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Other insurance-based policies (revised)

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Learning objectives

After studying this chapter, you should be able to:

- understand the product features of mortgage payment protection insurance and accident, sickness and unemployment insurance;
- understand the product features of personal accident and sickness insurance and private medical insurance;
- compare the relative merits of the various long- and short-term contracts concerned with insurance of a person's health.

Introduction

This chapter covers those protection policies which are short-term (general) insurance policies. These contracts are fundamentally different from the long-term policies discussed in earlier chapters in that they are all yearly or monthly renewable contracts. Thus an insurer can decide each year (or, in some cases, each month) whether to renew, on what terms and at what premium. With a long-term policy the insurer is bound to continue the cover on the original terms as long as the premiums are paid.

The contracts covered are:

- personal accident and sickness insurance (PAS);
- private medical insurance (PMI);
- health cash plans and dental plans;
- mortgage payment protection insurance (MPPI) and payment protection insurance (PPI);
- accident, sickness and unemployment insurance (ASU).

General insurance premiums are subject to insurance premium tax (IPT), currently at 6%.



Key terms

This chapter features explanations of the following ideas:

Accident, sickness and unemployment insurance (ASU)	Acute conditions	Budget plans	Chronic conditions
Comprehensive plans	Dental plans	Excess	Exclusions
Hospital cash plans	Moratorium	Mortgage payment protection insurance (MPPI)	Payment protection insurance (PPI)
Personal accident and sickness insurance (PAS)	Pre-existing conditions	Private medical insurance (PMI)	Standard plans

A Personal accident and sickness insurance

PAS pays out if the insured suffers a specified accident or is off work because of sickness

Personal accident and sickness insurance (PAS) is a relatively basic insurance which pays out if the insured suffers an accident or is off work due to sickness. Most contracts are annual but they can sometimes be taken out for shorter periods, e.g. for a business trip or a holiday. It can be standalone cover or a bolt-on addition to household, motor or travel insurance.

A1 Features

There are a number of different PAS policies available and each has its own structure and features. Across this type of policy, though, there are generally some common areas of cover, which include:

- death;
- permanent disablement;
- loss of an eye;
- loss of a leg, foot or toe;
- loss of an arm, hand, finger or thumb; and
- other specified injuries or accidents.

There will often be a table listing the events covered and lump sums payable, which may well differ according to the seriousness of the event. The policy will also include detailed definitions of each event.

PAS policies usually have two other benefits:

- **Medical expenses will be refunded** up to a specified percentage of the costs incurred when the insured suffers an accident.
- **Weekly sickness benefit will be paid** if the insured is unable to work due to illness or accident. There will usually be a short deferred period (e.g. four weeks) during which no benefit is payable. There will also be a maximum number of weeks benefit is payable, perhaps 26, 52 or 104 weeks. The benefit will probably be a fixed sum not related to earnings.

Some PAS policies extend cover to a spouse or the insured's children (up to age 16 or 18), although this may well be restricted to accident cover only.

A2 Exclusions

As with any type of insurance, there are certain exclusions from cover. These are designed to prevent the insurer from being exposed to risk as a result of the deliberate or negligent actions of the insured. Again, the exclusions vary between policies but will typically include:

- being under the influence of drugs or alcohol;
- wilful exposure to needless danger;
- suicide or attempted suicide;
- physical defects or illnesses existing prior to the start of cover;
- hazardous sports and pastimes;
- normal pregnancy; and
- war, invasion, hostilities, etc.

In the event that the insured suffered from an accident or illness resulting from one of these conditions the insurer would refuse payment.

A3 Group personal accident and sickness insurance

Group PAS policies exist to cover members of a group such as a firm's employees or members of a social or sports club. In these cases the cover may be restricted to specific activities – for example:

- engaging in the firm's business;
- engaging in the activities of the club;
- participating in a specific sport; and
- travelling for and participating in a specific holiday.

A group scheme may be contributory where members pay their premiums through the body that arranged the policy (common for sports clubs or holiday schemes), or non-contributory where an employer provides the cover as a benefit of employment. Employer provided policies may link benefits to salary rather than a fixed sum.

