भारतीय बीमा संस्थान
INSURANCE INSTITUTE OF INDIA

INSUNEWS

Weekly e-Newsletter

12th – 18th November 2022

Issue No. 2022/46

QUOTE OF THE WEEK

"The greatest weapon against stress is our ability to choose one thought over another."

William James

INSIDE THE ISSUE

INSURANCE TERM FOR THE WEEK

Water Damage Clause

A water damage clause is a provision in a property insurance contract that details whether the insurer covers water damage to the property, and if so, under which circumstances and for how much. Usually, most homeowners and renter policies include such clauses.

Losses from water damage can be extremely high. This is because repair can literally involve ripping out sections of the building and replacing them completely. This can cost in the 10s or even 100s of thousands of dollars. For this reason, it is important for property owners to know exactly the exact type of coverage their property insurance offers. For example, a water damage clause often excludes coverage for water damage. In such cases, it may be necessary for those in flood-prone areas to seek extra coverage. Generally, water damage clauses provide coverage for smaller losses, such as pipes bursting and plumbing issues.

INSURANCE INDUSTRY

Your Money: Does your insurance policy align with your life goals? - Financial Express – 18th November 2022

The trigger for the intent to buy an insurance policy mostly comes when we see a neighbour or a close friend or colleague buy a cover. In all probability, we call the same agents who have sold policies to our acquaintances. But this is not the correct way to go about buying an insurance product.

One should first be convinced that insurance is a must in his life journey. The fact is, insurance is beneficial at all the life stages of an individual. That is why life insurance, which manages financial risks of the future, remains the foundation of any financial plan. There is no dearth of financial products such as bonds, equity or bank deposits.

Managing financial risks

However, there is one fundamental difference between life insurance products and all other products. In all these, one gets a return, high or low on his investments only. If the family needs money suddenly at some point in future, they get the investments made by him up to that point of time plus some return. So that amount is a function of the investments primarily. In life insurance, you can get a return on others' investments as well, if your own investments are not good enough to reach the required financial goal set by yourself.

The next step will be to select an insurer and then the product that addresses his financial needs. This exercise must be taken up by himself. An agent does not know his life goals and concerns. He may try his best but he can never fully understand why a certain goal is more important than others.

Goal-based approach

So, children's education may be a very important goal for one while someone else may want to make enough provision for a physically or mentally disabled dependant. Another may be keen to make enough provision for an old mother suffering from dementia. It is the habit of almost all the agents to decide beforehand which products they will try to sell to a particular individual on the basis of the individual's

paying capacity only. After all, the agent has been given a target to bring a certain premium income and he is always running after that.

These days customers can find out which insurer to select and for which products. When he is confident that he has selected the right product, he is most likely to be committed to keep that policy in force. In case he has some doubt, it is better to discuss it with an insurance intermediary. The intermediary knows that the customer is knowledgeable enough and wants to consult an agent for validation of his decision only and good post sales services.

It is better to consult an agent who understands something about the profession of the customer. In such cases, there will be little chance of mis-selling of products or customers getting poor post sales services.

(The writer is Nirjhar Majumdar.)

TOP

Understanding the workings of graded covers within group insurance policies – Moneycontrol – 18th November 2022

It is quite common for an employee's cost-to-company (CTC) to include the insurance premium paid by the employer. This insurance premium could be for several group plans, including group health insurance, group term life, and group personal accident.

Differentiated insurance benefits based on grades

A large number of employees do not pay close attention to the details of these benefits. Sometimes hidden in this headline are the eligibility rules of insurance. Many companies offer differentiated insurance benefits for employees based on pre-set eligibility criteria.

Unless the employees familiarise themselves with the rules, it is difficult to verify if the eligibility criteria have been correctly applied. Also, it is important to know when the employee would become eligible for a higher cover and the relevant qualification criteria. Here are some common types of grading criteria prevalent in the market. A common way to differentiate insurance benefits is on the basis of designation. This criterion is used for health, life and accident insurance. Here, the sum assured (SA) could be differentiated based on the designation level. Typically, organisations would categorise all designations into three or four groups. For each category, a separate SA may be decided.

For example, all employees at the field level may be given a health insurance SA of Rs 2 lakh. The starting supervisory level may be given an SA of Rs 3 lakh, the middle management an SA of Rs 5 lakh, and so on. Sometimes the benefits can be nuanced based on designation. For example, within health insurance, the room rent eligibility for field-level staff may be 1 percent of SA, whereas for senior management there may not be any room rent limits.

The salary link to group life and accident covers

For accident and life insurance, generally SA is allocated to each designation. For instance, field-level staff may be assigned an SA of Rs 10 lakh, whereas senior management may be assigned an SA of Rs 1 crore. For accident and life insurance, insurers may mandate that the assigned SA should not exceed 10 times a person's CTC.

Linking the SA to a person's CTC is most common for life and accident insurance. Companies typically fix a certain multiple between 1 and 10 times the salary. The SA then is directly proportionate to the individual salary. The important thing is for the company to update the salary and SA with the insurer whenever there is a change, especially at the time of appraisals. Generally, the accident and life insurance policy is less visible to the employee, as it is not utilised in the usual course. However, it is incumbent on

the employee to check with the HR department that the SA is updated whenever a salary change occurs; else their nominee(s) would find it hard to fight for the right SA when the need arises.

Another variant of the salary-linked SA is to limit the SA to certain pay bands. Herein, instead of linking the SA to actual salary, the company may choose to classify all employees into a pay band and assign a median SA to all those who fall in that pay band. For example, employees with salary up to Rs 10 lakh could be classified as pay band 1. Employees with salary between Rs 10 lakh and Rs 20 lakh could be pay band 2, and so on. The company may choose a median pay of Rs 6 lakh for pay band 1 and Rs 15 lakh for pay band 2.

All employees within pay band 1 will then get an assured SA, based on the salary multiple of Rs 6 lakh. In such cases, the number of revisions required by the company would be lesser. Also, the company would then not need to disclose the actual salary of each employee to the insurer.

Higher life and accident covers for larger families

A third option to differentiate benefits could be based on family size. This is more commonly used for health insurance, rather than accident and life insurance. Companies may choose to provide a higher SA to employees with larger family size. For example, an unmarried employee may be given an SA of Rs 2 lakh, married employee without children may be given an SA of Rs 3 lakh, and married with one child may be given an SA of Rs 4 lakh.

The rationale here is that the larger the family size, the more the health-care need. This also takes care of the life stage of the employee, and to some extent the age. The average age of employees who are married with children would be higher than those who are unmarried.

At an older age, the propensity to fall ill is higher and that's why a higher SA is justified. Though rare, in a few cases, employers may use a combination of the above criteria to segment the benefits. For example, while the SA in group personal accident and group term life could be a multiple of the salary, the multiple itself could be determined based on the family size or designation of the employee.

For unmarried or field-level employees, the multiple could be 2, whereas for married or supervisor-level staff, the multiple could be 3, and so on. In such a method, the SA distribution can be considered to be more equitable. These are determined based on the person's need, yet with a common basis across all employees.

Keep your current designation, family status updated

However, the drawback of such a method is that it is administrative-intensive. HR and employees would always need to keep the designation or family status updated. Any change in this, along with the salary, would need to be updated with the insurer.

Other than the criteria for grade-wise changes, it is important for the employee to understand the basis of calculation of the SA. For example, if the SA is based on salary multiple, then it is important to understand the various components of salary which are considered. Companies are known to consider the full CTC, including variable salary.

Some employers may only consider the fixed salary, while others may consider only the basic salary component of the fixed salary. Employees should also know the conditions put forward by the insurer for the employee to become eligible for the full SA.

In group life insurance, insurers require the employee to go through a medical examination where the SA crosses a particular threshold. If the employee does not fulfil this requirement, then the SA is not fully approved.

The insurance amount considered in CTC letters are steadily increasing.

(The writer is Abhishek Bondia.)

TOP

Insurance for all - Financial Express – 15th November 2022

From the risk of the spread of diseases globally to events such as floods and famines, India needs to have a definitive approach to building a resilient framework for its people. As India enters Amrit Kaal, 25 years leading up to India @100, every Indian must possess the insurance trifecta: life, health, and general insurance.

Recently, PM Narendra Modi set a target for making India a developed nation by 2047. A crucial element of this is an Insured India@100. Insurance is more than financial security for an individual, family, or society. It is a crucial way in which we ease the impact of certain eventualities and contingencies in our lives. Not to mention, it helps maintain a continuity that we all strive to maintain—continuity of health, lifestyle, security, and mental peace. This is what our government has actively been working to realise. A historic issue plaguing the Indian insurance sector has been a misalignment of tariffs and mis-categorisations. This mismanagement stemmed from the piecemeal development of the market spanning various eras of regulatory and political dispositions and catered to insurance needs arising therefrom.

The need for insuring life versus material possessions was characteristic of Independent India. Hence, more people insured lives over material possessions. The government, too, regulated the sector for the huge liquidity that could fund development. The focus thus remained on the voluminous life insurance space, whereas other insurances became “miscellaneous”. This continued up to 1991, when there was little focus on proper categorisation, the viability of tariffs, etc. To address these issues, in 1999, the RN Malhotra Committee recommended changes, including re-opening the sector to private participation and forming a regulatory body, namely the Insurance Regulatory and Development Authority, to regulate, promote and ensure orderly growth of all segments within the Insurance industry.

Perception shift: Development of all segments of insurance, i.e., the trifecta- health, life, and property, would first need a cultural shift in perception towards insurance. This means giving due importance to every segment of insurance in terms of regulation and promotion. Currently, insurance penetration in India, measured by the share of insurance premiums in the GDP, is very low compared to competing economies. Overall insurance penetration is reported at 4.2% vis-à-vis global levels of 7.2%, with non-life insurance share of merely 1%.

It is important to create awareness about the benefits of insurance in times of need. The government has been actively working on it alongside IRDAI, which launched the “Bima Bemissal” initiative for consumer education on “promoting insurance and protecting the insured”. Pure insurance products: The consumers must be educated to understand the difference between insurance for consumer protection versus insurance for investment. Over 2002-2009, private companies increasingly sold unit-linked products, marketing their investment returns. The lack of simultaneous growth in pure insurance products threatened customer protection, sustainability, and efficacy of the sector. At that time, IRDAI increased the monitoring of private players through regulatory restrictions on ULIPs. To avoid such pitfalls, consumer awareness about the actual benefits of different products available in the market is critical.

Creating partnerships: There are two aspects of creating a partnership ecosystem. One is strategic partnerships between financial institutions. For example, bancassurance, wherein the bank acts as a distribution agent for insurance products, has a 56% share in the insurance distribution business in India. Insurance companies need to develop integrated digital capabilities with other financial institutions incorporating speed and cost-efficiency in their services.

The second aspect is public-private partnership. InsurTechs have leveraged emerging technologies and micro-insurance policies to gain market share. In tandem, the government has proactively issued regulations to position the sector to embrace innovative solutions such as automated insurance death claim settlement and efficient premium pricing, maximising value for the consumer.

Government impetus: Since 2014, the government has created a strong public social security system, through initiatives such as Atal Pension Yojana, Pradhanmantri Suraksha Bima Yojana (PMSBY), and Pradhan Mantri Jeevan Jyoti Bima Yojana (PMJJBY). These have ensured insurance penetration to the remotest and most deprived persons through low-cost policies across insurance lines. Currently, Atal Pension Yojana has a subscriber base of 4.01 crore. PMJJBY and PMSBY have 13 crore and 25 crore subscribers, respectively. Fasal Bima Yojana, a crop insurance policy, protects farmers from the perils of nature.

