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QUOTE OF THE WEEK

"The greatest use of a life is to spend it on something that will outlast it."

WILLIAM JAMES

Insurance Term for the Week

Travel Insurance

Travel Insurance is a type of insurance that covers different risks while travelling. It covers medical expenses, lost luggage, flight cancellations, and other losses that a traveller can incur while travelling.

Travel Insurance is usually taken from the day of travel till the time the traveller reaches back to India. Taking Travel Insurance ensures a comprehensive coverage in case of any emergency in another country. Travel Insurance is also available for trips taken in the home country of the traveller like Bharat Bhraman & E Travel, but it is a more popular option for travel abroad.

Some of the risks covered under Travel Insurance are: Personal Accident Cover, which covers: Insured's Death, Permanent Total Disability, Accident & sickness medical expense reimbursement, Dental treatment relief, Emergency evacuation, Repatriation of remains in case of death, Baggage delay, Loss of checked baggage, Loss of passport, Flight delay, Hijack, Home burglary, Trip curtailment, Trip cancellation, Missed connection/missed departure, Bounced hotel/airline booking.

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INSURANCE INDUSTRY

Govt's digitisation push catalysing innovations in insurtech industry: InsuranceDekho CEO - The Economic Times – 4th March 2024

The government's push towards digitalisation and technology adoption has catalysed innovation within the insurtech industry, which bodes well for bolstering the growth prospects of the industry, Ankit Agrawal, Founder and CEO, InsuranceDekho, has stressed.

In an interaction with IANS, he said that the government's decision to promote Insurtech innovation can be considered a positive step towards the development of ingenious insurance products, distribution channels, and customer engagement solutions. "Initiatives such as the 'Digital India' campaign and the introduction of Aadhaar-based e-KYC have facilitated the seamless onboarding of customers and enabled insurers to offer digital insurance products and services," Ankit Agrawal noted.

Furthermore, to give the desired impetus to the sector, the government has also launched Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) to provide financial protection against healthcare expenses for millions of vulnerable families, thereby expanding the health insurance coverage. The Indian insurtech sector has also come up with microinsurance products tailored specifically to protect the economically vulnerable population with insurance coverage on health, agriculture, and livelihood. "The products have been devised with the intention of driving maximum insurance for the otherwise underprivileged sections of society," said Agrawal.

In addition to this, the industry has been making great strides to expedite technology integration with the help of Insurtech startups to leverage digital platforms for facilitating distribution, claim processing, and customer engagement aimed at enabling easy access to various insurance products. Various studies have shown that increased insurance penetration multiplies the economy by reducing overall financial distress and making long-term growth capital available to important nation-building industries. "Working towards the larger goal of becoming a fully insured nation by 2047, the government should consider the exemption of GST on insurance policies to bring down insurance premiums," Agrawal said. This can further be supported by a rise in tax exemption limits under 80C to prioritise savings and promote insurance coverage, for giving the desired fillip to economic growth, he added.

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Point of sales person strategies for extending insurance coverage to all – Your Story - 3rd March 2024

The Indian economy is unquestionably set to become the third largest globally and expected to reach a GDP of $5 trillion in the next three years and a staggering $7 trillion by 2030. This growth will reflect in all sectors of the economy, including the insurance industry, which is projected to be the sixth-largest insurance market worldwide by 2032. This tremendous growth can be attributed to several factors including increased awareness around protection tools, a rise in disposable income levels, and transformative regulatory developments. Despite this phenomenal growth, a 'missing middle', particularly in Tier II and III cities, still remains underinsured. People in these areas research insurance products on the internet but don't want to transact online. Instead, they prefer to buy from a local touchpoint who can address their queries and assist them in person.

To address this gap, the Insurance Regulatory and Development Authority of India (IRDAI) revised the guidelines for the point of sales person (PoSP) model in 2015. This enabling initiative by the regulator is helping the industry secure lives across the nation and extend the protective umbrella of insurance to every Indian. Under the PoSP model, people from local communities are trained to become agent partners to sell insurance products directly to customers. This includes extensive training, ranging from

product knowledge to advanced technology. These partners use their local networks to foster trust and provide personalised services, bridging the gap between insurance providers and potential customers in Tier II and III cities. By merging in-person interactions with digital resources, they enhance accessibility to protection tools and simplify the buying journey, driving financial inclusion across demographics.

(The writer is Dhruv Sarin.)

TOP

INSURANCE REGULATION

Insurance regulator IRDAI considers proposal to increase policy surrender charges - The Telegraph – 5th March 2024

Insurance regulator IRDAI may consider rationalising the proposal to increase the surrender charges of a policy after discussions with life insurance companies. In December 2023, the IRDAI came out with an exposure draft on more encompassing product regulations and sought to repeal certain extant regulations based on recommendations of the regulation review committee. Among the changes proposed in the exposure draft were the modifications to the surrender value of life insurance policies. Surrender value is the amount payable on withdrawal or termination of a policy during the term.

The regulator has proposed the creation of a premium threshold defined for each product and said in the exposure draft that there should not be any surrender charges imposed on the balance of premium beyond the threshold limits, irrespective of the time of surrender. However, there needed to be more clarity within the draft on what would be the threshold limits. The exposure draft further proposed that in the case of individual non-linked savings and protection-oriented life insurance policies, there would be a slab-based guaranteed surrender value.

Adjusted for survival benefits this would be 30, 35, 50 and 90 per cent of the total premium paid if the policy is surrendered during the second, third, fourth, seventh and the last two years of the policy. “The surrender value beyond the seventh year shall follow a smooth progression and converge to at least 90 per cent of total premium paid less any survival benefits already paid, as the policy approaches maturity,” the exposure draft said. The implication of the proposed changes is a sharp increase in the amount that life insurers would have to shell out on the surrender of a policy leading to a direct hit on the margins. The regulator’s logic behind the change is that policyholders should be able to avail a fair and reasonable amount towards the end of the term which is closer to the expected maturity value.

However, industry sources said the life insurers have made certain points with the regulator. In 2022-23, around 40 per cent of the total benefits paid by life insurers to policyholders were on account of surrender/withdrawal of policies. A higher surrender value would only encourage more surrender rather than positioning life insurance as a long-term savings and protection product. Sources said that some of the proposals placed with the regulator include lowering threshold limits for the calculation of surrender values, a five-year milestone beyond which policies could be considered long-term and different product constructs based on policyholder preference for liquidity against protection and return.

“If we look at long-term products such as PPF (public provident fund) with a 15-year tenure, withdrawal and premature closure are only allowed after five years. Long-term products including life insurance have different objectives rather than providing liquidity. So the life insurers are engaging with the regulator to understand and have more clarity,” an industry source said.

The IRDAI may consider approving the final regulations around surrender value in its board meeting in March.

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LIFE INSURANCE

Financing the Future: Women, Innovation, and the Road Ahead - The Economic Times – 8th March 2024

In the vast landscape of finance, recognising the challenges and contribution of women isn't merely an acknowledgment or appreciation. It is a compass guiding innovation, inclusivity, and growth. As Robert Frost's "The Road Not Taken" reminds us, celebrating these pioneers signifies embracing the path less travelled, paving the way for transformation in the financial world.

However, regardless of the progress, the path forward remains uneven. Survey data from the CFA Institute states that women comprise 21.7% of the financial workforce and hold 15.9% of key managerial positions, globally. At a cumulative level, these numbers are even more stark, with a mere 9% of women reaching the top. While a glimmer of hope exists, in the financial sector, statistics demand a dramatic shift.

Breaking Through: The Power of Female Leadership
All women, who have risen to leadership positions, have shattered the glass ceilings. They have risen to the top, defying traditional norms, and pave the way for future generations to have a more enabling environment. Their journeys haven't been easy; neither are the journeys of young women entering the financial services sector today.

Integrating into male-dominated teams requires additional assertiveness to ensure their voices are heard. These women deserve our gratitude for pushing the cause of inclusivity, for challenging the status quo daily, and for navigating the double duties of excelling professionally while efficiently managing their homes. They are redefining standard norms of motherhood, raising children who value equality, and cultivating a generation with a more progressive perspective. This is not an easy task, when the metrics for judging mothers are at a physical presence level, for e.g., providing hot meals and being around to pick up/drop them from school. Corporate India must become cheerleaders for this cohort as they truly #InspireInclusion.

Innovation Beyond the Spreadsheets: The Power of Multitasking Marvels
I do not believe that multi-tasking is a woman’s domain. I think women learn to identify tasks that can be done parallelly and sequentially, in order to cope with the multiple expectations and responsibilities that their own values & beliefs, the family and society place on them. The old age adage of “Necessity is the mother of invention” aptly describes the situation the expertise acquired by working women who want to have it all.

Thus, women employ the most innovative ways of working to get everything done. The skill of parallelly juggling sales targets and grocery lists translates into deep strengths. Women become experts at resourcefulness, drawing on every available tool to get the job done. This fosters an environment where teams are encouraged to think outside the box and to explore uncharted territories with fresh perspectives. As women leaders challenge established norms, the very paradigms of finance are shifting towards a more innovative future. Women bring to the table strategic resourcefulness and innovative solutions, which are an asset in the world of finance where they continue to do their bit to #InspireInclusion.

Building Bridges for a Better Tomorrow: The Power of Inclusive Leadership
Leaders with empathy and an ability to understand perspectives and needs, #InspireInclusion and champion diversity, equity, and create clear pathways for women's career advancement at all levels. Initiatives like offering sabbaticals for family care or ensuring clean, safe restrooms for women working in the field, or ensuring new mother returning to their field jobs are given territories close to home are testaments to this commitment. These leaders understand that supporting women creates a more resilient, well-rounded workforce.

International Women's Day serves as a powerful reminder of the progress made. However, the glass is less than half full. Until women's representation reaches at least 35-40%, women who enter the corporate world will continue to carry the mantle of leadership to pave the way for generations to come. Now is the time to converge, to join forces. For those hesitant about the outcome, remember, a more equitable future will benefit everyone. It is a cause worth fighting for, at every level.

As leaders, it is our responsibility to pave the way for a more inclusive future. The benefits of gender diversity in leadership have been strongly established over the past few decades. Yet, boardrooms and C-suites in India remain largely homogenous. It is imperative that we actively work towards changing the narrative where most leadership roles are held by men. On this International Women's Day, and every single day, we must determinedly #InspireInclusion and demonstrate a commitment to diversity to foster a more equitable workplace with the right attitude and culture. Every decision, every promotion, every leadership opportunity then becomes a chance to demonstrate a commitment to diversity.

(The writer is R.M. Vishakha.)

TOP

Decreasing persistency in insurance policies, good life going out of insurance cover - Business Standard – 7th March 2024

In the year 2023, more people have been saying goodbye to their life insurance plans and either surrendering or allowing their policies to lapse by not paying subsequent policy premiums. As per the data of insurance regulatory and other large life insurance companies recent release of data shows that 50% of the life insurance policies are not seeing their maturity. The good life which has no background of any past illness are dropping from the insurance by either surrendering their policies or not renewing it. This is an alarming situation for both insurers and underpenetrated insurance market like India which stands at 2% in Indian as compared to more than 60% insurance penetration of World average and up to 100% in some of the developed countries.

