survey shows. Overall health insurance coverage is lower in metros compared to other urban clusters, largely because of the low adoption of

public health insurance schemes in metros, the survey shows. But the adoption of private mediclaim policies is significantly higher in metros compared to other clusters.

Data from NSSO surveys on healthcare expenditure also show that the penetration of private health insurance is lower among rural and lower income groups.

A recent Brookings India research paper based on analysis of NSSO data on health expenditure of Indian households over the past decade by Shamika Ravi, Rahul Ahluwalia, and Sofi Berkgvist shows that private health insurance is largely limited to the richer urban households while public health insurance is evenly distributed among income classes.

The study suggests that access to public health insurance schemes may not have lowered the health costs of households but has increased the likelihood of hospitalization.

"This could mean that people suffering from ailments are more likely to be treated if they are covered by insurance," the authors of the study wrote.

Source

As an earlier Plain Facts column pointed out, the lack of affordable and accessible healthcare facilities in India often cause people to delay or avoid recognizing illnesses, let alone seek treatment for them. If public health insurance schemes are driving people to report their illnesses and to seek treatment for them, that in itself is a significant first step in the battle against ill-health in the country.

Back

Health insurance collections jump over a fifth in a year – The Indian Express – 21st December, 2016

From specialised packages to lifelong cashless cover, more and more Indians are buying health insurance products.

In 2015-16, health insurance companies collected Rs 24,448 crore in premium according to figures compiled by the Insurance Regulatory and Development Authority of India (IRDAI) — 21.7 per cent higher than the year before. This is the highest year-on-year growth in premium in the last five years, and the first time that the growth rate has gone upward during this period (see graph).

Low penetration of health insurance has always been a concern in India given that the government sectors struggles with a huge patient load and the private sector is largely unregulated and often exorbitantly priced. In 2015-16, the number of Indians covered by health insurance was 35.90 crore (out of an estimated population of 125 crore) according to IRDAI statistics, up 24 per cent from the previous year's 28.80 crore.

These figures include the number of people covered under the Rashtriya Swasthya Bima Yojana (RSBY) — a scheme originally targeted at migrant workers and managed by the labour ministry and recently transferred to the health ministry in preparation for the National Health Protection Scheme (NHPS) announced in the 2016-17 budget.

RSBY is currently running in 398 districts in 19 states with 4.13 crore enrolled families, with the premium paid by the state varying between Rs 745 per family in Mizoram and Rs 191 in Karnataka. NHPS, which found mention in the PM's Independence Day speech this year, will provide a cover of Rs 1 lakh to every target family.

"Health insurance continues to be the fastest growing segment… The industry grew by 21 per cent in FY 2015-16 and by 2020, it is expected to exceed Rs 50,000 crore with standalone health insurance companies growing faster than market. With thrust on innovation, wellness and customer centricity, the new health regulations offer numerous opportunities and will propel the industry forward…," said Ashish Mehrotra, MD and CEO Max Bupa Health Insurance.

Statistics of Apollo Munich show there has been an increase in the number of people opting for sum-insured policies in the range of Rs 5 lakh and above this past year, said CEO Anthony Jacob. "We have been clocking a steady growth path for the past five years and believe that we are in the business of paying claims. Hence our insurance payouts have also grown at a CAGR [compound annual growth rate] of 12 per cent in the last five years. Also, we have seen a steady 55:45 payout ratio of reimbursement of claims versus cashless claims at Apollo Munich. We expect this trend to change in the coming year, as a result of demonetisation and re-monetisation efforts of the government," he added.

Source

Pre-intimation can make the hospitalisation experience better – Mint – 21st December, 2016

Making the adoption and utilisation of health insurance customer-friendly, simple and jargon-free for the policyholder is a continuous process that each industry stakeholder is tackling in its own way.

Low adoption numbers, and frequent accounts of health insurance related grievances point to the fact that there is a lack of awareness and gaps in customer service. Understanding customers' needs and formulating policies that can best suit them, as well as equipping them with complete knowledge of the fine print is crucial to customer service and satisfaction. Undoubtedly, there is a lot that needs to be done.

With the advent of corporate employers providing cashless health insurance group covers to their employees, as well as a slow but steady penetration of cashless retail health policies, cashless health insurance is laying the foundation for more customer-friendly healthcare policies in the country.

