भारतीय बीमा संस्थान
INSURANCE INSTITUTE OF INDIA

INSUNEWS

Weekly e-Newsletter

7th – 13th December 2019

Issue No. 2019/50

QUOTE OF THE WEEK

"Technology is nothing. What's important is that you have a faith in people, that they're basically good and smart, and if you give them tools, they'll do wonderful things with them."

Steve Jobs

INSIDE THE ISSUE

Insurance Industry	2
Insurance Regulation	5
Life Insurance	12
General Insurance	25
Health Insurance	36
Crop Insurance	54
Motor Insurance	55
Survey	56
Pension	57
IRDAI Circular	60
Global News	61

INSURANCE TERM FOR THE WEEK

New Business Strain

Definition: New business strain is the strain on the business created due to inadequate premium amounts in initial years, which are not enough to cover for the expenses, commissions and statutory reserves.

Description: In insurance, the expenses are front ended whereas returns are realized over time. However, with the premium payments being received over the contract term, this strain tends to get reduced.

Source

INSURANCE INDUSTRY

Public sector banks offering incentives to staff to achieve cross-selling targets - Hindustan Times – 12th December 2019

After the government banned direct payment of commissions to employees of public sector banks (PSBs) for pushing third-party products such as insurance policies and mutual funds to existing customers, business associates of banks are now offering incentives such as junkets to encouraging cross-selling, three persons with direct knowledge of the matter said, requesting anonymity.

Cross-selling targets have been given to bank executives at the branch level, and to achieve the targets, staff sometimes even missells such products to gullible customers like account holders under the Pradhan Mantri Jan Dhan Yojana (PMJDY), the three persons said. The government banned the practice of paying commissions directly to employees on September 10, 2018.

In order to bypass the government directive, banks and their business associates, such as insurance firms and mutual fund houses, have devised a new system. Instead of commissions, they now offer incentives to employees through prepaid "achiever" cards, which work like debit cards and come the incentive amount credited to them by a third party for pushing its products among customers of public sector banks (PSBs).

The firm also offers trips to exotic destinations such as to bank executives in the name of imparting training and education, the persons mentioned above said.

"We have raised this matter with top officials of finance ministry, DFS (Department of Financial Services) and senior management of PSBs. Promotions, transfers and of bank executives are now largely dependent on cross-selling mainly because the lion's share of these incentives are cornered by senior executives of PSBs," State Bank of India Officers' Association (Chandigarh Circle) general secretary Deepak K Sharma said.

He said this "unscrupulous practice is rampant in all PSBs" and it has reached an "alarming level" as banks' executives are even being "forced to miss-sell" these products to account holders in rural and semi-urban areas, including accounts under the PMJDY, the government's financial inclusion programme. "Even the newly created FI&MM [Financial Inclusion & Micro Market] network is not left alone.

It is pertinent to mention that the target customer group of the financial inclusion initiative of the government is from the lower income group and special low cost insurance products have been designed and rolled out for them, but even they are being compelled to purchase the products of SBI Life which carry a hefty premium," he said in a letter dated November 21 to the SBI management. The letter has been reviewed by Hindustan Times. SBI Life is a joint venture between SBI and global insurance company BNP Paribas Cardif.

A government official mentioned in the first instance said several complaints against PSBs related to this issue have been received by the government and the matter is under investigation. Spokespersons for the finance ministry, the Reserve Bank of India (RBI), DFS, SBI and SBI Life did not respond to queries sent to them on this matter.

"The government is likely to issue appropriate instructions to PSBs to stop this unethical practice," the government official cited above said. He said the government had issued instructions to all PSBs on September 30, 2011 to take action against misselling products such as insurance policies and mutual funds.

"The Reserve Bank of India guidelines prohibits the banks to adopt coercive methods or other unfair means to market or sell these products to their customers. However, instances have been brought to the notice of the Government that the branches/officers of the banks continue to adopt unfair and barred practices/tactics for cross-selling of products.

This has been viewed seriously. Such practices are exploitative in nature, violative of rights of the customers and carry an inherent risk for the reputation of the institution," the 2011 circular of DFS that was issued to all PSB chairmen had, instructing them to take action against such practices.

Soumya Datta, general secretary of the All India Bank Officers' Confederation (AIBOC), said several complaints of misselling from various PSBs had been received, which is because of undue pressure on employees to achieve targets at the cost of their core banking business. "We have raised this matter with the government and expect some instructions in this direction soon," he said.

"We have highlighted the pressure exerted on field-level officers by the banks in promoting unethical practices to sell third party products of private companies and the payment of incentives and other rewards being encouraged by PSU [public sector undertaking] banks," four bank associations said in a joint circular issued on September 29, 2019.

The circular, signed by the AIBOC, the All India Bank Officers' Association (AIBOA), the Indian National Bank Officers' Congress (INBOC) and the National Organisation of Bank Officers (NOBO), added: "We categorically emphasised this is one of the main pain points of the bankers, who were losing focus on core business of the banks due to the pressure created by the top management."

Chartered accountant Vijay Kumar Gupta said, "Cross-selling is a revenue stream for banks and there is nothing wrong with it. But, it should be done ethically after assessing needs of the banks' customers and explaining pros and cons of such products. Misselling such third-party products to gullible customers just to achieve targets and avail {of} incentives is not only unethical but also illegal. The government and RBI should take up the matter and come out with a detailed policy on this matter."

TOP

Source

FDI limit in insurance companies may rise to 74% - The Economic Times – 10th December 2019

The government may raise the overseas investment limit in insurance to 74% in the February budget, up from 49% now, possibly paving the way for foreign control of companies, said people with knowledge of the matter.

The Insurance Regulatory and Development Authority of India (IRDAI) sought the views of various stakeholders on the matter in a December 2 letter at the direction of the government, they said. The letter to insurance companies and others has called for suggestions on raising the foreign direct investment (FDI) limit.

"The government is seriously contemplating opening up the sector as it wants long-term stable money to be invested in the country. IRDAI is seeking inputs from industry people on government instructions and a report is expected to be submitted soon," said a person involved in the discussions. "If all goes well, the government is planning to introduce this as part of the budget announcement and take a shortcut so that it gets Parliament's nod as part of the Finance Bill."

The finance ministry and IRDAI did not reply to queries.

It's been proposed that the stake limit could be raised to 74% over time. However, foreign insurers want it to be set at 74% without delay, said the people cited above.

The government increased the limit on FDI in insurance intermediaries to 100% on September 2.

The initial inputs gathered by the regulator centre around unwinding provisions related to Indian ownership in insurance firms, solvency of firms owned by foreign promoters, exercising long-term liability contracts on overseas owners and securing policy holders' rights in case the insurer is foreign owned.

The government raised FDI in insurance under the automatic route to 49% from 26% in 2015. Prior to this relaxation, approval for investment up to 49% required approval by the Foreign Investment Promotion Board (FIPB), which was disbanded two years ago.

Ownership and control had to remain with Indian residents as per the 2015 Insurance Act amendment that raised the overseas limit to 49%. Until then, the Insurance Act did not provide for this, so it was possible for offshore strategic partners to have substantial control rights, including reserved matters or veto rights on operational and financial policy decisions of the joint venture.

Several overseas investors increased their stakes in Indian insurance joint ventures after the limit was raised in 2015. Higher FDI enabled companies to go in for initial public offerings. Listed life insurance companies include HDFC Life, SBI Life and ICICI Prudential. Listed general insurance firms are ICICI Lombard, GIC Re and New India Assurance.

In the July budget, finance minister Nirmala Sitharaman had announced that the government will examine suggestions from various stakeholders to further open up FDI in the insurance sector.

In order to facilitate the higher investment limit, the government will have to amend the Insurance Act, alter provisions pertaining to Indian ownership, monitor the solvency of foreign firms so that the local business is unaffected by any challenges faced by the parent and that they stick around to honour long-term contracts, said the people cited above.

POOR EXPERIENCE WITH FOREIGN BANKS

If some foreign banks are anything to go by, the government will need to tread carefully, said some experts.

"The experience with foreign banks has been very mediocre as they have unwound business in India after their global operations took a hit," said one of the persons cited above. "And, since insurance, especially life, is a long-term liability and the government will have little power over foreign-owned entities, it has to be very careful before taking such a call."

The question of control also has to be decided, said one person close to development. "The government is keen on Indian promoters running the show even with only 26% stake in the joint venture," he said.

Industry participants have also pointed to confusion about defining and structuring foreign direct investment and foreign portfolio investment (FPI) in a company. Some listed companies have had FPI investment over the years that if counted under FDI will amount to an 80-85% overseas stake.

IRDAI may also raise queries over the impact of a foreign entity buying out or increasing stakes in a domestic firm and what happens to policyholders who have bought insurance due to their comfort with the Indian entity. Also, whether a change in ownership would be tantamount to nullifying contractual obligations.

India has 24 life insurance companies and 34 general insurance firms. Only about four in 100 Indians have life cover, offering companies a potentially massive market in the world's second-most populous country.

(The writers are Sachin Dave, Saloni Shukla and Shilpy Sinha.)

TOP

Source

INSURANCE REGULATION

No recession in insurance, growth on track: IRDAI chief - The Hindu Business Line – 13th December 2019

Insurance industry is now facing winds of change thanks to proliferation of low-cost insurance schemes brought in by the government and digital technology which is driving change in all sectors of economy. The focus everywhere now is on big data and analytics. TheInsurance Regulatory and DevelopmentAuthority of India(IRDAI) has been a catalyst for this change. Subhash C Khuntia, Chairman, has been responsible for bringing in a host of reforms over last one year after assumption charge. As a veteran civil servant and the first insurance regulator with a Ph.D in Economics, Khuntia has been focussing on harnessing digital technology for benefit of all stakeholders and making regulation all encompassing yet modern. He spoke to Business Line on industry and issues. Excerpts:

Largely, there has been no adverse impact on insurance so far. I hope and expect it will continue. There is, however, a slight slowdown in motor insurance has been noticed due to recent dip in new vehicle sales. Actually, people should look for more and more security by preferring insurance in times of slowdown as insurance is anti-cyclical protection.

How has been the growth rate so far?
Things are fine up to this first half ended September 2019. Total insurance industry clocked 20 per cent growth. Life insurance and general insurance grew by 21 per cent and 16 per cent, respectively. Due to increased awareness, health insurance catching up. Standalone health insurance grew 36 per cent.

Do you plan to intervene in any manner?
We would like all insurance companies to participate in crop insurance. But the rates of reinsurance and premium are market- driven. Regulator is not in picture in the whole issue.

Ayushman Bharat is being implemented in three models of insurance, trust and mixed model. As far as we are concerned, there have been no frauds. However, a panel has been set up to look into and data collection is being done and we will tract on the basis of data analytics. But there is nothing much to worry in this regard.

How is the health of health insurance? There have been complaints from policyholders on rejection of claims while industry speaks about false claims and losses...

We are trying to sort out the issues so that health insurance cover will be more beneficial to all. There are issues such as problems arising out of different sets of exclusion, for instance. I have been telling insurers to explain features of policies more clearly. The more time one takes in underwriting, more speed can be achieved in claims settlement.

Efforts are also on to introduce a standard health cover product which will be like a standard banking product. Because it will be standardised model, there should not be much need for explanation.

What about pricing of the proposed standard health insurance product?

It will be reasonable as all insurers will be mandated to offer this and competition positively impacts Pricing.

(The writer is G Naga Sridhar.)

TOP

Source

Panel to suggest ways to cut losses in non-life biz - Deccan Chronicle – 13th December 2019

The Insurance Regulatory and Development Authority of India (IRDAI) on Thursday constituted a working group to recommend ways to prevent and minimise losses in the general insurance industry.

The regulator in a statement said that while loss prevention and loss minimization are aspects insurers are concerned with right from the time a risk is assessed to the time a claim occurs, there is a need to synergise the activities of the various stakeholders involved in these activities for the benefit of all concerned. Research and education in this area needs to be encouraged. Collaboration with the government and various government agencies in this regard will benefit the society at large. It is, therefore, important that all stakeholders work together towards a common end on a common platform.

The panel has been setup under the chairmanship of T.L. Alamelu, member (non-life), and would have G Srinivasan, Director at the National Insurance Academy, Kunnel Prem, CEO, of Insurance Inform-ation Bureau of India, M Nagaraja Sarma, secretary general of the General Insurance Council C.S. Ayya-ppan, deputy general manager of the New India Assurance Company, Girish Gangadharan, senior manager, GIC Re, Thangaraju Mallan, senior vice-president corporate underwriting at HDFC Ergo General Insurance, Ramanan V, appointed actuary at Max Bupa Health Insurance, S.K. Jain, vice president, Insurance Brokers Association of India, and Yegnap-riyaBharath, CGM (non-life), IRDAI, member convener as members.

TOP

Source

Irdai Okays debt ETFs of CPSEs as eligible class of investment for insurers - The Economic Times – 11th December 2019

Irdai on Wednesday allowed insurance companies to invest in debt ETFs (exchange traded funds) of CPSEs.

The instruments have been permitted as eligible class of investment, according to guidelines issued by the insurance regulator.

The Insurance Regulatory and Development Authority of India's (Irdai) guidelines allow insurers to invest in various exhaustive asset categories.

"Irdai hereby permits debt ETFs with underlying debt securities of central public sector enterprises (CPSEs) proposed to be launched in India, as eligible class of investment, and as part of mutual fund exposure," the regulator said in the circular on Wednesday.

Irdai said such debt ETFs should be issued by mutual funds registered by Sebi and governed by its regulations.

"The debt ETF shall invest in a basket of securities issued by CPSEs which are part of constituents of a publicly available index. The minimum investment by the insurer shall not be less than creation unit size and it shall not be reduced to below creation unit size," Irdai said.

TOP

Source

IRDAI allows policyholders to choose their own health insurance TPA - The Economic Times – 11th December 2019

Instead of solely depending on the insurer, policyholders can now choose third-party administrator at the time of buying a health insurance policy or at the time of renewal.

According to a circular issued by the Insurance Regulatory and Development Authority of India (IRDAI) on Tuesday, "For the purposes of this sub-regulation, the choice of the policyholder to choose a TPA for rendering health services is limited to the TPAs with whom the insurer is having Service Level Agreements in place. Based on the health insurance product and geographical location of the policyholders, the insurer may also limit the number of TPAs amongst whom the policyholder may choose a TPA of their choice. The insurer explicitly shall provide the list of the TPAs engaged, from amongst whom the policyholder may choose a TPA of their choice, at the time of proposal or the renewal as the case may be."

Amit Chhabra, Head- Health Insurance, Policybazaar.com said, “This initiative by the regulator will allows the customer/policyholder more flexibility and at the same time, keeps the entire health insurance

ecosystem on toes, to ensure customer/policyholder gets best service experience." He further explained, let's say a policyholder has had a prior good experience with a specific TPA, they may choose to use the same TPA for any health insurance claim. "So that gives the customer flexibility," he added.

Here is a look at how this will benefit a policyholder.

These regulations may be called the Insurance Regulatory and Development Authority of India (Third Party Administrators - Health Services) (Amendment) Regulations, 2019.

What is a third-party administrator?
A TPA is a middle man appointed by a health insurance company who facilitates settlement of a health insurance claim. TPAs help you (the insured) process your health insurance claim using various hospital bills and documents. However, they are not responsible for claims rejection or acceptance.

What the IRDAI circular states
According to the IRDAI circular, the policyholder can choose a TPA of their choice from a list of TPAs engaged by the insurer.

Here is what the IRDAI circular states:
Where the services of the TPA are terminated during the course of health services rendered by the said TPA, every insurer shall allow the policyholder to choose an alternate TPA from amongst the TPAs engaged by it.

(b) The insurer shall explicitly provide the names of the TPAs amongst whom the policyholder may choose the TPA of their choice at the point of sale. The Policyholder may be allowed to change the TPA of their choice only at the point of renewal. Provided that the policyholder shall have no right to seek to dispense the services of the TPA and request the insurer to undertake to render the health service directly.

Provided further that the insurer shall have the prerogative of whether or not to engage any TPA or to terminate the services of the TPA or not to engage the services of the TPA for a particular health insurance product or discontinue the services of the TPA to service a particular health insurance product.

(c) Where the policyholder did not choose any of the TPAs, the insurer may allow the policy servicing to a TPA of its choice.

(d) Where the insurer engages the services of only one TPA, no option need be provided to the policyholder.

(The writer is Navneet Dubey.)

TOP

Source

Over 4 lakh complaints, can't probe each one: Insurance Regulator – Newsclick – 9th December 2019

On November 15, 2019, the Insurance Regulatory and Development Authority of India (IRDAI) admitted in the Rajasthan High Court that it received 4,09,750 complaints of unfair business practices in 2018-19 alone. "It is impractical to investigate each and every complaint," said IRDAI in a written document submitted to the court.

This document was produced as part of its defence while the court was hearing a PIL filed by whistleblower Nitin Balchandani, a former employee of ICICI Prudential Life Insurance Company Ltd. Balchandani had taken to the court with a complaint about rampant corruption in ICICI Prudential, which was affecting the poorest in rural Rajasthan.

He claimed that he had repeatedly written to the IRDAI, Reserve Bank of India, Prime Minister's Office and Serious Fraud Investigation Office (SFIO) detailing his findings and seeking action, but received no response. In 2018, he approached the high court with a PIL. Besides the fraud by the insurance firm, he highlighted the alleged inaction by the regulatory authorities and sought action against the officials involved.

In his PIL, he explained that he had recorded instances of farmers, widows, pensioners, students and senior citizens being defrauded by ICICI Pru Life. Although he had been raising the matter since 2015 with regulatory bodies, no action was taken. He had carefully documented over 250 cases of fraudulent sale of insurance by ICICI Pru Life.

"With each case that we highlighted, we would get responses for that particular case and in some instances the money would be returned. However, no attempt was made to correct the systemic process through which the fraud was being carried out, and we would come across more instances of people being defrauded soon as one was resolved," Balchandani, who has set up a registered firm called Insurance Angels—for helping those who have been sold insurance policies fraudulently—said. He resigned from his job at ICICI Pru Life in 2012, after highlighting instances of inappropriate sale of insurance that his bosses had allegedly preferred to ignore.

In his petition in the HC, Balchandani detailed instances where poor farmers seeking loan under the Kisan Credit Card scheme were sold insurance without their knowledge. Age and income details were manipulated so that insurance could be sold to students or people from the BPL category. The call verification process for sale of insurance was manipulated, and an employee of the bank would receive the call instead of the person to whom insurance was sold.

In its nine-page reply filed on November 15 this year, IRDAI states that it had taken note of these complaints and conducted inspections in the premises of ICICI Pru Life in September 2017 and again in June 2019. The "said (inspection) reports are under analysis" the reply stated.

IRDAI stated that the Integrated Grievance Management System (IGMS) was in place to take care of complaints, but did not elaborate on why each and every complaint could not be handled by this system. "The systems might be in place, but it is quite clear they do not work," Balchandani said.

IRDAI was recently in the news after Finance Minister Nirmala Sitharaman submitted in Parliament that the recruitment procedure initiated in May 2019 by the regulatory authority was cancelled after it was found that things like basic qualifications and other criteria could be challenged in court. A total amount of Rs 22.47 lakh had already been incurred by the government as expenses on the process.

Money life reported, "In fact, there were two vacancies for the post of AGM (Legal). However, out of 42 applicants, only three remained after the scrutiny. Out of these three, only one candidate appeared for the written examination. If there is only one candidate appearing for the written examination, how would IRDAI make the selection? This raises doubts about the recruitment process itself."

During the course of the hearings in the HC, Rajat Dave, counsel representing RBI, had stated that a reply in the matter would be produced by RBI too. Although the petitioner had made the RBI a party in the case, the court had not issued any notice to it.

Since 2017, the Special Operations Group (SOG) of Rajasthan police has been carrying out investigations in this matter. Speaking to The Wire in March 2018, MS Ranawat, then additional SP with SOG had, said, "So far our investigation has revealed fraud and serious violation of IRDAI guidelines. The bank and the insurance authorities also did not cooperate with the investigation and tried to mislead us. The scale of the fraud is massive."

Meanwhile, ICICI Pru Life had also filed a case against whistleblower Balchandani, accusing him of theft of confidential information and charging him under Sections 420 of the IPC and 66 of the IT Act. Balchandani spent a month behind bars, but with no evidence to back charges, the HC quashed the charges against him in January 2018.

On November 6, 2019, the court made it clear that replies were to be filed and no additional time would be granted to the respondents. The matter was listed for hearing in another three weeks. In its final order on December 2, 2019, the court abruptly dismissed the PIL. "The judges said the SOG of state police was investigating this matter. But they knew this all this while. Besides, a reply had not yet been filed by the RBI. I don't know why the PIL was dismissed prematurely," Balchandani said.

Commenting on the status of the case, Abdul Rehman, the current investigating officer in the case, told this reporter, "I have submitted a report to Jaipur. There are documents I have sought from ICICI that are still to arrive."

