Subject SA1

CMP Upgrade 2022/23

CMP Upgrade

This CMP Upgrade lists the changes to the Syllabus, Core Reading and the ActEd material since last year that might realistically affect your chance of success in the exam. It is produced so that you can manually amend your 2022 CMP to make it suitable for study for the 2023 exams. It includes replacement pages and additional pages where appropriate.

Alternatively, you can buy a full set of up-to-date Course Notes / CMP at a significantly reduced price if you have previously bought the full-price Course Notes / CMP in this subject. Please see our 2023 *Student Brochure* for more details.

We only accept the current version of assignments for marking, *ie* those published for the sessions leading to the 2023 exams. If you wish to submit your script for marking but have only an old version, then you can order the current assignments free of charge if you have purchased the same assignments in the same subject in a previous year, and have purchased marking for the 2023 session.

This CMP Upgrade contains:

- all significant changes to the Syllabus objectives and Core Reading
- additional changes to the ActEd Course Notes and Assignments that will make them suitable for study for the 2023 exams.

0 Changes to the Syllabus

There have not been any changes to the Syllabus.

1 Changes to the Core Reading and ActEd text

This section contains all the ***non-trivial*** changes to the Core Reading and ActEd text.

General

Throughout the course the following changes have been made:

- where the term 'State' refers to the government of a country, it has been capitalised
- references to 'his or her' have been amended to 'their'
- in the Core Reading, the term 'student' has been amended to 'candidate' throughout
- dates have been amended from May 2021 to May 2022 unless specifically mentioned below.

Chapter 1

Section 4

On page 12, the link to the professional guidance section of the IFoA website has been updated to:

actuaries.org.uk/standards/standards-and-guidance.

Chapter 2

Section 1

On page 5, the first sentence of the second paragraph below the solution has been amended to read:

The aim of an IP insurance product is to replace part of the income that the insured would have earned if they became unable to work due to accident, mental health condition or illness.

Section 3

On page 25, the ActEd text has been amended to read:

Concerns such as these in the UK have led the government to propose establishing a lifetime cap of £86,000 to an individual's care costs from October 2023 in England. This cap does not include accommodation or food costs. At the time of writing (May 2022) it remains to be seen whether the insurance industry will develop products that could cover these capped costs.

Chapter 3

Section 1

On page 5, in the first paragraph of ActEd text, the final sentence has been deleted.

Chapter 5

The syllabus objective at the start of the chapter has been amended to include the following point:

- external influences – demographic, medical, economic, political, social, pandemics and climate change.

Section 1

On page 3, the second bullet point in Section 1.2 has been amended and some additional ActEd text has been added below:

- **Demographic factors – for example in many countries, there is a demographic trend that shows people are living longer, especially with disabilities or chronic conditions, than has historically been the case. Often, more than one chronic condition is diagnosed in an individual, described as multi-morbidity.**

  The term comorbidity it also used to describe a situation where multiple diseases or conditions are present. This is the term defined in the Glossary (Chapter 27).

On page 7, the following changes to the ActEd text on long-term care insurance have been made:

In the UK, sales of LTCI have been disappointingly low. The immediate needs annuity market is currently only worth around £100 million in premium income each year. At the time of writing (May 2022) there are no insurers active in the pre-funded LTCI market. As mentioned in Chapter 2, the proposed change to introduce a cap on personal care costs could lead to insurers launching new products.

In the USA, despite recent reductions in the size of the market, in 2014 it was estimated that 7.2 million individuals had LTCI cover with an annual premium income of around $12 billion each year. Reasons for the fall in demand are uncertain, however could be attributed to a rise in premiums with a reduction in benefit levels following initial pricing errors and a perceived lack of need. In 2000, there were around 100 providers of LTCI in the USA, this had fallen to less than 12 by 2020.

On page 9, the first sentence of ActEd text has been amended to read:

As mentioned in Chapter 3, these penalties have now effectively been abolished, although some individual States have introduced their own penalties.

Also on page 9, the two paragraphs of ActEd text before the question have been deleted.

On page 15, the following text has been added before the question:

Note here we are using the UK-style definition of major medical expenses from the glossary:

'A PMI product variant that pays a fixed amount (from a schedule relating to severity) to policyholders who undergo surgery of a non-investigative and non-cosmetic nature.'

Also on page 15, in the solution, the second paragraph has been amended to read:

A big negative is the lack of peace of mind for the customer. There is no guarantee that the costs of the treatment will be covered – hence the customer will have to find any extra from somewhere, or go through the State (and hence potentially wait for treatment).

Section 4

On page 37, additional Core Reading has been added to Section 4.1 along with a question. Replacement pages are attached.

Chapter 6

Section 2

On page 12, the first sentence of Section 2.3 has been amended to read:

Genetic tests are used for many purposes and are increasingly accessible to consumers.

On page 14, the Core Reading before the bullet point list has been amended to read:

Regulations on the use of predictive genetic tests by insurers constitute a range of approaches including guidance, legislation and moratorium.

Section 4

On page 22, the sentence below the bullet point list has been amended to read:

In the UK, fertility rates have been reducing since 2012 following a period of relative stability from 1977 onwards.

On page 32, the second paragraph of Core Reading has been replaced by the following text:

Many populations have experienced excess mortality as a result of the pandemic, with the additional impact of increased morbidity likely to represent a long-tail event. Long COVID is a term used to describe a range of symptoms that persist beyond 8 weeks from initial presentation. The exact prevalence is unknown, but in the UK, it is suggested that more than 1 million people may experiencing self-reported long COVID (https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/prevalenceofongoingsymptomsfollowingcoronaviruscovid19infectionintheuk/3february2022).

The virus attacks multiple organs of the body including the lungs, heart, kidneys, pancreas and brain, thus the potential for a future morbidity burden is substantial (https://www.mayoclinic.org/diseases-conditions/coronavirus/in-depth/coronavirus-long-term-effects/art-20490351).

On page 34, the final bullet point under the heading 'Physical' has been amended to read:

- **increased morbidity in an insured population due to pollution.**

On page 35, all references to 'undertakings' have been replaced with 'firms'.

Also on page 35, the final Core Reading bullet point under the 'Liability' sub-heading has been amended to read:

- **firms that do not take into account the impact of their investment decisions on climate change experience direct claims for damages.**

On page 36, new Sections 4.8 and 4.9 have been added. Replacement pages are attached.

Section 5

On page 37, the second sentence under the heading 'Morbidity' has been amended to read:

The following table illustrates the top five causes of disability adjusted life years lost (DALY's / 100,000) in 2019 globally and by income region.

On page 38, the final sentence of Core Reading has been amended to read:

However. causes of death from non-communicable disease are increasing, and those from communicable diseases decreasing in low-income countries.

On page 38, in the table, the final column showing data for the UK has been deleted.

Also on page 38, additional text has been added before and after the first paragraph of ActEd text:

For the UK, the leading causes of disability are the same as for high income countries, shown in the table.

This data was collected before the Covid-19 pandemic. Initial data on the impact of Covid-19 on global deaths over the first year of the pandemic suggest it would be the 4th largest cause of deaths. The impact would vary significantly by country. For example, in 2020, Covid-19 was the leading cause of death in the UK, ranked 3rd in the USA but only 38th in Australia.

Summary

On page 46, the final bullet point of external influences has been updated to include environment factors and mental health.

