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INSUNEWS

– Weekly E-newsletter

Insurance Term

Family Insurance

Family insurance typically refers to health insurance policies that cover the medical expenses of an entire family under one plan. This can include the policyholder, their spouse, and dependent children, and sometimes even dependent parents. Family health insurance offers a cost-effective way to ensure that all family members have access to quality healthcare services. Many family health insurance plans offer flexibility to add or remove dependents, accommodating changes in family dynamics. Family health insurance is often more affordable than purchasing individual policies for each family member. The sum insured is shared among all family members, meaning the policyholder, spouse, and dependent children (and sometimes parents) can all access the coverage.

QUOTE OF THE WEEK

"The only thing standing between you and outrageous success is continuous progress."

Dan Waldschmidt

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High Premiums, Low Funds Key Barriers to Buying Health, Term Insurance - Business Standard - 16th April 2025

A survey of nearly 4,000 individuals, conducted by India's leading insurance aggregator Policybazaar, revealed that 31 percent of respondents cited high premiums, and 26 percent pointed to insufficient funds as the primary reasons for not purchasing health, and term insurance. According to the "How India Buys Insurance" report, about 83 percent of the respondents surveyed said they are aware of the need for a health insurance policy, but only 19 percent actually own one, showing a gap between intent and ownership. While there is an increase in inclination towards health insurance, 30 percent of the respondents neither own such a policy nor do they intend to buy it in the future. Lack of funds and trouble understanding products were cited as major deterrents to buying health insurance policy, according to the report. About 20 percent of the respondents said they do not fully understand health insurance, and 18 percent saw buying it as a cumbersome process.

When it comes to term insurance, nearly 48 per cent of respondents are still uninformed about the benefits, and only 9.6 per cent of the respondents own it. However, there is a growing interest for the product among the customers, the survey noted. Limited understanding of personal finance is a key reason behind lack of term insurance adoption. Lack of sufficient funds is a concern with term insurance as well. While 35 per cent of respondents cited it as a reason, 27 per cent found high premiums to be a deterrent. On the other hand, 48 per cent said product and process complexity is restraining purchase of term insurance policy.

The writer is Aathira Varier.

TOP

Indians Prefer Health Insurance above Equities, MFs, and Government Bonds - The Economic Times - 16th April 2025

Health insurance has become one of the preferred choices for Indians, and falls in the basket of top three 'must-have' financial products for them. The preference has shooted up to an extent that it is ranked above equities, mutual funds, and government bonds for them. According to a survey released by Policybazaar, 28.3 percent of respondents ranked health insurance above equities, mutual funds, and government bonds. However, in its 2nd edition of consumer insights report titled "How India Buys Insurance 2.0," Policybazaar said Indians continue to severely underestimate healthcare costs with nearly 48 percent of policyholders opt for coverage of Rs 5 lakh or less. A staggering 75 percent of health insurance buyers in India have coverage of Rs 10 lakh or less. The issue is most pronounced in South India, where 66 percent of policyholders have coverage of Rs 5 lakh or less, the report said. The report highlighted that about 51 percent of non-buyers of the health insurance believe that critical illness treatments, such as cancer, kidney transplants, or cardiac procedures, cost less than Rs 5 lakh – which is far from the ground reality today.

Speaking on the data released in the report, Sarbvir Singh, Joint Group CEO, PB Fintech said, "A large proportion of consumers plan to sell ancestral assets or borrow money during a crisis rather than opt for simple, accessible solutions like health and life insurance to protect their families." "As an industry, it's imperative that we strengthen awareness and improve the overall customer experience to drive broader adoption and ensure financial security for all."

Challenges remain with term insurance

At the same time, 47.6% of Indians remain unaware of term insurance and its benefits. However, is said, there are signs of improvement. Industry-wide, term insurance grew by 18% in FY24, compared to a CAGR of just 2% over the past five years. The survey found that 56% of respondents who are aware of term insurance have a positive attitude toward purchasing it. A key issue in term insurance adoption is not just a lack of awareness but also a limited understanding of personal finance, it highlighted. Many non-buyers fail to consider key financial factors such as child education, marriage, loan obligations, spousal retirement, and medical contingencies when evaluating their family's long-term needs.

Notably, experts have recommend a life insurance cover of 15-20 times one's annual income to ensure that dependents can sustain themselves for at least 10 years. Only 13% of non-buyers accurately estimate their insurance needs in line with expert recommendations.

The writer is Vikas Kumar.

TOP

Moderate premium growth to hurt insurers' Q4 show – The Economic Times – 15th April 2025

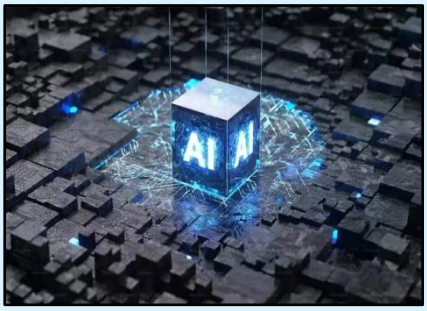
The insurance sector is poised for soft fourth quarter results. Life insurers are facing moderation in annualised premium equivalent (APE) growth amid weak unit-linked insurance policies (ULIP) demand due to market volatility. VNB (value of new business) margins are expected to shrink across players. General insurance companies, on the other hand, are expected to report muted growth due to slowdown in motor sales and deterioration in combined ratio. HDFC Life is seen posting 12-15 percent APE growth with a 100 basis points drop in VNB margin on a year-on-year basis, while ICICI Prudential's APE may stay flat with a 50 basis points margin squeeze and Axis Max Life may see a 200 basis points drop despite 10-14 percent APE growth. SBI Life's margin could fall 50 bps, while LIC stands out with a strong 18 percent VNB margin. LIC's APE could fall 10-12 percent. "Q4FY25 is likely to be a soft quarter for the insurance sector, given that APE growth for life insurance companies is likely to see moderation due to slowdown in the sale of ULIPs," said Emkay Global in its report. "However, VNB margin is expected to be stable, supported by lower contribution of ULIPs albeit offset by lower credit life growth on account of lower MFI disbursements."

In general insurance segment, ICICI Lombard may see single-digit growth in gross premium due to weak motor premiums, lower group health volumes, and the 1/n premium accounting rule. Star Health could also see flat to single digit growth in GWP (gross written premiums) with deterioration in combined ratio. Insurance companies have been adjusting to slower growth since February, mainly attributed to market volatility. Private life insurers posted 19 percent YoY APE growth in January, slowing to 8 percent in February and they are expected to show some recovery in March given the end of the financial year purchase of insurance products. Similarly, general insurers saw 7 percent GWP growth in January, followed by a 3 percent decline in February. Health premiums slipped 4 percent YoY in February due to exits from group health, while motor premiums grew 10 percent and 3 percent YoY in January and February due to lower auto sales. Combined ratio in health insurance is expected to remain high due to rising medical inflation and increased claims frequency continue to hurt the claims ratio.

The writer is Shilpy Sinha.

TOP

Gen AI driving over 30 pc productivity gains for India's insurance industry – IANS – 11th April 2025



Artificial Intelligence (AI), especially Generative AI, is transforming the India's insurance industry this year, with productivity gains of over 30 per cent, a new report said on Friday.

Insurers who are using AI in underwriting are seeing up to 36 per cent efficiency gains by using both structured and unstructured data more effectively, according to the report by Boston Consulting Group (BCG).

In customer service, tools such as AI-powered knowledge assistants have led to over 30 per cent boosts in productivity, while also improving service quality. In claims processing, AI is helping resolve up to 70 per cent of simple claims in real-time, reducing costs by 30 to 50 per cent and offering a smoother experience for customers.

Even in IT, AI is proving useful as smart automation tools are helping insurers cut their cloud migration timelines in half and save 30 per cent in costs, the report mentioned. Despite the growing potential of AI, the report found that many insurance companies are still stuck in pilot phases and have not fully scaled their AI projects. However, a few forward-looking insurers are using AI as a competitive advantage, particularly in underwriting, claims processing, customer service, and IT operations.

Pallavi Malani, India Leader-Insurance Practice at BCG, said that GenAI is reshaping every part of the insurance business. She pointed out that while Indian insurers are experimenting with several AI-based proof of concepts, most of them have not yet scaled. "Particularly in India, we see that insurers are undertaking several proof of concepts but

these use cases have not been scaled up," Malani stated. To fully benefit from AI, companies must think beyond just technology and data, and include business impact, process changes, and employee readiness from day one.

The report stressed that insurers who align their AI investments with business goals, and focus on high-impact areas, are pulling ahead of the competition.

TOP

INSURANCE REGULATION

IPA urges IRDAI to bring pharmacists under the ambit of professional indemnity insurance coverage – Pharma Biz – 12th April 2025

For safeguarding the pharmacy professionals in the country from all legal complexities owing to negligence or errors or omissions in the course of their career, the Indian Pharmaceutical Association (IPA) has written to the Insurance Regulatory and Development Authority of India (IRDAI) to include the pharmacists under the ambit of professional indemnity insurance coverage. In a letter to IRDAI chairman Debasish Panda, IPA secretary Dr. Subhash Mondal has said that on the lines of the doctors and nurses, the pharmacists should also get the benefit of the professional indemnity insurance scheme to ensure the longevity of their career without facing financial consequences in the event of a lawsuit. Talking to Pharmabiz from Kolkata, Dr. Mondal said in the healthcare sector, the doctors and the nurses are availing the benefits of the insurance, but pharmacists are not included under its purview. He said other professionals like engineers, architects and lawyers have been already brought under the purview of this insurance scheme. However, the pharmacists in India do not have the same provision despite their critical role in safeguarding the health of the people.

In the letter to the chairman, Dr. Mandal says that the pharmacists are directly involved in medication management, patient counselling, clinical decision-making and ensuring the rational use of medicines. While they engage in these responsibilities, they are likely to be exposed to risks such as medication errors, incorrect dispensing and adverse drug reactions. In many cases, pharmacists are patients' first point of contact regarding drug-related inquiries. As a result, there is a need for the comprehensive professional indemnity insurance scheme for pharmacists similar to that of doctors and nurses. Such benefits would not only protect the pharmacists from financial liability arising from negligence or errors in their professional duties but also enhance the credibility of the pharmacy profession.

Dr. Mandal wanted the IRDA chairman to consider the matter with urgency as the inclusion of pharmacists into the professional indemnity insurance scheme will serve as a significant step towards reinforcing the importance of the pharmaceutical profession in India's healthcare system. Further, it will encourage the pharmacists to practice the profession with greater confidence with knowledge of protection against risks associated with their job. He assured IRDA of all help and details, including direct interaction, for a favourable decision to support the pharmacist community. While clarifying IPA's demand for the indemnity insurance scheme, the secretary said inclusion of pharmacists into the insurance scheme is largely positive when their role in patient care and the potential for financial risks associated with their profession are considered. Since they are directly involved in medication management, counselling and clinical decisions, chances for errors are there or adverse reactions which may result in legal claims. In this circumstance, insurance coverage is necessary for professional negligence, he said.

The demand of the IPA was welcomed by the community pharmacists association in Kerala, and its secretary LR Jayaraj, who is also the secretary of All Kerala Chemists and Druggists Association, said professional insurance coverage for community pharmacists is necessary in the wake of emergence of numerous medications and treatments in the present-day world.