It should be noted that business news website The Ken has recently had carried a report about rampant mis-sale of credit cards by private banks. In October 2017, an official of ICICI Bank in Madhya Pradesh set himself on fire and committed suicide, after complaining of impossible targets at work.

It is reported that IRDAI is set to launch cat (catastrophe) insurance to protect the poorest from the ravages of natural disasters.

(The writer is Rosamma Thomas.)

TOP

Source

Irdai plans to standardise insurance guidelines for houses and shops - Business Standard - 7th December 2019

The Insurance Regulatory and Development Authority of India (Irdai) is coming out with standard guidelines for products aimed exclusively at units like 'dwelling houses' and small commercial establishments.

Currently, there is no standardisation of insurance cover for units like small shops and houses. These units, however, can be covered under fire and allied perils insurance, which are mostly aimed at bigger units.

Irdai is expected to come out with norms in the next few months, said a source close to the development. Standardisation would entail affordable insurance products to help cope with and recover from common risks while adhering to certain levels of cover, premium and benefit standards.

In the last few years, the need for such standardisation was accentuated by increasing loss of small houses and commercial establishments due to natural calamities.In May, Irdai had come out with an exposure draft on revisiting the product structure for dwellings, offices, hotels, shops and micro, small and medium enterprises (MSME) against fire and allied perils.

It constituted a working group to look into the specific needs of the segment. The working group made various recommendations, after which it was decided to work on the product design and draw up the proposed policy wordings. These include the terms and conditions in plain language, keeping the target segments in mind. The group also recommended standardisation of products in the segment. It suggested that all perils relevant to a segment be covered in the base product itself to avoid mis-selling.

Also, the working panel suggested a system of default sum insured for all dwellings. It recommended that the General Insurance (GI) Council or Insurance Information Bureau of India (IIB) create a database of cost of construction for each square feet carpet area for different geographies and construction types.

The insured will declare only the carpet area and the sum insured of the dwelling will be auto-calculated at the given rate. At present, there are around 91 products offered by registered general insurance companies, targeting low income segment of the population, according to Irdai's annual report for 2017-18.

Some other recommendations of the group included insurance of houses in multi-storied apartments on the total saleable price of the apartment based on 'ready reckoner' rates published by each state government. It also recommended restricting tenure of the dwelling structure policies to five years.

It also talked about doing away with upfront discount and providing in-built sum insured auto-escalation at the rate of 10 per cent per annum. India continues to see one of the lowest insurance penetration rates at 3.69 per cent, according to the annual report by IRDAI. The penetration for non-life insurance sector in the country stood at 0.93 per cent in 2017.

Before the abolition of the Tariff Advisory Committee in 2002, there were certain standardised products in the micro insurance space. However, after the abolition, the products went off the shelves due to lack of demand, according to a senior official in a general insurance firm.

Earlier, IRDAI, in order to propagate micro insurance in various segments, expanded the categories of entities or individuals who may be appointed as micro insurance agents. These include non-government organisations (NGOs), self-help groups (SHGs) and micro-finance institutions (MFIs), among others.

Suggestions

- All perils that can affect a segment should be covered in the base product
- GI Council or IIB likely to create a database of cost
- Tenure of policies up to 5 years
- Call for doing away with upfront discount

(The writer is Namrata Acharya.)

TOP

Source

IRDAI pushes insurers to list on bourses - The Hindu Business Line – 7th December 2019

The insurance regulator, on Friday, urged more insurance companies to list on the bourses as it would make them more efficient in operations and transparent in disclosures.

"Listed insurance companies are doing quite well in terms of good valuation. I urge other insurance companies to start listing as they cross a critical mass," said Subhash Chandra Khuntia, Chairman, Insurance Regulatory and Development Authority of India (IRDAI).

Addressing the Assocham Insurance Summit, Khuntia said that listing helps companies provide more disclosures and abide by market discipline, making their conduct more efficient.

The IRDAI had earlier issued a draft that all insurance companies that have completed 10 years of operations should list on the stock exchanges. Speaking to reporters on the sidelines, Khuntia, however, said that some of them have been finding it difficult as they have not crossed the critical size. "We are not forcing them, but I am nudging them," he said, adding that Reliance General Insurance had taken permission but it may not go through with it due to group-level problems.

PSB consolidation

The IRDAI is also working on issues related to consolidation of public sector banks as many of them are also promoters of insurance companies. Under the current norms, the IRDAI does not normally allow a bank to be the promoter of more than one insurance company. Additionally, each bank is allowed to be a corporate agent of only three insurers of the same type at a time.

In case a merged bank has promoter stake of more than 10 per cent in an insurer and wants to continue, then the IRDAI is looking at whether the bank can be allowed to do so without being involved in the management of the company.

"If they give up directorship of the board, they can hold the shares. It will take care of the issues of conflict of interest. Banks feel it will be a valuable share and they should not give up. So, we are looking at that angle as well," said Khuntia.

Alternatively, the bank can reduce their stake to less than 10 per cent and lose the promoter tag and continue to hold the shares. Khuntia said that for corporate agency, banks will have to opt for three insurers. But they will get a smooth transition time to ensure that policyholders are not affected.

"They will have to decide which three to keep and which to divest," he told reporters. The IRDAI has also written to the Life Insurance Corporation of India to give a timeframe to reduce its shareholding in IDBI Bank. The life insurer currently holds 51 per cent equity in the bank, against the mandated 15 per cent cap. The IRDAI had made a one-time exception for LIC.

TOP

Source

LIFE INSURANCE

Life insurance: Private insurers' premium collections up 27% - Financial Express – 13th December 2019

Individual annualised premium equivalent (APE) increased 27% year-on-year (y-o-y) in November for private players, bucking the 2-4% y-o-y growth trend of the past two months. Almost all players reported strong performance, partially aided by a low base. Life Insurance Corporation (LIC) almost doubled its premium, a change from muted performance in recent months. HDFC bounced back after a decline in October and ICICI Life reported a second consecutive month of high-teen growth. SBI crossed 20% growth after three months. Interestingly, equity mutual funds reported net outflows.

Growth rebounds

Private players reported 29% y-o-y growth in overall APE in November 2019, with 27% growth in individual APE and 53% y-o-y growth in group business. Overall industry APE was high at 67% y-o-y owing to 1X y-o-y rise in individual APE for LIC and 1.4 X y-o-y increases in group business.

ICICI Life reported 20% y-o-y increase in individual APE, on a low base of 24% y-o-y drop in November 2018. Average ticket size in the individual non-single segment was up 69% y-o-y (down 9% m-o-m). On considering overall (individual and group) adjusted APE including accrued but not received premium, its APE was down 5% y-o-y, against 16% growth in October 2019.

HDFC Life reported 43% y-o-y growth in individual business post recording a 15-20% y-o-y decline over the past two months. A low base (20% decline in November 2018) appears to have helped. Overall APE was up 49% y-o-y on the back of 81% y-o-y growth in group business.

SBI Life's individual APE growth was up 22% y-o-y higher than 3-14% y-o-y growth observed in the past three months. In any case, management has guided for about 20-22% growth for FY2020E (reported 24% in 1HFY20 but has been weakening since).

November performance suggests that it may be on track to achieve its target. The company will continue its focus on protection though yoy growth in protection will be lower in FY2020E (individual protection APE was up 1.3X in 1HFY20 and 5X in FY2019).

Max Life's growth in individual APE was modest at 17% y-o-y; down from 28% growth in August and 48% growth in July but higher than 2-3% y-o-y growth in the past two months. Ticket size in individual non-single segment was up by 8% y-o-y (up 4% m-o-m). The company has increased focus on non-par savings business significantly in 1HFY20.

Strong growth momentum for Birla Sun Life and Tata AIA observed in 2HFY19 had slowed down in the past two months but revived in November 2019. Individual business for Birla SL increased 63% y-o-y, most likely led by strong traction in the bancassurance channel.

However, Tata AIA reported 50% y-o-y growth in individual APE, higher than 22% in October. Thus, all the three banca partners of HDFC Bank fared well in November. LIC almost doubled its individual APE in November post 6% growth in October and decline in September.

LIC agents seem to have pushed their paddle hard since it was the sunset month for some of LIC's popular products —Jeevan Lakshya, Jeevan Umang and Jeevan Labh (all three par products). These products are being re-priced. We would expect weakness in its growth hereon.

Growth may not sustain

We don't think high growth in APE will sustain over the next few months. Growth in the previous two months was moderating and raising concerns of weak FY2020E. After a strong November, it now seems that mid-to-high teens growth may hold.

TOP

Source

Here's why falling interest rates will not hurt your insurance returns – Moneycontrol – 12th December 2019

If the drop in interest rates in the country has been bothering you as an insurance customer, do not worry. Your insurer has already started taking steps to ensure the returns on your product stay intact.

Life insurance companies are now turning to external hedging to manage the interest rate risks in the product portfolio. With more number of insurers turning to non-participating savings plans (products without bonuses), the companies want to ensure that returns to customers do not get impacted.

Instruments like interest rate futures, interest rate swaps, forward rate agreements and partly paid bonds. Among the 24 life insurers, at least 16 of them have started the hedging process in the past four to eight weeks.

"Non-par savings is becoming a popular product. Hence, it is essential that the returns are commensurate with what is promised at the time of policy purchase," said the chief financial officer of a large life insurer.

Why external hedging?
Interest rates have seen a consistent reduction in the country. The Reserve Bank of India (RBI) has cut repo rate (the rate at which the central bank lends money to banks) by 135 basis points this year. The repo stands at 5.15 percent. This has led to a fall in interest rates consistently after five consecutive rate cuts by RBI.

This volatility in the interest rates directly impacts the returns paid to policyholders when their insurance products attain maturity. About 40 percent of annual new business premium comes from non-par savings products.

Product guidelines mandate insurers to offer 4 percent or 6 percent return to policyholders for savings products. However, the drop in interest rates is constantly a cause of worry. Insurers offer between 4-5 percent of internal rate of return for policies. The hedging through the use of external instruments has made this possible.

A recent survey by global actuarial and consulting firm Milliman found that partly paid bonds are the most popular hedging instrument for Indian life insurers. This is due to price transparency and simplicity of execution. A partly paid bond is an instrument which is purchased on an instalment. Unlike a regular bond where the investor has to lend the full amount, partly paid bonds have an initial down-payment followed by the rest of the instalment.

Among the other instruments, forward rate agreements are the second most popular as per the survey where the life insurers rated FRAs highly on hedge effectiveness. FRAs are instruments where one party agrees to borrow or lend a certain amount of money at a fixed rate on a pre-specified future date.

(The writer is M Saraswathy.)

TOP

Source

Term insurance for patients with pre-existing diseases: it is possible! - The Pioneer – 11th December 2019

Life is unpredictable, and you cannot say what will happen in your life in the future. It is one reason that makes the prospect of buying a term insurance plan appealing. A term plan will help you keep your family secure and financially stable even in your absence. Nowadays, you can also opt for getting survival benefits with some of the best term insurance plans available online as well as offline. However, there is one common myth prevalent amongst some people in India related to term insurance. It says that an individual who is suffering from pre-existing diseases is not eligible to buy a term plan, which is not entirely true.

Just like sudden death, critical illnesses may also come unannounced and deterioration individual's health and well-being badly. Keeping that aspect of life in mind, you can find some renowned Indian insurance companies like Max Life Insurance, offering critical illness riders for term plans. These riders or additional covers have been created by the insurers to protect you and your family against financial liabilities resulting from critical illnesses.

Now, let's talk more about the next question that you may have started to think about –

Do You Need Critical Illness Riders?
Your health, which is a crucial aspect of your life, may face a critical illness at any stage of your life. Sometimes, it becomes challenging to pay for medical expenses related to some diseases. You may even have to skip work or quit your job for the same until your health is back in good condition. If you have not bought a medical insurance policy, but only a term plan, you will not get any benefit during such times.

However, you can get additional benefits by opting for term plans with critical illness riders at a slightly higher premium. In case you are diagnosed with a specific illness, be it cancer, heart failure, lung diseases, deafness, to name a few, your insurer will provide you a lump sum amount to help you pay for the hefty medical bills.

All insurance companies offer term plans with critical illness riders for a predetermined list of illnesses, which may vary from one insurer to the other. So, it is advisable to check this list before buying a term plan along with the other policy terms.

Why Medical Tests Are A Must While Buying a Term Insurance?
You might have even seen or heard of the catchy term insurance ads that say, '*No Medical Tests Required*.' However, it is not generally advised to buy term insurance without getting specific medical tests done. It is because your health status determines your eligibility for the benefits that a term plan offers. An insurer will be able to give you a customized term insurance plan online or offline based on the health test reports.

So, you must know what medical tests are required for term insurance before buying one. Failing to get these tests done may cause problems for you in the long run. Most medical tests include full body checkup, HIV test, blood test, routine urine analysis, and similar others.

Let's dig deeper to unravel the truth about the importance of medical tests about term plans –
Ensure Lower Risk of Claim Rejection
Getting the required medical tests done before buying a term plan ensures there is no risk of getting your claim rejected.

Less Premium Required
Healthier individuals need to pay a higher premium of a term plan as same as the unhealthier ones as it depends on the risk perceptionof the insurer.

Gives Better Coverage
Based on the health test status, one can get better risk coverage through the chosen term plan than in the case where the reports are not all good.

Medical tests, therefore, can help you get maximum benefits while buying a term plan. You are also advised to consider purchasing onlineterm insuranceplanto save time and gain easy access to the information related to the policy.

TOP

Source

Life insurance industry registers strong growth in November – Financial Express – 11th December 2019

Indian life insurance industry registered strong growth in November, led by positive performance across all categories. Insurance industry saw new business premiums at Rs 26,221.24 crore compared to Rs 14,857.76 crore – a growth of 76.48% – data from Life Insurance Council show.

Individual annualised premium equivalent (APE) increased 27% y-o-y in November for private players, bucking the 2-4% y-o-y growth trend of the past two months, suggest data from Kotak Institutional Equities.

The data from Life Insurance Council show that categories such as individual single premiums, individual non-single premiums, group single premiums and group non-single premium saw positive growth in November.

"Almost all players reported strong performance, partially aided by a low base. LIC almost doubled its premium, a change from muted performance in recent months. Among large players, HDFC bounced back after a decline in October and ICICI Life reported a second consecutive month of high-teen growth. SBI crossed 20% growth after three months," said a report of Kotak Institutional Equities.

In April-November period, life insurance industry saw new business premiums at Rs 1.69 lakh crore compared to Rs 1.23 lakh crore in the previous financial year – a growth of 37.22%, data from Life Insurance Council show.

Insurance industry and Life insurance Corporation of India (LIC) witnessed APE at 67% and 110%, respectively, for November. APE is the sum of annualised first year premiums on regular premium policies, and 10% of single premiums, written by insurance companies during any period from both retail and group policyholders.

"LIC almost doubled its individual APE in November after 6% growth in October and a decline in September. LIC agents seem to have pushed their pedals hard since it was the sunset month for some of LIC's popular products namely Jeevan Lakshya, Jeevan Umang and Jeevan Labh (all three par products). These products are being re-priced. We would expect weakness in its growth hereon," said the Kotak Institutional Equities report.

Players like Bajaj Allianz, HDFC Life, SBI Life, Max Life, Tata AIA continued to see its APE growth in positive territory in the current financial year.

TOP

Source

Digitisation makes buying simplified life insurance products increasingly effortless - Financial Express – 10th December 2019

Insurance is one of the fast-paced industries in terms of the adoption of digital technologies. With the advent of the internet and consumers becoming more perceptive with digital, today, buying insurance has become effortless. Purchasing of policies is instantaneous, touchless, and can be purchased online or using mobile devices. Customer experience is not just about the front-end presentation – Today, the customers want self-service capabilities. They want to begin their research online, seek views through their social networks, and get feedback from their peers. There is a shift happening from, "I spoke to my Dad, and he introduced me to his financial advisor," to, "I'm talking to my social network, and I intend to buy online." Therefore, people do buy simplified life products without a financial advisor.

While current distribution channels will not go away soon, direct-to-consumer is an emerging channel, especially for products that are simpler and have modest insurance value that cater to the millennials and mid-market consumers. Driven by customers' needs, digital transformation continues to remain a key priority for the insurance carriers. However, many insurers remain constrained by the complexity of their backend systems, resulting in genuine concerns around agility, value, and delivering the right consumer experience.

In India, too, the picture is not very different. Consumers are demanding more simplified products, as well as a growing preference for bundled products with the overlap of income and mortality risk. They are also willing to make a choice themselves rather than be led by an intermediary. Ultimately, much of the struggle comes back to the antiquated backend architectures. Without an agile, flexible architecture in place, many insurers struggle with launching products fast enough to capture new customers with these preferences and gain market share. However, many non-traditional disruptions are underway. Last

year, Amazon, Flipkart, and Paytm were all in the news for seeking Insurance Regulatory and Developmental Authority of India's (IRDAI) approval to sell insurance. There is a broad consensus that simplified products sold via digital platforms that allow consumers to buy insurance seamlessly present an excellent opportunity to penetrate and grow the under-penetrated insurance sector in India. One significant catalyst is the advent of widespread and affordable internet connectivity in cities and towns that have allowed making insurance products available digitally.

And this is where Insurtech comes in. After the FinTech, it is Insure Techs that are looking to disrupt this industry with cutting-edge technology to simplify insurance for the end customers. Insure Techs have made innovation readily available and adoption seamless. More and more insurers are aware of the disruption technology is causing to this industry and, at the same time, looking for avenues to engage with Insure Techs. Outsourcing service providers, on the other hand, are collaborating with Insurtech to build an ecosystem to leverage the technology for their clients to help them with faster go-to-market solutions.

Insurtech is often viewed as being a collection of smaller, customer-centric startups that push larger traditional insurers to rethink the customer experience they provide and to transform their business models. There is more to it – Insure Techs are technology enablers that help enterprises address industry needs at a much quicker pace. They can simplify products and launch them in just two months instead of more extended gestation periods of 12-13 months traditionally. InsureTechsutilise technologies such as IoT and AI to make the claims processing happen seamlessly, and processing of policies now takes only a few weeks. Insure Techs are putting AI to achieve accuracy in underwriting. They are using machine learning to automate the claims processing and implementing robotic process automation (RPA) to automate several processes in the backend, making it much easier for the insurance carriers to deal with the growing customer needs.

The InsurTech story is more of partnerships and eco-systems in the form of innovation labs, long-term collaboration, idea accelerators, and sponsorships. From the use of AI and chat bots to digital marketing, InsurTech is driving the development of innovative customer-centric products. They are reimagining the selling and servicing of insurance and taking advantage of broader technology trends such as big data, machine learning, AI, and wearable devices, to name a few. By having a modernized back-end that can plugin APIs and exposes those capabilities into the presentation and experience layer, you can create an engagement model that makes consumers want to work with you and be loyal to your brand. By breaking down the customer journey, prioritising pain points, and redesigning those journeys to focus on what matters most for the policyholders, carriers can differentiate themselves as a customer-centric business.

InsurTech as a concept is relatively new in India as the insurance companies still follow the legacy mindset with processes more focused inwards than outwards. We believe it will be the disruption driven by Insure Techs that will finally drive growth and penetration of insurance in India. Leveraging digital technologies, developing innovative, simple, and on-demand products, and driving customer engagement levels will be the catalysts for growth.

(The writer is Chirag Buch.)

TOP

Source

Reasons why you shouldn't cancel your life insurance policy – DNA – 10th December 2019

Inflation rate is simply trending high on the increasing curve, incomes have gone down, unemployment has gone up and prices are out of control. When times get tough, the downward economy can play destruction with a typical Indian household budget. With the recession affecting so many families, it is natural for everyone to look for ways to decrease the budget or cut various expenses that may seem extraneous or based on luxury. However, your life insurance policy shouldn't be one of them.

But unfortunately, many families consider life insurance to be a luxury rather than a need. Life insurance may seem a little insignificant now, but it can mean a great deal of value to the ones you love later down the road. If you have considered cancelling your life insurance policy to add some money to your account, consider the fact that premium of insurance only increases with time. Hence, if you have a life insurance policy, cancelling the policy maybe one of the expensive mistakes you ever make as the same policy will cost you same next year, even if your health hasn't changed.

The key is to make the right choice for not only the immediate future and your current budget but by also keeping the long picture in mind. As well said, it is always a wise decision to buy a life insurance policy; it is an even smarter decision to do everything you can to keep it in force. Here are the top three reasons why you should avoid cancelling your life insurance policy.

Your only protection against the unforeseen events in life

Life is too uncertain and its unpredictability can rip you off both financially and mentally. However, the risk of an untimely death cannot be ruled out. In order to cover the financial losses arising out of such a risk, it is recommended to be invested in a life insurance policy. As it is not only the protection against those bad times which are difficult to predict but also against the events which can cause big troubles to your family after your unfortunate demise. Once you have brought a life insurance policy, your family can have a safe and secure future. Your insurance provider will pay the sum assured to your family members, thus providing a high degree of financial security when you are no longer around. Although it's difficult to conceive of now, the financial burdens when that time comes can be significant.

