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QUOTE OF THE WEEK

"Ultimately, education in its real sense is the pursuit of truth. It is an endless journey through knowledge and enlightenment."

- A. P. J. Abdul Kalam

INSIDE THE ISSUE

INSURANCE INDUSTRY

Agents can't pocket commissions on direct sales: Irdai – Mint – 5th February 2019

It's a popular notion that insurance products are push products. You don't really feel the need for insurance unless a calamity drives home the realisation.

So you need an intermediary—you know them as agents or brokers—to act as a go-between the insurer and you, the customer, and convince you to buy insurance.

Things, however, are slowly changing as awareness is picking up and customers are lining up to buy insurance products on their own.

Direct sale is picking up and the latest notification by the Insurance Regulatory and Development Authority of India (Irdai) refers to handling of commissions embedded in insurance products that are sold directly rather than through an intermediary.

In a circular issued on 25 January, the regulator observed that insurance companies were paying commissions embedded in insurance products to intermediaries even when the sale was direct and not routed through them.

The circular, accordingly, advised insurers to refrain from this practice. "The Authority hereby advises the insurers not to book new or renew the business directly received from customer in the name of the insurance intermediaries and shall refrain from remunerating them for such direct new or renewal business," noted the circular.

What is direct sale?

It's important to understand that direct sale is not the same as a zero load product which is free of commissions. Direct sale simply means the customers reach out to the insurer directly to buy a product.

"When customers buy products online themselves by going to the insurer's website or even when they buy products offline either by approaching the insurer directly or through their direct sales force that are salaried employees of the insurer, it's termed as direct sale because no intermediary is involved," said C.L. Baradhwaj, executive vice-president, legal and compliance and company secretary, Future Generali India Life Insurance Co. Ltd.

A direct sale or purchase doesn't automatically ensure a commission-free purchase. "The commissions are embedded in insurance products at the time of file and use.

So unless the product expressly states a lower premium for direct sales, the same premium is charged even when a product is logged under direct sale," said Puneet Sahni, head, product development, SBI General Insurance Co. Ltd. The commissions technically get retained by the insurer and are used to meet expenses.

Direct mandate

According to the circular, even direct sales are getting logged under intermediary code. An Irdai official we spoke to said the circular largely pertains to non-life insurers as direct sales comprise nearly one-third of the business.

"Some insurers are giving codes of agents even when the policy was sold directly thereby enabling the agent to earn a commission on a direct sale. One of the reasons why insurers assign an intermediary even under direct sale is to service the policy.

Commissions (including subsequent renewal commissions), however, are paid to intermediaries on the sale of a product. So when an intermediary has not sold a product, she doesn't have the right to the commission," said the official.

The circular aims to ensure that intermediaries are not remunerated unnecessarily and only those who actually sell products are able to pocket the money.

What it means

From a customer standpoint this may not really translate into cheaper products, given that embedded commissions even under direct sales may not be passed on to customers.

However, it's a step towards ensuring better hygiene in the industry. First-year commission on sale of bundled regular premium life insurance plans can be as high as 35% (excluding rewards).

In the case of non-life products, the commission can be up to 15% of the premium (excluding rewards). The amount of commissions, therefore, is substantial in insurance products to be given away to intermediaries as a freebie or to keep them motivated even when they don't clock in sales. The Irdai circular aims to curb such practices.

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Source

Industry expects budget boosting insurance penetration - The Economic Times – 1st February 2019

The insurance industry expects the budget proposals to increase disposable income through hike in tax rebates, pensions, health cover for the masses and digital connectivity, and help the sector grow faster.

"The interim budget aims to uplift the poor, both in cities as well as in villages," ICICI Lombard General Insurance's Bhargav Dasgupta said.

For the insurance industry, the schemes aimed at boosting farmers' income and reducing tax outgoes for the middle-class will encourage consumption, while the plan to develop 1 lakh digital villages will boost digital infrastructure, he added.

It can be noted that apart from providing income tax rebate of up to Rs 5 lakh and Rs 6000 per annum in basic income support to small farmers, the budget also rolled out a target to have 1 lakh 'digital villages'.

The life insurance industry will benefit from the increase in disposable incomes, high digital connectivity in the hinterlands and focus on infrastructure boosting job creation, Pankaj Razdan of Aditya Birla Sun Life said.

The mega pension scheme for the unorganised sector is also a positive for the sector, he said as it is a well- thought-out plan.

Aegon Life' Saba Adil explained the proposal to remove tax threshold on gross income up to Rs 6.5 lakh, if managed well, can give an impetus to life insurance industry as insurance is an important tax saving tool.

With the Ayushman Bharat being the focus, health insurance penetration and healthcare infrastructure will get a major boost, Tapan Singhel of Bajaj Allianz General Insurance said.

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Source

IRDAI REGULATION

Irdai asks insurers to diversify risks to avoid repeat of IL&FS-type fiascoes - The Economic Times – 7th February 2019

Following the recent defaults by entities like the IL&FS, the regulator Irdai Thursday said insurance companies will have to think about mitigating their risks by not concentrating their investment in a few entities.

The regulator also said insurers need to diversify their investment strategies so the risks faced by them are multi-dimensional.

"Insurance firms will have to think how they will mitigate their own risks also and must diversify. If they concentrate all risks in a few entities then they will be in trouble," Irdai chairman Subhash KhuntiaKhuntia at an industry event.

Last week Khuntia had said insurers having exposure to IL&FS, which has a debt of over Rs 94,000 crore, should make provision and not to write them off.

Many insurers and mutual funds have exposure to the debt instruments of the crippled IL&FS group which was taken over by the government last October and the national insurer LIC owns the maximum stake in the crippled company with 25.34 percent shares.

Noting that the insurance industry is basically for risk mitigation and risk management, it needs to think about both the liability as well as investment sides as well since most of them are long-term investors. Speaking about the risks related to calamities arising due to climate change, Khuntia said, "for most insurers, there is investment risk involved and so they have to find ways to do innovative risk transfers.

"There are many methods like risk pooling and securitisation of climate risk liabilities through instruments like catastrophe bonds. We need to deliberate on a much larger scale because climate change is real," he said.

Risk pooling is a system under which insurers come together to form a pool, which can provide protect them against catastrophic risks such as floods or earthquakes, while catastrophe bonds (also known as cat bonds) are risk- linked securities that transfer a specified set of risks from a sponsor to investors.

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Source

India: Committee recommends regulatory sandbox approach for insurance innovations – Asia Insurance Review

A committee of the Indian insurance regulator, IRDAI, has recommended that a facilitating environment to support deployment of technical innovation, similar to that for Fin Tech products, should be created for the insurance industry as well.

The committee on the regulatory sandbox approach in insurance sector in India was constituted by IRDAI last September. The committee set up under the chairmanship of IRDAI chief general manager Randip Singh Jagpal has now submitted its recommendations.

Regulatory sandbox approach
A 'regulatory sandbox approach' can be used to carve out a safe and conducive space to experiment with Fin Tech solutions, where the consequences of failure can be contained, the committee said in its report.

According to the committee, encouraging the deployment of InsurTechs will help reach new segments of customers, reduce cost of transactions, improve customer service as well as raise operational efficiencies.

A regulatory sandbox approach also facilitates innovations in the insurance sector, make insurance products more affordable and relevant to the insured and above all give a fillip to insurance penetration.

This regulatory sandbox method is expected to help companies achieve a better success rate with their products. According to industry estimates that at present, for every 10 new products that are filed, two fail to make the mark.

Committee's recommendations
The committee had invited suggestions and comments from all insurance and reinsurance companies and all foreign reinsurance branches in India. The committee's report is based on the suggestions/ inputs received from the various constituents.

The recommendations include:
The purpose of the regulatory sandbox is to foster growth and increase the pace of the most innovative companies, in a way that provides InsurTechs in particular and the Fin Tech sector in general with flexibility in dealing with regulatory requirements and at the same time focusing on policyholder protection.

The authority should create a core sandbox committee with dedicated personnel to monitor and supervise digital innovation activities and provide support and advice to applicants. The committee would facilitate the rollout of experiments and seek to provide the ecosystem required for the experimentation.

The regulatory sandbox would have defined entry and eligibility criteria, boundary conditions, process flow, timelines and success factors/ exit parameters for the applicants, along with appropriate controls for protection and risk management.

At the same time, the process and criteria would be flexible to provide a conducive environment for encouraging and enabling a wide variety of experimentation, including provisions for no enforcement action orders, waivers and relaxed reporting requirements.

The committee proposes a cohort basis approach for receiving applications. The applicants would include insurers or insurance intermediaries or any other entity other than an individual having a minimum net worth of INR2.5m ($34,925) for the last three years.

The applicant can apply in any one or more of the five categories namely: insurance solicitation or distribution, insurance products, underwriting, policy and claims servicing and any other. The applicant could apply singly or jointly in one or more than one category, provided that if the category involves insurance products or underwriting, then the applicant necessarily has to partner with an insurer.

Permission shall be granted for a period of six months which can be extended for another six months. In no case can the proposal be allowed to go beyond 12 months. However, if the proposal covers 5,000 persons or obtains INR5m of premium or any other parameter which the authority may specify, the proposal will be deemed to have been completed.

Strict requirements around confidentiality of policyholders' data have been proposed.

The committee has called for comments on its report which can be submitted to IRDAI on or before 26 February 2019.

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Source

LIFE INSURANCE

Insurers dance to new tunes to lure millennials - Financial Chronicle – 5th February 2019

Why should insurance companies conduct a marathon run or a zumba dance event? At a time when insurance agents are becoming passé, especially among millennials, insurance companies are trying out different ways to reach out to youngsters and be relevant for them.

Max Life is conducting a marathon run in Gurugram and Haryana and it is one among the several fitness programmes like zumba, kickboxing and healthy food workshops the company has been conducting. Bagic4fitness was a campaign by Bajaj Allianz General Insurance encouraging audience to start a fitness activity and demonstrate to all. The company recently held a marathon and a helmet safety campaign in Pune.

"The age of neighborhood insurance agent has gone. In yesteryears, this agent would sell the right policy to the right customer in that community at the right time. Today insurance companies have to communicate to millennials who don't even know who all live in the locality. We have to be present where they are that could be social media, fitness clubs or eco clubs. The marketing strategies are fast evolving to reach out to this group of population who are very important for our business," said Manik Nangia, Chief Operations Officer, max life insurance.

Millennials or those born after 1990 contribute to nearly 30 per cent of online term sales. They also choose a higher average cover or sum assured compared to non-millennials. The average sum assured of life policies bought by millennials is Rs 75 lakhs as against Rs 70 lakhs for non-millennials, found Max Life.

Millennials also seem to be more aware of the risks to health and life in today's world and their propensity to cover risks like critical illnesses, including cancer and heart disease through riders is higher than non-millennials. Around a third of life insurance policies bought by millennials have an add-on rider against one-fifth for non-millennials. These make millennials a customer segment that cannot be neglected.

Insurance companies are making several changes in their marketing strategy and processes to be relevant for the millennials. "Across all our touch points our attempt is to keep the tonality of our communication relevant to the younger audience. We have amplified our focus on content marketing. The "unplanned travel" content is an initiative in that direction. We believe millennials resonate with brands with purpose. Two of our recent initiatives, bagic4fitness and marathon were intended to reach out to them," said Chandra Mohan Mehra, Chief Marketing Officer, Bajaj Allianz General Insurance:

According to Nangia, millennials live in a world of apps that provide instant gratification. They expect the insurance companies and other financial services companies to provide the same speed and convenience offered by food tech apps or cab ride apps. They do not want to sit face-to-face with an insurance agent and hear him. Instead they would spend time on browsing internet content and going through virtually available reviews. Further, the on-boarding process should also be fast and hassle-free.