In a cashless health policy, the policyholder pays only a small percentage of the final bill (10-20% co-pay) and the rest is settled between the hospital and the payer (insurance company or third party administrator).

In the case of cashless policies, an estimated amount is pre-approved by the payer when the patient is admitted. Thus, the patient does not have to bear a financial burden that is typical of medical expenditures during hospitalization.

There are other benefits and features that policyholders can use to their benefit and reduce trouble at the time of hospitalization.

For example, most policyholders do not know that in the case of pre-planned hospitalization, it is possible to get the process of cashless health insurance and eligibility check started before the patient is admitted to the hospital, i.e., a few days in advance.

Eligibility checked in advance: As soon as the policyholder learns that treatment is required in the next few days, she can raise the request for pre-intimation with the hospital or the payer directly. When the payer receives this request, it will initiate the first step of pre-authorisation, which is eligibility check.

In this step, the payer verifies the policyholder as a customer, and checks details such as past history of insurance usage, whether the treatment is eligible for insurance, and the sum that can be pre-approved for the upcoming treatment.

Let's take the case of a cataract procedure. Upon finding out the need for treatment, and fixing the schedule for the surgery, the payer can be pre-intimated so that an eligibility check can be done well in advance.

Fulfilling all the criteria of eligibility, the sum for the treatment can be approved even before the patient enters the hospital.

Further, along with the pre-intimation details, carrying electronic copies of health card and ID proof on your smart phone at the time of pre-authorisation will ensure that you don't have to run around to get these documents.

Lesser waiting time: For a pre-planned hospitalization, pre-intimating the payer will save you the trouble of getting the paperwork ready and starting the process of pre-authorisation at the time of admission. Having the pre-intimation number, the treatment can start immediately upon getting admitted.

Also, by starting the health insurance process early, the policyholder can significantly reduce the waiting time she would have to otherwise experience.

Another example is that in the case of child birth, the soon-to-be parents can inform the payer and/or the hospital in advance so that the baby, when born is registered in the policy as a dependent.

Having done so in advance will ensure that the newborn is insured should the need for any kind of treatment arise after birth and that the parents don't have to pay out of pocket for the treatment.

The policyholder can start the pre-intimation process by notifying the payer as much as a week to even 48 hours in advance.

For cases such as appendicitis, cataract, maternity, and other pre-planned hospitalizations, the policyholder can notify the payer and/or the hospital, share details such as policy ID, required identity proof, and initial details of

the treatment required to start the insurance process in advance. Many payers also generate a pre-intimation number, which the policyholder can produce at the hospital upon arrival. Furthermore, payers are also enabling their customers to raise such requests through mobile apps and chat platforms on their websites.

When it comes to planned hospitalization, a simple proactive step from your side can ensure that your experience at the hospital and while utilising your health insurance is seamless and quick.

To simplify health insurance, both insurers and hospitals are using simple customer-friendly tech tools such as mobile applications, SMS and e-mail updates, to ensure more transparency, and seamless channels of communication with the consumer at all times.

Source

While these efforts evolve and continue to find ground, as a consumer, being more informed and investing some time in understanding how your policy can truly benefit you in the time of need is essential.

Back

Regulation

Foreign reinsurers to be operational in 6-9 months: IRDA – Deccan Chronicle – 16th December, 2016

Insurance Regulatory and Development Authority of India (IRDAI) today said it expects foreign re-insurers which will get final clearance from the regulator to be operational in the country over the next six to nine months.

"We are hopeful that global reinsurance companies which will get final clearance from the regulator to open their branches in India and will be operational in the next six to nine months, IRDA whole time member (finance & investments) V R Iyer said here today on the sidelines of CII organised InsureInd.

"We have received seven applications from major foreign reinsurance companies including Llyods which have shown interest to open their branch offices in India. Applications from seven companies are in the different stages of consideration of the insurance regulator," she said.

A foreign reinsurer has to clear three stages of licences from the insurance regulator to begin operations, Iyer added. Presently, state owned GIC Re is the only reinsurer operational in the country and foreign reinsurers have liaison office in India.

Liberalising the sector to foreign re-insurers will break the monopoly of GIC Re. But government has now allowed minimum 10 per cent of the reinsurance business that an insurance company will buy has to go to the public sector.

