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Health Insurance Options for Senior Citizens


The comfort of a comprehensive Health Insurance still remains a dream for citizens in the August days of their life. It is ironical that despite the significant growth in the insurance industry and Health Insurance having been in India for more than 25 years, a senior citizen is today unable to have all his major medical expenses covered when he needs it most. It was our former Prime Minister Rajiv Gandhi, who first mooted the idea of medical insurance, which was then taken up and introduced by the Public Sector General Insurance Companies for the first time in 1986. But the heartening news is that the insurance market is fast evolving over the last few years and has come out with some solutions to provide relief for people above 60 years, in the form of exclusive Senior Citizen’s Health Insurance Policies. However, these solutions are not without riders and inbuilt restrictions.

The major concern which a senior citizen’s insurance would require to address is coverage for pre-existing ailments. Depending on the insurer, the pre-existing ailments are covered after 48/24/12 months of continuous coverage. Where the coverage for pre-existing ailments is available in the first year of the policy itself, it is to be noted that if treatment was received by the insured person during the preceding 12 months from the date of first policy, such ailments would be covered only from second year onwards. Some policies, while providing cover for pre-existing conditions of Hypertension and Diabetes, do not provide cover for ailments already manifested and attributable to these two conditions before the date of the Policy. However, despite the coverage available for pre-existing ailments, all policies exclude certain ailments from the scope of the Policy during the first or two years of the operation of the Policy. These ailments are clearly stipulated in the policy document. All policies also invariably contain a 30 days waiting period whereby any expenses incurred for treatment of illness contracted by the insured during the first 30 days from the commencement date of the Policy are not be payable.

Next comes the imposition of limits on reimbursable medical expenses. Majority of the policies require the insured to bear 10% to 30% for all claims for ailments, whether pre-existing or not. This percentage goes up if the claim pertains to a pre-existing ailment. In addition to this mandatory capping, the policies also do have restrictions on the maximum amount admissible which would be the limit of Company’s Liability in the event of a claim irrespective of the sum insured. These limits vary according to the kind of ailment. Some policies also make it conditional that the treatment should be taken in the network hospital only.

Most of the policies insist on the pre-acceptance medical checkup for fresh entry into the scheme. The proposer would be required to undergo the medical checkup at his/her own cost. Some insurers do not insist on pre-acceptance medical test but do provide a discount on the premium on production of the medical reports to their satisfaction. The premium structure is based on age band which is broken into a block of 5 years starting from 60 onwards. The basic premium, exclusive of service tax, ranges between Rs. 4,000 and 7900 for a sum insured of Rs. 100,000.

The Policy provides coverage for Room, Boarding, & nursing expenses, Surgeon, Anaesthetist, Medical Practitioner and Consultants Fees, Anaesthesia, Blood, Oxygen, OT charges, Surgical appliances, Medicines, drugs, Diagnostic material & X-Ray, Dialysis, Chemotherapy, Radiotherapy, cost of
pacemaker, artificial limbs, cost of sent & implants. The amount payable is indicated as either a percentage of sum insured or as fixed limits. The Policy also pays emergency ambulance charges for transporting the patient to the hospital subject to maximum limit of Rs. 1,000 to 1,500 per policy period depending upon the Policy terms. Pre and Post Hospitalisation expenses relevant to the treatment for which hospitalization was done are also considered as part of claim. As an incentive for having claim free years of insurance, some policies provide cost of Health checkup at the end of a block of every three or four claim free years. The amount admissible could be anywhere between 1% and 2% of the average sum insured during the block of three or four years. Having a claim free year of insurance can also result in increase in sum insured at the time of renewal or a discount in the renewal premium (upto 5% either way). But the point to be noted here is that there should not be any break while renewing the policy. In exceptional circumstances, the break in period for a maximum of seven days can be condoned as a special case subject to medical examination and exclusion of disease during the break period. Since a break in insurance can result in forfeiture of all renewal benefits, the senior citizens should ensure that the renewals are done in time without fail. Though it is not mandatory to send renewal notices to the insured, insurers generally send them well in advance. However, it is important to keep a track of the renewal date by oneself and not to wait for insurance company’s reminder for renewal of the policy.

The age group for fresh entry into the Policy is normally between 60 and 70 years but some insurers allow the entry upto the age of 80. Policy can be renewed beyond 70 and up to the age of 90 years.