Regulatory ease: There has been a shift in our attitude as a regulator from rule-based legislation to principle-based legislation. There is an increasing focus on strengthening financial and reporting norms for insurance companies akin to banks for sustainable growth of the industry. IRDAI is actively working on revamping institutional set-ups such as Insurance Information Bureau and Life and General Insurance Councils.

Ease of doing business: Reforms ensuring ease of doing business in the sector encourage investments and business opportunities for the insurance trifecta. Recently, the regulator permitted the launch of standardised group and health insurance products without prior approval.

Development of strong regulatory market: Ease of doing business ensures benefits go beyond the insurance trifecta. For instance, IRDAI eased norms for reinsurance companies, which offer "insurance for insurers", by exempting disclosure of underwriting profits and filing stewardship returns. Reinsurance firms protect the balance sheets of insurance firms and reduce their earnings volatility.

India can benefit immensely from a strong reinsurance ecosystem, by offering insurance for a gamut of risks, ranging from earthquake and cyclone risks to drought risks. The existence of advanced financial structures, such as reinsurance companies, will also support insurance of niche risks in the industry, such as cyber risks and pandemics. Increasing use of global best practices such as retrocession, wherein reinsurer passes on some risk to another reinsurer or capital markets through securitisation, would also help maintain stability in the reinsurance business.

Integrated ecosystem approach: Today, global insurance companies increasingly consider the impact of climate change and sustainability on their investments and underwriting portfolios. Indian insurers can also adopt the ecosystem approach entailing digital integration of insurance providers from different industries having different customer bases. For example, a Swiss-based joint venture "Well Network," integrates insurance, pharma, and telemedicine businesses, enabling them to tap into a quarter of Switzerland's population. An approach of having lighter, transparent regulations coupled with targeted reforms in the insurance industry is going to be transformational for the insurance industry. I truly believe that our government would leave no stone unturned to achieve our aim of "Insurance for all" for India@ 100.

(The writer is Bhagwat Karad.)

TOP

Insurance companies are now a part of RBI's Account Aggregator – The Economic Times – 15th November 2022

In a recent move, the Insurance Regulatory Development Authority of India (IRDAI) has given its go-ahead to insurance companies to become a part of the Reserve Bank of India's (RBI) Account Aggregator (AA) system. The circular includes a guideline on how Insurers- life, non-life and health can share data with the account aggregators, who are NBFCs that retrieve financial information from entities to provide all savings and investment data at one place.

Once fully functional, investors can register on any of the above platforms and get their bank account, mutual fund, insurance, PF investment, PPF and other financial data at one place. "Insurers can share information with AAs only after taking the due consent of policyholders," the circular stated.

Account aggregation sometimes also known as financial data aggregation is a method that involves compiling information from different accounts, which may include bank accounts, credit card accounts, investment accounts, and other consumer or business accounts, into a single place. The regulator has said that insurers will have to enter into a contractual agreement with AAs with defined rights & obligations of each party and modalities of dispute resolution mechanism before sharing any information.

"There shall be adequate safeguards built in IT systems of Financial Information Providers (FIPs) in the insurance sector to ensure that it is protected against unauthorized access, alteration, destruction, disclosure or dissemination of records and data," said the insurance watchdog added. IRDAI has also asked the companies to build a required interface based on RBI specification for receiving the consent, authentication and safely sharing the information with AAs.

The guidelines state that the Insurers will have to prominently display the names of the aggregators with whom they share data. Besides this they will have to abide by code of conduct applicable to them including redressal of grievance of the customer before sharing any data with AA, clarified IRDAI. The inclusion of insurance along with banking and capital markets in the AA ecosystem can impact the way MFDs service their clients as they will have access to a lot more information.

TOP

Insurance arbiter access up – The Telegraph – 14th November 2022

The scope and reach of the insurance ombudsman to address grievances of policyholders could widen as the insured subscriber base in the country grows.

The insurance industry regulator IRDAI has already announced Bima Sugam — an online platform, in the likes of Amazon, for selling, servicing, and settling claims with an aim to provide a plug-and-play solution with an API interface for all insurance companies. It is expected to be operational soon. A platform for grievance redressal is also being set up.

The regulator is also exploring the integration of ombudsman services, which has already introduced online grievance submission during the Covid pandemic.

At present, policyholders can approach the insurance ombudsman for claims up to Rs 30 lakh if the insurer does not respond to the complaint within a specific time period. An increase of this threshold along with increasing the ombudsman services to small and medium enterprises is also under discussion. The regulator may also explore whether there can be additional ombudsman offices in more states but in a cost-effective manner as the insurance penetration improves.

"We are trying to bring in a complaint redressal mechanism which you will come to know very soon. This will be a modern technology-driven facility where people can immediately complain and it will get passed on to the insurance companies. The key thing is that people must give their feedback immediately," said Bejon Kumar Misra, advisory committee member of the IRDAI in Calcutta on the occasion of Bima Lokpal Day.

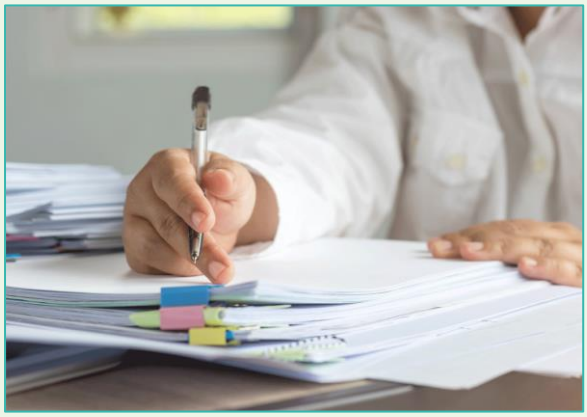
At present, there are 17 offices of insurance ombudsman in the country including Calcutta. The Calcutta office had recorded a total of 3,224 complaints in 2021-22 of which 2,935 complaints were disposed during the year. Nationally, there were a total of 45,370 complaints in 2021-22, of which 40,527 complaints were disposed off.

Kiran Sahdev, insurance ombudsman, Calcutta said that the online registration of complaints has already been introduced where a policyholder can register their complaint from anywhere and need not visit the office of the insurance ombudsman. Individuals can register and track their complaints at www.cioins.co.in.

(The writer is Pinak Ghosh.)

TOP

Insurance companies' commission to agents under GST scrutiny – The Economic Times – 14th November 2022



Goods and services tax (GST) authorities have informed the insurance regulator about alleged malpractices by more than a dozen insurance companies while allocating commissions to agents, people in the know told ET.

The Directorate General of GST Intelligence (DGGI) has been investigating these companies for allegedly floating shell companies to pay high commissions and accounting for the payments under other heads to reduce tax outgo. During its probe, the Mumbai unit of DGGI conducted inspections on some companies and also summoned their executives, the people said.

Insurance industry executives, though, said GST authorities had wrongly interpreted marketing and sales-related expenses as commission on services and were seeking tax. Some of these insurance companies have approached the finance ministry seeking a resolution to what they view as legal differences on the interpretation of the GST statute, industry insiders said. According to a senior government official, the probe has revealed that some companies pay as high as 70% commissions to agents, even though it is ordinarily around 15% in the sector.

These companies, which include both life and non-life insurers, are under the scanner of the tax authorities for allegedly showing bogus expenses made to shell entities to pay the excess commissions, this official said. "So, while nearly 15% was paid through legitimate channels, the extra amount was routed to firms and showed as marketing or advertising expenses. These companies raised fake invoices, and GST is the only law which treats a fake invoice as a document," explained the official. The department is probing transactions of these firms running into more than ₹5,000 crore and involving GST of over ₹500 crore. "In certain cases, they have also confessed to the wrongdoing," another official added.

Meanwhile, in the fourth week of October, general insurance companies met with senior finance ministry officials to apprise them of their point of view and seek a solution.

"The issue is about interpretation and since it's a GST issue, the finance ministry was approached. Tax authorities have slapped huge claims on insurance companies because they interpret marketing and sales-related expenses as services and are seeking tax on those," said a senior insurance executive. "From insurance companies' perspective, these are necessary expenses to sell products and not taxable. The finance ministry officials have been very receptive and assured to look into the matter," the executive said.

Insurance industry insiders told ET that the companies have already paid crores of rupees in taxes "under protest". Companies are wary of warnings of strict action including arrest and have sought a fair hearing.

(The writers are Rashmi Rajput & Joel Rebello.)

TOP

Rs 28,500 cr underwriting loss leads to premium hikes by general insurers - The Indian Express - 13th November 2022

Covid-19 pandemic seems to have hit the general insurance industry's performance. With a record underwriting loss of Rs 28,500 crore in FY 2021-22, the Rs 2.23 lakh crore industry with 31 players has been pushed into red, leading to a hike in premium in many segments. The loss occurred despite insurers reporting a higher investment income during the year. The industry reported underwriting losses of around Rs 19,400 crore in the previous year. "The high underwriting loss has led to a hike in premium by 5-10 percent in many segments, especially health in the last six months," said an insurance official. According to data available from insurers, in FY 2021-22, a total of almost 18 lakh Covid claims were settled for an amount of Rs 16,190 crore, almost double of what was paid in terms of number of claims and amount in FY 2020-21. Almost 1,17,000 claims amounting to Rs 1,163 crore were repudiated or still pending for payment by the general insurance companies during FY 2021-22 and over 2,15,000 claims amounting to Rs 1,500 crore have been rejected or pending with general insurers in the last two years. "Many insurers burnt their fingers while settling Covid claims," said an official.

Saddled with the huge overall losses of three PSU general insurers — Oriental Insurance (OIC), National Insurance Company (OIC) and United India Insurance (UII) — the segment has slipped into net losses of Rs 2,842 crore in FY 2021-22 as against a net profitability of Rs 3,869 crore during FY 2020-21. With a net profit of Rs 3,869 core, the industry had returned to black in 2020-21 after having registered net losses of Rs 1,402 crore in 2019-20. Underwriting is the process insurers use to determine the risks of insuring a business, health of a person or venture. The insurance company determines whether a firm poses an acceptable risk and calculates a fair price for your coverage. The industry has suffered operating losses of Rs 1,148 crore in FY 2021-22 as against an operating profit of Rs 6,616 crore in FY 2020-21. The segment had a total investment income of Rs 32,286 crore, up 11 percent, in FY 2021-22.

Excluding Bajaj Allianz General Insurance, Care Health Insurance and state owned ECGC, the profitability of the rest of insurers for the industry can be attributed to their investment income and not pure underwriting in 2021-22. On the other hand, except New India Assurance (NIA), the country's largest general insurance company, which has ended the year with a Rs 164 crore of net profit, the rest of the three general insurers OIC, NIC and UII have recorded heavy losses of Rs 3115 crore, Rs1674 crore and 2136 crore respectively in FY 2021-22. OIC, NIC and UII have incurred losses, despite having large investment income of Rs 2,296 crore, Rs 2,650 crore and Rs 2790 crore respectively, due to huge underwriting losses in FY 2021-22. NIA has the largest investment income of Rs 6,665 crore while ICICI Lombard General Insurance (Rs 3,000 crore), Bajaj General Insurance Rs 1,760 crore, HDFC Ergo General Insurance (Rs 1,279 core) are the top three private sector general insurers in terms of investment income. Overall, 20 full-fledged private sector general insurers, led by Bajaj Allianz General Insurance, have been able to grow their net profitability by 46 percent year on year (y-o-y) to Rs 4,100 crore in FY 2021-22.

