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Insurance Term for the Week

Absolute Assignment

Absolute Assignment in insurance refers to the complete transfer of all rights, liabilities, and benefits of a life insurance policy from the policy owner (assignor) to another person or entity (assignee). After the assignment, the assignee becomes the new policy owner and is entitled to all the benefits such as death benefits and maturity benefits.

People often choose absolute assignments for various reasons such as:

- To use the insurance policy as collateral for a loan, with the lender becoming the assignee.
- To gift the insurance policy to someone else, making the recipient the new policy owner.
- To change the policyholder due to the original policyholder's inability to maintain the policy.

Absolute assignments can be done at any time after the policy is issued. However, it requires the mutual consent of both the assignor and the assignee.

To conduct an absolute assignment, the policyholder needs to submit a written request to the insurance company. This request must include details of the existing policy and the proposed assignee. The assignor and the assignee must both sign this request. Once the insurance company approves and registers the assignment, the assignee becomes the new policy owner.

QUOTE OF THE WEEK

"The art of effective listening is essential to clear communication, and clear communication is necessary to management success."

JAMES CASH PENNEY

INSIDE THE ISSUE

INSURANCE INDUSTRY

'Insurance coverage expansion to underserved segments can save govt $10 bn' – Business Standard – 14th November 2024

The government could potentially save nearly $10 billion annually by expanding insurance penetration to include underserved populations and events, which could be redirected towards stimulating economic growth, according to a McKinsey report.

This includes providing comprehensive life insurance cover, which could help reduce the burden of ex gratia benefits to families affected by the loss of life or livelihood due to accidents and other unforeseen events. Robust and affordable private health insurance coverage could lessen the strain on public healthcare, freeing government funds to improve Idia's healthcare infrastructure, the report stated.

Additionally, targeted interventions in crop insurance could help minimise crop losses, compensate for crop damages, reduce loan defaults, and enhance production yields, according to the report. Further, creating natural disaster insurance pools with mandatory coverage for ecologically sensitive areas could minimise financial losses for small and medium-sized enterprises (SMEs) and other businesses affected by catastrophic events.

The gross written premium of Indian insurance has exceeded $130 billion, growing at a compound annual growth rate (CAGR) of 11 per cent in the three-year period FY20-23, outpacing its Asian counterparts. From FY16-23, the life insurance segment recorded an 11.4 per cent CAGR, while the general insurance market grew by 15 per cent over the same period.

This growth aligns with the Insurance Regulatory and Development Authority of India's (Irdai) goal of "Insurance for All by 2047," aimed at enhancing availability, accessibility, and affordability. The regulator has introduced customer-centric regulations that simplify the purchase process, allowing insurance players to innovate and cater to a larger consumer base. Furthermore, the growth of private and digital insurers is outpacing that of public sector insurers. Capital influx into the insurance sector is also driving this expansion.

"Substantial investments in innovation and growth have transformed the insurance industry. Fueled by domestic and foreign private capital, insurers have prioritised enhancing customer experiences through digital channels, optimising sales strategies, and improving business performance metrics like policy persistence," the report noted. Current regulations cap foreign direct investment (FDI) in insurance at 74 per cent, and private equity firms can invest directly in insurers.

However, despite these efforts, challenges remain. The industry's penetration rate slipped to 4 per cent in FY23 from 4.2 per cent in FY22, highlighting gaps in product innovation, distribution efficiency, and renewal management. "Operational inefficiencies, profitability issues, gaps in coverage, limited regulatory support that stifles innovation, and rapidly evolving risks are significant challenges hindering the industry's performance. Additionally, limited financial literacy and suboptimal advisory services have exacerbated concerns about misselling," the report said.

Over the past five years, the top five private life insurers in India have recorded a 17 per cent CAGR in new business premium, while their profit rose by only 2 per cent, indicating issues with cost management and operational efficiency. Rising expenses—including commissions, operational costs, employee salaries, and marketing—contribute to these challenges.

On the regulatory front, certain measures have impacted insurers' profitability, including new surrender value norms for life insurers and stagnation in third-party pricing for motor insurance.

"The change in surrender value methodology may lead to higher payouts, while reducing the minimum premium term from two years to one could drive up costs. The stagnation of third-party pricing for motor insurance, which has grown by less than 2 per cent annually since 2019 (compared with an inflation rate of 5 to 6 per cent), hampers market competitiveness and discourages innovation in the motor insurance sector," the report observed.

To build a resilient ecosystem, insurers must focus on driving value growth. While factors like rising premiums, strong competition, and capital inflows may support short-term gains, long-term success will depend on prioritising innovation. Insurers need to adapt to evolving customer needs, invest in talent and technology, and commit to sustainability. Data, analytics, and technology will be key enablers in this process.

(The writer is Aathira Varier.)

TOP

GST Council may waive 18% tax on senior citizens' insurance plans in Dec – Business Standard – 12th November 2024

The GST Council is expected to discuss potential tax relief on select insurance plans at its upcoming meeting in Rajasthan on December 21–22, according to a report by The Times of India. The Council may consider eliminating the 18 per cent goods and services tax (GST) on term insurance plans and health insurance policies, particularly for senior citizens and coverage plans up to Rs 5 lakh.

Key proposals for insurance tax relief
The upcoming GST meeting will likely focus on insurance-related GST relief. Health insurance premiums currently generate around Rs 2,500 crore in GST revenue, a significant amount that has prompted cautiousness among states regarding a potential rate reduction.

Bihar Deputy Chief Minister Samrat Chaudhary, who leads the GST rate rationalisation committee had earlier said, "Every GoM member wants to give relief to people, with a special focus on senior citizens."

Concerns on broader GST rate cuts
Broader changes to GST rates for goods and services are not expected during this meeting. Currently, GST is levied across four slabs: 5 per cent, 12 per cent, 18 per cent, and 28 per cent, with the two highest slabs accounting for about 75 per cent of revenue. Given the Centre's recent cessation of revenue compensation to states, there is added caution around reducing tax rates.

Health insurance GST relief and panels
This discussion on health insurance GST relief gained momentum after Transport Minister Nitin Gadkari urged Finance Minister Nirmala Sitharaman to remove indirect taxes on health insurance, arguing it imposed an unfair burden on consumers, in a letter in July. Sitharaman later said that the letter was never meant to be public.

The GST Council has since assigned a group of ministers to evaluate rate adjustments in insurance. In addition, another panel, led by Minister of State for Finance Pankaj Chaudhary, is reviewing the future of the GST compensation cess on luxury and 'sin' goods, which is set to remain until March 2026.

Concerns with cutting GST on insurance
Although Covid-19-related claims have decreased, insurers have maintained higher premiums, citing increased handling costs. This has led to concerns that insurance providers might not pass on any GST relief to policyholders. The GST Council is scheduled to meet in Rajasthan on December 21 and 22.

(The writer is Vasudha Mukherjee.)

TOP

Ways to build and maintain robust technical capabilities in Insurance - Express Computer – 11th November 2024

Technology is transforming the insurance industry in innumerous ways, making strong technical capabilities essential for insurers to stay competitive and ensure customer satisfaction. The integration of advanced technologies across various insurance functions—such as customer management, risk assessment, underwriting, claims processing, and operations—has made it imperative to establish a robust tech foundation. This calls for companies to invest in long-term technical infrastructure and foster a culture of technical excellence. Some of these strategies that will enable insurers to build and maintain their technological edge are illustrated below.

Enhancing tech infra and tools

Learning and using the required tools and infrastructure facilities is very important for any sector looking for a tech upgrade. As artificial intelligence (AI), machine learning, and cloud-based tech dominate the tech play, insurance companies should use them to streamline processes, increase efficiency, and improve decision-making capacities. For instance, AI-based claims automation tools can streamline processes, enabling insurers to conduct accurate claim assessments and settlements. Insurance firms can use AI to automate routine tasks, reduce processing times, and thereby improve customer satisfaction by making quicker solutions.

Integrating big data and machine learning into risk assessment and pricing models enhances decision-making speed and accuracy. It can help companies analyse reams of datasets to identify patterns and improve risk prediction and fraud detection in no time. Cloud-based platforms provide better-enhanced data security, help build scale fast and result in enhanced collaboration with teams. They facilitate seamless remote access to critical information, improving operational efficiency and agility.

Predictive data analytics can help Insurers to assess potential policy cancellations, frauds, other risk events and be well prepared to handle them. Drones can be used to perform such risks and claims surveys that are otherwise very complex or sometimes impossible for humans to perform.

Sharp data analytics offers insurers the option to personalise offerings based on consumer needs, fix pricing and improve overall delivery. API integration automates interactions between different systems, resulting in real-time data exchange.

Staying abreast of industry trends

Black swan events and changing regulatory norms make insurance face sudden risks. This means one needs to stay informed and a step ahead of broader industry trends to remain in the growth trajectory.

To deal with changing regulatory norms, insurers must have a select team to monitor changes in local and international regulations that work with legal and risk management to interpret key regulatory changes, update company policies, and maintain compliance timelines.

Insurers should also be in tune with new risks, especially in fields as diverse as cybersecurity, AI integration and climate change. Understanding these issues will help insurers build relevant products and offer efficient claims for their customers. Insurance firms must also participate in industry forums and conferences and collaborate with regulatory bodies to learn more about emerging trends in the sector, share knowledge, and stay informed about the competition, that allows them to stay ahead of the curve and anticipate problems quickly.

Improve cybersecurity

As everything goes digital-first, stringent cybersecurity norms are essential. Insurers must implement advanced cybersecurity options, including encryption, multi-factor authentication, and continuous monitoring to safeguard data. Regular penetration testing can identify vulnerabilities in digital infrastructure and help achieve timely resolutions. Encryption protects sensitive information from unauthorised access.

Implementing multi-factor authentication and robust monitoring systems helps prevent access and reduces the risk of identity theft. Insurers must set up dedicated cyber security teams for audits and vulnerability assessment. It can help them identify threats soon and reduce the risk of attacks.

Developing technical excellence

A culture of technical excellence is crucial for long-term success of an organisation, and it calls for developing employee capabilities and building collaboration. Insurers must work on technological training programmes covering multiple insurance-centred verticals, from underwriting and claims management to emerging technologies like AI, machine learning, and blockchain technology. Encouraging a knowledge-sharing culture where employees can exchange ideas and learn from each other helps in continuous improvement. Promoting collaboration between technical and business development teams can lead to innovative and efficient solutions. Recognising and rewarding employees who offer creative solutions will help in continuous improvement and engagement.

Building and maintaining robust technical capabilities in insurance requires a mix of advanced infrastructure, ongoing technical training, strong cybersecurity measures, and a culture of innovation to help insurers stay competitive in a changing market.

(The writer is Irfan Shirwani.)

TOP

INSURANCE REGULATION

Simplify terms and conditions in insurance policies to reduce complaints: IRDA advisory panel member– The Economic Times– 11th November 2024

Insurance companies need to draft the terms and conditions of the policy in a language that is simple and easy-to-understand, which will help in reducing the grievances of customers, an IRDA advisory committee member said on Monday. IRDA's Insurance Ombudsman Advisory Committee member Pushpa Girimaji also stressed on the need to reduce the number of 'non-entertainable complaints' by the insurance ombudsman.

Insurance Ombudsman is a quasi-judicial grievance redressal machinery to resolve complaints of insured persons against life and non-life insurance companies. At an event to mark the foundation day of the insurance ombudsman, Girimaji also stressed on the need for insurers to be fair in deciding insurance claims of customers. "There is a need to bring down the number of complaints in the insurance sector. The terms and conditions specified in insurance policies should be drafted in a way that it is simple and easily understood," Girimaji said.

TOP

Data, tech & Bima Sugam to transform insurance sector: Irdai boss at BFSI – Business Standard – 8th November 2024

Chairperson of the Insurance Regulatory and Development Authority of India (Irdai), Debasish Panda, laid out an ambitious roadmap for the nation's insurance sector at the Business Standard BFSI Insight Summit 2024. In a conversation with Business Standard consulting editor, Tamal Bandyopadhyay, Panda shared his vision of a future propelled by advancements in technology, data, and digital innovation. He emphasised Irdai's commitment to making insurance both accessible and affordable, placing policyholders firmly at the core of the authority's regulatory mission.

"Insurance must reach every household, touch every citizen, and support enterprises," Panda said, emphasising that universal insurance and pension access are crucial to achieving a 'Viksit Bharat' by 2047. He highlighted Irdai's efforts to build a more agile, adaptable regulatory framework that prioritises policyholder needs.

The digital platform Bima Sugam, according to Panda, will be instrumental in revolutionising the sector by acting as a comprehensive public infrastructure for policyholders. "Bima Sugam will be a gamechanger, enabling customers to navigate the entire insurance journey—from purchasing and claims processing to servicing requests," he explained. This initiative will empower customers to explore a variety of products in one marketplace, independent of intermediaries tied to specific companies, while also allowing distributors to conduct transactions more efficiently.

Irdai's recent regulatory overhaul, Panda said, focuses heavily on integrating data and technology, essential to reaching India's vast population. "For a population of 1.4 billion, it is impossible to physically reach everyone. Leveraging technology and data is indispensable," he said, adding that enhanced data analytics from the revamped Insurance Information Bureau will support personalised risk pricing and product innovation.