Heck! At Rs 680 a month for Rs. 1 Crore policy it's cheap!

Unlike an investment plan, a term plan will not provide a return to you in the form of survival benefit when you are alive, but it will secure your family's future in your absence by providing a high coverage at a nominal rate. One of the major advantages of a term insurance plan is its affordability. Term insurance plan comes with a low premium charge along with a high level of insurance cover. Term plan being the simplest form of protection plan can provide great value for the premium paid. It will secure your family's financial future and help them to meet their basic needs in your absence.

The cost of life insurance depends on various factors and the policy chosen. Just as a general guide - a healthy 25-year-old can easily secure Rs 1 Cr of term life insurance for a tenure of 35 years for around Rs 600- 800 p.m. – much less than most people think of. However, the actual cost would depend on factors as you age, health and the amount covered. The life cover is at least 10 times the amount of premium paid towards the policy.

Your family will need to dip into their rainy day funds in the absence of a valid life insurance

In India, the sole breadwinner's affiliation towards his families is very strong. To someone who spends more than half of his day working to provide comfort and luxuries to his family, financial security might seem redundant to him. But the question that needs to be answered is whether the family has enough financial resources to maintain the current standard of living if something happens to the breadwinner or the family will dip into using the emergency fund for their daily living?

In an unforeseen event of loss of life, you don't want your family to suffer financially. In order to take care of their financial needs, you can keep a basic term plan in your financial portfolio.

(The writer is Santosh Agarwal.)

TOP

Source

Life Insurance for Smokers: How smoking can affect your life insurance premium – Financial Express – 10th December 2019

The tobacco epidemic is one of the biggest public health threats the world has ever faced. According to the World Health Organization (WHO), India is home to 12% of the world's smokers, killing nearly 10 million people annually.

While the long-term effects that smoking causes are known to many of us, however, there are other downsides to being a smoker as well. One of them is that life insurance will certainly cost you more if you're a smoker. Since the odds of dying from smoking-related grounds are so much more and have been well documented, life insurance companies protect themselves from the higher risk by increasing rates for tobacco users. It likely won't prevent you from getting a policy, but you'll feel it in your wallet. It adds to your life in other forms, i.e. by way of medical expenses and even your insurance premiums!

How smoking can affect your life insurance premium

To start with, first let's look at the basics of life insurance. You buy a policy to provide financial protection and security after you die. So, how do insurance companies exactly put a price on that security. A lot of the cost of life insurance depends on your current state of health and your family history. But what's one of the biggest factors insurance companies look at when assessing your health risk? Whether or not you're a smoker.

Many insurers consider the higher risks associated with smoking when adding a premium charge for tobacco users. This is because health hazards of smoking and the risks it puts on your life are well known. Smoking restricts your blood vessels causing heart diseases and high blood pressure. It irritates your lungs and causes lungs to produce more infections. We all get that as we age but smokers get it faster and to a greater degree.

Underwriting is when an insurance company reviews your health risks after you've applied for life insurance. This process lets an insurer calculate the coverage you're eligible for. It also ensures your premium reflects the level of risk. When you are applying for a life insurance policy, you will be inquired about your usage of tobacco products in the last 12 months. While it may be easy to lie verbally, it is practically impossible to cover up the traces of nicotine in the medical test even if you are an occasional smoker. To stay adequately cover, the customers need to be honest with the insurer about their smoking habits as life insurance companies take smoking as a serious clause and are extremely strict about it. It's important to note that although e-cigarettes or vaping are touted as the healthier alternative to cigarettes, as of now insurers make no distinction between the two and qualify you as a smoker in the eyes of insurance underwriters.

Being a smoker puts people at a higher risk of smoking-related illnesses which translates to higher premiums.

Baseline differences between smokers and non-smokers with premium

Smoking comes with a price. But exactly how higher are life insurance rates for smokers as of non-smokers?

Whether you buy term life insurance, which covers you for a certain number of years, or permanent life insurance, such as whole or universal life, there's a distinct difference when it comes to the price of life insurance premiums for a smoker or non-smoker. For instance, let's take an example of a 30-year-old man opting for Rs 1-crore term life insurance policy. The lowest estimated annual premium who doesn't smoke is Rs 8,260. As a smoker the same man would pay 78% increase in the price for the same amount of coverage: Rs 14,750.

The table enclosed below compares the premiums of smoker's vs non-smokers by three leading insurers providing term insurance of Rs 1 crore life cover for a 30-year-old and covering age till 70 years.

INSURER	PLAN	NON-SMOKER PREMIUMS (Annually)	SMOKER PREMIUMS (Annually)
India First Life Insurance	e-term Plan	8260	14,750
ICICI Prudential Life Insurance	iProtect Smart	12,502	19,383
HDFC Life Insurance	3D Plus Life Option	12,478	20,322

Source: www.policybazaar.com

Quit for good

For individuals that smoke, the best way to improve health and life insurance coverage or rates is by quitting or reducing smoking. But you will have to banish all nicotine products for at least 12 or 18 months before buying life insurance to qualify for lower premiums. If you've tried to quit in the past and haven't succeeded, keep trying. It has been estimated that it can take 8 to 30 tries to really kick the habit for good. Obviously, this is easier said than done, but there is plenty of support out there for smokers who want to kick the habit.

(The writer is Santosh Agarwal.)

TOP

Source

Insurance purchase to get simpler as IRDAI issues circular – The News Minute – 9th December 2019

Insurance products still remain a mystery to ordinary people, especially the critical terms written in fine print. The Insurance Regulatory Development Authority of India (IRDAI) has now issued a circular meant for the point of sales products and persons for life insurance (POSP-LI). It's a master circular that tries to define the way the policies are presented to the prospective customers.

It says, for example, how there should be two parts in the key features document (KFD) and how the proposal form will be attached to it through a perforated joint to be torn off and the KFD portion retained with the customer and so on. This master circular is to cover vanilla life insurance policies. The POSP-LI factor comes in since most such polices are sold by life insurance companies through agents recruited by them. IRDAI has stipulated the type of polices that can be sold through the agents. These include pure term insurance products with or without return of premium. They can sell non-linked non-participating endowment product, immediate annuity products and non-linked non-par health insurance products with fixed benefits.

The circular goes on to mention that the POSP-LI being used as the intermediary to sell the life insurance policies, have to be given formal training for 15 hours internally organised by the company and an examination conducted at the end of the training and a certificate issued. There will be codes assigned to trace the policies back to the POPS-LI who sold them. Any misconduct on the part of the POSP-LI will be the responsibility of the insurer. Any penalties imposed will be paid by the company.

The master circular mentions that the KFD document must contain the relevant information on the policy terms, including the sum assured on death, maturity and surrender value and so on. The exclusions, details of the registered name and address of the life insurance company must be stated on the KFD document. If the policy is being taken online, a hard copy of the KFD has to be mailed to the proposer /insured.

Finally, there are instructions on the time the insurance company can take, once the proposal form and the premium has been collected. Within four days, the policy acceptance or rejection has to be communicated to the proposer. If there is a rejection for any reason, the refund of the money must take place within seven days. The proposer's Aadhaar card or PAN card can be used as proof of identity of the proposer for these policies.

(The writer is S. Mahadevan.)

TOP

Source

Life Insurance or Health Insurance: The perpetual dilemma answered – India Today – 9th December 2019

It is a universal fact that we always want our family to be secure when we are not there. It is a great relief to know that your family is insured financially if your health takes an unexpected turn. In case of a shortage of funds, paying for both health insurance and life insurance regularly can be tough, and with rising expenses, it will only get tougher.

Life Insurance vs. Health Insurance

There is no doubt that each and every type of insurance serves a different purpose and offers different types of protection and benefits. Life Insurance plans offer death benefits to the nominee in case of premature death of the insured. The aim behind this is that the funds that the family gets in the form of death benefits will be sufficient for it to deal with daily expenses and liabilities after the insured's death. It is designed to provide cover against funeral expenses, medical expenses or any other kinds of debt. This plan offers the required support to your family so that they do not suffer financially after your death.

On the other hand, health insurance helps you pay medical expenses that include doctor visits, medication, tests, hospital stays, and other procedures. This plan makes sure that the person is able to afford timely medical help and can stay healthy as well. The important thing is that people should have both life insurance and health insurance, especially when they have dependents. The best thing you can do is limit the coverage of what you exactly need so that you can easily afford both types of insurances. It's important to note that the type of insurance you need also changes at different stages of life. Staying informed about this can play an important role when it comes to securing the future of your family.

Insurance for Youngsters with Dependents

It is advisable for the young generation to go for both life as well as health insurance to create a protective shield for themselves from all unwanted situations. Usually, youngsters do not feel the need to invest in an insurance plan. But we can't deny that nowadays, instances of people from that age group falling ill is quite high. Therefore, we cannot really be sure of what is waiting for us in the future, but we can definitely stay insured or protected against the uncertainties of life. What's more, it will also give tax benefits.

Raising a Family

Whether it's about kids or spouses, health insurance in India carries a great level of importance. Even if you are insured under a health plan provided by your employer, you must look for a separate insurance

plan that can offer sufficient cover when you need it. There are many affordable plans in the market that offer lots of benefits. In order to make the best choice, you must compare products using an online insurance web aggregator like PolicyX.com and find products that suit your needs. By doing this, you will be able to look at the pros and cons of each of the options available to you and choose wisely.

As far as life insurance is concerned, many people do not find it a worthy product to invest their hard-earned money into. But if you do thorough research, you will know that life insurance comes with a bunch of benefits.

One option is to buy life insurance with an adequate sum assured as per your requirements. Before getting life insurance or term insurance, you must make sure that you are investing for an adequate amount that should be equal to or more than 10 times your annual wage and use that to determine the policy's face value. Even ace cricketer Virender Sehwag suggests investing in both health insurance and life insurance with an adequate sum assured.

Apart from this, a different and most useful approach is to tally up all the expenses your spouse would incur if something happened to you. You must think about childcare fees, grocery bills, mortgage, car payments, and tuition and so on. Then deduct the same amount from your savings and investment accounts. Your insurance plan should cover the difference.

Retirement

It is a universal fact that the older you get, the more likely you are to suffer from health complications. Thus, middle-age probably is the right time to insure yourself as not all companies will offer the desired policy to you in the future. And even if they do, the premium will be much higher, keeping the age and additional factors in mind.

With growing age or after retirement, you might become dependent on your children because of a lack of income. In such cases, having life insurance and health insurance will be a big relief. With the required protection cover, you don't have to depend on others and can live your life happily on your terms.

If you are already insured with a term insurance plan which is coming to an end, then it is advisable for you to grab a small policy that offers a safety cover during the required period. Or if the current term plan has a conversion feature, you can easily turn a portion of it into a permanent life policy.

The best thing about the convertibility is that you don't have to go through the medical underwriting process all over again, which can be trickier. You should not forget that you only have a certain number of years to be able to take advantage of this feature. So, it's basically better reviewing all terms and conditions.

The Bottom Line

When you invest in the coverage that you truly require, paying for both life and health insurance simultaneously becomes a less daunting task. Young and healthy singles may not require it. But when it comes to people with dependents, these are the basic two needs that you cannot avoid.

TOP

Source

You can cancel your life insurance policy within free-look period – Outlook – 9th December 2019

If you are unhappy with a policy, don't fret. The Insurance Regulatory and Development Authority of India (IRDAI) understand the customer's behaviour and allows a time period of certain days to review a policy and if not satisfied with the particular policy the customer has the option to cancel the policy.

What is free-look period?

A window of 15 days is given to a policyholder to review thoroughly for the option to cancel the policy. The period starts from the date of the receipt of the policy document by the policyholder.

Always check the date when you receive the policy documents and retain the envelope. Download the free-look cancellation request form.

The policyholder should clearly mention about the types of product - unit-linked or traditional products. One must mention the reason behind the cancellation of the policy and provide correct personal and bank account details.

The best way to cancel your policy is visit to your nearest insurer's branch and submit your policy cancellation application and collect acknowledgement of the application for cancellation receipt.

The premium refunded will be adjusted to the proportionate risk premium on cover expenses incurred by the insurer on medical examination and stamp duty charges. In case of unit-linked insurance plan, one may not be able to get the actual refund as the refund payment will be subject to the Net Asset Value (NAV) fluctuations and other applicable charges.

(The writer is Nirmala Konjengbam.)
Source –
https://www.outlookindia.com/outlookmoney/insurance/you-can-cancel-your-life-insurance-policy-within-free-look-period-4008

TOP

Source

Life insurers April-November new premiums jump 37.2%; LIC holds the reins - Moneycontrol – 9th December 2019

Life insurance companies saw a 37.2 percent year-on-year (YoY) growth in their eight-month (April to November) period new premiums at Rs 1.69 lakh crore compared to a year ago.

Life Insurance Corporation of India (LIC) yet again beat the industry in the collections with a 44.5 percent YoY growth in new premium at Rs 1.2 lakh crore. Private insurers saw a 22 percent YoY growth in the first-year premium at Rs 49,078.27 crore.

Though the first half of the financial year is a slower period for life insurers, this year the companies saw a healthy double-digit premium growth.

An Emkay report said after two months of tepid growth, the life insurance sector has rebounded with strong premium growth in November 2019, helped by the push toward the sale of traditional products.

Private players grew 25.9 percent YoY, registering strong performance across the board and largely from the likes of Bajaj Allianz Life, HDFC Life, Kotak Life and Tata AIA Life which grew more than 40 percent.

The retail annualized premium equivalent (100 percent of regular premiums plus 10 percent of single premiums) for private players grew 26.9 percent YoY. The Emkay report said that in November LIC had a bumper month with APE growth of 215.3 percent YoY driven by the push toward the sale of traditional products.

About eight products of LIC are going off the shelf under the IRDAI new guidelines, the deadline of which has been now extended to January 31, 2020.

On an absolute new premium collection basis, HDFC Life Insurance saw a 26.5 percent YoY rise in new premiums to Rs 10,772.9 crore for the April to November period.

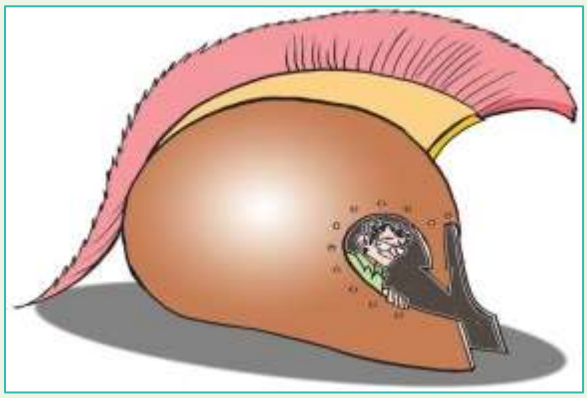
ICICI Prudential Life Insurance saw a 20.3 percent YoY rise in new premiums in the April to November period to Rs 7,060.2 crore. SBI Life Insurance saw a 38.7 percent YoY rise in the eight-month period to Rs 10,715.72 crore compared to a year ago.

The January to March period is the most crucial for life insurance companies from a policy issuance perspective. This is because the fourth quarter is when salaried professionals buy insurance for tax saving purposes.

TOP

Source

Insurance purchase to get simpler with plain vanilla policies, details here - Financial Express – 9th December 2019



At a time when life insurance penetration—ratio of premium to GDP—has dropped to 2.76% in 2017 from 4.6% in 2009, the insurance regulator has issued a master circular for point of sales products and persons for life insurance. (POSP-LI). The products will be plain vanilla life insurance policies where each benefit is predefined and disclosed upfront at the time of sale itself and is easy to understand.

An insurance company or an insurance intermediary authorised to solicit and market insurance products can engage a POSP-LI. The category of products that will be offered by POS-Life will be pure term insurance products with or without return of premium. They can sell non-linked non-participating endowment product, immediate annuity products and non-linked non-par health insurance products with fixed benefits. The premium paying term under POS-life product will always be equal to policy term. The death and maturity benefits including return of premium will be paid only in one lump sum.

Key features document

There would be two parts in the key features document (KFD) cum proposal form, where the first part would be the KFD and second part would be the proposal form. Both the parts will be joined by perforation so that the first part can be easily separated and given to the life assured for his record and the second part, which is the proposal form, will be kept by the insurance firm.

The KFD document must contain all the key benefits under the plan including the sum assured on death, maturity benefit, and surrender value, paid up value, exclusions, registered name and address of the life insurer. In online mode, an explicit and exclusive consent will be taken for KFD in a screen and a copy of such KFD has to be mailed to the proposer.

The turnaround time for issuance of policy/acceptance of risk will have to be communicated within four days from the date of collection of proposal form. If the proposal is not accepted for any reason, the refund of payment will have to be done to the proposer within seven days. The proofs of identity acceptable for POSP Life are PAN card and Aadhaar.

Training of POSP-LI

A life insurance company or a life insurance intermediary proposing to engage as POSP-LI will have to conduct in-house training of 15 hours for the candidate, conduct an examination and issue certificate to

successful candidates. The POSP-LI is allowed to distribute micro insurance products of life insurers and the commission payable will be applicable to the individual agents as approved under the micro insurance product. Every proposal form— both paper and paperless, insurance policy and other related document will carry provision to record the POS code in order to tag the policy to the POSP-LI who is selling the said policy.

The life insurer will be responsible to record the POS code in the proposal form and insurance policy. The insurer will also be responsible for the conduct of the POSP-LI representing him and any misconduct on the part of the POSP will make the life insurer liable to penalty.

Compliance

The life insurers and insurance intermediaries will make suitable provisions in their policy administration system to capture the identity proof details submitted by POS persons attached to POS code. If POS persons are authorised to collect and remit the premium, they will have to issue acknowledgement on collection of premiums and every insurer will put in place procedures to enable this.

(The writer is Saikat Neogi.)

Source

TOP

GENERAL INSURANCE

Pre-merger blues: PSU general insurers seek Rs 12,000 crore lifeline – Moneycontrol – 11th December 2019

The three state-owned general insurance companies (National Insurance, United Insurance and Oriental Insurance) have sought a capital infusion of Rs 12,000 crore from the Centre, to stay afloat and conduct business.

This has been cited as the pre-condition before the proposed merger process begins. “Capital is the immediate need of the business. We can have the merger only once the entities have a healthy balance sheet,” said a senior official.

It is likely that this proposal will be considered in the upcoming February 2020 budget. It has been almost two years since the merger was first proposed. The first use for this capital is to spruce up the solvency or minimum capital across the three general insurers.

At the end of June, United India’s solvency stood at 140 percent while that of Oriental Insurance stood at 156 percent. For National Insurance, the latest solvency figures are available for March 2019 and it stood at 104 percent.

Two of them are below the 150 percent mark stipulated by the Insurance Regulatory and Development Authority of India IRDAI). This roughly means that the assets must be 1.5 times the liability.

Similarly, their combined ratio is a cause of worry.

At the end of June, National Insurance had a combined ratio of 117.76 percent, United India's combined ratio stood at 131.38 percent and Oriental Insurance's combined ratio stood at 132.39 percent. This indicates that the insurer is making underwriting losses or in simple terms, the claims paid are higher than premiums collected. A ratio below 100 percent means that the claims and premiums are proportionate to each other.

"Valuations (during listing) will also depend on our capital. Hence this proposal needs immediate consideration," said the director of one of the merger candidates.

The merger process

The PSU insurers' merger has been a pet project of the BJP government. It was announced by former finance minister Arun Jaitley in his February 2018 budget speech. The idea was that the merged entity would subsequently be listed on the stock exchanges. The idea to merge the three insurers was to create a stronger and larger insurance company that was sustainable in the long run. The other two state-owned entities, New India Assurance and General Insurance Corporation of India, are listed on the exchanges.

EY was appointed as the consultant for the process in December 2018. The initial estimates suggest this will be the largest non-life insurance company in India valued at about Rs 1.5 lakh crore. On one hand, while there has been a delay in the merger process, there are also human resource concerns. The insurers' unions have also expressed concerns about the merger of the entities, saying this would lead to retrenchment of staff at the mid and junior levels.

Considering these challenges, sources said that the actual merger will only be initiated in FY21. The listing could either be end of March 2021 or the first quarter of FY22.

(The writer is M Saraswathy.)

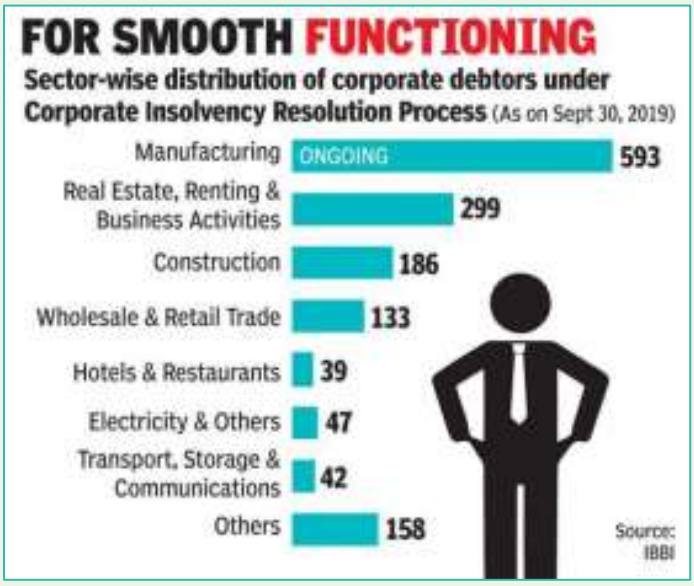
TOP

Source

Government to protect buyers of companies facing insolvency from promoters – The Times of India – 11th December 2019

The government is set to firewall companies facing insolvency resolution from the action of their promoters to make it more attractive for suitors.