(The writer is George Mathew.)

TOP

Leveraging key technologies like AI and ML to increase insurance penetration - The Times of India – 13th November 2022

Consumer behaviour has changed dramatically, alongside the advent of technology and rapid digitisation in insurance. Subsequently, technology-driven innovations across the value chain have become much more prominent in the financial services ecosystem. With the threat of the massive pandemic globally,

the perspective towards financial protection has changed in the country, as well as on a global level. This has led to a significant surge in demand for insurance, especially in the health and life insurance categories.

However, while certain segments of the population are gradually gaining awareness, a large chunk of the country's 1.3 billion people do not have insurance of any kind, especially for health. Both health and life insurance penetrate majorly into the top 40-50 cities of the country, and there are millions of people who have the purchasing power in insurance but do not have accessibility, making it an underpenetrated market. This is where technology comes into the picture.

The cornerstone for Insurtech companies
By now, it is common knowledge that technology has transformed every aspect of our lives and taken centre stage. For the insurance sector, things are not too different. In the past few years, cutting-edge technologies like AI, Blockchain, and IoT became the key for Insurtech platforms to build robust business strategies, expand their reach, and cater to an underserved market. Thankfully, younger generations today are from the digital native generation, who know how to execute these technological platforms for the best suited insurance products and seamless services.

Customer Data and Intelligence
Indian insurance sector has evolved to a whole new level, in the last 2-3 years, where customer data and intelligence drives the entire value chain. Traditionally, insurance underwriting was a highly employee dependent process, which involved numerous levels of analysis, identifying historical data with complex systems, process, and workflows. This AI driven processes help collect, read, and deliver insights and predictions from the huge data pool. This automation process also excludes outdated rules which take weeks and months to complete the end-to- end underwriting process.

The AI based automation
Like most other industries, Insurtech, too, has multiple tasks related to the business's daily operations. This would mean, investing heavily in human resources, making it an additional cost, the company has to bear. However, with AI, incumbents in the industry are automating complex, tedious tasks, including addressing customer queries. With quick, efficient, and seamless services alongside the data collected, providing the best suited insurance policy is becoming easier today.

RPA-enabled data management
In Insurtech platforms, RPA (Robotic Process Automation) automates the usual workflow, significantly reducing the overall costs and making the end-to-end process more efficient. This efficiency means that claim process time duration is cut down, data collection is automated and far more accurate than manual collection, leading to consumer happiness as well as satisfaction amongst the insurers' community.
Technology has brought in a paradigm shift to the entire insurance industry and the changes are expected to get accelerated in the next two years. Newer innovations, rapid advancements in technology will result in major disruptions in the Insurtech space, and companies that adopt these technologies quicker will thrive.

(The writer is Layak Singh.)

TOP

India's InsurTech Moment: The growth story of less-talked sector – The Economic Times – 11th November 2022

The Indian InsurTech market has grown considerably over the last few years, especially with a steep 2x funding growth in the last two years. Funding to Indian insurtechs has grown at a Compound annual growth rate (CAGR) of 34 percent from FY17-20, taking off in 2021, stated a recent report by PGA Labs.

In 2021, Indian insurtech companies raised a total of US$800 million in equity funding. This is more than 2019 (US$380 million) and 2020 (US$290 million) funding sums combined. Tracking the Insurtech ecosystem landscape, the report also highlighted that the global insurtechs also witnessed a CAGR of 37 percent in fundraise during that time period with 2021 proving to be a watershed year.

Legacy insurers have started paying much more attention to newcomers and they've become a big funder. Somehow, they have recognised that teaming up with technology firms can be a game-changer. Globally, 20+ Insurtech unicorns have emerged in the past three years. Root, Wefox, Hippo, Next insurance, Lemonade, Waterdrop and Unqork are among the global unicorns.

The list also comprises Indian unicorns such as Acko, PolicyBazaar (publicly listed) and Digit Insurance (to IPO in 2023).There are currently over 142 Insurtech startups operating in the country, as per Tracxn. While InsurTech fundraising has been fast paced across Asia in recent years, innovators in China and India appear to be moving beyond a supporting role and confront the region's industry incumbents, said a report by S&P Global Market Intelligence.

Most funding in case of Indian Insurtechs has hitherto been for sales & distribution players, however product development is starting to gain traction. A couple of years back, the insurtech was an 'underdog' in the sector, but it is coming up with a bang from support of the legacy players as well as the interests of new players.

B2C business models with higher revenue

When it comes to revenue generation, the PGA Labs report said that B2C business models are valued higher by investors due to higher operating leverage and perception of higher proximity to customers. During the past few years, the revenue of established B2C marketplaces has exceeded the agents-based marketplaces revenue.

Leading InsurTechs in terms of growth and funding

PolicyBazaar has the highest funding followed by GoDigit and Acko during FY17-21. The year 2021 saw the maximum capital inflow, with Acko and Digit raising $225 Mn and $200 Mn, respectively, making it to the top funding deals of the year.

In case of growth rate, GoDigit exhibited the highest CAGR followed by Navi and Acko, the report added. It further highlighted that Turtlemint has the largest funding among the B2B2C marketplace during FY17-21, while InsuranceDekho has the highest growth rate, followed by Turtlemint. Other key insurtech companies in India eyeing a significant market share include Paytm Insurance, ENSUREDIT, Onsurity, Plum, Riskcovry, RenewBuy among others.

Importance in the Indian FinTech space

The Indian fintech market is one of the fastest-growing globally, estimated to reach $1.3 Tn by 2025, growing at a CAGR of 31%. Among its key sub-sectors, lending tech is likely to account for 47%, or $616 Bn, followed by insurtech at 26% ($339 Bn) and digital payments at 16% ($208 Bn), stated a report by Inc42's while adding that India's Insurtech sector offers a $339 Bn Market opportunity.

The key growth factors driving insurtech companies in India include the rising insurance awareness across Tier 2 cities and beyond, widespread use of women-specific insurance products, and better SME participation.

Consumer inclination, improved reach & technology blend, emergence of the national health stack which has helped improve the penetration into the insurance sector, are among other key factors, it added. Moving forward, the industry is set to grow even more, on the back of supportive initiatives and rising demand among new customer segments, according to a new report by the Boston Consulting Group and the India Insurtech Association.

(The writer is Sheersh Kapoor.)

TOP

Misselling of insurance products by banks on the increase – The Tribune – 11th November 2022

Instances of misselling insurance products through banks are on the rise. Customers easily fall prey to the aggressive marketing techniques of bank employees, primarily on account of trust reposed in the bank they have been banking with.

The Insurance Ombudsman at Chandigarh, having jurisdiction over Punjab, Haryana, Himachal, Jammu & Kashmir, Ladakh and Chandigarh, received 3,917 complaints in 2021-22. According to officials, almost 80% of the complaints are related to misselling.

Misselling refers to certain 'unfair business practices', including wrong sale of product, loading on products and promise of higher returns. According to insiders, at times the agents deliberately mislead the customers into buying the wrong plan and sometimes the sale is an outright fraud. In the past, there have been instances where the customers don't understand the policy and the agent is unable to explain the nuances.

As far as disposal of complaints is concerned, the Insurance Ombudsman office at Chandigarh has recorded a disposal rate of 91.44% as against the national average of 89.33%. Of the 3,917 complaints lodged in 2021-22, the Ombudsman has disposed of 3,582 complaints. Health insurance, which was in the news last year due to numerous Covid-related disputes, accounted for 32% of the pie with 1,263 complaints.

There are 17 offices of Insurance Ombudsman across the country, including in Chandigarh. Insurance Ombudsman is an alternate grievance redressal platform for resolving grievances of the aggrieved persons. The quasi-judicial grievance redressal machinery can redress complaints against both life and non-life insurance companies. "The Insurance Ombudsman does not charge any fee for the resolution of complaint against life, general and health insurance companies and insurance brokers," said Atul Jerath, Insurance Ombudsman.

45,370 complaints in last fiscal

The total number of complaints across 17 Insurance Ombudsman offices was 45,370, of which 40,527 complaints were disposed of in the last fiscal The ombudsman at Chandigarh received 3,917 complaints in 2021-22.

(The writer is Vijay C Roy.)

TOP

INSURANCE REGULATION

IRDAI board likely to discuss key reforms on commission, bancassurance on Nov 25 – The Hindu Business Line – 17th November 2022

The Insurance Regulatory and Development Authority of India (IRDAI) is likely to discuss key reforms with respect to commission payouts, expenses of management (EoM), bancassurance tie-ups and capital limits at its next board meeting on November 25, said sources.

IRDAI's Insurance Advisory Council has submitted 10-11 long-standing reforms to the regulator, which are likely to be taken up at the meeting. These include relaxation in EoM limits, increase in the maximum rate of renewal commission and introduction of discounts in premium for directly sourced policies, sources said.

More flexibility

"Relaxation of EoM limits will benefit the entire industry. It will benefit the bigger players more because they have a larger renewal book and there is likely to be a little more weightage given to the renewal book," said Vighnesh Shahane, MD and CEO, Ageas Federal Life Insurance.

Currently, there is no flexibility for insurers that have expenses of management lower than 100 per cent. If approved, this modification could give more headroom to such insurers to pay higher distributor commissions, said industry players.

Other proposals reportedly include increasing the allowable expense or renewal premium to 17.5 per cent from 15 per cent and making additional allowable expenses available for more capital-intensive verticals such as rural business, government schemes and insurance awareness. IRDAI is also likely to consider increasing the number of insurance tie-ups that a bank can have from the current limit of three each for life, health and general insurance companies.

Reports suggest that the council has proposed a maximum of nine tie-ups each, however, industry participants believe that a total of 27 tie-ups is unlikely to be allowed as most banks currently don't even utilise the available limits. IRDAI might also consider regulations with respect to relaxing the capital requirement for micro and regional insurance companies, opening up the insurance sector for investment by PE (private equity) firms and increasing the cap on insurance tie-ups for insurance marketing firms.

(The writer is Anshika Kayastha.)

TOP

IRDA directive to shun brokers for gilt trades baffles insurers – The Economic Times – 15th November 2022

Insurance companies, a significant investor group in the financial markets, have been told by the regulator that they can no longer cut deals with brokers for trading in government securities. According to a new directive by The Insurance Regulatory and Development Authority (IRDA) that has sent all insurers into a tizzy, buying and selling of sovereign securities can only happen on the anonymous trading screen.

"Several insurers have reached out to IRDA. We think IRDA should issue some clarification. It's too harsh a directive... insurance companies will find it very difficult to directly trade thinly-traded securities on screen without a broker," the CFO of a life company told ET. IRDA has also laid down that while using intermediaries for trades in equities and corporate bonds, no broker should handle more than 5% of the total volume in secondary market transactions. The insurance regulator has inserted these conditions in the 'Master Circular on Investments' while reviewing the earlier set of directives which were issued in 2016.