Pricing reforms also featured prominently in Panda's address, with Irdai's approach favouring market-driven mechanisms over regulatory intervention. "The aim is to make insurance affordable and accessible while ensuring fairness through personalised pricing," Panda said. He also predicted a rise in demand for Do-It-Yourself (DIY) insurance solutions, particularly from millennials seeking flexible, tailored products aligned with their risk profiles.

On the health insurance front, Panda highlighted that recent circulars mandate coverage for individuals with disabilities, mental health conditions, and surrogacy-related needs, creating an inclusive framework that ensures no one is excluded. Bima Sugam, together with a data-driven approach, "will transform the insurance sector, bringing transparency, choice, and convenience to consumers," Panda added, reaffirming Irdai's commitment to steering the industry towards a more inclusive, technology-driven future.

(The writer is Nandini Singh.)

TOP

Irdai Chairman Debasish Panda pitches for 100% foreign direct investment in insurance sector – The Telegraph – 8th November 2024

Irdai Chairman Debasish Panda on Friday pitched for 100 per cent foreign direct investment in the insurance sector, saying a lot of capital is needed to achieve the goal of 'insurance for all' by 2027. Speaking at Business Standard's annual BFSI event, Panda said insurance is a capital-intensive sector, and the country would need more players in the segment to increase insurance penetration.

Irdai Chairman Debasish Panda on Friday pitched for 100 per cent foreign direct investment in the insurance sector, saying a lot of capital is needed to achieve the goal of 'insurance for all' by 2027.

Speaking at Business Standard's annual BFSI event, Panda said insurance is a capital-intensive sector, and the country would need more players in the segment to increase insurance penetration. India gradually started opening the insurance sector by allowing private and foreign investment in 2000. Currently, up to 74 per cent FDI is permitted in general, life and health insurance.

"We need a lot of capital, which means we need a lot of new entities to come in. There may be some consolidation also happening. So, all of that churning will happen. "And if the FDI route is also opened that will only augment the domestic investment as well, otherwise, domestic investment may get crowded out. ... perhaps its time to open up for 100 per cent FDI so more players who want to come and operate on their own terms without trying to look for an Indian partner that may also help," he said.

Panda further said achieving universal insurance will be crucial in India's journey towards a 'Viksit Bharat' by 2047. He also said the digital platform Bima Sugam, an initiative of Irdai, will be instrumental in revolutionising the insurance sector by acting as a comprehensive public infrastructure for policyholders.

According to him, the initiative will empower customers to explore a variety of products in one marketplace, independent of intermediaries tied to specific companies, while also allowing distributors to conduct transactions more efficiently.

TOP

LIFE INSURANCE

Child insurance: Waiver of premium can help secure education goal – Business Standard – 13th November 2024

Vineet Kumar (name changed on request), a 32-year-old Faridabad-based advertising executive, is the father of a one-year-old. While he finds fatherhood fulfilling, he admits to certain anxieties. “I do sometimes worry about what would happen to my child if I am not around,” says Kumar. A child insurance plan can offer the necessary reassurance to parents like him.

Key features

These plans generally mature when the child reaches 18 to 25 years. Thus, their payouts are aligned to milestones like higher education and marriage.

These products can help with disciplined, goal-based wealth creation. Most importantly, they provide insurance coverage. “On the unfortunate demise of the parent, an immediate lump-sum payout is made. Also, all future premium payments are waived. If the product comes with a premium payment term of, say, 10 years, and the parent passes away after two years, the life insurance company pays the remaining eight premiums, thereby ensuring the policy continues to be in force and offers all the promised benefits upon maturity,” says Srinivas Balasubr-amanian, chief of products, ICICI Prudential Life Insurance.

Child insurance plans ensure a secure future even if the breadwinner passes away early. “They take care of the problem: How can I ensure my child’s education and other goals are not compromised, even if I am not around?” says Madhu Burugupalli, senior exe-cutive vice president and head of products, Bajaj Allianz Life. These plans may be unit-linked or traditional, guaranteed-return plans. “Some also offer income to the family during the policy term, usually 1 per cent of the sum assured or equivalent to one annual premium,” says Sameep Singh, product head-investment, Policybazaar.

Systematic investment plans (SIPs) usually stop when the breadwinner passes away. Term plans may not be able to provide for longer-term needs. “After the breadwinner’s demise, shorter-term needs take precedence — household expenses, repayment of home loan, school fees, etc.,” says Burugupalli. By the time the child is ready for college, the funds may be exhausted.

According to Singh, most families lack adequate term cover, with the sum assured rarely exceeding Rs 1-2 crore. “Such a cover may not suffice to fund the child’s higher education and provide for the wife’s retirement,” he says.

Deepesh Raghaw, a Securities and Exchange Board of India (Sebi) registered investment advisor (RIA), notes that if the family members are not financially savvy, term plan payouts tend to get squandered. Child plans make payouts at the right time. “They can ensure that the child’s education goal is met, even if the breadwinner passes away,” says Balasubramanian.

Not cost-effective

Many of these children plans may not be as cost-effective as a term plan plus mutual fund combo. “Returns, especially in traditional plans, tend to be suboptimal,” says Raghaw. Plans insuring the child’s life, not the parent’s, should be avoided. These policies are also less suitable for older individuals or those with pre-existing conditions. “If you are over 50, the mortality charge will be high due to age. And if you have health issues, the insurer will apply a loading on this charge,” says Raghaw.

Tax-exempt returns are limited to Rs 2.5 lakh for unit-linked insurance plans (Ulips) and Rs 5 lakh for traditional plans. Should you opt for a non-participating traditional plan or a Ulip? The former guarantee the payout amount. “But with a Ulip, especially with a longer horizon, a bigger corpus can be accumulated due to the equity exposure,” says Singh.

Checks to be run before purchase

> In a guaranteed-return traditional plan, get an advisor to check the internal rate of return and make sure it offers at least 6 per cent

> If you are buying a Ulip, check the cost structure and avoid expensive plans

> Ulips are of two types – Type-I and Type-II

> In a Type-I plan, you get the higher of the fund value or the sum assured; in a Type-II plan, you get the fund value plus the sum assured

> To ensure your child gets a higher amount, buy a Type-II plan

(The writers are Sanjay Kumar Singh & Karthik Jerome.)

TOP

Private insurers may post slower growth in H2 amid margin pressures and regulatory impact – The Economic Times – 12th November 2024

The private insurance sector is expected to see a moderation in growth for the second half of FY25, as slower retail annual premium equivalent (APE) growth and regulatory changes weigh on margins, according to an analyst note by Elara Securities. After reporting strong APE growth in the first half of the fiscal year, industry projections suggest a dip in expansion rates for the remainder of the fiscal year, driven by a higher mix of unit-linked products (ULIPs) and the recent implementation of surrender value regulations. In October, private insurers posted an 18% year-over-year (YoY) increase in APE, outperforming the Life Insurance Corporation (LIC), which reported a 1% decline. Despite this positive surprise, largely driven by established firms like HDFC Life, ICICI Prudential Life (IPRU Life), Max Life, and Aditya Birla Sun Life (ABSL), many companies have struggled to match growth expectations, likely due to new commission structures and delays in product launches.

In the retail APE segment, private firms saw 12% YoY growth, contrasted with LIC’s 15% decline. HDFC Life and IPRU Life reported strong October gains at 21% and 22%, respectively, bolstered by the new

surrender norms that appear to benefit large firms. However, SBI Life, a prominent player, continued to show weaker performance with 10% YoY growth, likely hindered by bancassurance channel challenges. For H2FY25, analysts expect a subdued APE growth rate of around 14% YoY, significantly lower than the 20% seen in H1FY25. Margin compression is anticipated to persist due to a shift toward ULIPs, which typically yield lower margins, and the surrender value regulations that may dampen profitability. This compression is projected to lead to a moderate 8% YoY growth in value of new business (VNB) for the four leading private insurers in H2FY25.

Key factors impacting outlook

H1FY25 saw robust growth in APE for firms like HDFC Life (25%) and IPRU Life (27%), but H2 is expected to experience a deceleration, especially among mid-sized and small insurers. The ULIP segment reported a 42% YoY growth in H1FY25 for key private firms, though growth in non-linked savings remained muted. The increasing share of ULIPs is likely to pressure overall margins.

TOP

Why Indian students studying abroad need life insurance – Financial Express – 11th November 2024

Life insurance offers financial protection for your family regardless of your location. For students studying abroad, therefore, it is advisable to consider this option, as the unpredictability of life cannot be overlooked. While this insurance cannot prevent loss of life, it can alleviate some financial burdens for the family. Therefore, obtaining life insurance is a beneficial decision. Additionally, numerous agencies offer this service at very affordable premiums. A significant number of students pursuing education abroad rely on loans to finance their studies. They typically repay these loans using their earnings in the host country. Nevertheless, life is unpredictable, and unforeseen events can occur, potentially resulting in loss of life.

In the unfortunate event of such incidents, the parents of these students would not only face the emotional toll but may also encounter financial challenges. This is due to the obligation of repaying the loan from their regular income. While individuals cannot prevent tragic occurrences or emotional distress, they do have the opportunity to mitigate financial burdens. Moreover, the fact that you can get life insurance for a comparatively low premium is another reason you should opt for it. If you look at the situation from another perspective, the Ministry of External Affairs has recently confirmed that around 1.33 million Indian students are pursuing their higher studies abroad. And if we look at the geopolitical situation of the world, there are war-like situations in almost every continent. Whether it is Russia and Ukraine, Israel Afghanistan, or Mexico, they are always on high alert. Recently Iran attacked Israel. There are some Indians present in Israel who are waiting for help.

So, in these situations, the native population is also not safe. Also, in the Covid phase, we have seen thousands of students evacuated from the effected countries. Taking notice of this condition, insurance companies are expanding their market and providing health insurance at all-time low premiums. Now, as you know the importance of life insurance, you should start searching for the best agents in the market. Opting for a plan that provides additional coverage is important. Situations like critical illness or disability are something you should consider while finalizing. This will financially help you during any disease outbreak and conditions beyond death. Consider coverage settlement amount, payment terms, and other policy conditions before making the final purchase.

TOP

'New surrender rules painful but will drive insurance demand' – Business Standard – 8th November 2024

Addressing the 'pain point' of the Indian insurance sector, industry leaders said on Friday that the revised surrender value rules will boost customer confidence by shifting the balance in their favour, ultimately driving demand in the sector. On the final day of the three-day Business Standard BFSI Summit, Vibha Padalkar, MD and CEO HDFC Life, emphasised that while Insurance Regulatory and

Development Authority of India's (Irdai) revised surrender rules benefit customers, balancing early exits with long-term product stability remains a challenge.

At the panel moderated by Tamal Bandyopadhyay, consulting editor, Business Standard, Padalkar said that this move is seen as a step towards more customer-friendly solutions, positioning the insurance sector well for the mission of 'coverage for all' by 2047. "The pain is there and disconnect in terms of what we are trying to do because we are giving very long term guaranteed products. So, having an exit early on could potentially lead to an ALM (asset-liability management) mismatch, especially if interest rates move sharply…but that is history now. When we look at the bigger picture…it is pro-customer…at the end of the first year, the customer gets a much larger amount than zero … .and so on…At the same time, we don't want customers to exit as these are long-term products…so, we will see how it evolves," Padalkar said.

Mahesh Balasubramanian of Kotak Mahindra Life Insurance Company expressed similar sentiments, noting that the move will increase demand in the long-term. "We are happy that customers are going to get a higher return on surrender when they come in for the first year. It does cause some short term pain, we have made sure that the pain is absorbed by us," he said. Anup Bagchi, MD and CEO of ICICI Prudential Life, believes while the new rules may be painful in the short term, anything that increases trust in the sector is ultimately beneficial. "We have to ensure that we make processes smooth and then that would generate demand. We have to make it as instant as possible," he said.

TOP

GENERAL INSURANCE

Non-life insurers post 27.5% premium growth in October, shows data - Business Standard – 12th November 2024

Non-life insurers have reported a 27.53 per cent year-on-year (Y-o-Y) growth in premiums in October, driven by growth in standalone health and multi-line insurers. Recovery in motor sales also supported the growth of general insurers. Additionally, some companies reported their premium figures based on the new reporting format effective from October 1, 2024.

Data indicates that general insurers collected Rs 25,396.68 crore in premiums in October, reflecting a 23 per cent Y-o-Y increase. The largest general insurer, New India Assurance, reported a 0.62 per cent Y-o-Y increase in premiums, while the second largest, ICICI Lombard General Insurance, posted a 7.48 per cent Y-o-Y growth. Other state-owned insurers, United India Insurance reported a 2.44 per cent Y-o-Y rise, National Insurance saw a 156.70 per cent Y-o-Y growth to Rs 2,488.12 crore, and Oriental Insurance's premiums rose 11.6 per cent.

Among major private general insurers, Bajaj Allianz General reported over 100 per cent Y-o-Y growth to Rs 3,859.72 crore, while HDFC Ergo saw a decline of 10.39 per cent Y-o-Y to Rs 1,629.85 crore. Standalone health insurers (SAHI) reported robust growth of 25 per cent Y-o-Y in premiums in October, reaching Rs 3,119.06 crore, with Star Health and Allied Insurance reporting a 13.7 per cent Y-o-Y growth to Rs 1,283.63 crore.

The Insurance Regulatory and Development Authority of India (Irdai) revised the format for reporting premium figures. The regulator has mandated that long-term premiums be reported based on the 1/N method, where N is the number of days of the policy. The new norms are effective from October 1, 2024. For the month under review, some companies have reported figures using the previous method, while others have adopted the new Irdai format. As a result, the numbers are not directly comparable.