A4 Taxation

There is no tax relief on premiums or taxation on benefits for a PAS policy paid by an individual.

In some cases, an employer will fund a 'group' PAS policy and, in such cases, if the employer pays premiums this is a benefit-in-kind which will be subject to income tax under PAYE. From the employer's perspective, the cost will be allowable as a business expense.

A5 Marketing

PAS insurance is aimed at people needing to cover one-off events in activities not covered by other insurances, or where legal action might be necessary to obtain redress for injury or occupational illness. It might be particularly appropriate for a self-employed person.

As the events covered are limited by precise definitions it is important that the client understands these, as well as the exclusions.

Often, advisers will meet clients who have PAS policies instead of income protection insurance (IPI). This is generally because PAS is more widely marketed and the premiums appear more reasonable. It is important that the client understands the differences between PAS and IPI, and the fact that PAS is not a direct substitute for IPI or critical illness insurance, which offer far more comprehensive covers. (See section G.)

PAS is not a substitute for IPI

Question 9.1

To what types of contract is PAS sometimes bolted on?



B Private medical insurance

PMI is primarily aimed at acute conditions and is not designed for chronic conditions, where long-term care insurance might be more appropriate

Private medical insurance (PMI) provides cover against the costs of private medical treatment. PMI is generally an indemnity policy. This means that the insured person can only claim back from the insurance company (or companies) up to the amount of the costs that have actually been incurred. If there are several policies, the maximum claim from all sources is still the total costs incurred. A few benefits under PMI policies may not be subject to the indemnity principle, such as NHS cash (a cash payment where NHS treatment is given free), a critical illness cover rider or helplines.

In medicine there is a distinction between **acute conditions** and **chronic conditions**.

- **Acute conditions** are characterised by their rapid onset and are usually amenable to cure. Treatment is normally of short duration and will often resolve the condition more or less fully. An example might be a hip replacement or removal of an appendix.
- **Chronic conditions** are long lasting and usually incurable, and so not necessarily susceptible to successful treatment. An example might be asthma, later stages or some forms of cancer and diabetes.

PMI is primarily aimed at acute conditions where the speedy treatment that can be provided privately will be most effective. It is not designed for chronic conditions which are incurable, where long-term care insurance might be more appropriate although the initial diagnosis of a chronic condition is usually covered. Accident and emergency (A&E) treatment is also not usually covered, partly because few private hospitals are geared-up for such treatment.

In September 2011 the Association of British Insurers (ABI) published its latest Statement of Best Practice for Sales of Individual and Group Private Medical Insurance. It also publishes Private Medical Insurance Common Definitions guidance. The rules are mandatory for ABI member companies and are generally adopted by others, too.

The statement is based around four principles:

Principle 1	ABI common definitions must be used in all policy documents where those words apply.
Principle 2	Each customer should get all the information mandated in the statement.
Principle 3	Explanations must be given of core terms and conditions appropriate to the customer's circumstances.
Principle 4	Customers must get specific information, generally at point of sale. This includes: <ul style="list-style-type: none"> • The ABI consumer guide 'Are you buying PMI?' • 'Your underwriting options'. • Your PMI cover for long-term/chronic condition(s). • Cover for cancer, in a distinct section.

Firms must include examples of their approach to cancer claims. This will include what is covered, including limits on time periods, cycles of treatment, maximum payments and circumstances in which they would not provide cover. That is important because cancer can start as an acute condition, but if effective treatment options become exhausted, the condition may become chronic.

Because of the high cost of cancer claims (it is now not uncommon for insurers to receive some claims for cancer treatment exceeding £100,000) and the improving nature of NHS cancer care, some PMI insurers now limit their cover for cancer or exclude it completely. Care needs to be taken when comparing policies to check what level of cancer cover the insurer provides and any restrictions it may impose. If a customer is happy to rely on NHS cancer treatment, they may be able to reduce the cost of their PMI cover by choosing to have no or lower cancer cover.

The cancer charity Cancerbackup (now merged with Macmillan) has developed a 'Gold Standard' for cancer care, but even PMI policies that meet its criteria may not pay for all cancer cover. In particular, if a patient wants experimental treatment or to use drugs that are not licensed in Europe or do not meet the approval of NICE (the Government's National Institute of Health and Care Excellence) it is possible or likely that their insurer will not cover the cost, or may cover only part of the cost.