Chapter 7

Section 1

On page 4, the first alternative definition of any occupation has been amended to read:

'Totally unable by reason of illness, mental health condition or injury to follow any occupation for which they are suited by training or education.'

Chapter 8

Section 1

On page 8, the link at the end of this Section has been amended to:

actuaries.org.uk/learn-and-develop/research-and-knowledge/actuarial-research-centre-arc/recent-research/project-discount-rates

Section 7

On page 35, the 6th paragraph which is Core Reading, has been amended to read:

There is increasing integration of Environmental, Social and Governance considerations (ESG) in investment practices within all types of insurance company, due to reasons of risk and return and the public interest as well as the more traditional ethical reasons.

Section 8

On page 38, the following material has been added as Section 8.1:

8.1 Removal of barriers for consumers

Care is needed to during the design of health and care products to ensure that barriers for consumers are removed or minimised. An example could include removing barriers for consumers with mental health conditions such as:

- **signposting customers to alternative options (*eg* specialist broker) and/or support services if cover has been declined**
- **training claims staff to identify vulnerable customers, deal with these customers compassionately and identify support services if required**
- **identifying and changing areas of the underwriting process that may cause anxiety**
- **bundling a product with support services for mild mental health symptoms and conditions**
- **providing rehabilitation services where appropriate (*eg* for income protection insurance products).**

These ideas were introduced in Chapter 6 around mental health conditions.

The remaining Sections in Section 8 have been renumbered.

Summary

On page 43, the sections on administration, expenses and lapses have been combined with material on the new barriers for consumers section, under the heading 'Other considerations'. The new section reads as follows:

Other considerations

- Barriers for consumers – insurers should take care to remove any barriers that are preventing customers accessing their services.

- Administration – systems need to be ready and tested prior to product launch. Key staff must be recruited and trained.
- Expenses – all the expenses that are associated with a product need to be allowed for in pricing.
- Lapses – important factors in determining lapse rates include:
  - distribution methods and after-sales service
  - economic confidence
  - ongoing competitiveness of the product.

  Competitive pressures have caused lapse and re-entry problems for insurers.

Chapter 9

Section 1

On page 5, in the penultimate paragraph of ActEd text, the final sentence has been deleted.

Section 3

On page 11, the second sentence of the first solution has been amended to:

The URR (unexpired risk reserve) is the total amount required to cover expected future claims and expenses in the unexpired period of cover in excess of the UPR.

Chapter 10

Section 2

On page 13, the following text has been added to the end of Section 2.9:

In 2020, the FSB decided to suspend identifying new G-SII companies, following an adoption of a holistic framework: an activities-based approach for assessing systemic risk. This includes an annual assessment of potential systemic risk arising from specific activities and exposures across insurance sectors.

Section 3

On page 16, the first bullet point in Section 3.1 has been amended to read:

- **those who are appointed, or who provide support, to Chief Actuaries, Small Insurer Chief Actuaries, With-Profits Actuaries, Appropriate Actuaries, and Reviewing Actuaries, appointed by or in respect of UK authorised insurance companies and friendly societies writing long-term insurance business [APS L1: *Duties and Responsibilities of Life Assurance Actuaries*].**

On page 20, the text leading into the bullet point list has been amended to read:

In order to limit the impact of climate change on the financial system, many regulators are working on regulations whose aims include ensuring that financial institutions:

Section 4

On page 24, in the second paragraph of Core Reading, the final sentence has been deleted.

Chapter 11

Section 0

The penultimate paragraph of ActEd text has been deleted and replaced with the following:

In 2021, the PRA launched a Quantitative Impact Study to gather feedback from the insurance industry on potential reform to Solvency II regulation in the UK. In particular, it is considering changes to the matching adjustment and risk margin, and the potential impacts of these on insurers. The PRA are continuing to consult the insurance industry and are issuing updates via their website:

https://www.bankofengland.co.uk/prudential-regulation/key-initiatives/solvency-ii/solvency-ii-reform-quantitative-impact-survey

Section 4

On page 10, the second paragraph under the 'Equivalence' sub-heading has been amended to read:

Equivalence can be 'full' (granted for an indefinite period), 'temporary' (granted for a limited period until 31/12/2020 with the possibility to extend by 1 year) or 'provisional' (granted for a ten-year period with possible extension for further ten-year periods).

Also on page 10, the final sentence of ActEd text has been deleted.

Finally on page 10, the following Core Reading has been added at the end of the page:

(Source: eiopa.europa.eu/browse/regulation-and-policy/international-relations-and-equivalence_en)

Chapter 12

Section 2

On page 8, the table of risk-free discount rates has been updated, along with the text immediately before and after it:

The table below shows a selection of the risk-free discount rates published by EIOPA in April 2020:

Term (years)	*1*	*2*	*5*	*10*	*20*	*40*
Euro	–0.405%	–0.415%	– 0.325%	–0.116%	0.124%	1.487%
UK	0.472%	0.391%	0.415%	0.483%	0.531%	1.358%
USA	0.509%	0.355%	0.365%	0.569%	0.718%	0.433%

The table shows that the yield curve is upward sloping for both the UK and the EURO and that the risk-free rate can be negative (as in the case of the Euro for the shorter terms).

Section 3

On page 19, the ActEd text between the example and question has been amended to read:

Examples of type 1 exposures include derivatives, securitisations, cash deposits and reinsurance arrangements. Examples of types 2 exposures include receivables from intermediaries and policyholders.

Chapter 13

Section 1

On page 3, the following ActEd text has been added before the final line of Core Reading:

Chapter 11 also discussed the reforms currently being consulted on by the PRA.

Section 2

On page 6, in the third paragraph of Core Reading, the final two sentences about phasing in PBR and the number of States that had adopted it, have been deleted.

Section 3

On page 8, the second sentence of Core Reading has been amended to read:

Whilst the Chinese banking and insurance regulator (the CBIRC) aimed to make C-ROSS comparable to international standards, it also wished to reflect the characteristics of the Chinese insurance market, with particular recognition that China's insurance market is still relatively young in comparison to the US or European insurance markets.

On page 9, the final bullet point has been amended to read:

- **health and care insurers will need to consider ways to streamline reporting processes and automate much of the work in order to shorten reporting time and reduce operational risks.**

Section 8

The fourth bullet point has been amended to read:

- **fsb.org**

Chapter 15

Section 2

On page 8, the Core Reading in the first bullet point has been amended to read:

- **'Speaking Up: A Guide for Members' which sets out the IFoA's view of good practice in relation to speaking up. The IFoA has also produced a specific guide for employers of actuaries entitled 'Whistleblowing: A guide for employers of actuaries'.**

Also on page 8, the final bullet point has been amended to read:

- **'A Guide for Ethical Data Science' which is intended to complement existing ethical and professional guidance and is aimed at addressing the ethical and professional challenges of working in a data science setting.**

On page 9, the two middle paragraphs of ActEd text have been amended to read:

You may already be aware at least of the existence of these standards and guidance and may have read some. The FRC and the IFoA have made a number of changes to their professional standards and guidance in recent years.

The UK FRC is planned to relaunch as the Audit, Reporting and Governance Authority (ARGA) in the second quarter of 2023. This new regulatory body is expected to provide oversight of the UK actuarial profession.