The 10-odd amendments set to be moved by finance and corporate affairs minister Nirmala Sitharaman in Parliament will provide that promoters of companies where insolvency action is initiated will have unlimited liability in case of any criminal action, while the corporate entity will be ring-fenced from the action. The move follows the recent attachment of assets of Bhushan Power and Steel promoters by the Enforcement Directorate, throwing the insolvency action of the company is disarray at a time when steel major JSW appeared to be ready to take it over.



In an interview, Sitharaman had recently told TOI that the government was looking at various options to deal with the situation. The amendments are seen to be a fresh set of "emergency measures" initiated by the government to ensure smooth functioning of the three-year-old law. Sources said necessary go-head for introduction of the Bill is in place and it will be placed in Parliament during the ongoing session.

The Bill will also seek to provide comfort to companies, especially those in the real estate sector, by stipulating that insolvency action can be initiated only if 10% or 100 home buyers (whichever is lower) or debenture holders agree to the move. The amendment has been necessitated as there have been instances where

a single home buyer has approached the National Company Law Tribunal invoking provisions of the Insolvency and Bankruptcy Code and action has been initiated. This made both real estate developers and home buyers jittery, prompting the government to move in for classes of financial creditors where an authorised representative has to be appointed, which includes home buyers.

Further, the government intends to provide some comfort to related parties by improving the definition to ensure that entities that are connected to promoters are ineligible to participate in the resolution process. IBC has barred promoters and some of the related parties to bid for companies to avoid a situation where they walk away with the entity after forcing lenders to take a steep haircut as was the experience with some of the initial cases.

Cabinet to discuss merger of general insurers today

The cabinet is likely to clear the merger of three public sectors general insurance companies — United India, National and Oriental Insurance — at its meeting on Wednesday. The merger to has been in the works for over one-and-a-half years.

(The writer is Sidhartha.)

TOP

Source

Panel for hiking deposit insurance cover - The Hindu Business Line – 11th December 2019

Minister of State for Finance Anurag Singh Thakur told the Rajya Sabha, in a written reply on Tuesday, that an RBI committee headed by former SEBI chief M Damodaran has recommended that the bank deposit insurance cover be raised to Rs. 5 lakh from Rs. 1 lakh. The Deposit Insurance and Credit Guarantee Corporation, a wholly owned subsidiary of the RBI, provides insurance for bank deposits.

TOP

Source

Health Insurance Terminologies: A ready reckoner for deconstructing the cocoon– Financial Express – 10th December 2019

The rapidly increasing cost of healthcare in India has become a challenge for many. It is alarming to know that majority of the Indian population do not have a Health Insurance policy. The primary factor is arguably a lack of awareness about the importance of health insurance. Even among those who recognize its importance, most consider it to be an expense. Instead of buying health insurance in advance, many Indians either dig into their savings or opt for loans at the time of medical emergency.

People also find it very perplexing to understand the jargonized world of Health Insurance. This leads to a perception about Health Insurance being an opaque Cocoon, which is difficult to look through or impregnate, to understand the nuances.

Here is a ready reckoner for deconstructing this Cocoon:

Any Health Insurance Policy has numerous features, which are usually built around the inference that any medical emergency would lead to a hospitalization. This covers expenses related to room rent, doctor fees, medicines, laboratory investigations, etc. incurred for hospitalization of more than 24 hours.

Usually in case of medical emergencies, there are situations or treatments, which may fall outside the purview of Inpatient Hospitalisation. To cover such costs, many of the contemporary Health Insurance companies provide additional coverage over and above the Inpatient hospitalization coverage.

Domiciliary Hospitalisation Coverage – Coverage for the expenses related to medical treatment taken at home for more than three consecutive days as recommended by the Treating Doctor/s in instances where the patient cannot be transported to the Hospital or there is unavailability of room in the hospital.

Day-care Hospitalisation Coverage – Coverage for the expenses related to surgical treatment and procedures where admission and discharge happen on the same day.

Pre–Hospitalisation Coverage – Coverage for the expenses related to consultations, medicines and diagnostics before admission to the hospital for a certain number of days ranging from 30 to 90 days.
Post-Hospitalisation Coverage – Coverage for the expenses related to consultations, medicines and diagnostics after discharge from the hospital for a certain number of specified days ranging from 30 to 180 days.

In addition to the above coverage, some health insurance plans provide the following broad choices:
Choice 1 – Enhancement of Features/Coverage:
A- Waiver of mandatory 'Copay' – 'Copay' is a feature in which the customer must pay a percentage of the claim payable amount. Under this feature, the customer has the option to waive the Copay with a marginal increase in the premium amount.

B- Reduction of the waiting period for pre-existing diseases – If one has a pre- existing disease like Diabetes, there is an inbuilt waiting period for this disease to be covered. Under this feature, one can reduce the waiting period with a marginal increase in the premium amount.

Choice 2 – Lowering the premium amount by reducing the coverage
A- Deductible – Deductible, as an option, helps reduce the premium. Deductible is the amount chosen as the expense of hospitalization the customer is willing to bear. Higher the deductible, lower is the premium.

B- Voluntary Copayment – 'Voluntary Co-Payment' is a deductible, which is a percentage of the claim amount and not a fixed amount. One can choose a Co-Pay percentage to reduce the premium.

C- Room Rent Capping – In most of the hospitals, the expenses are linked to the category or type of the room, viz. General, Shared, Private, Deluxe etc. By capping the room rent, the insured/patient fixes an upper limit to it payable under the policy. As a result, the Inpatient expenses that are linked to the room rent also get capped. Hence, lower the room capping, lower is the premium. Based on the city of residence, one can decide to cap the room rent.

Choice 3 – Add – on coverage over and above the core coverage
A. Organ Donor Expense Coverage – This benefit covers the medical and surgical expenses of the organ donor when harvesting for a major organ transplant for insured.

B. Critical Illness Coverage – If diagnosed with any of the listed Critical Illnesses during the policy period, a lump sum equal to the Critical Illness Sum Insured selected will be payable.

Knowledge of Health Insurance terminologies helps in better selection of coverage, features and benefits best suited for one's needs. A health insurance plan should have the option to choose one's own covers. This enables in opting the essential coverage only that will also increase or decrease the sum insured. Many of the new- age contemporary health insurance products provide the above-mentioned choices on the features, which empower the insured with the flexibility to choose. Hence, it is recommended to avoid the risk of buying pre-packaged health insurance.

(The writer is Vijay Sinha.)

Source

TOP

DICGC collected Rs 88,523 cr premium from banks, payout towards claim totaled Rs 296 cr – Financial Express – 10th December 2019

The Deposit Insurance and Credit Guarantee Corporation (DICGC) has collected Rs 88,523 crore as premium from banks, and the total payout to depositors of failed commercial banks on account of claims stood at Rs 296 crore, the Rajya Sabha was informed on Tuesday. DICGC, a wholly-owned subsidiary of the Reserve Bank of India (RBI), provides insurance for bank deposits up to the limit fixed by the Corporation.

"Since the inception of deposit insurance, the total premium paid by commercial banks is Rs 88,523 crore and the total payout to depositors of failed commercial banks on account of claims is Rs 296 crore," said Minister of State for Finance Anurag Thakur in a written reply in the Upper House. On whether the government will consider hiking the insurance cover cap that was revised more than 25 years ago, Thakur said no proposal has been received from the RBI in this regard.

DICGC provides an insurance coverage of up to Rs 1 lakh to a depositor of a bank. He further said the DICGC Act, 1961, provides that the Corporation may, from time to time, having regard to its financial position and to the interest of the banking system, raise, with the previous approval of the government, the financial limit of the total amount payable to one depositor in respect of his deposit at all the branches of a bank taken together.

The RBI had constituted a committee under the chairmanship of M Damodaran to look into banking services rendered to retail and small customers, including pensioners, and also to look into the system of grievance redressal mechanism prevalent in banks, its structure and efficacy and suggest measures for expeditious resolution of complaints. The panel had, inter-alia, recommended that the deposit insurance cover provided by DICGC should be raised to Rs 5 lakhs so as to encourage individuals to keep all their deposits in a bank convenient for them.

TOP

Source

Placing availability and cyber insurance at the crux of robust business planning - The Economic Times – 9th December 2019

India is at the cusp of digital transformation, witnessing an accelerated adoption of emerging technologies such as cloud, AI and ML for business relevance and growth. These technologies have benefitted large and small scale enterprises by empowering them with superior business capabilities. However, digital transformation is leading to unprecedented growth in the volume of data generated through various sources, thus leading to the complexities of data management that businesses need to address to realize the true value of the technologies. Businesses are faced with challenges such as threats of data risk and cyberattacks.

The damages caused by cybersecurity threats put businesses in a position which lays emphasis on the urgency of cybersecurity. According to a study by Frost & Sullivan, large-sized organizations in India incur an average of $10.3 million of economic loss from cyberattacks whereas a mid-sized organization incurs an average of $11K. With this day and age, relying completely on traditional methods of data protection would not be fruitful, doing more damage than good. They can be a step on the ladder but certainly is not sufficient in the long run.

Traditional data protection strategies have centered around the three foundational components of IT: people, process and technology. Data protection with people begins with education and a continuous

focus on making employees aware of the most recent threats in the industry. While this is critical, it is impossible to achieve full organizational protection in this way. It only takes one weak link, or one unknown threat, before the data is compromised. Focusing on process is also essential.

As many have pointed out, recent ransomware attacks would have been mitigated if patches had been applied on a timely basis. And finally, traditional data protection employs technology for network and endpoint protection such as firewalls and anti-virus. All these protections are essential and should not be ignored. Clearly however, they are not sufficient as evidenced by the explosive growth of cyber insurance.

Cyber insurance is not entirely new, but it has been growing (unsurprisingly) at a similar pace with malware and ransomware. India's cyber-security market is pegged to grow to $35 billion by 2025. Recent incidents have proven that the adverse effect of malware on government agencies, and businesses have made this a board-level topic with a demand for better protection. Costs of ransomware are not just connected with the ransom demand itself, but tangible internal costs such as incident response, forensics, call center increases, legal engagement and public relations. External costs and insurance coverage are associated with the liability of failing to keep the data secure.

However, there is another fundamental insurance component that many have ignored — data backup with air-gapped protection. This implies that critical data is backed up, stored offline, and that restoration of this data is regularly validated. Backup and validation of data restore is the cyber insurance that provides the most immediate and tangible benefit to the enterprise when compromised. With proper technology and process in place, Recovery Time Objectives (RTOs) can be minimized for critical systems, with the added benefit of leveraging the data to set up virtual labs where forensics can be applied to the incident. This insurance not only provides Availability for the business, but confidence for the board that they are better prepared.

A second, real and tangible benefit is that employing a viable Availability solution can reduce the cyber insurance premiums that are paid by the enterprise. While annual costs for cyber insurance ranges from $1,000s to $100,000+ depending on the revenues, industry and company size, one of the factors that determine the premiums are the existing protections that are implemented. Leveraging solutions such as Veeam can potentially reduce the costs (and premiums) associated with first-party coverage.

While we see no abatement in the immediate future for malware and ransomware, Veeam can help your organization implement data insurance through backups with offline storage and regular validation of restore. This data protection is essential to not only provide the executive team and board with confidence that they are better prepared for this new business environment, but it also provides confidence for the industry and your end users that their digital life is protected and always available.

Having a data protection insurance policy — inclusive of a cyber insurance plan and an Availability solution in place — is smart business when planning for the future.

(The writers are Danny Allan and Sandeep Bhambure.)

TOP

Source

Lavish 'desi' weddings run for insurance cover – The Times of India – 10th December 2019

The big fat Indian wedding has got itself a big fat insurance cover. As expenses of lavish weddings soar, financial risks increase in step. Which is why the idea of insuring weddings — scoffed at a few years ago — has caught on with insurers recording an uptick in the number of families signing up. When wedding budgets hover around Rs 50 lakh, it is best to cover the risk of a cancellation or postponement, and protect the families concerned from massive financial hit.

"More families with large wedding budgets have been buying insurance of late. We've sold over 70 wedding insurance policies to event management companies this year, a 30% increase since last year. There's also been a 25%-30% increase in individual families who have purchased wedding cover directly,

as compared to last year," said Shreeraj Deshpande, chief operating officer at Future Generali India Insurance in Chennai.

Cancellations and postponements are the biggest fears, because wedding venues mostly have a no-refund policy, and caterers swallow a meaty 10% penalty while some show the appetite to charge 50-70% of total payment on cancellation. Such charges can be difficult to digest for families already reeling from the aftershocks of a cancelled or postponed wedding.

An insurance also covers burglary and theft during the wedding, personal accident at the venue, and even damage caused to property by fire or earthquake. Not that the insurer will be there through thick and thin. Sudden deaths in the family is open to a claim, but sudden "change of heart" as reason for cancellation will not be covered. Neither will insurers consider a claim if a wedding is called off over disputes between bride, groom, family and friends or suicide or attempted suicide at the wedding venue.

Even so, families are happy to pay premiums of 1% to 1.5%, or Rs 50,000 for Rs 50 lakh cover, said Subramanyam Brahmajosyula of SBI General Insurance. "Premium for aRs 50 lakh-Rs 60 lakh cover could range between 0.25% and 0.30%," said Deshpande. It makes sense, say wedding planners. Shruti Ravindran of Vida Wedding talks of a client whose wedding she organized.

"A client in Chennai suffered both emotional and financial losses when the groom's side called off the wedding. With a budget of Rs 25 lakh, the décor was booked, photographer fixed, shopping over. The wedding was cancelled barely a month before the big day. No refund came their way. The same bride approached us a second time after three years but the budget was reduced to Rs 5 lakh. The family opted for an intimate wedding this time around. Insurance could have helped such situations, at least cover cancellation costs."

Rescheduling is another "horror". "Postponing a wedding is a herculean task. Advances to venue, to caterer, for decorations, music, printing of cards, even for hotel bookings and travel costs may get covered under the insurance, but rescheduling costs double," said wedding planner Aneesha Sudhakar of Wedding Mela. Among the biggest hassles of a lavish wedding being postponed is a flight ticket that may have to be rebooked at higher rates. This is the kind of risk for which families organising weddings seek policies that cover more than the cancellation cost.

Some wedding planners include guidance on wedding insurance in their portfolio of services. One starts on a note of reassurance: "Wedding insurance can help ease the financial burden in case of ... a cancellation if things go awry," and offers to "speak with different companies about payments and options to find the right insurance plan ... The peace of mind that wedding insurance brings is worth the initial effort taken to find a policy that works best for you."

TOP

Source

Future perfect – The Telegraph – 9th December 2019

Women should plan for their retirement in an organised way so that they can lead a secured senior life with enough resources at hand to explore their areas of interest without worrying about health costs and finances.

Working women often face gender bias at the workplace when it comes to pay or feel the pressure of family responsibilities weighing on them. Life expectancy is another key reason why women should plan more to achieve their retired life goals.

The financial gap

The pay gap between the two genders is real — and that means women are able to put aside less money as savings compared with men.

Apart from the gender wage gap, women are more likely to take time off to care for children or elderly relatives. Even though more men are increasingly taking on the role of caregivers, in our country it remains a role predominantly taken up by women.

Such career breaks can affect a woman's retirement preparedness, especially if you are taking an early career break between the age of 35 and 45, which is when many working women are starting families and also hitting their highest annual earnings.

Even when these women rejoin the workforce, they lose out on years of salary gains or promotions and end up missing out on compounding interest over the course of their lives. Although the financial gap between men and women is narrowing, there's still a lot of distance to close in on.

Putting away more money earlier in your career into avenues that will earn good returns can help your savings grow even if you are not working for a while. Planning early for one's life goals and making prudent investments is the key to protecting one's wealth, and more so for women.

Health and life expectancy

It is necessary to remember that men and women are biologically two fundamentally different creatures. As a result, healthcare and medical requirements are different. Various studies have found that women are more susceptible to certain forms of cancer and tend to develop other chronic ailments such as arthritis and osteoporosis at a higher rate than men.

At the same time, women live longer than men. According to the 2011 census, there are 4.05 crore women who were 65 years and over compared with only 3.6 crore men in that age group. Moreover, the average life span in India for women is 69.8 years, while for men it is 67.3 years.

As a result, the healthcare costs for women are likely to be substantially higher than that for men. According to the Health View Services Report — The High Cost of Living Longer: Women & Retirement Health Care, it was estimated that lifetime healthcare costs for a 65-year-old woman living till 87 years will be nearly 18 per cent higher on an average compared with men.

Hence, the younger you are, the larger this healthcare cost differential becomes. It is necessary to take these factors into consideration when planning your retirement.

You must ensure that all the additional healthcare and day-to-day expenses are met comfortably, without having to compromise on the overall quality of life. In order to ensure maximum coverage and benefits, you can use various online calculators to estimate your retirement savings goals.

Family goals

Whether it is by natural destiny or social design, women more often than not take up the role of the caregiver. They tend to give the needs of others more importance. If you are a working professional or a home entrepreneur — single or married — it is more than likely that you are also juggling the unpaid role of a family caretaker and making other financial sacrifices in your journey to achieve your life goals.

Life goals see no gender and women should have equal benefits that empower them to achieve their life goals. An interesting finding of Bajaj Allianz Life India's Life Goals Preparedness Survey 2019 showed that women are looking to enrich their lives by setting goals that enable them to have a well-balanced life. They have a higher inclination towards travel, health and fitness compared with their male counterparts.

To achieve your long-term life goals such as traveling the world, retiring rich and healthy, or sending your child to study abroad, you should start investing as early as possible. Today, many investment solutions have evolved. Life insurance and small savings have always been safe avenues, while mutual funds, stock markets, realty, gold funds are also in favour now. Life insurance products are also more innovative and value-packed now. You can customise these products based on your needs.

Allocating a portion of your income systematically every month in your choice of investment goes a long way in building a corpus for your life goals, and reap benefits in the long run. So, by being financially proactive, you can have a smooth and fruitful retirement.

(The writer is Tarun Chugh.)

TOP

Source

Know all about student travel insurance - Financial Express – 9th December 2019

Students going abroad for higher studies know many challenges await them as they suddenly become responsible for their own well-being without much external support. As a student preparing to go abroad, buying student travel insurance should be at the top of your to-do list. Not only is it prudent to buy good insurance cover, in most countries which are popular study destinations, it is also mandatory to have insurance cover. So, as you contemplate what kind of insurance to buy, here are some ways to compare the various features in an insurance policy and zero in on a good insurance plan for yourself.

What is student travel insurance?

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

How is it different from travel insurance?

Travel insurance is generally for a shorter stipulated amount of time whereas student travel insurance will be spread across months or years together. While travel insurance solely covers travel related risks, student travel insurance covers travel as well as academic related risks like paying tuition fees in case of the discontinuation of schooling due to unavoidable circumstances, paying for stay of one family member when the policyholder requires hospitalisation for more than a week, payments for medical and dental treatments, etc. Having a student travel insurance cover makes you eligible for reimbursement in case of any unfortunate scenario.

Studying abroad is expensive, but what is even more expensive than that is medical treatment, which is a certainty when you are in an unfamiliar area for a prolonged time. Having an insurance cover that helps as an active backup plan is always a good idea.

How to select an insurance plan?

Most universities abroad have their own set of regulations and guidelines regarding insurance. Make sure that you pick an insurance plan in coherence with those suggested guidelines. Also look at getting insured from a company that offers you a product which is designed to suit all your needs.

Any good insurance plan should ideally cover medical expenses, evacuation and repatriation, personal accident, tuition fee, loss of checked baggage, bail bond insurance, family visit, etc. There are also optional coverages such as pre-existing illness, mental illness and alcohol-related disorder, maternity and baby

cover, cancer screening and mammography, etc. These are the most sought-after covers by the overseas universities, ensuring full protection for students studying abroad. These options provide students flexibility to make their own plan by choosing the relevant covers and thus making it a university compliant plan.

How are claims settled?

The procedure followed for settling claims under student travel policies is quite hassle free, subject to prompt intimation of claim. Claims can be considered for settlement directly to the hospital (cashless settlement), in case expenses are over $500 and subject to all other policy terms. Insured may also submit all claim documents to the insurer after settlement of the bills to the hospital either during his stay abroad or on his return to India.

(The writer is Sasi kumar Adidamu.)