To help ensure that patients understand what will and will not be covered, many insurers now provide specially trained cancer nurses or claims staff to provide help and guidance to the customer.

Customers may be able to reduce the cost of their PMI cover by choosing to have no or lower cancer cover

B1 The need for private medical insurance

The argument in favour of private medical treatment, and hence insurance of its costs, is as follows:

- The NHS is not good at providing timely treatment of acute, but non-life threatening conditions.
- There can be very long waiting lists for treatment and in some cases a long waiting list just to see a specialist for diagnosis.
- In some cases recently there have been allegations of 'waiting lists to get on the waiting list'.
- Some common treatments may be restricted or rationed – especially those that are not life threatening but can have a significant impact on quality of life (e.g. cataract operations and joint replacements).
- Many people thus prefer to have operations done privately to avoid a long wait and to get a higher quality of service (e.g. a private room and the personal attention of a consultant).
- Private treatment can also increase the chance of the time and place being suitable to the patient. The patient may be able to effectively choose their hospital and surgeon, which is not generally possible with the NHS.
- The risk of a healthcare acquired infection such as MRSA, MSSA or CDI may be lower (partly because each patient usually has their own room, rather than sharing a ward with other patients and their visitors).
- The NHS provides a standard level of provision which may not be to the taste of all patients.

PMI can increase the chance of the time and place being suitable to the patient

B2 Features

Many people would ideally like to have private medical treatment, but are inhibited by the costs involved. PMI can enable such individuals to get private medical care when required, usually with a consultant and hospital of their choice, with the insurer paying all or most of the cost.

A PMI policy will pay out when the insured needs private medical treatment as defined in the policy. It will fund items such as:

- accommodation costs (including meals);
- nursing charges;
- theatre fees;
- drugs;
- dressings;
- doctors' fees;
- consultants' fees;
- anaesthetists' fees;
- outpatient treatment;
- diagnostic tests and investigations;
- home nursing during recovery;
- costs of a parent staying with a young child in hospital;
- minor surgery carried out by a GP;
- chemotherapy, radiotherapy, etc.;
- private ambulance.

Some insurers now adopt an 'open referral' system. This is where the patient's GP refers the patient to a specialist but does not specify which specialist or hospital. Instead, the insurer appoints the specialist and hospital, often in conjunction with the patient.

Some insurers have links with hospitals to provide the treatment. All insurers' contracts vary in detail, but there is a broad division of the market into budget plans, standard plans and comprehensive plans. A working party has produced standardised product guide wordings to make it easier to compare products.

Most PMI policies are restricted to residents of the UK and do not provide any cover for treatment abroad. Foreign treatment might be covered by a travel insurance or holiday policy.

Some PMI policies operate on an open referral system where insurer appoints the specialist and hospital often in conjunction with the patient

Question 9.2

What is the main distinction between acute and chronic medical conditions?



Basic plans may suit those with smaller budgets or those who are willing to meet a proportion of costs themselves

B2A Basic plans

Many insurers offer basic or budget plans with low costs, no extra benefits and limits on the cover for different types of treatment:

- Often premiums can be reduced if the insured pays the first part of each claim. The greater the proportion of the claim the insured is willing to pay, the lower the risk to the insurer and so the lower the corresponding premium will be.
- Cover is mostly restricted to the costs of accommodation, drugs, dressings and doctors' fees. Outpatient treatments, home nursing and private ambulance services may not be covered at all, or may be subject to restrictions.
- There may be limits on the cost of treatment covered in any one year.
- Some plans may offer a discount if the insured makes efforts to remain healthy – for example if they are a member of a gym.

This type of plan may suit those with smaller budgets or those who are willing to meet a proportion of costs themselves in order to benefit from cheaper cover.

B2B Mid range plans

These cost more than basic plans but give wider cover:

- More items are covered, with longer claim periods and higher limits.
- There is often a wider choice of hospitals.
- Outpatient treatment is more likely to be covered.
- Consultant fees, diagnostic tests and services such as physiotherapy may be covered – often to a set limit.
- Psychiatric cover may also be included.