Section 3

On page 12, the first paragraph of ActEd text in Section 3.1 has been amended to read:

There are currently (May 2022) 74 full members of the IAA including the Institute and Faculty of Actuaries from the UK and the Society of Actuaries from the USA. Other countries with a member actuarial organisation include South Africa, Australia, Ireland, China and India.

Summary

On page 15, the fifth bullet point under the heading '*Other non-mandatory resource material*', has been amended to read:

– Ethical data science.

Solutions

On page 19, in Solution 15.1, the explanation of the specific TASs has been amended to read:

The Specific TAS of most relevance to Subject SA1 is TAS 200. Its purpose is to promote high quality technical actuarial work on particular insurance matters where the FRC has identified that there is a high degree of risk to the public interest.

Chapter 16

Section 3

On page 7, the third bullet point of Core Reading and the accompanying ActEd text under the heading 'Proprietary companies' have been deleted.

Chapter 21

Section 2

On page 9, the heading 'Examples' has been amended to read 'Example' and the first sentence under this heading has been deleted.

Section 3

On page 20, the final two sentences of ActEd text on this page have been deleted.

Chapter 22

Solutions

On page 36, in the solution to question 22.2, the bullet point list has been amended to score:

½ for two examples, maximum 1½

On page 45, in the solution to question 22.4, the points in the bullet point list that score ¼ mark have been increased to ½ mark each.

Chapter 23

Solutions

On page 16, in the solution to question 23.2, the bullet point list has been amended to score as follows:

Claim rates would be investigated by studying experience over a period of, say, 3–5 years, splitting data at least by: [½]

- gender
- age-group
- sum insured … [½ for any two ideas]

Chapter 24

Section 1

On page 3, the following ActEd text has been added to the end of the final paragraph on the page:

These were replaced by the Sustainable Development Goals in 2016.

On page 4, the first sentence of the penultimate paragraph of ActEd text in Section 1.1 has been amended to read:

There is mixed evidence as to whether the Millennium Development Goals (MDG) were achieved.

Also on page 4, the first sentence of the final paragraph of ActEd text in Section 1.1. has been amended to read:

The United Nations Sustainable Development Goals (SDGs) comprise 17 goals with 169 targets to be met by 2030.

Section 4

On page 16, in the first paragraph of Core Reading, the final sentence has been amended to read:

What is the appropriate metric to measure healthy life expectancy, or, for that matter, the contribution of different diseases and injuries to potential years of healthy life that are lost due to their occurrence?

Chapter 25

Section 2

On page 13, the following sentence has been added to the first paragraph of Core Reading in Section 2.4:

The code could also consider issues with respect to vulnerable customers such as those with disabilities or mental health conditions.

The ActEd text immediately following this paragraph has been amended to read:

The ABI Mental Health and Insurance Standards, issued in the UK, were disused in Chapter 6.

In terms of misrepresentation, insurers will classify each case according to whether the misrepresentation was innocent, careless or deliberate, as defined below. There are also guidelines as to how to deal with the policy fairly for each case.

Chapter 26

Section 3

On page 5, the first sentence has been amended to read:

You are in the exam and you have 3 hours and 20 minutes to answer up to four questions.

Glossary (Chapter 27)

The following definitions have been added to this chapter:

Cedant

The term cedant is most commonly used with respect to reinsurance, where a ceding insurer (the cedant) transfers all or part of the risk on business it has written to a reinsurer. The ceding insurer pays the reinsurer a premium in respect of the risk transferred.

Multi-morbidity

See *Comorbidity*.

Partial benefit

Under IP policies, a benefit is usually only paid if policyholders are unable to work. However, there may be cases where their ability to work is clearly limited by their condition, but they've attempted to continue working as best they can. In these cases, health and care insurance companies sometimes agree to pay a partial benefit even though the policyholder was never so incapacitated to be 'unable to work' (as defined by the claims criteria).

The following definitions have been amended:

Chronic illnesses

Chronic diseases are defined broadly as conditions that last one year or more and require ongoing medical attention or limit activities of daily living or both. This should be contrasted with *Acute illnesses*.

In some jurisdictions, PMI may not generally cover treatment for chronic illnesses, although some insurers may offer treatment for cancer that includes palliative care.

Comorbidity

Comorbidity is where an individual has more than one disease or condition present at the same time. Conditions described as comorbidities are often chronic or long-term conditions. An example of comorbidity is that an individual with arthritis could commonly have other chronic conditions such as diabetes or heart disease.

Proportionate benefit

Under IP policies that use an 'own occupation' claims definition, a proportionate benefit can be paid to claimants who return to work but in a new, lower-paid occupation. That is, if a claimant takes up employment in an occupation that is different to the one from which they were originally incapacitated, the claim benefit may continue, but it is usual for the continuing benefit to be reduced. The reduction will relate to the ratio that the gross earnings from the new job bear to those from the occupation against which disability was being claimed.

It is a standard requirement that disability from the original occupation continues whilst a proportionate benefit is being paid. Unlike for a partial benefit, companies typically require a full claim to be established before a proportionate benefit can be claimed.

Rehabilitation benefit

Under IP policies that use an 'own occupation' claims definition, a rehabilitation benefit can be paid to claimants who return to their own occupation but in a reduced capacity. The amount of benefit is usually calculated in the same way as that for proportionate benefit, as described above.

Rehabilitation can also apply to the process of counselling, whereby disability counsellors assist disabled persons with advice on practical matters to do with the benefit and their disability, in order to aid a return to work.

2 Changes to the X Assignments

Assignment X1

Question 1.3

Parts (i) – (iii) of this question have been amended. Replacement pages are attached.

Solution 1.3

The solution to parts (i) and (ii) have been amended. Replacement pages are attached.

Assignment X2

Solution X2.4

On page 13, the fourth bullet point has been amended to read:

- Allow proportionate benefits on a return to work in a new less well-paid role or rehabilitation benefits on a return to work in a reduced capacity. This will also encourage employees to return to work, and so help to reduce claims costs. [½]

Assignment X3

Solution 3.1

In the solution to part (iii), on page 4, the penultimate point has been amended to read:

The IFoA also publish non-mandatory guidance on speaking up for actuaries and also for their employers. This should reassure the insurer that any issues within its business will be identified. [½]

At the top of page 5, the final point of part (iii) (a) has been amended to read:

Non-mandatory guidance is also issued on:

- conflicts of interest – this would ensure that any conflicts of interest within the insurers business were managed appropriately [½]
- ethical data science – provides assurances that actuaries will also apply all professional and ethical guidance to the handling of data within their work. [½]

Assignment X4

Question X4.3

This question has been amended to be gender neutral.

Assignment X5

Question X5.1

This question has been amended to be gender neutral.

The first paragraph of the question has been amended to read:

A proprietary health and care insurance company writes a range of long-term health and care insurance products. The company is based in a country that is about to adopt a solvency regime that is identical to Solvency II.

Assignment X6

Question X6.2

The marks for parts (i) (a) and (b) have been amended as follows:

(a) Low volumes of new business [12]

(b) Low profitability [10]

Solution X6.2

The marks for parts (i) (a) and (b) have been amended in line with the changes to the question.

3 Other tuition services

In addition to the CMP you might find the following services helpful with your study.

3.1 Study material

We also offer the following study material in Subject SA1:

- Mock Exam and AMP (Additional Mock Pack).