"Irdai recently revised the format for reporting premium figures. Insurers must now recognise and report long-term premium income over the period of risk using the 1/N method. This approach ensures that premium income is allocated more evenly over the policy period, improving transparency and aligning with global best practices in financial reporting. This adjustment reflects a more accurate view of premium income spread across the policy duration," said Sharad Mathur, managing director and chief executive officer, Universal Sompo General Insurance.

"The norms are already applicable in motor insurance, so this segment will not be impacted. The new norms will affect other long-term policies like health and home insurance. However, the changes will not impact the revenue or cash flow of the companies, though there may be some effect on the expense of management (EoM)," said an official from a general insurer.

GROWTH CHART

Non-life insurance premiums (₹ cr)

	Apr-Oct 2024	Y-o-Y (%)	Oct 2024	Y-o-Y (%)
General insurers	156,640.60	9.02	25,396.68	23.04
SAHI*	21,336.60	24.77	3,119.06	25.04
Specialised PSU insurers	6,294.88	-7.87	1,862.27	171.88
Total	184,272.08	9.93	30,378.01	27.53

*Standalone health insurers
Source: General Insurance Council

According to a Nuvama report, the industry grew 27.6 per cent Y-o-Y, with SAHIs' gross direct premium income (GDPI) growth at 25.1 per cent Y-o-Y. Public multi-line insurers reported GDPI growth of 24.9 per cent Y-o-Y, while private multi-line insurers showed strong GDPI growth of 22.1 per cent Y-o-Y. Public multi-line insurers continued to lose market share (-122 basis points Y-o-Y to 30.4 per cent) to private multi-line insurers (+49 basis points Y-o-Y to 54.6 per cent) and SAHIs (+138 basis points Y-o-Y to 11.6 per cent).

The report also noted that the revival in retail motor sales contributed to improved premium growth. Meanwhile, in the April-October 2024 period, non-life insurers reported a 9.9 per cent Y-o-Y growth in premiums, primarily driven by the performance of SAHI players, who posted a 24.77 per cent premium growth. General insurers saw a 9.02 per cent Y-o-Y increase in premiums during this period, while specialised public sector unit (PSU) insurers reported a 7.9 per cent Y-o-Y growth. "The slowdown in motor sales during the financial year and the drop in commercial rates have affected the growth of multi-line general insurers during this period," a general insurer said.

(The writer is Aathira Varier.)

TOP

General insurance penetration rising in India, say leaders at BFSI Summit – Business Standard – 8th November 2024

At the Business Standard BFSI Insight Summit on Friday, top leaders of India's general insurance companies expressed confidence that general insurance sector penetration is rising in India. During a discussion with Business Standard banking editor Manojit Saha, Anuj Tyagi, managing director and chief executive officer (CEO) of HDFC Ergo, highlighted the evolution of the insurance distribution framework in recent years. "The distribution framework has evolved over the past few years, offering companies different tools," he noted.

This progress has enabled insurance providers to customise products and target specific regions, potentially increasing market penetration. Tyagi said, "Insurance companies are now able to tailor specific products and focus on particular areas of specific states. This will show green shoots in terms of penetration." He expressed optimism that the groundwork is set for a significant rise in insurance penetration. "The groundwork is done; soon, insurance penetration will increase," he added. Tyagi also mentioned the role of the "Bima Trinity" in enhancing accessibility. "The Bima Trinity should help reduce costs, but the main objective is to increase insurance accessibility," he said.

Animesh Das, managing director and CEO of Acko General Insurance, shared his vision for comprehensive general insurance coverage across India by 2047. "The goal is to cover the entire population with general insurance by 2047," he stated. Das emphasised the importance of technology, not just for efficiency but as a core element in the industry's growth. "Technology or digital distribution is

often seen as a tool for efficiency, but it needs to be at the core as well," he said. He noted the need to adapt to the digital preferences of the new generation, especially as decision-makers at home increasingly belong to the internet-native generation. "Most decision-makers at home will be people born after the internet era. The insurance industry is catching up," Das said.

Das underscored the importance of a robust digital framework, stating, "In the insurance ecosystem, ease and convenience of doing business, along with product approval timelines, are fundamental. Additionally, building a sharp digital framework to engage with the emerging audience is crucial." On making health insurance more affordable and accessible in India, Das stressed the importance of efficient distribution to reduce costs, enabling insurers to offer more benefits to customers. "Distribution efficiency is key to cost savings, which enhances product affordability by allowing insurers to pass on more benefits to consumers," he explained.

Das highlighted that customised, data-driven products also contribute to affordability by addressing users' needs. "You need to create products that are convenient for users — both at the time of purchase and during claims," he said. He added that precise underwriting can help reduce unnecessary costs, ultimately benefiting genuine customers. Further discussing affordability, Anup Rau, managing director and CEO of Future Generali India, noted that India already has some of the lowest health insurance premiums globally. "Health insurance premiums in India are among the lowest in the world," he said, adding that affordability could still improve.

Rau suggested that government intervention, particularly through tax relief, could make a significant impact. "I would prefer GST relief to make health insurance more affordable," he said. On value-added services in the general insurance sector, Das advocated offering such services similar to those in banking. "Value-added services make a lot of sense. There are good examples in banking, like credit card lounge access, built on top of financial products," he said, suggesting similar add-ons could enhance the health insurance experience.

Tyagi highlighted the potential of value-added services to transform general insurance from a "push" product to a "pull" product. "Insurance companies can shift from being a push product to a pull product with value-added services," he explained. Tyagi pointed out the unique nature of insurance, where neither sellers nor buyers prefer to use it. "Insurance is a unique product where neither the seller nor buyer wants to experience it," he said. "For instance, neither party wishes for the insured car to break down," he noted, adding that this reality underscores the importance of additional benefits that add value beyond claims.

(The writer is Rimjhim Singh.)

TOP

General insurance companies see signs of growth revival – Business Standard – 8th November 2024

The penetration of general insurance products like health, motor and property remains low in the country but there are early signs of a growth revival in the industry and beginning of expansion of the market, according to top CEOs (chief executive officers) of general insurance companies.

Speaking at the Business Standard BFSI Insight Summit, the heads of some of the largest general insurance companies said that they faced many growth challenges in recent years but the industry is on the cusp of a new phase of growth and expansion. This will help the industry realise the government and the Insurance Regulatory and Development

Authority of India (Irdai)'s vision of "insurance for all by 2047", when India is expected to be a developed country.

"Low penetration of insurance products such as health and motor is an issue but green shoots are clearly visible now. Various insurance companies have already begun to make fresh investments, open offices at newer centres, and recruit new distributors. The groundwork has been done and it will start to show up in policy sales and penetration data soon," said Anuj Tyagi, MD & CEO of HDFC Ergo General Insurance Company.

According to Irdai data, the premium to gross domestic product (GDP) ratio for the general insurance sector has been stagnant at around 1 per cent for some years now, which has raised concern in the industry regulator and the government. Tyagi added that growth in policies and penetration is being aided by regulatory moves such as Vima Vahak, Vima Vistar, and Vima Sugam. "We now have regulatory freedom to launch bespoke products, a new distribution framework is in place, and every insurance company has been allotted specific states in the country to drive growth and penetration of insurance products. This will kick off the new phase of growth," said Tyagi.

Anup Rau, managing director (MD) of Future Generali India Insurance Company, said that the premium to GDP ratio doesn't provide a full picture of the insurance penetration in the country. "Between 2014 and 2013, India's population grew by around 11 per cent but the number of new policies sold tripled during the period. However, in the last seven years, the average ticket size grew by only 1.3 per cent per annum, adversely impacting premium to GDP ratio," he said.

According to Rau, the more relevant number is policy cover. It has grown at a faster rate than premium, given the growth in new policies. "Average premium per policy in motor insurance has not gone up in years while it has declined in case of crop insurance even as the number of policies continued to grow," said Rau.

Aminesh Das, MD & CEO of Acko General Insurance, said that general insurance is in a catch-up game with more mature industries like banking and telecom. "In the era of digital distribution, the insurance industry is catching up with early movers such as banking and telecom. Digital innovation in the industry is now happening at a rapid pace and this will help us attract millennials in a big way, driving the regulator's vision of 'insurance for all by 2047'," he said.

Industry leaders said that affordability of health insurance is also an issue and it can be partly mitigated through a reduction in goods & services tax (GST). "A lower rate of GST on health insurance premiums will directly lower their cost and make them more affordable, and expand the market," said Tyagi. Rau said health insurance premium in India is already one of the lowest, reducing the scope for further decline. "Reducing GST on insurance is a better option to drive penetration, compared to government using tax revenues to subsidise insurance premium in a bid to grow penetration," he said.

Industry CEOs also said that the new wave of growth will kick in when insurance companies start launching value-added services. "Value-added services will increase brand engagement with the customer, leading to stickiness and making it easier for us to sell new products to them," said Das. Tyagi said property insurance – one of the least penetrated products in the industry – is likely to gain the most from bundling of insurance with value-added services.

Industry leaders also touched upon the subject of claim settlement but said that low claim ratio is largely a perception issue rather than a fact. "The industry settled nearly Rs 25,000 crore of claims during the pandemic and saved millions of families from financial ruin, but we got a bad name simply because we declined a handful of claims," said Tyagi. Rau said, "How can we have a low claim ratio when the loss ratio for the health insurance industry is more than 100 per cent? Settling claims is the core of our job and there's no compromise there. However, the industry needs to improve the underwriting and onboarding process of new customers, so that fewer questions are asked during claim settlement."

(The writer is Krishna Kant.)

TOP

Industry leaders discuss insurance changes for 2047 vision – Business Standard – 8th November 2024

At the Business Standard BFSI Summit on Friday, top leaders from the insurance sector deliberated on the industry's expectations from the insurance amendment bill and what it will take to fulfil the mission of 'coverage for all by 2047'.

On the final day of the three-day event, Alok Rungta of Future Generali India Life Insurance shared his perspective, noting that even after 25 years, the country still has only a few insurance companies. "The industry is expecting many things. First is 100 per cent foreign direct investment (FDI). Second, there is a lot of talk on composite licences. These are the two big points that the industry is looking forward to," Rungta said.

He made these remarks during an insightful panel discussion titled 'A Quarter of a Century Since Liberalisation: What's Next?', moderated by Manojit Saha, banking editor at Business Standard. Offering his views on the proposed bill, panelist Sharad Mathur of Universal Sompo General Insurance said, "One thing is clear — our regulator is very progressive and has become more of a developer. I am hopeful that we may see the rise of monoline and sector-specific insurers. This is possible if investors, whether international players or institutional investors, are given the flexibility and freedom to operate."

'Need for a perpetual licence'

Sumit Bohra, President of the Insurance Brokers Association of India (IBAI), shared the brokers' perspective, emphasising the need for a perpetual licence. "From a broker's perspective, a perpetual licence is what we are looking for. Currently, the licence needs to be renewed every three years, which hampers business continuity. If this goes through, distribution will receive a significant boost. The regulator has already submitted a white paper on perpetual licences to the finance ministry. We'll have to see how it progresses," Bohra said.

Role of micro-licences

Discussing how insurance penetration can reach the last mile, Mayank Bathwal of Aditya Birla Health Insurance suggested that micro-licences tailored for specific regions or business categories could be a solution. "What will it take to achieve 'insurance for all', which is the key mantra of both the Centre and the regulator? I believe the concept of sub-licences is very interesting, as it allows companies to focus on particular segments aligned with their existing market," Bathwal noted.

He added, "Another aspect to consider is how we can make insurance more relevant for customers. There have been discussions around value-added services, which give the insurance sector an opportunity to introduce new offerings."

(The writer is Nisha Anand.)

TOP

Insurers hope amendment Bill will drive customer engagement – Business Standard – 8th November 2024

Insurers expect the proposed Insurance Amendment Bill to boost growth of the sector and customer engagement as it will open the market to a large extent. The industry leaders were discussing the future of the sector at Business Standard's BFSI Summit 2024 on Friday.

At a panel discussion themed Quarter of a century since liberalisation ... What Next?, panelists said that currently relations with customers are purely transactional. However, going forward, post the

amendment Bill, customer engagement will become more than that. It will be on the back of value-added services, which will be included in the Bill, they said. “In the initial concept (of Insurance Amendment Bill), value-added services are included. I think that can be a big shift if it happens. And, that way, you can present your option to consumers. Today, you can only sell pure insurance products. With value-added services, you can then sell other related services to the poor category,” said Mayank Bathwal, chief executive officer (CEO), Aditya Birla Health Insurance.

He also added, “So, for health insurance, there are related health services. For retirement, you can offer lots of other retirement services. These don't necessarily have that core component of insurance. But it is clearly related to the core offering, and the whole offering as a combination becomes much more attractive. One of the problems with insurance is that it's a very episodal engagement. But if these services start coming in, the customer will feel that I'm getting something back for what I've paid. I think that's the big one that we are seeing.”