This option may appeal to those who have a slightly larger budget and who wish to extend the range of cover, but do not have the budget or the will to stretch to the comprehensive cover.

B2C Comprehensive plans

These plans are the most costly, but give the fullest cover:

- Claim periods can be longer, with higher limits and often a wider choice of hospitals.
- Services such as home nursing and private ambulances are covered.
- Most plans also cover the costs involved in a parent needing to stay at the hospital with a child who is ill or injured.
- Other items covered may include alternative medicine, dental treatment, travel abroad and cash payments for nights spent as an NHS patient.
- Policies may cover a whole family, not just one individual.

Most PMI policies allow a choice of hospital although many will have recommended hospitals in each area, particularly where the insurer has links with the hospitals. Budget plans may restrict the choice of hospital.

Where the customer spends much or all of their time living or working abroad, international PMI is usually recommended. Benefits under such plans are designed to cover a wider range of treatments than UK PMI policies and may include primary care (GPs and dentists), chronic conditions and pregnancy/childbirth. Such policies are beyond the scope of this text.

B3 Excesses and co-payments

Many PMI policies have an excess whereby the insured has to pay the first £X of any treatment. The higher the excess, the lower the premium will be. Alternatively, the excess might be expressed as the first £X of any policy year's claims. Excesses will tend to be higher on budget plans in order to keep the premiums as low as possible.

A co-payment is where the customer pays part of the cost of the treatment, often up to a pre-set limit. This system also has other names, such as shared responsibility.

Excesses will tend to be higher on budget plans in order to keep the premiums as low as possible

B4 Exclusions

Most policies will have some exclusions. Typically, a PMI policy would not meet the cost of any claim for:

- treatment related to alcohol, drug or substance abuse;
- chronic long-term illnesses which cannot be cured;
- rehabilitation for more than a specified number of days;
- cosmetic surgery purely to improve appearance;
- HIV and AIDS;
- kidney dialysis;
- conditions arising through intentional self-inflicted injury or attempted suicide;
- normal pregnancy and childbirth;
- termination of pregnancy;
- organ transplants;
- treatment for sleep apnoea;
- sex change or gender reassignment;
- routine check-ups;
- injuries or illnesses arising out of war, hostilities or warlike operations;
- injuries related to dangerous sports; and
- treatment abroad (although some policies will cover this).

Consider this...

Why are chronic long-term illnesses generally excluded from PMI cover?



B5 Application and underwriting

B5A Basis of cover

PMI cover can be arranged on the following bases:

- single;
- joint or married/civil partner (two adults);
- single parent (one adult and one or more dependent children);
- family (two adults and one or more dependent children).

Dependent children are usually defined as those below age 21 and living at home or who are in full-time education (generally up to age 25).

Contracts can be arranged individually or by groups. A high proportion of the market is group cover arranged by employers for selected classes of employee, such as senior managers:

- In this case, the scheme will cover all employees above a certain grade with the employer paying the premiums and providing the scheme as a benefit of employment.
- Group premiums are lower than individual premiums to reflect the lower costs of group processing and the bargaining power of a large group.
- There may be reduced underwriting for groups of more than 20–50, or no underwriting at all if the cover is automatic for all those at work on a given day in a large group.
- If the employer pays the premiums the employees are subject to income tax on them as benefits-in-kind. Such premium payments would also be subject to employer's National Insurance contributions (NICs). However, the premiums would be a deductible business expense for the employer's corporation tax.