All the four Public Sector Insurers, namely, United India, New India, National and Oriental Insurance, and some Private Sector Insurers are offering Mediclaim Policies for Senior Citizens. Star Health is offering Senior Citizens Red Carpet Health Insurance and the policy does not insist on pre-insurance medical test. National Insurance has introduced Varistha Mediclaim for Senior Citizens but pre-acceptance medical check-up is required for fresh entrants. Bajaj has Silver Health (Health cover for seniors). While choosing the policy, it would be worthwhile to go in for a policy which has the least capping on ailments even it would mean a higher premium since otherwise the advantage of having maximum medical expenses reimbursed would be lost.

A word of caution to the younger generation... take the mediclaim policy in your individual capacity as soon as you start earning and never discontinue a mediclaim policy even if you were to be covered by your employers subsequently.

Getting back to the plight of senior citizens whose financial resources are depleted and with the spiraling cost of medical treatment, the mediclaim insurance needs to be more sensitive to the needs of this section of our society. We owe it to them.

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**Don’t Renew your Health Cover Blindly**

Make sure the insurer is offering same terms & conditions and not shifting you to another product, says Preeti Kulkarni

_The Economic Times/ Preeti Kulkarni/ May 17, 2012_

PS Chohan, an octogenarian, was in for a shock when he received a renewal notice from his health insurance company of two decades. “The insurer had earlier approved a cataract surgery claim of Rs.
42,044, but it has imposed a sub-limit of Rs. 24,000 under some new rules,” he says. The company cited a market survey conducted by its third-party administrator (TPA) to justify the downward revision. Certain other terms and conditions of the old policy, too, were modified.

Seventy-two-year-old Lata Rao, who has had a health cover of Rs. 1.5 lakh since 2005 faced a similar predicament in 2009, when she started undergoing treatment for cancer. After releasing the entire claimed amount for the first two years, the insurer started deducting 25% from the approved amount from third year onwards, citing the co-payment clause in the policy. Simultaneously, the premium was also hiked by nearly 200%. “In effect, for a sum insured of Rs. 150,000, the company charged Rs. 68,164 as premium, in addition to co-payment,” points out her husband IS Rao. The experiences of Chohan and Rao are narrated only to show the ugly practice of tweaking of the terms and conditions by insurance companies at the time of renewals. The practice is against the Insurance Regulatory and Development Authority (IRDA’s) diktat prohibiting companies from arbitrarily altering the terms of a policy. Also, the companies are required to intimate the revisions to all policyholders at least three months prior to the renewals, besides seeking IRDA’s approval for the changes.

PAY ATTENTION TO DETAILS

“Due to IRDA’s diktat, it is not easy for the companies to revise their terms at will. If companies feel the need to change the clauses that are unfavorable to them, they simply launch new products and attempt to get the existing policyholders to migrate to the new one,” says Arvind Laddha, CEO of Vantage Insurance Brokers and Risk Advisors. That is why it is important to read the wordings carefully to ascertain whether you are giving your assent to the same product or a completely different one. Remember, as per IRDA’s directives, insurers cannot force you to switch to another product. “You should not blindly agree to the changes in the list of hospitals where cashless claims can be made, particularly if there is a contraction in the network of such hospitals,” says Laddha. Many insurers ask the insured to bear a part of the cost if they decide to undergo treatment in a non-network hospital.

“While the insurer can change the premium amount if there is a change in the age slab of the customer, no other changes can be made in the policy conditions. Policyholders can also oppose any exclusion, which did not form part of the policy at inception, introduced at the time of renewal,” adds Divya Gandhi, head, general insurance and principal officer, Emkay Insurance Brokers.

INTRODUCTION OF RESTRICTIONS

Typically, at renewal, insurers seek to introduce co-payment clauses, sub-limits for certain diseases or on room rents and doctors’ fees into the contract. Some also exclude ailments if there was a related claim. “All such changes which are imposed subsequently or are not in accordance with the original terms and conditions of the policy are illegal and can be opposed. However, insurance companies usually ignore any opposition and the insured is compelled to assert his rights by filing a consumer complaint and obtaining appropriate orders,” says consumer activist Jehangir Gai. If your insurer has adopted such a high-handed approach, you can write to the insurance ombudsman or approach the consumer court.