Similarly, Alok Rungta, managing director (MD) & CEO, Future Generali India Life Insurance, also said that customer engagement needs to be more than transactional. “The engagement has to be higher rather than making a transaction. Today, it is a transaction, not an engagement and that is where the customer experience also changes. See, there are only four steps, if you ask me about the lifestyle of a customer. I buy, I renew, or I cancel. So, these are the transactions which happen,” Rungta said. According to a Swiss Re Sigma Report, the overall insurance penetration stood at 4.2 per cent in FY23 from 4 per cent in FY22. The non-life insurance sector stood at 1 per cent for both years. Bathwal said that out of this, the retail health insurance penetration stood at 4 per cent and it can be further boosted by reducing health care and distribution costs.

Moreover, the ‘missing middle’ in the country find health insurance unaffordable and value-added services can make a big difference for them. This is because they cannot afford higher sum-insured products. Meanwhile, Sharad Mathur, MD & CEO, Universal Sompo General Insurance, said that introducing variants in health insurance products will solve problems of affordability in regions beyond the metro cities.

Mathur said, “Affordability is especially felt among the underprivileged people of far locations of metros, Tier II, III and IV cities. To achieve this, we have seen variants of health insurance low-sum insured, high benefit health products. We have seen in Tier III and IV locations off-take of health insurance products rising and some insured is very low. So, it makes sense for insurers to reach out to them and the locations as this helps us in achieving two objectives — insurance inclusion and making sure that loss ratios remain low and products are tailor-made in such a way that they remain affordable. I do not see affordability issues in high-end markets. So, variants of health insurance products are able to address the situation of affordability in rural areas.”

However, health insurance faces several challenges, including grievance during claim settlement and fraudulent claims. However, Bathwal said, “Health insurance is not necessarily about misselling. Most of the times, it is not the intent of the distributor. Health insurance has the element of medical complexity. My only plea to everyone involved in the sales process is that all stakeholders should ensure that the customers understand what is being sold to them. This will solve most of the grievances.”

“With the use of technology, frauds have definitely come down. Maximum claims take place in the health segment. Some people also manufacture claims, leading to frauds. What we have experienced in our businesses is that such frauds have come down over a period of time because of the use of technology,” said Sumit Bohra, president, Insurance Brokers Association of India (IBAI). He also spoke about the importance of getting perpetual licence for insurance distributors. He added, “In our case, the licence has to be renewed every three years. So, that's the process and probably business continuity is being hampered because of the lack of process and all that. So, probably if this goes through, the distribution will get a new flip. There's a lot of investment, which will come into the broker's segment.”

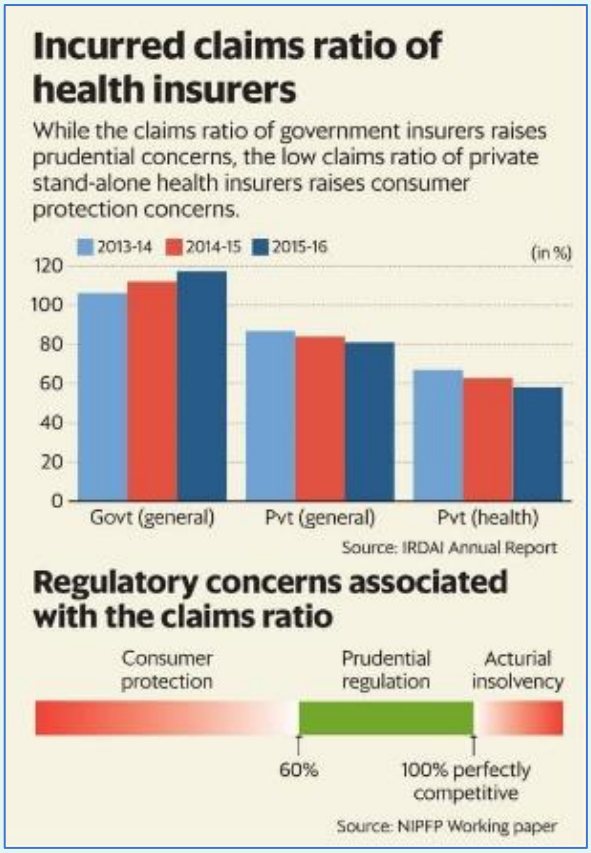
(The writer is Aathira Varier.)

TOP

HEALTH INSURANCE

The dice is loaded against those buying health insurance in India – Live Mint – 14th November 2024

Both anecdotes and data seem to suggest that Indian health insurance policies that are bought by us as individuals don't pay up as much as they should. As we listen to the stories of our friends and family about the run around given by hospitals and medical insurance firms to pay up claims of a hospital bill, we quietly send up a prayer—please let me not be the one whose claim is rejected if I ever need to use my policy. There is increasing distrust in the medical insurance market for privately bought covers. Covers bought by corporations, called group covers, seem to have less problems of claims getting rejected.



The anecdotes are supported by data. A May 2018 working paper, titled Fair Play in Indian Health Insurance has done a deep dive into the sector. The big findings are two. One, claims are not paid as much as they should be. Two, India has the highest complaints rate when compared with other countries.

The claims ratio is a key number to judge if the insurance industry, in general and a firm, in particular, is being fair to its customers. A claims ratio shows how much of the premium collected is paid out. A claims ratio of 100% means that the company is efficient. A claims ratio of over 100 means that the firms are unviable—they are paying out more than they are getting.

Most of the Indian public sector health firms have a ratio of over 100%.

The problem sits in the data for private health insurance claims ratios: these are at 58% in 2015-16, down from 67% in 2013-14. The paper says that such low claims ratios raise the issue of consumer protection. "The observed claims ratio in India would have triggered mandatory refunds if they were operating in the US," says the paper.

Some countries make refunds to consumers mandatory if the claims ratio is below a certain threshold. For example, a claims ratio of below 80% in New York will trigger a refund. A poor, and declining, claims ratio in India points to high costs and an unwillingness to pay privately bought health covers. The paper also finds that India has the highest complaints rate when compared to other countries.

The paper also uses case studies to show the unwillingness of insurance firms to even abide by the contracts they have written themselves, their arrogance in not even appearing for hearings when the customer goes to court and the irrelevance of the paltry fines imposed by the regulator when firms are found guilty. The paper documents the failure of the ombudsman system in insurance. Of the 17 ombudsmen in India, in March 2018, "all offices of the insurance ombudsman were vacant. Some of these offices were vacant for 2-3 years in 2017 resulting in a large backlog of cases".

The dice is clearly loaded against an individual buying health insurance in India. When a market gets privatised, as insurance did in 2001, the government appoints a regulator to make sure that the rules of the game are put in place and there is no market failure. Unfortunately, for the Indian consumer of insurance products, while a regulator was put in place, it took forward the basic mindset of a monopoly market in which consumers did not matter. We need an urgent change in regulatory thought in medical insurance. The regulator needs to shed its capture by the industry and work in consumer interest.

We have no option but to buy medical cover given the high and extractive costs of Indian hospitals. Today we are at risk of paying a hefty health insurance premium for years and then also facing the risk of the insurance firm refusing to pay for an imagined or convoluted reason. For example, this paper documents the case where an insurer refused to pay for an organ donation surgery despite the policy explicitly having a clause that covered the costs of this organ transplant. In another case, the insurer did not even bother to appear in court when taken to court for non- payment of a claim.

What can we do? First, be very sure of what policy you are buying. There is fine print and exclusions that will hurt you when you go for a claim. Use the Mint SecureNow Mediclam Ratings to choose a policy—we've done a deep dive to figure out which are the policies with good features and reasonable costs. You can see the ratings here. Second, go through an agent or broker who you know and can lean on to push the insurance company to pay up. Third, if the company refuses to pay up, make a big noise about it. The unwritten rule in some firms is to pay the claim if the customer makes a lot of noise. Even as the government is rolling out a medical cover for the poor, it also needs to push the insurance regulator and the medical system to treat the patient fairly.

(The writer is Monika Halan.)

TOP

Health insurers sweeten coverage for diabetics, but additional premiums remain a bitter pill – Moneycontrol – 13th November 2024

With over 101 million Indians estimated to be suffering from diabetes and another 136 million at the pre-diabetes stage, as per the Indian Council for Medical Research (ICMR), there is an urgent need to tackle this health challenge that has assumed epidemic proportions.

Along with measures to reduce blood sugar levels and obesity, Indians also need to ensure that they have adequate health insurance cover in place to deal with any health complications that might arise. But how easy is it for such individuals to obtain comprehensive health insurance policies that will pay for diabetes and related ailments?

Health insurers say 'yes' to diabetes coverage

While age and pre-existing medical conditions such as diabetes or hypertension add a layer of complexity to the health insurance buying process, insurers are now increasingly open to covering diabetes, say industry watchers. Several companies today offer coverage from day one, particularly by way of rider benefits or covers that can be purchased by paying additional premiums. Other options include buying regular health covers with waiting periods ranging from two to three years or dedicated policies that come with waiting periods of 2-3 months. Put simply, during this period, your health insurance will not pay for any hospitalisation expenses arising out of such illnesses.

"Insurance companies offer diabetics restrictive or comprehensive coverage, subject to the absence of any micro or macrovascular complications. Compared to earlier, when diabetes would attract a waiting period of 3-4 years in addition to a loaded premium, today, many cover diabetes from day one," says Rupinderjit Singh, Senior Vice President - Health Insurance, ACKO. However, insurers take calls on the basis of the severity of diabetes and the complications, if any. For instance, insulin-dependent diabetics will still find it challenging to obtain health coverage, points out Singh. Likewise, if your diabetes has already resulted in ailments such as diabetic neuropathy or kidney issues, insurers will think twice before issuing a policy.

“Many insurance companies now offer plans with day-one coverage, and most new plans are open to covering both type 1 and type 2 diabetes. Specific plans for diabetes patients are available, and some insurers even accept customers on insulin or with HbA1c levels up to 10, depending on underwriting,” says Siddharth Singhal, Head, Health Insurance, Policybazaar.com.

Moreover, rider benefits are also now offered to help diabetics access health insurance. “Insurance plans have become highly modular, allowing customers to choose the specific features they want in a policy. This flexibility enables customers to adjust premiums based on their choices—adding features for a slight increase in cost or removing them for a discount,” he adds.

Besides health insurance covers, policies have rolled out wellness programmes for such policyholders. “Insurers have begun to link premiums to health outcomes – rewarding policyholders who actively manage their health. Some insurers also integrate preventive health programmes with their plans, offering wellness coaching and lifestyle support, which both assist policyholders and mitigate the insurer’s long-term risk,” says Narendra Bharindwal, vice-president, Insurance Brokers Association of India (IBAI).

Be prepared for stricter evaluation, higher premiums

While policies for diabetics are increasingly available in the insurance space, you have to be prepared for stringent underwriting – that is, risk assessment process before insurers take calls on premiums and policy issuance – processes. “Most insurers have an HbA1C limit of 8 for control and no existing micro or macrovascular complications to offer a full-fledged cover. There are some restrictive covers which can be availed if complications exist along with some co-morbidities. Therefore, it is advisable to get a policy as early as possible to ensure maximum coverage,” says Singh of ACKO.

According to Singhal, not all insurers have a strict HbA1c cut-off of 8. “Some plans even accept levels up to 10, though this varies case by case. Based on the extent of the disease, whether it is type 1, type 2, insulin-dependent, whether it started at a very young age or at a later age – insurers assess each case individually. It's essential to declare your current medical condition accurately and completely to avoid issues during a claim,” he says.

Depending on the severity of your diabetes and other complications as also the product and company that you have chosen, you might have to pay an additional premium, which is termed as loading. And, insurers’ stances on loading and the quantum vary greatly. “Duration of diabetes, HbA1C levels, and overall health status – including age and co-morbidities like hypertension – are primary determinants. For instance, diabetics with well-managed HbA1c levels under 7 percent may see a minimal increase of around 15-20 percent, whereas poorly managed cases with additional health issues could face a loading of up to 50 percent. Notably, some insurers, like New India Assurance, have recently eliminated the additional 10-20 percent loading for diabetic and hypertensive individuals,” says Bharindwal.

Singhal echoes the view that many insurers do not charge additional premiums. “Most health insurance companies do not apply risk-based loading, but if they do, it typically ranges between 10 percent and 30 percent, depending on the plan and the insurer. Generally, you can opt for a plan with minimal or no loading, if available, which might be a preferable choice,” he adds.

Based on the manageability and control on HbA1c, the loading can vary from 10 percent and 50 percent for customers. “The parameters taken into account are Hb1Ac, duration of diabetes, weight, any other comorbidities, etc, to account for the short-term and long-term health risks,” says Singh of ACKO.

Ensure complete, transparent disclosures

Most health insurance companies require you to go through pre-policy issuance medical check-ups if you are over 45. So, health conditions such as impaired lipid profiles, diabetes and hypertension will show up in your health tests in any case. However, even if you are younger and health checks are waived off, it is in your interest to be upfront about any ailments – including diabetes – that you may have been diagnosed with.

Failure to make these disclosures can result in your claims being rejected. Health insurers can do so even if, say, your claim is unrelated to your diabetes. Worse, the company could even cancel the policy on the grounds that concealing health information constitutes a breach of contract.

(The writer is Preeti Kulkarni.)

TOP

How hospitals should tackle insurance disputes to ensure patient care in India – Healthcare Radius – 10th November 2024

In India, the relationship between hospitals and insurance companies is a complex one. While insurance offers financial relief to patients, it also brings about its own set of challenges—especially when disputes arise over what is covered, how claims are handled, and when payments are made. These disputes can delay treatment, frustrate patients, and put hospitals in a difficult position. Let me break down how hospitals are managing these issues and why it's so crucial for both hospitals and patients.