Close to half the portfolio of insurers are held in sovereign papers and other state-backed securities. Of the 100-odd government bonds, about 5-6 are liquid papers. IRDA, in the 'Master Directive' released on October 27, 2022, has categorically said that "all secondary market trading in government securities shall be placed via NDS-OM only." The Negotiated Dealing System - Order Matching (or, NDS-OM), operationalised by the Reserve Bank of India (RBI), is a faceless trading platform where orders are matched without revealing the identity of the buyer or the seller.

"But it would be a challenge in getting the right price for illiquid papers in the absence of proper bid-ask quotes from brokers. The other directive on spreading trades across a larger number of brokers could force companies to empanel less efficient brokers. The intention of the regulator may be to lower transaction cost and bring in greater transparency. But, it may not help if a trader is unable to fish out fine quotes which typically come from brokers," another senior industry official told ET. "Most of us feel IRDA should take a relook and tweak the circular," said the person.

In trades executed on the NDS-OM platform, the Clearing Corporation of India (CCIL) acts as the central counterparty providing guaranteed clearing and settlement functions for transactions in money, government securities, foreign exchange and derivatives (like currency forwards and interest rate swaps). For the handful of liquid securities, for which there are ready takers, the execution and settlement of trades usually take place smoothly on the NDS-OM screen. However, about 25-30% of the deals by insurers are 'voice trades' - where a trader calls a broker or an institution (which would be the buyer or the seller) to obtain quotes and then put through the trade on NDS-OM with the buyer and the seller simultaneously punching in the orders. Alternatively, two institutions can strike a bilateral deal, involving a broker which issues a contract note and reports it on the stock exchange. Here too, the trade is reported on NDS-OM.

The insurance industry bodies are expected to send in their representations soon, asking for more time to implement the directive, modification of the language of the circular with regard to government trades as well as on the distribution of trade volumes to brokers. "Today, an insurance company typically uses 8-10 brokers. With a 5% cap, the number of brokers has to be increased to 20," said another person. According to the IRDA directive, the total volume of the business including debt and equity given to each empanelled broker shall be monitored on a rolling three months basis to ensure that none of the panel brokers exceeds the limit of 5% of the total actual secondary market transactions through brokers, up to that particular period.

The Insurance Act, 1938 requires a life Insurer to invest his controlled funds as per Section 27A and a general insurer to invest his total assets as per Section 27B in 'approved investments'. The Act further requires a life insurer to hold not less than 50% and a general insurer to hold a minimum of 30% in approved securities, which includes investment in GOI securities.

(The writer is Sugata Ghosh.)

TOP

Irdai boss signals faster regulatory reforms to boost insurance penetration – Business Standard – 11th November 2022

Irdai chief Debashish Panda said on Friday that regulatory reforms and technology innovation like sand boxes would be expedited to increase insurance penetration and density. Addressing the BimaLokpal day, Panda emphasised on three As -- awareness, accessibility and affordability -- as well as new technology platforms -- beema sugam and beema bharosa portal -- in this respect.

The Insurance Regulatory and Development Authority of India (Irdai) chairman highlighted the huge potential of insurance in the country and emphasised the need for the Insurance Ombudsman to be fair and equitable. Insurance ombudsman, Delhi, Sumeet Jeerath appealed to both complainants and insurance company representatives to cooperate and follow the path of conciliation and mediation in a spirit of give and take to reach amicable settlement in maximum number of cases.

TOP

GENERAL INSURANCE

Travelling with your family? Know all about multi-member travel insurance – Financial Express – 14th November 2022

After almost two years of pandemic-led restrictions and millions of cancelled trips, many homebound people worldwide are finally executing their held-up travel plans. There has been a significant uptick in the travel demand as evidenced by packed airlines and hotels, as the world got back to normal after a series of COVID-19 lockdowns and restrictions. However, travel has undergone a great deal of change ever since the pandemic. There is a larger awareness of the uncertainties that can strike out of nowhere, and there is an increased tendency to better prepare for this. Understandably, more people are now taking into account the risks associated with travel and want to secure their trip. Since every trip differs

in nature and size, so does travel insurance. While there are individual plans for single and multiple trips, there are also specifically designed multi-member plans for those who are travelling with their families.

Here's all you need to know about them:
What is multi-member travel insurance?
As the name suggests, multi-member travel insurance, often called family travel insurance, is a policy that covers the entire family when they travel to locations abroad or domestic. Such policies are great to cover a family with small children as well as elderly citizens. Buying this plan makes sense when you travel with your family because it costs much less than buying individual plans for each member. These policies also come with additional discounts which make them even more affordable.

While travelling with family is always more fun, it also comes with a lot more responsibility than travelling solo or with friends. This is especially true if one is travelling with children. Small changes in weather or cuisine can lead to bigger medical emergencies. Moreover, medical bills in foreign countries can cost a bomb. On the other hand, a missed flight or lost baggage can land the family in trouble and cause a lot of anxiety. It would also put a lot of financial pressure to make alternate arrangements. A family travel insurance policy can come in handy in all such situations.

How can you drive minimum damage from short-term market fall?
Multi-member Vs Floater policies
Travellers are presented with two options for insuring more than one person – multi-individual and floater policies. While they both cover multiple travellers against travel risks, the key difference is that of sum assured that can be used by each individual. For instance, if you opt for a sum assured of $100,000 for a family of 4 under floater plans, the entire sum assured can be used up by 1 person, or divided among 4, depending on the need. However, under multi-individual plans, the specific sum assured is allocated to each member which is their individual limit. So, every person in the case above will be eligible for a cover of $100,000 individually. Multi-member plans cost a little more than floater plans but provide higher coverage.

Benefits of multi-member travel insurance cover
Cover against medical emergencies: Any medical emergency arising during the course of the travel is covered by the travel insurance policy. This includes any sickness among the family members or even any accidents that they may, unfortunately, get into. Most travel insurance plans extend the accident and sickness cover for up to 30-60 days from the date of hospitalisation as long as it starts during the course of the trip. Some policies even cover the cost of emergency transportation and evacuation services if the patient needs to be transported to another medical facility.

Cover against trip delay, cancellation and curtailment: Traveling with family always comes with some uncertainties. The trip may have to be cancelled or cut short due to a medical emergency. You may have to find accommodation at a hotel due to a delayed flight as you may not want to spend the night at the airport with your family. Costs arising due to such events are covered by a family travel insurance policy. If the trip is to be cancelled due to a death in the family, or a sudden climate-related calamity in your destination, you need not worry about the bookings you have already made. The insurance policy would cover such costs. In case of a trip is cut short, you need not worry about booking a return flight at exorbitant prices either.

Cover against loss of belongings: A comprehensive family travel insurance policy protects you against loss of checked-in baggage. So if you arrive at your destination and your luggage is lost, you would need to buy new clothing and personal care items which may have been lost. The insurance policy would pay you a lump-sum amount to cover such costs. If the baggage is delayed for some reason, you are covered against that too and you would be compensated for your expenses for the duration you need to survive till your luggage arrives. In a foreign country, your passport is your most valuable possession. Losing the same can lead to a lot of harassment and mental trauma, especially if you are travelling with family. Even if the passport of a single family member is misplaced, the entire travel plan may be jeopardised. Having a family travel insurance policy covers you in such instances. Moreover, it also covers the cost of arranging for a duplicate copy of the passport.

Choice of single and multi-trip insurance: Like individual travel insurance plans, many insurers offer the option to opt for multi-trip or single-trip family travel insurance. So, families who like to travel multiple times a year, need not worry about buying a policy every single time. Multi-trip insurance is not only more convenient, it also turns out to be more economical than buying a policy for every trip. Moreover, as already explained, a multi-member policy is always more economical than buying an individual policy for every family member.

Having travel insurance is mandatory for travelling to many countries. However, that should not be the only reason to get yourself and your family covered. Travel insurance should be bought to ensure your family is protected when they need help in an unfamiliar location. A family travel insurance plan takes care of your family in such situations, just as you do.

TOP

4 reasons why you should take insurance on your education loan – Financial Express – 14th November 2022

For getting the costly higher education in a foreign university, many students not only need to take out a loan, but also require protection against the risks involved in travelling abroad and staying in the country of study away from home.

"Education loans are a huge financial responsibility, especially if taken to study abroad. Parents either opt to pledge collateral or become co-applicants all the while using personal funds for subsidiary expenses. The total cost of education and the tension of repaying the loan sometimes even compel students to rethink their plans. While the concern is understandable and repayment manageable, life is uncertain. We take insurance for our vehicles, but when it comes to education loans, many overlook the benefits. An education loan insurance is the best solution and plays a significant role during repayment," said Ankit Mehra, CEO & Founder, GyanDhan.

1. Why should parents take insurance on their child's education loan?
When students apply for an education loan, the responsibility to repay the loan falls on the co-applicant/co-borrowers, who in most cases are parents, until and unless the student becomes financially independent to repay. Purchasing loan insurance assures that, in the event of a misfortune, the co-applicants are not responsible for repaying the entire education loan amount plus interest. Borrowers of government bank education loans, for which even retired parents are designated as co-applicants, may find this to be a big comfort. Given the cost of any education loan process, education loan insurance policies offer waivers in the interest rates, which comes as a relief for many students. In some cases, in a tragedy that results in a critical injury for the student, the insurance company pays off the entire education loan amount, and not the co-applicants.

2. What will be the benefits if students take Insurance on education loans?
Think of education loan insurance as an airbag in a car that cushions the blow in a car accident. The loan insurance cushions the financial blow to a borrower already going through a hardship.

It safeguards the applicant in the wake of any unforeseen incident, terminal disease, and in some cases, loss of job.

The liability of an overseas education loan insurance does not extend to the family member as they are a co-applicant. However, they benefit from it if the borrower is incapacitated and cannot repay the loan.

Applicants are not required to pay the premiums of an overseas education loan insurance separately as they are already included in the EMIs of an education loan.

In the case of an unsecured education loan from NBFCs, getting education loan insurance for one's security is a smart decision.

3. What are the types of Insurance that students can take for their secure career?
When it comes to loan insurance, there are three that students can take to secure their career –
Health Insurance
Education Loan Insurance
Student Travel Insurance

4. What if a student defaults for any reason will the insurance company be liable for that?
No. The insurance company is liable to pay the loan amount in the case of a terminal disease or the death of the applicant. However, it also depends on the type of loan insurance the student has taken. Some loan insurance policies are liable in case the student loses employment.

(The writer is Amitava Chakrabarty.)

TOP

HEALTH INSURANCE

GST on Health Insurance to reduce, deadlock persists on input tax credit: Sources – Times Now – 17th November 2022

The awareness for health insurance has increased after Covid. To increase penetration, government is ready to reduce GST on health Insurance premium. But ET Now has learnt that deadlock persist on input tax credit. During talks with Insurance companies Government has in principle agreed to reduce GST on health insurance policies from 18 percent to 5 percent without input tax credit. But Insurance Industry insists on input tax credit. Insurance companies continuously demanding to reduce GST in health insurance premium. According to insurance companies, 18 percent GST is a big hurdle in health insurance sale.18 percent GST on Health Insurance policies is hampering penetration. Industry says loss due to GST cut will be compensated with increased premium and high volume. Insurance Companies want GST on Health insurance to reduce from 18 percent to 12 percent with Input Tax credit. There is an 18 percent GST imposed on life and health insurance currently. A high GST rate is not supportive of increasing the insurance penetration. The demand for reduction of GST on health insurance premium has been around for some time now due to the low penetration of health cover in India.

