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INSUNEWS

- Weekly e-Newsletter

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• Quote for the Week •

"Our greatest glory is not in never failing, but in rising up every time we fail."

Ralph Waldo Emerson

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Insurance Industry

Price insurance correctly for it to work properly – Here is why - Financial Express – 23rd February 2018

Even though the mega-medical insurance scheme—Modicare?—for 10 crore households announced in the budget cannot possibly be a substitute for good primary care facilities in rural areas, there can be little doubt the scheme will do wonders once it takes off since it is well known that medical emergencies drag even non-poor families below the poverty line. Interestingly, it is not just the massive Modicare that will rely on an insurance cover, the government is already using insurance in a big way in other areas as well. The Pradhan Mantri Jeevan Jyoti Bima Yojana (PMJJBY is for life insurance) has been purchased by 5.3 crore people at an annual premium of a mere Rs 330 per person, and Pradhan Mantri Suraksha Bima Yojana (PMSBY covers personal accidents) has been bought by 13.37 crore persons at an annual premium of Rs 12 per person. And though the overall area insured under the Pradhan Mantri Fasal Bima Yojana (PMFBY) has increased by a modest 6.5% between 2015-16 and 2016-17, the number of farmers insured has increased by 20.4% (from 47.5 million to 57.2 million) and the sum insured by 74% (from Rs 115,430 crore to Rs 200,620 crore) over the same period.

But if the various insurance plans are to succeed, the government has to relook some of these schemes to ensure they are priced correctly—if they are not, insurers are certain to be out of pocket and the scheme will then die a natural death. A report in Business Standard points out that while the government has estimated Modicare will cost around Rs 1,000-1,200 per family per year, 30 non-life insurance firms in the country have written to the finance ministry saying the premium needs to be at least Rs 2,500 for the scheme to be viable. The report is not surprising since, as this newspaper has pointed out in the past, most schemes are either terribly under-provided for or are simply not delivering. The current medical insurance, Rashtriya Swasthya Bima Yojana (RSBY) that has been bought by 3.6 crore families, has been ineffective in reducing the burden of out-of-pocket spending on poor households precisely because it is under-provisioned for.

In the case of the PMJJBY, while LIC charges a premium of Rs 1,529 per annum to a 20-year-old for a 20-year cover for Rs 6 lakh—going up to Rs 6,273 for a 45-year-old —this scheme charges a mere Rs 330 for everyone between 18-50. And as compared to Rs 100 per Rs 1 lakh of personal accident cover from non-life insurers, the PMSBY charges a mere Rs 12 per year for a Rs 2-lakh cover. As compared to a premium of Rs 1,028 crore for the life policies in FY17, its second year of operations, the claims were for Rs 1,249 crore, giving it a claims ratio of over 120%. In the case of the personal accident policy, the premium collected was Rs 120 crore and the claims Rs 205 crore, giving rise to a 171% claims ratio.

Ironically, while these schemes are under-provided for, some health insurance schemes such as the ESIC that blue collar workers have to mandatorily pay for, ESIC's reserve fund was Rs 49,358 crore as on March 2016; in FY16 alone, the surplus was Rs 6,497 crore—for a person whose average income is Rs 10,000 per month, the ESI costs Rs 7,800 a year for hospital expenses while a group insurance cover of Rs 2 lakh would cost Rs 5,000 a year and will cover both out and inpatient costs. While premiums on the various PM schemes need to be raised—and maybe even get citizens to pay more—workers need to be given cheaper alternatives to schemes like ESIC.

Source

Paytm floats two new insurance entities – Mint – 22nd February 2018

Digital payments firm Paytm, owned by One97 Communication Ltd, has registered two new insurance units with the Registrar of Companies (RoC), implying a foray into standalone insurance products.

The two entities—Paytm Life Insurance Ltd, and Paytm General Insurance Corporation Ltd— registered on 21 February, indicate the company will look at offering differentiated insurance products like health insurance, motor insurance and others.

According to RoC, the company has three directors One97 founder Vijay Shekhar Sharma, senior vice president-Paytm Shankar Nath and Paytm chief financial officer Madhur Deora.Mint could not ascertain the ownership structure of the company. Paytm declined to comment.

As per regulatory norms, non-life insurance and general insurance products require separate registrations.

Mint reported in November 2016 that One97 planned to sell products such as loans, insurance and wealth management to drive revenues. Paytm was in active talks with banks to offer financial products like insurance, loans and mutual funds to Paytm Payments Bank account holders.

Paytm Payments Bank started operations in May last year, with its first branch in Noida. It offers a zero-balance savings account with facilities like online transactions, debit card and a 4% per annum interest on deposit of up to Rs lakh.

In January, the company launched a new investment arm named Paytm Money Ltd to offer investment and wealth management products. It also pledged to invest close to $10 million upfront in the new entity. Paytm Money is yet to get approval from the Securities and Exchange Board of India (Sebi).

Source

Paytm Money is the fourth product from One97 after its online shopping product Paytm Mall, Paytm Payments Bank and Paytm wallet. Paytm's owner One97 was valued at over $7 billion in May 2017 when the company raised $1.5 billion from SoftBank. The company currently has over 200 million registered users on its platform.

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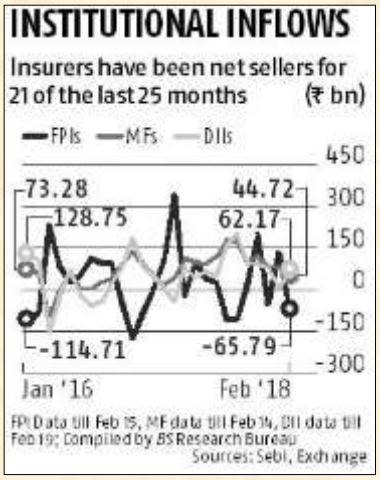
Domestic insurers play contra as mutual funds lap up shares – Business Standard – 21st February 2018

Domestic insurers have largely remained on the sidelines even as mutual funds (MFs) have stepped up their purchase of shares in the past two years. MFs have bought shares worth Rs 1.8 trillion from January 2016 to date. Domestic institutional investors (DIIs) as a category, which mainly comprise MFs and insurance companies, have purchased less than Rs 1.3 trillion. This means insurers have remained net sellers during this time, with estimated sales of more than Rs 400 billion.

Rich valuations and redemption requests from investors, predominantly in unit-linked insurance plans (Ulips), had led to the outflows, experts said. Insurers are one of the largest drivers of Indian stocks, besides foreign portfolio investors (FPIs). In the past, insurance firms such as Life Insurance Corporation of India (LIC), the country's largest insurer, have helped prop up the market against steep falls.



According to experts, Indian stocks have become expensive and there is a bias away from the same. Insurers have been cautious as the market has run up significantly in the past two years. Corporate earnings have also failed to meet expectations for several quarters now, which have dampened the buying sentiment of insurers.

"Insurers are long-term players and they do not try to outperform the market month-on-month. If they feel the valuations are expensive they would be more than willing to stay away," said Aneesh Srivastava, CIO, IDBI Federal Life Insurance. "For MFs, a lot of asset chasing happens when the market is good, and that is when a lot of short-term money is deployed. That is not the case with insurance."

In 2017, the BSE Sensex rose about 28 per cent. During this period, FPIs bought net shares worth Rs 528 billion, while MFs have shopped for stocks worth Rs 1.2 trillion. DIIs have purchased Rs 882 billion worth of shares. Insurers have sold shares worth about Rs 300 billion. Ulip investors have a tendency to withdraw once their lock-in period is over, especially if the market is at high, according to experts. The asset allocation in Ulip products varies from customer to customer, but typically about 75 per cent is invested in stocks. Traditional products such as term, endowment, and whole-life policies are more long term, and have 5-20 per cent invested in stocks. These products are driven more by fund managers than by investors.

FPIs have historically been the dominant player in Indian equities, given their size and trading patterns. However, that has changed in the past couple of years with DIIs, particularly MFs, stepping up purchases, and providing much-needed support to the market. A rise in the share of domestic investors reduces dependence on the more volatile foreign inflow.

In the last two calendar years, equity schemes have seen monthly inflows of Rs 40-60 billion via systematic investment plans (SIPs). MFs have pumped Rs 1.6 trillion into Indian equities during the period, more than twice the Rs 714 billion put in by FPIs.

"The equity investment culture is rising and is taking a more formal form. Most new-age investors are professionals earning a livelihood in other industries; stock markets are simply a vehicle for their savings. Given the lack of expertise, resources and time, these investors are investing through insurance schemes and MFs," Jefferies said in a note.

Source

Back

From insurance to farm: Policy tweaks dilute govt's initial resolve - The Indian Express – 20th February 2018

For a government that had laid down the dictum of "Minimum Government, Maximum Governance" upon taking office, the spate of administrative intrusions for tweaking rules for businesses across sectors seems to be in clear divergence with its stated motto.

The latest in a growing list of such interventions is the draft IRDA (reinsurance) Regulations, 2018, which, instead of further opening up the sector, explicitly proposes an "order of preference" that places the country's largest reinsurer, GIC Re, at the top of the pecking list in several areas of business, followed by foreign reinsurance branches (FRBs) in India in the second tier, while the third preference, in case both Indian reinsurers and the FRBs concur, would go to cross-border reinsurers. The provision of the first right of refusal for Indian reinsurers and FBR, as provided in the draft, clearly tightens the regulatory framework in favour of players already established in the country.

Earlier this month India's drug pricing regulator, the National Pharmaceuticals Pricing Authority (NPPA), reviewed coronary stent prices after a year of having slashed them by as much as 85 per cent. Despite overwhelming evidence that the price caps were not working, instead of letting the market decide prices, the NPPA further tightened the price of drug eluting and biodegradable stents, while marginally relaxing the cap on bare metal stents. In addition to stents, it also capped the prices of other products used in stenting, including the guidewire, balloon catheter, etc.