Why the sudden surge? Well, it's a mix of things like prices going up (inflation) and over selling or mis-selling of policies. Because of increasing awareness in major cities and metros in India about the other asset classes which are delivering more returns than an endowment life insurance policy which delivers only 4.5% of the returns at the end of the maturity, because of this people are moving towards term policies rather than endowment policies. Endowment policies promises returns at the end of the maturity has been remained as a major saving instrument for people across India besides covering risk is losing its sheen and more and more people are surrendering these policies.

Recent release of data by IRDAI, the life insurance sector paid out a total of Rs 4.96 lakh crore in benefits, which is about 64.08% of the net premium. Here's the kicker, benefits paid due to surrenders or withdrawals shot up by a whopping 25.62% to Rs 1.98 lakh crore. The public sector insurers took the lead, making up 56.27% of the total, while private insurers covered the rest. What's more, out of all the surrender benefits, 62.51% came from private insurers' unit-linked policies, and the public life insurer chipped in with 1.56%.

Also, IRDAI data suggests that total life insurance for the first-year individual premium has come down by 7.03%, whereas life insurance policies are just grown by 0.68%, when compared to last year Dec, 2023. Rajiv Agarwal, Co-founder of Integrated Risk Insurance Brokers explains that “typically, a decrease in the first-year premium may indicate that fewer new policies are being sold or that people are buying less expensive policies. However, if the number of policies sold is still growing, it could suggest that more people are entering the market but choosing less expensive options.

If the people buying these new policies are satisfied with their coverage and continue to renew them in subsequent years, the persistency ratio could increase. This is because even though the initial premium is lower, more people sticking with their policies over time contributes positively to persistency. Conversely, if the decrease in premium results in people not renewing their policies after the first year, the persistency ratio could decrease. This might happen if the decrease in premium leads to policies with less comprehensive coverage, or if customers are dissatisfied with their policies for any reason".

Good life going out of insurance in India is not good for insurance companies as the claim rates will go up substantially. As the insurance is for everyone, if a greater number of policies are dropped mid-way or lapsed there is definitely increases the risk for dependents whose insurance policies are lapsed. So, there is a need for an intervention from all the stake holders to increase the persistency ratio to make the whole insurance as a win win situation.

TOP

Keep records, communicate: Dealing with unclaimed insurance policies - Business Standard – 7th March 2024

A life insurance policy sold through an agent has a higher unclaimed fund rate than one sold through another channel like bancassurance or a digital platform, Business Standard reported recently. "Unclaimed life insurance funds are the unclaimed death or survival benefits from policies," says Tarun Mathur, co-founder and chief business officer, Policybazaar.com. Such funds are proceeds of insurance policies, including death or survival benefits, not claimed by the beneficiary or the policyholder. Life insurance funds go unclaimed for several reasons and knowing them is important. If a policyholder does not communicate details to beneficiaries it can hinder making a claim. Policyholders should update their mobile number, email address, bank details, and address with the insurer to stay informed about policy events. "Updating beneficiaries' contact details is also crucial for the insurer to identify rightful beneficiaries in case of unforeseen events," says Mathur. "Apart from this, sometimes the policy has a beneficiary who has already passed away. Or sometimes, there is no beneficiary mentioned at all," says Naval Goel, chief executive officer (CEO) of PolicyX. Forgotten policies: People with multiple life insurance policies may forget those purchased years ago or for small sums. Goel says, "Usually, except for term insurance, life insurance policies are for the long term. The coverage extends up to 100 years. So, sometimes the policyholder himself forgets about a particular policy if he has more than one."

If the policyholder or beneficiary fails to provide the necessary KYC, documents, or bank details, policyholders or beneficiaries cannot claim policy benefits. Not submitting claims: Policyholders must initiate the claims process when there is a need. "A significant portion of unclaimed funds arises from policyholders failing to submit maturity claims, death claims, or claims that are deemed non-payable due to disputes or other reasons," says Gagandeep Singh, senior president and Head of Health, Life PoSP vertical, PolicyBoss.com. Communication: In some cases, policyholders cannot be contacted. Singh says, "These may include changes in address or contact details, the life insured getting married and becoming difficult to trace due to a lack of information, relocation to a different place or abroad, or a change in status to non-resident Indian (NRI)." Unclaimed funds can also occur in death claims when there are discrepancies in the title, such as the nomination not being filled out or updated with the insurer. Singh says, "Additionally, situations may arise where the nominated beneficiary has passed away before the policy matures, leading to complications in claim settlement." In the case of business insurance policies, unclaimed funds can result from partner disputes or the dissolution of partnerships and companies. Singh says, "Disputes may arise between keyman's insurance policies where employers or proposers refuse to pay, causing delays in claim settlement."

Unclaimed funds remain with the insurance provider until rightful beneficiaries or policyholders initiate a claim. Mathur says, "Insurance providers actively try to locate and notify beneficiaries through letters, phone calls, and all other means of communication. If no response is received within 12 months, the amount is classified as unclaimed." Unclaimed funds are invested in various market-linked funds by the life insurance company. The same happens with these unclaimed funds. "When the policyholders or the nominees reach out, the companies provide them the due death or maturity benefit. If these funds remain unclaimed for 10 years, the insurers transfer them to the Senior Citizen Welfare Fund," says Goel. Policyholders or beneficiaries must consult financial advisors and contact the insurance provider for assistance in finding and claiming funds. Mathur says, "Many insurance companies offer online portals where policyholders can log in to check unclaimed funds. Even the customer support department of your insurance provider can guide you to check for unclaimed funds." They can visit a branch of the insurer along with the policy details and their details. The insurers usually ask for your bank details and KYC documents while claiming the unclaimed funds. "If the beneficiaries are reaching out for the death benefit, their identity proofs, policy documents, and proof of relationship with the deceased will be asked for," says Goel.

Policyholders must maintain records of all their policies. The family must be kept in the loop. Singh says, "This would mean sharing policy details, contact information, and instructions for filing claims. By involving family members in the knowledge of policies, the risk of funds going unclaimed due to a lack of awareness or information is significantly reduced." Regularly review your policy: That is another preventive measure against unclaimed funds. Singh says, "It is highly recommended that individuals review their policies periodically to assess their changing needs, update beneficiary information, and ensure that their policies remain active and relevant. Regular reviews help policyholders stay informed about their coverage and minimize the risk of funds being left unclaimed." Insurers send reminders, about the importance of timely claim submissions. Do not ignore any SMS or message from them, thinking it's a marketing initiative. Singh says, "Today, insurance companies have invested in digital platforms and technologies to make the claims process more efficient and user-friendly. A lot of insurance companies have started providing online claim submission options, automating claim settlement procedures, and minimizing paperwork to facilitate faster and smoother claims processing."

(The writer is Bindisha Sarang.)

TOP

Latest claim settlement ratio of life insurance companies in India released in 2024 - The Economic Time – 5th Mar 2024

The main reason why we buy a life insurance policy is to secure the future of our loved ones in case of unfortunate events. So, it is important to check how your insurer settles claims before you invest your hard-earned money in it. Here the concept of claim settlement ratio comes into play. It is one of the crucial metrics that give you a rough sense of how the insurance company honours the policyholders' claims.

What is a claim settlement ratio?
Claim settlement ratio is a percentage of claims that the insurer has paid out against the number of outstanding claims during a financial year. As a thumb rule, the higher the claim settlement ratio, the more reliable the insurer is. So if you are planning to buy a new insurance policy or renew your existing one, you must check the claim settlement ratio of the insurer along with other factors such as premium amount and coverage.

IRDAI releases latest claim settlement ratio of the life insurers in 2024
The Insurance Regulatory and Development Authority of India (IRDAI) has recently released the details of claim settlements of all life insurance companies for the year 2022-23. The individual death claim settlement ratio of the life insurance industry was 98.45% in 2022-23. It means that the life insurance industry settled over 98% of the total individual death claim requests received during FY 2022-23. The overall claim settlement ratio was 98.64% in 2022-23.

What is claim settlement ratio by number?

In terms of number of policies settled during 2022-23, Max Life Insurance has the highest claim settlement ratio of 99.51%. With a 99.39% claim settlement ratio, HDFC Life Insurance came second on the list. Aegon Life Insurance bagged the third position with a 99.37% claim settlement ratio. Claim settlement ratio of life insurance companies 2024 (in terms of numbers). LIC alone settled over 9.22 lakh claims during 2022-23. Meanwhile, the private insurance sector paid 1.54 lakh claims during the same period.

Total Claims	Claims paid		Claims Repudiated		
Insurance Company	Number of Policies	Number of Policies	% of Total Claims	Number of Policies	% of Total Claims
Max Life	19659	19563	99.51%	96	0.49%
HDFC Life	17558	17451	99.39%	103	0.59%
Aegon	316	314	99.37%	2	0.63%
Edelweiss Tokio	500	496	99.20%	4	0.80%
Bharti Axa	2116	2097	99.10%	19	0.90%
PNB Met Life	5292	5242	99.06%	48	0.91%
Bajaj Allianz	15502	15353	99.04%	145	0.94%
Tata AIA	5475	5421	99.01%	53	0.97%
Canara HSBC OBC	2119	2098	99.01%	19	0.90%
Pramerica Life	753	744	98.80%	8	1.06%
Aviva	803	793	98.75%	10	1.25%
Reliance Nippon	8759	8635	98.58%	122	1.39%
LIC	922207	908576	98.52%	8003	0.87%
Kotak Mahindra	4333	4257	98.25%	65	1.50%
Aditya Birla Sun Life	6314	6195	98.12%	119	1.88%
Sahara	657	643	97.87%	7	1.07%
Shriram	4003	3899	97.40%	86	2.15%
SBI Life	36896	35807	97.05%	1007	2.73%
India First	3147	3054	97.04%	83	2.64%
Exide Life	2143	2063	96.27%	30	1.40%
Star Union	1806	1735	96.07%	68	3.77%
Ageas Federal	1445	1388	96.06%	45	3.11%
ICICI Prudential	14333	13656	95.28%	638	4.45%
Future Generali	988	939	95.04%	49	4.96%
Private Sector Total	154917	151843	98.02%	2826	1.82%

The claims repudiated ratio indicates how many claims the insurer finds to be invalid and hence, has not paid the claimed amount. There could be many reasons why a life insurance company will repudiate a claim after it has accepted it for processing. Near to 100% shows how efficient the insurance company is in settling claims. If a policyholder wants to get a sense of how easy it is to file a claim and how those claims are being processed and paid by the insurer, a claim settlement ratio by numbers can be a useful indicator.