TOP

LIFE INSURANCE

Life insurance is an interest area for us, says Star Health chairman Anand Roy - Live Mint - 16th April 2025

Star Health & Allied Insurance Co. Ltd plans to venture into life insurance business by potentially acquiring a life insurance company once the government allows composite licence for insurers in India, says Anand Roy, chairman, Star Health. Roy expects a 10 percent rise in the cost of average health insurance premium this year in the wake of rising medical inflation. He also denied reports of any stake sale discussion with Life Insurance Corp. of India (LIC), which has been planning to partner with a health insurer through stake acquisition in the imminent composite license regime. After dealing with a hit on profitability due to unusually high insurance claims last year, Roy, in an interview

with Mint, said Star Health has taken measures to bring claims settlement ratios back on track this year, while looking to double the company's sales to over ₹30,000 crore by fiscal year 2028. Edited excerpts:

Star Health is already the largest health insurer. Would you look at adjacencies once composite licence is allowed?
Life insurance is an interest area for us. Protection plans are something that we are definitely considering. We will wait and see how the regulations evolve. We have a large distribution channel with more than 20 million lives covered. Out of all insurance lines, health insurance line is the only one where there is constant engagement with the consumer, whether for claims, for renewals, or for wellness activities. So, we are in a good position to market other lines of businesses. We'll see what the regulatory requirements are, and then probably we will decide on any acquisition. We'll wait for the composite license, and then we may consider something of that sort.

How do you plan to fund your growth or any potential acquisition? Would you sell shares?
We are quite well capitalized already. We are at 2.2 times in terms of solvency margin against the regulatory need of 1.5 times. So, our focus is currently on providing better ROEs to our investors, and then having a profitable growth journey, even if you need capital for certain exigencies or any kind of acquisition. We do have the option of accessing a sub-debt because we are a profitable company. We can dive into this sub-debt option in case we need to. It's a very reasonable way of raising capital, because you redeploy that, and you can nullify the interest cost. There are reports suggesting LIC is in talks with Star Health for a stake purchase... We are a large enough company and we have strong promoters. As far as interaction with LIC or anyone is concerned, that's not true. We have not engaged with anyone.

With or without LIC, do you have plans to diversify your business? Would you look at becoming a full-fledged general insurer to grow bigger and faster?
I strongly believe that the next 10-15 years will be the period of health insurance business. Indians are becoming aware and more active about health and healthcare. Health insurance is growing at the fastest among all businesses. So I think it is a business that we definitely have a strong conviction, and we would like to be in this business. But yes, if the regulations allow us tomorrow, with this insurance Amendment Act, which is in the offing, with composite licence, we will evaluate. We have a very large distribution, strong brand across the country, a big set of agents and consumers. So whenever there are other opportunities, we will consider at that point of time. But for us to diversify, the insurance Amendment Act needs to get passed. And then it may take another few months for the regulator to set the rules, the capital requirement and so on. We have conducted surveys of our own distributors, our own employees and all of that, and we have seen a very strong intent to align with other lines of protection-driven insurance, such as term life insurance.

Have you appointed any external agency to advise on your diversification or restructuring plans?
We engaged BCG as a partner to do the entire strategy for us. We have that (strategy) in place, but it needs more capital, it needs technology, it needs people, it needs products. So probably once the regulations are defined, maybe in 3-4 quarters we should be out with a plan. That will be subject to our board's approvals and all of that.

What is Star Health's focus right now?
At Star Health our focus continues to be on retail. 95 percent of our business is retail. Last year, we did ₹17,500 crore business with a growth of about 15 percent GWP even though last year was challenging for us and the industry. We not only grew by 25 percent in terms of new business on the retail side last year, on the optics front also we are the best in the industry. Our expense of management is the best in the class. Both on growth matrices and our OPEX we did well. Our overall retail growth came at around 50 percent. The beauty of Star Health is that it is not a large metro city-based company. We are there in tier-1, 2 and 3 towns across 1,000 plus locations, with operations in 17,000 out of total 19,000 PIN codes in India. So, going forward, we should be able to maintain this growth of at least 25-30 percent on new business. Our business growth strategy is both value and volume-led. Last year, our volumes were also growing at close to 10 percent on the retail side. We believe consumers should feel policies are affordable and valuable. So, we are constantly introducing products specific to different markets, and we are confident that we'll maintain this growth. But Star Health seems to be dealing with issues on the claims side. Our claims ratio definitely was distorted last year (FY2025) and was higher than what we had projected. We had projected something around 66-67 percent claims ratio, but it went up significantly. And that led to a deterioration in our financial performance, which has also been something of a concern.

Why were the claims higher than expected? How do you plan to address this issue?
There are multiple reasons. Number one is definitely we saw higher medical inflation. We have seen more and more consumers moving towards tertiary care hospitals and corporate hospitals. And that is expected as well because people buy insurance to go for better quality treatments. But then the medical inflation in these hospitals has been very, very concerning for us. The second part is that we saw a very extended monsoon season last year as compared to other years, which impacted our claims. Finally, multiple regulatory interventions were introduced last year,

whether it is cashless everywhere, a campaign by the regulator, whether it is health, new health regulations, or master circulars were brought in. All of these have impacted consumer behaviour as well as the utilization of health insurance, which led to deterioration in our loss ratios. Every player's loss ratios have deteriorated. To bring the performance back on track, we have taken multiple steps. Firstly, we were forced to make some price corrections in 5-6 products because of the increase in claims experience. Secondly, we have seen that there are certain businesses where we are not seeing any improvement in terms of claims ratios, especially corporate businesses. While we were not a large player there, whatever we were operating, we have recalibrated our business in those segments. We have been a profitable company, and we want to bring that back from this year onwards.

While claims have been higher than anticipated, there have been reports on how Star Health has dealt with claims settlement and the regulatory actions against the company in this regard. Can you clarify on this?
Star Health is the largest standalone health insurer. Last year, we have settled more than 20 lakh claims. We are paying out more than 5,000 claims every day. We are one of the largest claims pay masters in the country. We have over 14,000 network hospitals. If you look at our claims payouts, our claims rejection ratio (for April-December period of FY25) is about 10 percent which is one of the lowest in the industry. And the payout ratios are also around 87-88 percent. So, what should consumers do to ensure their claims are settled?

Firstly, one should not hide any known ailment from their doctor or while applying for health insurance. We have a range of 35-odd products, offering covers for all. But non-disclosure and suppression of facts lead to issues at the time of hospitalization. So if consumers disclose better and then opt for different policies, it will be helpful for both. So, we are doing our bit to educate our consumers. As far as news reports are concerned, I can tell you, the regulator has been hyperactive on medical insurance in terms of services improvement for the last six months. They came out with a master circular, and they had conducted follow up inspection of about 10 insurance companies on adherence to that master circular. All leading insurers were inspected. A thematic inspection was done, and Star Health was one of them, being a large company. There is no truth to the media report that the regulator intends to take any action on Star Health.

While growing the new business, what is the ideal range of claims settlement ratio that you would be looking at in the coming years?
So, our aspiration is that consumer grievances should be reduced. We track it every month, and we see that it is on the downward trend because of the efforts we have been taking over the last few years. Claim settlement ratio is basically how much of the claim does the insurance company pay out. For us, it is around 87-88 percent right now, and I think that is one of the best in the industry. Why is the balance12 percent not paid? It is because some of our retail policies have limits such as room rent capping, capping for maternity, cataract, and so on. As a target the incurred claim ratio, which is directly impacting our profitability as an organization, ideally should be in the range of 65-67 percent. We should have an overall combined ratio of 95-97 percent, and that is the target we have kept for ourselves from the financial performance point of view.

Profitability has been affected in recent quarters. With increasing claims, rising costs how do you intend to enhance your profitability without compromising on growth?
I think profitable growth is in the DNA of this company. This year has been a one-off, but we are still profitable. The profits have decreased over last year because of the higher claims ratio. For the next three years, we have a vision of doubling our topline and tripling our bottom line. So, by FY2028 we want to reach ₹30,000 crore in topline and ₹2500 crore in bottomline. We are on track for that and this year, we are thinking of something around ₹20,000-21,000 crore topline, which we are very confident of achieving.

What steps will you take to achieve those targets?
We are a retail-oriented company. We have four growth drivers called ABCD — agency, bank assurance, corporate and digital. This year, agency and digital have done extremely well. We will continue to double down on those two channels. We have added close to 80,000 new agents this year. We are the largest employer in the entire general insurance industry. We employ more people than New India Assurance, which is a public sector company. Given our distribution strength we can improve productivity. It will come through efficiencies and technological investments we have made. So, the idea is to grow the new business in retail by around 25 percent, which will take us to our top line aspirations. On the digital side, we have a very strong presence.

We are the largest player in the digital business. We have probably more than 50 percent market share in the direct digital business among all insurers on the health side. So that is something that we will continue to invest in. And digital business now contributes more than 20 percent of our new business growth. So that will be our main step, other than the bank assurance. The corporate segment has been kind of loss-making for the industry. We will be very selective in the corporate business, focusing more on small corporates. So, this is the strategy that we have to achieve our targets. And, we will introduce multiple new products in the next few months which is going to cater to all segments of the society, including the affordable segment, the missing-middle, as the Niti Ayog calls it for the people who are not poor enough to be covered under the government schemes and not rich enough to buy health insurance

plans. We will focus on tier-2, and 3 cities and increase penetration to ensure our topline goals are met. And with the investments we have made in product pricing, repricing of products, selection of risk, and moving towards more cashless facility in our preferred network of hospitals, I think we will be able to manage our bottom line targets as well.

How do you plan to protect your market share with more corporates venturing into health insurance and life insurers planning to start selling health products once composite license is allowed?
Star Health commands one-third of the health insurance market right now. One out of every three policies sold is of Star Health. We have maintained this market share even after covid. In fact, we have been able to increase it by a bit. We are quite confident, given our brand, our services felt in the market, our distribution strength, and our products going deeper into Bharat, we will not only maintain our market share but also grow it. Even today, health insurance is the most competitive business. All the 30 insurance companies are selling health insurance of some kind as it has become the largest segment. Despite such competition, we are maintaining our market share. We are growing and are quite confident we will be able to do even better in the coming days. Our projection is that by FY2028 if we are able to achieve our topline our market share should improve from 33 percent now to 35 percent.

As a part of cost control, is there a retrenchment underway at Star Health? How do you want to reduce the expense ratio?
Our expense ratio is the lowest in the entire industry. Irdai allows health insurance companies to opecrate at 35 percent expense ratio. We are operating at close to 30 percent. However, we are investing a lot in technology. We are investing a lot in automation. Because of that, there are certain areas where we are doing some manpower optimization. But, nothing so dramatic. These are regular annual processes.

Considering the medical inflation and rising claims, do you think the average health insurance premium will increase in the coming years?
Health insurance premiums are a factor of medical inflation. Like other products health insurance premiums will increase depending on the escalating medical expenses. The regulator is also becoming more aligned to the fact that you can take a soft price increase annually rather than some lumpsum price increase once in three-four years, which affects the population. Health insurance will probably mirror the inflation rates. We try to make it as soft as possible. We also provide a lot of discounts to our consumers who are otherwise staying healthy. So for retail, I would say there can be a rise in average premium rates in the range of 8-10 percent every year.

Medical inflation and rising hospital tariffs are putting pressure on the claims ratio and profitability of the sector. With insurers consistently hiking tariffs, retail demand is coming down, which is not desirable. How is Star Health dealing with this?
The common public's out-of-pocket expense has increased in the health insurance space. Medical inflation is high and rising hospital tariffs are putting pressure on claims ratio and profitability of the sector. With insurers consistently hiking tariffs, retail demand is coming down, which is not desirable. How is Star Health dealing with this?

During and after covid, there was a significant rise in demand for health insurance, but that has softened now. And what insurers have been doing ever since is to innovate products, including Star Health. We launched a very successful product called SuperStar this year, which has become the market leader in the retail side. We have been trying to bring more coverage and make sure that affordability factor for the public is addressed. While doing so, our CAGR from 2019 to 2025 is over 10 percent. But it can be better, given the low penetration.