There have been other interventions in the medical sector. On January 28, 2016, the finance ministry withdrew concessional customs duties on 76 specified drugs through a notification "to eliminate the disadvantage to the domestic manufacturers of such drugs". Subsequently, with the Ministry of Health and Family Welfare citing an impact of the move on the prices and availability of these drugs, the concession of customs duties on three drugs — Octreotide; Somatropin; and Anti-Haemophilic factor concentrate VIII & IX — was restored through another notification on February 17, 2016.

Incidentally, the provision announced in this Budget that assured a wide range of crops a profit of 50 per cent over the cost of inputs and imputed labour through minimum support prices is a throwback to cost-plus approaches of earlier decades that clearly failed in the agriculture sector. While this deviates from the principle of subsidising the farmer and not the crop, this comes at a time when other sectors such as power that have followed the cost-plus interventions have now shifted to the market-based auction route for tariff determination. The Budget interventions such as the hike in Customs duties on 46 items too marked a "calibrated departure" from the underlying policy of reducing import duty over the last two decades, while thwarting a proposal to further harmonise the peak customs duty at 7 per cent with the aim of both bringing the import tariffs in line with ASEAN duties and addressing the issue of "duty inversion" — when the tariffs on finished goods are lower than that on components and raw materials — that hurts domestic manufacturing.

The duty hikes in the Budget were not isolated instances of interventions by the government. Earlier, on June 30, 2017, a notification was issued to slap a basic customs duty on smartphones of 10 per cent effective from July 1, making imported devices more expensive than locally made ones. The department of revenue said that the government took the decision "on being satisfied that it is necessary in the public interest so to do." The duty covered cellular mobile phones and specified parts of cellular mobile phones like charger, battery, wire headset, Microphone and Receiver, keypad, USB Cable etc.

Then on December 16, 2017, another notification was issued to raise customs duty on imported mobile phones, television sets, digital cameras, microwave ovens, LED bulbs and a number of other electronics goods. The duty on push-button phones and mobile handsets was raised to 15 per cent from 10 per cent and that on TV sets to 20 per cent from 15 per cent.

A senior government official had defended the decision by stating that this was being done "to protect our MSME" and that there was "a marginal rate increase". "The idea is that there are countries of the world…who try to systematically dump those goods, which are manufactured only by MSMEs in India…that's why the government has to proactively protect their interest by marginal increase in the customs duty," the official had told The Indian Express.

Experts, however, said that the customs duty interventions will certainly affect trade. "The customs duty interventions by the government both by the duty increases announced in the Budget and the changes announced on certain products after the Budget would certainly have an impact on trade. While the ostensible reason appears to be promotion of manufacturing in India, which may take some time depending on the product, businesses will need to grapple with the short term effects of the changes," M.S.Mani, Partner, Deloitte India said.

There have also been duty interventions in the solar power sector, despite protests from the nodal ministry. In September 2017, a duty on solar panels was imposed following a notification from the Central Board of Excise and Customs in September 2016, under which solar panels and modules generating power have been classified alongside "electrical motors and generators" under the Customs Act, thereby attracting a 7.5 per cent duty. They were earlier listed with "diodes, transistors and similar semiconductor devices, photosensitive semiconductor devices, including photovoltaic cells, whether or not assembled in modules or made up into panels," where import were duty free. The implementation of this levy began a year later in September 2017 at some ports and comes despite opposition from the New and Renewable Energy ministry.

The stock markets too have resorted to interventions that queer the level-playing field. The two premier exchanges in India, BSE and NSE, have joined hands to end licensing agreements with all foreign exchanges. Consequently, NSE and BSE will stop offering live prices with Singapore and Dubai exchanges, respectively, the main aim of the move is to stop Singapore Exchange (SGX) from starting stock futures.

Under the new indirect tax regime of Goods and Services Tax (GST), even as the taxpayers got an upper hand for self-compliance in the returns filing process, the government acted against profiteering by companies. Consumer goods companies such as Hindustan Unilever Ltd were served anti-profiteering notices, following which HUL even deposited an amount of Rs 119 crore with the anti-profiteering authority. As per the latest official figures, 221 anti-profiteering applications have been received by the Standing Committee and State Screening Committees as on January 31, 2018 and notices of initiation of investigation have been issued in 9 cases involving 52 applications.

Industry has been seeking more clarity regarding the anti-profiteering rules, especially the applicability of the anti-profiteering provision in case the input costs went up or the businesses suffered genuine losses in the

transition to the new indirect tax regime. It was this fear of return of inspector Raj which had prompted the Chief Economic Adviser Arvind Subramanian to suggest a sunset clause for anti-profiteering when it was initially proposed in the GST Council meeting in June last year. Subramanian had then moved a suggestion seeking the insertion of a sunset clause of nine months or a year in the anti-profiteering rules to limit the provision citing fear of return of a "raid raj". Subsequently, a sunset clause of two years was incorporated in the anti-profiteering rules.

On the direct tax front, the Budget announcement to levy Long Term Capital Gains (LTCG) tax also attracted criticism from several quarters including the indirect reference by the Reserve Bank of India Governor Urjit Patel. Patel, in the central bank's sixth bi-monthly policy press conference on February 7, said that multiple taxes on capital impact investment and savings decisions. "The other thing that we need to keep in mind is that the taxation on capital in India is from several sources and I think that at the marginal rate it absorbs. So, just from the back of the envelope, you have a corporate tax rate, you have a dividend distribution tax rate, for dividend income above 10 lakhs you have the marginal tax rate, which is, whatever bracket people come in, that would be at the highest level, you have a securities transaction tax and you have a capital gains tax. So, there are five taxes on capital and that would obviously also have an impact on investment and savings decisions," Patel had said.

Source

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India: Inadequate skilled workforce a huge challenge to insurers – Asia Insurance Review

The Indian insurance sector today faces the challenge of limited expertise and skilled workforce, says Mr Antony Jacob CEO of Apollo Munich Health Insurance. In an article in *Businessworld*, he wrote that a skilled workforce is required for risk based underwriting, creating innovative products that will appeal to people. Niche high-end skills in complex and highly-specialised areas such as risk management, credit evaluation and financial engineering are also in demand.

The lack of suitable candidates needed to handle such functions is the biggest challenge employers facing today. A recent survey estimated that there is a need of at least 2.1 million insurance educated employees by 2025. There is also a lack of awareness among students and young professionals about national and internationally recognised certifications and training for skill development. A recent market research reveals that awareness level of internationally recognised certifications and training is medium among young professionals, though there are many firms offering such courses.

Mr Jacob says that despite building excellent educational institutions, the insurance industry is struggling hard to meet skill requirements. This is because the current education system does not consider the component of skilling in its curriculum, which in turn fails to churn out a skilled workforce necessary for the industry. Most Indian educational institutions continue to follow the traditional approach to teaching that is based on content delivery rather than on knowledge delivery. All these have created a huge gap in what the industry needs and the output of educational institutions.

More than 700 million Indians are estimated to be in the working age group (15-59) by 2022, of which more than 500 million will require some form of vocational or skill training. Statistics also show that 47% of graduates in India are not employable due to lack of English language knowledge and cognitive skills. For skilling to take wings, integration of skill development and education is essential.

Digital and self-learning

At a time when businesses are focusing on digitalisation, it is important for employees to look at self-learning online to stay relevant. In today's environment the individual has to be aggressive about their own skill development in order to prove that they can deliver at a time when digital technologies are fast developing.

A fourth industrial revolution is dawning in the insurance sector with telehealth, mobile health, wearables, artificial intelligence (AI), machine learning, etc changing the business landscape. There will be greater depth and breadth of analytics talent throughout organisations.

Though insurers are learning new skills to stay competitive, and using technology to enhance customer experience, they face a paucity of talent in building the analytical capabilities necessary for today's business, says Mr Jacob.

Source

To meet the talent crunch, insurers need to effectively use the emerging tech platforms. Both industry and educational institutions must work together to create a ready talent pool.

Life insurance

Now you have to link your Aadhaar with postal life insurance policy - The Economic Times – 22nd February 2018

While the petition challenging Aadhaar is still being heard by the Supreme Court, the government is continuing its drive to make it mandatory for more and more schemes.

In its latest move in this drive, the government has issued a notification dated 15 February, 2018 asking all the postal life insurance (PLI) and rural postal life insurance (RPLI) policy holders to provide their Aadhaar details in their existing insurance policies. The notification also makes Aadhaar mandatory for all new insurance policies that will be issued in the future.

The notification says, "where Aadhaar number has not been assigned, the proposer/ insurant shall submit proof of application of enrolment of Aadhaar." An individual is required to submit his Aadhaar details to the Central Processing Centre (CPC)/ Post Office concerned.

Although other financial products and services like bank accounts and mutual funds are required to be linked with their Aadhaar by March 31, 2018, the notification regarding the postal insurance plan does not specify any such deadline by which existing policyholders will have to submit details of their 12-digit unique identity number.

The Aadhaar court case

The March 31 deadline is fast approaching but the Supreme Court is still hearing arguments to decide the constitutional validity of Aadhaar. However, the government has been making amendments to make Aadhaar necessary in our lives. Last year, government amended the prevention of money laundering rules (PMLA rules), making Aadhaar mandatory for every financial transaction of Rs 50,000 or above along with PAN.

Similarly, in the last budget, the government had amended the Income Tax Act making linking of PAN with Aadhaar mandatory and to provide Aadhaar details while applying for new PAN. Providing Aadhaar details while filing of income tax returns has also became a must.

Currently, an individual is required to link Aadhaar details with bank accounts, PAN, mutual fund folios, insurance policies, post office savings schemes by March 31, 2018. Apart from this, an individual is required to re-verify his mobile number using Aadhaar by this date.

Source

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Top 5 things to consider after you buy any life insurance – Mint – 20th February 2018

As we head towards the end of the financial year, it's quite likely you're going to buy a life insurance policy. Many Indians favour life insurance for the triple benefits of tax savings, investment, and life cover. Let's take a look at some essential steps to take once you receive the policy document in your hand. If there is something amiss with it, you can take immediate corrective actions and save yourself trouble down the road.