"Hence we do not bother them with filling several application forms and instead gather data from their digital identities and check their credit reports. We also remain connected with them and keep the policy a live document through initiatives, including offering of discounts for following a good life style and increasing cover at every milestone of his life," said Nangia.

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Source

Know the types of ULIPs - The Hindu Business Line – 4th February 2019

A unit-linked insurance plan (ULIP) is a product that combines insurance with investment. A small portion of the amount paid as premium goes to insurance and the rest is invested in market instruments such as equity, debt, or a combination of the two. Here are the types of ULIPs in the market.

Differing on death benefit

ULIPs are classified as Type I and Type II based on the claim amount received by the nominee in case of the policyholder's demise.

In Type I ULIP, the nominee receives the higher of the sum assured or the fund value as claim from the insurance company. The cost to the insurance company in this type of ULIP is lower because the sum at risk (the difference between the sum insured and the fund value) decreases over the years.Say, for example, the sum assured is Rs. 10 lakh and the fund value at the end of the second year is Rs. 90,000; the mortality charge (amount billed by the insurer to provide life cover to the policyholder) is calculated on the sum at risk (Rs. 10 lakh - Rs. 90,000).

Now, in the next two years, if the fund value becomes, say, Rs. 1, 80,000, the sum at risk decreases. This could bring down the mortality charge. Thus, in this type of ULIP, as the fund value and sum assured are expected to converge at some point, the mortality charge reduces over the years. Some of the examples of Type I ULIPs available in the market are Bajaj Allianz Life's Goal Assure, HDFC Life's Click2Invest and Edelweiss Tokio Life's Wealth Plus.

On the other hand, in Type II ULIP, in case of death, the nominee will receive both the sum assured and the accumulated fund value. But the sum at risk, in this case, increases with the age of the policyholder as the fund value may go up as the years roll by. This increases the cost to the insurer. Hence, the mortality charges in this type of ULIP could rise every year as the risk of death increases with age. Usually, the premium amount for Type II ULIPs is higher than that of Type I, given the benefits received in the former. Currently, not many insurers offer this type of ULIP.

Premium payment

For a unit-linked plan, an investor is required to pay premium for a specified period like any other insurance policy, and accumulate units. This premium can be paid monthly, quarterly, half-yearly or yearly. As ULIPs are also insurance plans, the premium paid can be claimed as deduction under Section 80C. Alternatively, you can pay the entire premium at one go and get covered for the full term. The advantage of paying a single premium is that you don't have to keep note of due dates. The plan will continue for the entire period without any hindrances.

If you pay your entire premium at once, you can claim the tax benefits only for that year. Note that, for the proceeds to be tax-free, you should ensure the premium payable for any of the years during the term of the policy exceeds 10 per cent of the sum assured.

Tailored to your needs

There are various types of ULIP funds to suit your financial requirements. For instance, if you are expecting high risks and high returns from your investment, you can opt for ULIPs that invest in equity funds. Similarly, for low risk, there are ULIPs that invest in cash funds or fixed-income and bond funds. ULIPs can be used as an investment tool for retirement. If your objective of investment is your child's education, you can opt for a ULIP that pays out, say, after the child turns 18.

But disclosures are not substantial for ULIPs and charges are relatively higher than mutual funds. So, a careful analysis must be done and a suitable quality ULIP with low charges and a track record of solid returns must be chosen based on an investor's needs.

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GENERAL INSURANCE

National Insurance, United India Insurance, Oriental India Insurance merger to be complete next FY2019-20 - Financial Express – 4th February 2019

The government expects to complete the merger of three state-owned general insurance companies by 2019-20. The merger of National Insurance Company, United India Insurance Company and Oriental India Insurance Company was first announced in the Budget 2018-19 and the government intended to complete the process in current fiscal itself.

However, as per the interim budget document 2019-20 released on Friday, the merger is under process and will see completion by next financial year as various steps are being taken.

As on March 31, 2017, the three companies together had more than 200 insurance products with a total premium of Rs 41,461 crore and a market share of around 35 per cent. Their combined net worth is Rs 9,243 crore with total employee strength of around 44,000 spread over 6,000 offices.

Initial estimates suggest that the combined entity formed after the merger will be the largest non-life insurance company in India, valued at Rs 1.2-1.5 lakh crore.

According to sources, a consultant has been shortlisted to advise on the proposed merger. The consultant, appointed on the basis of the bid floated last year in June, is expected to advise on organisational restructuring, rationalisation of human resources, management of operational issues, regulatory and compliance issues. In 2017, New India Assurance Company and General Insurance Corporation of India were listed on bourses.

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Source

3 state-run insurance companies merger not likely soon – The Times of India – 4th February 2019

The merger of three state-run insurance companies is unlikely to happen anytime soon, with the government preferring to move carefully on the issue, while the department of investment and public asset management (DIPAM) is not averse to take on the task of stake sale in public sector banks, a top official has said.

FM Arun Jaitley in his 2018-19 budget speech had said that the three public sector general insurance companies — National Insurance Company, United India Assurance Company and Oriental India Insurance Company — will be merged into single entity and subsequently be listed. The plan was part of the overall government strategy for consolidation in the public sector enterprises space.

“Mergers take time and you should take time in mergers anywhere. I am telling you with experience mergers have natural obstacles in terms of culture and manpower if nothing else. So, once you align the business then you should start aligning the culture and manpower and you have to go to the last man to be able to do so.

Mergers are one of the difficult transactions, it calls for skills, which are not available in abundance,” DIPAM secretary Atanu Chakraborty told TOI. “I am not able to put a timeline because I have not reviewed it. I intend to do so,” he said.

DIPAM had asked the department of financial services to get the issue of merger of the three companies examined and prepare a fresh road. There is a view within the government that the issue needs to be thoroughly examined before rushing into a merger.

Chakraborty also did not rule out taking over the task of stake sale in state-run banks within the parameters of the policy now in place. "Last year has not been the best for banks. So, we have not examined that issue in detail. Any disinvestment shakes up the company. We want them to be healthy before we take any decision," he said.

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Source

HEALTH INSURANCE

Centre plans to provide Ayush services to health, wellness centres - The Pioneer – 7th February 2019

In a move that will go a long way in boosting the Indian alternate medicines, the Government has ambitious plans to provide the Ayush services in at least 12,500 health and wellness centres under the Ayushman Bharat--Pradhan Mantri Jan Arogya Yojna across the country.

Shripad Yesso Naik, Minister of State for AYUSH after inauguration of the Conference of AYUSH/Health Ministers of States/UTs said here "at least 12,500 health and wellness centres need to be identified across the country for rendering AYUSH services to the people at grass-root level with special reference to preventive health care.

"We look forward to an effective integration in the National progress related to health. Research Councils under Ministry of AYUSH are conducting National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Disease and Stroke (NPCDCS) in states.

While the Central Council for Research in Ayurvedic Sciences is conducting NPCDCS programme in Surendra Nagar District in Gujarat; Bhilwara in Rajasthan and in Gaya, Bihar, and the Central Council for Research in Homeopathy is implementing the programme in Darjeeling in West Bengal and Krishna District in Andhra Pradesh.

The results are encouraging and would be scaled up, the Minister said.

In view of greater acceptance of the aurveda medicines, the Government's other premier research agencies like CSIR and DRDO too have come forward in developing herbal drugs respectively like BGR-34 to tackle diabetes and Leukoskin for treatment of white patches. Both ayurveda drugs are being sold by the AIMIL Pharmaceuticals from Delhi.

Rajiv Kumar Vice Chairman, NITI Aayog said that AYUSH deserves equal recognition and patronage as is enjoyed by the modern system of medicine. "Holistic nature of AYUSH systems need to be recognized nurtured and proliferated in the interest of the health of the mankind.

He emphasized on role of regulatory bodies is critical in maintaining the quality and standards of AYUSH systems and we need to have a robust regulatory system for AYUSH drugs and education.

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Source

Digi verification system to speed up approval for Modicare – The Times of India – 7th February 2019

In an attempt to expedite the coverage of Ayushman Bharat health insurance scheme, the National Health Authority is set to auto-approve gold (beneficiary identification) cards through a computerized verification system replacing the current manual approval through state health agencies.

This week, the NHA set a record by registering the highest number of hospital admissions as well as generating maximum number of gold cards on a single day so far since the launch of the scheme. On Tuesday, as many as 15,372 hospital admissions were registered, bringing the total to more than10.80 lakh beneficiary admissions under Pradhan Mantri Jan ArogyaYojana (PMJAY).

This was topped up on Wednesday with NHA issuing 4.63 lakh Gold Cards, the highest so far on a single day. Despite this, the data shows only 1.24 crore cards have been issued so far, which means the scheme has reached out to around 5 crore beneficiaries against a target of 50 crore.

"We are planning to roll out auto-approval from next week and hoping that these will fast-track issuance of beneficiary e-cards. Right now it is done manually by the state health agency and since they have to be very cautious with the verification process, it takes time. We have developed this software which will help us reach beneficiaries faster," NHA chief executive Indu Bhushan said.

The authority is also planning to partner with service aggregators like Uber and Zomato to spread awareness about the scheme.

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Source

Western India accounts for largest chunk of health insurance biz – The Times of India – 7th February 2019

Thanks to higher levels of urbanisation and industrialisation, the western part of the country, constituting Gujarat, Maharashtra and Goa, accounted for thelargest chunk of business in the health insurance sector followed by south, north and east in 2017-18, data issued by insurance regulator – the Insurance Regulatory and Development Authority of India (IRDAI) – revealed on Wednesday.

While the three western states accounted for 52.48 lakh health insurance policies issued, the southern state of Andhra Pradesh, Telangana, Tamil Nadu, Karnataka and Kerala put together accounted for 36.72 lakh policies followed by 35.25 lakh health insurancepolicies for North (UP, Uttarakhand, Haryana, Punjab, Himachal Pradesh, J&K, Rajasthan and Delhi) and 14.45 lakh in East (Bihar, Jharkhand, Orissa and West Bengal).

Interestingly, it was not just in terms of the total numberof policies issued that western India markets led the rest of the country in health insurance. They even fared better when it came to the amount of claims paid to customers at Rs12,249 crore followed by Rs 9,169 crore in south, Rs 6,009 crore in south, Rs 6,009 crore in north and a meagre Rs 1,841 crore in the east.

In the case of gross direct premium, west accounted for Rs 14,089 crore, south Rs 11,335 crore, north Rs 7,773 crore and east Rs 2,416 crore.

State wise, Maharashtra accounted for the highest number ofhealth insurance policies issued at 34 lakh, followed by Gujarat at 18.23 lakh, Delhi at 13 lakh, West Bengal 11.29 lakh. Down South, after Tamil Nadu, Karnataka accounted for 8.9 lakh health insurance policies issued, Kerala 8.12 lakh, Telangana 4.6 lakh and Andhra Pradesh 3.8 lakh.

However, the health insurance penetration in the north-eastern states remained abysmal with only 704 health insurance policies issued in Nagaland, 561 in Arunachal Pradesh, 239 in Mizoram, which was among the lowest figures.

Commenting on the data, Parag Ved, executive vice-president (consumer lines) Tata AIG General Insurance Company Ltd, said, "In group business, the premium pattern represents the size of manufacturing and service industries in the respective states. Maharashtra, Tamil Nadu, Karnataka and Delhi have higher density of workforce in manufacturing and IT services, which gets reflected in the insurance premiums. The observation of higher insurance penetration in states ofDelhi, Gujarat and Maharashtra can be correlated to the higher level of urbanization in these states."

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Source

Ola sells 2 crore in-trip micro-insurance policies per month - The Hindu Business Line – 7th February 2019

Cab-hailing app Ola on Thursday said it sold over two crore in-trip micro-insurance policies every month since its launch.