TOP

Source

Irdai may allow merged state-run banks to hold over 10% in insurance firms - Business Standard – 6th December 2019

With consolidation of 10 state-run banks underway, the insurance watchdog Irdai is planning to allow them to cross the 10 percent ownership caps in more than one insurance company but limit the management control to only one entity.

The regulator also wants such multiple ownerships only in one segment of the insurance industry--either in life or in general insurance and the extant rules do not allow a bank to promote more than one insurance company in a same segment.

Some of the 10 public sector banks that are merging into four are promoters of insurance entities as well. For instance, PNB, Union Bank, Andhra Bank, Canara Bank and OBC run life insurance subsidiaries now.

The move comes after the government had in August announced the second round of bank mergers under which 10 banks will merge to create just four large banks.

Accordingly, the third largest public sector lender Punjab National Bank will take over Oriental Bank of Commerce and United Bank of India; Syndicate Bank will merge Canara Bank; Andhra Bank and Corporation Bank will be amalgamated with Union Bank; and Indian Bank merging with Allahabad Bank.

"We are thinking of allowing state-run banks to own more than 10 percent in more than one insurance companies, but to have management say in only one of them," Khuntia told reporters on the sidelines of an Assocham event here Friday.

If a bank gives up the board membership of invested insurance companies and abdicate the decision-making process, then it can hold more than 10 percent stake in many of them but operating in the same segment-which is life or general, the regulator clarified.

The insurance regulator also wants more insurance companies to go public to get better valuation which has been evident from the valuation of the listed insurers like HDFC Life, ICICI Prudential, ICICI Lombard General, and SBI Life. "We'd like more insurers to be listed. Earlier, we had come out with a draft demanding all those completed 10 years of operations should list but they some of them are finding difficulties in share sale as some they are still yet to cross the critical size even after 10 years. Given that,

we are not forcing them but nudging them," Khuntia said. He said Irdai had given approval to Reliance General for listing but probably it may not go through now.

Raising concerns over the low insurance penetration the country he said only 10 percent of what could be insured is covered now. We have a protection gap of 90 percent now, whereas in Japan the protection level is 44 percent, in Taiwan it is a high 84 percent and Australia has a protection level of 67 percent. So, this is the gap that we have to bridge," he said.

On the persistency level in the insurance space, he said while the world average is 90 percent, our average is just 65 percent, he said, adding however that some domestic insurers have come close to 90 percent but he wants to see all of them touching the 90 percent mark.

TOP

Source

Authorities dispute rebate for taxes paid by banks on deposit insurance – Mint – 6th December 2019

Banks' cost of insuring deposits could see a jump if a tax dispute brewing between lenders and the indirect tax administration is not settled in the former's favour.

Officials of the indirect tax administration have questioned banks claiming credits for the taxes paid while insuring their deposits, a move that has emerged as a thorny issue for lenders. Industry watchers said tax tribunals have given divergent views on the issue, complicating the matter.

The tax authority's argument is that service tax that was earlier liable to be paid on the insurance premium banks pay for insuring fixed deposits is not eligible for tax credits as there is no tax on the interest paid on the deposits. The idea of tax credits is to make sure that the taxes paid on raw materials and the services used should be available as a rebate while computing the tax liability on the finished product or service so that the tax incidence on the business is limited only to the value addition offered by it and that there is no 'tax on tax'.

Experts counter the indirect tax administration's argument saying that banking services are taxable including lending operations although the interest component on deposits is excluded from the tax liability. Therefore, the tax paid on deposit insurance premium to the Deposit Insurance and Credit Guarantee Corp. (DICGC) should be eligible for credits. Lenders have to insure ₹1 lakh of the deposits.

According to Abhishek A Rastogi, partner at Khaitan& Co, who is arguing for banks, insurance is a mandatory business expenditure and would clearly fall within the definition of 'input services' for a bank which is into both borrowing and lending. Taxable banking services includes lending while what is excluded from valuation for tax purposes is the interest component. This means that the insurance services procured towards the core banking function is a legitimate input service for banks. "The controversy has arisen due to the contradictory decisions of different tribunals which is causing a great concern for banks and other taxpayers who are looking for tax certainty and judicial discipline" said Rastogi.

Service tax has been subsumed into GST, which was rolled out in July 2017. But its principles of taxation could have a bearing on GST too and unless the issue is resolved, it could lead to GST disputes too on the availability of credits for GST paid on deposit insurance premium.

(The writer is Gireesh Chandra Prasad.)

TOP

Source

HEALTH INSURANCE

PM-JAY adopts machine learning to tackle fraud – The Hindu Business Line – 13th December 2019

To better tackle fraud, the National Health Authority (NHA), which implements the government-run cashless health insurance scheme Pradhan Mantri Jan Arogya Yojana (PM-JAY), has devised a mobile-based field application for State and district authorities, to upload evidences from the site of investigation on real-time basis.

Up to 338 hospitals are under NHA scanner for alleged frauds and 111 have been de-empanelled, which means that they have been removed from the scheme. Penalties worth over Rs. 3.5 crore have been recovered. In Uttarakhand alone, penalties worth Rs. 2.5 crore have been recovered from 15 hospitals. In Uttar Pradesh on the contrary, Rs. 2.7 lakh have yet been recovered from up to 30 hospitals. In Chhattisgarh, action has been taken against 76 hospitals, and recovery made is Rs. 4.13 lakh. PM-JAY CEO Indu Bhushan said, "We have seen up till now that 1 per cent of all cases accepted under the scheme have been fraudulent."

Unlike its predecessor Rashtriya Swasthya Bima Yojana (RSBY), which did not have an efficient fraud control mechanism, PM-JAY is dabbling in machine learning and artificial intelligence to identify malpractice triggers. Five companies — SAS, MFX, LexisNexis, Optum and Greenojo — were taken on board for six months, starting July earlier this year, to conduct fraud analytics. According to an official, "There was no investment on the scheme's part during this exercise. We will now float a Request for Proposal to get a company on board."

WhatsApp-like group

"In a bid to improve our fraud-control mechanisms, we are equipping the State and district authorities with the field app. We have formed a WhatsApp-like group at district levels, in which we red-flag suspicious claims raised or pre-authorisations sought," an NHA official told Business Line. The teams at the field level swoop in on the suspect hospital and investigate the medical documents. During the on-going inquiry, they upload the documents onto the central server on real-time basis, and these papers are not retained after their upload at the local level," the official said. The official further explained, "This helps reduce the time of investigation as we get only 15 days to check the claim, as it has to be paid within two weeks of pre-authorisation."

Every pre-authorisation and claim submitted will be vetted through the system in a bid to identify fraud. "For example, if a male claims money for a delivery, which is a female procedure, there will be a system-level trigger pop-up. If a patient is being shown as signing up for a cataract surgery, third time around there will be a red-flag, as one cannot have three eyes, or for that matter, if a woman is shown to be undergoing a hysterectomy (uterus removal) twice, as a woman has only one uterus," the official further said.

NHA currently does not have the legal sanctity to prosecute hospitals for fraud. "This is left to the discretion of States. We are feeling the need for a National Health Insurance Act, like a law, to be put in place. Who will draft it, is the question. Will it be the NHA or the Insurance Regulatory and Development Authority?" said the official. "It is too early for us to say anything about an impending Act at the moment," Bhushan said.

(The writer is Maitri Porecha.)

Source

TOP

Insurance alert! Top 5 benefits that tailor-made schemes provide - Zee Business – 12th December 2019

Insurance companies these days have started to come up with tailor-made schemes because these plans provide good options for the medical and professional liability market. These plans are not only cheaper but help even the poor to come under the insurance net. Interestingly, these tailor-made insurance schemes cover those parts that the majority of the insurance schemes ignore. These insurance policies cover the insured from vector-borne diseases, accidents for specific travel periods like traveling on Railways, flights, etc.

Speaking on the importance of tailor-made insurance schemes CS Sudheer, CEO and Founder of IndianMoney.com said, "Insurers are targeting millennials and people with low income by offering micro cover for risks. Tailor-made insurance schemes protect you from vector-borne diseases, accidents for a specific travel period or even motor insurance based on how the vehicle is utilized. Millennials understand financial liabilities and know the extent of cover they need. Insurers have launched a number of tailor-made insurance schemes to cater to this rising class of customers."

Asked about the top five benefits of tailor-made insurance schemes CS Sudheer listed out the following:
1] Micro insurance for the poor: Micro insurance is vital to India's plans for financial inclusion. It has the potential to improve insurance penetration in India, which stood at a mere 3.69% in FY 2017-18. The insurance sector has the potential to touch $280 Billion by 2020.

Benefit: Microfinance deals with general and life insurance plans with a sum assured of Rs 50,000 or less. It offers financial protection to the low-income families in India, for whom the death of the breadwinner is a financial catastrophe. With more than 80% of India's population residing in rural areas, micro-insurance makes an insurance plan very affordable. Insurers use automation, elimination of documents and high volumes to keep costs low.

2] Satchet insurance at low premiums: Satchet insurance also called bite-sized insurance comes with low premiums and low cover. It focuses on a specific need. The insurance you get with the train ticket on the IRCTC website is a typical case of bite-sized insurance. Insurers are building bite-sized insurance products for the life and general categories. The focus is on health, travel and lifestyle needs. Satchet insurance targets a particular risk, making it a starting point for first-time buyers.

Benefit: Bite-sized insurance offers cover against a specific risk. A small ticket-size health insurance plan offers specific health cover for a short duration. Health insurance plans which cover vector-borne diseases like dengue and malaria are an example.

3] Insurance for all needs: Tailor-made insurance focuses on covering risks that most insurance plans ignore. You could avail of diverse covers like designer clothes, wedding dress, musical instrument, helmet, CCTV and even mobile screen insurance.

Benefit: Tailor-made insurance focuses on meeting even the smallest of risks with an insurance plan. Tailor-made insurance offers need-based cover and can increase insurance penetration in India.

4] Group health insurance plans: Groups of people, who assemble with a commonality of purpose or engage in common economic activity, may avail collective covers. Employer-employee groups, social and cultural associations, housing societies, alumni and even savings bank account holders enjoy this cover.

Benefit: As many members are covered, premiums could be lower than individual plans. Tailor-made group insurance plans, waive the waiting period for pre-existing diseases, cover senior citizens and even

offer maternity and newborn baby cover. Premiums are low, owing to the higher negotiation power of the group.

5] Term insurance plans: Tailor-made term insurance plans are offered under the 'affinity' group cover. Members who have commonality other than employment can be part of the affinity group. It's difficult for self-employed people with low salaries and no formal income proof to get term insurance. These people need term life plans but are slotted in the high-risk category.

Benefit: Tailor-made insurance plans cover the affinity group, but premiums may be higher due to the customer profile.

(The writer is Asit Manohar.)

TOP

Source

Delivery of Ayushman benefits picking up pace in J&K - The Hindu Business Line – 11th December 2019

Utilisation of cashless health insurance under the Pradhan Mantri Jan Arogya Yojana (PM-JAY), popularly referred to as Ayushman Bharat, have slowly started picking up pace in the Kashmir valley, despite the ongoing internet shutdown.

According to data available with the National Health Authority (NHA), a total of 13,068 patients were treated under the scheme in the Union Territories of Jammu, Kashmir and Ladakh. Of these, 8,491 patients were treated in the larger Kashmir region; up to 4,330 patients were hospitalised in Jammu; and 85 were treated in Ladakh-based hospitals. Also, up to 162 patients went to hospitals in Pathankot, Amritsar, Chandigarh, Delhi and Rishikesh for treatment. Officials said that September onwards, the number of patients seeking care under the scheme slowly started increasing even in the absence of internet and mobile phone connectivity. There were 2,432 hospitalizations in September, and in October, up to 4,376 hospitalizations had occurred, an increase of 79 per cent.

After abrogation of Article 370, with mobile connections snapped and travel curbs imposed, patients seeking government-based healthcare insurance showed a sharp drop in August.

Just 847 individuals were hospitalised in Jammu & Kashmir in August, a drop of close to nine times from 7,391 hospitalizations in the preceding month of July. "Even though numbers in September and October are still lower than that prior to the abrogation of Art 370 in July, cases under Ayushman Bharat have started picking up pace," a NHA official told *Business Line.*

"Hospitalizations under the scheme have slowly and steadily started increasing in J&K," confirmed PM-JAY CEO Indu Bhushan.

In the Kashmir Valley, 26 hospitals administer the scheme and most are private-run. In Jammu, 48 hospitals implement the scheme. In August, some private hospitals in Kashmir, where th after-effects of the abrogation were felt more, complained to J&K State Health Authority (SHA) about the delay in payments and temporary discontinuation of the scheme due to hurdles in claims processing.

"Certain private hospitals had discussed issues such as delayed payments with the J&K State Health Authority in August, and eventually, the payments were released. Things are slowly getting back on track," the official said.

Internet is still not functioning in public and private hospitals. "The doctors have to either courier documents of claims after speaking for pre-authorisation with the insurance company on phone or physically come and submit papers. All of this takes at least a week's time," said the official.

The NHA data further showed that up till November 18 for the month, 4,072 hospitalizations were recorded. In the week of November 18 to 25, a sudden spike of up to 5,500 hospitalizations were observed in a single week. Between November 26 and December 2, only 800 cases were recorded.

"The week-on-week data in this situation can be misleading, because some of these cases may have occurred in earlier months between August and October but their information is being uploaded now, because of a delay in processing claims," the official explained.

Since the launch of the scheme in December last year, up to 45,249 claims worth ₹24.3 crore have been submitted, of which 38,368 claims worth ₹19.7 crore have been cleared, till date. Popular procedures under the scheme in J&K are dialysis, gall bladder removal, breathing disorders, kidney failure, cancer care, cardiac stenting, and total hip replacement.

"We are slowly getting back on the trajectory of processing 38 claims per week per lakh population in J&K," said the official.

(The writer is Maitri Porecha.)

TOP

Source

The challenging quest for universal health coverage - Hindustan Times – 11th December 2019

The dream of providing universal health coverage (UHC) has never been as close to reality as it is now. As we mark the UHC Day, let us acknowledge that India needs UHC.

The World Health Organization defines UHC as ensuring that all people have access to needed health services (preventive, curative, palliative and rehabilitative) of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship. The UHC does not necessarily mean free health services, but ensuring access to affordable health services of adequate quality. People should not be exposed to catastrophic health expenditures. Ideally, health care costs should not be paid for out-of-pocket by users at the time of seeking services, but through a prepayment mechanism or tax revenues.

Contrary to this vision, about 60 million Indians fall into poverty annually due to expenditure on health. Out of pocket spending by families currently comprises over 60% of health care expenditure in India. This is the highest among the G20 countries. The comparable figures for China and Indonesia are around 35%. This expenditure is highly regressive, as it disproportionately punishes the poor, the sick, the women and the elderly. They are also inefficient, since they deter families from seeking timely care, and often, any care at all.

However, this may change soon. Why so and why now? First, the political will to support UHC has never been greater in India. The leadership has put health care for all at the top of the development agenda. Indeed, Prime Minister Narendra Modi has been so closely involved with the government's flagship health initiative, Ayushman Bharat, that it is often referred to as "Modicare".

Second, this political commitment comes with sufficient financial resources as well as the creation of enabling organizational structures at the national and state levels. Third, states have shown strong

leadership and willingness to adopt UHC as their primary health goal. Most have used their own resources to expand the coverage of the Centre's Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (ABPM-JAY) to groups beyond those originally targeted. The expanded ABPM-JAY covers more than 13 crore families, against the originally planned 10 crore. Some states, like Uttarakhand and Karnataka, have expanded the scheme to almost their entire populations.

Fourth, the initial momentum of the ABPM-JAY provides strong conceptual basis and a viable framework for achieving UHC. In slightly over a year, the ABPM-JAY has supported treatment for over 65 lakh people, saved about ~20,000 crore for poor households, and prevented lakhs of them from falling deeper into poverty. The private sector has been an enthusiastic partner, having provided about 60% of the treatments under the scheme.

The scheme has also provided the fulcrum for the Centre and states to expand health coverage to other vulnerable groups. For example, the ministry of labour and employment plans to bring, under it, all construction workers. Some states are using the scheme's IT system to cover government employees and retirees. The other pillar of the Ayushman Bharat is also off to a strong start, with over 20,000 health and wellness centres now providing expanded preventive, primary and promotive health services.

While strong momentum has undeniably been achieved, the progress towards UHC is not preordained. Several constraints pose challenges. In its 2019 report titled, Health System for a New India: Building Blocks, the NitiAayog identifies the deep fragmentation of the health system with respect to health service providers, purchasers and payers, and the digital technology that powers it, as a critical constraint. Addressing this constraint will be important.

Currently, outside the ABPM-JAY and the state schemes, less than 10% of India's population has comprehensive health insurance. A large section of India's middle class lacks health insurance coverage. Within the public sector, a multiplicity of organised payers — entities of the Central and state governments — operate multiple health care schemes, further fragmenting health insurance in the country. Consolidating these schemes could strengthen strategic purchasing, as a single — and larger — payer can negotiate better rates from hospitals and diagnostic centres. It can also better enforce quality standards, improve efficiency and protect consumers. A consolidated government scheme can plausibly extend benefits to the "missing middle".

Service delivery in India is also highly fragmented, with a large number of mainly small providers delivering over 64% of health care. Ninety eight percent of providers operate informally and employ less than 10 people. More than 80% of tertiary care facilities are based in the tier-1 cities. If UHC is to be achieved, this will have to change. By putting buying capacity in the hands of the bottom 40%, who live mostly in rural areas and smaller towns, the ABPM-JAY will help in this transformation. However, a separate set of incentives and policies will be needed to encourage investment in larger tertiary care hospitals in the tier-2 and tier-3 cities.

Currently, the health records of millions of patients get lost in the quagmire of manual systems or fragmented, non-standardised IT systems, offering no scope of interoperability or cross-sharing, thereby limiting the data-driven and evidence-based patient care. We will need to build a robust, secure and interoperable digital health care backbone that can seamlessly provide patient information to health care providers across hospitals. The recently released National Digital Health Blueprint provides a clear road map for achieving this vision.

The country has irreversibly set itself on course to achieve UHC. Removing the current fragmentation in health insurance, incentivizing investments in hospitals in underserved areas, and building a strong digital health care backbone will accelerate this process.

(The writer is Indu Bhushan.)

TOP

Source

Delhi among four states not on board health plan' - The Economic Times – 11th December 2019

Health minister Harsh Vardhan expressed concern over families eligible under the Ayushman Bharat not being able to access its benefits in Delhi, Odisha, Telangana and West Bengal as state governments were not implementing the scheme. The health minister said West Bengal had started implementation but later withdrew from the scheme.

He was responding to a question from BJP member Vijay Goel who sought information about the scheme's status in Delhi.

The minister shared that so far 10.8 crore poor families have benefited under Ayushman Bharat. He added as many as 65.5 lakh admissions in hospitals were done under this in the last one year. In a reply to a supplementary, he said roughly 60% of the payment under Ayushman Bharat scheme is to private hospitals and 40% is to government hospitals.

"As on 05.12.2019, total number of hospitals admissions under AB-PMJAY are 65, 45,733 amounting to cost of treatment of Rs 9,549 crore. The average cost per admission is Rs 14,588," he added. Over 20,000 hospitals have been empanelled till now for the scheme, he said.

TOP

Source

Did your insurer pay up for that costly surgery? – Mint – 9th December 2019

Given the bad quality of the air we inhale, the water we drink and the food we eat, health issues and diseases are on the rise. Having a health plan with an adequate cover is becoming more important than ever as hospital bills can easily derail your finances. But imagine buying a suitable health policy, paying the premiums regularly and still having your claim rejected at the last moment. To avoid such a situation, it's important to consider the claims settlement ratio of an insurer, apart from a plan's features and premiums. A higher claims settlement ratio denotes that the insurer has paid a higher percentage of the claims raised by its policyholders. To give you a ready comparison, we have designed Mint Secure Now Mediclaim Ratings (MSMR).

However, it's also important to understand that your job doesn't end at selecting the insurer with the highest claims ratio. Your health insurer can reject your claim for various reasons. We tell you some of the common reasons behind the rejection of claims and when you can make a request for reconsideration.

Rejection of claims

The reasons range from filling in incorrect details to hiding pre-existing health conditions to not following the claim procedure correctly.

It is important to take the utmost care when filling in your form and not let an agent do the work on your behalf. "Many people fill inaccurate or wrong details in the health insurance application form, leading to a claim rejection. Wrong information, especially with regard to medical history, leads to claim rejection.

The main reason for this is insurance agents filling wrong details deliberately—they mention that you are healthy so that you can get lower premiums. When the insurer gets to know this, the claim gets rejected," said C.S. Sudheer, CEO and founder, IndianMoney.com, a personal finance education company.

While hiding some information may help you get a policy or a lower premium, remember that it can cost you later in the form of claim rejection. “Hiding pre-existing diseases is a common reason for health insurance claim rejection. Also, if you make a claim against an exclusion, it is bound to get rejected," said Sudheer. Exclusions are conditions that are not paid for by the insurer; these could be pre-existing ailments, waiting period on certain ailments or permanent exclusions on certain procedures or treatments.