What are the challenges?
India continues to have one of the highest healthcare inflations globally and post covid, it has become kind of tricky. Healthcare providers have become more commercial in nature and more corporatized in nature. They have their own profit and loss to take care of, and health insurance and healthcare go hand in hand. Both are two sides of the same coin. So, one side of the coin is very tightly regulated, and the other side is totally unregulated. That kind of friction remains. And who is getting affected the most in this, are mostly the consumers. The government has to play a role, to bring some kind of health regulator, or some kind of governance or an apex body for the healthcare sector, so that some discipline is brought in there. Insurers are tightly regulated for every price increase. We have actuarial science to manage. Recently, the regulator said that you cannot increase senior citizen premiums by more than 10 percent in a year. But there's no such law for regular healthcare of senior citizens. Then let's say CABG treatment, which was costing ₹1 lakh in 2019, is costing ₹3 lakh today at the same hospital. There is no regulation on that side. This imbalance creates consumer dissatisfaction. So, something has to be done in the interest of the larger society.

The government can focus on the poor segment, but it alone cannot take care of all of the 1.5 billion people. Of course, health insurance companies too have to become more transparent and consumer centric. But, India has 50-60 percent of healthcare spending out of pocket. And today, people from the middle-income segment get severely impacted if a single incident of hospitalization happens in the family. The growth of health insurance is a multi-decade opportunity, but growth can come only with good consumer experience, which is the main challenge we are facing right now.

What are some of the steps you would expect from Irdai, or other regulators or the government for better growth?
For the last three years or so, the regulator has been extremely helpful in terms of creating reforms which has propelled growth of the insurance industry. Particularly coming to health insurance, there has been a master circular which gets into a lot of granular details like claims have to be paid in one hour, three hours, and so on and so forth. Those are actually moving away a little bit from principle-based regulations to rule-based regulations back again, which can be avoided. But beyond that, the larger problems for health insurance are frauds. Various studies have shown that 10-15 percent of insurance claims are lost to fraud. We have to see how the regulator, along with the government, can bring insurance fraud into the ambit of financial frauds. A fraudster should be blacklisted from that bit of insurance for a reasonable amount of time, including corporates, hospitals, and distributors. Second point is, as a nation we need a healthcare regulator, an apex body where there should be some standardization of protocols, standardization of tariffs, certain amount of discipline has to be brought in.

Insurance penetration is only 1 percent as far as general insurance is concerned, and hardly 5 crore Indians have health insurance. Healthcare costs are going up. So, in the interest of society, the government has to introduce some kind of healthcare regulator, which is going to be helpful. At the government level, we have suggested that 18 percent GST should be done away with, especially for health insurance business or at least for senior citizens, if not for everyone. If not a complete waiver, it can be at least brought down to 5 percent.

Is there any serious talk on the creation of a healthcare regulator?
This is a larger discussion. It is not something that is happening right now. It's more for society's good rather than for insurance companies. The argument is that health is a state subject and the central government alone may not be able to do much. But then the same thing was discussed during the creation of real estate regulator. RERA came into being, and see how beautifully it is operating now, giving so much confidence to the public. I think something like that has to be done especially because health is an even more important subject.

The writer is Anirudh lascar.

TOP

Term insurance for self-employed: Besides securing family, cover biz debt – Business Standard – 11thApril 2025

Online insurance platform Policybazaar.com witnessed a 58 percent year-on-year rise in term insurance sales to self-employed individuals in 2024–25 (FY25), with millennials and Gen Z constituting 88 percent of buyers. Women made up 15 percent of self-employed buyers in FY25, up from 9 percent in FY20. These figures point to the growing awareness among the self-employed regarding the need to buy financial protection for their families. Families of the self-employed face significant financial uncertainty upon the policyholder's death. "The primary source of income is lost. There may be outstanding personal financial obligations. And there may be business-related debt," says Vinod Singh, co-founder and chief executive officer (CEO), Finhaat. Salaried individuals may receive basic term cover from their employers. "Self-employed persons do not have any such cover, which makes it important that they buy adequate protection themselves," says Varun Agarwal, head of term insurance, Policybazaar.com.

The approach to estimating the required sum assured remains broadly the same. "Basically, your existing assets plus the life cover should be sufficient to provide for all the financial goals, liabilities, and regular expenses of the family," says Deepesh Raghaw, a Securities and Exchange Board of India registered investment advisor. Singh adds that the self-employed must also factor in their business liabilities and purchase supplementary term insurance. Those unable to undertake detailed calculations may adopt a simpler method. "The rule of thumb suggests you purchase a sum assured equal to 10–15 times annual income. If a self-employed person's income fluctuates, they may buy a cover worth 20–25 times their annual expenses. To that they may add an amount for liabilities and goals," says Agarwal.

As individuals' assets grow and they repay their liabilities, their insurance needs reduce. "If a person believes his/her assets will grow adequately to meet the family's financial goals and fut-ure expenses, and all their liabilities will be paid off in, say, 15 years, that should be the tenure of their policy," says Raghaw. Agarwal suggests that for most people, a term cover till an age between 60 and 70 suffices. A few riders are crucial for the self-employed. "If there is a temporary disability, say, like a fracture, it means loss of income for a self-employed individual, which makes it crucial that they buy a personal accident cover," says Raghaw. (The salaried may perhaps get paid leave for that duration.) Agarwal suggests that accidental death benefit riders are important for younger individuals who use two-wheelers. Singh recommends adding a critical illness rider and a keyman insurance policy to cover business-related risks.

While many business owners have proof of income in the form of income tax returns (ITRs) and bank statements, others may lack such traditional proof. "Nowadays, insurers are moving towards surrogate pro-ofs to determine a self-empl-oyed person's income," says Agarwal. Alternative proofs that insur-ers are using include credit card statements, vehicle ownership records, home loan repayment history, mutual fund statements, credit scores, and Goods and Services Tax (GST) filings. Incomes of self-employed persons tend to fluctuate. For those struggling with lump-sum payments, splitting premiums into monthly instalments can help. "While an annual premium of ₹25,000 may appear burdensome, a monthly payment of ₹2,000 plus is easier to make," says Agarwal. Alternatively, Raghaw suggests that the self-employed save and invest that amount each month.

The writers are Sanjay Kumar Singh & Karthik Jerome.

TOP

GENERAL INSURANCE

Combating rising cyber threats and fraud in insurance sector - DQ India - 16th April 2025

India's life insurance industry is undergoing a rapid digital transformation, unlocking massive potential for financial inclusion, operational agility, and customer-centric innovation. As per a report by the Confederation of Indian Industry, India is projected to become the sixth-largest insurance market globally by 2034, growing at a CAGR of 32–34 percent. This growth is being propelled by digitisation across the value chain, from onboarding and claims to customer servicing. However, with this progress comes risk: the rapidly expanding cyber threat landscape. As digitisation deepens, attacks from malicious actors have also increased. Insurers today are custodians of not just financial capital, but also sensitive health, identity and behavioural data, making them attractive targets. In 2023, CERT-In recorded over 1.6 million cybersecurity incidents, underscoring the need to embed cyber resilience within digital strategies. To fully realise the benefits of digital expansion, insurers must ensure that cyber readiness evolves in the lockstep with innovation.

Cyber risk as a business imperative

Cybercrime has outpaced conventional business threats, now ranked as the top global risk. According to the World Economic Forum, scammers siphoned off over $1 trillion globally last year, with some countries incurring losses exceeding 3% of their GDP. The BFSI sector including insurance sector is facing a new reality: sophistication of threat vector evolving at a speed significantly higher than mitigation measures. Furthermore, the mitigation measures continue to be primarily reactive compared to sophistication seen for these threat vectors. In India, where digital infrastructure continues to develop and regulatory frameworks are evolving, the risk is compounded.

This requires a mindset shift across boardrooms and business units. CIOs, CISOs and Chief Risk Officers must move beyond reactive compliance to adopt a proactive, intelligence-driven approach to threat mitigation. Investments must span beyond perimeter defences—towards embedding cybersecurity into organisational culture, data strategy, and governance frameworks.

Vulnerabilities in a digital era

Life insurers have adopted technologies like AI-driven underwriting, digital KYC, mobile-first servicing, video pre-issuance validations and paperless claims. But, these innovations bring new vulnerabilities. Cybercriminals are using GenAI tools to run sophisticated scams, from voice clones to deep fakes. According to a Deloitte survey, around 60% of Indian insurers observed a significant rise in fraud post-digitisation. This coincides with a more complex threat landscape, where traditional fraud detection is no longer enough. To tackle the increasing cyber threat and to protect customer's sensitive information, the government introduced the Digital Personal Data Protection Act (DPDPA), a progressive step to enhance transparency, accountability, and consumer trust. The Act encourages stronger internal controls and data governance aligned with digital innovation.

The high cost of complacency

Recent high-profile breaches across the industry, ranging from database leaks to social engineering attacks, demonstrate that insurance data, rich in KYC details, financial records, customer profile and health data, is among the most coveted by threat actors. While technical vulnerabilities can be exploited, it is often lapses in operational oversight and delayed detection that cause the most damage. With customer trust on the line, insurers must consider breach readiness as fundamental as solvency.

Policyholders at risk

The threat doesn't end at the enterprise level. Policyholders are being directly targeted through increasingly creative scams:

- Spurious calls impersonating insurers or IRDAI officials
- Fraudulent websites and mobile apps mimicking legitimate services
- Misuse of leaked data for identity theft or bogus claims.

In this context, customer-facing security measures, such as secure self-service portals, proactive communication, and public awareness initiatives, are just as critical as internal firewalls. These measures serve a dual purpose: protecting customers from harm while also reinforcing the insurer's credibility and commitment to safeguarding their data.

Data analytics: A silent sentinel for risk mitigation
A vital enabler in combating fraud and cyber risk is the strategic application of data analytics. Life insurers sit on vast repositories of structured and unstructured data, and with the right tools and governance, these datasets can uncover anomalies, predict risks, and personalise safeguards. Data analytics has significantly enhanced performance across fraud detection, customer experience, product design, and distribution. With AI/ML layered on top, analytics can now detect deviations in behaviour patterns, automate red flags, and inform more intelligent underwriting in real time.

Moreover, it also streamlines operations, eliminates redundancies, and strengthens channel oversight - especially vital across varied distribution models.

From compliance to capability: Building cyber resilience
The industry must adopt a layered defence strategy, one that includes technology, training, and testing. Recommended approaches include:

- AI and behavioural analytics to detect fraud at the source
- Biometric and liveness verification to counter deepfake-based identity fraud
- Tabletop cyber drills and red team exercises to prepare teams for real-world threats.

Insurers must treat their workforce as the first line of defence. Regular training and awareness campaigns can significantly reduce phishing incidents and social engineering attacks. According to an IBM report, organisations with well-trained employees experienced nearly 19% lower average breach costs compared to those with limited training investment. In a high-risk digital environment, investing in cyber awareness is a cost-effective strategy that strengthens organisational resilience.

Looking ahead: A strategic imperative
As India's insurance sector accelerates towards digital maturity and sophistication, the cyber threat landscape will only become more complex. Resilience must become a strategic differentiator -- encompassing risk identification, real-time response, and vigilance across the value chain.
Ultimately, a secure insurer is not just one that prevents attacks, but one that earns and sustains trust with every digital interaction.

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Traveling from India? Why Travel Insurance is Your Best Travel Partner – The Tribune – 15th April 2025

With more Indians traveling overseas for family visits, jobs, education, or holidays, international travel has grown in popularity. Although organizing travel, lodging, and sightseeing takes precedence, one crucial component that should never be overlooked is travel insurance. Having travel insurance India guarantees that you are covered against unforeseen circumstances, regardless of whether you are traveling to crowded cities in the USA, picturesque Europe, or dynamic Southeast Asia. Your plans might be completely derailed by an unexpected sickness, a delayed flight, or misplaced luggage. You can handle such situations stress-free with the aid of travel insurance, which serves as a safety net. In order to prevent you from having to spend your funds during a crisis in a foreign nation, it provides financial coverage for medical crises, trip cancellations, and other unanticipated circumstances. Additionally, it satisfies certain visa criteria for specific places, making the visa procedure easier for Indian tourists. Being ready is crucial in the fast-paced world of today, when anything may happen at any time. When compared to selecting locations or activities, Make My Trip's travel insurance may not appear thrilling, yet it quietly supports each stage of your trip. Consider it a trustworthy travel companion that is always available, silent, and dependable.