Is the policy as per your expectations?

With the sheer range of life insurance products out there, it's easy to get things mixed up. Perhaps you wanted a term plan and ended up with a unit-linked insurance plan (Ulip). Perhaps you wanted a child education plan, and received a retirement plan. Make sure the policy is what you had expected it to be. Check the key policy benefits such as sum assured, policy term, and the premium amount and ascertain they are as per your expectations. If you have doubts, call the insurance company and get your answers.

Are the personal details, nominee details correct?

If you have shared your personal and nominee details correctly, it would lead to a smooth claims process. Remember that you will not be around when a claim is made. It is your family who will need to bear the brunt of any mistakes in the policy details. Therefore, check if your policy document contains all your personal information, bank details, contact details and nominee details correctly. If not, you can contact your insurer to have these corrected as soon as possible. This will help avoid any confusion during the claims process.

Have you told your nominees?

Your family would make an insurance claim in your death. While they are grieving losing you, they should be spared the additional strain of not knowing what monies you have left behind for them. Whenever you buy a

new life insurance policy, always inform your nominees about it. The policy document should be stored in a safe place accessible to your nominees. Additionally, you must also explain to them the benefits of a policy.

Automate premium payments

If you have several insurance policies, keeping track of their due dates will be undoubtedly exhausting. You can save yourself these hassles by automating your premium payments via your bank or credit card. This will ensure that your policy remains in force and your nominees receive its benefits. Also, evaluate your life cover periodically. Ideally, you should do it once every five years so that your life cover is in tandem with your lifestyle, income, and family's long-term money requirements. If it's not, buy additional covers.

Unhappy with policy? Use free look period

It is possible that you are not satisfied with your policy or have been sold a product you did not want. There is recourse for you. However, you must act fast. You can get a refund by simply returning the policy within 15 days, or 30 days in case the policy is issued through a distance marketing channel.

Source

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Insurers seek ways to harness blockchain – The Economic Times – 20th February 2018

The life insurance industry came together on 19th February 2018, Monday to discuss blockchain technology that will enable them create a safe repository of records to rein in costs for running medical tests and evaluations, ensure confidentially and security of data collected from individuals, and reduce frauds in the system.

With the help of the technology, the industry will be able to create a safe repository of records, including medical records for potential and existing policyholders which will be accessible to all insurance sector organizations joining the platform. This will help in bringing down the number of medical procedures that any prospective policy holder will have undergo while purchasing policies from different companies.

"The purpose of blockchain is that nobody should lose money because of not knowing some signals and nobody should be allowed to do fraud," said Nilesh Sathe, member of the Insurance Regulatory and development Authority. Blockchain will make it difficult for anyone to tamper the system. While a company can have its artificial intelligence or robotics, blockchain technology demands greater collaboration between companies for it to work efficaciously.

Sathe refereed to case of multiple claims being made which were fraudulent and settled by some insurers because of lack of co-operation in the industry. "we will form a small working group among some companies and then take up three-four ideas to roll out the blockchain," said Arijit Basu, MD of SBI Life.

Regarding reservations over sharing data, Basu said that the data cannot be tampered with by any outsiders. "We have to identify areas in which we have to share data," said Basu. "The reservation is when we think our customer can be weaned away to another insurance company. That is the concern but we can co-operate in many areas where it may not happen."

The Economic Times

The Insurance Information Bureau (IIB) has become very active in having a common repository. IIB has been talking with insurance companies to collaborate information. "In the next 3-6 months, we will come up with some idea. We will go to the regulator with the plan," said Basu. "We have not issued any guidelines and we do not want to come upwith guidelines right away," said Sathe. "If it does not shape up, we will ask insurers to join the chain."

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General Insurance

NCDRC dismisses plea of insurance firm – The Hindu – 22nd February 2018

The National Consumer Disputes Redressal Commission (NCDRC) on February 15 upheld an order passed by the Haryana State Commission and dismissed a plea filed by National Insurance Co. Ltd justifying the repudiation of a claim for insurance cover on a stolen vehicle.

The national forum held that the insurance company "was expected to make a clear stipulation in the insurance contract". Previously, the Rohtak district forum had directed the insurance firm to pay the complainant over ₹6 lakh as cover for a vehicle which was stolen within a year being insured.

Vehicle not registered

The insurance firm had contended that the claim was repudiated as the vehicle had not been registered within the stipulated period of time, which was in violation of the Motor Vehicles Act. "It was pleaded that non-registration of a motor vehicle with the transport authority is a violation of [relevant sections] of the Motor Vehicles Act, 1988, as well as the terms and conditions of the insurance policy. Had the vehicle been registered, it would have been easy for the police to trace the same. On the aforesaid allegations, the opposite party justified the repudiation of the insurance claim," observed the NCDRC.

However, the commission held that the repudiation of the claim based on "the commission of offence" under relevant sections of the Motor Vehicles Act "prior to the theft" was not justified.

Source

"The company, instead of providing the insurance cover for one month, issued the policy for one year and charged premium without making it clear to the insured that in case the person failed to get the vehicle registered within a month from the date of purchase, the cover would stand withdrawn," the NCDRC said.

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How banks must use insurance to cover risks – Business Standard – 21st February 2018

The Indian banking sector has been attracting lot of public attention of late. Be it the recent fraud reported at a major public sector bank, NPA resolution, the need for recapitalization and the impact on fiscal deficit or rising cyber-crime.

But before we look into various risk issues, let me make a provocative statement on the state of the Indian banking industry and the use of insurance as an effective risk transfer solution: The banking sector in India is largely not buying insurance covers for the risks which it needs to transfer: rather, it is buying insurance for the risks it doesn't need to transfer. This may sound disturbing for any stakeholder of the bank and I would attempt to explain this below, given my experience of cover 15 years as risk and insurance advisor.

We all know that the real value of insurance is to transfer low-frequency and high-severity risks, that is, big risks which could impact the net profit or balance sheet of an organization.

Typically big risks for banks and financial institutions can be categorized as credit risk, market risk and operational risk. Operational risk is most suited for using insurance to transfer the risk. Fraud/crime accounts for almost 85 percent to 90 percent of the big losses in the operational risk for Indian banking sector and globally also it remains the biggest threat. Professional indemnity and management liability ranks as another major risk for banks globally. Cyber risk is the biggest emerging risk for the sector.

Most banks in India either do not have any coverage for the top three operational risks as stated above or even if they have some restrictive cover, the limits purchased are abysmally low ranging from around Rs. 20-50 Million and in some cases going up to Rs. 250 million. Globally, for similar sized banks., it is common to see crime insurance cover of $100 million to $500million limits and more. Interestingly, the deductible in such a global insurance programme is around Rs. 50 million, which is the size of insurance purchased here locally in most cases.

Crime/fraud insurance with proper limits remains the biggest risk exposure not covered adequately by Indian banks. There is an inherent legacy when it comes to insuring crime. Generally, most banks are uncomfortable in sharing data about employee frauds. Besides, a delay in getting a final police report on the fraud acts as an impediment against processing claims. Given the severity of this risk, banks need to become comfortable in opening up with the insurers so that they can provide a meaningful solution to this risk.

Cyber security is the biggest emerging risk and not many banks till date have a robust cyber insurance programme. Only four private sector banks and two public sector lenders have cyber risk insurance programmes but the limits in most of them are on the lower side compared to the potential risk exposure.

The professional indemnity risk and management liability, which can potentially cause major losses, are not addressed by most banks insurance programmes. Private sector banks with foreign listings have reasonably good protection with directors and officers (D&O) liability insurance. The new Companies Act in India also empowers class actions. Any major impact on the share price of a bank due to alleged negligence by the management can also trigger class action suits and claims by investors. So the absence of a proper D&O policy in most banks is a cause for concern.

The question to ask is, if a major operational risk loss was to happen in India, will the insurance policy protect the investors and other stakeholders? With the current coverage and limits, the answer is clearly "no".

Most banks are buying insurance for small operational risk like theft, burglary, laptop, glass plates etc. with very small limits which they need not buy. Banks, by their, nature is in the business of providing capital and taking risks. Using insurance for such a low-value risk item is a bad financial decision and waste of time and administrative costs. It is simply trading rupees between banks and the insurance company without any real risk transfer. Banks should self-insure such risks.

It is interesting that the Reserve Bank of India (RBI) proactively came up with risk mitigation suidelines in 2014 under the Basel-II framework. It allowed capital relief of up to 20 per cent of the total operational risk capital of a bank, provided the bank carries out a true assessment of their entire operational risk (advance management approach) and buys a prescribed quality insurance programme. The banking sector can have lower capital requirement of several thousand crore with capital relief under these guidelines.

Given the challenge on fiscal deficit and a need for recapitalization post the NPA restructuring under the bankruptcy code, buying adequate insurance cover can considerably reduce the operational risk exposure and help in capital preservation for banks.

Business Standard

The recent fraud at a major public sector bank could be a wakeup call for the entire banking sector in India. It is about time for the regulations to revisit banks' strategies on the operational risk management framework and the use of insurance market capital with minimum level of insurance coverage and limits commensurate with risk exposure. This can be advised by RBI proactively to de-risk the banking system before we are faced with a crisis.

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Impossible to say which is the best insurer in India – Mint – 21st February 2018

Writer Kapil Mehta is co-founder of SecureNow.in

It is often difficult to analyse who the best insurers are. While some of the information is available that can be studied, much of it is not; and even if it is, it isn't available in aggregate form.

I am often asked who the 'best' insurers are? I try to dodge that question because the answer requires a detailed analysis of what one is looking for. When Alice in Lewis Carroll's stories asks which way she should go, the Cheshire Cat wisely replies, "That depends upon where you want to get to." Insurer selection, however, would have flummoxed the Cheshire Cat because in insurance, even if you know where you want to get to, it is hard to get the data that helps you find your way.