Group premiums are lower than individual premiums to reflect the lower costs of group processing and the bargaining power

B5B Underwriting

Individual contracts can be fully underwritten or accepted without medical information subject to a **moratorium**:

A moratorium typically means that medical conditions that an individual has had in the previous five years before the start of the policy are excluded for a period of e.g. two years

- This typically means that medical conditions present within a number of years (often five) before the start of the policy (pre-existing conditions) are excluded from cover for, say, the first two years of the policy. In addition to this two year qualifying period, the individual must have remained free of treatment for two full years. This type of moratorium underwriting is often called a 5/2/2 rolling moratorium. That can mean that where someone has a regular check-up (which is classified as treatment) they would never get to a point where that condition is covered under their policy.
- Excluding pre-existing conditions clearly reduces the real value of the cover but at the same time it makes it simpler and cheaper to obtain, which appeals to many customers. Equally, those who do not have any pre-existing conditions may benefit from a quicker process without any exclusions.
- Given the potential impact of pre-existing conditions being excluded, it is vital that the client understands the nature of the plan for which they are applying. If they do not fully appreciate the implications of the moratorium they could have an unpleasant surprise later when trying to make a claim.
- Where a contract is fully underwritten the proposal form will have many questions about medical history. Many insurers also now offer reduced underwriting where someone is switching from an existing PMI policy.

Since December 2012, underwriters have been unable to take into account gender when setting premiums under insurance contracts. While this is likely to have significant impact for certain kinds of policy, such as life, income protection and critical illness insurance, the likely impact for PMI is much lower since relatively few PMI providers previously offered differentiated premiums for men and women.



Question 9.3

What are the three main types of PMI?

B6 Claims

In virtually all cases, a claim starts with a referral from a GP. The exception to this rule is that emergency admission to an NHS hospital may sometimes lead directly to a transfer to private treatment.

In the event that the insured needs to make a claim, the first port of call should be to call the insurer. Some claims may be extremely expensive, often adding up to many thousands of pounds, and so insurers are careful about admitting claims. In some cases insurers will have specialist teams to discuss potential claims before agreeing to treatment and the claimant will be required to speak to a specialist nurse in order to obtain sign-off on treatment. There may also be a further requirement for the claimant to make contact with the insurer again before each further stage of treatment may take proceed.

When a claim is made, the insured will need to provide the appropriate evidence of medical needs and costs. Payment will usually be made directly to the hospital or doctor. Claim payments are tax-free and there is no tax relief on premiums, except where an employer pays for a group scheme for its employees. The claims process is summed up in the ABI guidance:

Before you receive any treatment privately, you should call your insurance company to check that you are covered for the treatment that you will receive. Your insurer will give you all the guidance you need, confirm what your cover includes and, if necessary, send you a claim form. Stay in contact with your insurer who will confirm whether any treatment you plan to receive is within your cover.

PMI policies are usually annually renewable so premiums may increase substantially each year, particularly following claims, or the insurer could even decline to renew.

B7 Private medical insurance abroad

PMI policies sold in the UK are unlikely to provide cover for treatment outside the UK, unless specifically sold as international PMI. For short trips abroad, cover is likely to be provided through travel insurance, which will generally cover treatment abroad, evacuation to a nearby country for treatment where standards in the particular country are not considered high enough or even repatriation to the UK for treatment.



Consider this...

Why might repatriation to the UK for treatment be considered instead of treatment in the country where the condition arose?

Travel insurance policies generally only cover short trips of up to a month. For longer periods abroad, an alternative is generally required. For travel to European Economic Area (EEA) states, cover may be at least partially provided for EU citizens through the European Health Insurance Card (EHIC – formerly known as E111) which provides cover on a reciprocal basis around the EEA. Importantly, the agreement provides for treatment at the same level as home nationals, not UK levels of cover. This is relevant since certain treatment provided through the NHS free at the point of need will be subject to charge in other countries.

As mentioned in section B2C, international PMI provides another option for cover. These policies are similar to UK policies but may offer a broader range of cover for services provided in the UK by the NHS, such as GP services. The cost of these policies is determined primarily by the area the insured intends to reside, with higher risk/highest cost areas resulting in higher premiums – cover for North America, for example, tends to be very expensive given the cost of medical treatment there.

B8 Private medical insurance marketing

The soaring cost of private medical treatment means that PMI premiums are fast becoming too expensive for many people. Consequently, both providers and clients are looking for new methods to reduce costs. One new provider's approach is to provide market **policies with much larger excesses** than usual, under which the insured pays as much as the first £1,000, £2,500 or even £5,000 of each claim:

- This means that the insured pays for all straightforward treatment, such as consultations, X-rays or therapies.
- Supporters of this approach suggest that it will appeal to people in good health, particularly if the large savings in premium are invested to build up to the amount of their excess in two or three years.