TOP

Mental Health Insurance: IRDAI asks insurers to cover mental health; here's what you should know – The Economic Times – 16th November 2022

Incidences of mental health issues have risen post COVID. The pandemic is said to have had a tremendous impact on the mental well being of people. Several efforts are being done at various levels to address this issue.

In an official notice, which is available on its official website, the Insurance Regulatory and Development Authority (IRDAI) has directed insurance companies to provide cover for mental illness under health insurance policies before October 31, 2022.

"All insurance products shall cover mental illness and comply with the provisions of the MHC Act, 2017 without any deviation. Insurers are requested to confirm compliance before October 31, 2022," IRDAI has said, the media reported.

The MHC Act, 2017 or the Mental Healthcare Act, 2017 came into force on May 29, 2018. As per Sec 21(4) of the said Act, every insurer shall make provision for medical insurance for treatment of mental illness on the same basis as is available for treatment of physical illness. On March 27, 2017 the Lok Sabha had unanimously passed the Mental Healthcare Act 2017. It got approved by the President of India in April 2017.

MHC Act 2017 defines mental issues as...

The Mental Healthcare Act 2017 stresses to provide for mental healthcare and services for persons with mental illness and to protect, promote and fulfill the rights of such persons during delivery of mental healthcare and services.

It defines “mental illness” as a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognise reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drug.

Is the concern for mental health visible?
"But, in reality, this is not occurring," says a report published in The Lancet Psychiatry. "In 2018 and 2019, the Insurance Regulatory and Development Authority of India took no action to ensure that insurance companies included mental illness in their policies. The scenario started changing after the COVID-19 pandemic and subsequent lockdown in India, which exacerbated the incidence of mental disorder symptoms among the general population," says the report which was published in October 2021, a year after the onset of the pandemic.

The report also highlights an insurance claim for expenses associated with hospitalization with a diagnosis of schizoaffective disorder, which was rejected because the policy excluded psychiatric disorders.

What should people know about mental health insurance?
Under MHC Act 2017, the mental insurance plan will cover the cost of the treatment if the patient requires hospitalization. This will include the cost of the treatment if the patient requires hospitalization. This will include the cost of diagnostics, treatment, medicines, hotel rent and other fees. However, this can vary from company to company. You need to explore the market before buying insurance. The price and coverage of the plans can vary. Currently the Act does not include mental retardation or intellectual disability.

TOP

Health insurance: Take OPD cover in your plan – Financial Express – 16th November 2022

With HEALTHCARE increasingly more expensive and the share of out-of-pocket expenses growing, it is important to optimise your health insurance and ensure the best coverage. Insurance companies are now offering a host of options to customise and address the unique medical needs of customers.

You should review your existing coverage and try to upgrade to a policy that offers cashless outpatient department treatment (OPD), daily cash rider, guaranteed cumulative bonus and lower sub-limits. Moreover, add certain essential riders and take a top-up to make the insurance cover comprehensive. If your existing plan does not offer these cost-effective features, consider porting to a plan that offers these features from the same or a different health insurer.

While a basic health insurance covers only hospitalisation, a substantial part of healthcare costs is related to doctor consultations, medicines and diagnostics. A policy with cashless OPD will take care of such

expenses and is beneficial to those with higher out-of-pocket expenses or parents with young children prone to ailments that require over-the-counter medicines or medical tests.

Cashless OPD will include professional fees, diagnostic fees, medicine bills, treatments for fractures, dental treatments, minor surgeries from authorised diagnostic centres, dental care centres and pharmacies. However, most insurers exclude OPD expenses incurred towards spectacles, contact lenses, ambulatory devices such as walkers, etc.

Vikul Goyal, founder & CEO, Bimaplan, an insurtech, says health insurance with cashless OPD benefit helps in reduction of out-of-pocket expenses. "Senior citizens must opt for OPD cover as it along with consultation fees, also covers diagnostic charges and pharmacy bills. This makes the cashless OPD benefit flexible and comfortable, especially for those suffering from chronic diseases who need regular OPD visits," he says.

Guaranteed cumulative bonus

Look at a policy with guaranteed cumulative bonus that protects loss of cumulative bonus post claim, in exchange for the same premium. There are a few health plans that offer guaranteed cumulative bonus of 25-30% per year, going up to 200% of sum insured, irrespective of claim. However, if you opt for fresh coverage for this amount, you will have to pay an extra premium.

Also, look for a policy that offers a loyalty discount on the applicable premium after a few years of renewal. Some insurers offer additional discounts if the policy is renewed through National Automated Clearing House or standing instruction either by direct debit of bank account or credit card. Nayan Goswami, head, General Insurance, Sana Insurance Brokers, says opting for guaranteed cumulative bonus is beneficial as it results in a higher coverage amount without any extra premium.

Restore benefits, riders

Go for a policy that offers restoration benefits if the sum insured is exhausted in the policy year due to hospitalisation. It is an ideal feature in a family floater plan. If the base cover of the floater is exhausted, the family members continue to get coverage on restoration of sum insured.

Avoid a health insurance plan with high co-pay or deductible. While it may reduce your premium, your out-of-pocket expenses will be higher. Better opt for a higher deductible super top-up plan and higher base plan. Most health plans offer essential riders, for an extra premium such as critical illnesses, that you can choose based on your needs.

EXTRA COVER

* Cashless OPD includes professional fees, medicine bills, diagnostic fees, treatments for fractures, dental treatments, minor surgeries, etc
* Guaranteed cumulative bonus protects loss of cumulative bonus post claim, in exchange for the same premium
* Add essential riders & a top-up plan to make the insurance comprehensive

(The writer is Saikat Neogi.)

TOP

The criticality of critical illness insurance – The New Indian Express – 14th November 2022

It is interesting to note that prior to the start of the financial year 2020-21, barely 10% of those with the means were interested in buying health insurance to cover new age diseases. But a documented study back then showed that since the advent of the fear instilled by the pandemic, 71% considered health insurance a necessity.

Notably, and almost overnight, 57% of those surveyed claim to understand the importance of comprehensive health insurance plans. I would, however, not be too surprised if those high numbers have fallen off a fair bit, as it is human nature to get complacent once there is some semblance of a return to near normalcy.

In this context, it would be prudent for every sensible person to take time out to understand and consider purchasing a very crucial insurance product, namely critical illness insurance. Most people tend to overlook it believing that since they have Mediclaim they are adequately covered. But the fact is, firstly there has to be hospitalisation for mediclaim to kick in, and further, there are often caps and sub-limits that will easily be exceeded in the event of a critical illness.

Furthermore, escalation in premium payable in case of mediclaim is a given, especially post a year like the last couple of years where huge pay-outs have been made. In contrast to this, there are critical illness insurance policies that offer the optional benefit of covering several (approximately 30 plus usually) critical illnesses such as cancer, heart attack and kidney failure for a maximum of 30 years without any change in premium.

What also makes some of these product offerings distinctive is that it gives full claim payout on the first diagnosis of any of these covered critical illnesses, even without hospital bills. This payout amount is particularly crucial as it can also safeguard one's family against the loss of income arising out of an illness that could put one out of action for a prolonged period of time.

Critical illness policies usually come bundled with an equivalent Term Plan and that usually adds an enhanced financial ring around the family of the one with a critical illness in the event of non-survival. That the payment of Premium paid under such a policy can be demarcated and qualifies for deductions under both, Section 80C as well as Section 80D of the Income Tax Act, offers an additional benefit.

Finally, one must remember that if ever diagnosed with a critical illness, it can affect one physically, emotionally, and financially. By investing in a critical illness cover, one can at least take the inevitable financial pain and insecurity out of the equation. We have made this part of our MUST DO Financial Decisions List and having thought it through, a large number of people we know have discussed it with us and made the right choice. Again, like most insurance products, it is about acting in time to secure your family's financial future.

(The writer is Ashok Kumar.)

TOP

World Diabetes Day 2022: Can blood sugar patients take health insurance? – Zee News – 14th November 2022

World Diabetes Day 2022 is being observed across the globe today, i.e. November 14. The day provides an opportunity to raise awareness of diabetes as a global public health issue and the efforts needed for its diagnosis, prevention and management. This year's theme of World Diabetes Day 2022 is 'access to diabetes education' and it underpins the larger multi-year theme of 'access to care'. According to the World Health Organisation, there are about 422 million people worldwide who have diabetes and 1.5 million deaths are directly attributed to diabetes each year. So, while diabetes may appear as a common disease, it's can be lethal as well and no one should take it lightly.

According to World Health Organization, diabetes cases are increasing rapidly in India with an estimated 8.7% diabetic population in the age group of 20 and 70 years. The Government and the medical fraternity are putting in concerted efforts to drive awareness around the ailment so that it can be managed better. Dr. Preet Pal Thakur, co-founder, Glamyo Health, said that the ever-increasing crisis of diabetes and its comorbidities can have long-term deleterious repercussions on health and quality of life. He also urged the government and private organisations to incorporate effective preventive and educational programs/campaigns to raise knowledge about the risk factors for diabetes and its complications.

When it comes to health insurance, a diabetic person often wonders whether s/he is eligible for taking health coverage or not.

Can a diabetic person get health insurance?
Experts say that a diabetic patient can avail of health insurance but he/she may have to pay some extra premium for that.

Pooja Yadav, Chief Product Officer, Edelweiss General Insurance, said, "Health insurance policies do cover lifestyle diseases like diabetes, which are diagnosed after policy inception. However, for persons with pre-existing diabetes (where the medical condition exists at the time of buying the policy), the health insurance coverage is usually offered with either a waiting period or loading or both on the Biresh Giri, Executive Vice President and Appointed Actuary at ACKO, said that many insurers issue policies to individuals with 6.5 – 7 HBA1C readings today which are not at a very severe level. "There are products in the market specific to diabetic patients where the disease is covered with a waiting period and Co-Pay," he said.

Why health insurance is necessary for blood sugar patients?
Managing diabetes can often become strenuous financially and impact household savings, so one should take into consideration various factors while taking the health policy. "Managing diabetes can often become strenuous financially, thereby impacting household savings and consequently so, various planned life goals. Therefore, getting a diabetes-specific health insurance plan that covers Hospitalisation expenses along with pre and post-hospital care, day care treatment, dialysis, ambulance cover, consumable allowance as well as domiciliary hospitalization among other benefits can secure your health and finances against unforeseen medical emergencies in the future," said Ajay Shah, Director and Head - Retail, Care Health Insurance.

Do diabetic patients need to pay a premium compared to non-diabetic/healthy persons?
Yadav said that the premium for any health insurance coverage is dependent on various factors such as the benefits offered under the health insurance coverage, the sum insured opted for, the age of the insured and medical history among other factors.

Giri said that insurance companies assess diabetic patients to be at high risk as compared to other individuals because their chance of hospitalisation is higher. "As a result, individuals with diabetes have to pay 15-30 per cent higher premiums. In a usual case for a healthy person with a family of three - parents and child, the premium comes up to approximately 10,000-12,000 for a coverage of 10 lakhs. If the policyholder is diabetic in this case, the premium may go up to 10-20 per cent more depending on the severity of the condition," he said.

(The writer is Akash Sinha.)