	Total Claims	Claims paid	
Insurance Company	Benefit Amount (₹crore)	Benefit Amount (₹crore)	Claim paid ratio
Aegon	86.69	86.14	99.37%
Aviva	98.85	97.60	98.74%
Bharti Axa	150.73	147.85	98.09%
Pramerica Life	30.59	29.82	97.50%
HDFC Life	1440.20	1389.90	96.51%
Sahara	5.50	5.31	96.49%
Canara HSBC OBC	193.76	186.19	96.09%
PNB Met Life	425.34	407.33	95.77%
LIC	19327.63	18397.77	95.19%
SBI Life	1766.28	1676.95	94.94%
Max Life	1312.47	1242.15	94.64%
Tata AIA	821.70	776.70	94.52%
Bajaj Allianz	639.80	603.03	94.25%
Kotak Mahindra	341.83	320.92	93.88%
Edelweiss Tokio	63.05	59.02	93.61%
Star Union	121.33	113.46	93.51%
Reliance Nippon	219.26	204.06	93.07%
Aditya Birla Sun Life	496.96	458.32	92.23%
India First	173.40	159.81	92.17%
ICICI Prudential	2142.35	1949.70	91.01%
Ageas Federal	67.47	61.05	90.48%
Exide Life	114.33	100.52	87.92%
Future Generali	41.05	32.81	79.94%
Shriram	141.05	109.49	77.63%
Private Sector Total	10893.98	10218.15	93.80%
Grand Total	30221.61	28615.92	94.69%

Source: IRDAI

Claims paid by amount: What policyholders must know

The claim paid ratio by amount indicates the percentage of the total value of claims submitted to an insurance company that is ultimately paid out. A high ratio would suggest that the company is paying out a large proportion of the total value of claims submitted to it, while a low ratio would suggest that the company is denying or delaying many claims. Both claim-paid ratios by numbers and claim-paid ratios by amount are used to measure the financial performance of an insurance company and to assess its ability to pay out claims to policyholders.

Claim settlement ratio of life insurance companies 2024 (by amount)

In terms of benefit amount paid against the claim, Aegon Life Insurance recorded a 99.37% claim settlement ratio. Aviva Life Insurance recorded a claim settlement ratio of 98.74%, according to IRDAI data. With a 98.09% claim settlement ratio, Bharti Axa Life Insurance came in the third position. "The claims paid ratio by amount can be useful for policyholders who are more interested in the amount of money they might expect to receive if they file a claim," said Sanjiv Bajaj, Jt. Chairman & MD, Bajaj Capital.

To get a holistic idea about the claim-paying ability of the insurance company, a policyholder must check and compare both the claim settlement ratio by number and the claim paid ratio by benefit amount before buying the insurance policy.

(The writer is Anulekha Ray.)

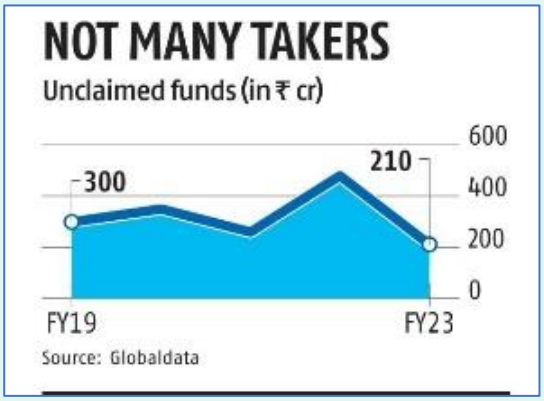
TOP

Unclaimed insurance funds higher in agent-sold policies: Analysts - Business Standard – 4th March 2024

The unclaimed funds within the life insurance sector are higher from policies sold by agents as against other channels like bancassurance or a digital platform, said analysts and officials from insurance companies. Unclaimed life insurance funds refer to the proceeds of insurance policies including death or survival benefits not claimed by the beneficiary or the policyholder. Bancassurance means selling an insurance product through banks.

"The insurance companies can easily verify the bank details with the bank for bancassurance customers and also get new bank account, contact details and address from the bank based on Permanent Account Number (PAN) numbers. The updating of customer mobile and email in policies sourced through digital channels also helps to instantly connect with customers to get bank details during payout," said Vighnesh Shahane, MD & CEO, Federal Ageas Life Insurance. "In the case of agency channels, the attrition makes it difficult to connect with customers once the agent leaves the company," Shahane added.

Recently, the Insurance Regulatory and Development Authority of India (Irdai) issued modifications in the master circular for unclaimed insurance. The regulator directed the insurers to contact the customer 12 months instead of 6 months in advance before declaring the funds unclaimed amounts. The regulatory notifications also include measures on communication with customers, updating their contact and bank details and adoption of digital methods like customer portals and apps, and advertisements in print/digital media to trace customers.



Swarup Kumar Sahoo, Senior Insurance Analyst at GlobalData, said Life Insurance Corporation of India (LIC) accounted for more than 90 per cent of the total unclaimed funds in the last five years.

"Since LIC generates most of its business through agents, we can estimate that agents-sold policies account for a major share of the total unclaimed insurance funds. However, the actual data-specific number on unclaimed funds by distribution channel is not available," Sahoo said.

In FY23, the unclaimed insurance funds in the life insurance industry sharply declined to Rs 2.06 crore from Rs 4.82 crore in the year-ago period. According to Vineet Arora, COO, HDFC Life Insurance, unclaimed funds are agnostic to distribution channels. He said policyholders must notify their respective life insurers in case of a change in their contact details or a change in bank account.

(The writer is Aathira Varier.)

TOP

GENERAL INSURANCE

Next big reform in Indian insurance will be indemnity cover for shipping - Business Standard – 5th March 2024

The Insurance Act will have to be amended to make room for an Indian protection and indemnity facility (P&I) for shipping companies in the country, an expert committee set up by the finance ministry has said. The Act does not have any provision for entities like mutual insurance associations to operate in the sector. “This (amendment in the Act) also means the new line of business will have to wait for the formation of a new government after the general elections,” said a government source aware of the developments. Finance Minister Nirmala Sitharaman told a shipping conclave in Mumbai last year that India needs to have a P&I facility, so it is likely that the amendment will be pushed rapidly in the legislative agenda when a new government assumes office. India goes to elections in April and May this year.

The committee, set up under the chairmanship of M P Tangirala, additional secretary in the finance ministry, also plans to reach out to Indian insurance companies to pick capacity in this line of business to make a P&I club a reality in the Indian insurance market. On the question of whether the government will contribute any initial capital in the business, the committee, representatives of various ministries, industry representatives and the sector regulator, Insurance Regulatory and Development Authority of India, will take a call. "A model the committee could look into is the GIC cargo pool of Rs 500 crore meant to offer cargo insurance for marine voyages of Indian companies importing fertiliser from Russia,” said S Mohan, Director at Insurance Brokers Association of India. The pool, set up in 2022, covers not only fertiliser but also the risks of oil and gas imports. State-owned reinsurer GIC Re holds a 40 percent share in the pool and other companies in the private and public sectors hold the remaining stakes. A P&I facility offers shipping companies an insurance cover like the third-party cover given to motor vehicles. Traditionally, a non-life insurance company offers only a cover for the transit of cargo to a transporter. A P&I facility pools in risks from member insurance companies to offer a larger cover for damages to others – it is an arrangement needed if a ship capsizes, spills cargo or collides with another vessel. These are vast sums involved. The London-based International Group of P&I Clubs, for instance, from which more than 90 percent of such cover originates globally, limits the payouts to about $3.1 billion.

A P&I club transfers risks of catastrophes from a single company to a much larger entity. It is not a single insurance underwriting company but a group of insurance companies plus other firms with stakes in this line of business. The stake of each company in the club is determined by the percentage of business it agrees to contribute in the pool. The advantage of this structure is that unlike a company that will have to report to its shareholders, a P&I club is bound to report only to its members comprising of ship owners, operators, charterers, freight forwarders and warehouses. Such an entity can act both as insurance provider as well as receiver for its members. Given the heightened risks to shipping lines in the current global environment, the Indian government has been pushing to create a domestic P&I club. This has become more necessary as there are also ships touching Indian shores bringing oil and gas from Russia and Iran among others, which are denied such covers by the current P&I clubs. If there is any catastrophe, for instance, the entire cost of those will have to be assumed by the Indian government. While the International Group of P&I Clubs of London is almost like a monopoly bringing together 13 country-based P&I clubs, newcomers are muscling into the business. This includes such associations in both China and Japan where business volumes are building up, though the Japanese entity is the only Asian member of the London Club.

Over the past few years, GIC Re has studied the prospects to guide the government on the feasibility of offering this business from India. A suggestion in this regard is to place the club in the fast-emerging Gift

City insurance hub. While this will still need an amendment in the Insurance Act the subsequent steps can be put on the fast track, a source said. As a trial, India's largest insurance company by market share, New India Assurance Company has begun to offer a similar but limited cover to coastal shipping vessels. It is expected that this will be the model which will expand over the next few years. Those asking for cover will be the ships with the Indian flag. Of the 1500 odd vessels in the Indian Register of Shipping there are no large ocean-going ones like oil carriers and similar ones. So the scale of risks for the companies that pick up stake in the Indian P&I entity shall also be limited. The Asian P&I clubs like the Chinese ones were initially backstopped by their governments. "One of the options for the government will be to offer some sort of sovereign guarantee to build volumes in the business" said a source. The capacities which the insurance companies will bring on their own, shall be limited, said the source.

(The writer is Subhomoy Bhattacharjee.)

TOP

HEALTH INSURANCE

India Can Become World's Largest Health Insurance Market, Says Dr Devi Shetty At Republic Summit - Republic World – 8th March 2024

Cardiac surgeon Dr Devi Shetty while speaking at the Republic Summit 2024 spoke about the importance of universal health insurance. He further highlighted that India has the potential to become world's largest health insurance market. With this, he urged hospitals to become better help givers for people to be able to trust them.

While speaking at the Republic Summit, Dr Devi Shetty said, "Universal health insurance is the key. There is a lack of trust among hospitals and health insurance companies. We need to look into better options to increase our health funds. We need to get into universal health insurance. People do not trust either hospitals or health insurance companies. Hospital needs to become help giver for people to trust them." Elaborating on the same, he said, "We have the potential to become world's largest health insurance market. If people trust health insurance then slowly every stage of the society will be able to afford the insurance." He said that there are 300 million households in India, if 100 million buy premiums, it will have a direct or indirect impact on 100 million more.

The need to monitor surgery data

Surgery count is a great indicator of health infrastructure as per Dr Shetty. He said, "Policy makers must monitor surgery data to ensure blood bank and outgoing patients are working." Global healthcare in future is dependent on software. Dr Shetty said, "India can lead development of modern medical equipment." He further emphasised on the need for a cultural shift in medical colleges. "Policy makers must allow best surgeons to teach in medical colleges."

TOP

Health Ministry to consult states on fixing hospital treatment costs - The Economic Times – 7th March 2024

The health ministry will start consultations with state governments this week for suggestions on fixing charges for treatment at healthcare centres across the country. This follows the Supreme Court last week raising concern over the wide variation in treatment costs between government and private healthcare centres. It directed the Centre to expeditiously fix treatment charges to be paid by patients, giving six weeks for the same. The SC criticised the Centre's failure in specifying the range of rates within which private hospitals and clinics can charge patients. Although a rule in this regard was framed twelve years ago, the court noted that it has not been enforced yet. The Supreme Court had also asked the Union health secretary to call a

meeting of his state counterparts to end the disparity in rates and ensure notification of a standard rate within a month. "Health is a state subject; the Centre can only to some extent direct the states. However, as suggested by the court, we will hold consultations to seek their suggestions and file a reply before the Supreme Court," a person in the know said. Highlighting the stark difference in treatment costs between government and private healthcare centres, the apex court asserted that citizens have a fundamental right to healthcare, and the government cannot evade its responsibility in ensuring this right.