It will usually be cheaper and easier for a client to join a **group PMI scheme** (such as one set up by an employer) than to arrange individual cover.

Care is needed to ensure that clients with **pre-existing medical conditions** understand that these may not be immediately covered by their PMI policy:

- This is particularly important where a client is considering leaving one PMI scheme for another.
- The client may be covered for treatment of an existing medical condition by their current scheme, but the new scheme may exclude that condition, e.g. for a rolling period of two years.
- The usual process is that a client's pre-existing medical conditions are not covered until there has been no claim for that condition(s), e.g. for two years.
- Once the qualifying period of 'non-claim' is passed, inclusion is automatic.
- Both adviser and client need to understand the significance of **moratorium underwriting**:
 - Such underwriting is superficially attractive to insurer, adviser and client alike. By forgoing immediate medical evidence, possibly including medical examination, it enables the contract to be set up quickly and avoids the inconvenience of a medical examination for the client.
 - However, underwriting is not forgone, it is merely deferred until a claim is made.
 - At that point, the insured may find that they have little or no cover, or substantially less than anticipated.

It is important that clients understand the conditions of PMI policies. They provide cover for acute conditions only and not for chronic conditions. Thus, there is no guarantee that policies will continue to fund treatment for heart disease, cancer and other diseases once these are deemed to be chronic. Advisers should also make potential clients aware of any policy exclusions.

It is usually easier and cheaper for a client to join a group PMI scheme (such as their employer's) than to arrange individual cover



People seeking to change providers to secure a reduction in premium need to exercise care. If they have a medical condition covered under their present policy, it is likely that they will not be covered for this pre-existing condition under a new policy for some while, and maybe not at all.

It is possible that the provision of PMI will become more important because of government cuts as waiting lists for appointments to see specialists will be extended.

C Mortgage payment protection insurance

The object of mortgage payment protection insurance (MPPI) is to protect a client against inability to keep up mortgage payments due to accident, sickness or unemployment.

If a homeowner with a mortgage gets income support, income-based jobseeker's allowance, income-related employment and support allowance or pension credit, their benefit may include an additional element, e.g. **support for mortgage interest (SMI)**. See chapter 3, section E1.

C1 Mortgage payment protection insurance components

MPPI pays out a monthly benefit if the insured cannot work because of sickness, accident, disability or unemployment

MPPI pays a monthly benefit if the insured is unable to work for one of three reasons:

- sickness;
- accident or disability; or
- involuntary unemployment.

The unemployment and sickness/accident elements may be available separately. Generally, sickness claims are more costly for insurers rather than accidents because (except at younger ages) sickness is a much greater risk than accidents and that risk tends to rise with age.

Benefits are usually payable for up to 12, 18 or 24 months only and the maximum benefit is usually, say, 100% or 125% of monthly mortgage costs (usually including the cost of any associated insurance policies). Benefits are not taxable.

The **cost** of MPPI tends to be relatively high compared to the level of benefit. Cost is often quoted per £100 per month of benefit with premiums of between £2.40 and £7.00 per £100 of benefit, based on a 12 month payment period being quoted on a leading comparison website during 2013. In context this means payment of up to £84 per year for a maximum benefit of £1,200. Prices have generally risen over recent years partially due to rises in unemployment and, it is suggested, due a fall in sales (though sales figures are no longer widely published).

C1A The need for mortgage payment protection insurance

For many people their monthly mortgage payment is one of their largest and most important regular outgoings. If they could not work because they became ill or incapacitated in some way, or if they became unemployed, insurance could help by paying their regular mortgage payments for them.

The CML and the ABI calculated that 55% of homeowners were in need MPPI in 2003

The Council of Mortgage Lenders (CML) and the ABI estimated in 2003 that 55% of homeowners were in need MPPI. The remaining 45% did not need MPPI because their risk was limited. The 55% level was set with the aim of reducing the average number of possession orders.