For further details on ActEd's study materials, please refer to the 2023 *Student Brochure*, which is available from the ActEd website at **ActEd.co.uk**.

3.2 Tutorials

We offer the following online tutorials in Subject SA1:

- a Tutorial (lasting a total of two days)
- a mini-Online Classroom.

For further details on ActEd's tutorials, please refer to our latest *Tuition Bulletin*, which is available from the ActEd website at **ActEd.co.uk**.

3.3 Marking

You can have your attempts at any of our assignments or mock exams marked by ActEd. When marking your scripts, we aim to provide specific advice to improve your chances of success in the exam and to return your scripts as quickly as possible.

For further details on ActEd's marking services, please refer to the 2023 *Student Brochure*, which is available from the ActEd website at **ActEd.co.uk**.

3.4 Feedback on the study material

ActEd is always pleased to receive feedback from students about any aspect of our study programmes. Please let us know if you have any specific comments (*eg* about certain sections of the notes or particular questions) or general suggestions about how we can improve the study material. We will incorporate as many of your suggestions as we can when we update the course material each year.

If you have any comments on this course, please send them by email to **SA1@bpp.com**.

4 The role of the State in healthcare provision

4.1 Complementary roles of State and insurers

The level and form of the State provision of health care is likely to have a significant impact on the benefits which can be provided by an insurer in a particular jurisdiction.

An illustration of this is the approach taken in the United Kingdom. Significant State provision of healthcare has been in place in the UK since the 1940s. Thus, for the most part, insurers try to provide coverage in areas where UK welfare benefits are not available or are deemed to be inadequate. For example:

- **CI insurance has no obvious counterpart in UK State healthcare benefits. Thus the provisions of CI benefits are solely done by health and care insurers in the UK.**
- **IP insurance provides benefits that augment UK welfare provision, which is intended to provide only a subsistence level. Additionally, IP insurance benefits can continue to retirement, if the disability persists; UK welfare payouts may run for a shorter duration, or change definition and amount after an initial period. There is thus a clearly defined role for insurance in this area.**
- **The UK State currently provides benefits on disability in old age, on a means-tested basis. LTCI therefore has a niche for those whose prospective wealth is above the expected threshold, at the time of needing care. In this way, the claimant is not forced to sell assets, such as the family home, in order to meet costs.**

  For example, in the UK, the eligibility to State benefits on long-term care partly depends on your level of savings, including the value of your home. In England, if this is above a certain threshold you will be expected to meet all of the costs of personal and residential long-term care initially (nursing care is free), and so most people in this situation will be forced to sell their homes in order to meet the costs of care.
- **Depending on the precise nature of the product chosen, PMI can be an alternative to the NHS for acute in-patient procedures and certain out-patient consultations or treatment. It does not, however, attempt to compete with the accident and emergency. In the past PMI in the UK has not offered cover for general practitioner services of the NHS but this is beginning to change with some PMI policies offering limited cover for private GP services either face to face or virtually.**

Private healthcare provision can vary significantly between jurisdictions, ranging from the primary coverage for particular population groups to a supporting role for public systems.

In countries where the State offers very limited healthcare provision, private healthcare can provide a significant role in healthcare financing. An example of this approach is the United States which is the only country in the OECD where voluntary health insurance represents the main health financing and coverage system for most of the population. In this situation there is a risk that the poor are not able to find affordable healthcare. From the perspective of the insurer, there is a risk that they cannot profitably sell business to poorer policyholders.

Where the State provides a wide range of generous benefits, then unless the State operated a monopoly on health provision, the benefits offered by an insurer are likely to be complimentary to the State benefits. The purchase of private healthcare could be motivated by factors such a desire for reduced waiting times until treatment can be obtained, or to cover gaps in the State treatments.

An example of this approach is the UK where the National Healthcare Service (NHS) offers comprehensive free healthcare to all.

Question

Outline reasons why there may still be a PMI market in a country with a comprehensive free healthcare system.

Solution

Patients may use private healthcare to offer:

- faster access to treatment
- perceived better quality treatment
- a higher standard of accommodation *eg* private rooms
- choice over who carries out the treatment
- choice over where and when the treatment is carried out.

4.2 Means testing

As mentioned above, one possible solution to increasing social welfare cost in a jurisdiction is through means testing, as a way of targeting funds to those who need it most. Means testing could apply in a number of ways to reduce the cost of various types of health and care benefits such as long-term care provision, and medical services.

One example of a means test is in South Africa. Individuals with very low incomes receive a subsidy for public sector healthcare, however healthcare is only subsidised for those earning less than a specified threshold.

Question

Suggest which insurance products might be affected by the introduction of means-tested co-payments towards acute hospital services costs. Describe the effect in each case.

Solution

The introduction of means-tested co-payments might increase the demand for:

- PMI, if individuals need to make a significant co-payment, or if the level of co-payment makes private treatment a more attractive alternative to any State care
- cash plans, offering fixed payments while in hospital.

There may also be a slight increase in demand for CI and IP insurance products because the level of perceived needs for some customers when ill and requiring hospital treatment may increase.

Arguably, there may also be a slight decrease in claim rates on some products. The need to make a co-payment may deter some people from having hospital treatment and hence reduce claims on, say, cash plans, where the cost of the co-payment is not fully indemnified. (Of course, in the long run, not having medical conditions treated would probably lead to more problems, and therefore more claims, later!)

The introduction of means testing can be driven by a number of factors such as:

- **demographic change**
- **a movement to a low tax environment**
- **competing demands on public expenditure.**

4.3 Future role of the State

Insurers need to consider that different political parties in a country may have very different views about the role of the State in healthcare provision. It is possible that a change in government could lead to material changes in the approach a State takes to providing health and care benefits. This section sets out some of the issues to consider.

Question

Outline the areas in which government can affect health insurance products.

Solution

Government action can affect health insurance products in the following areas:

- regulation or legislation directly affecting insurance products, *eg* disclosure requirements or restrictions on the rating factors used
- taxation (on benefits, premiums or investments)
- changes to State healthcare benefits (*eg* State disability benefits)
- changes to the national healthcare system (*eg* to its funding or efficiency)
- actions leading to changes in the economy
- communication (*eg* public statements criticising the actions of insurers).

The future role of the State in healthcare provision is crucial to the planning of insurance strategy. Changes to State health care provision may considerably impact the benefits which an insurer can offer in the future. In particular, consideration needs to be given to expectations of future trends and any promises made by the State about future healthcare provision.

This section sets out some of the issues to consider. It's worth keeping abreast of current developments. We also recommend that as you read through the list of indicators for each product type you consider:

- how they might change or develop in the future
- the impact that a change in this area will have on health insurance business.

Income protection insurance

- **In many developed countries, the government may provide subsistence levels of income to individuals that cannot work. So insurance is needed as a top-up – how far is this recognised by the public?**

  The types of benefits that could be provided by the State were covered in Chapter 3.

- **A State may see its role as investing in the prevention side rather than in increasing the benefits to a more generous level. For example by encouraging healthier practices at home and at work, and by rehabilitation**

  Preventing disease and encouraging a healthier lifestyle is clearly a long-term aim of any government. For example, vaccination programmes or steps to try to prevent obesity in children.

Question

Outline the benefits to a government of encouraging preventative measures to improve the nation's health.