Why health insurance is booming in India

Over the last few years, health insurance has seen massive growth in India. This is thanks to a mix of private insurers and government programs like Ayushman Bharat. More people now rely on insurance to cover their medical costs, which means hospitals are constantly dealing with different policies and rules for each patient.

However, insurance in India is still not as straightforward as we'd like. Many policies come with limitations. For instance, pre-existing conditions, certain surgeries, or specialized treatments might not be covered or could have a waiting period before coverage kicks in. Naturally, this leads to disagreements between hospitals and insurers over what should and shouldn't be paid for.

Common disputes hospitals face with insurers

There are several types of disputes that regularly crop up between hospitals and insurance companies. Here are a few of the big ones:

Pre-authorization Delays: Hospitals often need permission from insurers before starting certain treatments. This can be a real issue, especially in emergency situations, where any delay can affect patient care. Hospitals must jump through hoops to get these approvals, adding to the overall complexity.

Claim Denials: Sometimes insurers deny claims, arguing that a particular treatment wasn't necessary or doesn't fall under the patient's policy. Hospitals then have to go back and forth, providing medical justification for the treatment and ensuring they get paid.

Payment Delays: Even when a claim is approved, it doesn't mean the hospital will get the payment quickly. Delayed payments can hurt a hospital's ability to function smoothly, as they rely on steady cash flow to pay for staff, medical equipment, and supplies.

Partial Payments: Some insurers may only cover part of the bill, leaving the hospital to either absorb the remaining cost or ask the patient to pay the difference. This can be especially tough for patients who aren't in a position to cover these unexpected expenses.

Coverage Exclusions: Many insurance policies have exclusions, meaning they won't cover certain treatments or procedures. Patients often aren't aware of these exclusions, leading to disputes when the hospital charges for something the insurance company won't pay for. Hospitals then have to either negotiate with the insurer or explain to the patient why they're responsible for the uncovered amount.

How hospitals are (or should be) dealing with these challenges

To tackle these issues, hospitals have developed a few strategies that help manage insurance disputes without affecting patient care too much.

Pre-admission Counseling: Many hospitals now have dedicated insurance desks where patients are informed about their coverage before being admitted. This helps avoid surprises down the road. By explaining the extent of their coverage and any out-of-pocket expenses upfront, hospitals can manage expectations better and reduce delays.

Asking for Policy Documents in Advance: Hospitals are increasingly asking for patients' insurance policy documents before treatment begins. This allows their in-house teams to verify coverage, exclusions, and other terms early on. By doing this, hospitals can prevent disputes and make sure both the patient and hospital are clear about what is and isn't covered.

Dedicated TPA Teams: Hospitals often have Third Party Administrators (TPAs) working with them to handle insurance claims. These TPAs act as middlemen between hospitals and insurance companies. Having a dedicated TPA team ensures all the paperwork is done right, which helps avoid disputes and speeds up the approval process.

Dispute Resolution Teams: Some hospitals have set up specific teams to handle insurance disputes. These teams are made up of healthcare professionals, legal experts, and claims staff who work together to sort out any disagreements with insurers. They negotiate, provide medical explanations, and ensure the hospital gets fairly compensated.

Partnering with Legal Experts: For more complicated cases, hospitals often bring in legal advisors who specialize in healthcare and insurance law. These experts help interpret the fine print of insurance policies, ensuring hospitals follow all the necessary regulations and avoid legal pitfalls.

Patient Education: Hospitals are taking a more active role in educating patients about their insurance. By explaining things like exclusions, co-payments, and deductibles in simple terms, hospitals can help patients avoid misunderstandings. Some hospitals even help patients file their claims or appeal denials to make the process smoother for them.

Government Support and Regulation: The Indian government has introduced schemes which have their own set of rules for insurance claims. Hospitals that work with these government programs follow specific guidelines to avoid disputes. However, more regulation is still needed in the private insurance sector to ensure that hospitals and insurers are on the same page, which could reduce disputes in the future.

The effect on patient care

Despite all these efforts, insurance disputes can still affect patient care. If there's a delay in getting approval from an insurer, the hospital might have to hold off on treatment, or in some cases, ask the patient to pay upfront and seek reimbursement later. Both options put extra stress on patients, especially when they need immediate care.

Hospitals also face their own challenges. Waiting for payments or dealing with denied claims can strain their finances, making it harder to invest in things like new technology, additional staff, or expanding their facilities. Hospitals are constantly balancing the need to provide top-notch care with the reality of running a sustainable business.

Conclusion

Hospitals in India are learning to manage insurance disputes more effectively, but there's still a long way to go. The key to navigating these challenges lies in building better communication between hospitals, insurers, and patients. By educating patients, improving claims processes, and working closely with TPAs and legal advisors, hospitals can reduce the number of disputes and ensure that patients get the care they need without unnecessary delays.

In the future, more collaboration between the healthcare and insurance sectors, along with stronger government regulations, could help make the system smoother for everyone involved.

(The writer is Dr. Shashank Chaudhari.)

TOP

Port bank-based health policy – Financial Express – 11th November 2024

Many banks collaborate with insurance companies to provide health insurance policies to their customers. These bank-based policies, which are typically group policies, are designed to cover a large pool of customers.

Since these are group health plans with little room for personalisation, these often come at a discounted rate. However, these policies do not have any room for customisation because they are designed for a group. These policies come with standard room rent caps, sub-limits and certain specific exclusions. So they may not cater to your individual needs.

Then there is the risk of termination of the policy by the bank. This can happen if the bank decides to stop its collaboration with the insurance company or it is acquired by another bank. This could leave policyholders without any health insurance coverage. If they decide to buy a new plan with another insurer, they may lose all the accumulated benefits and may have to go through the waiting period again. To overcome these limitations, one can explore retail health insurance plans instead of bank-based ones.

Porting bank-based policy to retail insurance

The good news is that you can port your ongoing bank-based policy to a retail insurance plan. As per the new regulations, policyholders can port, or transfer, their bank-based group health insurance policies to individual retail health plans without losing accumulated benefits. So, if you have already served part of your waiting period, or the entire waiting period, under your current group policy, your new policy would also consider that waiting period to be already served.

To make the switch, you have to inform your insurer at least 45 days before your bank-based policy expires. You will need to furnish relevant documents including your current insurance plan and your medical history. The new insurer will use this information to assess your application and will make a decision about your porting request within 15 days. If your request is approved, you can avail of continuous coverage with all benefits being carried forward.

Porting an existing policy is beneficial for you, especially if you are someone with pre-existing conditions. You get broader coverage and more customisation, choose add-ons like outpatient coverage, consumable cover, reduced waiting periods, and even coverage for pre-existing conditions to further customise the policy. You can also choose plans with no room rent capping and no sub-limits, and can even get plans that cover your entire family. Retail plans also offer you more control on how much you pay while buying the policy and while making the claim. You can do so by managing deductibles, co-payments, and room rent limits.

Another factor that sets apart retail plans from bank-based plans is the option of lifetime renewability which ensures that you are covered throughout your life, unlike group plans which may terminate if the bank discontinues them. Also, you have the option of covering pre-existing conditions and tailor the coverage as per your individual needs.

(The writer is Siddharth Singhal.)

TOP

In a boon, insurance opens up to an unserved sector: Neurodivergent care – The Economic Times - 10th November 2024

Santosh V (name changed), a professional, had to struggle to get a standard health insurance cover for his autistic child with companies rejecting the proposal on underwriting grounds. When finally he did manage to find a company that would accept the proposal, he found that some of the key costs related to autism treatment would not be covered. One in a hundred kids are estimated to have autism spectrum disorder - a neurodivergent condition where brains process information differently than most people. This is a condition that can be treated through behavioural, occupational and speech therapy. While treatments are available, a major challenge for parents is managing the costs.

Insurers face challenges in extending treatment for pre-existing conditions. Unlike hospitalisation, consultation coverage lacks standardisation in procedures and fees. Additionally, insurance relies on distributing risks among large numbers, making volume essential for viability. Therapies for neurodivergent disorders can be costly and place a heavy financial burden on families. While physical health conditions have long been covered by insurance, neurodivergent disorders are only now being included. The insurance regulator has mandated companies to offer coverage for previously uninsurable groups. The govt has also launched the Niramaya Health Insurance Scheme that provides up to Rs 1 lakh in coverage for individuals with autism, cerebral palsy and multiple disabilities.

Bajaj Allianz General Insurance (BAGIC) offers coverage for neurodivergent with coverage including therapy, medication and social accommodation. "To make these policies widely viable, collaboration among insurers, healthcare providers and regulatory authorities is essential. Such partnerships can help create fair, well-designed coverage options that not only reflect the realities of neurodivergent care but are also affordable. Greater awareness about neurodivergent conditions and their healthcare costs will further drive the need and support for these specialised policies," said Tapan Singhel, MD & CEO, BAGIC.

Star Health's Star Special Care policy is tailored for children and young adults (aged 3-25) with autism. It covers room, nursing, emergency ambulance, and post-hospitalisation costs, along with modern treatments. It provides coverage for therapies like behavioural, speech, occupational and botox injections. "Our aim is to expand health insurance coverage to unserved segments, whether it's senior citizens, cancer patients, or individuals with autism or special needs. Covering these groups requires special products, which require volume to be viable. GST waiver on health insurance would make these covers affordable and increase its appeal. Additionally, employer-provided insurance can be customised to include such treatments," said Anand Roy, CEO, Star Health and Allied Insurance.

TOP

Out-of-pocket expenditure in India decreasing amid govt's healthcare push – Siasat – 10th November 2024

The out-of-pocket expenditure (OOPE) by the common people on health in India is decreasing, largely due to increased government investment and an improved public healthcare framework, the Centre said on Sunday.

The National Health Accounts (NHA) data for 2021-22 reveals a positive trend.

As per the data, between 2014-15 and 2021-22, government health expenditure (GHE), as a percentage of GDP, rose from 1.13 per cent to 1.84 per cent. Additionally, GHE's share of overall government spending grew from 3.94 per cent to 6.12 per cent, reflecting a robust commitment to public health. During the same period, per capita health spending

tripled from Rs 1,108 to Rs 3,169, according to a statement by the Ministry of Health and Family Welfare. "This increase allows the government to strengthen public healthcare infrastructure, making services more affordable and accessible to the public, thereby directly reducing OOPE," it added.

OOPE in healthcare refers to the money people pay directly from their own pockets for medical services, such as doctor visits, medicines, and hospital stays. Social Security Expenditure on healthcare, including government-funded health insurance and social health programmes, rose from 5.7 per cent of total health expenditure (THE) in 2014-15 to 8.7 per cent in 2021-22.

"This expansion protects individuals from catastrophic health expenditures and lowers their OOPE (NHA 2021-22)," said the government. Programmes like Ayushman Bharat, along with various state-level health insurance schemes, have provided insurance coverage to economically vulnerable populations. This reduces their reliance on personal finances for healthcare, contributing to the decline in OOPE. According to the government, the decline in OOPE makes healthcare services more affordable, encouraging individuals, especially in rural areas, to seek medical care without financial worry. This leads to more equitable access to healthcare across various socio-economic groups.

"Reduced OOPE allows the public healthcare system to cater to a broader population base, distributing healthcare resources more equitably and strengthening the overall system to handle increased demand," said the government. The decline in OOPE and strengthened public healthcare funding align with India's long-term goal of achieving universal health coverage. With ongoing investments, the nation moves closer to a system where healthcare access is a right rather than a privilege.

(The writer is Neha Khan.)

TOP

Expanding healthcare for India's elderly: A new phase for PM-JAY – The Pioneer – 9th November 2024

India is home to a significant elderly population, with approximately 138 million people aged 60 and above, including more than 10 crore individuals over the age of 70. This segment of the population has unique and pressing healthcare needs. As people age, they are increasingly susceptible to multiple chronic conditions that require specialised care and consistent medical attention. According to the Longitudinal Ageing Study of India (LASI), every fourth Indian over 60 years and every fifth Indian over 45 years reports poor health. Additionally, 75 per cent of the elderly have one or more chronic diseases, and 40 per cent experience disabilities. 1 in 4 elderly individuals has multi-morbidity, with diabetes and cancer rates rising, particularly in urban areas.

As per the Global Health Estimates data of 2019, non-communicable diseases such as ischemic heart diseases, stroke, and diabetes are leading causes of disability-adjusted life years (DALYs) lost among individuals over 60. This highlights the growing need for specialised treatments and consistent medical attention for age-related disorders. The rising prevalence of hypertension, heart disease, and respiratory issues among the elderly increases the need for hospitalisation and specialised care, placing immense pressure on healthcare providers and overwhelming the elderly and their families. The financial burden associated with recurrent hospital visits and treatments is a significant challenge.

Also, India's current medical inflation rate, standing at approximately 14 per cent which worsens the healthcare difficulties confronting the elderly. Escalating medical costs, including those for hospitalisation, doctor consultations, and medications, make it increasingly challenging for this

vulnerable population to access necessary care. Inflation, coupled with the high cost of living, leaves many elderly individuals struggling to afford even basic healthcare services. Additionally, as medical inflation continues to rise, insurance companies are compelled to cover higher expenses for medical procedures and treatments. This, in turn, results in increased premiums for policyholders. For many elderly individuals, these higher insurance costs compound the financial burden, deepening the overall healthcare affordability crisis.