"Over 20 million policies have been availed by customers every month since our trial phase in April 2018 and we are thrilled with the phenomenal response that we have received across the country," Ola Financial Services, chief executive officer, Nitin Gupta said.

The in-trip insurance services, launched in April 2018, saw acceptance from all age groups, the company said. Also, metro cities such as Bengaluru, Delhi, Chennai and Mumbai registered the fastest adoption growth rates, it added.

Ola offers customers an option to buy insurance through its app when they book their ride. The risk covered through this offering includes coverage against lost baggage, accidental medical expenses, accidental death or disability, and OPD treatment, among others. The insurance is offered in the price range of Re 1-Rs 49.

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Source

'Integrated approach needed to bring in universal healthcare' - The Economic Times – 7th February 2019

India needs a comprehensive approach to healthcare, where the providers and payers work together with the focus on patients to attain universal healthcare.

The payers (private insurance schemes, state schemes and Ayushman Bharat) and providers (hospitals, diagnostic services and pharmaceutical industry) should adopt a patient-centric strategy, DG Shah Secretary-general Indian Pharmaceutical Alliance, said at CII Healthcare, Pharma and Medtech Conclave 2019 here on Wednesday.

At present, stakeholders -- pharmaceutical industry, doctors, and hospitals -- are regulated by different ministries, with most of them fighting turf battles.

"Healthcare is in a flux right now. There is growth in the different parts of the sector; pharma, medical device, private health insurance, hospitals and diagnostics – accompanied by a pressure on margins, regulations, innovation and a need for enhanced supply of infrastructure and manpower.

There is an urgent need to take an integrated approach to all the different facets of the healthcare sector", Parijat Ghosh, partner Bain & Company who moderated the session said.

Experts feel Ayushman Bharat needs to evolve further.

Joy Chakraborty chairman CII WR taskforce on Healthcare stated "Government programmes like the Ayushman Bharat would be a game changer, with even the underprivileged getting access to quality healthcare. Due to these programs, there would be a demand for at least one million doctors and 2.5 million medical workers by the year 2025".

India is called pharmacy of the world with every third tablet sold globally by an Indian manufacturer, and every fifth patient treated by an Indian doctor. However ironically, only 40% of the population has access to basic healthcare facilities.

This is set to change now with the launch of Ayushman Bharat- Pradhan Mantri Jan ArogyaYojana, according to Malti Jaswal senior consultant, World Bank.

She added that under the scheme, primary health centers would be converted to health and wellness centers (HWC) which would be well equipped for universally screening of common non-communicable diseases such as diabetes, hypertension and three common cancers.

"The idea is set up 150,000 HWC by December 2022. Almost 10 lakh people have already benefited under the scheme since its launch and Rs 1456 crore have been spent," she said.

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Source

Ayushman push comes at the cost of other health schemes - The Hindu Business Line – 7th February 2019

The push for an insurance-based health model in India has come at a huge cost for preventive public health schemes. According to experts, the Centre's contribution towards the National Health Mission (NHM) has consistently declined over the years; from 60 per cent in 2014-15, it has dipped to about 50 per cent in the 2019-20 Interim Budget, they point out.

Of the Rs31, 274 crore allocated in the 2014-15 health budget, the NHM had received Rs18, 609 crore (61 per cent). In 2019-20, of the Rs63,298 crore (total budget), it was allocated Rs31,745 crore (50 per cent). However, this year, the NHM has taken the maximum beating. Compared to last year, there has been a five per cent decline: from 55 per cent in 2018-19 (Rs30,683 crore of Rs56,045 crore) it is down to 50 per cent in 2019-20 (Rs31,745 crore of Rs63,298 crore).

"The share in the Budget has been continuously declining over time; however, the maximum decline of 5 per cent was seen in 2018-19," stated Avani Kapur, a Fellow at the Centre for Policy Research and Director of the Accountability Initiative.

While the Pradhan Mantri Jan ArogyaYojana (PM-JAY) has received Rs6,400 crore (nearly one- tenth of the total health budget which stands at Rs63,298.12 crore) — the largest share of the pie in health budget — experts say that it is at the cost of allocation to other schemes.

Worrying numbers
Allocation to National Health Mission reduced from 55 per cent of the total health budget in 2018-19 to 50 per cent in 2019-20
Budget allocation for non-communicable diseases faced a cut of up to 28.63 per cent
The revised estimates of the 'Reproductive and Child Health filexi pool' in NHM are down 30 per cent in 2018-19 compared to the previous year; the allocation has further dipped in 2019-20

A close scrutiny of the Budget documents indicate that budget allocation for non-communicable diseases decreased fromRs1,004.67 crore in 2018-19 toRs717 crore in 2019-20, a 28.63 per cent cut.

'Reductions harsh'

Further, the revised estimates of Reproductive and Child Health filexi pool in NHM, which looks after routine immunisation, pulse polio programme and maternal health, have reduced fromRs7,545.07 crore in 2017-18 toRs5,253.51 crore in 2018-19, a 30 per cent decrease. This despite utilisation of up toRs7640.24 crore in actual figures of 2017-18. The current year's allocation, atRs5,253.46 crore, is even lesser.

Furthermore, whileRs3,066.80 crore was spent in 2017-18 to build infrastructure and procure equipment under the head capital expenditure, the allocation has been reduced by 43 per cent toRs1,750.90 crore. For example, under the head Establishing New Medical Colleges (upgrading district hospitals), there is a decline of nearly 40 per cent over the expenditure in 2017-18, a statement released by Jan Swasthya Abhiyan (JSA) said. WhileRs3,300 crore was spent in 2017-18 actuals, the current allocation stands atRs2,000 crore.

"These reductions are especially harsh in the context of the government's recent announcement of providing funds and land for setting up private hospitals in Tier-2 and Tier-3 cities," said JSA.

Experts say that it is striking that the Centre's spending on health stands at merely 0.31 per cent of the GDP, which is much lesser than what was spent a decade back. The National Health Policy 2017 talks about increasing public spending to 2.5 per cent of the GDP by 2025, but this would remain a far cry if the Centre's allocations towards health are not increased considerably by at least 30 per cent annually.

"During the earlier period, sustained focus on public sector provisioning helped India improve access to select essential services and this helped us come close to achieving a number of Millennium Development Goals," said Indranil Mukhopadhyaya, Associate Professor, School of Government and Public Policy in OP Jindal Global University, Haryana.

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Source

Insurance alone cannot be the panacea for India's ailing health sector – Financial Express – 6th February 2019

At a time when India's ailing public health sector demands strengthening of primary health care system, Narendra Modi government has once again presented a budget with misplaced priorities. The increase in allocation to health sector in Budget 2019 should have been directed towards reviving primary health care, rather than at Ayushman Bharat insurance scheme, which does not cover a majority of the treatments, Sourindra Ghosh and Imrana Qadeer wrote in The Indian Express this week.

There has been an increase of more than Rs 7,000 crore on health sector in Budget 2019 compared with last year, which amounts to a 9.2 per cent increase in real term, Ghosh (PhD scholar at the Centre for Economic Studies and Planning, JNU) and Qadeer

(Distinguished Faculty at Council for Social Development, Delhi.), wrote. However, most of the increase in expenditure has gone towards funding the Pradhan Mantri Jan ArogyaYojana (PMJAY), which provides Rs 5 lakh annual coverage for in-patient care to 10 crore poor families.

On the other hand, the allocation to National Rural Health Mission (NRHM) has been reduced in real terms. Its share in the health component of the budget has declined sharply over the past four years. Meanwhile, National Urban Health Mission (NUHM) too has received a paltry amount. Even under NHRM, the money to be spent on controlling communicable diseases like TB, diarrhoea, pneumonia and hepatitis has been reduced.

According to the National Sample Survey 2014, 97 per cent of illnesses in India are treated in out-patient care centers, which accounts for 63 per cent of the overall medical expenditure. Therefore, most of the expenditures are not even covered by the insurance scheme for in-patient care.

In this context, the funds should have been used to improve the worn-out public sector district hospitals, community health centres, primary health centres and sub centres in underserved areas, rather than on insurance, Ghosh and Qadeer wrote.

The revised estimates for the 2018-19 reflect under-utilisation of funds by various programmes. National Rural Drinking Water Mission and the Pradhan Mantri Matru Vandana Yojana have utilised only 78 per cent and 50 per cent of the allocated funds, respectively.

Swachh Bharat Mission (rural), also did not fully utilise the Rs 15,343 crore allocated to it in the budget 2018-19. Its allocation has been further reduced to Rs 10,000 crore for 2019-20. The neglect of the ICDS has not only continued but also accelerated since 2014. This is evident from the fact that this year's allocation for the scheme, in real terms, remains below the expenditure of 2013-14.

Focusing on insurance which may largely benefits private sector, while ignoring public health infrastructure and public provisioning cannot be regarded as a pro-poor policy, Ghosh and Qadeer wrote.

TOP

Source

Portability issues hamper Ayushman Bharat - The Hindu Business Line – 6th February 2019

When Naveen (name changed) from Bihar came to Jharkhand for his mother's eye treatment, the surgery was done free of cost under Ayushman Bharat, as both States are on board to implement the scheme. But at a broader level, the picture is not so encouraging.

Of the 3.3 lakh admissions under the insurance scheme, there are just around 3,800 portable cases – beneficiaries going for treatment to other States, totallingRs10 crore of the claims as of January 5.

Several hitches in portability under Ayushman need to be addressed for such cases to ramp up significantly.

Key issues

Portability is a key positive under Ayushman as many States lack internal capacities for sophisticated procedures. Hence, in such cases, there are a large number of people who would access services outside the State. While Ayushman allows people to get treated free of cost in any other State, there are certain technical issues that need to be addressed for this to happen seamlessly. One, the transaction management system (TMS) within a State is different from that outside the State. Integrating the State and national TMS has been an issue. The other issue is monitoring of portable claims.

Officials in Bihar explain that when a person from the State goes to another State for treatment, it becomes difficult to ensure the legitimacy of claims. Fraud in small procedures done outside the State is difficult to track.

In Bihar, there are about 388 portable cases (pre-authorisation claims), with a chunk of the admissions in NHCP (National Health Care Providers such as AIIMS) and Uttar Pradesh. In Jharkhand, there are just about 414 portable cases, with over half the procedures done in Bihar and Uttar Pradesh. In Chhattisgarh, only a little over 100 cases pertain to patients who have done treatments outside the State.

Key inter-State portable cases under Ayushman

Patient's Home State	Hospital State	Total pre-authorisation claims	Total pre-authorisation amount (₹)
Chhattisgarh	Gujarat	50	1,84,000
Chhattisgarh	Jharkhand	30	2,68,000
Chhattisgarh	Madhya Pradesh	11	1,32,000
Bihar	NHCP	195	90,09,000
Bihar	Uttar Pradesh	143	23,44,000
Jharkhand	Bihar	188	25,52,000
Jharkhand	Uttar Pradesh	110	18,85,000
Jharkhand	NHCP	54	24,91,000
Gujarat	Dadra & Nagar Haveli	11	87,500
Gujarat	Daman & Diu	58	3,06,000
Haryana	Chandigarh	97	22,49,000
Haryana	NHCP	243	89,41,000
Madhya Pradesh	Gujarat	826	2,50,00,000
Madhya Pradesh	Uttar Pradesh	74	6,31,000
Maharashtra	Dadra & Nagar Haveli	54	40,800
Uttar Pradesh	Uttarakhand	340	33,83,000
Uttar Pradesh	NHCP	296	1,00,00,000
Uttar Pradesh	Haryana	106	15,41,000
Uttarakhand	Uttar Pradesh	59	15,25,000

Source

In some of the north-eastern States, the numbers are not too heartening, either. Manipur, for instance, has seen just four pre-authorisation claims for portable cases totaling aboutRs17,500. Mizoram has four such cases, while Tripura has 11, and Nagaland has only two cases.