Why Indian Travelers Should Never Skip Travel Insurance
Here's a closer look at how travel insurance, which provides much-needed support at all phases of a foreign trip, becomes a must-have tool for every Indian visitor.

Smoothens the Visa Process for Many Countries

Many foreign locations--especially in Europe and Asia--have made travel insurance required for visa applications. Those Indian passport holders seeking Schengen, UK, or Canada visas, for example, have to provide current insurance records. Having the correct policy from the start saves time and raises the possibility of a successful visa application. This one-time action keeps you ahead of the process and helps you prevent last-minute anxiety.

Protects Against Medical Emergencies Abroad
An unexpected medical problem while on holiday may be financially taxing as well as unpleasant. Particularly in Japan or the USA, medical procedures can be rather costly. Travel insurance covers cashless hospitalization, medical visits, and emergency treatment. Knowing you have a solid safety plan can let you concentrate on recuperation instead of costs.

Covers Flight Delays, Cancellations, and Missed Connections
Many times, international travel consists of large distances and several layovers. Missed connections and extra expenses might result from delays and cancellements. Travel insurance covers lodging charges resulting from unanticipated events or helps you recoup such costs, including rebooking flights. This encouragement helps you maintain going ahead with your vacation plans and lessens the annoyance of the situation.

Secures Your Baggage and Valuables
Particularly when your basics are inside, lost bags or stolen goods may ruin your entire trip. Travel insurance covers lost, stolen, or delayed baggage so you may replace what is required free from financial burden. It guarantees that a luggage accident won't sour the essence of your trip and lets you keep on with assurance.

Offers Support in Case of Legal or Personal Emergencies
Unfamiliar rules and linguistic restrictions might be frightening when overseas. Many travel insurance packages provide emergency support services such as linking you to legal aid, assisting with misplaced passports, or planning emergency transit back home. When you live distant from known support networks, these services really change things.

Customizes Protection Based on Your Travel Purpose
One-size-fits-not travel insurance is not. Plans may be tailored to fit your particular needs whether your journey is for a quick holiday, a lengthy business trip, or study abroad. This lets Indian visitor's pay only for what they need, so the insurance is more reasonable and pertinent for the kind of journey they are planning.

Conclusion
Having travel insurance at hand can help you make all the difference between a tense trip from India and a seamless one. From paying medical bills and getting visas to protecting your stuff and providing backup help, overseas travel insurance is really your best vacation friend. So, be sure you're covered before you head off on your next trip. This is the one choice that ensures mental clarity anywhere you go.

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Non-life insurers' premium grows 6.2% in FY25 at Rs 3.08 trillion – Moneycontrol – 15th April 2025

India's non-life insurance industry reported a 6.2 percent year-on-year increase in gross direct premium in 2025, reaching Rs 3,07,611.84 crore, provisional figures released by the Insurance Regulatory and Development Authority of India (IRDAI) show.

In the previous year, the sector collected Rs 2.89 trillion in gross premium.

March was a slow month for the sector, which includes general, health, and specialised insurers, with a growth of just 0.49 percent from the year-ago period. While general insurers continue to dominate with an 83.9 percent share of the overall market, standalone health insurers registered a robust 15.99 percent growth over the previous year.
General insurers, who wrote Rs 2, 58,091.73 crore in gross premiums for the year, showed a moderate 5.2 percent growth compared to FY24. March figures reveal stagnation with a 0.10 percent dip year-on-year, signalling a slowdown in policy issuances. Among private players, SBI General Insurance led with a stellar 26.19 percent monthly growth and a 10.64 percent annual increase. Tata AIG's premiums grew by 13.41 percent in March and 17.31 percent cumulatively, crossing Rs 17,703 crore.

Future Generali and Shriram General Insurance also posted strong annual growth of 10.13 percent and 23.63 percent, respectively. On the other hand, larger insurers like HDFC Ergo and Reliance General saw steep drops in their March premium collections, down 28.53 percent and 26.96 percent, respectively. Public sector giants such as New India

Assurance, Oriental Insurance, and United India Insurance grew at a modest pace, clocking between 1 percent to 8.4 percent annual growths.

Standalone health insurers collected Rs 38,413.57 crore in FY25, up 15.99 percent from the previous year. The segment now accounts for over 12.5 percent of the total non-life insurance market. Care Health Insurance and Aditya Birla Health Insurance reported more than over 20 percent annual growth. Star Health, the largest player in the segment, grew 9.58 percent annually and only 3.53 percent month on month in March. In contrast, specialised insurers such as the Agriculture Insurance Co of India and ECGC Ltd witnessed a decline of 0.75 percent in cumulative premiums.

The writer is Malvika Sundaresan.

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Deposit interest rate cuts likely to be moderate in current cycle – Business Standard – 14th April 2025

The cut in deposit interest rates during the current easing cycle is expected to be moderate compared to the previous one because the highest cut in the policy repo rate is anticipated to be about 100 basis points (bps), as against 250 bps in the previous cycle. In addition, the credit-deposit (CD) ratio will remain elevated for major banks. Also, regulatory factors, such as the revised liquidity coverage ratio (LCR) norms and the potential increase in deposit insurance coverage, will weigh on lenders, thus limiting their ability to implement significant deposit rate cuts. The monetary policy committee of the Reserve Bank of India (RBI), in its February meeting, reduced the repo rate by 25 basis points. In April, it reduced the policy repo rate by another 25 bps to 6 percent.

The committee also changed the policy stance to "accommodative", signaling the likelihood of further easing in the coming months. Amid global uncertainties stemming from American tariff policies, economists are anticipating a deeper rate-cut cycle in the current easing phase, ranging between 75 and 100 bps. In the previous easing phase, from February 2019 to March 2022, the RBI reduced the policy repo rate by 250 bps. Consequent to a 250 basis point cut in the repo rate, the weighted average domestic term deposit rate (WADTDR) on fresh retail deposits had declined by 209 bps while on fresh retail and bulk deposits it went down by 259 bps. However, the transmission of 250 bps on outstanding deposits was 188 bps, according to the RBI's Monetary Policy Report. Anil Gupta, group head (financial sector ratings), Icra, said while the easing rate cycle had begun, banks might take time to pass on the deposit side. The extent of the deposit rate cut is likely to be limited compared to the previous easing cycle. At present, the CD ratios of banks are still high. The aggregate CD ratio remains above 80 percent. This can be attributed to the base effect of the merger as well as high growth in previous years.

BANKS TAKE RBI CUE

Deposit rate cuts by banks on select tenures so far (in bps)

SBI	10
Bank of India	25
Kotak Mahindra Bank	15
Canara Bank	Up to 20
HDFC Bank	35 and 40
Yes Bank	Up to 25

The LCR norms, which the RBI has postponed by at least a year, along with a possible increase in deposit-insurance cover, are expected to weigh on banks, leaving them limited room for significant deposit rate cuts, a senior bank executive said. Two public-sector bank executives said funds from middle-aged and the senior citizens had a substantial share in retail term deposits. Maintaining stability in the resource profile is important in the coming quarters, given the demand for money and competition. This limits the scope for any aggressive deposit rate cuts. Following the 50 basis-point rate cut in the current easing cycle, banks have been slow to pass on the revised rates to consumers, both for loans and deposits, largely due to a prolonged liquidity deficit. But some major banks have started the transmission. State Bank of India (SBI), the country's largest lender, has reduced interest rates on term deposits of below ₹3 crore by 10 bps for select tenures, effective April 15.

Additionally, the bank has revised the interest rate on its special deposit scheme, Amrit Vrishti, and withdrawn another special deposit scheme. Separately, HDFC Bank, the country's largest private lender, has reduced interest rates on savings accounts by 25 bps. Earlier, the bank had reduced deposit rates by 35 bps on fixed deposits (FDs) for 35 months and by 40 basis points on FDs for 55 months. Yes Bank has lowered FD rates on select tenures by 25 bps. Bank of India (BoI), which is state-run, has reduced interest rates on term deposits in select tenures by 25 bps.

Notwithstanding the revision in interest on term deposits, owing to expectations of further cuts in the policy rate in the near term, this class of liabilities will continue to attract customers because they anticipate that banks will go slow on cutting rates on FDs amid pressure of deposit mobilisation. "Banks are giving higher interest rates on short-term fixed deposits than on longer-term. Customers, especially senior citizens, are inclined towards term deposits ranging between one and three years. As customers are seeing that long-term rates will come down, now is the right time to lock in and hence the preference," said a senior banking official with a state-owned bank. In a rate-cut cycle, customers block their money in term deposits. "There will be a bit of migration from savings accounts to term deposits because

customers will try to get higher returns. Whenever there is a rate-cut cycle, customers automatically move towards term deposits," said Madan Sabnavis, chief economist, Bank of Baroda.

The writers are Anupreksha Jain & Abhijit Lele.

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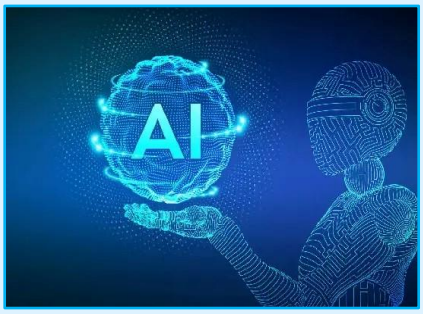
Harnessing AI and Data analytics to drive underwriting efficiency in general insurance - The Economic Times – 13th April 2025



Globally, the general insurance industry is undergoing a transformative shift. Driven by changing customer expectations, rapid digitisation, and the growing complexity of risk landscapes, the sector is embracing data, technology, and Artificial Intelligence (AI) to redefine operational efficiency and customer experience. Once heavily dependent on manual processes and historical data sets, the underwriting and claims management functions in general insurance are now leveraging AI-driven tools to deliver faster, more accurate, and customer-centric services.

In the traditional model, underwriting and claims processing were lengthy, document-heavy procedures that often led to delays and inconsistent results. Customers, already dealing with the stress of an incident or loss, were burdened with extensive paperwork and follow-ups, while insurers manually sifted through data to verify claims and assess risks. The first wave of digitisation aimed to ease this by encouraging online submissions and leveraging technologies like Optical Character Recognition (OCR) for faster document processing. While this was a significant step forward, manual intervention was still required, and customer frustrations remained.

Today, the integration of AI and behavioural analytics is creating a win-win scenario for both insurers and policyholders. AI algorithms now process vast and complex data sets including customer details, insurance records, credit scores, geospatial data, and even climate patterns, to generate precise risk assessments and detect fraud. For instance, AI-driven behavioural analytics examine individual choices, purchasing patterns, and even digital footprints to identify genuine insurance buyers at the underwriting stage itself. Advanced facial analytics and computer vision technologies can analyse a 15-second selfie video to assess vital signs like resting heart rate and biological age, reducing dependency on physical medical tests and enabling instant policy issuance.

Deloitte's studies show how machine learning systems detect fraud patterns that traditional methods often miss, helping insurers offer competitive rates while safeguarding themselves from monetary losses. By embedding fraud detection mechanisms early in the policy lifecycle, insurers can prevent fraudulent claims before they arise. Moreover, tools like Robot Process Automation (RPA) and AI are automating repetitive tasks such as document verification, significantly cutting down policy distribution times. Underwriters using Google Cloud AI solutions, for example, have reported up to a 75% reduction in processing time, allowing them to focus on more complex cases.

AI's capability extends to personalised pricing and proactive claims management. Using telematics for vehicle insurance and wearable health tech for personal policies, insurers now customise premiums based on real-time behavioural data. McKinsey reports that data-driven insurers have seen customer engagement rise by 20%, with policy persistency improving by 15%. Geospatial analytics, powered by platforms like IBM Watson, enhances disaster forecasting and enables insurers to adjust underwriting standards for high-risk zones affected by floods, storms, or wildfires.