While the expansion of the Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB PM-JAY) is a significant step towards improving healthcare access, covering an additional 6 crore individuals from 4.5 crore families, and focusing on seniors aged 70 and above, several challenges persist in the insurance market. Current insurance products are limited, particularly for individuals over the age of 70. Pre-existing diseases (PED) such as diabetes, cardiovascular conditions, and cancer often result in waiting periods or outright denial of coverage. Furthermore, insurance premiums for senior citizens are substantially higher due to the associated health risks, making insurance unaffordable for many. Denial of insurance based on PED, combined with exorbitant premiums, often forces elderly individuals to rely on personal savings or government schemes, leaving them without adequate financial protection against serious illnesses.

According to the United Nations Population Fund (UNFPA), India's elderly population is projected to nearly triple by 2050, reaching 320 million. This demographic shift will necessitate more comprehensive solutions to safeguard the well-being of the nation's senior citizens. While the expansion of PM-JAY is a welcome development, it does not fully address the broader geriatric needs of India's aging population.

AB PM-JAY is largely limited to inpatient care. The scheme does not cover outpatient services, which make up a considerable portion of healthcare costs. Research published in the International Journal of Preventive Medicine shows that outpatient care accounts for 40-80 per cent of health expenditures in India. Consequently, even with the enhanced insurance coverage, many individuals may continue to face out-of-pocket expenses for treatments that do not require hospitalisation.

There is an urgent need to expand coverage to include services such as long-term care, outpatient services, mental health support, palliative care, and rehabilitation, which are essential for ensuring the well-being of the elderly. Additionally, the government must focus on reducing financial barriers to healthcare, such as high insurance premiums, and ensuring the inclusion of PED coverage without long waiting periods.

(The writer is Ashish Panghal.)

TOP

Take private cover with Ayushman Bharat – Financial Express – 9th November 2024

Senior citizens above 70 years should combine Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) with a private health insurance plan for a comprehensive cover. They can use the government cover for primary hospitalisation. And for expensive treatments that go beyond Rs 5 lakh or prolonged hospitalisation, make use of a private cover.

The AB-PMJAY provides a base floater cover of Rs 5 lakh for all senior citizens above 70 years, which is beneficial to cover primary and tertiary expenses. To supplement the cover, senior citizens should consider private plans of at least Rs 5 lakh to cover additional expenses such as outpatient treatments, specific diseases, or higher room categories as health expenses tend to increase with age. This combination will ensure comprehensive coverage and address

both essential and advanced healthcare needs. Moreover, they can look at a top-up which is a cost-effective strategy to expand coverage for expensive treatments. This can help them avoid high premiums for comprehensive coverage, while ensuring they are covered for substantial expenses if need be.

Siddharth Singhal, head, Health Insurance, Policybazaar.com, senior citizens are vulnerable to high-risk illnesses, treatments for which can be very expensive and may go beyond Rs 5 lakh. "To ensure more comprehensive coverage, seniors can combine it with a private health insurance policy that covers additional healthcare expenses, including any specialised services for expensive treatments," he says.

Added advantages

Unlike private insurance, there is no waiting period for any pre-existing conditions in AB-PMJAY and the coverage starts immediately after enrolment. Aadhaar is the only document needed for enrolment in the scheme. If there are two members above 70 years in a family, then the Rs 5 lakh coverage will be shared between them. Senior citizens will have to generate an Ayushman Vaya Vandana card to enroll. Separate enrolments are not needed for people above 70 years in a family. After enrolling the first family member aged 70 years or above, the names of other family members above 70 years can be added under the scheme using the 'add member' feature.

Senior citizens already covered under public health insurance schemes like the Central Government Health Scheme will have the option to either continue with their existing scheme or opt for AB-PMJAY. Those under private health insurance policies or the Employees' State Insurance scheme will also be eligible to avail of the benefits of AB-PMJAY. Once a senior citizen chooses the AB-PMJAY scheme and surrenders the existing government health insurance scheme, he cannot switch back as it is a one-time option and cannot be reversed. However, residents of Delhi and West Bengal cannot apply for the scheme as the state governments had not signed up for the scheme.

Limitations of AB-PMJAY

As the treatment is restricted to empanelled hospitals only, senior citizens may face limitations, especially in case of any emergency. Moreover, there is limited participation of major private hospitals in the scheme and not all hospitals offer every speciality. These factors can limit the usage of AB-PMJAY.

It also does not have a reimbursement clause. Most private health insurance policies include reimbursement clauses, where the insured can go to non-network hospitals and claim reimbursement of the bills up to the insured limit. So combining AB-PMJAY with a private health insurance plan can provide flexibility in choosing healthcare providers. Under AB-PMJAY, all admissions will be limited to general wards. In contrast, a private health cover will have the option of a private room as per the terms and condition of the policy.

To maximise benefits, senior citizens should understand the coverage limits and exclusions of both AB-PMJAY and a private cover. Rakesh Goyal, director, Probus, an insurance broking firm, says the insured can use the government cover for surgeries and major ailments, while reserving their private insurance for conditions not fully covered by PMJAY. "Keeping track of claim procedures and ensuring timely renewals of both policies will enhance benefits."

(The writer is Saikat Neogi.)

TOP

Ways AI and data analytics are transforming India's health insurance sector - Tech Circle – 8th November 2024

The health insurance market in India is projected to reach $23.8 billion by 2028. As the country's digital economy approaches the $1 trillion target, the insurance sector is digitizing rapidly, moving away from traditional sales methods. It is adopting a "phygital" model, blending physical and digital services to enhance customer experience. Key insurance processes, like policy issuance, claim settlement, and pre-medical check-ups, are being digitized, providing clients with a seamless and faster experience.

Technologies such as machine learning, artificial intelligence, automation, and data analytics are revolutionizing the industry, transforming operations to better serve customers.

Today's Insurance companies are leveraging technologies like artificial intelligence and data analytics to collect and analyze vast amounts of client data, from medical histories to current ailments and lifestyle habits like food and exercise regimens, data is used to create health insurance plans tailored to each individual's needs. Customers pay premiums according to their risk profile thanks to personalized risk assessments made possible by AI and data analytics. With customisation now possible, users feel their needs are being met, leading to greater customer satisfaction.

(The writer is Sumeet Aggarwal.)

TOP

SURVEY AND REPORTS

East India better insured to take on retired life than other regions: IRIS – Business Standard – 12th November 2024

People in Eastern India are better prepared to take on retired life than their counterparts in the country's North, South or West, thanks to their enhanced saving propensity for their future, a study reveals. According to the findings of the fourth edition of the India Retirement Index Study (IRIS), conducted by Max Life Insurance Company in partnership with KANTAR, a marketing data and analytics company, East India outshone other regions, scoring an impressive 54 on the Retirement Index, significantly higher than North and South India, both at 48, and West India at 49, as well as the national average of 49.

India retirement index is the degree to which Indians feel prepared for retired life on a scale 0 to 100. It is based on how prepared the country is for a healthy, peaceful and financially independent post-retirement life, surveyors explained. The survey, according to officials, is aimed at understanding the retirement readiness of urban India, with insights into awareness, aspirations and challenges of consumers during retirement and its planning. The study further revealed that about 72 per cent of East Indians are investing specifically for retirement even as 82 per cent of the region's investors were confident about maintaining their health through retirement. The corresponding retirement investment figures for West, North and South India stood at 66 per cent, 60 per cent and 58 per cent respectively, officials said.

The investment figures for retirement in the eastern region rose by a significant 5 per cent compared to 67 per cent last year and life insurance remained the preferred financial product, with 68 per cent choosing it for retirement security, the IRIS 4.0 study revealed. Notably, East India also led in National Pension System (NPS) ownership, with nearly one in four holding an NPS account. Financial product awareness among the respondents from the region was also high, with 97 per cent of individuals aware of life insurance and about 90 per cent having awareness of health insurance, the study found.

The East India survey was conducted across six urban hotspots Ranchi, Jamshedpur, Patna, Cuttack, Guwahati and Kolkata during June-July this year amid respondents belonging to the age group of 25-65 years, officials said, while claiming that the country-wide survey was conducted across 28 cities. The IRIS findings, highlighting a strong shift in retirement readiness among the respondents in East India, claimed that around 56 per cent advocated for retirement planning before turning 35 years of age and that 94 per cent among those over 50 expressed regret for not starting earlier.

Retirement planning is becoming increasingly important for Indians, especially given rising life expectancy. It's encouraging to see people in the region prioritizing financial stability, health, and

emotional well-being by starting to plan early, said Rahul Talwar, EVP & Chief Marketing Officer, Max Life.

On the issues of retirement-related anxieties, the study finds that basic needs and child support decreased in the region with fewer people worried about meeting basic requirements (62 per cent) and children's futures (64 per cent). Health awareness, the study claims, remains strong in the East with 82 per cent of respondents confident about staying healthy through retirement. An increase in regular health check-ups also demonstrated a proactive approach to health management, the findings stated.

However, despite the robust emotional security expressed by people in the region, with nearly 95 per cent respondents expressing confidence in the support of family and friends during retirement, feelings of loneliness persisted among a significant section with some 64 per cent of people expressing concerns about it, and 76 per cent sharing worries about changing environmental factors, such as global warming and pollution, which could affect retired life. In East India, one in every four individuals still feels that during retired life, they will have to depend on other family members, the IRIS data claimed.

The survey also revealed that as many as one in every three East Indians prioritized medical needs and children's future in their retirement plans with an overwhelming majority of respondents wishing to live close to their children post-retirement, reinforcing the importance of familial support even within nuclear households. The findings offer a deeper understanding of evolving retirement needs and priorities, and we believe they will inspire a more proactive approach to holistic retirement planning across the country, Talwar maintained.

These findings, officials believe, will guide the insurance sector to create tailored, innovative solutions that address both the financial and health aspects of retirement. Moving forward, our focus will be on building more awareness around early planning, enhancing retirement-specific products, and driving initiatives that foster comprehensive well-beingfinancial, physical, and emotionalduring the golden years, Talwar added.

TOP

New biz premium of life insurers rises 13% in October, shows data - Business Standard – 11th November 2024

Life insurance companies reported a 13.16 per cent year-on-year (Y-o-Y) growth in new business premium (NBP), totting up Rs 30,347 crore in October, even as the number of policies sold saw a sharp decline. The growth was largely driven by strong performance from private sector life insurers.

According to data from the Life Insurance Council, state-owned Life Insurance Corporation (LIC) of India saw a 9.48 per cent Y-o-Y increase in premiums, reaching Rs 17,131 crore, while private insurers reported an 18 per cent Y-o-Y rise in NBP to Rs 13,216.51 crore.

As of October 1, revised surrender value norms came into effect, requiring life insurers to pay an enhanced special surrender value to policyholders after the first policy year, provided the customer has paid one full year's premium. Previously, such payments were not made to customers surrendering their policies in the first year.

While insurers had requested an extension from the insurance regulator to implement the new norms, no extension was granted. Despite this, most companies managed to implement the new regulations for about 80 per cent or more of their products.

Analysts believe that growth in term insurance and unit-linked insurance plans likely supported the rise in premiums, despite the new surrender value norms coming into effect in October 2024. According to a Nuvama report, growth in October 2024 was affected by the implementation of the new surrender value regulation, though it remained stable. "In the coming months, growth may fluctuate as the industry finds its balance," the report said.

Data reveals that for LIC, the individual premium segment saw a 9.4 per cent Y-o-Y drop, adding up to Rs 3,712.62 crore, while group premiums increased by 15.5 per cent Y-o-Y to Rs 13,267.93 crore. Group yearly premium collections surged by 140.75 per cent to Rs 150.54 crore. Meanwhile, SBI Life Insurance, the largest private sector life insurer, saw a slight 3.8 per cent Y-o-Y decline in NBP to Rs 2,648.38 crore, while HDFC Life recorded a 28 per cent Y-o-Y growth, reaching Rs 2,799 crore.

Other major insurers, including ICICI Prudential Life, Bajaj Allianz Life Insurance, and Max Life Insurance, posted Y-o-Y growth of 25.29 per cent, 21.46 per cent, and 15.3 per cent, respectively. During the April-October period, the life insurance industry's NBP grew 18.56 per cent Y-o-Y to Rs 2.19 trillion. LIC's premiums grew by nearly 22.5 per cent Y-o-Y to Rs 1.32 trillion, while private sector insurers saw a 12.9 per cent Y-o-Y increase in premiums, totalling Rs 86,880 crore. The number of policies sold in October 2024 stood at nearly 1.2 million, a 46 per cent drop compared to the previous year, largely due to the revised surrender value norms. During the April-October period, the number of policies sold decreased by 5.42 per cent Y-o-Y to 14.5 million, compared to last year.

(The writer is Aathira Varier.)

TOP

INSURANCE CASES

Insurance firm, bike owner told to pay Rs 23 lakh compensation – The Tribune – 10th November 2024

The Motor Accident Claims Tribunal (MACT) here has directed an insurance company, rider or owner of a motorcycle to pay compensation of Rs 23.20 lakh to three minor children of Dharmender Singh, a resident of Uttar Pradesh, who died in an accident two years ago.

All three minor children had filed a claim petition under Section 166 of the Motor Vehicles Act represented through their father's sister. The claimants said that on September 30, 2021, their father was going from Baltana towards Nabha Sahib village while riding pillion on a motorcycle. On the way, they reached near K Area, Zirakpur. At that time, the rider of the motorcycle tried to overtake another bike, which was going ahead of them, without caring for the traffic coming from behind.