Let's say that you want an insurer who has the best claims record. For that you must know the claim settlement rates by product, claim payment times, claim complaints, extent of litigation, who wins the legal cases and how often the insurer pays interest on late claim payment. Some of this information is available but much of it is not, or is available in aggregate form. For example, you can get overall claim settlement rates but these are not published by product. Details of litigation are not available though I'm sure an enterprising analyst could go to all the district, state, consumer and ombudsman courts to put this together. There are other relevant areas where no information is available. For example, in the quality of policy placement. This is an important consideration because every single insurance buyer is impacted. The requirement here is to measure items such as clarity of coverage, error-free policy contracts and timely endorsements, but there is no public information on these.

The Insurance Broking Association of India (IBAI), where I am a director, decided to address this lack of synthesized information by developing a robust measure of an insurer's performance on policyholder-friendly metrics. The focus was on general and health insurers where brokers distribute over 25% of insurance. Life insurers and new insurers without a long track record were excluded from the study. Brokers represent clients through a formal mandate; typically, they work with several insurers and get a privileged view into insurance processes such as placement, grievance handling and claims that are required to evaluate an insurer's performance. We identified four criteria. Claims and grievance were given the highest weightage of 40%, followed by policyholder and broker orientation, quality of policy placement and domain knowledge. Each criterion was further split up into smaller measures. Overall, 40% of the total score was based on quantitative information from public disclosures and 60% on a broker survey. The survey was introduced to capture feedback on measures where public information was unavailable or not consistently measured across insurers.

The design was such that no single measure or survey result could swing the overall outcome. We got responses from 150 brokers and the survey was filled out by their founders, directors or senior executives. The results showed wide variation among insurers, from a high of 88% to a low of 13%. There was strong correlation between the quantitative assessment and survey results.

The top quartile general insurers were recognized and awarded earlier this year. They were, in alphabetical order, Bajaj Allianz, Future Generali, HDFC, ICICI Lombard, Iffco Tokio, New India and Tata AIG. This exercise will be repeated each year to be an additional perspective for the industry and buyers. Not all awards are created equal. I have been on some juries where assessment has been extremely superficial. Readers would do well to consider only those awards seriously that have been peer-reviewed, have a quantitative foundation, do not require payment and are objective. Such awards nudge companies to improve and focus on policyholders. On a separate note, there are some headwinds for the industry coming up. All bank accounts need to be linked to Aadhaar by 31 March 2018 to remain operational. Over the years, the Electronic Clearing Service (ECS) mandate has been used widely by the industry to collect renewal premiums automatically. If these ECS mandates become invalid because of lack of Aadhaar linkage, there could be substantial unintended insurance lapses, which is terrible for policyholders.

The other development that would have significant implication is the introduction of the National Health Protection Scheme. There are many cost estimates but my assessment is that the scheme will cost far more than what is budgeted for. Most likely this scheme will be larger than the entire health insurance industry today. When fully implemented, it will mean that over 10 million more people may want to be hospitalised in private hospitals. Health insurers and hospitals will need to significantly scale-up to participate in this scheme and ensure that they are a part of the government's implementation plan. The large number of current and proposed public listings suggests that scrutiny of an insurer's financial performance is likely to increase significantly. The markets will look carefully for the source of profits. In the case of general insurers, this is typically due to investment rather than underwriting. Such scrutiny will put pressure on insurers to increase premiums, which in turn, will impact customers.

Source

Finally, a new chairperson of the Insurance Regulatory Development Authority of India (Irdai) will be announced shortly. Given the highly regulated nature of insurance, all eyes are on North Block.

Back

An insurance for threats from the cyber world – Mint – 21st February 2018

The Bajaj Allianz Individual Cyber Safe policy covers 10 types of risks related to identity theft, social media, cyber stalking, IT theft loss, cyber extortion, and privacy and data breach by a third party, and more.

Bajaj Allianz General Insurance Co. Ltd has a new insurance policy to cover the risks coming from cyberspace and social media. Called the Bajaj Allianz Individual Cyber Safe policy, it covers 10 types of risks related to: identity theft, social media, cyber stalking, information technology (IT) theft loss, malware, phishing, email spoofing, media liability, cyber extortion, and privacy and data breach by a third party. The sum assured ranges between Rs1 lakh and Rs1 crore. Excluding taxes, premium is between Rs 662 and Rs 8,933. Sub-limits up to 25% apply to all the covers. It also covers payments to consultants for proving the extent of loss, court expenses and reasonable legal fees.

What is covered

Under the identity theft, social media and cyber stalking covers, insurer covers costs of prosecuting a criminal case against the concerned third party. In the IT theft loss cover, you can claim damages against a financial institution or payment system operators.

Let's take a person who has saved credit card details in a computer, and these details get stolen and are used for fraudulent transactions. "Upon investigation, if the culprit gets caught and the policyholder decides to file a criminal suit, insurance company will pay for prosecuting the claim," said Sasikumar Adidamu, chief technical officer, Bajaj Allianz General Insurance. Any financial loss suffered by the policyholder, subject to sum insured limitations, will also be covered.

The malware, phishing, email spoofing and cyber extortion covers take care of losses due to these activities. The policy also covers costs incurred for psychiatric or psychological counselling for stress or anxiety resulting from the covered events. However, all these costs covered have a sub-limit. Except IT theft loss cover, phishing cover

and email spoofing cover, which have a sub-limit of 25%, 25% and 15% respectively, all other covers have a sub-limit of 10%. Further, only one kind of claim can be raised at a time.

What is not covered

The policy will not cover 'dishonest or improper conduct', which means deliberate, criminal, fraudulent, dishonest or malicious act or intentional violation of any duty, obligation, contract, law or regulation or any losses that are caused intentionally and against the law.

However, if the insured is accused of improper behaviour and final decision of a court is pending, the insured can claim cost of defence. If the court establishes improper behaviour of the policyholder, the money will have to be repaid to the insurer. The policy also defines 'duties of the insured'. These include measures by the insured to avoid any cyber attack, such as: having an updated antivirus, regular backup of data, and employing 'best practices' for passwords. Failure to observe these can jeopardise your claim, though the insurance company can waive these conditions.

Mint Money take

Your need for this policy would depend on your exposure to social media and cyber-world, said Akshay Garkel, partner, Grant Thornton India LLP. "As a end user, I would subscribe to this policy. Though I would go for a basic policy initially. To quantify what amount will be sufficient is difficult. My exposure to social media and internet and dependence on it is proportional to the cover that I should subscribe to," he said.

"The exclusions are very subjective and have open-ended terms and can have multiple interpretations. More clarity on these could be helpful," he said. If the exclusions are a worry, Garkel said that the best way to deal with those is to approach the cyber cell of law enforcement. If it accepts your complaint and certifies it as valid, you have a stronger case.

Source

Back

Indian firms look for cyber security cover - The Economic Times (Bangalore edition) – 19th February 2018

With the rise in cybersecurity attacks in the last few years, companies from across sectors like manufacturing, auto, IT, BFSI and other government bodies are now pouring millions into buying cyber insurances. In India, however, only a handful of companies have started selling the product including Bajaj Allianz, Marsh among others.

For the uninitiated, cyber insurance is an emerging insurance product which protects businesses and individual users from internet-based risks like ransomwares, cyber frauds, phishing attacks, etc. Cyberattacks targeting businesses nearly doubled in the past year, from 82,000 in 2016 to 1,59,700 in 2017, according to Online Trust Alliance (OTA), an internet society initiative.

"There has been an uptick on cyberinsurance purchases in the last 18 months," said Anup Dhingra, senior vice - president-FinPro from Marsh. He further cites that the high cost of this insurance may be an additional factor which is stalling its growth when compared to other insurance products.

Interestingly, these insurances are now also opening opportunities for cyber security companies and ethical hackers. After an attack happens, when the claim is made by the insurance-customer, a process of forensics follows.

This forensics is majorly done by reputed cyber security companies and is now welcoming ethical hackers to mitigate the deal. "80% of these forensics are usually outsourced as per requirement. When a company pays millions, they expect the best talent to review it," Dhingra said. Singapore is usually a preferred destination to outsource such jobs.

When compared to global counterparts, cyber security is still quite nascent in India and a robust infrastructure is yet to be built. Sasikumar Adidamu, chief technology officer at Bajaj Allianz, said these factors eventually increase the cost of cyber insurances.

"Typically, a cyber insurance will cost you a minimum of ?10 crore which can go upto $100million. But, now we are building a network of ethical hackers in India who understand the pain points of an attack and can help mitigate it."

According to industry estimates, 300-400 of cyber policies have been sold in India till date.

Lokhande further explains that compared to other developed countries, it still costs 10-15% lesser in India. Average cost of a cyber insurance in India is around $7.5 million. Dhingra further adds that GDPR will also boost cyber-insurance and strengthen policies.

Bryce Boland, APAC CTO of cyber security firm FireEye, said they assist companies in three areas which includes cyber security, risk underwriting, investigation or forensics.

"US is at the moment leading in this sector but APAC contributes a major share as well," he said. He said the challenges with these insurances include credibility, massive adoption of technology and shortage of talent.

Saket Modi, CEO of Delhi-based cyber security company Lucideus, said even before a cyber insurance is sold, they first check the cyber security maturity of the company and score it between 0-5 based on the strength of the company's cyber infrastructure.

"If it scores between 4-5 which is quite good, the premium of the insurance reduces. But if its not strong, the company ends up paying a higher premium for the same insurance," said Modi.

Explaining how the forensics work, Modi said they first analyse the root causeof an incident. "Based on the root cause, we find out if the company was at any fault or there was nothing the company could do to defend itself against the hack.

Source

There are a lot of "known unknown" loopholes that are impossible for any company to be able to defend itself against. In such a case, the insurance company is bound to pay," he said. "Over the last year, we have worked on almost 20 such cases," he added.

Back

Crop Insurance

Congress protests non payment of crop insurance money to farmers – The Times of India – 22nd February 2018

The Congress party on Thursday created ruckus in the Assembly over the crop insurance issue.

The party leaders were miffed at the allegations by the ruling BJP that private firms were involved in the crop insurance by the earlier UPA government.