Pre-existing diseases, as the name suggests, are illnesses you may already have before buying the policy. Waiting period is a time specified by the insurer during which certain conditions are not covered by the policy. For instance, in the first 30-90 days of buying a policy, most insurers provide a cover only in case of accidental hospitalization; they, typically, do not entertain claims due to an illness in this period. Also, there are various diseases and ailments which are not covered for a specific period after a policy is bought. Insurers usually specify this period beforehand. Then there are certain ailments, such as Alzheimer’s, Parkinson’s, epilepsy, HIV/AIDS and so on, which are not covered by a policy at all and are, hence, permanently excluded from the scope of a policy.

Also, “if you don’t inform the insurer within 24 or 48 hours of hospitalization, the claim could get rejected," added Sudheer. Normally, during a cashless claim, you have to inform the insurer at the time of hospitalization or before that. In case of a reimbursement policy, where you pay the bills and get them reimbursed later, if you are delinquent in intimating your insurer within the specified time, your claim could get rejected. Ideally, “you should inform the insurer about a planned hospitalization at least 3-4 days in advance. If it’s an emergency, intimation must be done within 24 hours," said Sudheer.

In some cases, absence of proper documents may also result in claim rejection. Keep in mind that insurers may ask for original documents—be it the doctor’s prescription, medical reports or bills.

“Claims can also get rejected because of proximate clause. For instance, consider the case of a pregnant woman having fever and cold. As a precaution, doctors may advise her to get admitted, but had she not been pregnant, the doctor would not have advised hospitalization. In such cases, the insurer may decline to pay a claim if the policy does not cover pregnancy," said Mahavir Chopra, director of health, life and travel insurance, Coverfox.com, an online aggregator of financial products.

Also, in case a person is under the influence of alcohol at the time of an accident, the insurer may refuse to pay for hospitalization expenses, added Chopra.

Remember that sometimes when the insurer rejects a claim, it also terminates the policy simultaneously. “In cases where claim gets rejected because of non-disclosure or misrepresentation of facts, the insurer may also terminate your policy. However, it depends on the discretion of the insurer," said Chopra.

Request to reconsider

In some cases, you can request the insurer to reconsider your claim. “The health insurer could reconsider the claim if you can convince them that the claim is genuine," said Sudheer.

Start with understanding why the claim was rejected in the first place. “Go through the health insurance claim form submitted to the insurer and check the name and policy number. If there are errors, ask the TPA (third-party administrator) to reopen the case and inform the insurer. Claims get rejected due to system errors. The TPA representative can help you there. Record conversation and any documents if possible. Check documents sent with the claim form for mistakes and incorrect documentation or lack of attestation. A common reason for claim rejection is medical procedures deemed unnecessary. Get an opinion by a licensed medical practitioner to prove your claim in such cases," said Sudheer.

Once you have all the clarifications and supporting documents, write a request letter to the insurer to reconsider the claim. If you do not get a proper response, you can escalate the request to the company’s

internal grievance Redressal mechanism and the Integrated Grievance Management System, set up by the Insurance Regulatory and Development Authority of India.

In case you think the resolution is unfair, the next step is to approach the insurance ombudsman. The ombudsman is required to pass an order within 90 days of receiving a complaint, and its decision is binding on the insurer but not on you, the policyholder. If the order is in your favour, think carefully about whether you want to continue with the same insurer or not. "If you think it is not suitable, port to another insurer," said Chopra.

If you are not satisfied with the ombudsman's decision, you can move the court. It's advisable to go through all the terms and conditions, including the exclusions and waiting periods, carefully when buying a health insurance policy. If you are thorough in your research, you wouldn't have to worry about claim rejection.

(The writer is Ashwini Kumar Sharma.)

TOP

Source

Tapan Singhel: 'After Ayushman Bharat, govt should think of parametric solutions for loss from floods' - The Indian Express – 9th December 2019

With the frequency of floods across the country increasing over the last few years, there is a need to create awareness around it and cover the losses. Tapan Singhel, MD & CEO of Bajaj Allianz General Insurance, told Sandeep Singh that while "we as a country is not realising how big a social issue it can become, we need to think of parametric solutions". He added that India as a country needs to become more obsessive about environment, law and order, healthcare and public transport to create a happy society. Excerpts:

Does the economic growth concern you?

Economic growth is critical as it results in upliftment. But to link economic parameters with external factors is not right. We have to see how to increase domestic consumption, how do we focus on societal aspect and get a more inclusive growth. I feel that if we focus more on health and happiness of people, and get these parameters right, then as a society and nation, we will be happier.

So you are worried that economic growth is not leading to a better society?

If you see, even though the consumption has risen and people have more disposable income, they are getting more meals, but the overall happiness seems to be missing. I believe that the measurement and indexing of economic growth are wrong. So, if you are not getting happier with more money coming to you, then you should not worry about what the GDP growth is, but we need to introspect as to whether we are on the right path. The economy, for me, is something that is self-fulfilling. I am not saying that we should get cut-off from the world. No, we should be open, but we have to set our benchmarks right and we must see what kind of economic growth we want.

So where should the priority lie?

Look at the pollution levels and its effects. If Singapore can control the number of vehicles on roads, why can't we decide on the number of vehicles that should ply on the road? Why can't we make public transport much better and conducive? Why can't we make law and order better so that people can live freely without any fear and at the same time do things that improve the economy? I think the obsession and priority about these factors should be much higher.

Do you think the Ayushman Bharat scheme is helping on inclusiveness?
Because of Ayushman Bharat, now a common man has a sum insured of Rs 5 lakh and many hospital chains are saying that they will open 200-300 more hospitals. Earlier, they were not doing so because they did not know how they will get their revenue. The scheme makes that viable now and will help improve the healthcare across the country.

Hospital chains will open, there would be better healthcare available and more healthcare spend. So everyone benefits. In fact, those who can't afford are better placed today as they are covered under the government scheme. On the other hand, the penetration of health insurance among people who can afford is only 15 per cent.

After universal health, where do you think the government should focus?
Now we see that floods are going very frequently and I don't think we are realising how big a social issue it can become. If the home of an average man in the age of 50-60 years gets destroyed by flood, he loses everything and at that age there is no way he can get it back.

However, if you add Rs 200-300 in the house tax and provide a cover, then all individuals impacted by flood can get money into their Jan Dhan account against the loss. There should be no survey etc. It is called parametric solution. If the loss by flood comes to around Rs 20,000 crore and insurance covers losses of around Rs 3,000 crore and government gives around Rs 1,000-Rs 2,000 crore, the total uncovered loss is around Rs 15,000 crore. Who has lost it? Its the poor and the kind of societal pressure that will come on that person is too big and there is no way to address that. If a parametric solution is provided, it will benefit millions of people and the nation as a whole.

How do you see growth for the industry in the absence of green shoots and lack of fresh investments in the economy?
General insurance is asset-based insurance and there is a direct correlation. However, while new business is slow, the old ones continue to be there and several areas are hugely under-penetrated and that will bring growth for the industry. I feel that the industry will continue to grow in double digits. If, somehow, the slowdown sustains for the next four-five years, then you will have a crunch in general insurance, because then the old vehicle numbers will also go down.

What role can the government play?
We have to look at government intervention. If you look at crop insurance, the claim outgo is 90-120 per cent. It is a very effective mechanism of distribution of government subsidy as the entire amount is going to the end user. My belief is that in a societal issue such as flood, government should take steps to create that kind of insurance programme which leads to massive awareness. It will not only lead to money flowing into the system but also solve these societal issues. In US, it is mandatory to have a cover for flood and cyclone and so penetration of home insurance in US is 95 per cent, here we have 1 per cent. Insurance and government have to work together to provide solutions that benefit the society.

(The writer is Sandeep Singh.)

TOP

Source

Busting myths around senior citizen health insurance - Deccan Herald – 8th December 2019

Healthcare persists to remain a critical lifeline for elderly citizens as they grow old. However, over the two decades, out-of-pocket health expenditures for aging adults are expected to increase manifold.

Considering the existing rate of medical inflation in India, adequate health insurance has become essential, especially if your parents are senior citizens. Due to the verity of life, we need to embrace an increase in the list of medical ailments. This calls for medical attention and comprehensive health insurance which tackles the financial lumber of medical expenses.

Whether it is surgery, a life-threatening disease or regular medical check-ups, the bills are many times unaffordable. A health insurance plan ensures these bills are taken care of.

Senior citizens intend to maintain their dignity and lead an independent life post-retirement. A senior citizen pays approximately between Rs 20,000 and Rs 30,000 every year in health insurance premiums, depending on the health of the insured and policy benefits. Hence, senior citizen health insurance plans cogitate the needs and requirements of individuals 60 years old or above.

A senior citizen's health insurance plan offers several benefits such as cashless admission, routine health check-ups, free-of-cost ambulance facility, and coverage for critical illnesses, etc.

A cloud of myths and misconception refrains people to purchase health insurance for their aging parents.

Below are a few myths which need to be broken while purchasing a health insurance cover for your parents or a senior citizen:

Group insurance is adequate many organizations cover their employees under corporate group health insurance policies as a part of their employee welfare program. However, if you are covered under your employer-provided health insurance cover, do not disregard the significance of having individual health insurance for your parents.

Though corporate group policies are beneficial, they might not extend cover to your aged parents or a dependent, which requires you to make co-payments, etc. In addition, your policy will only be applicable until the time you are employed with your current organization. Hence, the widespread notion to have a group health insurance is adequate is incorrect.

One cannot purchase health insurance if they have pre-existing diseases/conditions Several buyers fret about the pre-existing health conditions component of the policy. As a result of this, many people do not enroll for a health insurance policy considering the fact that their parents are ineligible for the policy.

Health insurance policies cover pre-existing diseases/conditions either from Day 1 or have a waiting period ranging from 1-4 years. A policyholder can raise a claim once the waiting period is over against their pre-existing disease. It's best advised for a policy buyer to disclose their medical conditions to the insurer so as to avoid claim rejection.

Fit people do not require health insurance maintaining a healthy life is good but just being healthy does not protect you from unanticipated incidents akin to ill health or accidents. Diseases similar to malaria and dengue or critical illness like cancer can be contracted even by the fittest of individuals.

The premiums for healthy individuals will be less costly and while you are healthy, you shall exhaust the waiting period to get maximum benefits of your health coverage.

Health Insurance has traditionally been focused only on 'financial coverage' and protection. However, it is also necessary to focus on the 'Care' aspect of health insurance. The retirement period is the golden era of an individual's life. Apt health insurance is quintessential for one to enjoy these golden years to the fullest.

(The writer is Mayank Bathwal.)

Source

TOP

'Ayushman Bharat Working To Identify Those Left Out' – India spend – 8th December 2019

About 70% Indians rely on private healthcare for their health needs and bear out of pocket costs, which plunged 55 million people into poverty in 2012.

India has earlier tried out national insurance models such as the Rashtriya Swasthya Bima Yojana (RSBY) that started in 2008, aiming to cover hospitalisation expenses upto Rs 30,000 for families below the poverty line. Its overall performance was poor and the scheme failed to reduce impoverishment.

In September 2018, Prime Minister Narendra Modi launched the ambitious Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB-PMJAY), the National Health Protection Scheme, in Ranchi, Jharkhand. The scheme that subsumed RSBY provided an insurance cover of Rs 5 lakh to 100 million 'poor and vulnerable' families identified by the socio-economic caste census (SECC) of 2011.

More than a year later, we spoke with Indu Bhushan, the chief executive officer of AB-PMJAY and the National Health Authority (NHA), which is responsible for implementing the scheme.

"We have gone beyond RSBY," said Bhushan, sitting in his seventh floor NHA office on New Delhi's Jan path. By December 2, 2019, PMJAY has covered over 6.8 million hospitalizations worth Rs 7,160 crore and has issued over 67 million e-cards to beneficiaries, according to PMJAY website and NHA. It is present in all but four states--Odisha, Telangana, West Bengal and New Delhi.

Pointing to the large screen showing the PMJAY dashboard, Bhushan said two-thirds of the hospitalizations were in private hospitals and for tertiary care. "So we are taking care of problems like catastrophic expenditure," Bhushan said. "We have spent Rs 8,000 crore, but the savings to people is Rs 15,000 crore."

Bhushan, 58, is a former Indian Administrative Service officer, Rajasthan Cadre where he worked for nine years, before moving to the World Bank as a senior economist in 1994. He holds a doctorate in health economics and masters in health sciences from Johns Hopkins University, USA apart from degrees from Indian Institute of Technology (IIT)-Banaras Hindu University and IIT Delhi. Before his current role, he served as Director General, East Asia, Asian Development Bank.

Edited excerpts from the interview:

How has the first year of PMJAY been? What has been working, and what has not?

In the first year, the momentum has been quite good and we are quite pleased with the way the scheme has rolled out. We have to expand it; there is huge disparity amongst the states, because some states have started the scheme for the first time. When you have to create an ecosystem to start a new scheme, it takes time. This is what is happening in Uttar Pradesh (UP) and Bihar. Also, these states have poorer infrastructure to provide services.

The portability feature has proved to be quite handy. [Portability allows patients seek healthcare in any empanelled hospital anywhere in the country]. For example, 10,000 people have gone outside UP to Uttarakhand--most of them to Rishikesh AIIMS [All India Institute of Medical Sciences]. Many people are going to Delhi. Similarly, Bihar is sending people outside because they don't have health infrastructure.

In terms of recipient states, Delhi is the national healthcare provider and Gujarat and Maharashtra are other recipients in bigger states.

[Since September 2019, 50,544 of the 6.8 million hospitalizations (0.7%) involved the use of the portability feature, according to figures shared by the NHA with India Spend.]

We need to improve the performance of the scheme in the green-field states. We need to work on awareness generation and strengthen the supply of services in these states. For that we are working with NITI Aayog [the Centre's policy think-tank] to understand how we can provide incentives for new hospitals to come out in these places. In some cases, for states which are far away like North-East and some of the islands like Andaman and Lakshadweep, we are working to provide transport cost to the mainland--because it is the major cost component in these places.

We are trying to improve awareness in general, as well as provision and quality of services. We are also trying to get more and more hospitals on board. We have now also revised our packages. Earlier, some providers had indicated that rates were low and so we are working on that. Our aim is to get all the big hospitals to our scheme.

To ensure quality of services, we are working with the department of health research at ICMR [Indian Council of Medical Research] to develop standard treatment workflow. Our IT systems will ensure that those workflows are followed.

Does this take care of unnecessary treatments that happen in the private sector? Around 3,000 cases of fraud worth Rs 4.5 crore were discovered during audits, said AB-PMJAY annual report 2019.

We are building some checks and balances--like in hip replacement, we are putting in place boards that will examine whether those procedures are required. We are also working on cancer care so that the right amount of treatment is given--not over or under treatment.

If the person needs chemotherapy, radiation, or surgery, that should be decided by qualified treatment provider. Similarly in cardiovascular disease, we have a system where they could scrutinise whether the person needs a stent or if the hospital has prescribed a stent to earn money.

Next is the detection and prevention of fraud and abuse. For that we are strengthening our IT system and when we find some patterns [of malpractice and fraud], we come down heavily on that.

Every week we share with states, the potential fraud cases based on our analysis of the data. We are also finalising a company which will help us with forensic analysis and big data analysis and give us alerts that we can share with states. We are developing the capacity with the states so that they could do it themselves. Finally, we are improving our IT system and have come up with a tool called 'Zero', which will be more robust, more user-friendly, more secure and interoperable.

We provide those triggers, and many of the fraud cases have been detected. Till now, 300 hospitals have been suspended, we have claimed the money back and FIRs [first information reports] have been launched.

At an event in November 2019, Alok Kumar, senior advisor to Niti Aayog, spoke about a plan for health systems to cater to the middle class--which is currently not covered in any scheme. Are there any plans to broaden this pool of beneficiaries?
We are only one year old and right now we have to consolidate what we are doing before expanding. Our aim is to strengthen the ecosystem for providing services for health insurance.

Also, our database is very old. It is a 2011 database so we have to clean it up and exactly identify the people still left out and how to make them part of the scheme.

Once we have covered all the poor people, the call has to be taken by the government whether they want to expand and bring in [the middle class]. So the vision document that Mr Alok Kumar had shared recently shows the long-term vision. But when we go to them, we want to be sure that we have a system and an ecosystem ready.

Is the addition of new beneficiaries being done by the NHA or through various government departments?
We are not adding new beneficiaries, we are only identifying beneficiaries who have been left out. That call [of adding beneficiaries], the government has to take.

So is a list being enumerated?
I would not say enumerated, but we are looking at the group of people who are being left out.

For example, we are working with other ministries: Like the ministry of labour is prepared to pay for all the construction workers and *bidi* workers, so we will include them. Similarly, we are looking to include workers of micro, small and medium enterprises [MSMEs] in collaboration with the MSME ministry.

We have also signed an MOU [memorandum of understanding] with the ESI [Employees' State Insurance], and we are working with ESI to consolidate those workers.

You mentioned standard treatment workflow to be enforced for quality of care. Has there been any study to measure it?
We have not done a quality of care study but we have feedback from the beneficiaries. We call all the beneficiaries who have availed the services. More than 80% said they are satisfied with the services. Some very minor numbers are not happy and some said they were charged money for the services. We get the money refunded to them, lodge a complaint, and ask the state governments to review that.

Since PMJAY has the advantage of having a big pool, has it brought down the cost of medicines?
About the medicine cost, I don't know. In India, the medicine cost is quite low anyway.

Medicines comprise a bigger share of out of pocket expenditure. For example, 70% of household cost on health is on medicines.
Now, instead of the beneficiary paying of it, we are paying for that. But we have not conducted a study to show that the costs have come down but hopefully as the scheme becomes deeper, the cost will come down. Not only the cost of drugs and pharmaceuticals but also that of implants and devices should come down.

An October 2019 Federation of Indian Chambers of Commerce and Industry report said that the rates are not viable for private hospitals to make a profit or even survive and they are going through a slump.
We have revised the rate and we have taken into account all the inputs that we have received from various industry associations.

Do you have insights about how it has improved care in rural areas?
It's been only one year so we can't expect a huge change. We are seeing some development in that direction and many district hospitals are getting more money. They are improving their infrastructure, they are bridging the gap.

We are also seeing that many private players are planning to expand their operations in tier-2 and tier-3 cities which may help in further expansion.

Are the funds for the scheme enough? In 2019-20, Rs 6,500 was allocated to the scheme while it is estimated that Rs 10,000 crore is needed.
They are more than enough--since the uptake of the scheme was not that much? We had not used the entire amount, so I think money has never been a problem for this scheme.

What are the challenges that you foresee?
There are huge number of challenges: How to reach the last mile, how to ensure the quality of services, how to ensure that no frauds take place and how to ensure IT system continues to work and there are no glitches.

We work on all these every day. We get feedback that due to connectivity, the services are not available in some places. We need to respond to that. In general, we get the feedback that many poor people are being missed out. Those are always there.

This scheme takes care of tertiary care, but what about secondary and primary care because that is where more people are affected? Catastrophic expenditure is for tertiary care, but a lot of it is paid out of pocket at the secondary and primary level.

We are hoping that once we have very strong health and wellness centres, they will take care of much of the primary and secondary care. The government system has to be stronger to provide free drugs and diagnostics. For tertiary and for catastrophic expenditure, we have PMJAY services.

(The writer is Swagata Yadavar.)

TOP

Source

Universal Health Care has the Potential to Boost Economic Growth – Business world – 7th December 2019

The Universal Health Coverage (UHC) programme, adopted globally, aims to provide promotive, preventive, curative and rehabilitative services without any financial hardships. It ensures equal access to care regardless of income level, social status, gender, caste or religion, providing affordable and accountable health care to individuals and populations with the government being the guarantor and enabler, although not necessarily the only provider of healthcare services.

In India, the concept of UHC was anticipated way back in 1946 by the landmark Bhore Committee report which envisaged a country where no individual will fail to access adequate care because of the inability to pay. Now UHC is one of the 17 Sustainable Development Goals (SDGs) adopted by the United Nations (UN) for eliminating poverty and building a more resilient planet. It's also based on the World Health Organization (WHO) constitution of 1948 declaring health as a fundamental human right, as well as on the Health for All agenda set by the Alma-Ata declaration of 1978. UHC has the potential to boost economic growth, improve educational opportunities, reduce impoverishment and inequalities, and foster cohesion. Steps taken for achieving UHC will address public health challenges and vice versa.

In India, in October 2010, a high-level expert group (HLEG) on UHC was constituted by the Planning Commission with the mandate of developing a framework for providing easily accessible and affordable healthcare to all Indians. The critical area for the provision of UHC as per the recommendations were health financing, health infrastructure, health service norms, skilled human resource for health, access to medicines, vaccines and technology, management and institutional reforms, and community participation. Key recommendations pertaining to these areas were provided. The group had proposed that the government (central and state) should increase public expenditures on health. It also recommended ensuring availability of free essential medicines by increasing public spending on drug procurement and that user fees of all forms be dropped as a source of government revenue for health. Experts also put a lot of emphasis on primary health care as well as trained human resources. To improve community participation, it was recommended that Village Health Committees or Health and Sanitation Committees be transformed into participatory Health Councils. It also suggested strengthening the management systems of UHC systems, apart from recommending several institutional reforms.