AI-powered underwriting systems are evolving into adaptive platforms capable of responding to market dynamics in real-time. They not only allow instant premium adjustments and swift decisionmaking but also continuously learn from incoming data to remain effective in changing risk environments. The future of general insurance lies in embracing intelligent, data-driven processes that deliver superior efficiency, reduced fraud, and outstanding customer experiences. With AI and advanced analytics at their core, underwriting and claims management are set to transition from reactive, manual operations to proactive, frictionless journeys. Insurers who seize this opportunity will not only benefit from operational gains but also build deeper trust with their customers ushering in an era of precise, personalised, and hassle-free insurance.

The writer is Rakesh Jain.

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Non-life insurers' premium touches Rs 3 trillion mark in FY25 amid slowdown - Business Standard – 11th April 2025

Non-life insurance premium (in Rs cr)

Premium	Mar-25	Growth (YoY)	FY25	Growth (YoY)1
General Insurers	21,319	-0	258,092	5
Standalone Health Insurers	4,800	11	38,414	16
Specialised Insurers	580	-36	11,107	-1
Total	26,699	0	307,612	6

Source: General Insurance Council

The gross direct premium underwritten by the non-life insurers grew 6.20 per cent Year-on-Year (YoY) in FY25 to Rs 3.08 trillion compared to 12.78 per cent YoY growth in FY24 at Rs 2.89 trillion amid broader economic slowdown and change in accounting norms.

The premium of general insurers rose by 5.20 per cent YoY to Rs 2.58 trillion, while standalone health insurers recorded 16 per cent growth to Rs 38,413.57 crore. The specialised insurers slipped 0.75 per cent YoY to Rs 11,106.54 crore.

In March 2025, the premiums of the non-life insurers was 0.5 per cent up at Rs 26,698.94 crore. The premium collected by general insurers was down by 0.1 per cent to Rs 21,319.28 crore while the standalone health insurers recorded 11.10 per cent growth to Rs 4,800.13 crore.

The writer is Aathira Varier.

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HEALTH INSURANCE

Heath insurance in India ought to cover preventive care as well - Live Mint - 16th April 2025

India's health insurance system ignores one of the most effective tools in modern medicine: preventive care. Despite overwhelming global evidence that early intervention reduces hospitalizations, disabilities and healthcare costs, Indian insurance policies rarely if ever cover the cost of preventive medication for chronic and life-threatening conditions. These are the very treatments that can keep patients out of hospitals—yet they remain out of reach for many simply because their value goes unrecognized. Worse, this blind spot sits atop a system already failing patients. Policyholders are treated as afterthoughts, left to navigate a maze that seems designed to protect the interests of hospitals, third-party administrators and insurers more than the people it claims to serve. Claims are delayed or denied on technicalities. Post-hospitalization care is minimal and short-lived. Price distortions go mostly unchallenged.

What we have today is not health insurance. It is hospitalization insurance—riddled with inefficiency, opacity and corruption. Until the Insurance Regulatory and Development Authority of India (IRDAI) begins to prioritize prevention, support continuity of care and put consumers ahead, meaningful reform will remain a distant dream. Take the example of evolocumab, a cholesterol-lowering injection used globally to manage cardiovascular risk. In the US, this life-saving drug is available for as little as $5 a month under insurance plans when it's prescribed for high-risk cardiac patients. Insurers recognize the long-term savings from preventing heart attacks, strokes and expensive hospitalizations.

But in India, the merit in that logic is overlooked. Health insurance policies routinely exclude the cost of such medications, even though they could avert catastrophic events. So we have a healthcare system that ignores science, side-steps economics and leaves patients exposed. We have forgotten that insurance is about pricing risks. There is a strong case—economic, ethical and clinical—for India to shift from reactive hospitalization to proactive health management.

Health insurance reforms must begin with these changes, reflecting the clinical and epidemiological realities of our times. Apart from making claim processes smoother, for which efforts are being made, we should include chronic-disease management—such as diabetes, hypertension and hyperlipidemia—in basic health plans, mandate that preventive drugs approved under standard treatment protocols be covered or subsidized, and push insurers towards a 'value-based coverage' mindset—just as it is in the US, where illness prevention is seen as worthy expenditure.

Beyond what is—or isn't—covered, there's another problem: the consumer experience. When policyholders engage with health insurers, they often feel ignored, dismissed and even defeated. The paperwork is burdensome and claims

are denied too often. Customer service is slow, opaque, and unhelpful. To call the system 'unfriendly' would be generous. At its worst, it feels hostile. The industry faces a trust deficit. Closing it requires more than new products. It demands consumer orientation that goes beyond promises of faster claim settlement. Covering preventive medication would make a big difference. Drugs that are clinically proven to reduce emergency hospital admissions are often expensive and need wider usage. Finally, how we assess success in the health insurance industry needs a relook. Today, insurers celebrate premium growth and claim ratios. But these internal metrics say nothing about public health outcomes—or the policy-holder's actual well-being.

The writer is Srinath Sridharan.

TOP

Healthcare for all: Don't rely on insurance alone – Live Mint - 16th April 2025

For many who've had the misfortune of having to invoke health-insurance coverage, the difficulty of it is what stays embedded in memory. Don't get us wrong. The concept, in itself, is excellent. But the process of getting claims met and the suspense over what part may have to be paid from one's own pocket are sources of anxiety in need of relief, especially when it adds to the distress of a medical crisis in the family. So, it counts as good news that India's government is taking further steps to ease the formalities. As reported by Mint, it plans to make it mandatory for health insurers to approve valid cashless treatment requests within an hour and final claim settlement requests within three. The latter should help relieve patients who are fit for discharge from hospitals but are kept waiting till the bills are settled. The delays are such that tales abound of patients feeling like hostages, with their cannula insertions held in place till the last rupee is paid. For those who do not have the benefit of cashless claims—in which hospitals take care of the details—the government promises to standardize application forms. Plus, the National Health Claims Exchange, an online platform designed to smoothen the processing of health claims by insurers, is to be strengthened.

All this runs alongside the Pradhan Mantri Jan Arogya Yojana (PM-JAY), a government-funded scheme that assures hard-up households a health-insurance cover of ₹5 lakh. The Centre recently expanded its coverage to all citizens aged over 70, regardless of economic status. For multitudes who can't afford private hospitalization for a health emergency, the PM-JAY is an important enabler. It also prevents healthcare burdens from pushing families into poverty or debt, thereby serving a broad economic purpose. An Indian School of Business study has shown decreased health-related borrowing, reduced precautionary savings and improved loan-repayment by borrowers, thanks to PM-JAY. Insurance is crucial in a scenario of high healthcare inflation, which tends to outpace the general cost of living in India. As estimates suggest, charges for medical attention have been rising in double digits annually. This is reflected in the health insurance premiums we pay, which have almost doubled over the past four years or so. And then there are many Indians who lack any sort of coverage.

Policy-wise, we must not let the larger issue at stake get side-tracked. India has yet to take a clear call on its long-horizon path towards the goal of health for all. Reliance on insurance reveals a preference for the US model, which features a huge market of expensive private services backed by fee-charging insurers. However, the law of large numbers that enables businesses to profit from risk pooling works even better if health risks are taken on directly by a national service. In theory, wider actuarial data makes space for lower costs. In essence, this is the European welfare model, with the state offering everyone high-quality care that's either free or heavily subsidized. With India's public health services derelict at best, barring our top-bracket institutes, welfare has taken an indirect approach that may prove too patchy and costly as we go along. We should gradually shift our focus from state-paid insurance to state-provided healthcare that rivals private-sector quality. A public health infrastructure upgrade would serve a broader purpose too. After all, as with education, equal access to healthcare is key to an equitable society.

TOP

CM: 1.7 lakh Ayushman cards ready for seniors - The Times of India - 16th April 2025

Announcing that 1, 69,000 Ayushman cards were ready for distribution, Delhi chief minister Rekha Gupta said lakhs of seniors (70+ years) would be able to receive health coverage of Rs 5 lakh with the implementation of Vay Vandana Yojana (VVY). The VVY scheme is available to all seniors above the age of 70, irrespective of their financial status. She also disclosed plans for establishing 1,139 Arogya Mandirs across Delhi, with 14-15 centres allocated per assembly constituency. The CM made these announcements after meetings with cabinet ministers, public representatives, and department officials to accelerate the distribution of Ayushman Arogya Cards throughout Delhi. Criticising the previous govt's slow implementation, she said there will be no further delay.

The distribution of Ayushman cards will be organised at the district level, with public representatives asked to assist in ensuring healthcare access reaches eligible residents. The CM stressed the importance of prioritising septuagenarians, acknowledging their increased medical requirements. On Oct 29, 2024, Prime Minister Narendra Modi announced the expansion of Ayushman Bharat Pradhan Mantri Jan Arogya Yojana to include all senior citizens aged 70 years and above. The proposed 1,139 Arogya Mandirs will offer general health consultations, awareness programmes, primary care, and preventive medicines. District magistrates and public representatives have been tasked with identifying suitable govt locations for these facilities. The programme includes plans for nine critical care blocks and one integrated public health laboratory in each district. Cabinet ministers Ashish Sood, Manjinder Singh Sirsa, Ravinder Indraraj Singh, and Dr Pankaj Singh also attended the meeting.

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No cashless claim for 3 health insurers in Ahmedabad - The Economic Times - 17th April 2025

In a major setback for health insurance policyholders in Ahmedabad, the Ahmedabad Hospital and Nursing Home Association (AHNA) announced that hospitals across the city will not settle any cashless claims by three insurers: Tata AIG, Star Health, and Care Health. Alleging arbitrary delisting of hospitals, refusal to revise and bring them at par treatment rates with current medical inflation, among others, AHNA President Dr Bharat Gadhavi emphasised that if insurers did not address the situation urgently, the cashless settlement processes across all of Gujarat with these insurers would be terminated. In response, insurers have hit back, alleging AHNA of making "unsubstantiated, misleading and factually incorrect claims" and of making no effort to engage with them directly. Read on to know what the matter is and whether policyholders in the city will be able to make health insurance-related claims if they get treated in such excluded hospitals.

Unjustified hospital blacklisting, refusal to revise rates main concerns, says AHNA

Notably, policyholders will still be able to claim reimbursement for the money they spend while getting treated in hospitals where cashless facilities are not available. In the case of TATA AIG, they have explicitly mentioned that "expenses for treatment at any hospital, by any medical practitioner, or other providers that are specifically excluded by Tata AIG and listed on our website will not be covered." In the cases of CARE and Star Health, the present suspension applies only to cashless claim settlements. However, this is not the first time these disagreements have cropped up.

As Dr. Gadhavi explained, this has been a persistent issue between these insurers and hospitals. According to him, over the last 1 year, AHNA has received the highest number of complaints from policyholders against these 3 specific insurance companies. According to data from the IRDAI Handbook, which highlights the status of grievances with general and health insurers during 2023-24, Star Health received 16,603 complaints during the year, the highest amongst all existing insurers. Star Health also had the most number of pending complaints from the previous year, at 795. Similarly, CARE Health got 6,492 grievances during 2023-24, followed by Tata AIG, which recorded 3,792 grievances during the year. Gadhvi further explained that these insurers have arbitrarily and erratically put multiple hospitals across the city in the excluded or blacklisted list without any prior intimation. Moreover, most hospitals were reportedly being forced to provide treatments at rates agreed upon with insurers 5-6 years before, which was making it unsustainable for hospitals to function. Additionally, insurers were not paying out or deducting funds from the pre-authorised claim amount at the time of the patient's discharge, causing them significant problems.