TOP

How Indian TPAs can leverage global opportunities in health benefits administration – The Economic Times – 13th November 2022

The Indian health insurance sector is on a path of tremendous growth. Increased awareness, large healthcare costs and medical inflation have made more Indians interested in health insurance. The health insurance market was valued at INR 1,886.25 Bn in FY 2021. It is expected to reach INR 2,517.90 Bn by FY 2027, expanding at a CAGR of ~5.12 percent during the FY 2021 - FY 2027e period. The pandemic has emphasised the importance of healthcare on the economy, and health insurance would play a critical role in the effort to strengthen the healthcare ecosystem.

Many health insurance providers in the country, to meet the

growing needs of their customers and operate effectively outsource claims processing to an Insurance TPA (third-party administrator).

Having realised the potential of technology, Indian TPAs have effectively created tech stacks that highlight claim abuse and fraud scenarios in time, thereby ensuring an effective insurance ecosystem across all touch points including policyholders, insurance providers and healthcare centres. While Indian companies make strides in international territories, there is not much stopping Indian TPAs to showcase their capabilities in benefits administration on a global scale. Let us look at how Indian TPAs' technology-powered processes and fraud management systems are poised to go global.

Technology adoption to replace traditionally inefficient processes

Working as government-regulated intermediaries between policyholders and insurance providers, Indian TPAs have been integrating new-age technology solutions in processes such as patient enrolment, administration of applicable benefits and claim processing. Replacing manual processes with home-grown IT solutions, these TPAs have not only done away with repetitive tasks but also eliminated errors that would otherwise increase the cost burden on policyholders and insurance providers alike. This has been done using digitalization and automation tools, powered by advanced technologies such as machine learning (ML) and artificial intelligence (AI) to introduce additional opportunities to deliver value-added services.

By reducing duplication of efforts, utilising automated workflows to reduce process time and harnessing the power of data analytics, Indian TPAs have been playing an important role in strengthening the domestic healthcare ecosystem. The advanced solution stacks can be readily deployed to facilitate the delivery of quality healthcare to patients across the world and serve international clients or organisations.

Employing data modelling to reduce administration costs

By deploying fraud detection engines to prevent instances of overbilling and optimising healthcare costs across the network of partner hospitals, Indian TPAs continue to support consumers in availing quality healthcare at affordable rates. The use of advanced claim engines that verify policyholder information and eligibility during the claims admission stage itself is supporting insurance providers in sifting through only the huge volume of claims and eliminating errors in a fraction of the time that was needed earlier.

As a result of these initiatives, insurance providers are now able to do away with operational excesses, reduce or eliminate non-admissible claims and optimise the cost of major surgical procedures; thereby controlling administration expenses even while medical inflation continues to rise unabated. This capability is even more vital when tending to a global set of patients; helping insurers and multinational companies in balancing between delivering healthcare benefits and managing operation costs.

Leveraging integration strategies to drive holistic cost-reduction

Just like insurers in developed countries, Indian Health insurance providers are consciously upgrading the overall health coverage in terms of inclusions and benefits offered, while trying to keep health insurance premiums affordable for the vast majority of India's population. However, it is the TPAs who are constantly innovating by using technology solutions to balance all objectives and use the wealth of data collected to explore avenues for cost optimization. Some examples are the introduction of packaged healthcare services at a pre-defined cost, forging partnerships with leading hospital chains to provide cost uniformity and sharing claims data with insurance providers and hospitals to highlight further areas that need cost-reduction.

Having catered to a diverse population and across the country's vast geography, Indian TPAs have proved their mettle and can make large strides in leveraging this experience to forge international partnerships. There are a wealth of opportunities in the offing for Indian TPAs to capitalise on in the global market and cater to a global audience. The combination of world-class claim management, cost-optimization through network expansion and the rich experience in transforming customer experience using latest

technologies truly distinguishes Indian TPAs as worthy alternatives to more expensive international players.

In summary, health insurance providers and TPAs in India have demonstrated how working relentlessly to enhance operations can reduce costs of operation, maintain high quality standards and ultimately make healthcare more affordable for the end consumer. As Indian TPAs continue to incorporate new technologies and make data-driven decision making the new normal, their capabilities on managing healthcare costs by better connecting all stakeholders in the healthcare ecosystem can very well go global.

(The writer is Satish Gidugu.)

TOP

How diabetes-specific insurance plans offer coverage and benefits – Business Standard – 13th November 2022

An increasing number of people are contracting this ailment at a young age. The situation may worsen as the country's demography alters. "India is still a young country, but as the population ages the burden of this disease will multiply," says Bhabatosh Mishra, director-underwriting, products and claims, Niva Bupa Health Insurance. According to the India Diabetes Report 2000-2045 (diabetesatlas.org), the number of diabetic persons in India is expected to touch 124.9 million by 2045. People who suffer from diabetes harbour a misconception. "Both in my clinical practice and in my interaction with other clinicians I am asked: Can diabetics get a health insurance cover? The answer is yes," says S. Prakash, managing director, Star Health and Allied Insurance. When people already suffering from diabetes try to buy a regular health insurance policy, they may be turned down or may get it only with a heavy premium loading. Moreover, these regular plans are offered to diabetics with a waiting period of two-four years for this condition. It is these issues that diabetes plans now offered by several insurers address. Some offer these features in the main plan while others do so in a rider.

PREMIUMS AND WAITING PERIODS OF DIABETES PLANS

Plan/Rider	Monthly premium for sum insured ₹5 lakh* (₹)	Waiting period (for in-patient) For diabetes	Waiting period (for in-patient) Illnesses other than diabetes
Care Freedom for Diabetes	1,166	2 years	2 years
Star Diabetes Safe Plan B	1,898	1 year	4 years
ABHI-Activ Health Platinum Enhanced (Diabetes)	1,750	Initial 30 days	3 years
Manipal Cigna-Prime Active (Diabetes/BP/Asthma) + Wellness	1,173	Initial 90 days	2 years
Niva Bupa Reassure with Smart Health+rider (Platinum)	1,272	Covered from Day 1	3 years
Care Classic with Instant Cover rider	1,438	Initial 30 days	4 years

*Premiums are for a 44-year-old male

Source: PolicyBazaar

Diabetes plans are targeted at people who don't have a health insurance policy and suffer from diabetes. In a regular health insurance plan (indemnity cover), a person already suffering from diabetes would have to undergo a long waiting period. "But people with diabetes tend to get infections and injuries often. Episodes of fluctuations in sugar levels are frequent. They are also at high risk of complications arising due to diabetes," says Mishra. The most powerful feature of these plans is that they enable early coverage of diabetes. "A diabetes-specific cover has little or no waiting period for this ailment," says Apaar Kasliwal, executive director, PolicyBoss.com. In some policies, there may be a waiting period but it is usually much shorter than the two-four years they would face in a regular cover. "Earlier, many people who had diabetes wouldn't buy health insurance because they had to face a two-four-year waiting period. Insurers have started offering diabetes plans to incentivise such people to buy health insurance," says Siddharth Singhal, business head-health insurance, Policybazaar.com.

Some of these plans also waive the waiting period for hypertension. They also cover other ailments and accidents, just like a regular health plan. These policies are not prohibitively expensive. "Their premiums, on an average, are around 20 percent more than that of a regular health insurance cover," says Nayan Goswami, head-sales & service, SANA Insurance Brokers. Many of these covers also nudge customers to

undergo quarterly screening and work on managing their condition. "Customers get discounts on their base and rider premiums for both getting themselves tested regularly and for managing their health situation well. If they do both, the discounts they earn can be sizeable," says Mishra. (Niva Bupa offers the waiver of waiting period on diabetes as a rider.) Players like Niva Bupa also offer acute care facilities. In case a situation arises, a diabetic person can consult a specialist online. The patient doesn't have to rush to a hospital. At the same time, the frequent issues diabetics are prone to don't get ignored.

Usually no health check-up is required while purchasing the policy. "In around 95 percent of cases, there's no health check-up. The policy gets issued on the basis of self-declaration and recent diagnostic reports," says Singhal. Adds Goswami: "Nowadays many insurers issue policies based on tele medicals and the latest reports. If the tele medical check-up throws up adverse findings, then tests may be required." Kasliwal says depending on age, current status (severity or complexity) of pre-existing ailment, and medical history, some insurers may ask for a medical check-up for better risk profiling. Prakash informs that if a person has already developed organ damage (say, damage to the kidney) due to diabetes by the time of buying the policy, that will not be covered. Acute cases may at times be excluded from coverage by some insurers. "Many insurers exclude diabetes type II or uncontrolled type II diabetes. But plans that cover both are also available," says Goswami.

Prior to purchasing one of these plans, go through the customer information sheet or the prospectus. "Check whether the offer to waive the waiting period applies only to outpatient department (OPD) consultations for chronic diseases or to in-patient treatment also," says Goswami. Adds Singhal: "As with any health cover, make sure there is no copayment or room rent capping." Policies that have disease-specific sub-limits should also be avoided. If the insurer asks for a health checkup, go for it. Some insurers waive the waiting period on diabetes if you undergo a health checkup, but impose it if you refuse to submit to it. If you already have a health indemnity cover, don't buy one of these plans. But make sure your existing plan has a substantial OPD cover. If not, port to a plan that has one since ailments like diabetes require a considerable amount of expenditure on OPD consultation and pharmacy.

(The writer is Sanjay Kumar Singh.)

TOP

The importance of Diabetes coverage in a health insurance plan – The Economic Times – 13th November 2022

Diabetes is known to be one of the most common chronic disease, which overtime if not managed can cause serious health problems, such as heart disease, vision loss, and kidney disease. Alarmingly, India has the second-largest adult diabetes population in the world. Nearly, every sixth person with diabetes in the world is an Indian as per Indian Council of Media Research (ICMR).

One cannot know for sure if they are susceptible to diabetes as it relies on various factors including age, weight, family history, genetic composition, and most importantly, lifestyle habits. This chronic disease can even turn into a life-threatening one, thus, people should opt for a health insurance plan that covers diabetes. By doing so, they can keep both – their finances as well as health in check. Additionally, a health insurance plan acts as an investment against unforeseen circumstances that might arise at any time and plunge a person's family into a terrible financial crisis.

On World Diabetes Day, let's explore a few of the crucial benefits of a health insurance plan that covers diabetes.

Advantages of health insurance plan with Diabetes coverage

Financial Coverage: The costs of hospitalization, today for getting treated for a major disease or chronic disease can cause a major dent in your savings. Thus, in the face of sudden hospitalization, a health insurance plan with adequate coverage ensures that all your healthcare expenses are taken care of even while prices of both hospitalization and medicines are skyrocketing every year. A sufficient health cover secures from unwarranted stress, safeguards your long-term financial goals thus, helping you to remain in good health and ensures financial security in the long run.

Condition Management Program: Diabetes or other chronic disease may restrict one from leading a normal lifestyle. Hence there are some insurers who offer built-in Condition Management Program under their specialized healthcare insurance plan, which allows you to track your current health status and rewards you for bringing about positive improvements in your health and well-being. At the end of the program, 'Health Scores' are calculated based on the improvement in your health parameters, and you also get to earn valuable reward points that can be utilized as discount in the renewal premium, which help make it easier and more affordable for you to manage your diabetes. And that means you have less to worry about on your journey towards better health.