Solution

Possible benefits of a healthier nation are:

- reduced demand on State resources
- reduced State benefits paid out on sickness and disability
- increased taxation revenue from the increased numbers able to work
- increased consumer spending, as more people are physically able to, and have the income to, spend more
- the above two effects may also lead to positive effects on the economy, *eg* greater productivity leading to more profitable companies
- if people are healthier, they feel happier and are more likely to feel good about the current government, *ie* they are more likely to re-elect them!

- **In a bid to manage costs, governments may also consider introducing stricter qualification rules for State benefits and requirements aimed at getting claimants back to work.**

  For example, in 2008 in the UK, the government changed the benefit provided on incapacity. This change resulted in a higher level of benefit being paid to the severe long-term disabled, but rehabilitation initiatives are employed to get people back to work, and so reduce the numbers receiving the benefit.

Critical illness insurance

- **Most countries do not provide State lump sum benefits on disability, and it is perhaps unlikely that they will intend to do so in the future. Therefore CI insurance is likely to continue to be provided by the private sector in many countries.**

Long-term care insurance

- **There has been considerable discussion in many developed countries with regard to the extent that governments fund the costs of long-term care, particularly given that the demand for long-term care benefits and the required funding for these benefits is increasing globally. This has been driven by increased longevity as a result of advances in medical technology and treatments. Also social change such as higher divorce rates which is leading to more elderly people living alone.**
- **Different countries are at various stages of this demand curve and have taken different approaches to meet this demand. A number of developed countries currently publicly fund a significant proportion of LTC costs, although in some countries LTC benefits may be limited.**

  For example, in England, other long-term care benefits are means-tested. The State will currently only cover personal and residential care costs if an individual's assets are below a certain level. Those with assets exceeding a threshold must normally fund the full costs of residential or nursing home care.

  As at April 2017, the State would only cover costs if an individual's assets are below £14,250. Those with assets above £23,250 must fund all costs themselves.
- **Countries where long-term care costs are currently heavily funded with public money may wish to consider increasing the use of private arrangements such as LTCI products.**

  Whilst countries may wish this to happen, turning this into a possibility can be difficult.

Source: Elliot S, Golds S, Sissons I, Wilson H, 2014, *Long-Term Care – A Review of Global Funding Models*. Institute and Faculty of Actuaries.

Question

Suggest reasons why it may be difficult for a country where the State heavily funds long-term care costs to increase use of LTCI.

Solution

It may be difficult to increase use of LTCI because:

- LTCI may be prohibitively expensive for individual's to purchase
- There may be a lack of disposable funds from those who need LTCI (*eg* money may be tied up in pension funds and property)
- There may be a perception (or requirement) that the State supports older people and so there should be no need for self-provision

- The insurance industry may be concerned about changing State cover in the future (*eg* as another party comes in to power and may change eligibility rules for State care leading to a higher volume and value of claims than expected).

Private medical insurance

- **Governments in many developed countries with significant State health care systems have seen the costs of healthcare rise, particularly where the country has an ageing population and individual treatment costs have been rising. Would the government prioritise healthcare costs relative to other items of spending or look to raise tax rates to afford additional costs? Alternatively would it look to manage costs by targeting resources at specific groups? Potentially private health care provision could meet some of the gaps.**

  For example, in the UK the NHS originally promised lifetime health care – but already certain benefits for the elderly are means tested and others fall outside of free provision for the majority of the population *eg* prescriptions and dental and optical care.

5 The role of employers in the provision of health and care benefits

In this section we consider group health products provided by an employer for its staff. We consider the influences on the demand for the two main products, group IP insurance and group PMI.

In some countries, the majority of both the private medical and income protection insurance markets is employer paid or sponsored (voluntary) cover. The attitude of employers to such staff benefits is vital to the future insurance revenue streams for these two products.

5.1 Valued benefits

From an employer's point of view, disability or medical benefits may be a normal part of the total benefits package, with the advantage that PMI may assist in an early return to work and IP demonstrates a continuing financial responsibility when an employee is ill for a prolonged period.

Such benefits within an employment package may also be a significant incentive in attracting and retaining staff, or to incentivise and reward individuals on promotion to higher grades.

Some schemes also cover dependants, although this has become less common due to the increased cost and the economic climate.

5.2 Tax efficiency

It may be tax efficient for the insurance premiums to be paid by the employer where these are then allowed as a business expense. However, the extent of any tax efficiency may vary by jurisdiction.

For example, an IP insurance claim benefit could be paid gross to the employer who then passes it on to the employee via the payroll system, so it could be subject to tax in the hands of the employee in the same way as was their pre-disability salary.

PMI could also be tax efficient for the employer.

Whilst tax efficiency for the employer will encourage groups to offer healthcare insurance to employees, the tax efficiency for its employees will affect the take-up rates (where cover is optional).

5.3 Relative cost

In general, due to economies of scale and greater pooling, group risks tend to be priced more cheaply per person than if the disability policy were bought on an individual basis. However there are many examples where this is not the case. For example, a young person in an elderly workforce where a single unit rate is calculated, or an office worker in a heavy engineering company may get a cheaper rate by applying to the insurer directly.

The above examples are comparing group schemes where there is a significant employee contribution and each employee is charged the same premium regardless of their individual risk factors.

However, group schemes are normally paid by the employer and membership is often compulsory for employees (often due to the preference of the insurer, who would be exposed to anti-selection if membership was voluntary). Therefore, in these circumstances, opting out for cheaper individual cover is neither financially advantageous, nor is it possible.

Even if cover were voluntary and the premiums were being paid by the employees, the cost of cover for the *scheme as a whole* is likely to be less than the total cost of individually purchased products.

Question

Economies of scale and experience rating are cited as two reasons for this. Suggest other factors may contribute to this difference.

Solution

The cost of cover will be influenced by claims costs. These are generally lower on group business because:

- there is less scope for anti-selection than in the individual market
- the employer can take an active approach to claims management – it is in its interest to reduce claims
- employees may be less aware that they have the cover and so may not make a claim when the need arises; this is much less likely with a considered purchase.

In addition, one could argue that a large employer is in a better position to negotiate a lower price with an insurer than is an individual (although in practice, a large scheme is likely to be experience-rated and so the cost will depend on previous experience).

Initial expenses also tend to be lower due to less underwriting and usually lower commission levels.

In addition, lives that are in poor health may be covered under a group scheme up to the free cover level for IP insurance and may be eligible for some group PMI benefits, but may be unable to obtain suitable (or any) individual cover because of their poor health.

Some large group PMI schemes also offer cover to employees on a 'Medical History Disregarded' (MHD) basis. This means that any medical conditions that existed before the cover started would be covered, whereas they would normally be excluded under individual cover. These schemes are usually heavily experience-rated, or cost plus (*ie* self-insured), so that most or all of the risk is borne by the employer.

- **trends in consumer preferences towards 'greener' products and companies**
- **firms' investments in carbon-intensive industries result in reputational damage, making it difficult to attract and retain customers and staff**
- **technological innovation causing shifts in market supply and demand, *eg* renewable energy**
- **transition to low-carbon economy reduces demand for life insurance products, *eg* occupational pension plans, where firms' customer base is heavily exposed to conventional carbon-intensive industries.**

From a health and care insurance company's perspective, transition risk principally relates to:

- changes in the values of assets held, *eg* equity holdings in companies with a significant dependency on fossil fuels / carbon consumption, due to:
  - the direct impact on the underlying entities of policy changes
  - a shift in market sentiment towards sustainability
- changes in demand for certain health and care insurance products
- adaptation of operational models.