Odd border cases

Interestingly, Dadra and Nagar Haveli, with just four hospitals empanelled under Ayushman, have seen 54 portable cases from Maharashtra – that is, patients from Maharashtra getting treated in Dadra and Nagar Haveli. In Daman and Diu there are 58 portable cases from Gujarat.

"There are 11 cases from Gujarat, where people living in border areas, have gone to Dadra and Nagar Haveli for treatment. Mostly people living in the border area for whom Dadra Nagar Haveli or Daman Diu is closer avail treatment there," explained Dinesh Arora, Deputy CEO, Ayushman Bharat.

TOP

Maharashtra govt pays Rs 713 crore premium to NIC for health cover - The Indian Express – 6th February 2019

Kolkata-based National Insurance Company (NIC) has managed to retain the Ayushman Bharat account of Maharashtra which generates the second largest health insurance premium after Tamil Nadu. The state has paid a premium of Rs 713 crore for the scheme, which started from January 1, for six months and indicated it would like to extend it for the whole year afterwards.

Advertising

Negotiations for the scheme on behalf of the state with the NIC were carried out by Sudhakar Shinde, CEO of Mahatma Jyotiba Phule Jan ArogyaYojana. NIC has agreed to run scheme with premium of Rs 640 per family per year. There will be a prospective saving of Rs 111 crore annually for the state government. Earlier, Maharashtra was paying a premium of Rs 690 per family.

NIC has been the insurer of state's flagship scheme Mahatma Jyotiba Phule Jan ArogyaYojana, that provides cover for Rs 1.5 lakh, since 2012 and has given benefit to more than 21 lakh beneficiaries till date. Since November 2016, the premium for the scheme increased from Rs 333 per family per year to Rs

690 per family per year over a period of five years. The scheme provides cover to 2.25 crore family in the state. The scheme will now include 83 lakh families who would be now eligible for the facilities under Ayushman Bharat scheme.

The grand Ayushman Bharat Scheme, known as Modi Care or Pradhan Mantri Jan ArogyaYojana (PM-JAY), providing Rs 5 lakh cover to 10 crore families, was a much promising business for the insurers, but most of the states have gone for the Trust Model where they are the managing the business by themselves without the involvement of insurers.

TOP

Source

App of world's largest health insurance, PM-JAY, launched; now on Google Play store- The Hindu Business Line – 5th February 2019

The world's largest cashless health insurance scheme — the Pradhan Mantri Jan ArogyaYojana (PM-JAY), popularly known as the Ayushman Bharat — is now active on Google Play store and one can download the PM-JAY app to access scheme details. Launching the app on Tuesday, PM-JAY's CEO InduBhushan said that the app will help people check if they are eligible for the scheme.

"One can also check the wallet which will display how much money has been used, register grievances, or check for nearby hospitals," said Bhushan. Sources said that the National Health Authority (NHA), which runs PM-JAY, was keen to release the app at the earliest so that it would figure at the top of the Google Play store and users can download the right app.

Fraudulent apps

The PM-JAY has been plagued by fraudulent apps which lure smartphone users and redirect them to pay under false promises of enrollment in the scheme.

"Google has assured us that once we launch the app, it will ensure through search engine optimisation that the app will figure at the top of the list," said a senior official in the NHA. Another official added that by simply feeding the name, village and ID details, beneficiaries can check eligibility.

Under tests

The mobile app was under testing for the last few days and has already reached 10,460 downloads and we expect this to touch a lakh, said Bhushan. Union Health Minister JP Nadda said that PM-JAY had now stabilised and that those States like Odisha, Telangana and Delhi which are keeping away due to 'political' reasons, are denying their people health benefits.

Up until Tuesday, 10, 80,183 patients had been hospitalised under the schemes and of Rs 1041.3 crore claims were submitted and Rs 808.2 crore approved. While 60,328 hospitals have applied for empanelment, 14,756 (24.45 percent) have been empanelled.

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TOP

Source

Tech-based health care plan faces multiple challenges – Mint – 5th February 2019

India's attempts at a complete shift from manual to technology-based healthcare services are being stymied by challenges ranging from a lack of funds to accessibility and quality assurance.

The government's ambitious scheme Ayushman Bharat-Pradhan Mantri Jan ArogyaYojana (AB-PMJAY), which aims to foster a paperless and cashless system, will need a major pool of funds to become technology-enabled though its budget has been increased by 166% this year, according to health experts.

"Technology has become the backbone for Ayushman Bharat as the entire system is cashless and paperless. It provides health insurance of Rs5 lakh per year to poor and vulnerable people identified as per the socio-economic caste census for secondary and tertiary care. With over 50 crore population entitled to this, technology is going to become an even bigger market," said InduBhushan, chief executive officer, AB-PMJAY and National Health Agency at the ministry of health and family welfare. "However, technology-based healthcare will cost more money and, therefore, both healthcare providers and other stakeholders should be prepared to balance this high cost as financial allocation would be much needed. Also, technological innovations in healthcare need to be backed by a robust policy framework," he said.

A funding crunch for technology-enabled healthcare service delivery systems is apparent, with a significant curtailment in technology-related programmes in terms of healthcare in the budget for 2019-20 presented last week. Initially Rs30 crore was allocated in 2018-19 (actual budget) for the Impacting Research Innovation and Technology (IMPRINT) scheme. However, this was reduced to Rs5 crore in the revised budget for 2018-19. This came down further to a meagre Rs3 crore in the 2019-20 budget. The programme aims to promote and support translation of innovative ideas and knowledge into deployable technology in healthcare.

A similar funding crunch has hit telemedicine, which is the use of electronic information to provide and support healthcare beyond geographies, time, and social barriers. In 2018-19, the budget for telemedicine was Rs55 crore. This was reduced to Rs45 crore in 2019-20.

“Telemedicine is a great technology. Despite having mobile penetration in rural India, there is no internet and speed to run telemedicine services. As a result of little awareness, many people are unable to use several apps launched by the Union health ministry for health services," said a senior health ministry official who did not wish to be named.

A report released by the Confederation of Indian Industry on artificial intelligence on Monday projects the healthcare sector to grow to $280 billion by 2020 but that technology-based healthcare is facing major challenges. “AI in healthcare is increasing human capacity instead of replacing human labour. AI applications face certain challenges as they require an effective framework of laws to govern privacy and data integrity," the report said.

TOP

Source

Health budget focuses only on Ayushman Bharat, other schemes ignored – Mint – 2nd February 2019

Making Ayushman Bharat scheme the representative of all the healthcare initiatives in Budget 2019-20, Narendra Modi-led National Democratic Alliance (NDA) government forgot to focus on unprecedented disease burden looming large on the country.

While the total health budget allocated to the ministry of health and family welfare for 2019-20 is Rs 61,398.12 crore against Rs 52,800 crore in 2018-19, an increase of 16.3%, the highest increase was witnessed in Ayushman Bharat-Pradhan Mantri Jan ArogyaYojana (PMJAY) i.e. Rs6,400 crore.

During the launching year of the scheme 2018-19, government allocated Rs 2,400 crore to the scheme, this year the increase has been over 166%.

Finance minister Piyush Goyal who presented the Budget 2019-20, said that by 2030 his government will work towards a distress free healthcare and a functional and comprehensive wellness system for all. Ignoring health areas, the centre has curtailed budget under the head of flexi pool for non-communicable diseases (NCDs), injury and trauma which are the largest cause of death in the country.

While in the year 2018-19, the budget for the said head was Rs 1,004.67 Crore, this year the budget has been slashed to Rs 717 crore. The budget for national program for prevention and control of cancer, diabetes, cardiovascular disease and stroke has also suffered cuts from Rs 295 Crore in 2018-19 to Rs 175 crore in 2019-20.

This is when the estimated proportion of all deaths due to NCDs has increased from 37.09% in 1990 to 61.8% in 2016, according to Indian Council of Medical Research (ICMR) India state-level disease burden study report ‘India: Health of the Nation’s States’, released in 2018.

Goyal claimed that the past five years have seen massive scale up of healthcare and Rs 3, 000 crore through free treatment made available under Ayushman Bharat scheme. “Lakhs of poor and middle class people are also benefiting from reduction in the prices of essential medicines, cardiac stents and knee implants, and availability of medicines at affordable prices through Pradhan Mantri Jan Aushadhi Kendras," Goyal said.

The budget has also largely ignored the reproductive and child health areas. Under flexible pool including routine immunization program and pulse polio immunization program, there has been a curtailment from Rs 7,411.40 crore in 2018-19 to Rs 6,758.46 crore in 2019-20.

"The interim budget is on expected lines given that the country is going to polls in another few months.

However, we would have expected more for the healthcare and diagnostics sector given that that seems to be the stated focus of the government since the beginning," Arindam Haldar, CEO, SRL Diagnostics said.

In Budget 2018-19, Modi government had announced one of its most ambitious schemes Ayushman Bharat which is a centrally sponsored programme anchored in the ministry of health and family welfare. It is an umbrella of two major health initiatives, namely health and wellness centres (HWCs) and PMJAY.

Dubbed as 'Modicare' and billed as the world's largest health insurance scheme, PMJAY aims to provide free health insurance of Rs5 lakh per family to nearly 40% of the population—more than 100 million poor and vulnerable families based on socio economic caste census (SECC). PMJAY was launched on September 23, 2018.

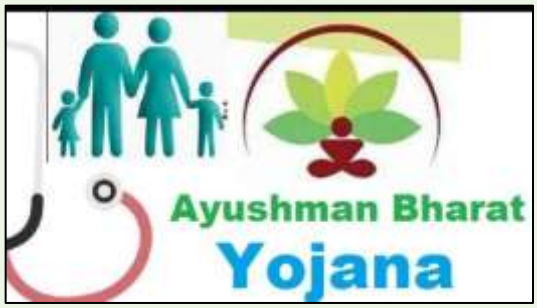
PMJAY is an entitlement based scheme. PMJAY provides cashless and paperless access to services for the beneficiary at the point of service in any (both public and private) empanelled hospitals across India.

India's spending on health continues to be very low with around 1.4% of the GDP. According to the latest annual report of Central Bureau of Health Intelligence 2017-18, India spends less than some of its neighbor countries such as Bhutan (2.5%) and Sri Lanka (1.6%).

TOP

Source

Union Budget 2019: 10 lakh people helped by Modi's ambitious Ayushman Bharat scheme, says Piyush Goyal - Financial Express – 1st February 2019



Budget 2019: Finance Minister Piyush Goyal Friday lauded the Pradhan Mantri Jan ArogyaYojana, popularly known as Ayushman Bharat scheme, saying that the world's largest healthcare programme has successfully treated around 10 lakh people after having been launched only last year.

The scheme, which was rolled out with the idea of providing medical treatment to nearly 50 crore people, has saved Rs 3,000 crore of the lower and middle classes that have undergone treatment under the scheme, Piyush Goyal said while presenting the Interim Budget 2019-20, which is also the Narendra Modi-led government's last as the Lok Sabha elections are due in April-May.

Emphasizing the central government's role in the healthcare sector of the country, Goyal said that the past five years have seen a massive scale-up in the sector. The finance minister also said that the poor, who earlier found it hard to access affordable medical healthcare treatment, have largely benefitted from the Ayushman Bharat programme.

Also, while mentioning the Pradhan Mantri Jan Aushadhi Yojana, Piyush Goyal said that the Jan Aushadhi centres have provided affordable medicines to people. Further, he noted that cardiac stents and knee implants have become cheaper, benefitting almost lakhs of people.

Meanwhile, Goyal also said that out of the 21 AIIMS in the country, 14 have been commissioned under the Modi-led government. "2/3rd of the All India Institute of Medical Sciences has come up under our rule, the 22nd one will soon come up in the state of Haryana," he added.