The Association of Healthcare Providers (AHPI), which represents medium and small hospitals, will also file an intervention in the Supreme Court on behalf of the industry this week, Girdhar Gyani, director general of the association, said. Gyani has also written to the health ministry recommending working out costing of various procedures based on established scientific principles and fixing rates in the 'range' to address the categorisation of establishments. Private hospitals say that the move will be "catastrophic" for the industry as there are too many variables involved. "The cost depends on so many other factors, even geographies. The input cost is higher in Delhi than in UP. Since the minimum wages are lower in UP, the hospital may choose to pass it on to the patients. But the same cannot be applied in a place like Delhi. If it is standardised, the quality will suffer," an executive said. A second executive said the cost structure is different in each hospital "as it depends on various factors like the experience of the doctors, facilities in the OT, the kind of infection control policy which is adopted by the hospital, patient safety measures, IT services etc." "Price cannot be standardised for a big hospital and a small clinic," the executive said.

(The writer is Teena Thacker.)

TOP

Cashless health insurance at all hospitals now but network hospitals are still better option for 'assured' cashless treatments - The Economic Times – 7th March 2024

General and health insurers have recently rolled out a "cashless everywhere" facility in India that allows policyholders to access cashless facilities for medical treatment in any hospital. Even if the institution is not in the network of your insurance company, you can still avail cashless treatment there. If it is a planned treatment, all you need to do is inform your insurance company at least 48 hours prior to admission to avail of cashless treatment at a non-network hospital. For emergency hospitalisation, you can inform your insurer within 48 hours of admission. Earlier, policyholders had to pay for treatment at non-network hospitals and then approach the insurer concerned for reimbursements.

On paper, cashless everywhere is a great initiative as it aims to reduce out-of-pocket expenses of policyholders for medical treatments. However, health insurance policyholders need to keep a couple of things in mind before opting for a cashless everywhere facility at any hospital. Cashless health insurance: What are network and non-network hospitals? Your insurance company usually has a tie-up with several hospitals for providing cashless treatment to policyholders. These hospitals are commonly known as network hospitals. The insurer usually negotiates rates with these empanelled hospitals to ensure more comprehensive coverage.

Cashless everywhere: How network and non-network hospitals will charge you

You need to understand if you go to a non-empanelled hospital, how it will charge you for the treatment. "(In such cases), the charges will be benchmarked against the existing rates prevailing in the given geography for the type of hospital — primary, secondary or tertiary. If the hospital is already on the panel of any other insurance company, the charges will be based on the rates of the empanelled insurers," says Mayank Bathwal, CEO, of Aditya Birla Health Insurance. "However, if the hospital is not empanelled with any other insurance company (and not in the blacklisted category), then the insurer, after validating

the policy details, will coordinate with the non-network hospital and negotiate a tariff based on benchmarked rates."

It is clear that when you go to a non-network hospital, your insurer will negotiate the rates on a caseby-case basis, says Rajagopal Rudraraju, Executive Vice President & National Head of Accident & Health Claims, TATAAIG General Insurance. Cashless hospitalisation: Will you have to pay from pocket at non-network hospitals? Will the overall cost of treatment vary depending on whether it is a network hospital or non-network hospital? Let's understand it with an example. Suppose, your insurance has a cap of Rs 50,000 for surgery at a network hospital. In a network hospital, you will usually get cashless treatment and so would not have to pay anything from your pocket.

If you choose to undergo the same surgery at a non-network hospital where the cost is fixed at Rs 70,000, the settlement of the claim will depend on the terms and conditions of your policy and your insurer. “If you opt for a hospital where the surgery costs exceed your insurance coverage, you will have to settle the excess amount out of your pocket,” says Nitin Deo, CTO, Zuno General Insurance.
Once you initiate your request to go for surgery at a non-network hospital, the insurance company will negotiate the rate with the hospital. If they fail to reach a consensus, you may have to pay the entire amount from your pocket. You will have the option to submit the bills and other documents to your insurer and claim the reimbursement amount later.

So, if you want an “assured cashless facility” and do not want to pay any money from your pocket, a network hospital could be a better option. "Insurers may have a working relationship with network hospitals, ensuring that the cashless facility is more likely to be available. Non-network hospitals may refuse cashless facilities, potentially requiring you to pay upfront and then claim reimbursement later," says Rudraraju.

Reasons for choosing network hospitals over non-network hospitals for cashless treatment
Here are the reasons why choosing an empanelled hospital may be more suitable for the policyholders, especially until the ecosystem is fully prepared for the "cashless everywhere" facility:
1) Tariff is fixed: "Empanelled hospitals have predetermined tariffs agreed upon with the insurance provider. This eliminates uncertainties and ensures that the charges for medical procedures are within a specified limit. This can result in faster discharge for the customer and better customer satisfaction for the insurance company," says Bathwal.

2) Streamlined cashless settlement process: "At network hospitals, the cashless settlement process is usually smoother and quicker since there’s an established relationship between the hospital and the insurance provider," says Suman Pal, Chief Claims Officer, Onsurity.

3) Quality assurance: Empanelled hospitals are vetted by insurance companies for quality standards, reducing the potential risk of unexpected complications or substandard care, says Pal.

4) Lower risk of fraud: "Empanelled hospitals are part of a network with established relationships and agreements. This reduces the likelihood of inflated billing or unnecessary procedures, minimising the risk of fraud. In contrast, non-network hospitals may not be subject to the same level of scrutiny, potentially leading to higher costs and misuse of insurance coverage," says Bathwal.

Cashless health insurance: When to go for network hospital, when to opt for non-network hospitals?
The cashless everywhere initiative gives the freedom to policyholders to choose any hospital based on their preference of treatment facility, physician and location, without having to worry about whether the hospital is empanelled under his or her insurer, says Parthanil Ghosh, President, Retail Business, HDFC ERGO General Insurance Company. How to decide when to go for network hospitals or non-network hospitals? Rakesh Goyal, Director, Probusinsurance.com says, "It's generally advisable to opt for empanelled hospitals for cashless treatment whenever possible to minimise financial strain and streamline the claims process. "It is advisable to consult the chosen hospital beforehand directly for more details on the cost, in case of planned hospitalisation." adds Ghosh. In emergency situations, where

immediate treatment is necessary and an empanelled hospital is not accessible, opting for cashless treatment at a non-network hospital may be the only viable option. "If a non-network hospital offers specialised treatment or facilities not available at empanelled hospitals, it may be worth considering, provided the out-of-pocket expenses are manageable," adds Pal

(The writer is Anulekha Ray.)

TOP

"Cashless everywhere", ease of hospitalisation initiative, runs into hiccups - The Hindu Business Line – 7th March 2024

The "cashless everywhere" initiative to ease hospitalisation woes for patients has run into difficult terrain, a little over a month after it was announced by the General Insurance Council. Doctors have pointed to difficulties in aligning products (lenses etc) and procedure rates with that outlined for reimbursement by health insurance companies, leading to irate patients who face the prospect of having to partly pay for their procedure, despite having health insurance coverage. Hospital representatives told businessline, off record, that they were not under the "jurisdiction" of this diktat, which they said needed more clarity.

The "cashless everywhere" initiative, launched in late January, allowed patients with health insurance coverage to avail treatment at any hospital and not just those institutions mentioned in their policy. In a separate development meanwhile, the Supreme Court has asked the Centre to fix treatment charges at hospitals, across the country. The Centre has been given six weeks for this. Pointing out that it's the State's responsibility to deliver healthcare, Indian Medical Association (IMA) President Dr RV Asokan, cautioned that an insurance-driven model could interfere with the doctor-patient relationship, as care would be dictated by organisations that are commercially oriented.

IMA template

Explaining the challenges involved in standardising the rate for medical procedures across hospitals, IMA- Hospital Board of India's Chairman, Dr AK Ravikumar said, there are multiple variables – from the type of product, length of treatment time etc. The cost of lenses for the eyes, for example, vary from ₹10,000 to a lakh, he said, adding that a patient requiring a high-end lens with more features (and with insurance cover for it), may have to settle for a lower-priced lens, under the proposed initiative.

The IMA has created a template based on specifications outlined by the Centre, the Clinical Establishments Act etc, he said, so rates can be standardised for different hospitals depending on their individual capacities and services. It requires a scientific approach, says Dr Ravikumar, calling for a wider discussion on this. The IMA- HBI advisory to members, points out that cashless payment should be for the actual treatment (as opposed to a standard package rate). Further, it pointed to "a one-time temporary MOU (memorandum of understanding) between insurance company and hospitals", that lacked clarity. "Do not sign MOU with packages, discounts, free bees, etc and do not compromise on quality health care to patients." the IMA-HBI said.

(The writer is PT Jyothi Datta.)

TOP

Fix hospital charges across India within six weeks: SC tells Centre - Financial Express – 4th March 2024

The Supreme Court has directed the central government to fix the treatment charges at the hospital that are paid by the patients within the next six weeks. According to a report by Indian Express, this move could lead to faster adoption of 'cashless' health insurance across the country. Currently, different hospitals charge different rates for treatment, making it difficult to implement the cashless health insurance system in the country. "We, direct the Secretary, Department of Health, Union of India to hold a meeting with his counterparts in the State Governments/Union Territories and come with a concrete proposal by the next date of hearing (in the next six weeks),'' said a two-judge division bench of the

Supreme Court while hearing a public interest litigation (PIL) filed by an NGO, as quoted by Indian Express. Reportedly, the general insurance industry is expecting a positive outcome on the hospital charges. Reportedly, the health portfolio of the industry contributes around Rs 1 lakh crore of premium.

Recently, the industry launched its scheme 'Cashless Everywhere', where a policyholder can receive treatments from any hospital in the country and not just from its own insurer's empanelled hospitals, is facing issues as hospitals across the country are not adopting standardised rates for providing similar treatments.

"In the event the central government does not come out with a concrete proposal by the next date of hearing, we will consider issuing appropriate directions in this regard,'' ruled a bench of Justices B.R. Gavai and Sandeep Mehta last week. The bench was hearing a PIL filed by an NGO — Veterans Forum for Transparency in Public Life, through its general secretary Wing Commander (Retd) Bishwanath Prasad Singh — praying for the SC's direction to determine the rate of fee chargeable by hospitals across the country from the patients in terms of Rule 9 of the Clinical Establishment (Central Government) Rules, 2012.

According to the NGO, the Central Government itself has notified the rates which apply to the CGHS (Central Government Health Scheme) empanelled hospitals and had suggested that till a solution is found, the Central Government can always notify the said rates as an interim measure. The government counsel further submitted that though various communications have been addressed to the State Governments/ Union Territories, there was no response and as such the rates could not be notified, Indian Express reported.

"The Union of India cannot shirk away from its responsibility by merely stating that communication have been addressed to the State Governments/Union Territories and they are not responding," said the bench. Tapan Singhel, Chairman, General Insurance (GI) Council said, "we have always maintained that we need to charge an appropriate cost for customers, whether it's at the time of taking out a policy or bearing certain expenses at the time of a claim. It is very encouraging to see the Apex court urging the Centre to take a decision on standard hospital rates. We feel that this, along with 'Cashless Everywhere' will eventually benefit our citizens, for whom it's a fundamental right to receive good healthcare."