Liability

Climate liability risks can arise from injured parties seeking compensation for the impacts of climate change. These impacts may be the first-order physical impacts related to climate change, or the second-order transition impacts.

Examples of climate liability risks are:

- **new links are established between air pollution and adverse health conditions, resulting in a new class of latent claims**
- **firms that do not take into account the impact of their investment decisions on climate change experience direct claims for damages.**

These liability risks principally impact general insurers, in terms of the potential for higher claims arising from the liability insurance business that they sell.

However, health and care insurance companies would also be exposed in terms of:

- the impact on the market values of assets held in affected companies
- counterparty risks arising from any relationships with affected companies
- reputational risk resulting from poor investment decisions.

4.8 Environmental factors

Environmental conditions (other than climate change) could also be a factor on general health levels, for example air pollution, which has separate drivers from climate change.

It is estimated that each year in the UK, around 40,000 deaths are attributable to exposure to outdoor air pollution, with more linked also to exposure to indoor pollutants.

Exposure to air pollution can cause a range of health issues including exacerbation of asthma, respiratory conditions, cardiovascular disease and stroke.

Indoor air pollution can be caused by emissions from domestic appliances burning carbon containing fuel such as coal or wood. Cleaning and personal care products can also contain volatile organic compounds that can have adverse impacts on health. Tobacco smoke is also a form of air pollution which can increase the risk of lung cancer.

Other environmental factors that could impact health and care insurers include exposure to:

- ultraviolet (UV) rays – can lead to skin cancer and also cause eye issues such as cataracts
- noise – repeated exposure can lead to temporary or permanent hearing loss
- lead – found in old paints and pipes which can then pollute drinking water, can cause anaemia and kidney and brain damage
- radon in the environment – radon is a radioactive gas found everywhere, higher levels are found in buildings and some areas are prone to higher levels than others, it can cause lung cancer particularly amongst smokers and ex-smokers.

4.9 Mental health

It is estimated that each year, 1 in 4 adults experience a mental health problem [source: https://www.mind.org.uk/about-us/what-we-do/].

They range from common problems, such as depression and anxiety to rarer problems such as schizophrenia and bipolar disorder. Our understanding of the causes of mental health conditions, and how they are treated, has developed radically in the last century.

In the UK in 2017, mental health was the most common cause of claim on income protection insurance policies. As well as the factors mentioned in the Core Reading above, mental health can also include stress, post-natal depression, ADHD, eating disorders and addiction.

People with mental health problems can experience barriers in their everyday life, and these can be exacerbated when dealing with complex consumer products, such as insurance policies. Health and care insurance companies therefore need to consider carefully how they engage with customers (and employees) about their mental health, in order to remove barriers and to meet the needs of these customers.

Mental health conditions can also be directly relevant to underwriting. The health and care insurance industry needs to ensure that all underwriting decisions are based on the best information available and seek to improve this information where possible. Mental health is also often associated with other issues, such as financial stress and comorbidities; the industry should seek to understand the effects that may confound with other factors. Health and care insurance companies should also seek to be as transparent as possible about underwriting decisions and pricing aspects of mental health.

In the UK, the Association of British Insurers (ABI) has launched its Mental Health and Insurance Standards. These are a set of voluntary guidelines which insurers can subscribe to in order to ensure they are meeting customers' needs in the area of mental health. It covers all areas of customer engagement from improving accessibility to communicating decisions.

The standards are available here:

https://www.abi.org.uk/globalassets/files/subject/public/health/abi-mental-health-and-insurance-standards.pdf.

Question

Suggest ways insurers could improve accessibility to health and care insurance for customers who may experience mental health concerns.

Solution

- Give customers a choice of how to communicate with them (*eg* telephone, email, text message).
- Implement processes to support customers who may need assistance to complete the application process (*eg* have staff who will go through forms slowly with customers and explain all terms that may be confusing).
- Implement training and staff awareness programmes to empower front-line staff. This could include
  - developing a basic understanding of mental health problems
  - showing compassion to customers and their concerns
  - using appropriate language.

(These ideas are taken from the ABI Mental Health and Insurance Standards. You may have thought of other relevant ideas too.)

5 Key medical conditions

This section considers the key medical conditions that affect mortality and morbidity rates in various countries of the world. It then goes on to consider these conditions in more detail, in particular looking at the current issues affecting them.

5.1 Key medical conditions affecting mortality and morbidity

The main causes of mortality and morbidity, and any specific diseases in a jurisdiction may impact any health and care business written by an insurer. The following section looks at this in more detail.

Mortality

The drivers of mortality experience can be complex and can vary significantly over time and by population.

Of the 55.4 million deaths worldwide in 2019, more than half (55%) were due to the top ten causes. Heart disease and stroke are the world's biggest killers, accounting for a combined 15 million deaths in 2019. These diseases have remained the leading causes of death globally in the last 20 years. Heart disease alone was responsible for 16% of the world's total deaths in 2019.

Heart disease includes angina, myocardial infarction (heart attack) and sudden cardiac death.

Chronic obstructive pulmonary disease claimed 3.3 million lives in 2019, while lung cancer caused 1.8 million deaths making it the 6th leading cause of death globally.

Diabetes killed 1.7 million people in 2019. However, in reality this is likely to be much higher. There are challenges in recording diabetes as a cause of death, and in addition, the true prevalence of type 2 diabetes is not clear due to a significant proportion being undiagnosed.

Deaths due to dementia more than doubled between 2000 and 2019, making it the 7th leading cause of global deaths in 2019.

Lower respiratory infections caused 2.6 million deaths worldwide in 2019, representing a steady reduction since 2000. The death rate from diarrheal diseases fell from 2.6 million in 2000 to 1.5 million in 2019. Tuberculosis is no longer in the global top 10, falling to thirteenth in 2019 with a 30% reduction in global deaths. Similarly, HIV/AIDS is no longer among the world's top 10 causes of death, deaths from this cause have fallen by 51% in the last 20 years.

Kidney disease is now the 10th leading cause of death globally. Mortality has increased from 813.000 in 2000 to 1.3 million in 2019. Kidney disease is one of the main complications that arise from poorly controlled diabetes.

Local factors mean that the main causes of death can vary significantly between jurisdictions.

People living in a low-income country are far more likely to die of a communicable disease than a non-communicable disease. However, causes of death from non-communicable disease are increasing, and those from communicable diseases decreasing in low-income countries.

X1.1 Long-term care insurance policies can provide benefits in the form of the care that the insured needs, or in the form of a guaranteed cash benefit payable when an insured event occurs.

(i) Outline the advantages and disadvantages for the insurer and the insured of policies with a cash benefit. [5]

(ii) Describe the differences between a pre-funded and an immediate needs long-term care insurance policy. [6]

(iii) Describe the advantages and disadvantages for the insured of each of these designs (*ie* pre-funded and immediate needs long-term care). [6]

A developed country has historically experienced very low new business volumes for its pre-funded long-term care insurance products.

(iv) Suggest reasons why there may be low pre-funded long-term care insurance new business volumes in this particular country. [6]

[Total 23]

X1.2 A consulting actuary is providing advice to a large employer concerning its health and care employer benefits.