TOP

Source

CROP INSURANCE

Telangana's Rythu Bandhu and Odisha's KALIA way better than PM-KISAN - The Hindu Business Line – 1st February 2019

When Union Finance Minister Piyush Goyal announced the Pradhan Mantri Kisan SAmman Nidhi (PM-KISAN) that seeks to provide an annual grant of Rs 6,000 to farmers, it immediately draws comparison to Telangana's Rythu Bandhu. One also weighs it with Rythu Bandhu's clones in Odisha and West Bengal, which are yet to be rolled out.

There are several differences between the Central farmers' financial scheme and the scheme that is in vogue in Telangana in the last two cropping seasons.

While the Central scheme has a cap of two hectares to make a farmer eligible for the scheme, the Rythu Bandhu of Telangana has no bar on the extent of land one should own. The State, however, had restricted the acreage to 50 acres in the Rabi season for Rythu Bandhu payouts. Capping the acreage at five acres would be disadvantageous to farmers in the rain fed areas, where the farmers, even if they have more land, would still require financial assistance.

Another major difference is both the quantum of the help and how it is distributed. As against the Centre's Rs 6,000 in three equal installments, farmers get Rs8,000 in two installments ahead of the Kharif and Rabi in Telangana.

The KCR government has promised to increase the assistance to Rs 10,000 from this year.

Disbursals

Piyush Goyal has said that the amount will directly be credited to the bank accounts of farmers, leaving no scope for any intermediary. The KCR government, however, chooses to hand over the cheques through people's representatives. (The Rabi disbursement, however, happened through direct transfer as the election code was in force.)

On tenant farmers

The Central scheme is yet to be evolved. Rules need to be formalised. As of now, it's not clear whether the PM-KISAN would include tenant farmers in the scheme. Keeping in view the concerns around ownership vis-à-vis tenant farmers, the Telangana government chose to keep tenant farmers out of the purview of Rythu Bandhu.

"The Centre seems to have done no homework before announcing the scheme," GV Ramanjaneyulu, the Chief Executive Officer of Centre for Sustainable Agriculture, felt.

Taking a cue from Telangana's Rythu Bandhu, the Odisha government has launched KALIA (Krushak Assistance for Livelihood and Income Augmentation), offering an annual assistance of Rs 12,500 each to each to farmers.

Of the four schemes, the Odisha's scheme looks more comprehensive as it covers the landless agricultural labourers too. It also seeks to provide help to vulnerable agricultural households, besides promising interest-free crop loan.

The Mamata Banerjee government in West Bengal too emulated Rythu Bandhu and announced an annual financial assistance of Rs 5,000 in two installments. However, payouts in Odisha and West Bengal are yet to happen.

The schemes in the three States have an insurance component attached to them. While the Telangana Government started an insurance scheme, Rythu Bima, providing a cover of Rs 5 lakh, Odisha and West Bengal have embed the insurance component into the schemes.

TOP

Source

MOTOR INSURANCE

Mumbai: Soon, RTO to keep tabs on your car insurance – The Times of India – 6th February 2019

If you have not committed a single road mishap and have not been challaned by traffic police for any violations for five years, you may qualify for lower insurance premium on your vehicle.

The transport department plans to "incentivize" good road manners by recommending lower car premium to the Insurance Regulatory and Development Authority (IRDA) On the other hand, it will suggest increased premium for regular traffic offenders as "penalty" and "deterrent".

State transport commissioner Shekhar Channe put forth this proposal at a road safety workshop held on Tuesday.

He also told media persons the computerized database of vehicles in Maharashtra, on Vahan software, would be linked to IRDA database soon. "Once this is done, we will get direct access to all car insurance data and ascertain if any vehicle across the state has paid the mandatory insurance. If the owner has failed to insure a vehicle, we will impound it and return it only after premium is paid."

Sanjay Datta, chief of underwriting and claims at ICICI Lombard General Insurance, said the information on penalties will help identify the outliers who frequently violate traffic guidelines. But for pricing of policies, traffic police data would only serve as peripheral data, as in India, pricing is specific to a vehicle and not a driver.

"In the US, where pricing is based on the driver, factors like traffic violations are taken into consideration for calculating the premium," said Datta.

Meanwhile, Channe also announced that bike and scooter dealers must compulsorily provide two helmets to every buyer. "Helmets should be part of the final delivery (free of cost) and if dealers do not provide these life-saving headgears, we will prosecute them." Those who purchase two-wheelers can lodge complaints with the local RTO in case they do not receive the helmets.

Vijay Patil, superintendent of police (highways), also present at the workshop, said helmets reduce risk of injuries by 70%. Channe said his department would put updetails such as "high risk zones" for mishaps on the website. State secretary (roads) C P Joshi said the state has taken note of 1,324 black spots or accident-prone areas.

TOP

Source

Motor insurance: Should you opt for lower IDV, voluntary deductible to reduce premium payable? - The Economic Times- 6th February 2019

When buying or renewing your motor insurance it is advisable not to blindly buy the policy with the lowest premium. If one car insurance policy premium is significantly lower than alternatives offered by other insurers, then in all probability the former's coverage may be less in terms of value or features.

Remember that a significantly lower premium is likely to be a trade-off for a lower IDV or a higher deductible or fewer benefits. Fully understand the implications of these trades-offs before you go for the lower premium policy.

When you decrease Insured Declared Value (IDV)

Insured Declared Value (IDV) means the maximum value for which your car is insured in case of total loss/theft in a particular year. This value normally decreases as the car depreciates over its lifespan. The value is mutually agreed between you and the insurance company and set at the start of your insurance policy every year. The insurance premium is calculated based on this value. For the same premium rate, a lower IDV implies lower premium and a higher IDV would mean a higher premium. Normally, most insurance companies allow you to choose an IDV within a certain pre-specified range. This is because the IDV of your vehicle depends not only on its depreciated value but also its market value. Therefore, you have the option of choosing a slightly lower IDV so as to reduce the premium payable. You can either do it by visiting the insurance company's portal or tell your adviser to do it for you.

How you would be affected

Lowering the IDV below the market value of your vehicle means that you are insuring your vehicle for less than what its worth and this would mean that you would get that lower IDV as compensation in case of theft or total loss. By implication it means that you are taking on some of the risks of total loss (to the extent the IDV is less than the actual market value of the car) and would have to bear some of the loss of value in such an event.

Rakesh Goyal, Founder & Director, Probus Insurance Broker told EconomicTimes.com that if your IDV for a vehicle is Rs 4 lakh, the insurance company would compensate claims worth Rs 4 lakh in case of theft or accident resulting in total loss. . But, if you have lower your IDV to say Rs 3 lakh while buying your policy then the insurance company would compensate only claims worth Rs 3 lakh. So, one should always insure one's vehicle for the correct IDV to ensure that one gets the right amount in case of a claim. "Don't reduce your car's IDV just for the sake of reducing the premiums as this would lead to high risks," he said.

When you increase the voluntary deductible

In vehicle insurance, there are two types of deductibles. The first is compulsory deductible where you have to pay a fixed amount of any claim for repair made by you under the insurance policy. For example, if the claim for repair of accidental damage to your car is say Rs 50,000 then you would have to pay a fixed amount (say Rs 1000) of this claim and only the balance would be reimbursable by the insurer.

The second type is voluntary deductible where you agree to pay an extra amount (in addition to the compulsory deductible) out of your own pocket at the time of claim. Due to this, your premium gets reduced (you get a discount on your premium amount) as you are taking a part of risk onto yourself by agreeing to pay a higher part of the claim. At the time of a claim, both the compulsory and voluntary deductibles will be deducted from your claim amount. Such deductions are applicable each time youmake a claim.

Take a look at the following example on how voluntary deduction will help in reducing premium amount:

Note: The premium outgo is the sum of Net OD + Total TP Premium + GST

Car Name: ALTO 800			
Place - Year of Purchase: Delhi - 2017			
With Voluntary Deductible Discount	**Shriram Insurance**	**National Insurance**	**Universal Sompo**
Insured Declared Value (IDV)	187390	187390	187390
Basic Own Damage (OD)	5860	5860	5860
Voluntary Deductible (Rs. 2500/-) Discount	750	750	750
Insurer Discount	3809	3066	2930
Net Own Damage (OD)	**1301**	**2044**	**2180**
Basic Third-Party (TP) Premium	1850	1850	1850
Personal Accident Cover for Owner Driver	315	295	225
Total Third Party (TP) Premium	**2165**	**2145**	**2075**
Goods and Services Tax (GST)	624	754	765
Total Premium Outgo (Incl of GST)	**4090**	**4943**	**5020**
Without Voluntary Deductible Discount	**Shriram Insurance**	**National Insurance**	**Universal Sompo**
Insured Declared Value (IDV)	187390	187390	187390
Basic Own Damage (OD)	5860	5860	5860
Insurer Discount	3809	3516	2930
Net Own Damage (OD)	**2051**	**2344**	**2930**
Basic Third-Party (TP) Premium	1850	1850	1850
Personal Accident Cover for Owner Driver	315	295	225
Total Third Party (TP) Premium	**2165**	**2145**	**2075**
Goods and Services Tax (GST)	759	808	901
Total Premium Outgo (Incl of GST)	**4975**	**5297**	**5906**

Source: www.policybazaar.com

How you would be affected

Suppose you have a claim of Rs 25,000 (after subtracting compulsory deductible) and your voluntary deductible is Rs 10,000 then in that case, the insurance company will only pay Rs 15,000 and the remaining amount you need to pay from your pocket that is, the balance Rs 10,000.

However, if your voluntary deductible was only Rs 5,000 then, in that case, the insurance company would pay the claim of Rs 20,000 and you would have to pay only the balance Rs 5,000. But, in the second case, the premium charged would be higher than in the first case.

Tarun Mathur, Chief Business Officer- General Insurance, Policybazaar.com says that in case of cashless claims, the voluntary deductible is paid directly to the repair shop or the workshop and not to the insurer as the same amount is pre-fixed and is only payable at the time of claim. "But in case you are making a claim through reimbursement mode then, the insurer deducts the amount of voluntary deductible at the time of reimbursement," he added.

Hence, it is a misconception that the higher the deductible the better, as the same has to be borne by you at the time of claim. "Choosing high voluntary deductible can reduce your car premium, but you must increase deductible only if you can afford the repair cost at the time of a mishappening. Just reducing the premiums for sake of it is not at all a good idea," Goyal said.

TOP

Source

Passenger vehicle sales muted in January –Financial Express – 2nd February 2019

Passenger vehicle sales remained under pressure in January, with top five car makers reporting negative or flat sales growth, hit by continued challenges of higher insurance cost and poor finance availability. Besides, price hikes taken by automakers in the range of 1-5% across models from January 1 also kept the customers on the back foot. Analysts at Kotak Institutional Equities are of the view that demand is still subdued across most segments due to weak consumer sentiment, which would impact industry volumes over the next few months.

Mayank Pareek, President, passenger vehicles business, Tata Motors said, “January 2019 has been a rather sluggish period for the entire auto industry and has resulted in muted consumer sentiment”.

While Maruti Suzuki reported a tepid growth of 0.2% year-on-year (y-o-y), Hyundai India's volumes grew by just 0.6% y-o-y.

Tata Motors' sales fell 11% y-o-y and Toyota Kirloskar Motor reported a sales decline of 9.14% y-o-y. N Raja, Deputy Managing Director, Toyota Kirloskar Motor said, "With the closure of special offers and year end schemes, the buying sentiment has witnessed a dip this month.

The tightening of vehicle financing availability has also added to the challenges in the market".

Mahindra & Mahindra posted a marginal 0.79% y-o-y growth in passenger vehicle sales, while Honda Cars India was the only exception recording a growth of 23% y-o-y.