During the discussion on crop insurance issued in Amreli, the the leader of opposition Paresh Dhanani claimed that the government had paid an excess premium of Rs 25000 crore to the private companies.

Dhanani alleged that under the new crop insurance scheme, a private firm was roped in which is now not willing to repay the insured amount to the farmers. The Government, during the discussion, claimed that only two to five percent of the premium was paid by farmers while 50% of the premium was paid by the Government and the remaining amount was government share.

Dhanani later claimed that the Government was running away from discussion on the farmers' suicide issue and said that if the government decides to discuss the issue, something positive will be worked out to prevent the farmers from committing suicide.

Source

He claimed that a question on farmers suicide was moved by a Congress MLAs but later, after admitting the same question, the government refused to bring it for discussion in the house.

Back

Government to fast-track 'Fasal Bima Yojana' with new professional team - The Economic Times – 21st February 2018

The government today said a professional team will be put in place by next month to fast- track the implementation of Pradhan Mantri Fasal Bima Yojana (PMFBY) and increase the coverage under the scheme to 50 per cent of the gross cropped area in 2018-19.

To address various gaps in PMFBY, the agriculture ministry has modified the guidelines which would be released next fortnight. The current portal has also been upgraded with new features, it added.

PMFBY was launched in 2016 under which farmers pay very nominal premium and get full claim for damages. The scheme is being implemented in 25 states. "There has been good response to the scheme. The coverage has increased. But there is more to be done. Efforts are being made to ensure more farmers take benefit of the scheme," Minister of State for Agriculture Gajendra Singh Shekhawat said at a Ficci-organised event here.

So far, 30 per cent of the cropped area has been insured but the target is to achieve 50 per cent next year, he said while urging states to cooperate in this endeavour. Joint secretary in the ministry Ashish Bhutani was of the view that the government's team is too small and a professional management should be in place by March.

Around 20-odd professionals will be hired to ensure that all issues related to PMFBY are addressed comprehensively, he added. Bhutani further said the guidelines of PMFBY are being modified to ensure all required data and the process to assess the crop damage is done faster and in a transparent manner so that there is no delay in settlement of claims to farmers.

Among the key changes being made to the guidelines, he said insurance companies will be made 'co-observers' to ensure that the crop cutting experiments (CCE) conducted by states to assess the crop damage are done properly.

At present, insurance companies suspect that the CCE data was being fudged. "So, we put in a provision of co-observing the CCEs and the data needs to be shared with companies even while in the process of doing CCE," he added.

Since part of the crop insurance premium is paid equally by both centre and state governments, Bhutani said many states are not releasing their share of premium on time, causing delay in claim settlements. This aspect is also being addressed in the guidelines.

Also, states are not providing the required crop data on time and lack of historical data is jacking up premium in some states. On the other side, insurance companies too are taking "undue time" in claim calculation, which is also causing delay in settlements, he said.

"We will issue the new guidelines on crop insurance in the next 15 days. We have taken comprehensive feedback from all stakeholders including farmers, states, banks, insurance companies. The guidelines address the gaps which were found in the implementation of the scheme," he said.

New technologies will be adopted to capture all data required to assess the crop damage on time. Even startup firms are being engaged for this purpose, he said. The portal has also been upgraded for seamless communication and data sharing among stakeholders. It will go online next week, he added.

As many as 5.70 crore farmers purchased the crop insurance policy PMFBY during 2016-17 crop year. Under PMFBY, farmers premium has been kept lower between 1.5-2 per cent for foodgrains and oilseed crops, and up to 5 per cent for horticultural and cotton crops. There is no cap on the premium and 25 per cent of the likely claim will be settled directly in farmers accounts.

Source

Back

Health Insurance

12 states have no state or central health insurance – The Times of India – 23rd February 2018

As many as 12 states, including Delhi, Madhya Pradesh, Haryana, Nagaland and Sikkim, have no government-sponsored health insurance, according to latest data with the IRDAI.

The Centre's planned 'Ayushman Bharat' could act as repreive for residents in these states, as more states have pulled out of participation in 2016-17 from the current national insurance scheme Rashtriya Swasthya Bima Yojna (RSBY), introduced by the UPA government.

For existing health scheme RSBY, the number of states participating in it has fallen to 15, the lowest since 2008, when the scheme was launched. The number of enrolled families in RSBY, which provides insurance coverage of up to Rs 30,000 for annual fee of Rs 30, has dropped to 3.63 crore in 2016-17 from 4.13 crore in 2015-16 . The number of empanelled private hospitals also came down to 4,926 in 2016-17 from 7,865 in 2009-10.

"One of the reasons for non-participation in RSBY is political expediency. Many ruling party states have opted out. Then there are states like Andhra Pradesh and Tamil Nadu, which have their own state health insurance, and

are implementing RSBY only in certain districts," said an insurance official, with a public-sector insurer participating in RSBY.

"At the ground level there have been implementation issues. Hospitals have been reluctant to treat RSBY patients. Hospitals still demand cash from RSBY card holders and hold that as guarantee till they are reimbursed from the insurer. There are delays in settlement, lack of awareness on the programme and its coverage," added the official.

Despite this, overall government sponsored health insurance has picked up and more people are being covered. In 2016-17, about 33.5 crore people were covered by government schemes, 56% higher than the 21.4 crore people covered in 2014-15. Gross premium collected has also increase to Rs 3,090 crore from Rs 2,425 crore two years ago. But the incidence of claims has also been on the rise, with claims shooting up to Rs 3,498 crore — 13% higher than the premium collected — making unsustainable over the long-term.

"Currently 33.5 crore people are having government-sponsored health insurance from the state or RSBY. Ayushman Bharat aims at covering 10 crore Indians at a proposed Rs 1,000 per family. While TN has managed to cover 3 crore people at Rs 680-699 per family. It remains to be seen if the new scheme will work parallel to existing state schemes and how much it will increase insurance penetration," said the official.

Source

Back

Tamil Nadu likely to 'opt in' for Ayushman Bharat, sources say – The Times of India – 22nd February 2018

Tamil Nadu is likely to work with the Centre for implementation of the national health insurance scheme Ayushman Bharat unlike states like West Bengal and Karnataka which have opted out of the scheme, sources said. Tamil Nadu's health officials held their first round of talks with a working group from the Centre on Friday on how best to implement the national health insurance scheme in the state, which has its own scheme.

"The Chief Minister's Comprehensive Health Insurance Scheme, which currently covers 1.57 crore families in Tamil Nadu, will not be scrapped. We are looking at how best to integrate the Centre's ideas with what is already in existence in the state," an official said.

In an earlier statement, Niti Aayog CEO Amitabh Kant said the health scheme would cost the Centre Rs 5,500 crore-Rs 6,000 crore every year. Insurance professionals said that the Centre's outlay for the scheme is quite low for coverage of 10 crore households, and Tamil Nadu has a more realistic budget for providing insurance.

"Talks with TN, might help the Centre come to a better understanding of how much a scheme of that scale would cost. For covering 1.57 crore families in TN ---about 16% of the national scheme's projected household coverage -- the state pays Rs 1,069 crore every year. In other words, the Tamil Nadu government pays about Rs 680 per family," said an official with a public-sector insurer. "Now compared to this, the 2016-17 budget allocation for the national health insurance Rashtriya Swasthya Bima Yojana (RSBY) was Rs 1,500 crore. In 2012-13, budget allocated Rs 1,096.7 crore for the RSBY, even as TN earmarked Rs 780 crore as premium for the state health insurance scheme the same year," he official said.

TN government officials said the working group from the Centre had marked out five different slabs for various states. "In the first category are states like Tamil Nadu, Maharashtra and Punjab, which have their own state health insurance scheme. The second category takes into account a plan for states such as Assam, Bihar, Gujarat and Haryana which have implemented RSBY. Then a plan for states which have opted out of the RSBY. The Centre is not taking a one size fits all approach," said the official.

"Each state has its own unique healthcare system and variations of different health insurance scheme. The Centre's working group is primarily looking at integration with existing schemes not an overhaul," said the official.

Insurance officials fear that Ayushman Bharat might turn out like the RSBY - with political affiliations having more of a role to play than an impartial assessment of whether the national scheme will help healthcare in the states. "From covering about 25 states in 2008 when it was launched, the RSBY now is present only in 15 states. Most of the BJP-ruled states have opted out of the RSBY. Likewise, with Ayushman Bharat it is likely non-BJP ruled states will opt out of it - excepting TN -- whose political situation is precarious enough that it will try to appease the Centre," said an insurance official.

Source

Premium on mega healthcare scheme to be Rs 900-1000: NITI - The Economic Times – 20th February 2018

Government's premium on insurance cover of Rs 5 lakh for every eligible household under the new National Health Protection Scheme (NHPS) would be around Rs 900-1000 per family annually, lower than the earlier estimate of Rs 1000-1,200, a senior NITI Aayog official said today.

The official further said that representatives of all states with the exception of Tripura, where the assembly elections are on, participated in a meeting on NHPS, organised by the government think tank and the ministry of health and family welfare.

"Premium for availing health insurance cover of up to Rs 5 lakh under NHPS is expected to be around Rs 900-1000 annually for every household, which will be borne by the Centre and states," the official told PTI. On whether West Bengal participated in the deliberations, he said, "Officials from the state's health department attended NHPS workshop for states on February 15-16.

"They also gave presentations. Out of 30 states, the only state that did not participate in the deliberations was Tripura, which was in poll mode." Earlier, West Bengal chief minister Mamata Banerjee had reportedly expressed apprehensions about joining the NHPS.

About 1 crore people in West Bengal would be eligible to join the scheme, the official said, adding if the state opt out, it would lose Rs 600 crore of Centre's share. Under the funding arrangement, the Centre will provide 60 per cent fund, while the remaining money would have to come from concerned states.

In case of special category states, the Centre will provide 90 per cent of fund. Earlier, it was estimated that the premium for providing healthcare to an eligible family would be around Rs 1000-1200.