The employer has about 1,200 employees all based in a developed country with a comprehensive free State healthcare service and unemployment benefits. It plans to introduce a flexible benefits package for all staff. Each employee will be allocated annually a fund which may be used to purchase benefits. The fund will be calculated as the notional value of the current benefits given to employees. The fund can be used to purchase additional holiday, gym membership, travel insurance cover, life assurance cover and a range of health insurance benefits (excluding income protection).

Employees can increase the value of their fund by reducing any existing benefits or holiday. Any fund value not spent will be added to basic salary.

(i) Outline suitable health insurance benefits which might be included in the overall package and options that could be considered for the overall package. You should include a brief description of the cover. [7]

(ii) Explain why income protection cover is usually provided as part of the basic employment benefits rather than as part of a flexible benefits package. [3]

(iii) Outline possible options and design features if income protection cover had been included in the flexible benefit arrangement. [5]

Currently, its group private medical insurance is provided by an insurer based in the same country.

(iv) Outline a typical schedule of benefits provided under a group private medical insurance scheme. [7]

The company has recently taken on a director from the USA who is concerned that private medical insurance is being purchased for benefits which might otherwise be provided by the State health service.

(v) Describe the points to be made to this director as to why this arrangement is provided for all employees. [6]

Based on the US experience in group private medical insurance the director from the USA is concerned that the premium rates for this insurance will rise in the future at a rate faster than retail price inflation.

(vi) Suggest reasons why this might happen. [5]

The company has concerns regarding the current cost of group private medical insurance and has suggested that this risk is retained internally.

(vii) Discuss the key advantages and disadvantages of this approach. [5]

[Total 38]

X1.3 A health and care insurer currently sells income protection insurance through insurance intermediaries. It pays all intermediaries the same commission.

The company is considering using alternative distribution channels to sell its IP insurance.

(i) Outline the considerations for the company when deciding on whether to use alternative distribution channels. [6]

It has also been proposed that the insurer could pay different commission to different intermediaries.

(ii) Suggest possible reasons why the insurer may be considering paying different rates of commission to different intermediaries. [6]

Currently, intermediaries selling health and care insurance in the country receive either initial commission (paid at the outset of a policy) or renewal commission (paid quarterly to the intermediary as long as the policy stays in-force) for each sale. Intermediaries may receive a combination of these from different insurers and products.

The regulator would like to discourage the commission method of remunerating intermediaries and would like them to move instead to a fee-based business model. Under this model, intermediaries would not receive commission for the business they provide to the insurer but would directly charge their clients a fee. The fee charged could be an initial fee, paid by the client to the adviser around the time the policy is taken out, together with an annual maintenance fee, or just an annual maintenance fee.

The initial fee an adviser could charge a client is likely to be much lower than the levels of initial commission currently paid.

(iii) Comment on the proposed new fee-based business model from the point of view of the customer. [2]

– These services may reduce the costs of some claims, and so the company may see costs increase if they are not provided. [½]

– There may be tax advantages to providing PMI rather than paying directly for treatment itself. [½]

– The company may not have the same economies of scale in terms of administration of the scheme as a large insurance company, leading to higher costs. [½]

– The company may also not have the same negotiating strength as an insurer to do deals with medical providers, also leading to higher costs. [½]

– The company takes over the employee relationship in this area, which could be problematic if any claims are declined. [½]

[Maximum 5]

Solution X1.3

(i) ***Factors affecting choice of distribution channel for IP product***

Cost

The insurer will need to consider the cost of changing the distribution channel used or using additional channels. [½]

For example, it will have established processes and systems for selling its IP product via intermediaries and would need to set up similar processes and systems for any new channels used. [½]

If it is considering moving to setting up its own direct salesforce, this would lead to high costs associated with setting up the channel such as recruiting staff and training them. [½]

There will be costs of setting up the new channel, *eg*

- recruiting and training staff for the own direct salesforce or for telesales
- setting up a website for internet sales
- advertising for brand awareness (as the company no longer has the IFA's recommendation).

[half for any sensible example, maximum 1]

Selling through intermediaries will lead to the insurer paying commission for sales made. [½]

Moving to a direct marketing such as online sales would lead to costs such as setting up a website and advertising the channel. [½]

If it does sell via a different channel (*eg* online), costs per policy sold may be lower, leading to reduced costs and either a reduction in premiums charged to customers or higher profits. [½]

Customer need

The insurer should consider what channels customer want to purchase IP insurance through. [½]

For example, customers many want advice before purchasing IP insurance, and so would not want to purchase it online. [½]

The insurer should also consider whether its product design is suitable to be sold via all channels. For example, if it is very complex, it may not think online sales are appropriate. [½]

Target market

The insurer should consider the potential target market that would purchase insurance through alternative channels. [½]

The likely target market for different distribution channels may vary by:

- age
- gender
- occupation
- financial sophistication
- location. [½ for each 2 examples, maximum 1 mark]

This could lead to an impact on the insurer's future experience, including on its claim and lapse experience. [½]

If the insurer sells to customers that do not understand its product, it could lead to an increase in complaints and potentially reputational risk. [½]

Competitors

The insurer should consider what channels other IP insurance products in the market use. [½]

For example, if these are only sold via intermediaries, there may not be a market for using alternative channels. [½]

This could lead to a reduction in the insurer's new business volumes. [½]

However, if other providers use alternative channels, it may need to consider alternative channels too in order to remain competitive. [½]

Other

The insurer should consider the impact that using alternative channels would have on its existing intermediaries. [½]

[Maximum 6]

(ii) ***Reasons for differing rates of commission***

Experience

Insurers may pay different commission rates where they see a difference in the quality of the business being sold by various advisers. [½]

This may be in the form of the:

- claim inception experience [½]
- claim recovery rates [½]
- lapse experience [½]
- underwriting administration experience. [½]

Where the claim inception experience is seen to differ between adviser this could be passed on via the premium or the commission. [½]

Remuneration

It may be that some intermediaries get other sources of funds from the insurer, *eg* they may get a fixed sum per month from the insurance provider on top of the commission paid. [½]

Some advisers may already charge partial fees so that they don't require full remuneration via commission. [½]

The insurer may be concerned about the credit strength of an adviser and therefore its ability to clawback any commission if necessary. It may reduce commission as a result. [½]

Target market

The insurer may have a strategic aim to increase market share in some areas and so might have increased commission in those areas. [½]

For example, the insurer may wish to increase the number of large policies it writes or it may wish to reduce risk concentration and focus on smaller policies. [½]

Or it may want to reduce its exposure to a specific industry and so offer lower commission rates to advisers in those geographic locations. [½]

Different advisers will target different population segments and so the insurer can try and use this, combined with different commission structures to achieve the desired mix of business. [½]

The adviser may have a different mix of business by product features or term. [½]

For example, one adviser may sell mainly shorter term IP insurance (for example 5-10 years) whereas another may sell these alongside mortgages leading to 20+ year terms. [½]

Other

The insurer may want to agree to a higher rate of commission with some advisers in order to retain their business, due to increased competition in the market. [½]

This may be more likely where the advisers are part of a large or national chain, leading to more negotiating strength. [½]

Higher commission may be paid where the insurer is in some form of a tie or other special relationship with the adviser. [½]