Commercial vehicle sales were a mixed bag last month, with Tata Motors being the worst hit. Sales dipped 6% y-o-y and the management attributed the fall to lagged effect of axle load norms and low consumer sentiment.

TOP

Source

REINSURANCE

Reinsurance firms approach IRDAI for separate set of accounting norms - The Hindu Business Line – 6th February 2019

Reinsurance companies have approached the Insurance Regulatory and Development Authority of India (IRDAI) for a separate set of accounting and reporting norms for the industry.

Same norms used

At present, re-insurers in the country, including state-run General Insurance Corporation of India, use the same reporting norms prescribed by the regulator for insurance companies.

"The industry has been in talks with the IRDAI on a separate set of guidelines for re-insurers for reporting, accounting and end-use," said an executive with a foreign reinsurance company.

Apart from GIC, there are nine foreign re-insurers that have set up operations in the country with branch offices. These include Swiss Re, Lloyd's India, and Allianz Global Corporate and Speciality.

The discussions come soon after the IRDAI eased rules for foreign reinsurers to create a more level playing field with GIC.

While the state-run reinsurer continues to have the first right of refusal, foreign reinsuers can bid for the contracts and win if they quote lower prices.

Still a few years away

However, foreign reinsurers say that while the development is welcome, it will still take a few years for the system to settle down.

Experts believe a separate set of reporting guidelines are necessary for reinsurers, as their nature of business and cash flows is different.

"The business of reinsurance is different from that of insurance, and so the reporting norms have to be different.

"For example, the cost of acquisition, or the way the costs are divided or premium is treated is different.

"The insurer gets the money as soon as the risk is underwritten, the reinsurer gets the money quarterly in an aggregated form," said Joydeep Roy, Partner - Leader, Insurance and Allied Businesses, PwC India, adding that the accounting needs to be tailored to reinsurance to help present the true picture of their accrual of risk and premium.

TOP

Source

Reinsurance reforms to help non-life biz: Moody's - The Times of India – 2nd February 2019

Rating agency Moody's has forecast bright prospects for the non-life industry, thanks to liberalization of reinsurance and the Ayushman Bharat programme adding depth to the insurance market.

"The liberalisation of reinsurance which allows newcomers to compete with GIC Re is a credit positive for the non-life companies. Besides providing an additional capital, it provides a bigger pool of experience," said Mohammed Ali Londe, analyst, Moody's.

He added that the timing is also good as the reinsurance companies can diversify, despite large payouts due to catastrophic claims, thanks to support from alternate capital. Reinsurance companies provide protection to insurance companies.

According to Londe, the new health programme Ayushman Bharat, or National Health Protection Mission (AB-NHBM), will boost premiums. "The move is credit positive for India's insurers because it will help grow health premiums and provide them with cross-selling opportunities," said Londe.

He said that even where the trust model was adopted it will help improve insurance awareness and penetration and will help the industry in building hospital networks and to get underwriting pricing right.

On the proposed merger of the three non-life insurance companies — National Insurance, Oriental Insurance and United India Insurance, he said that there were two upsides for the merged entity.

"If executed well, it will bring efficiency in risk selection, pricing and improved distribution," said Londe. He added that the government would however need to inject capital ahead of the merger.

The impact of opening of the reinsurance sector on GIC Re, which enjoyed a monopoly status for decades, would also be positive, Londe said. "This will give them an opportunity to be more sophisticated in their underwriting.

They can now see the pricing that rivals are willing to offer, also they would no longer be forced to follow the fortunes of the primary insurance companies," he said.

TOP

Source

INSURANCE CASES

IRDAI imposes Rs9 lakh penalty on United India – The Hindu – 7th February 2019

Insurance regulator IRDAI has imposed penalties totallingRs9 lakh on United India Insurance Co. Ltd. (UIIC) after it found the general insurer had violated certain provisions. A sum of Rs5 lakh is for violation of regulations that stipulate certain timelines such as those relating to assigning of surveyors ; for the surveyor to submit his report; the insurer offering a settlement of claim to the insured as well as paying the claim to the insured. The action against the State-owned insurance company followed a show cause notice that the regulator issued in August 2018 in connection with an onsite inspection during October 2015.

The UIIC had responded to the show cause notice in October 2018 and made further submissions during a personal hearing in December. The IRDAI order said an examination of the sample documents pertaining to the insurer revealed that there are numerous circumstances where the surveyor has been appointed beyond 72 hours. In 28 claims, the submission of survey report has been delayed beyond six months; and in 33 claims there has been a delay in settlement of claim by the insurer after the receipt of final surveyor report, the order said, directing the company to pay Rs5 lakh.

IRDAI had found three violations by the company, of which for two it decided to impose penalty on the company. The balance Rs4 lakh – Rs1 lakh each is for violations pertaining to four sample policies – was imposed on UIIC for violation of circular and guidelines on rates/discounts an insurer can offer and disclosure of material information.

On examining the sample policy files of UIIC, the order said, "the insurer has not recorded justification for the "extent of discount" given to different clients. The discount given is derived from market forces, as the insurer relies on quotes given by other competitors." The regulator said if UIIC "feels aggrieved by the order, it may prefer an appeal to the Securities Appellate Tribunal.

TOP

Source

United Healthcare files complaint against Dr Reddy's US arm - The Hindu Business Line – 6th February 2019

Dr Reddy's Laboratories on Wednesday said United Healthcare Services has filed a complaint against its US-based arm and some other entities, alleging a price fixing conspiracy to rig bids and allocate customers with respect to 30 drugs. The US-based insurance firm United Healthcare Services has filed a complaint against Dr Reddy's Laboratories and 42 other defendants, involving a total of 30 generic drugs, it said in a regulatory firm.

"The complaint alleges violations of Section 1 of the Sherman Act, and violations of the Minnesota and 29 other States' antitrust laws, Minnesota's and 16 other States' Consumer Protection statutes, and claims of unjust enrichment, seeking injunctive relief, recovery of treble damages, punitive damages, attorney's fees and costs," it added.

The drug firm said it denies any wrongdoing and intends to vigorously defend against these claims. "We believe that there is no material impact to the company's operations or consolidated results," it added. Dr Reddy's shares on Wednesday ended 1.47 per cent down at Rs 2,784.70 on the BSE.

TOP

Source

Gujarat court junks insurance company's claim that depression caused heart attack – The Times of India – 3rd February 2019

Can severe depression lead to heart attack? Can an insurance company deny claim after an insured person's death due to heart attack merely because he was suffering from depression?

The Gujarat State Consumer Dispute Redressal Commission has turned down arguments by the Life Insurance corporation of India (LIC) wherein it rejected insurance claim saying that the insured person, who died due to heart attack, was suffering from severe depression. The consumer court on Thursday ordered LIC to pay Rs 47.90 lakh towards insurance claim in two different policies.

The court said that there is no co-relation between depression and the cause of death and hence LIC could not have repudiated claims made by kin of the deceased on the ground that he was severely depressed.

The case involved a family of one Hetal kumar Patel from Nadiad. He died of heart attack in 2012. Two years before his death, he had bought nine different policies from LIC.

Hetal kumar Patel's family members claimed insurance money and the LIC repudiated the claims saying that Patel was being treated for depression and he had not declared his ailment while opting for insurance.

For seven claims, the family members successfully approached the district consumer dispute redressal forum in Nadiad. But for two policies, which involved amount higher than Rs 20 lakh each, Patel's widow Dr.Nilam Patel, two children and his parents knocked at the commission. LIC also challenged the lower court's orders.

LIC placed medical literature showing how damaging major depressive disorder could prove. Patel's advocate argued that there is no connection between depression and heart attack. He cited various orders passed by the Supreme Court and the National Consumer Dispute Redressal Commission (NCDRC) to show that insurance companies were directed to pay claims in case of deaths in which cause of death and the pre-existing ailments had no nexus.

The court said, "It is very clear that the husband of the original complainant was suffering from major depression and he died due to heart attack. Thus, it cannot be said that there is any nexus between the ailment and the cause of death."

TOP

Source

OPINION

4 lesser-known types of insurance worth buying - Financial Express – 5th February 2019

Insurance is often understood as life, health or auto insurance. At a time when the country is busy shopping for insurance to reduce its tax outgo, we are going to reiterate that tax saving shouldn't prompt your insurance purchases. They have a bigger purpose in your portfolio. They financially protect your life, health and valuables. And in that note, we are going to look at some lesser-known insurance policies and what purposes they meet.

Home insurance

Home is one of the most expensive assets we own and yet we leave it exposed to the risk of a damage without a financial security. Natural calamities such as flood, storm, earthquake etc. come unannounced

and you can be caught off-guard with the liabilities they bring along. Home insurance can help you financially secure your house and the content inside. It can be acquired by both the owner and the tenant.

Travel insurance

Traveling abroad can be an expensive affair and if it goes wrong in any way such as loss of important documents or baggage, a sudden illness etc, it would only mean more hassles and your expenses would go up. Also you don't want to be stuck in a foreign land in an emergency situation without a helping hand to rescue you out. This is where travel insurance comes handy. While it's mandatory to carry travel insurance when traveling to certain countries, it's advisable to carry it wherever you go.

Travel insurance plans can be bought for both domestic and foreign trips for single as well as multiple trips. However, like health insurance, travel insurance doesn't offer protection against any pre-existing conditions.

Wedding insurance

Weddings are grand in India and people often end up draining a good chunk of their savings in arrangement for their children's wedding. There is a series of events and postponement or cancellation due to burglary, fire, accident, death etc. can lead to huge losses. Wedding insurance can work as a line of defense if anything untoward were to come. A typical wedding plan covers expenses incurred during a wedding for booking venue, florist charges, catering services, food, transportation cost etc. Other inclusions and exclusions may vary from policy to policy.

Credit card protection

This acts as an insurance plan for credit cards, debit cards, retail and membership cards. Most credit card companies have a CCP plan nowadays with the basic proposition being the same as in all plans- coverage for theft, burglary, fraud, loss of card etc, covered for a premium. CCP also ensures that your card is blocked in case you lose it. A few companies also offer an interesting price protection feature, wherein the company pays you the difference of the price you have actually paid for the goods or service bought and the lowest printed price advertised for the same.

(The writer, Adhil Shetty is CEO, BankBazaar.com)

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Source

Can regulators urgently look into mis-selling? – Mint – 5th February 2019

Mis-selling has really gone out of bounds and so often I come across stories of people who have been duped. Here is what I have seen, heard and experienced myself. A 72-year-old was called by the bank manager of a private bank on maturity of his fixed deposit and recommended to move it to a scheme that could give him "10% guaranteed" return.

Thankfully, he checked with me and he was stopped from investing in an insurance product. In my own case, the few times I visit the bank, turns out a sour experience. The aim of the people working in the branch seems to be to sell insurance policies. Forget the service managers, even the teller will ask you for investments. Since when are tellers qualified to give investment advice? I wanted to open a locker and approached a public and a private sector bank. Both wanted me to buy a "five-year investment scheme" in order to open the locker and quoted these as being "bank rules". I would like to ask the Reserve Bank of India (RBI) if it is mandatory to buy an insurance product to open a locker.

Of course, even equity mutual funds are now being sold as products which will fetch 12-15% guaranteed returns over 2-3 years investment periods. I have had many individuals ask me how their investments will turn from negative to 15%? Many participants are not willing to believe that insurance does not give

a high guaranteed return. There are so many people who have invested a large part of their savings into insurance products believing the agents' lies of 15% guaranteed return. Gold schemes from jewellers are still a big hit with even the branded, listed companies promoting such schemes. Investors don't realise these schemes are nothing but lending money to the jeweller.

Recently, I did a session for teachers from rural areas in south India and was surprised to hear about the number of cases wherein people have fallen prey to phishing calls and have given out their PIN numbers or account information.