Insurers alleged that these excluded and blacklisted hospitals were found to be involved in fradulent malpractices, and hence, were removed from the list of network providers in the interest of policyholders. According to TATA AIG, "Some hospitals were found to be involved in malpractices; hence, they were delisted by TATA AIG. Such actions are necessary to protect policyholders from inflated costs that ultimately impact insurance premiums. Our priority is to ensure that our customers face no inconvenience and continue to receive uninterrupted healthcare services at an affordable premium." In its statement, Star Health said that it would take appropriate legal action against AHNA if attempts to damage its reputation continued. According to AHNA, Tata AIG had also previously made similar legal attempts.

As per a Star Health spokesperson, "Despite our responses to AHNA's earlier claims, the association has made no effort to engage with us directly. AHNA's repeated attempts to mislead the public are irresponsible and unwarranted. Few hospitals were investigated for fraud, waste, and abuse as a routine process, and after a thorough review process, they have been designated as excluded providers or have been de-empanelled or suspended for a cashless facility. While CARE Health did not comment on this, Star Health asserted that cashless services continue seamlessly across Gujarat, in cities such as Ahmedabad (including providers associated with AHNA), Vadodara, Surat, and others, and their customers face no disruption. However, they have repeatedly noted inconsistencies and multiple fraudulent patterns when it comes to cashless settlements in Gujarat.

Cashless claim settlement, network hospitals remain low in Gujarat

Data from the IRDAI handbook suggests that out of a total of 6, 75,903 claims settled in Gujarat, via cashless reimbursement or a combination of both. Out of these, 67% (4, 57,888 claims) had been settled via reimbursement mode, and only 29.43% of claims were settled in cashless mode in the state. The reimbursement mode settlement is significantly higher than the national average, where only 36.68% of claims were settled via reimbursement and 60.60% of claims were settled cashlessly. It also does not help that the number of network hospitals in the city also falls far short in comparison to its population. India's last official census in 2011, more than 10 years ago, pegged Ahmedabad's population at 72, 14,225. As of April 16, 2025, TATA AIG had 310 hospitals in its network in the city, while 25 were excluded or blacklisted. This means TATA AIG, at present, offers 1 network hospital per approximately 23,271 residents of Ahmedabad for cashless settlement. CARE Health had excluded/blacklisted 104 hospitals and had 174 hospitals in network, meaning 1 network hospital per 41,461 ndividuals. Star Health had 238 hospitals in its list of network providers, while 43 hospitals were excluded/blacklisted, thereby giving 1 network hospital per 30,311 individuals. While both parties have their own line of arguments in the ongoing tussle between these three insurers and hospitals, the only person who is hassled is the policyholder when the cashless service is denied. It remains to be seen if the regulator IRDA will intervene in this issue to ensure policyholders are not denied cashless facility.

The writers is Ira Alok Puranik

TOP

State govt initiatives to strengthen hospitals' financial stability through health schemes – The Times of India – 15th April 2025

The state govt is implementing initiatives to enhance the financial stability of its hospitals by directing officials to ensure that claims under Mukhyamantri Ayushman Arogya (MAA) Yojana are not rejected by the insurance company due to deficiencies in claims filed under the scheme. Instructions were issued to all chief medical health officers, principal medical officers, and hospital administrators to properly execute the Rajasthan govt health scheme (RGHS) and MAA Yojana in their respective areas. "The scheme ensures reimbursement for each OPD consultation under RGHS, while IPD cases receive compensation for actual expenses incurred, thereby creating a revenue stream for the hospitals. The funds generated will be utilised by the hospitals for improving their infrastructure and facilities," said a state govt official.

Talking about MAA Yojana, the official said, "Directions have been issued to ensure that the deficiencies in the claims filed under the MAA scheme are completed by having them monitored properly. This will also increase the revenue of health institutions. If a claim is rejected, the insurance company benefits, and your hospital's financial situation does not strengthen," he said. Under the RGHS, ministers, MLAs, ex-MLAs, All India Services, serving and retired employees of the state govt and of state autonomous bodies are beneficiaries. All RGHS beneficiaries have access to the cashless medical facility based on the Central Govt Health Scheme (CGHS) package rates as per the applicable medical rules for the respective RGHS category. Under MAA Yojana, cashless treatment is provided in empaneled govt and private hospitals. Treatment can be availed under the prescribed package at all govt hospitals in the state, such as community health centres, satellite hospitals, sub-divisional hospitals, district hospitals, hospitals affiliated with medical colleges, hospitals of the Govt of India located in the state, and private hospitals associated with the scheme. The task of empaneling hospitals with the scheme will be carried out by the Rajasthan State Health Assurance Agency.

TOP

Mediclaim cashless approval in an hour; claim settlement in 3 hours – Live Mint – 15th April 2025

For harried patients and their relatives who twiddle their thumbs for frustratingly long to get medical insurance claim settlement or cashless authorization approved, help may be at hand soon. The Centre is planning to make it mandatory for health insurance companies to approve cashless authorization requests within an hour, and final claim settlement requests within three hours, according to two people close to the development. Alongside, a professional agency may be hired to design standardized insurance claim and application forms that are easy to understand and fill. Such forms would also ensure that insurance companies settle claims in full and within the specified period.

"The idea is to have BIS-type standards in the insurance sector that streamline the operations of the health insurance industry," said one of the officials cited above on the condition of anonymity. BIS or Bureau of Indian Standards is the national standards body of India. The official added that the objective is to bring more people under health insurance coverage so that "insured patients do not face financial distress due to rising medical bills". This is in line with the Union government's aim to provide affordable health insurance coverage and insurance to all by 2047, which Irdai had announced in November 2022.

The writer is Subhash Narayan.

TOP

Irdai warns Heritage TPA against unilaterally closing health claims – Business Standard – 15th April 2025

The insurance regulator on Friday warned Heritage TPA against unilaterally closing health claims, saying that such actions violate regulatory norms, which mandate that only insurers are authorised to communicate claim decisions to policyholders. "The TPA is hereby warned for closing the health claims on its own and issuing the communication regarding denial/repudiation of the claim directly to the policyholders in contravention of regulations…" Insurance Regulatory and Development Authority of India (Irdai) said in a statement. The regulator also added that the TPA must ensure that the decisions on claims are not influenced by them and that the communication on claims repudiation "shall only be issued by the insurers and not the TPA".

The order is in response to the remote inspection conducted by the authority from November 8, 2021 to November 11, 2021. The insurance regulator noted that Heritage TPA did not forward the query letter sent by the insurance company to the policyholder before closing the claim and no reminder letters were forwarded to the policyholder. According to Irdai norms, TPA has to issue deficiency requests to claimants/insureds and in case of non-submission of requested documents within seven days, TPA shall send three reminders at an interval of seven days each. However, according to Irdai's inspection, the claimants/insured were informed that their claims were closed.

"It is not evident from documents shared that the TPA has taken permission from the insurer to close the claim… The wording of TPA's communication implies as if the TPA itself has closed the claims," Irdai said. Further, the insurance regulator said that the order shall be placed before the board of the TPA and will provide a copy of the minutes of the discussion. The TPA is also asked to submit an Action Taken Report to the authority within 90 days from the date of order.

The writer is Aathira Varier.

TOP

Ayushman Bharat: Key health conditions not covered under ₹5 lakh insurance – Business Standard – 14th April 2025

Delhi has recently become the 35th state or union territory to implement the Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB-PMJAY). If you are among the millions relying on the government-backed health insurance scheme for hospital treatment, it is important to know what is not covered. Being aware of exclusions can help you avoid last-minute financial surprises during medical emergencies. While the scheme offers an annual health cover of ₹5 lakh per family that is economically vulnerable — and to all senior citizens aged 70 and above, irrespective of income or socio-economic status — for secondary and tertiary hospitalisation, here's what Ayushman Bharat, launched on September 23, 2018, does not include.

Diseases and treatments not covered under Ayushman Bharat
According to the latest National Health Benefit Package guidelines issued by the National Health Authority (NHA), AB-PMJAY is not liable to pay for the following:

Outpatient treatments (OPD): Conditions that do not require hospitalisation, such as regular doctor consultations, diagnostics, and routine medication, are excluded.

Evaluation-only hospital stays: Expenditures during hospitalisation meant solely for evaluation or diagnostics, and expenses on vitamins, tonics, or supplements, unless prescribed as part of a certified treatment plan.

Dental treatments: Corrective, cosmetic or prosthetic dental procedures, root canals, cavity fillings, dental implants, and treatment for periodontal diseases are excluded.

Exception: Dental treatment arising from trauma, tumours, or cysts requiring bone treatment and hospitalisation is covered.

Infertility treatments: IVF and other assisted reproductive technologies are not covered unless specifically listed in the National Health Benefit Package.

Non-essential vaccinations and immunisations: Any immunisation that is not part of a national programme.

Cosmetic surgeries: Treatments purely for aesthetic reasons, such as anti-ageing procedures, laser tattoo removal, rhinoplasty, fat grafting, neck lifts, and similar surgeries.

Circumcision (for children under 2): Excluded unless required for medical treatment of an unrelated condition or resulting from an accident.

Persistent vegetative state cases: Where a patient is kept alive by machines and shows no cognitive or physical response, coverage is not provided.

Why are these conditions excluded?
The Ministry of Health and Family Welfare (MoHFW) explains that Ayushman Bharat is designed to target catastrophic health expenses — critical conditions requiring hospitalisation and intensive care. Excluding routine, cosmetic, or elective procedures helps ensure that the scheme remains focused, sustainable, and impactful for the largest segment of the population.

What to do if your treatment isn't covered?
Here are some steps you can take when facing a procedure that's not included in AB-PMJAY:

Check eligibility and hospital status on the official Ayushman Bharat portal.

Consult your doctor to confirm if the procedure qualifies under the scheme.

Plan ahead by saving for uncovered expenses or purchasing a supplementary health insurance policy.

What's covered under the scheme?

According to the MoHFW, specialties covered under AB-PMJAY include:

- Burns management
- Cardiology and cardiothoracic surgery
- Emergency room packages (for care under 12 hours)
- General medicine and surgery
- Interventional neuroradiology
- Medical and surgical oncology
- Mental health treatment
- Neonatal care
- Neurosurgery
- Obstetrics and gynaecology
- Ophthalmology
- Oral and maxillofacial surgery
- Orthopaedics
- Otorhinolaryngology (ENT)
- Paediatric medicine and surgery
- Plastic and reconstructive surgery
- Polytrauma care
- Radiation oncology
- Urology
- Paediatric cancer treatment

How to avail the benefit under Ayushman Bharat

Eligible individuals can access benefits by downloading an e-card from the official website https://pmjay.gov.in.

Documents required to apply:
- Aadhaar card
- Identity proof (driving licence, passport, or voter ID)
- Residential proof (utility bill, passport, or voter ID)
- Family details (names and Aadhaar numbers)
- Caste certificate (if applicable)
- Income certificate
- Bank account details

Steps to apply on the portal:
- Enter your mobile number and fill in the captcha
- Verify with the OTP received

- Select your state
- Check eligibility using your ration card number or other accepted documents
- If eligible, your name will appear. Click on the 'family members' section to view other household beneficiaries

Once verified, you can download your PMJAY e-card via:

- NHA Beneficiary portal
- Ayushman app
- Umang portal
- DigiLocker

You can then use the e-card to access cashless health services at empanelled public and private hospitals under the scheme.

The writer is Barkha Mathur.

TOP

Surgery costs in India up 300 percent in 10 years: Policybazaar calls for higher health insurance cover – CNBC – 14TH April 2025

Surgery costs in India have shot up by over 250–300 percent in the last decade, leaving millions financially vulnerable in the face of medical emergencies, according to a recent analysis by Policybazaar. The report shows that advanced procedures such as cancer surgeries, heart and kidney transplants, and liver treatments now cost anywhere between ₹18 lakh to ₹50 lakh — a steep rise from 2013 levels. Even routine surgeries like cataract removal and hernia repairs have seen a multi-fold increase.