However, the Indian Medical Association (IMA) and the Hospital Board of India have cautioned hospitals against accepting the Cashless Everywhere' initiative, recently unveiled by the by the General Insurance Council in its current format, highlighting the potential risks involved. There are over registered 40,000 hospitals in the country, which can now offer cashless facilities to all the health insurance policyholders, numbering over 30 crore, in the new system, Indian Express reported.

TOP

Insurance has to grow alongside as the healthcare sector grows. Viren Prasad Shetty, Narayana Health – The Economic Times – 4th March 2024

Viren Prasad Shetty, *Executive VC,* **Narayana Health**, *says: "Is the larger goal to make healthcare more affordable, then price cap does not achieve it because what happens right now in a dynamic pricing situation where you have multiple price points for multiple classes of people. You have very poor people below the poverty line who are getting treatment at Ayushman rates. You have government employees who are getting treated at CGHS rates. You have people* who are paying out of pocket, getting treated at general ward, semi-private, private, deluxe, super deluxe, all those rates. You fix one flat rate, what will happen? The poor may end up paying more. If you are a rich fellow, you are paying less. The poor person is subsidising the rich person."

So, what should we start with – the big picture, specifics on regulatory intervention or where Narayana Health is moving?
Viren Prasad Shetty: It is always an exciting time in our business. The Supreme Court's suggestion on capping rates is an impractical suggestion, but the anger is real. The opacity in the pricing structure is real. The impression that a lot of people have that healthcare is expensive is real. Some of these can be addressed, some of these simply cannot be addressed. If you look at healthcare costs going up in this country, that is simply a factor of more and more treatments being available.

The reason why people are finding it unaffordable is that you cannot expect people to pay out of pocket for a lot of things in healthcare. So, there are solutions that the industry is willing to propose, but without getting into draconian things like price fixing for everything.

In the past also, regulatory intervention has happened and that has affected Narayana Hrudayalaya's profitability quite a bit. I remember this happened pre-COVID when there was a cap on cardiac or heart health care. If there is a regulatory intervention, do you think it will be difficult to implement, but this in a sense will also have implications in terms of the price cap?
Viren Prasad Shetty: See, the question is what is the price cap meant to achieve? If you fix on the output side and you do not address anything on the input side, the cost remaining the same, the price to the customer will just flow to another dimension. So, what is the larger goal? Is the larger goal to make healthcare more affordable, then price cap does not achieve it because what happens right now in a dynamic pricing situation where you have multiple price points for multiple classes of people.

You have very poor people below the poverty line who are getting treatment at Ayushman rates. You have government employees who are getting treated at CGHS rates. You have people who are paying out of pocket, getting treated at general ward, semi-private, private, deluxe, super deluxe, all those rates. You fix one flat rate, what will happen? You will end up paying more. If you are a rich fellow, you are paying less. So, then the poor person is subsidising the rich person, that is not practical either.

Let us now change gears and talk about the big picture. For the healthcare sector, the big picture is that growth has been exponential. Expansion has been exponential. Health insurance is now the mainstay. But given that we have seen such a massive expansion and especially in tier II cities, cities outside metro, could we be suddenly staring at a situation of more supply and less demand?
Viren Prasad Shetty: No, more supply, less demand will not exist because the demand for health care is effectively infinite. As many as doctors and nurses and hospitals that are there in this country, it is still a very small fraction. And a lot of times, you get into trouble when you consider all beds as the same. You said 15 beds per 10,000, but not all beds are the same. If you look at organised, accredited hospitals that comply with standard accepted norms and say that you have NABH classification, those do not even account for 10% of the total beds in any city. Most of them are unorganised and in the nursing homes. So, it is not all the same.

So, oversupply, if you look at the large numbers, may seem adequate supply, but that is not really the case. We still have a long way to go. There still needs to be an incredible number, not just beds, but medical equipment and doctors and nurses in places where you can get treated even in the largest cities, forget about tier II and tier III towns. There is a long runway of growth and demand, but for affordability, you can no longer expect people to pay out of pocket. Just like no one is paying for an apartment out of pocket, no one is paying for their cars out of pocket, they are taking loans and EMIs. For healthcare, you need insurance and insurance also has to grow as the healthcare sector grows.

But herein some would say the sector is getting brutally comparative and with the advent of PE players now and with most of the hospital stocks having gone public or having ambitions to go public, suddenly there is a strong focus on profitability, cutting the corners, kicking in terms of efficiency. Could that come at the cost of compromise in terms of healthcare?
Viren Prasad Shetty: Those are two different things. Brutal competition enforces price correction, right? The thing about a drive for profitability invariably happens when there is a constraint on a number of competitions you have allowed. So, any regulation that makes it harder for people to make money in an industry will strengthen the hand of the incumbents.

People are already there, anyway, they have the buildings, so they will continue doing as they do and they would be very happy to see that no new people are entering the sector. You want the price to go down, you want it to be more consumer friendly, you allow as many people that want to open up hospitals to come in. Profit is a natural function of how much is available for you. At the exact point at which you make it too high, then it is more attractive for more people to come in. If it becomes too less, then no one else comes in; that is how a modern market economy is supposed to function.

So, when you say that, oh, hospitals are charging a lot; oh, the profit is very high, remember hospitals are charging a lot because it costs a lot to deliver. The profit is high, but that only exists in the balance sheet. The return on capital in our industry is very low. The payback period for every single hospital bed that you put in, the cost of land, cost of equipment, cost of all the doctors is extremely high. So, you are taking money, but you are making less money than what you did if you just left it in the bank. So, these things also need to be put into consideration.

This is the following sense which we get from when we speak to folks who are involved with policymaking that look at the EBITDA margins of hospitals. From Apollo Hospital to Fortis to Max Healthcare to NH, margins have exploded and they are making more money and that needs to be checked. Is that true?

Viren Prasad Shetty: How much money is a sector allowed to make? Any percent, EBITDA margin of 40%, we do not even know what is clear and it is not that the money is going anywhere. All the money that the healthcare sector makes goes into building more hospitals, goes into acquiring more doctors, into adding more medical equipment. You want a healthy, sustainable, vibrant business that attracts much more inbound investment from all the top private equity investors across the world, you want a healthy IPO market, so all doctors will say, yes, I do not just want to work for someone, I want to go and build my own institution and provide competition for the existing players. All that money gets reinvested. It goes right back into the country. It gets paid out in taxes. It goes out in salary to the doctors and nurses.

So, it is not just about the money, it just does not disappear into a black hole in this industry. It gets reinvested completely into building more beds and addressing the needs of our country. You want a strong and healthy balance sheet for all the healthcare players. And the minute too much money comes in, that is when everyone says, okay, now let us go and build and add extra because I believe I can do it for less. So, as with Yatharth and with NH and see the thing is that not every healthcare group is entirely concerned with absolute value extraction. Very few of them are. Most of them are looking for growth, they are looking for volumes, they are looking for treating more patients, for looking at the mass market opportunity that exists in this country. The perception will always be there with a few people who end up with very complex surgery and end up paying a lot of money and they feel that this is not something that they were well prepared for. It can be addressed. Hospitals can do a lot more towards giving estimates upfront and to counsel the patient and say that, see, this is something, it is very complex, this procedure you are about to get, this is how much it is going to cost. So, with enough education, people then feel that, fine, it is my choice that I want to get treated and pay this amount of money for that or not. If not, there are other hospital groups you can go to.

TOP

Addressing healthcare affordability challenges in health insurance in India - The Economic Times – 3rd March 2024

As India strides towards progress, the healthcare sector is facing an unprecedented challenge - escalating costs. The intersection of advanced medical technologies, skyrocketing pharmaceutical expenses, and an aging population has posed a challenge that strains the healthcare system and negatively impacts health insurance premiums.

Factors Contributing to Escalating Healthcare Costs

The relentless growth in medical technology and innovation has undoubtedly improved patient outcomes, but it comes at a cost. Cutting-edge treatments and diagnostic tools often have a hefty price tag, contributing significantly to the growing expenses in the healthcare sector. Additionally, the

pharmaceutical industry, driven by research and development, is witnessing rising costs of drug production. As a result, India has recorded one of the highest medical inflation rates in Asia, reaching up to 14%.

Furthermore, India is experiencing a demographic shift towards an aging population. While this demographic transition is a testament to improved life expectancy and healthcare, it also burdens the healthcare infrastructure, increasing the demand for medical services. According to the 2023 India Ageing Report by the United Nations Population Fund, India (UNFPA), it is projected that by 2046, the number of elderly individuals in the country is expected to exceed the population of children (aged 0 to 15 years).

Impact on Health Insurance Premiums

The spiraling costs of healthcare have a direct impact on health insurance premiums. The health insurance premiums rose by 10-25% over the last year. Insurance providers, grappling with the economic realities of a costly healthcare landscape, pass on these expenses to policyholders in the form of higher premiums. This has a cascading effect, making health insurance less affordable for individuals and families, particularly those with limited financial resources.

Shortcomings of Existing Health Insurance Policies

Existing health insurance policies, while providing a safety net, often fall short of addressing affordability concerns. Limited coverage, high deductibles, and exclusions for pre-existing conditions can leave policyholders vulnerable to out-of-pocket expenses, defeating the very purpose of health insurance. The need for comprehensive coverage that encompasses preventive care and wellness programs is more pressing than ever.

The Importance of Comprehensive Coverage and Preventive Care

Comprehensive coverage that includes preventive care and wellness programs is crucial in reducing long-term healthcare expenses. By focusing on preventive measures, such as vaccinations, screenings, and lifestyle interventions, the healthcare system can potentially mitigate the need for costly treatments down the road. Insurance policies that incentivize and prioritize preventive care contribute not only to healthier individuals but also to a sustainable and cost-effective healthcare ecosystem.

Governmental Efforts to Address Affordability

Recognizing the urgency of the situation, the Indian government has implemented various policies, regulations, and programs to enhance the accessibility and affordability of health insurance. Initiatives like Ayushman Bharat, a national health protection scheme, aim to provide financial protection to over 50 crore citizens, mitigating the financial burden of healthcare expenses.

Health Protection Package: A Ray of Hope

In the era of rapid technological advancement, digital health protection packages present a promising avenue to make healthcare more cost-effective and accessible. Telemedicine, health informatics, and similar add-ons in the form of health protection and insurance packages can bridge the gap between healthcare providers and patients, reducing the need for physical infrastructure and streamlining healthcare delivery, while also reducing out-of-pocket expenses. Furthermore, bundled packages will play an instrumental role in saving costs that a patient would otherwise spend on diagnostics and medicines.

Conclusion

Addressing the healthcare affordability challenge in health insurance requires a multifaceted approach. From comprehensive coverage and preventive care to government initiatives and health protection packages, the collective efforts of stakeholders can pave the way for a more accessible and affordable healthcare system in India.

(The writer is Piyush Jain.)

TOP

Ways InsurTech is Revolutionizing Health Insurance in India - Financial Express - 2nd March 2024

In the health insurance sector, technological advancements and regulatory shifts are driving an evolution. Insurers are embracing cutting-edge technologies, positioning themselves for a future that prioritizes efficiency and sustainability. The overarching aim of these transformative changes is to democratize health insurance, improve service standards for beneficiaries, enhance well-being of the consumers and ultimately reduce overall costs. From automated claims processing to personalized products, InsurTech solutions are driving a systemic overhaul.