IRDA believes with the clearance to opening of branches of foreign reinsurance companies, domestic insurers will be able to undertake more risks and manage their capital more efficiently, she said.

Source

"In India, catastrophic and disaster risks products are not available. With foreign reinsurance companies coming to the country, insurers can become creators," Iyer added.

Citing a consultant report, she said by 2025 the life insurance business is expected to touch USD 185 billion and non-life insurance to touch around USD 75 billion.

Back

Pensions

EPFO to receive your PF contributions only if UAN is linked to current employer – The Economic Times – 15th December, 2016

The Employees' Provident Fund Organization (EPFO) is devising ways to make your fund transfers and withdrawals as seamless as it can be.

It is bringing in a few changes in the way the Universal Account Number (UAN) functions and also in the reporting platform (ECR or Electronic Challan cum Return) of the employers, by which they communicate with the EPFO regarding employees' contributions, wages, etc.

The new version, UAN 2.0, is being introduced and simultaneously the EPFO is also launching ECR 2.0.

The existing ECR portal of the EPFO will be operational till 6.00 p.m. on December 17, 2016, and to carry out the migration and switchover to the next version of ECR under the unified portal, the revised portal will be launched three days later, on December 20.

In a nutshell, any ECR that the employer sends to the EPFO will now have to include the newly generated UAN of the new member, or the linked UAN in case it has been already been generated for the employee.

The present system

Currently, most employers straightaway submit the ECR to the EPFO, mentioning the details of the employee. Thereafter, the employer generates the UAN by mentioning the member ID or by linking the earlier generated UAN.

For a new EPF member, first generate UAN

From now on, for a member joining the EPF for the first time, the UAN will be obtained by the employer or member prior to the filing of ECR by the employer for that member. The UAN will be allotted upfront on the portal and will then be validated in the ECR file of the employer at the time of its submission.

For an existing EPF member, first link UAN

For someone who was already an EPF member earlier, the linking of the existing UAN with the present establishment should necessarily be done by the employer before filing of UAN-based ECR.

Earlier, it was done after filing of ECR based on the member ID. The concept of member ID is completely done away with and is replaced by UAN in the new versions.

How it helps

In both the cases above, whether it's for a new or existing UAN, it requires the allotment of UAN upfront and the ECR can be filed only in cases where UAN has either been allotted to member or the previous UAN has been linked to his present employer.

Launch of UAN 2.0

The UAN was launched by EPFO in 2014 with the objective to provide one umbrella number to its members for all the employments of an EPF member with different establishments. The EPFO, through a UAN, is able to provide a number of services such as updated passbook, dynamically updated UAN card, SMS services on registered mobile numbers of activated UANs, portability in case of KYC seeded UANs, etc.

To take the UAN to the next level of service delivery, the EPFO is revising the processes and integrating UAN 2.0 with ECR 2.0.

Launch of ECR 2.0

Simultaneously, the EPFO is also launching ECR 2.0. Launched in April 2012, the ECR is the online platform for filing of the returns mandatory for the employers. It is filed monthly and contains member-wise details of the wages and contributions, including basic details of the members.

Prominent changes in ECR 2.0

Among the changes are: the member ID has been discarded and the UAN will be the key field in the ECR. The uploaded name of the member will be for display only. The remittance will go against the UAN with whatever name is there in the UAN repository.

In addition, a new field for gross wages has been added. So now, in addition to the basic salary, the total monthly emoluments will also be disclosed to the EPFO.

Source

Conclusion

As an employee, whether new or existing, one needs to ensure a few things. Make sure that the UAN is generated and is linked to your employer. Simply uploading the KYC documents with a valid UAN is not enough. Do ask your Accounts/HR department to confirm it.

EPFO likely to retain 8.8 per cent interest on EPF for Fiscal Year 2017 – 18th December, 2016

Retirement fund body EPFO is likely to retain 8.8 per cent rate of interest on EPF deposits for the current fiscal for its over four crore subscribers — same as 2015-16 — at its trustees meeting tomorrow. "The Employees Provident Fund Organisation's apex decision making body, the Central Board of Trustees (CBT), may decide to retain 8.8 per cent rate of interest on EPF for the current fiscal tomorrow in its meeting in Bangalore," said a source.