DENIAL OF RENEWALS

Imagine paying premiums for years, only to see your renewal being turned down when you need it the most – during your silver years. After receiving several complaints from senior citizens, IRDA barred companies from rejecting renewals except on the grounds of fraud, moral hazard or misrepresentation.
Significantly, renewal cannot be denied simply because you had made a claim in the previous year.

LOADING ON PREMIUMS

It’s a major cause of consternation for most policyholders. Hike in premiums following a huge claim is often used as a tool to discourage renewal of the policy. Known as claim loading, this practice remains rampant though several voices have termed it unfair. If your original contract had clearly explained its working in detail, you may not be able to contest the hike, unless it is in violation of the declared claim loading structure. This apart, premiums can go up due to medical inflation, advancing age or resetting of the premium for an entire group/portfolio by the insurer. “In case of most insurers’ premium structure, either the premiums increase every year or premium slabs are prescribed for different age groups; say, Rs. 4,200 for the age band of 30-35 years and Rs. 6,700 for the 36-40 category. So, when a 35-year-old policyholder turns 36, his premium will jump by Rs. 2,500, but this cannot be termed loading,” says Gandhi. Therefore, the key is to determine the cause of premium revision, which again, the insurer is duty-bound to divulge at the time of renewal, before taking a call on opposing the changes.

IRDA to cap risk passed on to reinsurance firms

*Business Standard/ Niladri Bhattacharya & Yogini Joglekar/ Mumbai/ May 18, 2012*

Mumbai: Soon, insurance companies in India will not be able to pass on a majority of their risk to reinsurers. The Insurance Regulatory and Development Authority (IRDA) is set to specify the retention limit in this regard for insurance companies.

In a communication to the CEOs of insurers, IRDA said companies operational for more than 10 years would not be able to cede more than 30 per cent of their premiums to reinsurance companies. Those operating for less than 10 years would have to retain half the risk in their books. There were no such caps till now.

According to sources in the sector, most insurers retain nearly half of risk and move out the rest. Companies, generally, pass on or cede a part of their risk to reinsurance companies against a ceding commission. Under these agreements, reinsurers would bear the claims arising out of these risks.

According to IRDA, with most of the risk passed on to the reinsurers, an insurer is eventually acting as “service provider” rather than “risk bearing insurer”.

“If an insurer has low retention limit, then such insurers only act as an insurance service provider than as a risk bearing insurer. This amounts to fronting. Fronting insurers only rely on ceding commission without developing national retention capacity and underwriting expertise necessary for development of a viable domestic insurance industry,” it has said in a recent letter to the insurers.

The regulator said each insurer should formulate its retention policy for each type of product, based on emerging claims experience, financial standing, underwriting capacity and so on in the annual reinsurance program it gives to the authority. “In addition, the insurer shall clearly demonstrate that such reinsurance arrangements are prudent and in the best interests of with-profit policyholders, in terms of minimizing the cost to the with-profit funds.”
Insurers are divided on the latest mandate. “Reinsurance being the tool to manage a company’s risk, it depends from company to company as to how much risk premium they wish to cede with reinsurers,” said G N Agarwal, chief actuary, Future Generali Life Insurance Company. “It’s not a very good move for the industry because the regulator has suggested a cap on how much premium can be ceded. The regulator shouldn’t have intervened in the risk management business because every insurer has a different risk book and the company will have to cede premium accordingly. This may even lead companies having larger risks to suffer losses.”

According to G V Nageswara Rao, Managing Director and CEO, IDBI Life Insurance, as the regulator was trying to improve local capacity, the suggested cap was fair. “Most companies try to retain more risk on their own books and pass on a small portion to the reinsurers.

But, for smaller companies who don’t have enough risk appetite, this limit on ceding premium could pose a problem on their books,” he added.

General Insurance Corporation slips into red, posts Rs 2,469-cr loss in 2011-12

The Economic Times/ Shilpy Sinha/ Mumbai/ June 6, 2012

General Insurance Corporation, the state-owned reinsurer, has posted a loss of Rs 2,469 crore in 2011-12, the first in its history, as it had to pay out more due to natural catastrophes in countries such as Japan and Thailand, while yield on investments and inflow of fresh business were hit on account of the global economic slowdown.

2011-12 was a difficult year for reinsurance companies with substantial exposure to Asia, as countries as far apart as Thailand, Japan, New Zealand and Australia were hit by natural calamities such as earthquakes and floods.