Source

In his Budget for 2018-19, Finance Minister Arun Jaitley had provided an initial corpus of Rs 2,000 crore for NHPC which aims to provide medical cover of up to Rs 5 lakh to over 10 crore poor and vulnerable families, constituting 40 per cent of India's total population.

Back

ModiCare will raise insurance awareness – Mint - 20th February 2018

Report of the second panel discussionheld during Insurance conclave held on 13th February 2018

The topic was: Disruption in the non-life insurance sector that initial public offerings (IPOs) and technology can bring.

On the panel were: Gayathri Parthasarathy, head - financial services advisory, KPMG India Pvt. Ltd; Mayank Bathwal, chief executive officer, Aditya Birla Health Insurance Co. Ltd; K.G. Krishnamoorthy Rao, managing director and chief executive officer, Future Generali India Insurance Co. Ltd; Tapan Singhel, managing director and chief executive officer, Bajaj Allianz General Insurance Co. Ltd; and Rakesh Jain, executive director and chief executive officer, Reliance General Insurance Co. Ltd. The discussion was moderated by Deepti Bhaskaran, deputy editor, Mint Money.

Deepti Bhaskaran: Three companies in the non-life sector have listed. There's another one to go. How will IPOs change the game for the industry? And I'm not talking just about companies that are listed or are going to get listed.

Rakesh Jain: I think structurally, insurance is coming of age. I'm heartened to say that for the first time in 17 years—from the Government of India and the Budget—the most promising announcement is an insurance scheme. It clearly reflects that general insurance is coming up to this stature. Having said that, most of the insurers have gone through their own stages of evolution. I think companies have been, or were planning to be, listed at this point in time. Very often, the consumers and investors are going to be the same set of people. So, for an insurance company, this is the right time to make the right noise. Stature building is important because the next leg of growth is not going to be a function of just making a product or distribution. That phase is getting over. What adds further (to stature building) now is the accountability, the responsibility and obviously when companies do well, even the consumer perception about the products goes up significantly. For us, this is like a game-changing move; a move which really propels us in the big league. It gives us an opportunity to really play shoulder-to-shoulder with a bank or any other large-format financial institution.

Tapan Singhel: I'm super-excited about listing. Because for a change, I see in the market things are happening: what the regulator could not get done, nor could promoters get done—which is the discipline of underwriting. Look at the shift of companies that are listed or are going to be listed. Look at the actions they are taking in terms of cutting their loss ratios and expenses. A good disciplined business environment is always good for consumers. Listing is creating this environment; people now understand that they have to get the business right, otherwise the market is not going to give them anything.

K.G. Krishnamoorthy Rao: I think we should have expected listing because any investor who has invested in an insurance company after a certain point of time, would like to unlock the value. So the listing has happened now in this market after almost 17 years of operation. Underwriting is also coming to notice. The companies will start looking at their net combined ratio, which is the measure of general insurance industry's health. Naturally, customer will finally benefit because unless companies realise that they need to look at the customers, they will not be able to grow and that will determine their health in the stock market.

Mayank Bathwal: The real value discovery is in terms of where the value in the business lies. Getting topline just for the sake of topline, may not be as relevant as probably it was in the past. If you're making money, if you're creating value for your stakeholders or investors, I think that's where the focus will shift. And as a late entrant in this industry, we do hope we make underwriting profits at a pace faster than what we've seen so far.

Gayathri Parthasarathy: I think everybody is looking forward to listing for various reasons. One is definitely being customer-centric—how does one get there—getting the right discipline, getting the right amount of transparency and accountability which really leads to being customer-centric because then you become accountable to your investors and then finally hundred percent to your customers. So that's really a key theme.

Bhaskaran: From building an underwriting discipline perspective, the game-changing event happened more than a decade ago when the industry got de-tariffed. But that hasn't happened and now we are talking about IPOs building that underwriting discipline. Tapan, give me a perspective on why were the insurers not focusing on underwriting?

Singhel: I think some people wanted to capture the market share by thinking that they could let go of the price and recover later. That to me is a strategic mistake to be made, because in general insurance it's a yearly contract. So you really cannot capture market share by burning capital. If the only value you bring is a price discount, then the customer will go to somebody else who gives a price discount later. In the general insurance industry, you have to be disciplined from day zero. You have to be very careful on how you write the business and understand risk. It's a very technical business. Unfortunately, lots of people take it like FMCG or banking industry. It's more complex than that.

Rao: If you look globally, most of the markets, when they got de-tariffed, the rates came down and then at some point the shareholders started questioning the management. And then there was pressure on the managements to correct their bottom line. And that is how the rate started correcting. Unfortunately, in the Indian market there were two types of companies—public sector companies and private sector companies. Mostly, the public sector companies never concentrated on their bottom line as the mandate was to grow. Maybe the government looked at this as providing social security—the mandate always was to grow at whatever cost. The bottom line was never in focus. Fortunately for them, there was a large investment book that provided enough returns for them to survive. So because of that, when they were controlling around 70% of the market, it was always that they could determine where and how the market should go. Naturally, others followed. Everybody wanted to protect their market share. Maybe this is one of the reasons why this market has taken time to look at the importance of net combined ratio and the importance of generating underwriting profit.

Bhaskaran: Will IPOs and the focus on underwriting lead to price correction?

Rao: The concept of insurance itself is pooling of premium. So if you don't charge the right premium based on the risk exposure of the customer, naturally somebody else is subsidizing that. Maybe the customer who is not up to the mark, who is giving lesser premium now has to be worried.

Singhel: If you remember, a couple of months back we said that we will reduce the motor price by 10-15%. If I look at my growth, it is like 70% over the market growth, which is happening at a good pace; so the point it made was, if you are efficient and pricing is right, why should the premium go up? The issue is that the efficiencies and business mix have to come into scale.

I don't think the customer should suffer. But yes, one could see price correction if you have been operating on a combined ratio of over 100 for so many years and are now trying to bring it down. With with the new Motor Vehicle Act coming in, the pressure is very high for the companies to come below 100. Because then the reserves and the money made on reserves is going to disappear very fast.

Bhaskaran: How can technology help in keeping prices under control?

Parthasarathy: Efficiencies have to play a huge role in terms of not increasing the premium, and at the end of the day the customers need not pay extra. Technology can play a huge role in this. Look at what is our online subscription? What is the penetration? What's the adoption that we have today, compared to the expectations or the investments that go behind it? I think we are far low compared to what we should ideally be. Online can be key for customer acquisition and can bring in a lot of efficiency and also make the process easy for customers. Pricing is a very important aspect because if you price it right, then you don't need to worry about the premiums, as they are interlinked.

Bhaskaran: Will the online space bridge the information gap that exists between buyers and manufacturers?

Bathwal: In health, it is already happening. There is complete information symmetry as far as the consumers are concerned. They can go to the Policy Bazaar website or they can go to any other web aggregator site and they can compare any offering. I don't think it's an issue of availability of information. I want to bring in transparency and efficiencies from another perspective. What is it that makes underwriting profits in a health insurance company? What is your level of efficiency in expenses and what is your efficiency in managing claims? Let me pick one area of claims. When I looked at it from the outside, I always heard that there is inefficiency in this area. When I visited my joint venture partners, I saw that 97% of their claims were actually processed with no manual intervention and it was completely auto-adjudicated. I come to India and not even 1% of claims happen like that. I was shocked to see that information is flowing from a hospital to an insurer, and even in today's day and age through faxes, in some cases. Now that's where technology can come in. Now the data is transparently available. You can make the process efficient. You can bring down the cost of that administration. You can use that data for many other cases in the future, in terms of how do you adjudicate claims. You can bring in elements of standard treatment protocols, elements of removing inefficient costing. Every 1-2-3% of cost down is increasing your underwriting profit or giving an ability to pass on the benefits to the consumers.

Jain: The biggest challenge for India is awareness and people really coming into the fold of insurance. Anywhere in the world where penetration is deep, prices are optimal. So in some sense, across the different segments, even motor insurance, we see only 50% of the vehicles are insured. If 100% were insured, I can guarantee at least from my side that the prices will be far more optimal. The same goes for health. Only 2% of the people really buy health. What about the balance? They get it in some way or the other. So, structurally we have to see, does the online enable an environment wherein people come easily? Anywhere in the world, what we have seen is, you start with simple products. Awareness is because products are simple. It is aligned to the way the customer acts or interacts in the e-comm environment. You'll see simple things happening and people coming in the fold of insurance. What will happen possibly beyond that is then insurance companies, when they own the customer, will start to think it as a lifetime-value situation. You'll start to really cross-sell, up-sell and customize as per the needs of a particular individual and that's where product innovations take place. Today, there is a huge arbitrage on the two sides. I don't know how many people realise, we still perhaps don't have a formal KYC. How much do we know a customer? We are all shooting in the dark. So online is a great way to attract consumers. I expect online to create a spectrum of consumers to come in and mostly the millennials who will eventually lay down the foundation of insurance in this country.

Bhaskaran: How are insurers looking at ModiCare? Is it an opportunity or a threat, given the premium estimates?

Bathwal: We don't know what the pricing is going to be at this stage. So I think, let that get discovered. It's an opportunity in two senses, whether you participate in the process or not. One is the awareness. I don't think that there could be anything bigger than this in terms of creating awareness for health insurance. Second, the government is saying Rs5 lakh coverage for a family in that segment of our population; then is there any reason why we should sell any policy below Rs5 lakh at all going forward? This is a huge opportunity, irrespective of whether the insurance companies play in this or not.

Jain: I see this is a big opportunity. We need to recognise that the minimum healthcare cost in this country for many things run into a few lakhs. So this is like a realisation which really seeps in a point in time. The government a few years back had run a scheme—Rashtriya Swasthya Bima Yojana (RSBY) but the format was Rs30,000. And obviously we still see a lot of people not picking that up; and I think it was also because Rs30,000 was not adequate enough. Structurally, the healthcare infrastructure will evolve. The moment 40-50% of India will seek a medical intervention on a daily basis, all of us will go down there and create our own opportunities. I also personally feel that what we think as bottom-of-the-pyramid are the potential buyers of high-end products in the future. Everybody in India will grow economically too, and their needs will multiply and most of the insurers will be there to support them when they really look beyond Rs5 lakh to go into Rs10 lakh, Rs20 lakh or Rs30 lakh.