Shorter Waiting Period: If one is diagnosed with diabetes before purchasing the insurance coverage, it is considered a pre-existing condition, wherein there is a waiting period of two to four years, depending on the insurance provider. Also, there are very limited insurance options for the customers suffering from the chronic conditions. However, if you do a good research, you will come across some specialized healthcare insurance plans in the market that also covers conditions like diabetes, hypertension, asthma, obesity and dyslipidaemia, and what's more it has a shorter waiting period of only 90 days. This plan is good for people with diabetes, as it provides you not just insurance but a complete world of care.

Unlimited Tele-Consultation including specialists: Some specialized healthcare insurance plans offers unlimited tele consultations in major Indian languages with Doctors, including specialists to help take better care of health and to ensure complete all round protection. Tele-consultation benefit helps in keeping a tab on one's health, ensuring 24X7 immediate care.

Annual Health Check-up: The majority of health insurance plans in the market provide free of charge Annual Health Check-up each policy year (including the first year), for all Adult insured persons who have completed 18 years of Age. This package is complementary for you and mostly offered on cashless basis only. Thus, it's important to look for insurance that offers Annual Health Check-up, as a proactive approach to the health.

To conclude, if one already has a health insurance plan in place, it's a good idea to review the coverage. On the other hand, if one does not have health insurance, it is vital to get a specialized healthcare insurance plan as soon as possible in order to preserve one's physical, emotional, and financial health at all times.

(The writer is Priya Deshmukh Gilbile.)

TOP

Claiming maternity benefits becomes easier with new online portal – Zee News – 12th November 2022

In good news for Employees' State Insurance Corporation of India (ESIC) subscribers, claiming maternity benefits will become easier as the corporation has come out with an online portal for the same. Union Minister of Labour & Employment Bhupender Yadav launched the ESIC online maternity benefit claim facility during the commemoration of the 102nd birth anniversary of Dattopant Thengadi at Vigyan Bhawan, New Delhi.

Speaking on this occasion, Yadav lauded the efforts of ESIC for the initiative of using technology for easing the lives of Insured Women. He said that this portal will make the benefits easily accessible to the beneficiaries.

The newly introduced facility will ease the process of claiming maternity benefits for Insured Women as the process has now been made online, where the beneficiaries, at their convenience can now claim the maternity benefits from anywhere. Earlier, the beneficiaries, to claim the Maternity Benefits, had to visit the respective branch offices physically but now with the introduction of this new facility, one can avail of the benefits at their convenience.

Maternity Benefit is given to insured women in the form of cash benefit in case of certain contingencies such as in the advanced stage of pregnancy, after delivery / in the unfortunate event of confinement or miscarriage and who meet the eligibility conditions. Payment at the rate of 100% of wages is paid for 26 weeks as maternity benefit to the insured woman by ESIC to compensate for the loss of income during her childbirth. A total of 18.69 lakh women beneficiaries have been provided maternity benefits of Rs 37.37 crore during the year 2021-22.

Rameswar Teli, Minister of State for Labour & Employment also attended the programme as the Guest of Honour. Teli, also praised the initiative during the event and said that this step will help to realize the aim of women's empowerment more effectively.

TOP

SURVEY & REPORTS

Explained: Challenges, opportunities for, yet to become sixth largest, Indian insurance market – The Economic Times – 14th November 2022

India is on its way to become the sixth largest insurance market in the world, over the next decade with the insurance premiums growing at an average of 14 percent per annum in nominal local currency terms, according to recent reports.

Swiss Re highlighted that the non-life insurance market returned to a growth rate of 5.8 percent in 2021 after a marginal contraction in 2020.

Talking about the number of new insurance policies sold, a latest report by PGA highlighted the sector has witnessed an increase from 198 million in FY18 to 264 million in FY21 at 10 percent CAGR.

"Health grew at 7.5 percent during FY18-21 and it is expected to grow at 16.1 percent during FY21-31. Growth in other insurance policies is driven by increasing penetration of crop, fire & property insurance in India," it further said.

The life insurance space is also expected to grow at an exceptional rate of 6.6% in 2022 and further rise to 7.1% next year. Premiums are also projected to cross $100 billion for the first time in India by the end of year.

Total insurance market in India stood around INR 8 trillion in FY21 and is projected to reach INR 33 trillion by FY31 at 14.9% CAGR, the PGA Report added. While the Insurance value chain is transitioning from a rigid to a modular and open structure resulting in improved data flow, digital products & Customer experience.

Tech, distribution, and upskilling: Major challenges

Insurance – a key sector of any growing economy – has more than a few key challenges that it faces in India. Relatively few buyers & sellers in rural areas lead fixed costs to remain high, further leading to lower penetration.

The Covid pandemic has dramatically shifted awareness and education for the health insurance, leading to more footfalls for the policy, the awareness of other insurance products is growing at a snail's pace. The industry is filled with perceptions of slow and unreliable agents who do not have the policy takers' best interests in mind. Customers now expect instant access, immediate responses, and demand rapid action.

While online and Point of Sale (PoS) channels are slowly gaining popularity, there is heavy reliance on traditional distribution channels, making it tougher for advanced insurance plans to gain traction. Another major issue is the slow rate of digitalization by incumbents, apart from slowing down the pace of digitisation, lack of automation and high levels of manual data entry tasks expose organizations to a risk of error leading to high employee costs.

Claims management and customer engagements are still reactive with low focus on customer experience, the report added.

Government initiatives sailing the boat

Amid the ups and downs in the industry, government has taken several initiatives to make the Insurance industry more conducive to growth and ease of doing business. Here are some of the key developments:

-An increase in FDI in insurance from 49% to 74% announced in the Union Budget (February 2021) shall benefit domestic insurers by increasing competition & improving product offerings, the PGA Report highlighted.

-The General Insurance Business Amendment bill (August 2021) allows the privatization of state-run insurance companies, increasing insurance penetration and efficiency across the value chain.

-The Finance Ministry of India plans to infuse capital of INR 3000-5000 Cr in state-run general insurers to help improve the financial health of the general insurance firms

-The minimum capital requirement to set up an insurance firm is planning on being relaxed from INR 100 Cr to INR 20 Cr to widen the reach of insurers and help mini-insurers with niche product offerings.

-Introduction of the National Health Stack framework that envisages centralized health data allowing health insurers to improve underwriting, fraud detection and claims processing.

Leveraging tech, consumer interaction: Way forward for the sector

To unlock higher potential of the insurance sector, the industry needs to leverage technology within the organization and customer interactions.

Digitalization should be made a target to achieve across the value chain, with an order of priority - to reduce cost, improve efficiencies & support further ecosystem developments.

Players would need to be aligned with dynamic changes in customer behavior & preferences and manage perceptions by showcasing fiduciary responsibility, like offering quick personalized products can be prioritized over mass-product offerings to give customers more flexibility.

There's an urgent need to optimise usage of Data & analytics across functions for maximum efficiency, especially in the case of underwriting & claims.

Distribution should be reimagined to include technology & focus on high potential markets, the report said while adding that the hybrid distribution models with humans and technology can be adopted to focus on rural markets.

The claims management process would need to be simplified for the insurer and insured. Strategic partnerships can be considered to manage scale and gain access to a further set of partners.

Technology would need to be leveraged to create and maintain higher employee efficiency. Upskilling programs can be established that develops a mix of soft, technical and digital skills.

(The writer is Sheersh Kapoor.)

TOP

INSURANCE CASES

Insurance company challenges compensation awarded by tribunal, ends up paying four times more – PTI News – 14th November 2022

An insurance company which challenged the compensation of Rs 11.39 lakh awarded by a Motor Vehicle Claims Tribunal has been ordered by the Karnataka High Court (HC) to pay Rs 44.92 lakh to the victim instead.

The National Insurance Company approached the HC with an appeal against the 2015 judgment of the Motor Vehicle Tribunal which ordered it to pay compensation of Rs 11,39,340 to one Alwin Lobo, an engineer RPT engineer.

Lobo was traveling with his brother on a motorbike which was involved in an accident with an auto-rickshaw. He sustained severe injuries and spent several months in hospital. He sustained "permanent injury" to his head as well.

TOP

PENSION

NPS rules eased: PFRDA releases new exit form, know the changes - The Economic Times – 16th November 222

The Insurance Regulatory and Development Authority (IRDAI) and the Pension Fund Regulatory and Development Authority's (PFRDA) have agreed to streamline the procedure of issuing annuity to NPS subscribers by using a withdrawal form. This means that National Pension System (NPS) subscribers will no longer have to fill out a separate proposal form in order to choose an annuity.

IRDAI made the announcement about immediate annuity products via a circular dated September 13, 2022.

Benefits of parallel processing of exit and annuity components
At the time of withdrawal, NPS pensioners are currently required to submit an "elaborative" exit form to the Pension Fund Regulatory and Development Authority (PFRDA). Once they have decided on their preferred annuity plans, they must fill out a thorough proposal form provided by the insurance companies.

According to the PFRDA circular dated November 14, 2022, the benefits of the coordinated action by both financial regulators are manifold towards the benefit of Subscribers & stakeholders as described below:
a. Ease of Annuity and speed of its issuance
b. Parallel Processing of Lump sum payment and Annuity issuance
c. Payment of Retirement Income through Annuity immediately after one's retirement and hence uninterrupted income flow to the retirees ensured.
d. Ease of Old Age Income Support.
e. Ease of doing business for the associated stake holders.

According to the PFRDA circular dated November 14, 2022, “All Subscribers are hereby informed that at the time of initiation of the exit request, the completely filled proposal form along with the specified supporting documents including KYC (Refer Page no. 5 of Annexure A) is to be uploaded in the respective CRA system through their login credentials.”

Also, PFRDA intends to make the upload of the Withdrawal form/document mandatory at a later time based on the response and feedback to the common proposal from the stakeholders and subscribers. All senior citizens, including NPS Retirees who are receiving periodic annuity payments, will benefit from the provision of Aadhar-enabled authentication for life verification certification through Jeevan Praman

(the Indian government's initiative on biometric enabled digital services for pensioners), the circular added.

TOP

How the SC ruling affects your pension payouts – The Hindu – 13th November 2022

Successive governments in India have been trying to wean workers away from defined benefit pension plans, to market-linked ones. This is perhaps why the long-pending Supreme Court case on the Employees' Pension Scheme (EPS) has generated so much interest.

Last week, the Supreme Court gave some employees a window of opportunity to opt for the EPS, a scheme guaranteed by the Government of India. Here's what the ruling means for retirement plans.

(The writer is Aarati Krishnan.)

TOP

National Pension System (NPS) for organised and unorganised sector employees – Live Mint – 11th November 2022

NPS is the safest investment option for investors looking for low-risk and schematic investment methods. Under the NPS scheme, individual savings are collected in the form of a pension fund which is then invested by certified PFRDA fund managers into diversified portfolios including the likes of Government Bonds, Corporate Debentures, Bills, and shares. Further, the pooled savings are invested in accordance with the approved investment guidelines and standards.

Eventually, these contributions grow and get accumulated over years, depending on the returns gained on principle investment. National Pension Scheme is not just for employees working in the organised sector. It is even more beneficial for the unorganised sector. Keep reading to know how.

What All Measures Have Been Taken To Include Everyone?
The National Pension Scheme is a great option for any individual who has a low-risk appetite and is planning for early retirement. A regular monthly income in the form of a pension is no less than a boon for individuals retired from private-sector jobs.