Reinsurance refers to insurance bought by insurers from other insurance companies. GIC, the only Indian insurer allowed to provide reinsurance and which made a profit of Rs 1,033 crore in 2010-11 proved no exception to these global trends.

The corporation has increased its exposure to overseas markets in the past few years, a decision that did not prove beneficial during 2011-12 as it reported an underwriting loss - the difference between payouts to insurance companies and premiums received from them - of Rs 4,971 crore.

This includes a Rs 1,956 crore hit on account of floods in Thailand and Rs 400 crore and Rs 470 crore respectively due to earthquakes in Japan and New Zealand. GIC also made an additional provision of Rs 811 crore to cover possible losses arising from providing reinsurance for the motor vehicle industry.

"Most of the losses have come because of global programs where we participated," said A K Roy Chairman and Managing Director GIC. "We are cutting down exposure to such programs. So, for example if Munich Re covering catastrophe in various countries, we have brought down that exposure. "Overall GIC saw claims of Rs 7,672 crore against an income of Rs 5,924 crore from abroad.
Global reinsurance firm Swiss Re has termed 2011 as the costliest year for the reinsurance industry with catastrophic losses exceeding $110 billion, of which 60% is from the Asia Pacific region.

GIC saw its premium income rise 16% to Rs 13,000 crore in 2011-12. The company reported investment income of Rs 2,255 crore, marginally down from Rs 2,339 crore in the previous year. "We have made provision of Rs 2,491 crore. Actual payment of claims will be paid in next few years.

GIC's solvency ratio is more than 150% despite all this losses. Overseas business contributed 44% to the premium growth. The combined ratio, which is claims and operating expenses as a percentage of premium income, from overseas business was at 191%,” Roy said.

"GIC will grow more slowly at 10% this year. We have taken proactive steps, cut underwriting losses, brought down expense and are looking to improve investment income,” Roy said. It has a reserve of Rs 9,000 crore, which will come down to Rs 7,000 crore because of the provisioning on account of losses.

The corporation has been exiting segments where it has failed to make money over a five year period. GIC, for instance, has stopped providing reinsurance for insurers in the health and credit insurance businesses.

**Building had no insurance cover**

*The Indian Express/ Shilpy Sinha/ Mumbai/ June 6, 2012*

Even as all prime buildings of institutions such as Reserve Bank of India, Securities and Exchange Board of India and public sector companies have got their establishments insured, the government does not seek an insurance cover in a bid to save on high premium payment for their buildings that run into large numbers. The Mantralaya building, where a fire broke out on Thursday, was also left uninsured. A senior government official who did not wish to be identified said the Mantralaya building had not been insured. And, that is not a case in isolation. Senior officials with insurance companies confirmed that as a trend or rule no government building in the country is insured. “The logic is that the government has numerous buildings and if it insures them, the premium cost would run into huge numbers,” said the head of a general insurance company.

There are, however, some state governments that have created an alternative mechanism to cover their buildings. “The state governments of Gujarat and Rajasthan run their own insurance fund,” said a senior official with another insurance company.
Cashless treatment for road accident victims from August

The Times of India/ Dipak Kumar Dash, TNN / New Delhi/ June 22, 2012

The government will roll out the country’s first project for cashless treatment of road accident victims in August on the Pathankot-Amritsar stretch - the national highway linking the Golden Temple and Vaishno Devi. In this pilot project, the government will bear all medical expenses during the first 48 hours of hospitalization of road accident victims.

Road transport and highways ministry, which will implement the scheme across the country, claims it will ensure "right to emergency care for all road accident victims”. Before country-wide rollout of the project on all NHs, the government will run five such pilot projects.

The government is undertaking the first pilot project on the 108-km stretch of NH-15 which is used by around 75,000 vehicles every day on their way to Vaishno Devi and there is one bus every 1.5 minutes. Moreover, four laning of the stretch is underway and it has mixed traffic including tractor trailers and horse carts. Between April 2011 and March 2012, this road recorded 2,410 accidents.

Since a substantial number of victims are pilgrims, they have no local contact to help them in case of accidents, which is crucial for recovery. The government has fixed Rs 30,000 ceiling for reimbursement. In case the victim stays in hospital for three more days, the hospital will charge ‘discounted’ treatment amount as per Central Government Health Scheme (CGHS) or AIIMS norms.

A third party administrator -- nationalized insurance company -- will operate and monitor the scheme including recouping of medical expenses from the insurer of the vehicle.