While awareness has been created through various media forms about phishing, it could be augmented by direct messages to users. For example, a short video on safekeeping of account and PIN information could be sent regularly to customers. Similarly, short videos on the risks associated with gold schemes, chit funds etc. could also be sent to customers.

I am still without a locker simply because I refuse to buy an insurance plan to fulfil the banks sales target. I have the option of taking up the issue with the ombudsman but how many people can actually do this? Is there a way for consumers to share these wrong practices online with the regulator? And even then, is there any action being taken?

The mis-selling in insurance has gone on for just too long and nothing has been done. Firstly, can we have a common disclaimer for all market-linked instruments, i.e. for investment-linked insurance products and mutual funds? This itself can help reduce mis-selling as consumers will realise that insurance returns are also subject to market risk.

Can the regulator consider a single certification for a financial advisor? Today there are mutual fund agents, insurance agents, registered investment advisors who are allowed to distribute different products. This causes confusion for the investor. The insurance agent is only interested in pushing insurance and down-sells every other product because he doesn't make similar commissions. This is a huge conflict of interest. Further, there are chartered accounts, bloggers etc. who also provide investment advice even though they are not certified or in some cases qualified to do so. A single combined certification along with standard fees (like mutual funds) on various products, including insurance, would go a long way in reducing mis-selling.

Finally, customers need to protect themselves. How many investors really research an investment product before investing? Consumers cannot keep blaming the system for their own ignorance. Reading up is the only way to protect oneself against unscrupulous advice.

(Mrin Agarwal is a financial educator, founder director of Finsafe India Pvt. Ltd and co-founder of Womantra)

TOP

Source

Planning to buy an insurance policy? Know what leads to rejection of a claim - Financial Express – 5th February 2019

Insurance offers financial protection during an adverse situation. Health insurance provides financial protection including hospitalization expenses to the insured, while life insurance gives financial security to the dependent family members on the demise of the insured. Getting the claim on time is very crucial. Sometimes, the insurance claim gets rejected, resulting in extreme financial distress to the insured or the dependent family members. So you must know about the things that may lead to the rejection of your insurance claim. Let's check out the important causes for a claim rejection.

Furnishing wrong information while applying for insurance
Whether you apply for life or health insurance, the insurance company determines the premium based on the information provided by you. Sometimes, people furnish wrong details to lower the premium amount. Later, if the insurance company detects such a discrepancy, then it may reject the claim due to the incorrect information provided by you.

It is essential to fill the insurance details carefully and provide the right information. Don't leave any point blank: if the information asked is not relevant, then write down 'NA' or put a cross sign. After completing the form, take a photocopy for your record.

Lapse of Insurance policy
You are eligible to get a claim only during the policy period, i.e., when you have paid the premium within the due date. If the premium is not paid on time, then the policy lapses, and the insurance cover ceases to give you protection. Always pay the insurance premium on time.

You can set a reminder or auto bill pay to avoid overseeing the due date. Usually, insurance companies allow a grace period of 15 days for premium payments in case you missed the due date.

Not giving details of pre-existing diseases
Under the health insurance policy, pre-existing diseases are often covered after the lapse of the prescribed waiting period, i.e., 3 or 4 years as per the policy clause.

If you don't mention about pre-existing ailments at the time of application and make a claim within or after the prescribed waiting period, then the insurance company can reject the claim request citing non-disclosure of material fact.

If the insurance company gives the option of providing a health check-up report while applying for the insurance policy, then you should undergo all the prescribed tests and submit the true report.

It is better to have the application rejected at an initial stage due to pre-existing diseases, than getting your claim rejected during a medical emergency.

Not providing complete information
Concealing or not providing complete information can result in claim rejections or a delay in settlement. For example, you should give the right information related to your income if applying for life insurance, as the insurance company determines the permissible cover size based on that figure.

If you smoke or drink, then mention it correctly in the application. If you have already taken a life insurance policy from other company, then furnish the details in the form. Similarly, you should provide correct details for your height, weight, age, address, etc.

Filing the claim late
Filing the insurance claim late can lead to a rejection. Life insurance companies usually conduct an immediate survey to collect the correct information related to the demise of the insured. Claim delays can make the insurance company get suspicious about fraud.

Similarly, health insurance companies usually need to be informed within 48 hours of hospitalization for getting a timely claim; otherwise the settlement may get delayed unnecessarily. If you are going for a planned hospitalization, then you may request the health insurance company to pre-approve the claim. This will help reduce the chances of claim rejection.

(The writer, Adhil Shetty is CEO, BankBazaar.com)

TOP

Source

Legal safeguards in your insurance - The Hindu Business Line – 4th February 2019

Buyers of insurance sometimes feel helpless because they have little ability to change the insurance contract and its terms.

These contracts are one-sided and are not customisable. However, over the last decade, the regulators have built several mandatory provisions into the contracts that protect policyholder rights. Understanding these provisions should give you confidence in the policies, because even if you cannot make changes to the contract, there are safeguards in place.

In life insurance, an important protection is that claims cannot be rejected after three years.

This change was introduced in 2015. It shifts the responsibility of proving non-disclosure or misinformation onto the insurer and, that too, within the first three years of the policy.

This provision makes it absolutely important that you renew the insurance in a timely manner each year. The three-year period is restarted if there is a break in your insurance renewal and the policy has to be reinstated.

Understand your insurance

Further, every life insurance policy must have an illustration that is specific to what you bought and signed. The format of this illustration and the information to be shared is specified by the regulator.

It must give a clear sense of the possible returns and list the guaranteed benefits and surrender values. The insurer relies on this illustration to set your expectations on the insurance and make sure you understand what you have signed.

Long-term unit linked insurance plans (ULIPs) have to be designed in a way that all the charges put together do not exceed 2.25 per cent of the insurer's returns. This cap on expenses safeguards you from excessive charges in a ULIP. Finally, life insurances have a 15-day or more freelook period when you can return the insurance and get a refund. The 15-day period begins when you receive your insurance. This gives you the opportunity to return an insurance that is not in line with what you expected.

Claims in health insurance

Health insurance also has safeguards. The insurance must be renewable for as long as you live. An insurer cannot put an age limit as this prevents situations when the insurance is withdrawn as you grow old. This is an incentive to buy insurance early even if you are in good health because you will have the financial security of this insurance as you grow older.

Premiums cannot be increased for specific individuals based on their medical history or claims. If there are price changes, they must be applicable for the entire age group. A claim you make cannot be the basis of increasing premiums. Finally, disease definitions are standard across insurers. This removes subjectivity in determining whether you have a critical illness.

The regulations allow definitions that are more liberal. Some standalone cancer plans pay a benefit on early stage cancer, which may be excluded as per the standard definition. The safeguards around health exclusions are likely to become even stronger in the future. A report restricting exclusions has been published by a regulatory sub-committee and under consideration.

From a process standpoint, the law requires all health and life insurance policies to include a copy of the completed proposal form that was the basis of insurance. Claims must be settled within 30 days of receiving all documents. Insurers are expected to ask for all claim information in one go rather than piecemeal.

Insurance is a sector prone to litigation, given the conflict when a claim is rejected. Cases are filed with the ombudsmen, district and state courts and consumer forums. Over the past decade, many judicial precedents have been established and these tend to put the policyholder's interests central. These judicial decisions are slowly finding their way into insurance contracts. For example, a recent high court judgment disallowed exclusions relating to mental illness.

As a buyer, you may not know the various safeguards, but should take comfort from the fact that the industry has steadily been improving the way it treats policyholders and that trend will continue.
(The writer, Kapil Mehta is co-founder, www.securenow.in)

TOP

Source

PENSION

EPFO withdraws circular relaxing rules for payment of higher pension to eligible EPS members - The Economic Times – 8th February 2019

In a surprising move, the Employees' Provident Fund Organisation (EPFO) has withdrawn its circular dated January 22, 2019 where it had relaxed the rules regarding joint option form with employer. As per the new circular issued on February 7, EPFO has said, "In view of the judgement dated 12.10.2018 passed by the Division Bench of the Honorable High Court of Kerala at Ernakulum in WP (C) 13120 of 2015 and connected cases, the said circular is withdrawn with effect from the date of its issue."

EPFO, in its circular dated January 22, 2019 had relaxed the rules allowing Employee Pension Scheme (EPS), 1995 benefits by not insisting joint option from employer if the EPF account of the concerned employee has been updated in the EPFO records on the basis of the contribution received on the actual salary rather than the statutory limit.

This was done to smoothly implement the orders of the Supreme Court (SC) on paying pension to employees on the basis of higher contributions made earlier on the basis of actual salary. EPFO earlier instructed its regional offices not to ask for formal joint option of employee and employer where earlier contribution towards Employees' Pension Scheme (EPS) by them was higher than the statutory wage limit.

EPFO, in its circular dated January 22, 2019, has said, "If an employer and employee have contributed under the EPF Scheme, 1952, on wages higher than the statutory wage limit without joint option of employee and employer and the EPF account of the concerned employee has been updated by the EPFO on the basis of such contribution received, then by action of employee, employer and EPFO, it can be inferred that joint option of employee and employer has been exercised and accepted by the EPFO. Therefore, in such cases, for implementing the directions issued earlier, formal joint option of employee and employer should not be insisted upon."

Under EPF rules, an employer has to contribute 12 percent of the basic salary of an employee into EPF. Out of this amount, 8.33 percent goes into EPS. The current salary cap on EPF is Rs 15,000 a month. So, the maximum contribution to EPS is Rs 1,250 a month. A 1996 amendment in the EPS Act gives employees the option to raise pension contribution to 8.33 percent of the actual salary (basic + DA). To hike the contribution to EPS, one has to apply to the EPFO along with a consent letter from the employer. Supreme Court, through a ruling in 2016, made it mandatory for EPFO to allow higher contribution to

EPS. Even retired employees can opt for this. After a few years, EPFO even stopped accepting requests for raising the contribution to EPS.

Following several media reports including *Times of India*, in 2005, several private EPF trustees and employees approached EPFO with the demand to remove the ceiling on their EPS contributions and raise it to their total salary. The EPFO rejected the demand claiming that their response should have come within six months of 1996 amendment. In October 2016, Supreme Court ruled in favour of employees' right to raise their contributions to the pension fund without imposing any cut-off date for eligibility.

With effect from September 1, 2014, EPFO asked the existing members who were contributing on full salary to furnish a fresh option within 6-12 months. The circular dated January 22, 2019 has also withdrawn the following:

"For those employees who were contributing on higher salary prior to 01-09-2014, in such cases as well, joint option need not to be insisted for. From September 1, 2014, members of EPS who were already contributing to the Pension Scheme on actual salary to submit the fresh option, within prescribed limit to continue to contribute on actual salary. It also specifies that such members shall have to deposit an additional contribution into the pension fund at the rate of 1.16 per cent of salary exceeding Rs 15,000, from and out of the contributions payable by the employees for each month. However, for the period prior to September 1, 2014, there is no such provision in EPS, 1995 which requires the employees who opt to deposit contribution at actual salary to deposit any additional contribution."

TOP

Source

Govt notifies hike in its contribution to central govt employees NPS to 14% just before Budget 2019 - The Economic Times – 1st February 2019

Perhaps kicking off the provision of sops in the budget, the central government has notified the increase in its contribution to central government employees NPS accounts from 10% to 14% with effect from April 1, 2019. The notification was issued on 31.1.2019.As per the notification, "The monthly contribution would be 10 percent of the Basic Pay plus Dearness Allowance (DA) to be paid by the employee and 14 percent of the Basic Pay plus DA by the Central Government". Greater freedom in choosing pension funds and pattern of investment to central government employees has also been notified.

Choice of pension fund and investment pattern in tier-i of NPS has been notified as under: Choice of Pension Fund: As in the case of subscribers in the private sector, the Government subscribers may also be allowed to choose any one of the pension funds including Private sector pension funds. They could change their option once in a year. However, the current provision of combination of the Public-Sector Pension Funds will be available as the default option for both existing as well as new Government subscribers.