This type of systematic retirement can make a huge difference in your lifestyle post-retirement.

Best Features of NPS - Swavalamban
Easy & Quick - Eligible candidates from the unorganized sector can open their accounts via an aggregator and have an individual NPS-Swavalamban account.

Voluntary - open to anyone aged between 18 to 60 years. Also, individuals are free to decide how much amount they want to invest.

Safe & Secure - It is a safe and secure program regulated by PFRDA. It offers regular monitoring, transparent investment conditions, and performance reviewed by PFRDA-certified fund managers.

Cost-Effective - Subscribers can start investing from as low as ₹1000 per month. There is no minimum amount requirement.

What All Schemes Are Available?
Swavalamban Yojana is a well-known scheme introduced by the Government of India under which it will contribute Rs. 1000 per year to each NPS subscriber who has opened his account in the years, 2010-11,2011-2012,2012-2013 for a duration of 5 years as follows:

1. Accounts opened during 2010-11 will receive benefits till 2014-15
2. Accounts opened during 2011-12 will benefit till 2015-16.
3. Accounts opened during 2012-13 will benefit till 2016-17.
4. Swavalamban accounts opened during 2013-14 to 2016-17 will get benefits till 2016-2017.

Should the Unorganised Sector Consider Investing in NPS?
More than the organised sector, the Swavalamban scheme is beneficial for individuals working in the unorganised sector. It is a great way to secure regular future income for you and your family post your retirement. When you contribute a small portion of your salary during your working life, it gets accumulated as a pension for your retirement. The longer duration of pension ensures higher returns in the near future.

Unorganised Sectors Are More Secure With NPS
The National Pension Scheme offers more security to unorganised sector workers. The age eligibility of this Yojana for self-employed individuals, shop owners, and others is between 18 and 40 years. Note that their annual turnover should not be more than ₹1.5 Crore.

Under this voluntary pension scheme, each subscriber would receive a guaranteed minimum pension amount of 3000 every month, after reaching 60 years. And in case a subscriber dies, 50% of his pension will be given to his spouse as a family pension.

Hence, if you're looking for a low-risk, better returns and safe retirement scheme, then NPS is a great option for you.

TOP

GLOBAL NEWS

Asia Pacific: Life insurance business in advanced markets expected to fall this year but climb up in next 2 years - Asia Insurance Review

The life insurance market in Advanced Asia Pacific is expected to see premiums decline by 6% in real terms in 2022, according to Swiss Re Institute (SRI).

In its report, "Economic stress reprices risk: global economic and insurance market outlook 2023/24", SRI says that the decline is led by South Korea, Taiwan, Hong Kong, and Australia.

Saving business declined strongly year-to-date in South Korea, and domestic competition from alternative products is a risk to watch. In Hong Kong, restricted mobility during the Omicron outbreak has reduced premium growth this year, but SRI expects a strong rebound next year if the border with China reopens.

In Australia, SRI expects a contraction of 4.3% in real terms mainly due to high inflation. Regulatory tightening and market volatility have reduced demand for ordinary life and annuity products in Taiwan.

On a brighter note, growth tailwinds are coming from Japan, where the digitalisation of sales channels is supporting life protection and SRI estimates 1.5% real terms premiums growth this year and next.

SRI expects premiums in advanced Asia will grow by an annual average of 2% in real terms in 2023 and 2024.

Emerging markets
In emerging markets excluding China, life premiums should grow by an estimated 2% in real terms in 2022, with the largest increases in Asia (5%). The medium-term outlook is still brighter, with 5.1% expected average annual real growth – and 7.4% annual growth in emerging Asia (excluding China) alone, over 2023–24.

In India, the second-largest life insurance market in the emerging world, SRI expects life premiums to grow by 8% in real terms supported by economic recovery, risk awareness, and rising insurance penetration. In light of recent regulatory developments and a strong push from regulators, there is a possibility of a much stronger growth rate in India in the medium to long term.

The following table summarises forecasts for Asia Pacific's insurance industry:

Insurance premium forecasts, in real terms

	Total			Non-Life			Life		
	Past 2017–2021	Growth rate 2022	Outlook 2023–24	Past 2017–2021	Growth rate 2022	Outlook 2023–24	Past 2017–2021	Growth rate 2022	Outlook 2023–24
Advanced Asia Pacific									
	-0.5%	-3.9%	2.2%	3.1%	2.1%	2.3%	-1.7%	-6.0%	2.0%
Emerging Asia Pacific (excluding China)									
	2.5%	1.5%	4.0%	2.2%	1.4%	3.2%	3.1%	2.0%	5.1%
China									
	6.2%	2.6%	4.3%	8.5%	3.6%	4.7%	5.3%	0.2%	3.7%

Source: Swiss Re Institute, "Economic stress reprices risk: global economic and insurance market outlook 2023/24"

Non-life market

In advanced Asia, aside from Australia, lower inflation makes for more favourable real growth in premiums in the non-life sector than in other advanced markets.

SRI sees strong real premium growth in emerging Asia excluding China of 7.3% on average in 2023 – 24, driven by commercial lines, health, and a resilient economic backdrop.

Globally, the insurance industry is forecast to return to growth in 2023– 2024 after total global premiums are estimated to have contracted by 0.2% in real terms in 2022. Real non-life premiums are forecast to grow by 1.8% in 2023 and 2.8% in 2024; whereas life premiums are predicted to grow by 1.7% across 2023 and 2024.

TOP

Vietnam: Insurance association issues Code of Conduct for actuaries - Asia Insurance Review

The President of the Vietnam Insurance Association (VIA) has signed a decision to promulgate a Code of Conduct for the actuarial profession.

The Code of Conduct consists of 10 rules that help define the professional and ethical standards that an actuary must adhere to in order to carry out his or her responsibilities to society, stakeholders and the actuarial profession.

Rule 1 — professional integrity: Actuaries must act honestly, with integrity and in a manner appropriate to fulfill their responsibilities to the community, users and stakeholders.
Rule 2 — professional competence: Actuary is only permitted to provide actuarial services when he or she has the appropriate professional capacity and experience to do so.
Rule 3 — information disclosure and communication: Actuaries must take reasonable action to ensure that any information for which they are responsible or related is accurate and not misleading.
Rule 4 — conflicts of interest: Actuaries will not actively perform actuarial services involving actual conflicts of interest or potential conflicts of interest.
Rule 5 — information confidentiality: actuaries may not disclose to third parties any confidential information obtained from performing professional work for a service user.
Rule 6 — competence and prudence: Actuaries are to perform their work competently and with care.
Rule 7 — compliance and opinion: Actuaries must comply with all relevant laws, regulations and professional guidelines.
Rule 8 — continuing professional development: Actuaries should continuously strive to improve their professional competence.
Rule 9 — respect and support: Actuaries must always show respect for other actuaries in communication and conduct.

Rule 10 — work control: Actuaries must take reasonable action to ensure that actuarial services provided by them are not used to mislead interested parties or violate laws.
Actuaries must keep up to date, not only with the Code of Conduct, but also with applicable legislation and codes of professional conduct in the areas where they provide actuarial services.

TOP

Indonesia: Morbidity table expected to become reference for insurers - Asia Insurance Review

A morbidity table for critical illness is expected to be a reference for insurance companies in Indonesia in designing premium products and determining prices.

"Although this is the first time this mobility table has been in Indonesia, it is only a reference and has not yet become a standard for the insurance industry," said the finance director of Reasuransi Indonesia Utama (Indonesia Re) Ms Maria Elvida Rita Dewi.

She was speaking last week at the launch of the first edition of the Indonesian Morbidity Table for Critical Illness.

The Indonesian Morbidity Table was launched by the Indonesian Life Insurance Association (AAJI) together with the Financial Services Authority (OJK), the Association of Indonesian Actuaries (PAI), Indonesia Re, and Swiss Re.

The basis for compiling this morbidity table is the need of the insurance industry for a reference for actuaries to develop products and set premiums, especially life and health insurance products that provide protection against critical illness.

“The process of compiling (the table) is quite long. We collected them since Semester II/2018 and just finished in Quarter II/2022. One reason for the length of the process is that the data were not uniform.

Previously, insurance companies used data from neighbouring countries and adjusted them to Indonesia's circumstances.

TOP

Thailand: Insurance industry growth predicted to be flat in 2023 - Asia Insurance Review

The insurance regulator, the Office of Insurance Commission (OIC), has forecast that the sector will see flat growth next year with total GWP expected to amount to THB890bn ($24.8bn), close to the volume estimated for this year.

It is estimated that direct insurance premiums for 2022 full-year will be about THB886.2bn, with a growth rate of approximately +0.10% to +2.10% and split as follows:

Life insurance premiums are estimated at THB614.92bn, with a year-on-year change of -0.82% to +1.18%, consistent with the Thai Life Assurance Association's projections.

Non-life insurance premiums are estimated to amount to THB271.29bn, with a growth rate of approximately +2.25% to +4.25%, consistent with the estimates of the Thai General Insurance Association.

The projected direct premium income for the full year 2023 is about THB894.6bn, with a year-on-year change of -0.05% to +1.95%.

The most popular life insurance products are expected to be endowment life insurance products and health insurance riders. The most popular non-life insurance branch is motor. With the opening up of the country after COVID-related lockdowns are lifted, and the government's focus on tourism, international travel insurance will be another branch that will become more popular.

TOP

Indonesia: Govt mandates deposit insurance agency to guarantee insurance policies - Asia Insurance Review

The Financial Services Authority (OJK) is trying to accelerate the formation of a Policy Guarantee Agency (LPP) to provide protection for policyholders in the event an insurance company has its licence revoked or is in default.

To this end, the Deposit Insurance Corporation (LPS) has received a new mandate from the government to guarantee insurance policies. This was conveyed by the Minister of Finance Sri Mulyani Indrawati on 10 November 2022, according to a Bisnis report.

Previously, LPS was only in charge of guaranteeing bank deposits and resolutions. "LPS will get a new mandate, namely to operate a policy guarantee scheme," the minister said.

Previously too, the government's proposal was to establish a Policy Guarantee Agency (LPP) that would offer such protection. However, it is projected that the LPP could be established in the next 3-5 years at the earliest. The mandate for the establishment of the LPP is contained in the Bill on Policy Guarantee, which is one of 19 Bills in the 2020-2024 Mid-Term National Legislation Programme. The target for the enactment of the Bill is in the 2021–2024 period.

But insurance industry players hope that the government will establish the agency immediately because it can provide certainty of benefits, reduce the risk of default, and increase the credibility of the insurance industry.

The head of the Shariah life insurance division of the Indonesian Life Insurance Association (AAJI), Mr Paul Kartono said that the existence of a policy guarantee institution could boost insurance business three to four times. The life insurance industry's turnover in 2021 reached IDR241.2tn ($15.6bn).

Cases of default by insurers and disputes have occurred in recent years, such as at Asuransi Jiwasraya, Asuransi Jiwa Bersama (AJB) Bumiputera 1912, Asuransi Jiwa Adisarana Wanaartha (WanaArtha Life), and Asuransi Jiwa Kresna.

Indonesia's 2014 Insurance Law requires the establishment of a policy guarantee agency (LPP) by 2017. In January 2020, Ms Mulyani said that the government would formulate the establishment of the agency mandated.

TOP