For instance, the cost of a cancer surgery rose from ₹13.5 lakh in 2013 to ₹50.8 lakh in 2024. A heart transplant, which cost ₹9.8 lakh in 2013, now exceeds ₹34 lakh. Common surgeries like cataract have gone from ₹35,000 in 2016 to ₹1.26 lakh in 2025, Policybazaar said. "This is not just a financial issue — it's a health crisis," Policybazaar noted in its findings. The firm attributed the surge in surgery prices to several key drivers: high medical inflation, adoption of advanced technologies, rising demand due to an ageing population, and heavy reliance on imported equipment.

At Policybazaar, said, "Over the past decade, the cost of critical surgeries in India has escalated by over 250–300%, creating a silent crisis for millions of families. A ₹1 crore insurance plan today is what a ₹10 lakh cover was a decade ago — it's the new baseline for comprehensive protection."

The report also emphasised the emotional toll of being uninsured. Families often delay treatment, take loans, or exhaust their savings when faced with sudden medical costs. Around 75% of Indians still pay for healthcare out of pocket, the survey found. Policybazaar pointed out that rising medical costs make it essential for individuals and families to invest in adequate health coverage. A comprehensive ₹1 crore health insurance plan for a couple aged 35 in Delhi now costs around ₹2,000–2,500 per month — or ₹24,000 to ₹30,000 annually.

Such plans offer cashless hospitalisation, cover for organ transplants, chemotherapy, robotic surgeries, and additional benefits like OPD care and mental health services. "In a country where a single heart surgery can cost more than a year's salary, adequate health insurance is no longer optional," the report stated. Policybazaar urged consumers highlighted that medical inflation has consistently outpaced general inflation in India. As healthcare continues to evolve with AI tools and robotic surgeries, the cost of inaction may prove far greater than the cost of premium payments.

The writer is Anshul.

TOP

MOTOR INSURANCE

Higher motor insurance premium this year if more than 2 traffic challans last year? Here's what experts say – The Economic Times – 15th April 2025

Authorities were planning to link unpaid challans on a vehicle to higher premiums paid for the vehicle's insurance. Reportedly, if an individual carries forward more than 2 unpaid or pending challans from the previous financial year, they might be pushed to pay higher premiums towards their vehicle's insurance policy next year.

Similarly, if they rack up more than 3 traffic violations, like driving on a footpath or driving vehicles that are over 10 years old (in the case of petrol) or 15 years old (in the case of diesel) or more in a single year, their license could be confiscated for a minimum of 3 months. The consequence could also include cancellation of the vehicle's registration till the fine imposed is done away with.

Moreover, if there is no action by the person on the challan within 30 days of its generation, it would automatically be considered an admission of guilt on the part of the vehicle's owner. The new financial year has kickstarted this month, and people are wondering whether they will have to pay higher motor insurance premiums this time around if they have more than 2 pending, unpaid challans from the previous financial year. Will all these rules be actively enforced starting this financial year? We talk to experts and decode the matter.

Currently in draft stage; no timeline on implementation
Alay Razvi, Managing Partner, Accord Juris, says, "The present proposal has not been implemented yet, and it still is in the draft stage. Tracking challan status post-policy issuance poses practical and systemic challenges. As such, it would require a secure and continuous data-sharing mechanism between the Ministry of Road Transport, the State Traffic Dept., and motor vehicle insurers." According to him, implementing this would not be easy since this would require multiple privacy and compliance concerns to be addressed under the Digital Personal Data Protection Act (DPDP). The primary obstacle lies in the intricate task of unifying various state-level databases, a challenge further amplified by the requirements of India's Data Protection Act, says Rishi Seghal, Advocate on Record, Supreme Court of India.

"For insurers to effectively implement this, direct and real-time access to government e-challan systems is essential. Scalability will depend on overcoming these integration challenges, ensuring strict data privacy, and committing to substantial infrastructure investment", he adds. Sonal Alagh, Partner, Alagh & Kapoor Law Offices, concurs, noting that the proposed rule to suspend driving licenses for non-payment of traffic e-challans within three months has not yet been fully implemented. However, multiple experts say that the integration of e-challan systems with insurance premiums is under phased implementation in multiple states in India. States like Delhi are even piloting real-time data-sharing between traffic police and insurers via centralized platforms (e.g., PARIVAHAN PORTAL).

How will insurers determine the premium payable in light of challans issued?
Soayib Qureshi, Partner, PSL Advocates & Solicitors, says, "Proposed rules suggest a tiered premium model, where 2 pending challans in a financial year trigger a 10-20% premium hike." Others, like Alagh, expect that insurance companies might employ a point-based system wherein each valid, uncontested challan contributes to a score that determines the premium rate. However, experts anticipate that the premium pricing will largely be done via a telematics-based pricing mechanism. Insurers may use traffic violation history (e.g., more than two pending challans) as a metric to calculate risk-based premiums.

Notably, telematics-based insurance, also known more commonly as usage-based or pay-as-you-drive insurance, lets policyholders pay premiums in proportion to the amount of time they drive the vehicle. With a policy term of one year, insurers measure the distance covered by your car, either by the vehicle's odometer reading or via an app that the policyholder has to install specifically for this. It is also available as a kilometer benefit add-on cover with your existing motor insurance policy. Since it so comprehensively analyses the driver's behaviour and usage patterns, insurance companies generally reward drivers perceived as safe with lower premiums payable, while risky drivers might be subject to higher premiums.

How will erroneously generated challans be dealt with?
The plan to implement such a punitive measure against vehicle owners is not without practical challenges. Many times, challans are erroneously or wrongly generated, prompting drivers to contest them in Lok Adalats or virtual courts. However, if such challans are linked to premium calculations, it could potentially inflate the premium payable, even when the policyholder is not at fault.

A solution for this could be offered to vehicle owners. "The policyholder will have to dispute and resolve the challan before the policy term begins or during renewal. And in the event the issue subsists or is not resolved timely, there's a risk of unjustified premium hike," notes Razvi. "In case the proposal for enhancement in insurance premium happens on account of multiple pending challans, premium calculations would likely be adjusted once the errors are rectified, but the exact method for handling this remains unclear. It might involve providing evidence of wrong charges or submitting appeals to authorities to correct the record before insurance premiums are finalized. This should become clear if and when the amended provisions are enforced," says Rahul Sundaram, Partner, IndiaLaw LLP. Qureshi recommends that insurers provisionally calculate premiums, withholding hikes until resolution. "Post-verification, invalid challans trigger refunds. Regulators (e.g., IRDAI) should mandate transparent dispute mechanisms, requiring insurers to validate challan legitimacy before finalizing premiums, ensuring fairness," he adds.

The writer is Ira Alok Puranik.

TOP

Cams to detect uninsured vehicles, impose fines in smart cities – The Times of India - 14th April 2025

Vehicle owners without insurance need to be cautious on the streets as the automatic number-plate recognition (ANPR) cameras in Bihar's smart cities—Patna, Muzaffarpur, Bhagalpur, and Biharsharif—will automatically detect and issue fines for the offenders. Vehicles without insurance would be fined once per day, with a one-day grace period for e-challan payment. Following this period, subsequent violations will incur additional e-challans as penalties. Sanjay Kumar Agrawal, transport secretary, said that vehicles with outdated insurance certificates are subject to an e-challan under Section 196 of the Motor Vehicles Act, 1988. "Previously, automatic fines were issued for vehicles without insurance through the e-detection system at toll plazas. Additionally, fines were issued using handheld devices," he said.

He emphasised that all vehicle owners must have at least third-party insurance. "Having third-party insurance provides financial security and assists accident victims. There is a penalty for not having vehicle insurance, and in the event of an accident, there is a provision for covering medical expenses and compensation of at least Rs 5 lakh in case of death," Agrawal said. The transport secretary urged people to act as responsible citizens by getting insurance for their vehicles and ensuring the safety of others on the road.

Third-party insurance provides financial protection to the policyholder in case of an accident or damage to someone else's property. It also shields the policyholder from lawsuits filed by third parties and reassures the policyholder that they are covered in the event of an accident. Agrawal said vehicle owners with insurance will get protection of their assets from being seized in a lawsuit, and it also helps the policyholder receive compensation for damages or losses incurred.

The writer is Faryal Rumi.

TOP

CROP INSURANCE

Fraudsters exploit PM's crop insurance scheme in Koppal – The Times of India – 11th April 2025

The Pradhan Mantri Fasal Bima Yojana (PMFBY), a govt scheme aimed at supporting farmers, is hounded by serious irregularities in the district. Investigations have uncovered that unauthorised individuals are using farmers' identities to pay insurance premiums and fraudulently obtaining crop insurance payouts. Recent developments in Bommanal village, located in Hanumanal hobli of Kushtagi taluk, exposed this problem. An agricultural land designated as Survey No. 53, which produced maize, was later recorded as producing onions. Officials from the agriculture department approved this alteration without conducting the required field inspection or verifying the documentation produced. Even as the land owner was completely in the dark, fraudsters went on to claim compensation for damage to the onion crop, asserting that it was lost. The insurance company approved this claim. Despite the crop sown on the land and the original owner being different, fraudsters sought higher insurance compensation, said advocate Raviraj Kulkarni.

In another similar instance, an individual named Basavaraj filed a crop insurance claim under the name of Bhimavva Padachinthi. This person also allegedly engaged in irregularities regarding crop insurance compensation for the year 2023-24. Payments for crop insurance compensation were made starting from last week, and reports of illegal activities began to emerge from various locations, adds Raviraj Kulkarni. An official from the agriculture department confirmed that insurance claims are being submitted for crops that do not exist, on uncultivated lands. Some individuals are targeting crops that qualify for higher compensation and are subsequently filing fraudulent damage claims. Allegations suggest that some employees in the department are complicit in these activities for personal financial benefit.

Some fraudsters identify those who have relocated for govt jobs with fallow lands. They pay insurance premiums for these lands, while falsely claiming that high-compensation crops have been cultivated on them. They later produce documents asserting that crops have been damaged, to receive insurance payouts. Such illegal activities have been occurring systematically, states social activist Krishna Ganiger. Prakash H, a social activist from Koppal, remarks: "Each year, fraudsters target uncultivated agricultural lands across the district. They pay insurance premiums for high-compensation crops and later seek substantial compensation by alleging crop damage. The extent of this illegality and the amount of compensation involved are significant, as officials from relevant departments and some insurance company representatives are directly involved."

Statistical evidence suggests departmental involvement. In Hanumanal hobli, although maize farming is prevalent, only 16% of the crops reported damage. In contrast, the onion crop, which is cultivated less, has a damage report rate of 40%. An agriculture department official who did not wish to be named notes: "This is because higher compensation is available for onions." Advocate Raviraj Kulkarni claims, "There is a coordinated group behind these crop insurance compensation claims, and the truth will only emerge following a comprehensive investigation."

Rudreshappa TS, joint director of the agriculture department, acknowledges receiving irregularity reports and confirms instructing the vigilance department to take action. The department has requested the govt to implement Aadhaar OTP-based insurance premium payments to prevent future violations.

The writer is Chamaraj Savadi

TOP

SURVEY

Nearly Half of India Still Ignores Term Insurance: Survey - Outlook Money - 16th April 2025

It is very important to ensure that your loved ones are well protected, and term insurance is one of the ways to do so. Term insurance plan is the easiest way to secure the future of your family as it offers high coverage at affordable premiums. Despite this differentiating factor, nearly half of India still ignores term insurance. According to a recent survey, 47.6 per cent of India are not even aware of term insurance and its benefits. However, the survey said that there are sings of improvement. "The awareness gap remains one of the biggest barriers to term insurance adoption in India. The survey found that 47.6 per cent of Indians are unaware of term insurance and its benefits. However, there are signs of improvement," Policybazaar said in its latest survey titled 'How India Buys Insurance 2.0'.
As a result, industry-wide, term insurance grew by 18 per cent in FY24, compared to a CAGR of just 2 per cent over the past five years.