"Although providing 8.8 per cent rate of interest for the current fiscal will leave a deficit of Rs 383 crore, the body wants to utilise about Rs 409 crore surplus with it, which accrued after providing 8.8 per cent rate of interest for 2015-16," the source added.

He further said: "Labour Ministry top brass has been pursuing Finance Ministry higher ups to convince them for retaining 8.8 per cent rate for this fiscal to avoid any embarrassment."

The Finance Ministry had earlier this year decided to lower interest on EFF for 2015-16 to 8.7 per cent from the 8.8 per cent approved by the CBT headed the Labour Minister.

The government had to roll back the decision and provide 8.8 per cent rate of interest on EPF deposit for 2015-16 following protests by trade unions.

As per the EPFO income projections of Rs 39,084 crore for the current fiscal, providing 8.8 per cent rate of interest on EPF deposits will leave a deficit of Rs 383 crore. There would be a surplus of about Rs 69.34 crore if interest rate is lowered to 8.7 per cent.

The source said the Finance Ministry has been asking the Labour Ministry to align the EPF interest rate with other small saving schemes of the government like Public Provident Fund (PPF).

In September, the government reduced interest rates on small savings schemes marginally by 0.1 per cent for the October-December quarter of 2016-17, which resulted in lower returns on PPF, Kisan Vikas Patra, Sukanya Samriddhi Account, among others.

The Labour Ministry however wants to retain 8.8 per cent for the current fiscal as well, said the source.

The EPFO trustees will also consider a proposal to reduce the administrative charges to 0.65 per cent of total wage on which contributions are payable from 0.85 per cent at present. This will result in total annual savings of Rs 1,000 crore for around six lakh employers covered by the EPFO.

The trustee will also consider the proposal to abolish administrative charges on firms to fund expenditure in implementing the Employees' Deposit Linked Insurance Scheme (EDLI), 1976.

The agenda says that this could be seen as an attempt to promote the "Ease Of Doing Business in India" and to make Indian business more competitive.

It said that all administrative expenses of EDLI may be met from interest of EDLI corpus.

Source

The administrative charges to run EDLI scheme is 0.01 per cent while inspection charges is 0.005 per cent for firms, which subscribes to insurance schemes in lieu of EDLI Scheme.

The total corpus in EDLI administration account as on March 31, 2016 is Rs 2,372.83 crore. The interest generated on such a corpus would be around Rs 17.5 crore annually.

Back

EPFO moves to boost membership via amnesty plan for employers – Mint – 21st December, 2016

Employees' Provident Fund Organisation (EPFO) has proposed an amnesty for employers who have failed to get workers to sign up for the tax-exempt employee's provident fund (EPF) scheme that aims to bring more workers under the social security net.

According to the 'Enrolment and Establishment coverage campaign, 2017,' proposed by EPFO at its apex body meeting in Bengaluru on Monday, employers can get workers signed up now with a nominal penalty of Re1 per year of delay. The penalty otherwise applicable is 5-25% of the shortfall in contribution, depending on the period of delay.

The move gives an opportunity to all principal employers such as large state-run and private companies that hire contractors for specific projects to ensure that workers who are indirectly employed also get social security benefits.

Any worker who should have joined the scheme between 1 April 2009 and the end of this year, is eligible to join EPF now during a three-month window starting 1 January 2017, said an EPFO statement. In such cases, the employer has to pay his contribution with interest and the prescribed nominal damage of Re1 per year of delay.

Under normal circumstances, employers who default on their obligation to make EPF contributions are liable to be jailed for up to three years.

According to Sonu Iyer, tax partner and people advisory services leader, EY, failure to make PF contributions attracts imprisonment for a minimum of six months to up to three years, and a fine of Rs5,000.

The EPFO statement on the amnesty scheme was silent on prosecution but implied that only the prescribed nominal damage is applicable for employers who avail of the scheme.

"This campaign will be suitably staffed and resourced so that employers who come forth to extend social security to their employees receive all possible assistance from EPFO. The action will meet the twin objectives of increasing the enrolment, extending social security benefits to all workers and reducing litigation," said the EPFO statement.

Source

According to Amarpal Chadha, tax partner, EY, the amnesty proposal has to be approved by the government to come into force.

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