Choice of Investment pattern: The following options for investment choices may be offered to

Government employees: -

(a) The existing scheme in which funds are allocated by the PFRDA among the three Public Sector Undertaking fund managers based on their past performance in accordance with the guidelines of PFRDA for Government employees may continue as default scheme for both existing and new subscribers.

(b) Government employees who prefer a fixed return with minimum amount of risk may be given an option to invest 100% of the funds in Government securities (Scheme G).

(c) Government employees who prefer higher returns may be given the options of the following two Life Cycle based schemes.

(A) Conservative Life Cycle Fund with maximum exposure to equity capped at 25% - LC-25.

(B) Moderate Life Cycle Fund with maximum exposure to equity capped at 50% - LC-50.

(viii) Implementation of choices to the legacy corpus: Transfer of a huge legacy corpus of more than Rs. 1 lakh crore in respect of the Government sector subscribers from the existing Pension Fund Managers is likely to impact the market. It may be practically difficult for the PFRDA to allow Government subscribers to change the Pension Funds or investment pattern in respect of the accumulated corpus, in one go. Therefore, for the present, change in the Pension Funds or investment pattern may be allowed in respect of incremental flows only.

(ix) Transfer of legacy corpus in a reasonable time frame: PFRDA may draw up a scheme for transfer of accumulated corpus as per new choices of Government subscribers in a reasonable time frame of say five years. Once PFRDA draws up this scheme, change in the Pension Funds or investment pattern may be allowed in respect of the accumulated corpus in accordance with that scheme.

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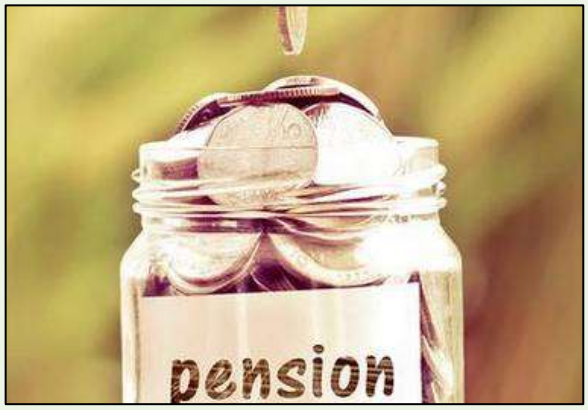
Source

Attractive pension plan for aamaadmi - The Hindu Business Line – 1st February 2019



The scheme proposed by Finance Minister Piyush Goyal in this Budget, the 'Pradhan Mantri Shram-Yogi Maandhan', intends to provide an assured monthly pension of Rs 3,000 a month to workers in the unorganised sector who earn up to Rs 15,000 per month.

This scheme seems to replicate the existing pension plan 'Atal Pension Yojana' (APY), which is meant for the citizens of India, including the unorganised sector workers. However, returns under the newly proposed scheme seem to be more attractive than the APY.

How it works

As per the Budget speech, a worker joining the Shram-Yogi Maandhan, on attaining 29 years of age or above, will have to contribute Rs100 per month, while those joining at the age of 18 will have to contribute Rs 55 per month. They will receive the pension amount of Rs 3,000 per month after attaining 60 years of age, till death. The government will also contribute during the accumulation period by depositing a matching share in the pension account of the worker every month. However, detailed information, including on maximum entry age and expenses charged, are not available.

Comparison with APY

APY was launched in 2015 to replace the earlier Swavalmban pension scheme for workers in the unorganised sector. Under this, a contribution from the government for eligible subscribers will be made for five years, subject to a maximum of Rs 1,000. The subscribers will receive a fixed minimum pension of Rs1, 000, Rs 2,000, Rs 3,000, 4,000 or Rs 5,000 per month, after the age of 60, depending on their contributions as well as age of entry.

Charges involved in maintaining the APY account are similar to the NPS including registration, record keeping, account opening and maintaining charges, and investment management fee. The monthly pension will be available to the subscriber and, after his time, to his spouse. After their deaths, the pension corpus will be returned to the nominee of the subscriber.

Attractive return

The monthly amount payable under the proposed pension scheme seems to be lower than that of the APY for a person of the same age. For instance, the monthly premium for a worker joining at the age of 29 for availing a monthly pension of Rs 3,000 is just Rs 100 under the new scheme, while under APY, it is Rs318. Assuming that, if the worker receives pension of Rs 3,000 per month for 20 years (until 80 years of age) after attaining 60, the IRR (internal rate of return) works out at 11.3 per cent for the new scheme. But under the APY, the IRR is just 6.9 per cent.

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IRDAI CIRCULAR

List of Foreign Reinsurers Branch, Lloyd's India and Lloyd's India Service Companies in India as on 31-01-2019 is available on IRDAI website.

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Insurer wise list of life insurance products launched / modified in the financial year 2018 - 19 is available on IRDAI website.

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IRDAI uploaded handbook on Indian insurance statistics-2017-18 on website.

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Report of committee on regulatory sandbox in insurance sector in India is available on IRDAI website.

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GLOBAL NEWS

China: Insurance asset management body gathers experts – Asia Insurance Review

The Insurance Asset Management Association of China (IAMAC) plans to establish a specialised evaluation database covering equity-related products. The association has already begun to gather experts to assess equity investment plans and insurance private equity funds.

These moves follow a call last month by regulators urging insurance companies to invest in stocks and bonds of high-quality listed companies to support the stable and healthy development of listed companies and capital markets. To this end, the CBIRC said it would simplify the registration process for insurers to establish equity investment plans and private equity funds. The CBIRC said that IAMAC would be designated to handle the registration process for the plans and funds. The regulator also encouraged insurers to invest in securities brokerage firms' asset management plans and trust products.

IAMAC will form a market-oriented expert team to evaluate independently insurance equity products. The experts will be appointed for a two-year term. The selected experts will review the registration materials of the equity products in accordance with relevant laws and regulation, and publish their evaluation opinions.

The main responsibilities of the team include mainly:
(1) Conducting a prudent risk assessment of equity products and related businesses, and independently publishing personal professional opinions;
(2) Making recommendations on the disclosure of information on equity products and related businesses;
(3) Providing professional advice on equity products and related businesses in conjunction with current regulatory requirements and IAMAC self-regulation rules;
(4) Conducting research on issues related to equity products and business, and providing suggestions for improving relevant rules and regulations.

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Singapore: Govt proposes to expand mandatory insurance cover for work injuries - Asia Insurance Review

The Ministry of Manpower (MOM) has reviewed the Work Injury Compensation Act (WICA) to provide injured employees with greater assurance of compensation, sooner after an accident.

MOM has proposed several amendments to amendments to the WICA, including expanding mandatory insurance coverage.

The key features of the proposed amendments include:

A. Broaden WICA Coverage, Increase Payout
1. The WICA requires employers to compensate their employees who suffer work injuries. Not all employees, however, are required by law to be covered under work injury compensation (WIC) insurance. WIC insurance provides greater assurance of compensation in the event employers are unable to pay. While the number of cases of non-compensation is low – only about five cases a year on average are not compensated due to lack of insurance and inability of their employers to compensate, MOM intends to broaden WICA coverage to provide greater assurance to more employees.

Expand mandatory insurance coverage
(a) To expand mandatory insurance coverage, prioritising lower-income employees most at risk of financial hardship, if their employers fail to compensate. More than 24,000 currently uninsured employees will benefit from mandatory insurance coverage by April 2021.

Expand scope of compensation
(b) Currently, only injured employees placed on medical leave are compensated. Those who are injured but have been certified by doctors to be well enough to perform light duties are not eligible for compensation at the moment. MOM intends to expand compensation to those placed on light duties as a result of work injury, such that they are no worse off than those given medical leave.

Update WICA compensation limits
(c) The maximum compensation levels under WICA will increase by at least 10% to keep pace with wage growth and increase in medical costs.

B. Speed Up Claims Processing

1. The WICA is intended to offer a lower cost and speedier resolution to WIC cases as compared to filing a suit in the courts. However, about 1,300 claims a year (or 24% of valid permanent incapacity claims) still take longer than six months to reach its conclusion. MOM intends to streamline various aspects of claims processes to speed up claims processing.

Allow compensation based on current incapacity

(a) One factor accounting for long processing times is having to wait for the final extent of injury to be determined. Nonetheless, the WIC Medical Board has advised that the vast majority of injuries do stabilise within six months after the accident. MOM proposes to compensate based on the assessment of incapacity at least six months after the date of accident. For employees with injuries that take longer to stabilise, doctors can still defer assessments to a later date.

Auto-process WICA claims

(b) MOM intends to process WICA claims by default, without requiring the employee to separately file the claim.

Allow MOM to determine basis of compensation, to resolve disputes

(c) To reduce delays from disputes over the salary used as the basis for compensation, MOM intends to allow compensation to be based on a multiple of the employee's basic monthly salary, if itemised pay slips are not available.

MOM to accredit WIC policies

(d) WIC insurance policies that exclude coverage of risky work situations increases the risk of employees not being compensated for their work injuries. MOM will accredit WIC policies, based on a core set of standard terms and conditions, to ensure adequate WIC insurance coverage to protect both the employers and the employees.

License insurers to process WIC claims

(e) To ensure that claims are processed in a fair and timely manner, MOM will license insurers to sell and process all insured WICA claims. MOM will also be empowered to overrule the insurers' decisions if necessary.

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New Zealand: Growth to slow as life insurers fix conduct issues – Asia Insurance Review

Growth in the New Zealand life insurance industry is likely to be hampered in the short term as insurers address issues raised by regulators following a review of the industry's conduct and culture, Fitch Ratings says.

Regulators concluded in a report issued on 29 January 2019 that life insurers were not doing enough to achieve good outcomes for customers and highlighted weaknesses in the approach of insurers to identifying, managing and remediating conduct risks and issues. However, Fitch expects implementation of the regulators' recommendations to address these issues to improve insurers' business profiles over the longer term.

The international rating agency believes insurers may revisit pricing and design of certain life products, which could inhibit premium growth, at least initially. Regulators have identified the presence of certain life products that are of poor value to consumers as the products have extremely low loss ratios and high rates of claims being declined.

Regulators called for changes to incentive structures and removal of incentives linked to sales measures, which create risks of sales being prioritised over customer outcomes. We believe changes to distribution channels could temporarily curb premium growth, but may ensure sustainability of earnings over the longer term.

Fitch thinks that implementation of the recommendations made by the regulators would strengthen insurers' competitive positioning and business risk profiles over the longer term, as well as improve the reputation of the industry as a whole.

The Financial Markets Authority and Reserve Bank of New Zealand conducted a review of 16 life insurers, and identified instances of poor conduct as well as a few instances of potential misconduct that were not currently widespread. The review follows a review of New Zealand banks in November 2018, prompted by similar action in Australia where a Royal Commission found incidents of misconduct in the financial services industry.

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China: Non-life insurance sector grows faster than life – Asia Insurance Review

China's insurance industry saw a stable increase in premium income in 2018 amid tightened regulations aimed at defusing financial risks, official data show.

Property insurers collected CNY1.2tn in premium income, up 11.52% year on year, while life insurance firms saw premium income grow marginally by 0.85% to CNY2.6trn.

The combined premium in the industry totaled CNY3.8trn ($567bn) in 2018, up by 3.92% year on year, according to data from the CBIRC.

Major insurers reported relatively faster growth in premium income. Combined premium income of CNY2.19trn was posted by the five biggest listed insurers including Ping An Insurance and China Life Insurance, representing an increase of 10.8% year on year. Their premium total represented around 60% of the market.

The big insurers with their scale have been able to perform better in the market which in the last two years saw tightened regulations aimed at fending off financial risks in the market.

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