"This year's report puts a spotlight on the awareness gap even more evidently than before. A large proportion of consumers plan to sell ancestral assets or borrow money during a crisis rather than opt for simple, accessible solutions like health and life insurance to protect their families," Sarbvir Singh, Joint Group CEO, PB Fintech. The survey, which is based on a survey of 3,955 respondents across 27 metros, Tier-2, and Tier-3 cities in India, found that 56 per cent of respondents who are aware of term insurance have a positive attitude toward purchasing it.
The report uncovers several key insights, including the fact that Indians continue to severely underestimate healthcare costs—nearly 48 per cent of policyholders opt for coverage of Rs 5 lakh or less.

Key Findings of The Survey

- Indians continue to favour traditional financial investments such as gold, fixed deposits, insurance-linked savings schemes, and real estate. According to the survey, 28.3 per cent of respondents ranked health insurance above equities, mutual funds, and government bonds.
- A staggering 75 per cent of health insurance buyers in India have coverage of Rs 10 lakh or less. Non-buyers also display a severe underestimation of medical costs.
- 87 per cent of term insurance non-buyers critically underestimate their family's financial needs.

TOP

PENSION

EPFO allows employers to make one-time payment of dues via demand draft – Business Standard – 11th April 2025

The Employees' Provident Fund Organisation (EPFO) has allowed members to make a one-time payment of past dues through a demand draft. According to rules, organisations have to deduct EPF contributions from their employees' salaries and remit them to pension fund through banks. This process is carried out online through the submission of an Electronic Challan-cum-Return (ECR).

Why are changes being made?
Several employers encountered technical glitches or delays while filing the electronic challan-cum-return (ECR), which prevented timely deposit of EPF dues. This led to penalties and dissatisfaction among employees. Field offices brought this issue to light, prompting EPFO to respond. In a circular, it advised against denying payments solely due to a missed ECR, particularly when employers are ready and willing to make the payments. The circular clarifies that in cases where employers are unable to make such payments online but are willing to clear past dues through a demand draft, the Officer-in-Charge of the regional office may allow the same. However, this relaxation applies strictly to one-time payments, and employers must continue using the digital mode for all future remittances.

The payment is to be made via a demand draft addressed to the Regional Provident Fund Commissioner (RPFC) of the concerned region and payable at the branch where the EPFO office holds an account. "It is therefore clarified that where the Officer-in-Charge of the Region is satisfied that such request is for a one-time payment of past dues and the employer is not seeking a mode other than the Internet banking for the payment of future remittances, he may collect the dues in the manner as is practiced for recovery of any demand in arrear, i.e., through a Demand Draft in the name of RPFC-in-Charge of the Region and payable at the bank branch where the Regional Office concerned holds a bank account," according to a Ministry of Labour and Employment circular on April 4, 2025," said the circular.

Additionally, an undertaking must be obtained from the employer for verification of beneficiaries in case any claims arise. EPFO has also emphasised the importance of collecting returns from employers and directed that any applicable damages and interest should be calculated and recovered in accordance with the existing compliance manual.

The writer is Ayush Mishra.

TOP

GLOBAL NEWS

Thailand: Regulator looks to accelerate assessment of damage from earthquake – Asia Insurance Review

Thailand's insurance regulator, the Office of Insurance Commission (OIC), has been working with the relevant organisations, such as the Insurance Assessors Association and the Thai Loss Surveyors and Assessors Association, to coordinate the system for receiving damage notifications relating to insured buildings.

Due to the high number of damage reports to insurers in multiple areas, insurance companies have assigned loss adjusters to inspect damage in reported places that are accessible. The OIC notes that there are currently 85 licensed property assessors working at full capacity to ensure that the affected insureds receive compensation as quickly as possible. Thus, the regulator has requested that all loss assessment companies prepare and expedite inspections and assessments of damages upon assignment by an insurer.

The OIC also requests the cooperation of the insured to:
Prepare important information, such as checking the coverage conditions in property insurance policies
Thoroughly survey and photograph the damage to the property as evidence for claims
Promptly notifying the insurer
Prepare the relevant documents, such as quotations, receipts and other necessary documents
Facilitate damage inspection by indicating damaged areas and providing complete relevant information

These will help the claim process move more quickly and efficiently, as well as allow the insured to receive the right and complete compensation in accordance with the terms of the insurance policy.

The OIC also reminds claimants to be aware of fraudsters claiming to help earthquake victims in managing their property insurance claims.

TOP

China: Tip-off service to combat medical insurance fraud - Asia Insurance Review

In its fight against fraud in health insurance funds China has launched a series of measures in the recent past. In yet another move, China's National Healthcare Security Administration in April this year launched a tip-off service via its official WeChat account, enabling social organisations and the public to report leads on medical insurance fraud. Eligible informants will be rewarded with a one-time payment ranging from CNY200 ($27.8) to CNY200, 000 according to the administration. Noting that the misuse of medical insurance funds undermines public interests, the administration has urged the whole society to make efforts in combating fraud.

In 2024, China's medical insurance watchdogs recovered CNY27.5bn of misused medical insurance funds, with a total of 10,741 suspects arrested. The NHSA in 2024 identified 2,008 fraudulent insurance institutions and worked with public security authorities to investigate 3,018 medical insurance fraud cases. The NHSA also plans to roll out very soon stricter regulation of medical insurance funds through a nationwide implementation of drug traceability codes. This initiative intends to curb fraudulent activities such as the resale and substitution of insured medications, as well as the misuse of medical insurance cards and counterfeit prescriptions.

The drug traceability code is a unique electronic ID for each medication and, will be used to build large-scale data models to enhance regulatory oversight. The NHSA will use this data to identify and crack down on violations, strengthening enforcement actions against illegal activities. According to industry sources it is necessary to upgrade the national medicine supply security code, which can track the medical distribution process to ensure transparency and accountability. China had also announced developing a points-based credit system for healthcare professionals who are certified to process medical insurance funds to curb the misuse of funds and strengthen punishment for violators. A scheme to encourage drugstores nationwide to integrate with the reimbursement system for outpatient services under the country's medical insurance schemes has already been implemented and this enables those covered by medical insurance schemes to have their purchases of medicine at drugstores reimbursed by medical insurance funds.

TOP

COI TRAINING PROGRAMS - MUMBAI

Non-Life Training Programs

Sr. No.	Program Name	Program Start Date	Program End Date	Details	Registration Link
1	Engineering Insurance - Operational Policies Underwriting and Claims	19-May-25	20-May-25	ClickHere	Register
2	Health Insurance : Medical Management and Fraud Control	22-May-25	23-May-25	ClickHere	Register
3	Miscellaneous Insurance Management	26-May-25	28-May-25	ClickHere	Register

Life Training Programs

Sr. No.	Program Name	Program Start Date	Program End Date	Details	Registration Link
1	Comparative Analysis and Performance of ULIPs & Mutual Funds	13-May-25	14-May-25	ClickHere	Register
2	Impactful Selling Strategies	13-May-25	14-May-25	ClickHere	Register
4	Legal & Regulatory Compliance in Insurance	13-May-25	14-May-25	ClickHere	Register
5	Understanding IFRS 17	28-May-25	28-May-25	ClickHere	Register

Common Training Programs

Sr. No.	Program Name	Program Start Date	Program End Date	Details	Registration Link
1	Risk Based Capital	13-May-25	13-May-25	ClickHere	Register
2	Program on AML, KYC and CFT Requirements	27-May-25	27-May-25	ClickHere	Register

International Training Programs

Sr. No.	Program Name	Program Start Date	Program End Date	Details	Registration Link
1	International Program – Technical Excellence in Life Insurance	19-May-25	31-May-25	ClickHere	

COI TRAINING PROGRAMS - KOLKATA

Non-Life Training Programs

Sr. No.	Program Name	Program Start Date	Program End Date	Details	Registration Link

1	Industrial Risk & Loss Inspections and Survey: Methods and Reporting	21-May-25	21-May-25	ClickHere	Register

Life Training Programs

Sr. No.	Program Name	Program Start Date	Program End Date	Details	Registration Link
1	Life Insurance Policyholders Service and Protection of Policy Holders Interest	16-May-25	16-May-25	ClickHere	Register

CERTIFICATE COURSES

CC1 - Certificate Course in Life Insurance Marketing

Particulars	Details
Date	12th July 2025
Duration of the course	4 months
Mode of Teaching	Self-study + 3 days Online Contact Classes
Total hours of Teaching	18 hours for Online Contact Classes (to solve queries)
Exam pattern	MCQ pattern + Assignments
Target Group	Graduate/Post Graduate, Freshers, Employees working in Insurance Companies
Fees for the course	₹ 5,900/- (₹ 5,000/- + 18% GST)

CC2 - Advanced Certificate course in Health Insurance

Particulars	Details
Date	12th July 2025
Duration of the course	4 months (3 hours on weekends)
Mode of Teaching	Virtual Training – COI, Mumbai
Total hours of Teaching	90 hours
Exam pattern	MCQ pattern
Target Group	Graduate/Post Graduate, Freshers, Employees working in Insurance Companies
Fees for the course	₹ 11,800/- (₹ 10,000/- + 18% GST)

CC3 - Certificate Course in General Insurance

Particulars	Details
Date	12th July 2025
Duration of the course	3 months (on weekends)
Mode of Teaching	Virtual Training - COI, Kolkata
Total hours of Teaching	100 hours
Exam pattern	MCQ pattern
Target Group	Fresh Graduates/Post Graduates, Broking / Insurance Companies, Freelancers
Fees for the course	₹ 14,160 /- (₹ 12,000/- + 18% GST)

CC4 - Certificate Course in Investigation and Fraud Detection in Life Insurance

Particulars	Details
Date	21st -23rd May 2025
Duration of the course	3 Days
Mode of Teaching	Virtual Training sessions
Total hours of Teaching	15 hours for online classes
Exam pattern	MCQ pattern
Target Group	Employees working in Fraud cells/ Claims Dept./ Audit functions of the company
Fees for the course	₹ 10,620/- (₹ 9,000/- + 18 % GST)

CC5 - Certificate Course on Application of Artificial Intelligence and Generative AI in Insurance

Particulars	Details
Date	Will be announced soon
Duration of the course	2 Days

Mode of Teaching	Virtual Training sessions
Total hours of Teaching	06 hours for online classes
Target Group	Insurance Professionals, Data Scientists and Technologists, Product Developers and Underwriters, Sales and Marketing Teams
Fees for the course	₹ 3,540/- (₹ 3,000/- + 18% GST)

Please write to college_insurance@iii.org.in for further queries.

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Post Graduate Diploma in Collaboration with Mumbai University

Post Graduate Diploma in Health Insurance (PGDHI)

Particulars	Details
Duration of the course	One Year (2 semesters)
Mode of Teaching	Weekend Sessions – Hybrid mode (Saturdays and Sundays) and Research Project
Eligibility	Graduates in any faculty are eligible. Students appearing in their final year degree examination are also allowed to apply*. Fresher's, working professionals (including medical doctors) in the health insurance sector can join this course to upgrade their professional qualifications, knowledge and for career advancement [*subject to their passing the examination].
Fees for the course	₹45,375/-
Cash Award Prize Scheme	₹15,000/- for the best performing candidate of III-PGDHI
Contact Email id	pgdhi@iii.org.in

Post Graduate Diploma in Insurance Marketing (PGDIM)

Particulars	Details
Duration of the course	One Year (2 semesters)
Mode of Teaching	Weekend Sessions – Hybrid mode (Saturdays and Sundays) and Research Project
Eligibility	Graduates in any discipline are eligible. Students appearing in their final year degree examination are also allowed to apply*. Fresher, working professionals in life/general insurance sector can join this course to upgrade their professional qualifications, knowledge and for career advancement [* subject to their passing the examination].
Fees for the course	₹45,375/-
Cash Award Prize Scheme	₹15,000/- for the best performing candidate of III-PGDIM
Contact Email id	pgdim@iii.org.in

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