Many people take out MPPI because:

- Their mortgage is their most important regular bill.
- State welfare benefits will help them with living expenses if they cannot work but only pay mortgage costs in certain limited circumstances.
- They do not expect any financial problem to last more than a few months.
- Lenders often sold MPPI as an integral part of arranging the loan.
- MPPI covers unemployment as well as sickness and accident – unlike many income protection or critical illness plans.
- MPPI is easy to buy because there is usually limited underwriting. This is possible because pre-existing conditions are excluded and the payment period is short.

Some MPPI policies cover monthly mortgage costs plus an extra amount (typically up to 25%) to cover other associated costs. As MPPI policies now cannot be sold at the same time as a mortgage, the link to a specific loan repayment amount is diminishing. Instead, the maximum benefit may be expressed as a percentage of the client's income. Such policies are sometimes now called short-term income protection (STIP), a term which can easily be confused with traditional long-term income protection insurance.

C1B Typical terms and conditions

Most policies' terms and conditions comply with the minimum standards originally set out by the CML and ABI. Typical terms and conditions include the following:

- MPPI is available from age 18 years to age 64 years.
- Pre-existing medical conditions are excluded.
- Claims for stress and mental health problems and back (musculoskeletal) conditions must usually be documented with clear medical evidence or the diagnosis of a specialist NHS consultant.

- The insured must be currently employed or self-employed for at least 16 hours a week and have been employed/self-employed continuously for at least the last six months.
- The insured must not be aware of any forthcoming redundancies.
- They must not be currently away from work for any reason.
- Maximum benefit will be limited to typically somewhere between 100–125% of monthly mortgage costs. This is also often subject to an overall limit of, for example, 65% of normal gross income or £1,500 a month if lower. Some providers will offer higher maximum benefits than others.
- There may be an initial waiting period (e.g. 60 days) before any benefit related to unemployment may be claimed, i.e. borrowers must cover themselves for the first two months.
- For unemployment insurance, a self-employed person may only be able to benefit if the business goes into involuntary liquidation. If they simply cease trading, e.g. because orders have dried up, the policy will not pay out.
- Any continuing income or income from other sources (e.g. from other insurance policies) will affect how much can be claimed.
- The policy may be cancelled or withdrawn by the insurer at a minimum of 90 days' notice or amended with at least 30 days' notice.
- MPPI is usually paid by monthly premium and premium rates are not guaranteed. However, some insurers are now offering some guarantees on rates, e.g. for two to five years or, in some cases, throughout.
- Single premium cover used to be widely available whereby the premium was simply added to the sum borrowed. However, that can provide very poor value for money if the loan is repaid early for any reason and if the loan interest rate is high. If the loan is repaid early, there may be a partial return of payment, and this must be fair to the customer under FCA rules. In 2009, the Financial Services Authority (FSA), the regulator at the time, effectively banned sales of single premium payment protection insurance (PPI) from April 2009, following recommendations from the Competition Commission.

For unemployment insurance, a self-employed person may only be able to benefit if the business goes into involuntary liquidation

Since 6 April 2012, providers have been banned from selling MPPI products at the same time as the loan and now have to wait until the later of seven days after the credit sale or the point of providing a personalised illustration before selling MPPI.

Providers cannot sell MPPI products at the same time as the loan

The details of different insurers' policies vary but the following are typical features:

- The policy provides a monthly benefit if the insured is unable to work due to accident, sickness or unemployment.
- Benefit will be payable for at least twelve months, but will probably be limited to a maximum period of twelve months or two years.
- The monthly benefit may be limited to, say, 100–125% of the mortgage repayments, including buildings and contents insurance, term or endowment premiums and the MPPI premium itself. Alternatively it may be expressed as a percentage of the client's income, e.g. 65% of income up to a maximum benefit of £1,500 a month.
- MPPI policies are designed to cover all mortgage related expenses, while STIP policies can provide wider cover, being linked to income rather than expenditure.
- There will be a deferred period, often 30 or 60 days, which might be different for accident and sickness as opposed to unemployment.
- The cover is not tied to any specific mortgage and will be portable to a new mortgage.
- There is a standard minimum level of cover agreed between the CML and the ABI.
- Premiums will normally be monthly or annual. Historically, it was often possible to pay a single premium which could be added to the mortgage, but this is no longer possible.