"Our aim is to save lives by providing ambulances at short intervals, tie-up with closest hospital so that victims get immediate care during golden hour," said MoS (highways) Jitin Prasada.

The government is working out the seed capital for the project. "When we roll out the plan for the entire country, we have to bid out the projects, may be region-wise," said joint secretary (road transport) Nitin Gokarn. Once the system - network of Nehru Yuva Kendra volunteers, call centres, ambulances and hospitals - is in place, the response time of ambulances will come down to 10 minutes from the present 17 minutes.

NHAI will place signboards at frequent intervals which will have the phone numbers of volunteers/call centres and ambulances.

Giving details of the scheme, a ministry official said they had identified Nehru Yuva Kendra volunteers who would get trauma care training so that they become the first responders to accident sites. As soon as the call centre receives an emergency call, it will pass the information to volunteers, ambulance, hospital, rescue vehicle and police.
Whoever reaches first will provide first aid to victims. He will click a photograph of the accident and upload it on the server that can be accessed by hospitals to ascertain the accident. Punjab government has told the Centre that there are 231 hospitals, clinics and nursing homes along the Pathankot-Amritsar stretch and they would issue a notification directing them to admit all cases relating to road accidents immediately.

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**Claim investigator can't declare driving license to be fake**

*The Economic Times/ New Delhi/ June 20, 2012*

An insurance claim investigator cannot declare unilaterally a driving license to be fake without any corroborating report from the transport authority, a Delhi district consumer forum has said.

Maintaining that an insurance firm cannot reject a claim based on the "uncorroborated whimsical report" of its claim investigator, the New Delhi District Consumer Disputes Redressal Forum directed Oriental Insurance Company Ltd to pay Rs 1.95 lakh to its policy holder for the damage to his car in an accident.

"It is seen that investigator is not basing his report on any direct report from Regional Transport Authority, but he himself is author of all reports sent to the opposite party (Oriental Insurance)."

"In the absence of a report of fake driving license from the office Regional Transport Office (RTO), the insurance firm cannot repudiate (a claim) on (the) uncorroborated whimsical report of the investigator," the forum said.

The forum’s order came on a plea by Delhi resident Bhupender Bakshi, who had said his vehicle was insured with the firm on the date of accident, September 29, 2008 and he had duly informed it of the same.

He said the loss was assessed by the investigator at Rs 1.45 lakh, but later the insurance firm rejected his claim on the ground that his driving license was fake.

The firm in its defense said its investigator had found Bakshi’s driving license to be fake.

Rejecting the contention, the bench presided by C K Chaturvedi pointed out to the firm that a letter from the RTO, Agra showed that driving license owned by Bakshi was valid till June 21, 2010 and there was no objection for its renewal.

"In these facts and circumstances the repudiation is arbitrary. We find the insurance firm to pay Rs 1,45,000 and award damages of Rs 50,000 to complainant,” the bench said.
Annual fitness test must for 5-yr-old cars in Delhi soon

The Hindustan Times/Atul Mathur/New Delhi June 20, 2012

If you own a car or two-wheeler that is more than five years old, you will have to get a fitness certificate for it every year or else your vehicle won’t be insured and you’ll run the risk of paying a fine. Till now, only private vehicles more than 15 years old needed a one-time fitness certificate to ply the Capital’s roads forever.

“Annual fitness certification of vehicles is a norm in many countries. It will not just check vehicular emissions but also ensure safety standards,” a senior Delhi government officer said.

Delhi chief minister Sheila Dikshit has approved of the transport department’s proposal, which will be brought before the state cabinet soon.

Senior transport department officials said all authorized service stations and big automobile workshops will be mandated to check vehicles and issue fitness certificates for Rs 300.

“This will not just help check the roadworthiness of vehicles but also help bring down the number of accidents and incidents of fire in vehicles,” said Anil Chikara, an automobile expert and senior officer in the state transport department.

He added that once the proposal is implemented, vehicle owners will be compelled to maintain their vehicles properly.

Service tax exemption on premium for exports withdrawn

According to Notification No. 19/2012 dated 5th June 2012 from the Ministry of Finance (Department of Revenue), service tax exemption on premium collected on insurance of export of goods is withdrawn with effect from 1st July 2012. Service tax of 12.36% is applicable on all marine transit export insurance premiums from 1 July 2012.
Please feel free to contact marketing@prudentbrokers.com

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