However, the provision of UHC has not been free from challenges and India has one of the largest disease burdens in the world. We also have major problems related to malnutrition as well as reproductive and child health, gender inequality and availability of trained HR. Apart from this, inadequate funding, weak public health systems, weak management systems, inequalities in access to healthcare, unknown quality

and health outcomes, commercialized, fragmented and unregulated healthcare delivery systems, and lack of integration between health and other sectors have added to the problems. There is also inadequate research to achieve healthcare for all as well as high out-of-pocket expenditure. Other factors like poverty, illiteracy, frequent and severe natural disasters have made matters complex.

Meanwhile, the Indian Government's expenditure on public health as part of the total health expenditure is about 30 per cent, which is the 17th lowest globally. We need adequate resources to empower healthcare services, reduce financial risks and barriers, and raise the capability of the population to effectively utilise available resources. There is enough evidence to show that strengthening of PHC is the most appropriate approach to achieve UHC. Hence, adopting an integrated national healthcare system built around a strong public primary care system would be the way forward.

Every year, over 63 million people face poverty due to healthcare costs alone, owing to the lack of financial protection of health-care needs. Consequently, out-of-pocket expenditure comprises 69 per cent of total health care costs in India. Less than a quarter of the Indian population has access to any mode of healthcare insurance. One of the key announcements made during the Union Budget 2018-19 was the Ayushman Bharat Program (ABP)scheme. It has two components –

a) Delivering comprehensive primary health care by establishing 150,000 health and wellness centres and,
b) providing financial protection for secondary and tertiary level hospitalization as part of the National Health Protection Scheme (NHPS). Additionally, the integration of Ayurveda and Yoga will further promote a holistic approach to the health of the community.

Simultaneously, there is also a need to pay close attention to the following areas: Nutrition and food security, water and sanitation, social inclusion to address concerns of gender, caste, religious and tribal minorities, decent housing, clean environment, employment and work security, occupational safety, and disaster management.

Although there have been numerous healthcare-related programs in India such as National Health Mission (NHM), Rashtriya Swasthya Bima Yojna (RSBY), Jan Suraksha Yojana (JSY) and several state-sponsored health insurance schemes, these are insufficient to provide and sustain UHC as they neglect primary care and outpatient care which are major contributors to out-of-pocket expenditure. Hence, the social objectives of these schemes would need to be merged and their scope considerably expanded to create a valued and viable model of UHC. Under financial protection, the plan will provide coverage of up to INR 500,000 a family a year for secondary and tertiary care hospitalization to almost 100 million low-income families (appx 500 million people). Thus, ABP will provide services for preventive, promotive, curative, diagnostic, rehabilitative and palliative care services. This program has also been referred to as 'the world's largest government-funded healthcare (insurance) program'.

TOP

Source

Mental health: The elephant in the rooms of corporate India - The Hindu Business Line – 6th December 2019

She was a go-getter and had been promoted within a year of joining — a rather rare feat at the media organisation where she worked as a writer. There would be weeks of productivity, when she would pursue articles with passion and mirth. Her chirpiness would suddenly fizzle into spells of depressive lows, aggravated by all manner of accusations she hurled at everyone around. As she

swung between manic highs and lows, her co-workers remained flummoxed spectators. She's 'mad', they decided.

Looking back on his high-performing employee's struggles with bipolar disorder at the workplace, Allen John (name changed) wonders whether things could have been handled better if his company had a mental health policy in place. It's been nearly two years since she left the job, and she hasn't been able to hold on to another job elsewhere either.

Mental health remains the elephant in the room in the formidable corridors of corporate India. Of the country's 1.1 million active registered companies, only 1,000 are estimated to have a structured employee assistance programme (EAP) for mental health, according to Optum Health International, a leading EAP service provider belonging to the Minnesota (US)-based UnitedHealth Group.

An EAP typically includes both preventive — workshops and awareness programmes on mental health — and counselling services — whether telephonic, face-to-face or via online chat — for employees and their family members.

In India, Optum's Prevention and Wellbeing, EAP and Wellbeing Services segment is headquartered in Bengaluru and active in over 65 cities. Its country head, Amber Alam explains that there are about four prominent EAP providers in the country, each catering to 200-300 employers. So, aside from a few other companies offering mental health support in bits and pieces, only a handful of Indian companies have a structured EAP, he says.

To emphasise the magnitude of the problem, Alam cites a 2015 study by industry body Assocham that found 42.5 per cent of employees in the private sector showed signs of general anxiety disorder or depression. The study — involving 1,250 employees from 150 companies — further found that the incidence of anxiety and depression among corporate employees increased 45-50 per cent during 2008-15, and nearly 38.5 per cent of those surveyed slept less than six hours — which is a major contributing factor for depression and hypertension.

Stress, anxiety, depression, marital discord, substance abuse disorders, personality problems, psychiatric problems, trauma and bereavement are some of the commonly cited mental health issues among corporate workers, says Alam. Another disquieting reality is that, more often than not, employees facing mental health issues end up quitting on their own, as happened with John's employee, says Kunal Sen, managing director of consulting firm Korn Ferry's recruitment services in India.

What is more, the World Health Organization estimates that depression and anxiety — among the more prominent mental health issues — cost the global economy $1 trillion a year in lost productivity. Given this harrowing backdrop, can India Inc afford to have a minuscule fraction its companies concerned about the mental health of employees?

On the other hand, WHO points out that for every $1 invested in treating common mental disorders, there is a return of $4 in improved health and productivity.

"It makes sense for organisations to nurture employees' mental health, not just from an ethical perspective, but also economic. The benefits to the employee cannot, of course, be quantified in economic terms, but are potentially life-saving," says physician and psychiatrist Shyam Bhat, who heads Mindfit, the multi-city mental health and wellness service of cure.fit healthcare.

Mental health is just as important a factor for productivity as physical health, affirm all the experts BLink spoke with.

Andrew Simoes, manager at recruitment agency Michael Page India, vouches for the improved positivity at his workplace after he spearheaded a few mental health initiatives last year, timed with the World Mental Health Day week. Besides creating awareness about the pervasiveness of mental health issues in society, the initiatives stressed the importance of addressing these issues and developing strategies to cope with them.

“I think it was like this monster which was buried until then,” he says with a wry laugh, recalling the positive reception the effort garnered. “Once it was brought out, people started acknowledging it and saying, ‘yes, this is something that needs to be looked at’. A lot of people have actually taken up counselling sessions post that,” he says.

He points out that, often, even if a company has effective measures to deal with mental health issues at a global level, it may be missing at its Indian unit. For instance, his company’s global operations use Optum’s services, but in India, though the services were available on paper, a lot of people were unaware of it, he says. “This has to do with the fact that mental health is still pretty much a developing idea in India. We don’t take it seriously,” he says.

Lack of awareness and stigma are among the barriers to improving employees’ mental health, affirms Bhat. Employees often worry that seeking help for mental health can jeopardise their career growth, he adds.

The prevailing taboo forces people to shove mental health issues under the carpet, says Nicolas Dumoulin, managing director of Michael Page India. If someone takes a hiatus from work owing to a mental health issue, it ends up being frowned on as lack of motivation. The solution lies in creating an environment of trust, he adds. “You need to have policies in place to say, look, this is something we can do if someone has a burnout, and this is what the trajectory would be, this is how we could integrate them back into the company, so on and so forth,” he explains.

In the current scenario, the looming fear of job losses and retrenchment can by itself have a bearing on employees’ mental health, says Korn Ferry’s Sen.

He then underlines a pertinent fact — mental health issues are far more widely prevalent than most people think. If nearly half the employees are affected, then there’s a larger malaise at play, and people do not feel they have to hide it as they are not the only ones facing mental health problems. A company’s approach towards an employee dealing with mental health issues simply needs to be the same as its approach in the case of a physical illness — give time off to sort out the illness and provide support, where necessary, Sen says.

A Belgian, Dumoulin jokes that in a country like India, especially in cities such as Mumbai, merely the task of getting to office every day can trigger stress, what with the long, gruelling commutes and heightened traffic woes. This stress is compounded by thoughts of the work and targets awaiting them once they reach office. Many are forced to stay back late in office, which means returning home late, and sleeping and eating less. This kind of work-life not only harms physical health but directly impacts one’s mental health as well, he says.

“It’s a vicious cycle which a lot of people have fallen into, especially in the metro cities... so it becomes more and more important to ensure your employees get support or at least get a platform to show how they feel,” he says.

What’s your policy?

Given the rising incidence of mental health issues, companies must necessarily have mental health policies, yet only a few have them, says Sen. Such policies should entail creating awareness or reducing stigma around mental health as well as providing access to mental health services, he says.

Interventions should be designed as part of an integrated health and well-being strategy that includes prevention, early identification, support and rehabilitation, says Vijay Chandra mohan, French multinational company Capgemini’s head of Health, Safety and Environment in India.

It could cover areas such as financial and legal counselling, sensitization to alternative sexual preferences, suicide prevention, psychological first aid (basic support care), he adds. Organisations should have counselling and psychiatry services provided to all employees with the assurance of confidentiality, says Bhat. Leave should be provided for mental health issues, besides promoting a culture of openness around mental health.

Stressing the importance of a preventive approach, he says, “Companies should foster healthy lifestyle practices that are known to improve mental health, including exercise, proper nutrition, work-life balance, and yoga and meditation.” Alam rues that Indians don’t take preventive care seriously, even for physical well-being. Just as you have health insurance to take care of hospitalizations during a physical illness, you now have mental illness covered.

“The Insurance Regulatory and Development Authority of India is trying to regulate that; it’s a great step. But, honestly speaking, do you think anybody at a workplace will call out and say, ‘You know what? I went to a psychiatrist and I am on medication. Here’s the prescription and the invoice, can you reimburse it?’ It’s going to take some time for anybody to do that confession, and for the company to develop a large heart to accept them and not fire them,” he says. IRDAI is regulating mental health illness, not EAP or psychological support, he adds.

Seconding the need for preventive care, Sen Makes a revealing observation: “There is a physical checkup in a lot of firms before you get employment, but rarely do you have a mental health checkup.”

Asked whether mental health checkups should be mandated, he replies, “Maybe sometime in the future. We are still at a very early stage in the evolution. A lot of millennials and Gen Z are entering the workforce and they are ill-equipped to handle some of these mental health problems. It is a worrying situation.”

The task of devising a corporate mental health policy has its own share of difficulties as each person’s struggle with mental health, as well as their coping strategy can vary significantly from another’s, says Dumoulin. At Michael Page India, rather than a policy per se, the company is focused on fostering a culture that allows employees to speak freely about mental health and normalize it. He, however, believes that in larger organisations with over 10,000 employees, a structured policy may work better.

Reaching out informally

Many of the companies BLink contacted for this story affirm that they are proactively taking steps to ensure employees’ mental wellbeing. However, they do not have a mental health policy as such. Many of them offer free counselling services through tie-ups with external service providers. Alam says the number of companies seeking EAP or mental health programmes has been increasing by 45-55 per cent year-on-year.

Corporate houses such as JSW Group, Capgemini India and Mahindra & Mahindra (M&M) have EAPs that include free counselling to employees and their families. At its steel manufacturing plants around the country, JSW Group had, between May and October last year, conducted 25–30 face-to-face counselling sessions as part of its EAP called We Care, says Ajanta Chatterjee, vice-president — human resources.

Capgemini India’s employee mental health awareness programme comes under an overarching framework of ISO-45001, an international standard for occupational health and safety management systems.

At M&M, employees are provided with counselling services as part of its ‘M Happy initiative’. RajeshwarTripathi, chief people officer, says: “We realised that one of the biggest ingredients of employees’ productivity is their mental well-being, although it’s not very easily admitted by the individual. There is still a taboo — that if I were to disclose I have a problem with my mental well-being, then it will go against me and my career.”

Ensuring employees’ mental well-being is inevitable and not a matter of choice, he adds. Oyo, Uber India, Google India, Mondelez India, American Express India and Panasonic India are some of the other companies which provide similar services.

In some instances, companies have stepped in to help employees grapple with mental health issues. Korn Ferry’s Sen Mentions how a senior employee who was grappling with depression after being laid-off was helped by the company not only in dealing with the illness but also finding a new job.

JSW Group's Chatterjee recalls an instance of an employee at their steel plant who was facing a marital issue. Through the company's manager referral service, the human resources department arranged for on-site counselling at the steel plant.

"The employee was encouraged to learn and practise alternative coping strategies. After the on-site counselling, the couple continue to work on their personal issues through telephonic counselling," Chatterjee says.

She points out that while JSW may not have a mental health policy, it offers help on a case-to-case basis. "Not only JSW, but most companies would help the employee tide over the period until they are able to come back to work," she says. Would they though? One can only hope that this indeed becomes the norm.

"Organisations will play a crucial role in our society's overall mental well-being since much of our time and energy is spent in the workplace. The workplace is often the source of stress, but it can also be the source of the solution," Bhat explains.

(The writer is Nandana James.)

TOP

Source

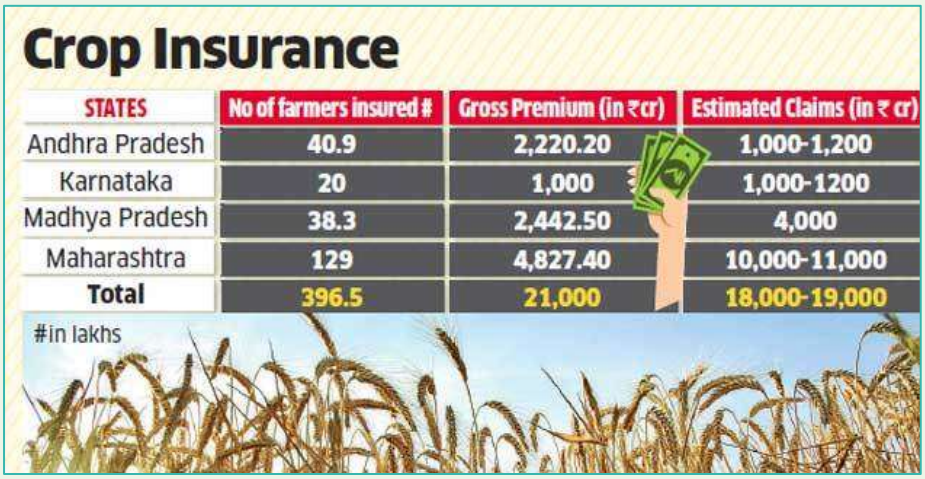
CROP INSURANCE

Heavy crop-damage payouts likely by insurance firms - The Economic Times – 13th December 2019

Insurance companies are likely to pay farmers heavy compensation as dry weather in June and floods in September damaged crops particularly in Maharashtra, where the outgo may be more than Rs 10,000 crore, agriculture ministry officials said.

Total claims for this year's summer-sown, or kharif, season are estimated to be about Rs 18,000 crore, which is close to the previous fiscals' approved claims of a little over Rs 19,000 crore, which included the winter crop also, a government official said.

Payment for damaged rice, cotton, oilseeds, pulses, sugarcane and horticulture crops will be paid under the Pradhan Mantri FasalBimaYoja (PMFBY) launched in 2016 in which a farmer contributes only 1.5% to 2% of the insurance cost and the balance is shared by the Centre and states.



Apart from Maharashtra, where farmers may get Rs 10,000 crore to Rs 11,000 crore, officials have estimated payout of Rs 4,000 crore in Madhya Pradesh, and Rs 1,000 crore to Rs 1,200 crore each in Karnataka and Andhra Pradesh. Compensation in other states would not be big as crop losses are estimated to be low, officials estimate.

"Surveys for the assessment of losses are on in these states. Preliminary surveys have indicated large scale of damages and huge estimated payouts. The picture will become more clear when claims settle by February-end. Insurance companies will have to take a major hit," said a senior agriculture ministry official, who deals with crop insurance.

According to latest data from agriculture ministry, 22.8 million farmers from these four states have been covered under PMFBY, comprising 57.5% of the total 39.65 million insured farmers across the country in this kharif season.

"This year, we have paid a premium of over Rs 20,000 crore for the risk cover of crops worth Rs 1.3 lakh crore. As per the estimations of the quantum of crop losses, we expect a claim payment of over Rs 18,000 crore," the official said.

This year, the incurred claim ratio, which refers to the claims paid as against the premiums earned, is also likely to be highest ever. "It will be in excess of 92%. Earlier, the claim ratio was 76% in 2016 followed by 86% in 2017 and 75% in 2018," the official said.

(The writer is Rituraj Tiwari.)

TOP

Source

MOTOR INSURANCE

Share of third party cover rising in motor premia - Financial Chronicle – 9th December 2019

The share of third-party insurance in motor premiums is rising. The past three years have seen a steady rise in this share and from this year onwards the growth momentum could spike higher.

Till a few years back, the own damage share in motor premium used to be 60 per cent and third party, 40 per cent. However, the share of third party (TP) premium has since gone up to 52.7 per cent in 2016-17, 55 per cent in 2017-18 and further up 59 per cent in 2018-19, data from the Insurance Regulatory and Development Authority of India (Irdai) shows.

Public insurers like United India, Oriental Insurance and New India Assurance have a significantly higher proportion of third party share in their motor premiums.

According to Sanjay Datta, Chief-Underwriting, Claims and Reinsurance at ICICI Lombard General Insurance Company, the TP premiums have been rising as a function of natural inflation with the increasing trend in claims and claim amounts.

"The TP losses have seen an increase and the Irdai has accordingly increased the premium (net of increase in some and decrease in some) in some of the TP segments, which is leading to a net increase in share,' said Sajja Praveen Chowdary, Head- Motor Insurance, Policybazaar.com.

On the other hand, the competition and market situation has driven up the discounts in Own Damage segment, leading to the OD share in total premium going down, he said.

Two-wheelers and private cars have a higher proportion of own damage in the motor premium. "As the vehicle gets heavier, the share of third party goes up. In case of commercial vehicles like trucks and buses, the TP share can be 60 to 70 per cent," said Datta.

Last year, the regulator had asked insurers to increase the personal accident sum insured for the owner-driver in the motor policy. There was a corresponding rise in premiums of two-wheelers and four wheelers.

Further, the three-year policies for cars and five-year policies for two-wheelers also have seen increased off-take of insurance policies. Insurance cover of two-wheelers has gone up significantly in recent times. It used to be considerably low until a couple of years back as most of the owners used to miss out yearly renewals.

(The writer is Sangeetha G.)

TOP

Source

SURVEY & REPORTS

Assocham, KPMG release report on Ayushman Bharat Programme- Big leap towards universal health coverage in India - Pharma Biz – 10th December 2019

Assocham in collaboration with KPMG jointly released a report titled "Ayushman Bharat Programme - Big leap towards Universal Health Coverage in India" by Union minister of state for health, Ashwini Kumar Choubey at Ayushman Bharat Conclave".

The purpose of this whitepaper is to find ways to leverage partnerships between the government and private sector as both are important stakeholders contributing towards rapid and effective implementation of the scheme. The report also provides insights into challenges being faced during implementation of the scheme and suggests additional interventions that can be incorporated to accelerate India's journey towards universal health coverage.

The conclave was organized to discuss the Ayushman Bharat scheme and how what can be the holistic approach towards universal health coverage (UHC). With the view to achieve UHC, the Indian government launched Ayushman Bharat in September 2018, which caters to all the verticals of healthcare service delivery – primary, secondary and tertiary care.

While the health and wellness centers (HWCs) aim delivery of an expanded range of services close to the community, Pradhan Mantri Jan Arogya Yojana (PMJAY) focuses on providing secondary and tertiary care services to the underprivileged section of the society. So far, a lot has been achieved through the initiative including benefits to more than 60 lakh treated beneficiaries after one year of completion of scheme.

Despite progress across many parameters, the existing state of Indian healthcare leaves much to be desired. In the last two decades, the private sector has been the major contributor to healthcare infrastructure development in the country with public sector's contribution being limited. Glaring challenges around healthcare financing, inequality of services, and fragmented social and regulatory standards have started to cripple the advancement in healthcare.

Ayushman Bharat with its key objectives also intends to elevate the overall healthcare system of the country and hence there is also a need to focus on bigger operational aspects such as provisioning of quality and standardized care, driving quality accreditation, emphasizing on learning and capacity development, leveraging analytics and technology and imbibing learnings from across the globe.

The report provides a comprehensive outlook on private participation and how the launch of Ayushman Bharat is aiming to achieve the vision of healthcare coverage for the underprivileged section of the society.

TOP

Source

PENSION

Is it worth compromising your PF for a higher take-home? – Mint – 10th December 2019

If the government's Social Security Code Bill, 2019, gets nod from the two House of Parliament, you will soon have the option to reduce your provident fund (PF) contribution — currently at 12% of basic salary — and increase your take-home.