Singhel: With good health insurance and good healthcare, the average life expectancy of Indians will move up. It has that powerful an impact. With execution, and money coming in, infrastructure will evolve. And the price is a challenge. The industry and the healthcare have to come up because you'll have 500 million people coming in. Look at the impact it will have on the country and getting that right is the challenge. We should all, as an industry along with the government, be super-excited to raise the average life expectancy of Indians. We have the opportunity to do that. If the business proposition is there even in a village, why would the healthcare system not evolve, why will doctors not go there? A simple example is crop insurance. See the investment in the claims today. People are looking at satellite imagery, they are looking at drones. Give it 3 to 5 years, you can actually insure even a metre of crop. Otherwise, before this announcement, nobody really looked at it at that depth.

Rao: This is a very powerful thing. We are covering 500 million people. First, all the government's insurance schemes have only increased awareness about insurance. Second, it is still not clear whether insurance companies will be part of it or states will have their own Trusts; we don't know what are the models being proposed. The success of it will be on how the implementation is done because some of the problems with the earlier RSBY has been frauds that used to happen in some of the places. How do we curtail that? What control measures are put in place, either by the insurance industry or by the government? That becomes very important as it's not that the scheme only has to run for 1 year. It has to be sustainable, properly priced, and proper control mechanisms have to be in place; then it can be sustainable and it will be good for the industry as well as for the public.

Source

Back

Modicare needs a dose of pragmatism - The Hindu Business Line – 19th February 2018

The new scheme will work, provided we take pointers from Obamacare, and don't expect unrealistic outcomes
The Union budget's biggest highlight was the introduction of a universal healthcare scheme which is estimated to cover 50 crore beneficiaries or almost 40 per cent of the Indian population. The scheme is tipped by the finance minister to be the largest state driven healthcare initiative in the world when it hits the ground running.

While one must appreciate the Government's thrust to address a primary concern for Indians, there must also be pragmatic optimism on the scheme, without its lapsing into an excess of euphoria. This piece tries to compare it with its American counterpart, Obamacare, and argues why certain provisions needs to be considered in detail.

Burden on taxpayer

The first thing that India needs to be aware of is the issue of individual mandate. The notion of telling young people with no health requirements to commit a certain sum of monthly income (else be penalised) would pose an additional burden on the taxpayer. Indians are well known for their inclination to be cautious in spending, hence the political impact of this would be significant as well. One of the issues that Obamacare had in America, was that many young people were reluctant to commit to an individual mandate on the healthcare system. This issue needs to be addressed head-on first. The way out is to look at a market-based model to leverage the prices down by using Statewide access and nationwide competition to drive down the prices.

Second, the finance minister was quoted as mentioning one healthcare player or multiple healthcare players across the country. It is important for India to not repeat the issues in Obamacare in lack of insurance continuity from State to State. There should be a concerted effort to remove the State barriers and have complete access across the country to multiple companies, and not just to one or two select firms. Not only will this help lower the premiums due to enhanced competition between nationwide players, it will also ensure that it solves the problem of having no insurance players in some States, as in the US with Obamacare.

It will also fit into the idea of 'ease of living' across State boundaries that the Prime Minister had eloquently articulated in his response to the budget speech.

Mobility within States has structural impediments especially if it's subsidy-related. Unless this is sorted out, the efficacy of the programme would be a challenge for the Government, especially since migration is increasing.

Careful with subsidies

Third, the challenge of incorporating the subsidies into the healthcare system needs to be done with care. Effective incorporation would be based on a case-to-case basis but there are complexities in this, much like in Obamacare.

At the moment, in Obamacare, the amount of an enrollee's subsidy depends not only on the person's eligibility and income category, but also on changes in income over the course of the year, family size and residential requirements.

These complexities make it an administrative nightmare for governments and that is something India needs to avoid. It would be important for India to look at the Scandinavian healthcare models in this regard, especially the ones in Sweden and Finland since they have been proposed by many experts in the field.

It is imperative to focus on a seamless integration of subsidies in the broader healthcare ecosystem that suits India's socio-economic environment.

Fourth, the amount of money required to finance such a massive scheme will surely overshoot the budgetary overlays in the coming year.The recurring costs for a healthcare programme of this scale needs to be addressed.

Are we looking at public-private partnerships to accelerate finance or is it completely billed by the state? If it's completely billed by the state, how different is it from the political left's policies?

A large part of the increase in Obamacare costs were accommodated by an increase in tax for the middle classes. In India's case, due to extremely low tax compliance, that option would not be particularly viable. Other ways of acquiring and, more importantly, sustaining finance need to be worked out.

Paradigm shift

Fifth, the provision of universal healthcare in any country (more so in India) requires a systemic shift to market-based insurance models which many Indians are not used to, both from an individual as well as private sector point of view. From the insurers' point of view, it's a bonanza and there need to be regulatory controls to ensure they don't go overboard.

Considering the state of medical corruption in India and the exorbitant costs in private healthcare, the Government needs to be wary about ensuring that the providers don't take citizens for a ride.

From the consumer's point of view, this essentially is a change in socio-cultural mindsets and would need a lot of awareness-building for Indians to feel confident about the programme.

There needs to be a comprehensive nationwide drive among the masses along the likes of Swachh Bharat to accelerate awareness regarding the insurance scheme.

Unless this is done, the usage and popularity of the scheme would be difficult to achieve and so will be the positive political results of the scheme's implementation.

In retrospect, the idea of universal healthcare, while being lucrative, needs careful deliberation and policy acumen to deal with. There should be a consistent and visionary approach that suits the Indian health psyche and social structures. In this context, it is also important to learn from other models such as Obamacare to avoid pitfalls and focus on improving them in our plan. This would make Modicare much better.

Source

Back

India: Insurance is only 1 option in funding National Health Protection Scheme – Asia Insurance Review

Insurance is only one of several options that can be chosen to finance the proposed National Health Protection Scheme (NHPS) that was announced in the 1 February Budget speech for the fiscal year starting 1 April.

In an article posted on the Brookings Institution's website, Ms Shamika Ravi, member of the Prime Minister's Economic Advisory Council and director of research at Brookings India, argues that the Budget allocation for the scheme is enough and that India needs to find new innovative ways of providing adequate accessible healthcare to all.

The central government has allocated INR20 billion (US$310 million) in the Budget for the scheme. The government plans to provide health cover of INR500,000 per family to 100 million families in India, which is about 500 million people or 40% of the population.

While the broad outlines of the scheme are known, the details are being worked out in discussions with state health secretaries, which will involve questions about how the centre and states will split financing the scheme in a 60:40 ratio, and how the national insurance scheme will fit in with the existing Rashtriya Swasthya Bima Yojana (or RSBY which targets those below the poverty line) and state level schemes in states like Kerala, Karnataka and Andhra Pradesh.

Ms Ravi says that India needs to consider new financing methods, like perhaps a medical saving health scheme or public provisioning of services because there is a large public health sector also that needs to be revived.

She said: "I think we have to think of a Singapore-type model where people actually put aside savings for health, and the equity aspect is there in that the government pays for health needs of people below a certain income level.

It is a better way of financing health because, in insurance, there are such huge asymmetries in information that neither the healthcare providers nor the patient has any incentive to lower cost or lower utilisation. If you are insured, you will be given all diagnostic tests and probably be over-diagnosed."

Insurance

Ms Ravi said: "But we also need to look at the utilisation of health insurance in this market segment. The claim-to-coverage ratio is much lower in the poorest two income quintiles compared to the average health insurance market. So you also need education and financial literacy and whatever else is required for people to start using health insurance.

"When the government is paying the premium, the claims-to-coverage will be taken into account while negotiating the premium with insurance agencies.

Source

To make it actuarially fair, you have to factor in that claims to coverage are low while setting the premium. If the claims to coverage increases – which it should ideally because people do fall sick, especially among the poor – then the government can adjust the premium with increased utilisation."

Back

Survey & Reports

Financial crime on the rise in India's life insurance sector - Deccan Herald – 22nd February 2018

Rising transactions with third parties, data privacy concerns and gaps in operational processes have augmented financial crime risks in the life insurance sector, stated EY Fraud Investigation & Dispute Services' report.

According to the report, 56% of the life insurers stated up to 30% increase in fraud over the last two years; 7% confirmed up to 50% increase.

The report noted that many life insurers were still in the process of complying with the implementation of IRDAI-mandated 'Fraud Monitoring Framework'.

Source

1 in 3 life insurers said their organizations did not have fully established whistle-blowing mechanisms, enhanced third party due to diligence processes and robust fraud-response procedures.

Back

IRDAI Circular

Source

Handbook on Indian insurance statistics 2016-17 is available for download on IRDAI website.

Global News

China: Insurance regulator instituting measures to curb systemic financial risk – Asia Insurance Review

Risk control will remain a priority in China's insurance sector with planned measures like limiting the share ownership of single share owners, a top CIRC official has said.

Each share owner will no longer be allowed to hold more than one third of shares in an insurance firm, down from the previous 51%, to prevent a single party enjoying too much power in making investment decisions, Mr Chen Wenhui, CIRC Vice Chairman said, according to a report in the *Shanghai Daily*.

The regulator will also study the feasibility of creating a "black list" for professional managers in the sector. It will establish a multi-level prevention system to cope with deep-rooted malpractices such as providing misleading information in sales, making claims difficult and cheating for compensation.

Source

"Preventing is the eternal theme of financial work," Mr Chen said. He added that the insurance industry itself should pay more attention to risk management and develop more steadily.

Back

Australia: Govt forms panel to develop framework for retirement products - Asia Insurance Review

Minister for Revenue and Financial Services, Ms Kelly O'Dwyer, has announced the establishment of a consumer and industry advisory group to assist in the next phase of development for a framework for Comprehensive Income Products for Retirement.