The insurer may put in place volume deals, whereby they agree to pay higher commission to brokers who bring in over £x*m* of business. [½]

Some brokers may do more administration, reducing the burden on insurers. [½]

[Maximum 6]

(iii) ***Fee-based business model – customer perspective***

+ This structure enables the customer to see what they are paying for advice. [½]

+ It allows them to compare the services offered by different advisers, and the fees charged for those services. [½]

+ Customers should feel reassured that the choice of products is right for them and not influenced by commission rates. [½]

– Customers may now find they need to find cash for an initial fee, which previously they would not have had to do. [½]

– If customers lapse their policy they may lose some of the value invested in the initial fee. [½]

– There is more administration for the customer, as they have outgo to both the insurer and the adviser. [½]

– The customer may be shocked by how much advice costs, which may deter sales. [½]

[Maximum 2]

(iv) ***Fee-based model – effect on intermediaries***

The effect depends very much on whether they currently receive more initial or renewal commission. [½]

Initial commission

For those earning more initial commission, advisers the move is likely to result in a short-term reduction in their income as the initial fee is likely to be lower than initial commission. [½]

They may need to find working capital from elsewhere to cover costs. [½]

This will be countered by an ongoing stream of income (annual maintenance fee), increasing over time (as the volume of fee-based business increases). [½]

In the long run, their total income could be unchanged. [½]

However, these advisers will now have an income stream that is more dependent on retaining their existing customers rather than identifying new ones. [½]

They will have to redesign their business model, focussing on customer service and retention, and with less emphasis on customer attraction. [½]

Renewal commission

Advisers currently receiving more renewal commission may not see a significant difference in income levels, provided the annual maintenance fee can be set at a similar level to the commission. [½]

All advisers

Fee-based business may be harder to sell to customers. [½]

This is because the amount the customer is paying for advice is transparent, which may put some customers off purchasing cover or make it unaffordable. [½]

The customer may even get the advice but then go and buy the policy directly rather than pay the adviser fee. [½]

Advisers will need to adapt to new sales methods and will need to reassess the products in the market to identify the most competitive products for customers. [½]

In order to attract customers, advisers may need to do more to win business, for example arranging appointments at evenings / weekends to suit customers, offering online advice tools for customers *etc*. [½]

In the long run, all advisers they may find their income stream is less volatile under the new regime, … [½]

… as they can predict more easily what fees they will receive, … [½]

… and will have more control over whether they do in fact receive those fees. [½]

There may be an overall fall in the advised-sales market, [½]

… as more customers seek more cost effective methods of obtaining cover. [½]

Advisers may lose business to directly written products, and 'cheap and cheerful' solutions such as bancassurers or white-labelled products sold in supermarkets. [½]

It may be more difficult for advisers to claim unpaid fees from customers than it was previously for insurers. [½]

Any disputes of this nature may be more time consuming as each one will need to be dealt with individually. [½]

[Maximum 7]

(v) ***Interaction with other departments***

Pricing

Claim managers will provide an analysis of rates of claims' incidence to feedback into any pricing exercise. [½]

They will also be required to provide an analysis of claim in payment to enable pricing actuaries to cost IP new business. [½]

Pricing actuaries will need to liaise with claims managers in order to understand the future strictness of the claim managers' approach so that this can be allowed for within the pricing process. [1]

For example, if claims managers are going to do more regular checks on claimants this would be expected to reduce the duration of claim and increase claim recoveries. [½]

However, it would also increase claims management costs that would also need to be considered. [½]

Underwriting

Claims managers will consider carefully the underwriting analysis performed at the time when the policy was accepted. [½]

Particular attention will be paid to the pre-existence of the condition for which the claim is now being made. In particular: [½]

- was this declared [½]
- to what extent was it linked to what was declared? [½]

The claims managers will need to liaise with underwriters, application-form designers and product developers to tighten wording to reduce anti-selection. [1]

Claims managers will investigate the loadings being applied by underwriters and compare these with the additional claims arising, to assess adequacy of these loadings. [½]

Product design

Claims managers would need to be fully aware of the product claim conditions, … [½]

… both the legal context and any intended discretion above this. [½]

Claims managers would not want to incur unnecessary litigation costs through disputed claims. [½]

Equally, they would not want to be too lax in accepting claims and thus giving the wrong message to other (current and potential) policyholders. [½]

Experience analysis

Claims managers would be part of process of in-depth analysis of experience to feed into: [½]

- the reports on profitability for management [½]
- reporting on state of company for regulatory solvency purposes [½]
- product design and pricing … [½]

  … so that appropriate contract terms can be offered to policyholders for forthcoming new business [½]
- the preparation of profit assessments for tax purposes [½]
- the process of reviewing terms for existing policies if this is permissible. [½]

[Maximum 8]

(vi) ***Key aspects of the claims and how to manage the claim***

A Teacher, stress-related claim

This claim has the potential to be a very long-term claim, coupled with a high level of claim. [½]

Stress is not uncommon in the teaching profession. [½]

The claim appears to be genuine and so the insurer should continue to pay it. [½]

In order to facilitate a return to the claimant's occupation, the insurer could offer support through counselling to address stress-related condition. [½]

Alternatively, if a return to the teaching profession does not appear to be possible, the insurer could offer one-off cash payment to fund a career change. [½]

This could be a lump sum to fund the career change coupled with some form of compensation for any reduction in earnings expected compared to the previous occupation. [½]

B Claimant playing football, ADL based claim

As the claimant has been in the press recently and won an award for scoring football goals, this claim appears to be fraudulent. [½]

The insurer would need to establish with certainty that policyholder is the same person as the one mentioned in press. [½]

If this can be confirmed, the insurer should cease payments with immediate effect. [½]

It may be that the claim started as a valid claim but the claimant has not informed the insurer as their situation has changed. [½]

The insurer could then take steps to recover income payments made after the insured recovered. [½]

C Linked claim for knee injury after broken hip, any occupation definition

The insurer should validate that hip and knee claims are linked. [½]

However, this doesn't seem unreasonable and so the claim may be valid. [½]

The insurer should also consider how the knee injury occurred. [½]

For example, it may have occurred due to an accident at work and therefore potentially be unrelated to the previous claim for a broken hip. [½]

As the definition is 'any occupation' the insurer will need to establish that injured knee prevents any form of work. [½]

It may be the case that the claimant could carry out a more sedentary job such as in an office. [½]

If some form of work would be possible the insurer should cease to pay the claim with immediate effect. [½]

However, if the injury prevents all work, the claim should continue to be paid. [½]

The insurer should ensure that an appropriate programme of recuperative care is undertaken. [½]

D Claim due to pre-existing heart condition, any occupation definition

The level of cover is under the free cover limit so there was no obligation for the medical condition to be disclosed. [½]

There may have been an actively at work clause in the group contract regarding the start of cover. [½]

If this is the case, the insurer will need to establish if claimant was at work at the time of the policy being effected. [½]

If the insured was not, the claim should cease immediately. [½]

If the insured was actively at work, or there was no clause, then the claim will need to continue to be paid. [½]

The insurer could check whether there is any individual IP insurance, or group IP insurance from a previous employer, that may also be paying out. [½]

The options available to the insurer will depend on the life expectancy of the individual. [½]

If the condition is not expected to be significantly life-limiting, the insurer could offer a lump sum payment to allow a change of lifestyle. [½]

[Maximum 10]