Automation in claim processing:
Using tech like Optical Character Recognition (OCR), Artificial Intelligence (AI) / Machine Learning (ML), GenAI (General Artificial Intelligence) Robotic Process Automation (RPA), insurers are witnessing faster claim settlements. IRDAI regulations suggest that health insurance claims should be settled within 30-45 days, and without error; leaving insurers and third-party administrators to turn towards automation for streamlining claim processes in a faster and effective way.

Enhancing Risk Assessment &Profiling:
AI and ML algorithms are leveraged to assess the risk profile of potential consumers, by analysing multiple data points, such as age,occupation, medical history, and lifestyle choices. These algorithms can calculate the likelihood of an individual, making a claim or engaging in risky behaviour.

Providing more affordable insurance products:
The highly competitive Indian health insurance market is tapping into telemedicine and home healthcare to prevent expensive hospital stays and emergency visits. Using micro-data analytics, insurers are crafting tailor- made healthcare coverage, aligning with individuals & financial capabilities and needs, especially for those residing in Tier 2, 3 cities, and beyond. This will be transformational in the healthcare industry in the years to come.

Fraud, Waste & Abuse Intelligence (FWA):
Healthcare insurance frauds lead to people paying more for their coverage, facing increased out-of-pocket expenses, and receiving fewer benefits. AI-powered investigations can be game-changer in this category, by tapping into various data sources like financial records and digital communications. Its advanced algorithms uncover hidden connections and trends, drastically cutting down the time needed for investigations.

The insurance industry is undergoing a seismic transformation driven by technology, and This momentum is set to surge even further in the next two years. With continuous innovations and swift technological progress in health insurance, the Insurtech landscape is poised for significant disruptions.

(The writer is Layak Singh.)

TOP

Domiciliary hospitalisation benefit: Get cover for treatment at home - Financial Express – 2nd March 2024

Individuals should look for a health insurance cover which offers domiciliary hospitalisation benefit or take it as a rider to ensure comprehensive coverage. It provides coverage for medical treatment at home, ensuring comfort for the insured unable to be hospitalised. This type of coverage is useful in situations where the insured is not able to get hospitalised due to non-availability of hospital beds or specific medical equipment. Domiciliary hospitalisation covers the treatment costs incurred at home when continuous hospitalisation is not possible. It offers convenience for patients needing medical attention without intensive care.

Reduces financial burden
Such a coverage reduces the financial burden by covering expenses like doctor's visits and nursing care at home. Including domiciliary hospitalisation in a health insurance policy ensures comprehensive coverage

for both hospital and home-based treatment, enhancing overall healthcare experience and financial security. This benefit ensures that the policyholder's treatment expenses are covered under their health insurance policy. However, home care treatment is not covered by default in every health insurance policy. So, if the insured's existing policy does not cover domiciliary hospitalisation, then he can port it to a new policy that has this feature.

Rakesh Goyal, director, Probus Insurance Broker, says domiciliary hospitalisation coverage can typically be added to an existing floater health insurance policy as a rider or as an optional add-on benefit. "This allows individuals to customise their health insurance coverage according to their specific needs and preferences." Domiciliary hospitalisation coverage is a part of the base plan these days in all the new and upcoming health policies. Siddharth Singhal, business head, Health Insurance, Policybazaar.com, says it can be included in some of the existing floater health insurance policies, thus eliminating the need for a separate policy. "It is advisable to select a comprehensive health insurance plan that covers all your medical insurance needs without you having to worry about financing sudden medical expenses."

Pricing of the policy

Since the domiciliary hospitalisation benefit is part of the comprehensive plan, the customer does not need to pay anything extra. It covers doctor consultation fees, nursing charges, the cost of medical equipment and medication costs. Key exclusions may include pre-existing conditions, non-allopathic treatments, self-inflicted injuries, and certain elective procedures.

To avail domiciliary treatments, the insured will have to be on a home based treatment for atleast three days. Individuals must check the waiting period associated with domiciliary treatment before buying such a cover. The insured cannot file any claims for domiciliary hospitalisation during the waiting period, which varies between insurance companies. "The policyholder must have the recommendation for domiciliary treatment by the treating doctor either in case the patient is immobile or the hospital lacks the bed/infrastructure, thus making home hospitalisation as the only option," says Singhal.

(The writer is Saikat Neogi.)

TOP

SC order | Standardisation of treatment rates will reduce undue charges, premium hikes: Bajaj Allianz CEO – Moneycontrol – 1st March 2024

The Indian general insurance industry is upbeat after a recent Supreme Court order directed the central government to hold consultations with state governments and arrive at a consensus on determining treatment rates at hospitals across the country. Tapan Singhel, MD and CEO, Bajaj Allianz General Insurance, who is also chairman of the General Insurance Council, industry association, said standardisation would bring in much-needed transparency in the healthcare sector, which currently does not have a regulator. It could lead to lower healthcare inflation and insurance premiums, he said, adding, "Transparency in rates will reduce frauds and any kind of extrapolation of undue costs."

The Supreme Court had, on February 27, pulled up the Centre for shying away from its responsibility of implementing the provisions of the Clinical Establishments (Registration and Regulation) Act, 2010 by putting the onus on the state. "The Union of India cannot shirk ... its responsibility by merely stating that communication(s) have been addressed to the State Governments/Union Territories and they are not responding," the apex court said. It pointed out that the Act was enacted to provide medical facilities to citizens at affordable prices. The counsel for the government had argued that the rates could not be determined as state governments had not responded to its communication on this matter.

The apex court made the observations while pronouncing its order on the writ petition filed by the Veterans Forum for Transparency in Public Life against the government of India. The plea called for directions to the central government to determine the rate of treatment charged to patients under the Clinical Establishments Act and the rules framed in 2012.

The petitioners were of the view that until rates are determined, the central government should notify the charges applicable to Central Government Health Scheme-empanelled (CGHS) hospitals. With regard to this, the Supreme Court stated that it would consider "issuing appropriate directions" to the centre if it fails to come up with a concrete proposal by the next hearing, in six weeks.

Standardisation, regulations must for healthcare industry

Not surprisingly, the general insurance industry is in favour of the implementation of the apex court's order. "It is important to ensure that citizens of the country have a fair and transparent mechanism of accessing medical treatment for which they should be able to pay a fair price," said Singhel. "If you look at this holistically, everyone—be it the Supreme Court, finance ministry or General Insurance Council—is saying that transparency is needed. This will serve the nation well."

Singhel also threw his weight behind the idea that the healthcare industry needs a regulator. "We have always been saying that there should be a regulator for hospitals. In addition, there was a note from the finance secretary to the health secretary mentioning the need for a health regulator. When there is such a big industry (healthcare) that affects the life of every citizen in the country, there has to be some regulatory structure in place (to govern hospitals)," he added.

Contentious 'customary and reasonable charges' clause

If the central and state governments can ensure standardisation of treatment rates across hospitals, disputes between insurers and policyholders will come down, said Singhel. Insurers often make part-payment of claims citing unreasonable charges levied by hospitals. "The moment you bring in transparency in charges, the (customary and reasonable causes) clause becomes redundant. This issue comes in because of variation in charges (across hospitals and geographies). If you implement what the Supreme Court is saying, then this clause has no relevance."

Hospitals resist 'Cashless Everywhere'

In January, general and health insurance companies came together to roll out a 'cashless everywhere' facility that allows policyholders to seek cashless treatment even if the hospital of their choice is not part of their insurer's network. However, some hospital associations' response to the move has been lukewarm, Singhel said. "Most hospitals welcomed this facility, but we did see resistance from some hospital associations."

The hospitals have not been forthcoming about their concerns around the implementation of this arrangement, said Singhel. "We were surprised as it is a simple, customer-centric initiative that should be welcomed by hospitals. I am not certain what their concerns are, but we will be happy to answer their queries. As hospitals, they will get more volumes and access to more customers. Overall, 'cashless everywhere' will bring in more transparency," he said. He pointed out that if more hospitals come on board, patient-policyholders will not have to pay for treatment. The facility would bring close to 40,000 hospitals into its ambit, making people's lives easier, he added.

No discrimination between corporate, retail policyholders

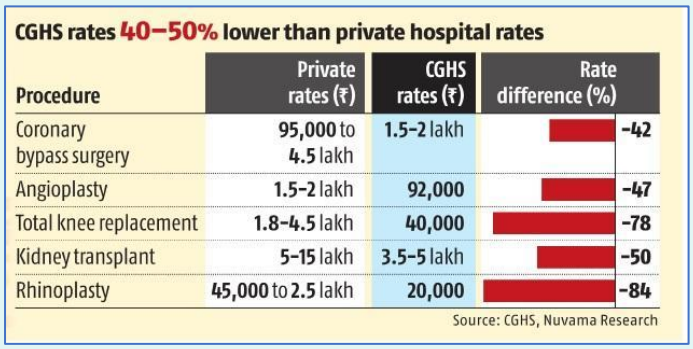
Singhel refuted the charge that corporate group health insurance claims get settled without hassles, while retail claims face greater scrutiny as individuals have no voice. "It is not so. I do not agree. I do not think this is an issue of discrimination—the issue is around policy wording. I do not see this as a group versus retail issue. For instance, in our case, over 90 percent of individual claims are getting settled straightaway. The issues around partial claim settlement come up when policies purchased have sub-limits or co-pay."

(The writer is Preeti Kulkarni.)

TOP

Private hospitals write to health ministry over rate standardisation - Business Standard – 1st March 2024

The Association of Healthcare Providers (AHPI), which represents medium and private small hospitals, has written to the Union Health Ministry and also decided to approach the Supreme Court, days after the apex court ordered the Centre to fix standardised rates for various medical procedures. Giridhar Gyani, Director General, Association of Healthcare Providers (India), said that a team of representatives has already met Health Secretary Apurva Chandra on Thursday to discuss the issue. A letter was also submitted to the Union Health Secretary, arguing that there was no scientific study on the cost of procedures. AHPI recommended chalking out the costing for various procedures based on the established scientific principles and fixing rates in the 'range' to address the categorisation of establishments. He added that their legal team is working on filing an intervention in the SC in a few days so that their views are heard by the apex court. Viren Shetty, the executive vice-chairman, of Narayana Health, said that while the directions of the apex court are 'noble in intention and spirit', they believe that enforcing national standardised pricing for all categories of patients will not improve healthcare provisions in the country.



"The private healthcare industry faces a complex challenge of balancing affordability, quality, and accessibility against growth and financial sustainability. Our national goal should be to ensure that all patients can access the care they need, at a quality that meets their requirements, and at a price that they can afford. A single price for procedures penalizes high quality, reduces patient choice, and forces our best and brightest doctors to leave the country," Shetty explained. He said that the solution to providing universal healthcare lies in investing in public healthcare infrastructure and promoting health insurance for those who prefer to get treated at private hospitals. "It is impossible to expect the average Indian to have access to Rs 2 lakh in hand in case they need emergency surgery, but they can all afford a few thousand rupees in insurance premiums. This would enhance price transparency, accommodate patients from multiple financial backgrounds, align pricing with quality metrics, and give patients their choice of healthcare provider," he added. "As a modern economy, India provides the space for multiple healthcare models to co-exist. We cannot turn the clock backward towards a command and control economy with rationed services."