While doing so the rider brought his motorcycle in the middle of the road and it was hit by a truck coming at fast speed from behind. After being hit Dharmender fell on the road and got crushed under the rear tyre of the truck. After the accident, the driver of the truck fled away from the spot.

They said that the accident took place due to the negligence of the rider of the motorcycle and driver of the truck. Due to the accident their father died in a hospital of Dera Bassi. They said their father was 29 years of age at the time of his death and was working as a contractor and used to earn Rs 30,000 per month.

The claimants have sought compensation of Rs 75 lakh along with interest @ 12% per annum from the date of filing of claim petition till its realisation. After hearing the arguments the tribunal held the claimants entitled to receive compensation of Rs 23.20 lakh along with interest in equal shares. The tribunal said that the driver, owner and insurer of motorcycle were jointly and severally liable to pay the amount of compensation.

Accident happened during overtaking
The claimants said that their father was going from Baltana towards Nabha Sahib village while riding pillion on a motorcycle. On the way, they reached near K Area, Zirakpur. At that time, the person driving the motorcycle tried to overtake another bike without caring about the traffic coming from behind. While doing so the rider brought his motorcycle in the middle of the road and it was hit by a truck coming at fast speed from behind.

(The writer is Ramkrishan Upadhyay.)

TOP

PENSION

EPF, EPS contribution limit may be hiked: Impact on salary explained – Business Standard – 13th November 2024

The central government may soon raise the wage ceiling under the Employees' Provident Fund (EPF) scheme from Rs 15,000 to Rs 21,000, impacting contributions towards EPF and the Employees' Pension Scheme (EPS). This adjustment, reported by The Economic Times, is seen as a step towards improving social security for workers by broadening EPFO coverage.

The current ceiling has remained unchanged since it was last updated in 2014, when it was doubled from Rs 6,500 to Rs 15,000. This adjustment, if implemented, will lead to changes in the contribution amounts both by employees and employers towards retirement and pension savings.

How will a higher EPF wage ceiling affect your salary?
A higher wage ceiling will influence both the benefits and deductions within your salary structure. Here's a breakdown:

Benefits for employees
Enhanced pension payouts and savings: "Due to the revised wage ceiling, contributions to the EPS will increase, which could lead to higher pension payouts at retirement. Additionally, contributions towards EPF will increase, which bolsters the retirement corpus," says Kinjal Champaneria, Partner at Solomon & Co.

Improved social security: With higher contributions channelled into the provident fund schemes, employees will enjoy a more secure financial safety net, aligning with the EPF Act's objectives.

Drawbacks for employees
Increased salary deductions: "Under Section 6 of the EPF Act, the employee's contribution to EPF is fixed at 12% of basic wages. With the raised wage ceiling, employees will face higher salary deductions, reducing their net take-home salary. This could strain employees earning close to the wage ceiling, as the mandatory contributions would increase," explains Champaneria.

Consider an employee earning a basic salary of Rs 23,000. Under the proposed Rs 21,000 wage ceiling, the EPF contribution structure would adjust as follows:

Employee's EPF contribution: The employee contributes 12% of Rs 23,000, equating to Rs 2,760 per month.

Employer's EPF and EPS contribution:
Total employer contribution remains at 12% of Rs 23,000, or Rs 2,760.

Of this, 8.33% of Rs 21,000 (Rs 1,749) goes towards the employer's EPS contribution, while the remaining 3.67% (Rs 1,011) contributes to the EPF.

"As the EPS contributions increase due to the new wage ceiling, EPF contributions decrease, enhancing the pension corpus over time," says Champaneria.

This formula applies with the wage ceiling in effect, impacting the final pension based on service tenure and average earnings.

What will you earn at the time of retirement if the ceiling is revised?
If you are 35 years old now, plan to retire at 58, and earn a monthly salary of Rs 23,000, here's what you can expect to receive as your pension after retirement:

1. Years of service: 23 years (from age 35 to 58)
2.Eligible salary: Rs 21,000 (the revised wage ceiling)

The pension amount under EPS is calculated as:
Pension = (years of service × pensionable salary) / 70

So, the estimated monthly pension at age 58 would be approximately Rs 6,900, with the increased ceiling limit. Without the increased ceiling limit, you will earn approximately Rs 4,929 per month.

The increase falls under the Employee Provident Fund & Miscellaneous Provisions Act, 1952 (EPF Act), enabling the government to revise the wage ceiling via official notification. The specific ceiling for EPF and EPS contributions is outlined in Paragraph 26A of the Employees' Provident Fund Scheme, 1952, which defines the maximum monthly wage for mandatory contributions.

(The writer is Surbhi Gloria Singh.)

TOP

EPFO reports 7.8% increase in claims settled, 7.6% growth in subscribers: Labour Ministry – Financial Express – 11th November 2024

The number of contributing organisations to Employees' Provident Fund Organisation (EPFO) in FY24 grew 6.6% on year to 7,66,000, and the number of contributing members rose 7.6% to 73.7 million. The EPFO also saw an increase of 55.4% in realising arrear dues to Rs 5,268 crore from over the previous year in FY24 while the number of claims settled rose 7.8% on year. The data was presented during the 109th Meeting of the Executive Committee of the Central Board, EPFO, according to an official statement.

During the meeting, which was chaired by Labour Secretary Sumita Dawra, the committee deliberated several proposals related to information technology, administrative, financial, and related aspects for good governance in EPFO. "It was appreciated that EPFO has relaxed the criteria for auto-settlement of claims with respect to the ceiling as well as the categories of admissible grounds for claim. Other reforms related to streamlining processes, making it easier for members to get their claims processed, were also taken up," the release said.

The committee approved the hiring of two Chartered Accountant firms for the preparation of Annual Financial Statements of EPFO, and to facilitate the automation of the process of preparation of financial statements. Moreover, the committee considered the draft 'New Compassionate Appointment Policy, 2024,' with a goal to bring relief to the dependents and wards of many employees of EPFO, who had unfortunately died in harness, many of which had occurred during the Covid pandemic period, the release said.

Additionally, steps to enable centralized pension payment as well as the interventions in improving IT related software and hardware were discussed, and timelines for completion of overhaul of the IT system were noted.

TOP

GLOBAL NEWS

New Zealand: Insurance legislation updated to provide new consumer safeguards – Asia Insurance Review

New Zealand has modernised its insurance legislation with the passing yesterday of the Contracts of Insurance Bill and the Contracts of Insurance (Repeals and Amendments) Bill, providing consumers with significant new safeguards. The modernised insurance law will provide Kiwis with confidence that they will be treated fairly by insurance providers, Commerce and Consumer Affairs Minister Andrew Bayly said in a statement.

"A secure insurance market is integral to New Zealand's economic success. It enables consumers and businesses to access finance and gives them the assurance to grow and invest," Mr Bayly said. He added, "Importantly, consumers will no longer have to rack their brains and guess what information is relevant to their insurance policy.

"Under the outdated existing law, consumers must disclose any information that might influence a 'prudent insurer' — a term that is poorly understood by consumers and has led to insurers voiding claims when consumers accidentally or unknowingly fail to disclose information. "Now, the onus is on insurers to ask the right questions and consumers must simply provide honest answers.

"This and other changes, such as requirements for insurers to write policies in plain language and pay claims within a reasonable time, improves the fairness and clarity of our insurance law. "Following select committee submissions, the Bill has been updated to safeguard Kiwis' access to life and health insurance if they have taken a genetic test.

"Genetic testing is a valuable, emerging technology that can unlock significant health and productivity benefits. However, there are international examples of insurers limiting cover, or increasing premiums, due to genetic testing results. "While we don't believe this is happening regularly in New Zealand now, the Bill includes provisions which mean the Government can, if needed in the future, regulate the use of genetic testing results by insurers.

ICNZ's response

Mr Kris Faafoi, chief executive of the Insurance Council of New Zealand (ICNZ), said, "We welcome the passing of the Contracts of Insurance Bill and strengthen New Zealand's financial wellbeing. It's long overdue and will benefit consumers and insurers. "The new legislation tidies up New Zealand's mishmash of outdated insurance laws into a single framework to support well-functioning insurance markets. It also brings New Zealand in line with international best practice."

Until the modernised legislation takes effect, insurance contracts are governed by various existing Acts and case law. Some of the Acts are over 100 years old. Mr Faafoi said, "The legislation strikes a balance between strengthening protections for consumers while promoting fairness, certainty and sustainability in the insurance sector.

Still a lot to do

"We know there's still a lot to do as the insurance industry works toward putting in place the changes required under the legislation. "Insurers have up to three years before the legislation comes into effect and updating their systems and procedures in that time will be a mammoth task while also running their everyday operations and complying with their regulatory obligations. "We will work closely with the government and regulators to ensure the new legislation and other regulatory reforms the industry is facing are done in a coordinated way with realistic timeframes that benefit both consumers and the industry as a whole.

"We are focused on getting on with the job and ensuring there is clarity and certainty for consumers and insurers parties for the long term. A sound and sustainable insurance market is essential to building a stronger economy and supporting the financial and economic wellbeing of New Zealanders."

TOP

New Zealand: Non-life insurance sector expected to be robust over short term - Asia Insurance Review

Non-life premium growth is expected to remain robust over the near term and on par with prior years, when New Zealand's non-life gross written premiums recorded average annual growth in the mid- to high single digits, says AM Best.

The Best's Market Segment Report, "Market Segment Outlook: New Zealand Non-Life Insurance," points out that in 2023, the industry saw significant rate adjustments following the Auckland Anniversary Weekend floods and Cyclone Gabrielle, which occurred early in the year and currently remain the catastrophes with the two largest non-earthquake losses in New Zealand's history.

Rate adjustments were a key driver of non-life premium growth that exceeded general inflation, which has declined steadily from its peak of 7.3% in the second quarter of 2022, to 2.2% in the third quarter of 2024. "The property and motor segments recorded the largest rate adjustments, reflecting the growing exposure to natural catastrophes and rising repair costs caused by ongoing inflationary pressure and supply chain disruptions," said Victoria Ohorodnyk, director and head of analytics for Southeast Asia, Australia and New Zealand at AM Best.

'Stable' outlook maintained for non-life market

AM Best is maintaining a 'Stable' outlook on the non-life insurance segment, citing solid premium growth supported by rate adjustments, particularly in the property, motor and commercial segments, despite a challenging economic environment.

The report also notes positive factors such as good capital buffers, which support insurers' ability to absorb some shocks from claims volatility, and robust investment yields amid high domestic interest rates, despite recent rate cuts.

Countervailing factors for this non-life segment outlook include New Zealand's increasingly volatile weather conditions, prompting tighter underwriting and greater reliance on reinsurance. Despite signs of stabilisation in the reinsurance segment, capacity constraints and higher costs may continue to affect primary insurers' earnings.

The report notes that the capital adequacy of New Zealand's non-life market remains robust. Insurers have successfully absorbed the impact of the 2023 major weather-related events, owing to the comprehensive reinsurance coverages in place. "To date, 2024 has been a relatively benign year from a catastrophe risk perspective, with fewer significant weather-related events than in prior years, easing some of the pressure on insurers' claims expenses and allowing them to build up their capital buffers," said Yi Ding, associate director, AM Best.

TOP

Singapore: Life market chalks up 23.5% growth in new business premiums in first 9 months - Asia Insurance Review

Singapore's life insurance industry recorded a total of S$4.3bn ($3.2bn) in weighted new business premiums for YTD3Q2024, an increase of 23.5% compared to the corresponding period last year, according to the Life Insurance Association, Singapore (LIA Singapore).

The growth underscores sustained demand driven by customers taking steps to protect their financial wellbeing with suitable insurance propositions, says LIA Singapore in a statement.

In the third quarter of this year, total weighted new business premiums increased by 18.2% to S$1.5bn compared to the corresponding quarter last year.

The growth was despite the unabated uncertainty in the global macro-environment reflected in continued economic volatility, inflation and geopolitical tensions.

New Business (Individual Life & Health) - Total Weighted Premium

Weighted basis	YTD3Q24 S$ m	YTD3Q23 S$ m	3Q2024 S$ m	3Q2023 S$ m	Year-on-Year Change	
					YTD3Q24	3Q
Single Premium	1,332.1	1,104.6	414.0	413.6	20.6%	0.1%
Annual Premium	2,976.6	2,385.6	1,122.6	886.9	24.8%	26.6%
Total	4,308.7	3,490.2	1,536.6	1,300.5	23.5%	18.2%
Source: LIA Singapore						

In-force premiums for Group Life & Health continue to show steady growth with a 13% increase in 3Q2024 from 3Q2023 to record a total of S$2.47bn to date. Increased uptake of annual premium policies shows greater prioritisation of getting better protected Despite the macroeconomic headwinds, demand for annual premium policies remained strong as the take-up of annual premium policies increased by 24.8% in YTD3Q2024 as compared to YTD3Q2023, amounting to S$3.0bn in total weighted annual premiums. On the other hand, single-premium policies increased by 20.6% in weighted premiums over the same period last year, totaling S$1.3bn for YTD3Q2024.