The rationale behind the move

The government's rationale behind reducing the employee PF contribution is to boost consumption with a higher take-home salary. The falling consumption has been dragging growth down. While the move may or may not be sufficient to boost consumption at a time when the GDP has gone down to a six-year low, it could certainly hit your retirement savings.

What you stand to lose

Deepali Sen, Founder, Srujan Financial Advisors said, "Saving less and spending more ideology has a high probability of being counter-productive and may leave you with less than needed corpus at a time when your prime earning years are behind you. Reducing the quantum of PF contribution could compromise on the retirement savings of many. In India, most people lack financial literacy. They may end up investing in instruments they do not understand and may mark-up their returns expectations to an aspirational level, which may not happen, thus leaving them with a less than expected corpus."

With EPF contributions, someone is unable to save much and make investments, ends up with at least some money in hand at the time of retirement.

"The move will allow people to choose from other investment avenues which give better returns. However, it needs financial literacy and discipline which most people do not have. If one reduces the quantum of PF contribution and spends it instead of investing it, there could be a huge dent in his retirement corpus," says Vikas Gupta, chief executive officer and chief investment strategist at Omniscience Capital.

If you think reducing your EPF contribution is a good idea, here's what you may miss out on:

Guaranteed risk-free returns

EPF is government-backed retirement savings scheme that offers a guaranteed rate of return. The rate of interest (ROI) on PF is reviewed every year and for FY20, it is 8.65%

The compounding effect

Compounding is the key to wealth creation, as generating returns on returns becomes a sequential process as long as you stay invested in the financial instrument. Even a small reduction in the quantum of investments can lead to a significant fall in your returns.

Sample this:

"If you start investing in ₹1,500 a month at the age of 26 and increase the investment amount by 5% every year, at a rate of 8.65% which EPF is currently offering, you will accumulate a corpus of ₹56, 88,524 by the time you retire at 60. However, if you start with just ₹500 less, your corpus will be reduced to ₹37, 92,349," Sen explains.

Also, interest rates in EPF have been falling for last many quarters. Therefore, an 8.65% return may be aspirational after a few quarters.

Income tax benefit
EPF contributions are eligible for income tax deduction under section 80C. The maximum amount of deduction that can be claimed this section is ₹1.5 lakh. Reducing the percentage of your EPF contribution may result in higher tax payout if you do not have other tax-efficient investments.

Premature withdrawals
While it is not advisable to make premature withdrawals from your retirement savings, the EPFO subscribers can make partial withdrawals after 5-10 years of service for specific needs including medical treatment, home loan repayment and unemployment, which may come handy during unforeseen financial crisis.

(The writer is Devansh Sharma.)

TOP

Source

Govt plan to allow EPF-NPS portability may be junked – Mint – 9th December 2019

The National Pension System (NPS) will not be an alternative to the Employees' Provident Fund (EPF), as the government is set to junk its much-talked-about plan to put in place EPF account portability with NPS.

This decision has been taken as the government has realized that the move is risky and controversial, and the two are not "apple to apple comparable" schemes in terms of their application and benefits, two government officials said, requesting anonymity.

"There is a growing realization that EPF, the mandatory mass social security scheme, is far better than NPS in terms of employee benefits, tax treatment, statutory requirement, and overall reach," said one of the two officials cited above.

"There are several reasons, but the bottom line is that EPF number portability with NPS is not a plan that the government is willing to pursue now," said the other official mentioned above.

That EPF and NPS are not alternatives to each other will be made public formally this week. The move will rest a four-year-old plan first mooted by then finance minister Arun Jaitley while presenting the 2015 annual budget.

Friction between the government and workers and trade unions, including those affiliated to the ruling Bharatiya Janata Party will be reduced, with the government taking a back seat on its four-year-old plan. This is particularly significant as it comes at a time when mistrust is growing because of accelerated labour reforms.

"We are reducing friction from labour reforms. We are making efforts to frame laws that are equally beneficial for both employees and employers. The Employees' Provident Fund will not be tinkered with to benefit NPS. We are also making changes to the gratuity payment rules and will make employees eligible for gratuity contributions after one year in service instead of five years now," said the second official.

A labour ministry spokesperson said he is not aware of the development.

"The EPF is completely a tax exempt scheme. It offers provident fund, pension, insurance, and disability benefits, among other things, but NPS does not have such mass benefit. EPF with more than 8.6% almost assured return from its own investments without any government contribution makes it a far better product. What it needs is a smoother online interface and work is on to achieve this," said the first official.

Authorities believe that while EPF is a statutory deduction scheme for all organized sector employees in any establishment having 20 or more employees, NPS is voluntary. Besides, while EPF deductions are 12% each for employees and employers, NPS deductions are 10%.

All central trade unions, including Rashtriya Swayamsevak Sangh affiliate Bharatiya Mazdoor Sangh (BMS) have been opposing the plan for four years. In October, BMS criticized the central government, terming the "latest draft Social Security Code, 2019, totally disappointing for the workers in the country". BMS president C.K. Saji Narayanan had said that there is no alternative to EPF from workers' benefit point of view and his organization totally opposes the NPS and EPF interoperability.

(The writer is Prashant K. Nanda.)

TOP

Source

Bid to spur consumption: Save less, spend more is new social security mantra - The Economic Times – 9th December 2019

Millions of organised sector employees may soon have the option of reducing their provident fund contribution — currently at 12% of basic salary — and therefore increase their take home pay. Labour ministry officials said this provision is part of the Social Security Code Bill, 2019, approved by the Cabinet and expected to be tabled in Parliament this week.

The rationale for allowing lower employee PF contribution is that higher take-home pay may boost consumption, which has been falling, dragging growth down. The Bill, however, retains employers' PF contribution at 12%. Details on how low employees' PF contribution can be brought down will be worked out after the passage of the Bill, officials said.

Also, as per the Bill, fixed-term contract workers will be eligible for gratuity on a pro rata basis. Currently, workers are not entitled to gratuity before completing five years of continuous service, as prescribed in the Payment of Gratuity Act, 1972.

The labour ministry has also done away with its earlier proposal to give subscribers of the Employees' Provident Fund Organisation an option to switch to the National Pension System vis-à-vis the Employee Pension Scheme under EPFO. It said the current arrangement provides multiple benefits such as higher rate of return and exempt-exempt-exempt status to funds invested in EPFO.

Social Security Fund Proposed

The ministry also decided to retain the existing autonomy of EPFO and Employees' State Insurance Corporation (ESIC), rejecting the proposal to corporatize them.

The Bill proposes setting up a social security fund using corpus available under corporate social responsibility. This fund will provide welfare benefits such as pension, medical cover, and death and disablement benefits to all workers, including gig workers.

"We have dropped all controversial proposals and kept our focus intact on the welfare of workers as well as improving the ease of doing business in India through amalgamation of existing laws under the Social Security Code," a senior government official told ET on the condition of anonymity.

As per the Bill, all establishments employing at least 10 workers will have to provide multiple benefits to employees under ESIC, while it would be mandatory for all workers employed in hazardous sectors. Companies with less than 10 workers can voluntarily opt to provide benefits under the ESIC scheme to their workers.

The Social Security Code subsumes eight central labour laws. They are the Employees' Compensation Act, 1923, Employees' State Insurance Act, 1948; Employees' Provident Funds and Miscellaneous Provisions Act, 1952; Maternity Benefit Act, 1961; Payment of Gratuity Act, 1972; Cine Workers Welfare Fund Act, 1981; Building and Other Construction Workers Cess Act, 1996; and Unorganized Workers' Social Security Act, 2008.

As part of its reform initiatives, the labour ministry has decided to amalgamate 44 labour laws into four codes — on wages, industrial relations, social security and safety, and health and working conditions.

The Social Security Code is the last of the four labour codes that have been approved by the Cabinet.

The labour code on wages was approved by Parliament in August while the code on occupational safety, health and working conditions has been referred to the parliamentary standing committee on labour. The Industrial Relations Code Bill, 2019, has been tabled in Parliament.

(The writer is Yogima Sharma.)

TOP

Source

IRDAI CIRCULARS

List of Insurance Marketing Firms as on 30.11.2019 is available on IRDAI website.

TOP

Source

New Business Statement of Life Insurers for the Period ended 30th November, 2019 (Premium & Sum Assured in Rs.Crore) is available on IRDAI website.

TOP

Source

IRDAI (Third Party Administrators - Health Services) (Amendment) Regulations, 2019is available on IRDAI website.

TOP

Source

List of corporate agents registered with the authority as on 30 Nov 2019.

TOP

Source

IRDAI issued order regarding Constitution of Working Group to make recommendations for Loss Prevention and Loss Minimization in General Insurance Industry.

TOP

Source

GLOBAL NEWS

Thailand: Non-life business forecast to show steady growth in next 5 years – Asia Insurance Review

The general insurance business in Thailand is predicted to grow from $7.7bn in 2018 to $9.1bn in 2023, an increase over the next five years of 18%, says a report from data and analytics firm GlobalData. The report notes that GWP in the country's general insurance market registered a compound annual growth rate of 3.1% between 2014 and 2018.

Motor, property and personal accident and health together accounted for a share of more than 90% in 2018. Motor insurance held the largest share of 55.5% and is a growth driver. During 2014-2018, motor insurance business accounted for 54%-55% of total general insurance gross written premiums.

Challenges

Global Data says its report suggests profitability is under pressure in Thailand's motor insurance business and is reflected in the loss ratio, which rose from 57.8% in 2014 to 65.3% in 2018 due to competition in the market. Mounting operational losses, however, may moderate the competitive pricing going forward.

Global Data believes the economic growth outlook is also an issue to contend with. As per government estimates, growth was at a five-year low by the end of the second quarter of 2019 as the country's export-oriented economy reeled under international trade conflicts and currency appreciation.

Opportunities

Against this backdrop, insurers are using technology and other measures to increase efficiency. Global Data sees telematics and usage-based insurance as two key technology-based solutions with significant growth potential in the industry.

Micro insurance, claims processing and customer relationship management are among the key focus areas. Also, the industry can look forward to opportunities in projects planned under the 'Thailand 4.0' stimulus plan.

TOP

Source

South Korea: Insurers to raise motor premium rates again - Asia Insurance Review

South Korean non-life insurers are moving to raise premiums for motor policies by around 5% against ballooning losses from the auto insurance business.

According to industry sources, seven non-life insurers – KB Insurance, Hyundai Marine & Fire Insurance, Samsung Fire & Marine Insurance, DB Insurance, Meritz Fire & Marine Insurance, Lotte Insurance and Hanwha General Insurance – filed for an increase in their auto insurance rates to the Korea Insurance Development Institute on 25 November.

Major players reportedly submitted a plan for a 4-5% rise, and smaller firms a 5-6% increase, reported *Pulse News*.

The review process for approval of premium increases usually takes up to two weeks. The new rates could be imposed in the New Year.

Insurers cited their higher loss ratio as the main reason for the rate hike. The loss ratio of local insurance companies hit 90% in November. Auto insurers consider 80% as the optimal ratio.

Non-life insurers incurred an operating loss of KRW824bn ($691bn) from auto insurance for the first nine months of this year, a year-on-year increase of 303.1%. The surge in the operating loss was attributed to increases in repairs & maintenance costs and insurance production costs.

The insurers had hiked their premiums last June after having raised them a few months earlier in January.

TOP

Source

Australia: P/C insurance sector seen as low risk - S&P - Asia Insurance Review

The industry and country risk in the property/casualty insurance sector of Australia (AAA/Stable/A-1+; unsolicited ratings) is low, according to S&P Global Ratings.

The assessment is the second lowest risk on S&P Global Ratings' scale and comprises the very low country risk as well as the low Australian P/C sector risk. The low risk assessment for Australia's P/C insurance sector is among the lowest globally.

Australian operating conditions have been supportive of solid returns generated by P/C insurers, with real GDP averaging about 2.6% over the past four years, reflecting good employment levels and steady population growth. Stable, although subdued, economic conditions are reflective of the policy interest rate edging lower to 0.75%, and a consumer price index (CPI) near a relatively low 1.9%.

Up until 2021, S&P Global Ratings expects moderate gross written premium growth across personal and commercial lines led by incremental premium hardening and moderate unit growth off the back of continued modest GDP growth and improved risk-based metrics.

S&P Global Ratings' Australian P/C sector evaluation incorporates the aggregate historic strong operating performance across personal and commercial lines. The international credit rating agency considers the sector well developed and advanced in terms of pricing and risk controls.

As of 30 September 2019, there were 97 licensed entities including some of the largest global P/C insurers, instilling a highly competitive operating environment that is supported by global reinsurers.

Local insurers have been particularly effective in managing large claims and exposure to natural peril and catastrophe events through reinsurance.

The combination of a very low country risk assessment and low insurance risk sector assessment results in a low risk Australia P/C sector Insurance Industry And Country Risk Assessment (IICRA), which is the second lowest risk assessment.

Country risk: Very low
S&P Global Ratings assesses the country risk of Australia as very low, based on its view of the very low political risk and a strong payment culture and rule of law. Australia continues to provide a supportive and stable economic environment for P/C insurers, benefiting from effective public policy making. That policy making has supported the economy's resilience to external shocks, and mitigates the impact of external imbalances while being supportive of sustained profitable growth for P/C insurers.

In S&P Global Ratings' view, the financial system benefits from the sovereign's strong creditworthiness and effective political structure. The country's rate of economic growth has been resilient, although relatively low, averaging about 2.6% over the past three years. S&P Global Ratings expects the rate of GDP growth to remain under pressure and decline to 2.0% for the year ended 2019 before incrementally improving toward 2.4%, while the forecast policy rate is expected to remain 0.75% for a few years.

P/C insurance sector industry risk: Low risk
S&P Global Ratings assesses the industry risk for Australia's P/C insurance sector as low. Key elements that are supportive include the industry's sound profitability, as measured by return on equity, and strong institutional framework.

Product risks, barriers to entry, and market growth prospects are supportive of the sector's risk profile and we assess these as neutral. Steady real GDP growth has supported the operating performance of the P/C sector, with nominal direct P/C premium growth strengthening since 2016.

Nominal direct P/C premium growth, excluding mortgage insurance, grew by 4.6% on average in the three years to 30 September 2019. This rate of growth was dampened by about 1.7% with compulsory third-party (CTP) adjustments, and system growth was well above average CPI and real GDP growth rates. Premium growth predominantly reflected increased premium rates with nominal volume growth across the three years (excluding mortgage insurance and CTP).

TOP

Source

China: Foreign investors can hold 100% stake in life insurers wef 1 Jan 2020 - Asia Insurance Review

The CBIRC has announced that wef 1 January 2020, restrictions on the stake of foreign investors in life insurance joint ventures will be officially lifted, and the foreign shareholding can reach 100%.

Relevant entities may submit an application for an administrative licence for 100% owned ventures to the regulator in accordance with "Regulations on the Administration of Foreign Insurance Companies", and "Implementation Rules for the Administration of Foreign Insurance Companies", says the CBIRC in a statement. The regulator will review and approve the applications in accordance with the law and regulations.

Last week, the regulator raised the ceiling on direct foreign investments in life joint ventures from 50% to 51%.

These moves by the CBIRC follow a 20 July 2019 directive by the Office of the Financial Stability Development Committee of the State Council. The directive, titled "Relevant Measures on Further Expanding the Opening of the Financial Industry".

According to a report by *Securities Daily,* a CBIRC spokesman said, “We hope that existing foreign banks and insurance companies in China can make full use of the new development space brought about by further opening up, and continuously improve the operating vitality and management capabilities of foreign institutions. At the same time, on the basis of equality and mutual benefit, we welcome more foreign financial entities to set up institutions and conduct business in China. We will continue to steadfastly fulfil our commitments to opening up, and work hard to create an environment that is

conducive to fair competition and the development of the insurance market by both Chinese and foreign investors."

Currently, there are at least 28 foreign owned life insurers in China, with AIA being the only company to have a 100% shareholding.

TOP

Source

Interest rates biggest risk for life insurers in 2020, says Moody's - Asia Insurance Review

Low interest rates will be the biggest threat to the profitability and solvency of life insurers, according to a recent report from Moody's Investors Service.

However, this is offset by solid regulatory capital and relatively conservative investment portfolios of insurers, said Moody's which assigned a stable outlook for the global life insurance sector.

"Low interest rates are the major risk facing the sector after falling to fresh lows and forcing life insurers to reinvest maturing assets at lower yields, weighing on their investment income as well as increasing their appetite for higher-yielding and higher risk assets," said Moody's VP-senior credit officer Dominic Simpson.

From a country perspective, Moody's view Taiwanese life insurance industries as the most exposed to a prolonged period of low interest rates in Asia due to its investment returns being already below or close to the guaranteed rate and a high duration gap.

On a global level, Norway and Germany were the other two very-high countries along with Taiwan.

It is more likely that countries will move into higher-risk categories over time as the recent decline in rates places additional pressure on insurers' profitability and reduces their ability to lower credited rates.

While GDP and unemployment levels are still supportive of the life insurance industry growth, the global economy is slowing and not conducive to rising interest rates.

This has led to an ongoing shift among insurers towards less interest rate-sensitive, fee-based, capital-light products such as unit-linked and protection policies which provide some defence from low rates.

For instance, Chinese insurers have responded to falling yields and a regulatory clampdown on short-term savings products by giving greater weight to protection products, in particular health insurance.

TOP

Source

South Korea: Insurers allowed to own healthcare entities as subsidiaries - Asia Insurance Review

Insurance companies in South Korea will be allowed to have healthcare or medical service entities as subsidiaries under revised guidelines, the financial authorities have announced.

According to Financial Services Commission (FSC) and Financial Supervisory Service (FSS), insurance companies will be allowed to own a stake of 15% or more in companies. They will be able to incorporate the entities as subsidiaries where appropriate and on regulatory approval. Healthcare subsidiaries will only be allowed to deal with policyholders and the insured for now while the financial authority reviews whether to allow businesses that target a broader consumer base, reported *Pulse News.*

The revised guideline on insurance companies comes as part of deregulation measures to boost related services and expand health promotion insurance products.

Insurance companies are also allowed to provide policyholders with healthcare devices, that have been verified to have reduced insurance risk, during the insurance subscription process. For example, they can give policyholders glucometers that measure blood sugar level or oral bacteria measuring device to consumers that sign up for diabetes or dental insurance.

The financial authorities, however, have set a limit on the price of healthcare devices that can be provided to policyholders to prevent excessive sales competition. Insurers will be allowed to provide devices priced at not more than KRW100,000 ($84) or not more than 50% of the first-year premium.

TOP

Source

Japan: Stable outlook for Japan's life insurers in 2020 - Asia Insurance Review

Moody's Japan KK says in a new report that its stable 2020 outlook for Japan's life insurance sector is supported by strong and stable underwriting margins that will continue over the next 12-18 months.

"Underwriting margins – which accounted for around 80% of our rated life insurers' core profits over the last five years – will remain strong thanks to the industry's substantial pricing power on both mortality and morbidity products," said Mr Soichiro Makimoto, a Moody's vice president and senior analyst.

Mortality margins will remain on a slow structural decline, but their impact will be muted by steady gains in morbidity margins, which collectively will offset the challenge from prolonged ultralow interest rates.

"In addition, life insurers' capital will remain strong, supported by high profit retention and the issuance of hybrid bonds," added Mr Makimoto.

However, investment risks will rise gradually as insurers seek to boost yields in a persistently low interest rate environment, but the risks will be offset by an increase in capital, which will serve as a buffer for potential losses.

Meanwhile, the duration gap improvement will stall. With regards to Japan's ageing population, Moody's expects the impact on life insurers to be mildly credit negative, as insurers are already adopting strategies to mitigate risks by shifting away from mortality products, and focusing instead on medical and retirement products, as well as gradual overseas expansion.

TOP

Source

Australia: Govt approves lowest health insurance premium increase in 19 years - Asia Insurance Review

Health Minister Gregg Hunt has announced that the average industry premium change for 2020, which will take effect on 1 April, will be 2.92%.

This is the smallest increase since 2001 and significantly lower than the 3.8% inflation rate for medical and hospital services this year.

Health insurers submitted applications for increases averaging 3.5% last month.

From 1 April 2020, a single person will pay an average of A$0.68 ($0.47) extra per week and a family on average will pay A$1.99 more a week.

There are 37 private health insurance funds operating in Australia and Mr Hunt says that he encourages consumers to shop around to get the best deal for themselves and their families.

APRA data show the proportion of the population with hospital cover dropped to 44.2% in the June quarter this year— the lowest level since 2007. The decline is attributed to rising health insurance premiums.

The public policy think tank the Grattan Institute has warned that less than 40% of the population will be covered by private health insurance by 2030 unless reforms are affected. Currently, over 13m Australian has private health insurance.

The government supports Australians with private health insurance and invests around A$6.3bn every year in the private health insurance rebate to keep cover affordable.

TOP

Source