The AHPI said that in 2014, there was an initiative by the health ministry through the Institute of Cost Accountants of India of which AHPI was a part. But it could not be completed as it is complex due to variables like level of specialisation (primary, secondary, tertiary, and quaternary) and geographical location. AHPI and the Karnataka government conducted a basic study later. The industry reckons that if one carries out a study on costs in government hospitals (which are highly subsidised) taking fixed and variable costs, these will not differ from the rates charged in private hospitals. The apex court on Wednesday rapped the central government for not specifying the range of rates for treatment services by private hospitals and clinical establishments. It has warned that it will consider issuing 'appropriate directions' in the matter of implementing CGHS rates as an interim measure across private hospitals if the Centre does not come up with a 'concrete proposal' by the next hearing. "What makes it even more difficult to standardised all treatment procedures are – the complexity of the case involved, co-morbidities, level of technology/equipment used, services offered, and doctor's experience. If a middle ground has to be reached, a price range on non-complex procedures looks more probable," Nuvama added. Price issues.

(The writer is Sohini Das.)

TOP

SURVEY AND REPORTS

For the first time, working women have surpassed men in life insurance ownership, says survey - Bhaskar Live – 7th March 2024

For the first time, working women have surpassed men in life insurance ownership, with 79 per cent now owning life insurance plans, as per a survey. While men's life insurance ownership stands at 76 per cent, the upward trajectory of women's ownership at 79 per cent signifies a shift in gender dynamics concerning financial preparedness and responsibility, says a survey by Max Life. Despite a positive trend in life insurance ownership, a significant gender gap in financial preparedness persists.

Urban India's men take the lead in financial protection at 46 points, surpassing the overall average for urban India of 45 points. The financial protection gap between men and women in urban India is primarily driven by a huge disparity in life insurance awareness levels, the survey found. The survey found that urban India's women demonstrate a strong commitment to safeguarding their families from life's uncertainties, gradually closing the gap with men, whose life insurance ownership is at 76 per cent, vs 73 per cent for women.

Prashant Tripathy, CEO and Managing Director, Max Life said, "As we celebrate International Women's Day, it is important to reflect on the financial readiness of women. The insights from the latest IPQ 6.0 survey underscore the remarkable strides women have taken in proactively securing their financial well-being through life insurance investments. However, the survey also sheds light on the enduring gender disparity in financial awareness. This requires intensive actions to empower women to assert control over their financial state".

TOP

International Women's Day: Only 26% women are decision-makers when it comes to buying health insurance, finds Future Generali study – Moneycontrol – 7th March 2024

Over 74 percent of Indian women prefer not to get involved in making decisions around buying health insurance. Only 21 percent, or one in five, purchased their health insurance policies independently, as per a study conducted by private general insurance company Future Generali India.

The survey polled 600 women aged over 21 years, with 80 percent of them falling in the age bracket of 21-35 years. Of those polled, two out of three were working women; more than 50 percent of the respondents were married with kids, while 27 percent were single.

Close to 43 percent of the respondents were covered under health insurance through their own or their husbands' employers. Over one-third (36 percent) were covered under family floater policies owned by their fathers or husbands. Only 21 percent said they purchased their health insurance policies on their own.

Awareness of policy conditions low

Compared to motor insurance, where over 50 percent women said they understood their policy benefits and clauses, only 32 percent were aware of their health insurance coverage details.

Despite the fact that only 26 percent of the respondents played a role in taking a decision on buying health insurance, over 53 percent of them paid the premiums. In contrast, more than half of those polled (56 percent) had a say in picking motor insurance policies. "Our findings show that 40 percent of the women respondents had done some level of research compared to 32 percent for motor. But while close to 60 percent women decide which motor policy to buy, only about quarter of them said they take the call

as far as health insurance is concerned, which obviously not a very encouraging number," said Anup Rau, Managing Director and CEO, Future Generali India.

Willing to pay higher premiums for women-specific needs

According to Future Generali, which rolled out its women-specific health policy Health PowHer, two out of three women felt that health insurance policies available today were "were too generic." The company said its new product addresses specific needs of women, including higher limits for female cancer treatment, coverage for puberty and menopause-related disorders, lump-sum benefit for new-born defect and also coverage for bone strengthening injections or joint injections that women in older age-groups might require, and so on.

Nearly 9 in 10 (86 percent) of those polled said they were willing to buy a health insurance plan that comes with value-added services that help prevent women-specific diseases and remain fit. "Now, 78 percent of the women said they were willing to pay higher premiums for such plans. Clearly, there's a market for a comprehensive health insurance product which has far greater degree and extent of coverage," said Rau.

Though fear should not be the driving factor for buying health insurance, this is the case currently. "When it comes to insurance, what you are selling is security and that promise of security in the future. Unfortunately, fear continues to be a key enabler of purchase, which is not something that we want. We want women to take the decision with the view that insurance is security for the future, not because we are fearful about the future," he added.

TOP

Demand for entry to junior-level frontline manpower in BFSI increases by 20–25% in 2024 - The Economic Times – 6th March 2024

Demand for entry to junior-level frontline manpower in banking, financial services and insurance (BFSI) sector has increased 20-25% in 2024 compared to a year ago amid a surge in housing loans, personal loans and credit cards, even as the financial services industry continues to combat high attrition. Industry executives said the surge in demand, particularly in sectors such as insurance, housing, NBFCs and retail banking, isn't limited to tier-1 cities as tier-2 and -3 cities are also experiencing a notable uptick.

"The demand for entry-level sales positions is surging within the BFSIsector," said Aditya Narayan Mishra, CEO, Ciel HR Services. "We can attribute multiple factors to the rise in demand: increased confidence among the households about the future prospects of our economy, a longish period of muted growth in the sale of consumer products and homes; and finally an aggressive push from the sellers of these product categories."

Kartik Narayan, CEO-staffing at Teamlease Services, said several open positions have come up for Q1. "The demand is fuelled by attrition, refill and growth." There is a lot of talent demand coming in from the microfinance sector, he said. "Attrition still poses to be a major challenge for companies," he added.

The average annual attrition in frontlineroles in the BFSI industry is 30-40%, according to industry estimates. In certain sectors, such as insurance, attrition is as high as 60-70%, while retail banking is facing talent exits in the range of 35-40%. In broking, annual attrition is about 25%, as companies continue to lose out manpower to peers in the sector or to other industries, said industry insiders.

Executives said there is one section of companies that is contributing to higher attrition, while in some it is showing signs of stabilising or lowering. "There is demand coming in bulk in the BFSI sector in the first few months of the year. Companies are looking to hire in sales, customer support, back-end technical staff and others," said AlokKumar, president-manpower, ManpowerGroup India. "In the frontline, there is a year-on-year demand growth of 20-25%."

The consistent hiring demand in the sector has led to an average 10-12% increase in pay, according to data from Ciel. About 83% of the open jobs are below Rs10 lakh CTC, according to Ciel data based on an analysis of over 110,000 open BFSIjob postings on leading job portals. The number of job openings in the

salary bracket up to Rs 6 lakh has doubled compared to the same time last year, while hiring in other salary ranges has remained consistent, showed the data.

Majority of available positions in business development (BD) and pre-sales fall within the salary range below Rs 10 lakh, with only a small fraction, around 13%, offering salaries above this threshold, Relationship managers are the most sought after by mutual funds and wealth management companies with salaries ranging from Rs 10-15 lakh. "Demand for frontline roles in BFSIcontinues," said Niren Srivastava, group CHRO, Motilal Oswal Financial Services. However, he added that attrition is gradually tapering off in many companies.

Sekhar Garisa, CEO of foundit (formerly Monster APAC & ME), said as the industry advances into 2024, it grapples with a dynamic landscape shaped by continuous technological innovations, strategic partnerships and an escalating emphasis on sustainability and security. "The anticipated trajectory for the BFSIsector in the coming year points towards a further shift into a digitised, interconnected and secure financial ecosystem. Forecasts suggest a growth rate of 11%, underscoring the sector's ability to adapt and thrive amid these transformative changes," he said.

(The writer is Rica Bhattacharyya.)

TOP

INSURANCE CASES

Firm penalized for failure to adequately pay hospital bills - The Times of India – 7th March 2024

Thiruvallur district consumer disputes redressal forum has directed United India Insurance to compensate for its failure to adequately reimburse hospital bills of a govt employee after a road accident in July 2022. D Palani, a junior assistant in the Thiruvallur court, was injured in a motorcycle accident at Pullarambakkam. Initial stabilization was provided at a local govt hospital, followed by treatment at two private hospitals in Porur. Despite being covered under an insurance scheme that facilitates cashless treatment, the victim was charged ₹1.2 lakh by the hospitals. After the insurance company reimbursed only ₹35,800 of the total expenses, the victim sought intervention from the chief judicial magistrate of Thiruvallur through two notices.

With no adequate response, he turned to the district consumer disputes redressal forum, highlighting the lack of assistance from the govt's nodal officer for insurance grievances. The forum found that it was not the fault of the grievance officer but a clear deficiency in service by United India Insurance, noting the unjust denial of full reimbursement for the surgery and treatment. There was no reply from United India Insurance to the forum too. Consequently, the insurance firm has been ordered to pay the outstanding ₹87,400 for the hospital expenses within a six-week timeframe. Additionally, a compensation of ₹25,000 has been awarded for the mental anguish and legal expenses borne by the victim.

Travel insurance for Indian parents visiting the USA is crucial yet often overlooked. It covers medical emergencies, trip interruption, travel delays, lost luggage, and emergency medical evacuation. OnshoreKare offers plans with pre-existing conditions coverage. It also helps meet visa requirements and offers robust customer support and emergency assistance services. The Council for Insurance Ombudsmen lacks data on insurance companies' compliance with consumer complaint awards. Ombudsman awards are binding, but they lack the power to seize insurer property for non-compliance. Activist Jeetendra Ghadge suggests publishing a list of non-compliant insurance companies. No disciplinary action has been taken by Irdai. To promote equal coverage for AYUSH therapies, IRDAI has instructed health insurance companies to update their policies. AYUSH, consisting of Ayurveda, Yoga, Unani, Siddha, and Homeopathy, is supported by the government. Insurers must comply with guidelines to ensure equal treatment and quality standards.

(The writer is Ram Sundaram.)

TOP

Insurance firm, bank fined for denying claim - The Times of India – 5th March 2024

Ernakulam district consumer disputes redressal commission ordered an insurance company and the intermediary bank to pay compensation for denying claim to a health insurance policyholder. The order is based on a complaint filed by P R Milton, a lawyer, and his wife Eva Milton who are natives of Ernakulam. The consumer commission ordered Rs 2,23,497 to be paid by Cholamandalam Insurance Company and intermediary Union Bank to the complainants. According to the complainant, he was admitted to a private hospital due to chest pain. The company promised cashless facility but the complainant had to pay the entire bill amount himself.

Non-life insurance companies can provide standardised rates for medical procedures to help the government. The SC asked the central government to consult with states and implement a law mandating notification of standard rates for medical procedures. The Insurance Regulatory and Development Authority of India (IRDAI) has proposed draft guidelines to enhance operational efficiency, reduce compliance burdens, and protect policyholders' interests. The guidelines include an extended free look period, collection of bank details, mandatory nomination, and simplified approval for opening new branches.