Financial Adviser (FA) Representatives – both independent and insurer-backed – led the charge in getting S$43.3bn sum assured in the first nine months of 2024, accounting for a notable 39.1% of the total amount of sum assured for YTD3Q2024. Tied Representatives added another S$37.0bn in sum assured, accounting for 33.5% of the total amount sum assured in the same period. The industry recorded a total of S$110.6bn in total sum assured during YTD3Q2024, expanding 4.8% over the corresponding period last year.

Non-par and linked policies record increased uptake

There was an increase in the uptake of non-par and linked products which accounted for 38% and 37% of the total weighted new business premiums respectively in 3Q2024 compared to 3Q2023. Non-par funds recorded total weighted new business premiums of S$1.64bn in YTD3Q2024 compared to S$1.31bn in the corresponding period last year, while linked policies experienced an increase of S$0.51bn in YTD 3Q2024 to reach S$1.58bn compared to S$1.08bn for the same period last year.

Par products contributed S$1.08bn in total weighted new business premiums for YTD3Q2024.

Integrated Shield Plans (IPs) are a stable cornerstone of health insurance coverage

In the first nine months of 2024, nearly 112,000 Singaporeans and Permanent Residents took up IPs. A total of 2.96m lives – approximately 71% of Singapore residents – are protected by IPs which provide coverage on top of MediShield Life.

Total new business premiums for individual health insurance for YTD3Q2024 amounted to S$381.2m, an increase of 18.7% compared to the same period last year.

Overall, IPs and IP rider premiums accounted for 87.0% (S$331.5m) and the remaining 13.0% (S$49.7m) comprised other medical plans and riders in YTD3Q2024.

Claims payouts

The life insurance industry paid out S$14.8bn to policyholders and beneficiaries in the first nine months of 2024, a 46% increase compared to the same period last year. Of this amount, S$13.4bn was for policies that matured. The remaining S$1.4bn was for death, critical illness or disability claims for more than 16,000 policies

Looking ahead

Mr Dennis Tan, LIA Singapore president, said, “Despite ongoing challenges, Singaporeans continue to take a long-term view as they continue to invest in addressing their protection needs and increase their financial resilience. It is heartening to note and speaks to the strong sense of self-reliance in Singapore.”

TOP

Bangladesh: More than 80% of life insurers seen as dragging their feet over settling claims - Asia Insurance Review

Thirty-one out of 36 (or more than 85%) life insurers have accumulated outstanding claims amounting to BDT36.43bn ($305m) over the past five years, according to data from the Insurance Development and Regulatory Authority (IDRA). The unpaid claims, due to 1.1m policyholders, were accumulated over five years until the second quarter of 2024 and represented 66.21% of the total claims during this period, reported the newspaper, The Daily Star.

IDRA data also show that the claim settlement rate among life insurers fell from 85% in 2020 to 72% in 2023. Officials and experts say that poor investment decisions, high agency commissions, excessive management costs, and unhealthy competition are to blame for the situation. An industry expert says that Bangladesh has more insurance companies than it needs. Excessive competition and a lack of management expertise.

IDRA spokesman Mr Zahangir Alam told The Daily Star that the regulator has two major options — appoint administrators or cancel the licences of errant insurers. But cancelling licences is seen as a harsh measure.

He said instructions have been given to recover unpaid claims by taking legal action against the directors who were involved in financial irregularities. IDRA has also appointed observers to several insurers with the worst settlement record. These insurers are also being pressured to secure new funding or dispose of assets. Bangladesh has over 80 insurance companies, including 36 life insurers.

TOP

Malaysia: Takaful association releases strategic transformation plan - Asia Insurance Review

The Malaysian Takaful Association (MTA) has officially launched the Hijrah27 framework, a strategic transformation plan with the core objectives of broadening public understanding of Islamic insurance and expanding its reach to underserved segments of the country. The goal is also for takaful to be the preferred Shariah-compliant protection choice in the country while seeking to enhance professionalism among takaful personnel and promote ESG.

The introduction of Hijrah 27 aligns MTA's mission with the goals of the Financial Sector Blueprint 2026 and the industry's Value-Based Intermediation for Takaful (VBIT) framework.

Hijrah 27 charts the future of the takaful industry. Its launch on 8 November signals a unified commitment to industry-wide growth and evolution for the framework that outlines the industry's roadmap for sustainable growth, broader accessibility, innovation, and impactful societal value.

At its core, the framework focuses on broadening public awareness of takaful and reaching out to underserved segments, including micro, small, and medium enterprises (MSMEs), enhancing professionalism among takaful representatives, and promoting initiatives aligned with ESG aspects.

Building on four decades of progress, Hijrah27 anchors the next phase of takaful industry growth on eight strategic thrusts, including digital innovation and strengthening regulatory governance. Hijrah27 addresses 19 key challenges spanning awareness, distribution, digital, product competitiveness, talent and ESG, identified through engagement with industry stakeholders and decision-makers.

MTA chairman Elmie Aman Najas said, "The takaful industry has progressed significantly over the past four decades, from establishing core principles and frameworks to developing its market presence and improving governance structures. The penetration rate has risen to an encouraging 20%, up from 15%, reflecting growing appreciation for takaful principles. In the last 10 years alone, takaful assets have more than doubled to MYR55.6bn ($12.7bn) from MYR23bn in 2014."

TOP

Thailand: Regulator and insurers suggest ways to keep medical insurance premiums affordable - Asia Insurance Review

The Office of the Insurance Commission (OIC) and the insurance sector have put forward proposals to rein in rising medical treatment costs, for a sustainable health insurance system.

The OIC has proposed the development of alternative health insurance arrangements to keep medical costs low, according to local media reports. Examples include allowing the insured to buy medicine from a pharmacy in the case of a minor illness or allowing patients to request a doctor to issue a prescription for them to buy medicine from a pharmacy.

In addition, a strategic plan for voluntary health insurance has been prepared to ensure that health insurance will be sustainable, instead of merely solving certain specific issues.

The OIC has also requested cooperation from the insurance industry to present new practices and products that can help keep medical expenses within acceptable limits, as well as to encourage the public to learn, understand, and use health insurance effectively.

Life insurers

In the life insurance branch, proposals raised to ensure that medical health insurance will be affordable include:

Set criteria for co-payments when policies are renewed by insureds with high claims;

Specify that the fees payable for surgery and medical procedures be set at a rate not exceeding 100% of the fee at the 90th percentile as specified in the Thai Medical Council's Medical Fee Handbook to curb medical fee increases;

Consider revising the criteria for general minor diseases (simple diseases) for children aged 3-5 years, who are more vulnerable than other age groups.

In this regard, the OIC says that the said practices have been set out in the Registrar's Order for approving the form and text of supplementary health insurance contracts. The business sector can comply with the criteria specified in the Registrar's Order.

Currently, the Thai Life Assurance Association is considering appropriate operational guidelines, including strategies or tools for additional cost control, and will present them to the OIC.

TOP

Taiwan: Regulator proposes amending rules on insurers' investments in interested parties - Asia Insurance Review

The Financial Supervisory Commission (FSC) has proposed relaxing restrictions on discretionary investment arrangements by insurance companies to invest in interested parties.

Financial holding companies in Taiwan count among their subsidiaries or affiliates several insurance companies as well as domestic securities investment trust and consulting enterprises. These group companies are subject to regulations on interested parties.

To bolster Taiwan's asset management sector, the FSC encourages life insurance companies to retain domestic asset managers to conduct discretionary investments of their funds.

In a statement, the regulator says that it has completed draft amendments to the "Regulations Governing Transactions Other Than Loans between Insurance Enterprises and Interested Parties" ('Regulations' for short), which will soon be announced.

Amendments

The gist of the amendments is:

1.Under existing regulatory provisions, when an insurance company intends to engage in discretionary transactions with interested parties, it may draw up internal operational rules with the concurrence of at least three-quarters of all directors present at a board of directors meeting attended by at least two-

thirds of all directors to give the managing department general authorisation to engage in those transactions according to the operational rules. The terms of such transactions may not be more favourable than those offered to other counterparties of the same category.

A proposed amendment allows the authorisation to extend to the management of discretionary transaction fees and commissions.

2.Under existing regulatory provisions, when an insurance company acquires (through investment) or disposes of an ETF issued by an interested party, and if the acquired or disposed amount exceeds 10% of the total beneficiary certificates issued by that ETF, the transaction amount shall be included in the total amount of the insurer's transactions with interested parties.

The proposed amendment stipulates that insurance companies investing in ETFs issued by stakeholders through discretionary transactions shall be exempt from including amounts exceeding 10% of the ETF's total issued certificates in the total balance of the insurer's transactions with interested parties, in accordance with the Insurance Act and other relevant regulations.

The FSC is inviting feedback on the proposed amendments.

TOP

COI TRAINING PROGRAMS

Mumbai – November 2024 – January 2025

Sr. No	Program Name	Program Start Date	Program End Date	Details	Registration Link
1	Managing Motor TP Claims and Controlling Frauds	03-Dec-24	04-Dec-24	ClickHere	Register
2	Equity investment & Valuation of Life Companies	08-Dec-24	08-Dec-24	ClickHere	Register
3	Enterprise Risk Management (ERM) and Role of Risk Owners and CRO	17-Dec-24	18-Dec-24	ClickHere	Register
4	Handling Customer Grievance, Ombudsman, Consumer Cases, Mediation and Arbitration	19-Dec-24	19-Dec-24	ClickHere	Register
5	Comprehensive Port Package Policies and Oil and Energy Insurance	02-Dec-24	03-Dec-24	ClickHere	Register
6	Reinsurance Management Program: International	02-Dec-24	14-Dec-24	ClickHere	
7	Life Insurance Financial Reporting and Analysis	06-Dec-24	06-Dec-24	ClickHere	Register
8	Management of Fire Insurance	09-Dec-24	10-Dec-24	ClickHere	Register
9	Workshop on Communication & Presentation Skills (Life)	11-Dec-24	12-Dec-24	ClickHere	Register
10	Challenges in Travel Insurance	12-Dec-24	12-Dec-24	ClickHere	Register
11	Engineering Operational Policies: Underwriting and Claims	12-Dec-24	13-Dec-24	ClickHere	Register
12	Liability Insurance: Focus Cyber & Crime	16-Dec-24	17-Dec-24	ClickHere	Register
13	Marine Cargo Insurance	19-Dec-24	19-Dec-24	ClickHere	Register
14	Compliance Management for Principal Officers of Corporate Agents-Banks	16-Dec-24	16-Dec-24	ClickHere	Register

15	Comparative analysis and performance of mutual funds Vrs. ULIPS	17-Dec-24	18-Dec-24	ClickHere	Register
16	Compliance Governance and Risk Management (IRCC)	18-Dec-24	20-Dec-24	Click Here	
17	Role of Group Insurance Schemes in realising Vision 2047	18-Dec-24	19-Dec-24	ClickHere	Register
18	Claims in Life Insurance-Legal and Regulatory Compliance	20-Dec-24	20-Dec-24	ClickHere	Register
19	Technical Audit of General Insurance Companies	02-Jan-25	02-Jan-25	ClickHere	Register
20	Health Insurance: Medical Management and Fraud Control	09-Jan-25	09-Jan-25	ClickHere	Register
21	Customer Grievance, Insurance Arbitration, Ombudsman and Consumer Cases	13-Jan-25	13-Jan-25	ClickHere	Register
22	Miscellaneous Insurance Management	20-Jan-25	21-Jan-25	ClickHere	Register
23	Trade and Credit Insurance	24-Jan-25	24-Jan-25	ClickHere	Register
24	Creating High performers in BancaChannel	06-Jan-25	06-Jan-25	ClickHere	Register
25	Enterprise Risk Management (ERM)	15-Jan-25	16-Jan-25	ClickHere	Register
26	Understanding Bond Markets for Insurance Investments	22-Jan-25	23-Jan-25	ClickHere	Register
27	New Vistas in Life Insurance Underwriting	03-Jan-25	03-Jan-25	ClickHere	Register
28	Comprehensive Financial Planning Series-Part 4 :Financial Planning : Focus on Estate Planning	10-Jan-25	10-Jan-25	ClickHere	Register
29	Fraud Control and Claim Investigation in Life Insurance	16-Jan-25	17-Jan-25	ClickHere	Register
30	Consumer Grievances and Effective Resolution	24-Jan-25	24-Jan-25	ClickHere	Register

Kolkata – November – December 2024

Sr. No	Program Name	Program Start Date	Program End Date	Details	Registration Link
1	Managing Motor TP Claims and Controlling Frauds	03-Dec-24	04-Dec-24	ClickHere	Register
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COURSES OFFERED BY COI

CC1 - Certificate Course in Life Insurance Marketing

Course Structure –

Particulars	Details
Date	11 January 2025
Duration of the course	4 months
Mode of Teaching	Self-study + 3 days Online Contact Classes
Total hours of Teaching	18 hours for Online Contact Classes (to solve queries)
Exam pattern	MCQ pattern + Assignments
Target Group	Graduate / Post Graduate, Freshers 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
Date	11 January 2025
Duration of the course	4 months (3 hours on weekends)
Mode of Teaching	Virtual Training – COI, Mumbai
Total hours of Teaching	90 hours
Exam pattern	MCQ pattern
Target Group	Graduate / Post Graduate, Freshers 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
Date	11 January 2025
Duration of the course	3 months (on weekends)
Mode of Teaching	Virtual Training - COI, Kolkata
Total hours of Teaching	100 hours
Exam pattern	MCQ pattern
Target Group	Fresh graduates/Post Graduates, Broking 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
Date	10th – 12th December 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.