The group's feedback and advice will help to ensure that Australia's A$2.5 trillion (US$1.96 trillion) superannuation system delivers on its promise of providing Australians with an income in retirement.

The central task of the reference group is to provide feedback and advice to the Treasury on possible options and scope of a retirement covenant in the Superannuation Industry Supervision Act. This would require superannuation trustees to design and offer appropriate retirement income solutions to their members.

The members of the advisory group bring together substantial expertise and experience from across the consumer and superannuation sector, including in asset management, aged care, consumer protection, product development and compliance, academia, and law.

Source

Following advice from the group, the government will undertake broader consultation with all stakeholders on the detail of its proposed approach. The reference group will include nine experts representing consumers and industry.

Back

Nepal: Insurers rush to issue rights shares – Asia Insurance Review

Six insurance companies are preparing to issue rights shares to raise a combined total of NPR7 billion (US$67 million).

According to the Securities Board of Nepal (SEBON), the six insurers are to issue right shares of such quantity on the basis of applications they have already submitted to the Board, reports *Republica*.

Surya Life Insurance (2,887,500 units) is to give four rights shares for every 10 shares held by current shareholders and the NIC Asia Capital is the issue manager.

Siddartha Insurance (2,244,973 units) is issue 3.5 rights shares for every 10 shares held and the NMB Capital has been chosen as its issue manager.

Gurans Life Insurance has appointed the Laxmi Capital Market as the issue manager for the allotment of 2,907,000 rights shares. It is providing one rights share for every two units held by existing shareholders.

Everest Insurance Company is allotting 7,290,000 rights shares through the Siddhartha Capital. National Life Insurance is the fifth company with plans for rights shares numbering 9,936,477. NIBL Capital has been appointed the issue manager.

The sixth insurer is Nepal Insurance which has been preparing to issue 3,019,886 rights shares. NIBL Capital is its issue manager.

The main reason that the insurers are raising funds is to meet capital requirements.

Last year, Prudential Insurance, a non-life insurer, issued 1,283,040 rights shares worth NPR128.30 million to its shareholders while seven other insurers registered bonus shares valued at NPR990.32 million, according to *Kathmandu Post*.

The insurance regulator, Nepal Insurance Regulatory Authority, has directed life and non-life insurance companies to boost their paid-up capital by mid-July this year with the intention of strengthening their capacity. Life insurers are to maintain a minimum paid-up capital of NPR2 billion, up from the existing NPR500 million, while non-life insurance companies have been told to boost their minimum paid-up capital to NPR1 billion from the current minimum required NPR250 million.

The regulator decided last March to increase the insurers' minimum capital. New insurance companies have been granted licences under the increased capital requirement.

There are 17 non-life insurers and 19 life insurers operating in Nepal. A total of 22 insurance companies are listed on the Nepal Stock Exchange.

Source

According to capital increment plans submitted last year by the insurers to the regulator, 10 companies said that they would meet the new capital requirement by making further public offerings of shares while the rest intended to issue rights and bonus shares.

Back

Japan: Insurers lower life insurance premiums on longer life spans – Asia Insurance Review

Major insurer, Nippon Life Insurance, will cut premiums for life insurance products by up to 20% as its payout is on the decline due to the rising longevity of policyholders, company officials say. The discounts will take effect on policies purchased after March.

On the back of people's longer life spans, other Japanese insurers also plan to lower mortality insurance fees. The size of the cut in insurance fees will vary depending on policyholders' age, sex and type of contracts, reports Kyodo News.

Sony Life Insurance will cut premiums for its mainstay products by 14.6% for 30-year-old men and 3.7% for women of the same age.

All the changes will be made after the industry's benchmark table containing mortality rates and average life expectancies was revised for the first time in 11 years. For the financial year ending 31 March 2019 and beyond, the table, used by each insurer to design products, shows improved mortality rates at every age bracket. The mortality rate, or the number of deaths per 1,000 individuals per year, for instance, for 40-year-old men fell from 1.48 to 1.18, while the rate for women of the same age was down from 0.98 to 0.88.

Meiji Yasuda Life Insurance will also discount premiums for collective life insurance contracts by up to 24% from April. Other insurers planning similar premium cuts include Tokio Marine & Nichido Life Insurance, Mitsui Sumitomo Aioi Life Insurance and Sompo Japan Nipponkoa Himawari Life Insurance.

Source

While a rise in longevity has prompted the insurers to reduce premiums for life insurance, policyholders are expected to pay more for health insurance as more elderly people are likely to make claims for medical expenses, industry observers say.

Back

Australia: Health insurance sector could consolidate further – Asia Insurance Review

The head of health insurer Nib Holdings says that Australia does not need 35 players in the arena as he welcomed the news that two of the country's largest health insurers are planning a merger.

Mr Mark Fitzgibbon, CEO and Managing Director of Nib, said that the merger would hopefully be a "harbinger" for the industry, according to a report in *The Australian Financial Review*.

HCF, ranked as Australia's third largest health fund, and HBF, ranked fifth biggest, are considering a merger that would see the new entity hold approximately an 18.4% market share, ranking behind Medibank and Bupa. Nib has a market share of nearly 9% while Bupa and Medibank have around 27% each.

Referring to the merger, Mr Fitzgibbon said: "We don't necessarily see it as a competitive threat...we'll see if it's the start of more widespread interest and consolidation. I'd regard that as a good thing."

"I don't think there will ever be forced mergers, but it's just a matter of doing the right thing as directors. If there is an opportunity to improve your efficiency and scale, I think we're all duty bound to seriously consider that."

Mr Fitzgibbon said: "The domestic Australian health insurance market is as soft as I can recall. Household incomes aren't growing and there's no shortage of competition in the market."

Source

APRA executive member Geoff Summerhayes said earlier this month that health insurers with low or negative member growth should actively consider mergers.

Back

South Korea: National Health Insurance Service to cover obesity-related surgery wef Nov – Asia Insurance Review

South Korea will extend its national insurance coverage to patients with obesity problems starting in November, the health authorities have announced.

The Ministry of Health and Welfare and the National Health Insurance Service said insurance coverage will be provided for weight loss surgery, such as lap-band, gastric bypass and other surgical treatments, reports the Yonhap News Agency.

A growing number of South Koreans are struggling with their body weight, with the obesity rate among adults hitting 33.55% in 2016. Noticeably, 5.31% of adults were regarded as highly obese.

The ministry said obesity is a disease that brings various complications, such as diabetes, high blood pressure and cardiovascular diseases, particularly among adult males.

Recent studies have shown that surgical procedures are more effective than non-surgical treatment at treating morbid obesity.

Source

Last year, the Ministry of Health and Welfare and the National Health Insurance Service announced plans to allocate KRW9 billion (US$7.8 million) to provide insurance coverage for the surgical treatment of morbid obesity.

Back

Macau: Govt and lawmakers debate possibility of universal health insurance plan – Asia Insurance Review

The Macau government has indicated that it has no plans under imminent consideration regarding the establishment of a mandatory medical insurance system in the territory.

The Secretary for Social Affairs and Culture, Mr Alexis Tam, however, still allowed for the possibility of a public debate on the medical insurance system, reported *Macau Daily Times*.

Lawmakers Si Ka Lon and Song Pek Kei had proposed that the Legislative Assembly debate the establishment of a medical insurance system.

Mr Tam said that 97% of the patients at the only government-run hospital, the Hospital Conde S. Januário (CHCSJ), are receiving free medical service. "Our medical protection is enough," he said. There are three hospitals in Macau providing basic and primary health care services. The other two are privately run.

Mr Tam said that the Macau government is paying MOP14,600 (US$1,800) per resident per year for medical services, and that the total amount of such expenditure represents 10% of public expenditure by the Macau government. He said that the government covers 75% of residents' medical services.

Lawmaker Au Kam San hopes the government would not completely rule out possible insurance systems just because it is satisfied with the current funding system for medical services.

Si Ka Lon also questioned whether the government can allocate part of the money it is currently using for public medical services to instead buy medical insurance for residents.

A Health Bureau report indicated that if a universal health insurance health system was introduced in Macau, per capital health expenses would more than double.

According to the report, medical spending by the Macau government and residents stood at MOP9.43 billion in 2016, while average spending per capita was MOP14,000. The report stated that under a universal health insurance health system, health spending would balloon to MOP23 billion with spending per capita reaching MOP35,800.

Source

Back

China: CIRC warns insurance funds again about financing local govts – Asia Insurance Review

Chinese insurance funds must not be used to provide covert funding to local governments and must serve the real economy, reported the Xinhua News Agency citing a deputy chairman of the CIRC.

The official, Mr Chen Wenhui, said that "fake creativity" in the use of insurance funds must also be banned.

"There must be long-term, value investment and diversified investment," Mr Chen said.

China is in the second year of a campaign to reduce risks from a rapid-build up in debt and riskier types of financial activities, which has included greater scrutiny of local government spending and debt.

The insurance regulator said last month it would "pay high attention" to liquidity, credit and asset-liability mismatch risks of insurers.

Last month, the Chinese authorities also said that they had tightened rules on how insurers can provide financing to local governments. In a notice issued then, the CIRC and the Ministry of Finance said that they “resolutely ban” local governments from illicitly starting new projects and building new debt through channels such as local government financing vehicles or government investment funds “in the name of attracting insurance companies”.

Thousands of local government financing vehicles, or LFGVs, have been created across China by local authorities to help them hit economic growth targets. The vehicles have taken on trillions of yuan in debt from banks, the bond market and shadow lenders, helping local governments bypass Beijing’s limits on borrowing. Much of the debt comes with implicit local government guarantees.

For any debt financing related to LGFVs, insurance companies are required to provide specific legal opinions on the compliance of their investments, the regulator and the finance ministry said in the notice.

Source

Insurance companies are required to view the vehicles as normal state-owned companies, and conduct strict risk assessment of LGFV projects based on their commercial viability instead of government creditworthiness.