Chickenpox claims 3 lives in Ernakulam, including an 11-year-old boy with probable dengue. Ernakulam recorded 223 cases in January and 195 cases in February. Health authorities warn of a rise in cases in the summer season, affecting students during the exam season. Precaution, immediate treatment, and isolation are advised. Vaccination is costly and not in the national immunisation schedule.

TOP

Illegal construction can lead to claim denial - Business Standard – 3rd Mar 2024

Nissan Enterprises, a company engaged in the trading of electronic items including cellphones, their accessories, cameras, and other audio-video consumer electronics, had purchased a policy from National Insurance to cover its stock stored in a warehouse in Bhiwandi. The policy was for a sum of Rs 5 crore and was valid from April 18, 2013, to April 17, 2014. During the tenure of the policy, there were heavy rains and waterlogging due to which the building collapsed. Several people were injured, and some also died.

Nissan Enterprises filed a claim citing subsidence as the cause of the build-ing's collapse. National Insurance appointed a surveyor to examine the site. However, since the claim was kept pending for long, Nissan Enterprises filed a complaint before the National Consumer Disputes Redressal Commission. The insurer subsequently repudiated the claim. The insurer contested the case. It stated that it had asked the insured to appoint a specialised agency to carry out a test to ascertain the reason for the collapse of the building. The agency reported that there was no visible sign of subsidence. During inquiries, it came to light that Arihant Developers, the construction firm responsible for the building, had initially erected it as a single-storey structure in 2004. Later, in 2011, the same developer constructed the first floor, on which the insured purchased three galas.

Thereafter, Arihant Developers started constructing the second floor, putting additional pressure on the existing structure. The building's plans were found to be flawed. Even though the pillars were weak, the builder had constructed another unplanned floor. This made the building legal only up to the first floor. The second floor was found to be illegal. The additional unauthorised construction had resulted in the collapse of the building. The report observed that the RCC members ought to have been strengthened prior to undertaking additional construction.

The National Commission noted the report's conclusion that the collapse was due to faulty structural design, poor construction, violation of ISI standards, as well as heavy corrosion. It further noted that while the policy covered loss due to subsiden-ce and landslide, it excluded settlement due to defective design or workmanship, or the use of defective materials. The National Commission observed that although the loss was of the stock kept in the building, the insured should have ascertained the structural strength before allowing the builder to raise an additional floor. Since the insured did not oppose the illegal addition to the structure, the National Commission held that the claim for loss of stock had been rightly repudiated by invoking the exclusion clause related to collapse due to subsidence. Accordingly, by its order of February 16, 2024, delivered by Justice A P Sahi, the National Commission upheld the repudiation and dismissed the complaint, holding that there was no deficiency in service.

weakened the pillars further. The structural report given by the expert after conducting an ultrasonic pulse velocity test revealed that while the building's construction was of a good standard, it did not meet the specifications prescribed by the Bureau of Indian Standards. The report concluded that the prolonged exposure to water, due to the failure of drains to function efficiently, likely caused the soil beneath the foundation to soften. It led to loss of strength and finally

(The writer is Jehangir B Gai.)

TOP

PENSION

PFRDA Chairperson launches mobile app for financial inclusion, boost NPS - Business Standard – 7th March 2024

PFRDA Chairperson Deepak Mohanty on Thursday launched a web application developed by Zerodha Broking Limited to provide easy access to NPS for subscribers. The app offers seamless access to NPS to a wider subscriber base, the Pension Fund Regulatory and Development Authority (PFRDA) said in a statement. Mohanty said that there is merit in joining NPS at a young age to harness the benefit of compounding.

NPS provides continuity to retirement saving accounts irrespective of one's employment status and is available for non-resident Indians (NRIs), it said. As youngsters are tech savvy, the facilitation by Zerodha Broking Limited would expand access to NPS, it added.

TOP

National pension system added 21.5 percent fewer corporate subscribers in 2023 - Business Standard – 3rd Mar 2024

The National Pension System (NPS) added 21.5 percent fewer fresh subscribers under the corporate segment in 2023 compared to the preceding year. Government officials and experts attribute it to the higher exemption limit of income tax of Rs 7 lakh announced in the FY24 Budget that no more requires employees under this income bracket to opt for NPS for tax-saving purposes. Data collated from the Ministry of Statistics and Programme Implementation (MoSPI) reveals that the corporate component is voluntary in nature and saw 158,212 new subscribers in 2023 compared to 201,517 during 2022. This segment mainly comprises employees in the public sector, public sector banks and private limited companies, among others.

"People enrolled under the corporate component of the NPS to take tax benefits see it as a tax-saving instrument rather than a long-term pension or savings product. So, when the finance ministry raised the exemption limit in the last Union Budget, people belonging to these income slabs saw no incentive to enrol under the NPS. That is what explains this sharp decline in enrolment," an official told Business Standard.

During Budget 2023, Finance Minister Nirmala Sitharaman had announced changes in income tax slabs and rebate limits.

Under the new income tax regime, the exemption limit was raised to Rs 7 lakh from Rs 5 lakh, indicating that a person who earns less than Rs 7 lakh annually need not invest to claim exemptions. And, the entire income would be tax free irrespective of the quantum of investment made by such an individual.

(The writer is Shiva Rajora.)

TOP

GLOBAL NEWS

Malaysia: Insurance market sees growth despite evolving challenges – Asia Insurance Review

Malaysia's non-life insurance market is poised for growth in 2024, driven by expanding industries such as technology, manufacturing and renewable energy, according to a report by Howden Markets Asia that provides consulting services in the insurance sector. Howden Markets Asia says in its report, titled "Singapore and Malaysia Insurance Market Appetite 2024", that clients in these sectors are increasingly aware of the critical need for insurance products — including property, casualty and specialty insurance to safeguard against operational risks and enhance business resilience. These findings are from a survey of over 20 insurers in Malaysia.

The demand from customers presents insurers with the opportunity to deepen market penetration and innovate in product offerings, leveraging digital technologies for personalised and efficient service delivery. For insurance companies, the Malaysian market's potential is underscored by the country's economic diversification and the government's supportive policies towards digitalisation and sustainable development. These factors encourage the development of new insurance products tailored to the specific needs of burgeoning industries.

However, challenges exist. The corporate employee benefits market is experiencing rising premiums due to escalating healthcare costs and increased demand for comprehensive coverage. Insurers are responding by innovating package solutions, emphasising wellness and preventive care to manage long-term costs. Macroeconomic challenges such as currency volatility, geopolitical uncertainties and potential global economic slowdowns could impact insurers' growth. Regulatory changes and the increasing prevalence of cyber threats also pose operational and compliance risks. While Malaysia's insurance sector faces potential growth opportunities in 2024, especially in high-growth industries, insurers must navigate macroeconomic and regulatory challenges with strategic agility and innovation to capitalise on these prospects effectively.

Market appetite

Insurers prioritise Employee Benefits, Property, and Workers' Compensation, diverging from Marine Cargo, which led among surveyed insurers in 2023. Claims Inflation, Talent/ Expertise and Development of AI events ranked as the top three events with the most likelihood of occurrence that will affect their business.

Survey metrics	Malaysia
Non-Life Insurers	14
Employee Benefits Insurers	10
Non-Life Market Share	70%
Source: Howden Markets Asia	

TOP

New Zealand: General insurance industry to reach $7.9bn by 2028, forecasts GlobalData - Asia Insurance Review

The New Zealand general insurance industry is set to grow at a compound annual growth rate (CAGR) of 7.3% from NZ$9.7bn ($5.9bn) in 2024 to NZ$12.9bn ($7.9bn) in 2028, in terms of gross written premiums (GWP), according to data and analytics company, GlobalData. GlobalData's Insurance Database revealed that the general insurance industry in New Zealand is expected to grow by 8.3% in 2024, supported by property and motor insurance lines, which together accounted for nearly 75% of the total general insurance GWP in 2023.

GlobalData insurance analyst Sneha Verma said, "New Zealand's general insurance industry is expected to witness a growth of 10.1% in 2023 after growing by 10.9% in 2022. The growth is supported by a rise in the demand for NAT Cat insurance policies due to an increase in the frequency of extreme weather events and an increase in premium prices across most of the insurance lines driven by inflation."

Property insurance

Property insurance is the leading line of business in the New Zealand general insurance industry, and accounted for a 41.7% share of the general insurance GWP in 2023. It grew by 9.8% in 2023, driven by the rise in demand for NAT Cat insurance policies due to the country's susceptibility to extreme weather events.

Increasing claims from weather events prompted reinsurers to increase reinsurance rates. This further increased premium rates of home and agriculture insurance policies and supported property insurance growth. This will further increase the premium rates of home and agriculture insurance policies and support property insurance growth. According to Stats NZ, the official data agency for New Zealand, contents insurance premiums witnessed an increase of 23.8%, and home insurance premiums increased by 23.1% in 2023 as compared to the previous year.

The changes to the Earthquake Commission Cover (EQC) limit have also contributed to an increase in home insurance premium prices. In October 2022, EQC cover for natural calamities doubled from NZ$150,000 to NZ$300,000, leading to an increase in the levy paid by households by NZ$180, irrespective of location within the country.

Ms Verma said, "High inflation has also played a major role in an increase in property insurance prices. The annual inflation in New Zealand stood at 4.7% in 2023, much higher than the target band of 1% to 3% set by the Reserve Bank of New Zealand. Property insurance is expected to grow at a CAGR of 7.9% during 2024-2028."

Motor insurance

Motor insurance is the second largest line of business, and accounted for a 32.9% share of the general insurance GWP in 2023. Motor insurance premiums grew by 9.4% in 2023, primarily due to premium rate increases driven by inflation and high claim payouts following cyclone Gabrielle. Motor insurance is expected to grow at a CAGR of 6.3% during 2024-28.

Ms Verma also said, "A gradual recovery in the economy after the pandemic and rising premium prices will support the growth of the New Zealand general insurance industry over the next five years. The insurers' profitability is expected to remain volatile due to high claims arising from frequent natural disasters and a subsequent increase in reinsurance rates."

TOP

Certificate Courses offered by COI

CC1 - Certificate Course in Life Insurance Marketing

Course Structure –

Particulars	Details
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 as well as employees working in Insurance Companies
Fees for the course	Rs. 5900/- (Rs. 5000/- + 18% GST)

CC2 - Advanced Certificate course in Health Insurance

Course Structure –

Particulars	Details
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 as well as employees working in Insurance Companies
Fees for the course	Rs. 11,800/- (Rs. 10,000/- + 18% GST)

CC3 - Certificate Course in General Insurance

Course Structure -

Particulars	Details
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 Companies, Insurance Companies, Freelancers
Fees for the course	Rs. 14,160 /- (Rs. 12,000/- + 18% GST)

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

Course Structure -

Particulars	Details
Course Date	14th May 2024 – 16th May 2024
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 Department/ Audit functions of the company
Fees for the course	Rs. 10620/- (Rs. 9,000/- + 18 % GST)

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

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 Class Room sessions (Saturdays and Sundays (full day)) 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	Rs.45,375/-
Cash Award Prize Scheme	Rs.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 Class Room sessions (Saturdays and Sundays (full day)) 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	Rs.45,375/-
Cash Award Prize Scheme	Rs.15,000/- for the best performing candidate of III-PGDIM
Contact Email id	pgdim@iii.org.in