C2 Eligibility

MPPI is usually only available for:

- mortgages of a main residence in the UK, Channel Islands or Isle of Man;
- permanent residents of the UK, Channel Islands or Isle of Man;
- those under 65;
- those in paid employment or self-employment.

C3 Exclusions

Typical exclusions include:

- conditions existing at the start of the policy, whether known about or not;
- conditions for which treatment was received in the twelve months before the start date;
- injuries sustained through self-infliction or a criminal act;
- alcohol or drug abuse;
- normal pregnancy;
- unemployment the insured might reasonably have known about at the start date;
- unemployment within, say, 60 days of the start date;
- unemployment which is voluntary, due to misconduct or as a result of a labour dispute;
- the ending of a fixed-term work contract.

C4 Taxation

There is no tax relief on premiums and no tax on benefits.



Question 9.4

What is the object of MPPI?

D Accident, sickness and unemployment insurance

Accident, sickness and unemployment (ASU) insurance is very similar to MPPI, but is not linked to or restricted by a mortgage. Many such policies are now called short-term income protection (STIP) policies (see chapter 6).

ASU is similar to MPPI but is not linked or restricted to a mortgage

D1 Features

Typical ASU features are:

- monthly or weekly benefit payable if the insured is unable to work due to accident, sickness or unemployment;
- benefit payable for a maximum period of two years;
- deferred periods similar to MPPI;
- exclusions similar to MPPI;
- benefit limited to a set percentage (say 75%) of earnings and/or a maximum monthly amount (e.g. £2,500);
- possibly some lump sum benefits for events such as loss of sight or a limb.

D2 Group accident, sickness and unemployment insurance

Sometimes an employer will offer a group ASU scheme for its employees, either free as a benefit of employment or with premiums being deducted from salary. Such schemes benefit from preferential premiums and underwriting reflecting the bargaining power of a bulk buyer. The relatively low premiums and the high perceived value make these schemes popular as part of an overall employee benefits package.

Cover under this type of scheme is sometimes limited to incidents occurring at work, so it is important for those covered under such a scheme to be aware of the terms of their cover. Equally, it is important for the employee to be aware that cover under a group scheme will cease when they leave their job, though in some cases it is possible for them to continue cover with the same insurer on an individual basis.

D3 Taxation

In the case of individual policies, premiums do not attract tax relief and benefits are not taxed.

Where an employer pays the premium under a group policy the premium payments are benefits-in-kind subject to income tax under PAYE, but allowable as a business expense for the employer. Benefits paid to the individual are not taxable.

Question 9.5

What is the key difference between ASU and MPPI?



E Health cash plans and dental plans

E1 Health cash plans

These are simple, relatively low cost, healthcare plans that pay up to 100% of the cost of treatment up to a pre-set annual limit or towards specified treatments including optical services and dental treatment. They may also pay a fixed cash sum for each day spent in hospital and a range of other benefits.

- There will often be a waiting period of up to six months before claims can be made, and pre-existing conditions are usually excluded.
- These low cost plans give the patients money to help pay for medical care, rather than providing a full indemnity against the cost of private medical care, as with PMI contracts outlined earlier.

Whilst they level of cover is much lower than a full PMI contract, for those unable or unwilling to afford PMI they offer an alternative method of obtaining at least some level of cover.

E2 Dental plans

Changes in the payment of dentists working for the NHS have resulted in a reduction of the number of NHS practices and difficulty obtaining treatment for many of those not currently covered by an NHS dentist. Given the cost of dental treatment, many have now purchased insurance to protect themselves against future dental costs.

Standalone dental insurance plans or, more strictly, a dental capitation scheme (similar arrangements include dental care contract schemes and maintenance plans) are, in effect, a way of budgeting for expected dental costs rather than a true insurance against incurring dental costs. These plans work in a similar way to health cash plans, but cover is restricted to dental treatment and thus should be less costly.

A typical plan might cover:

- the normal dental costs with the patient's normal dentist, e.g. check-ups;
- any other dental treatment needed, e.g. fillings, extractions, root canal treatment and caps/bridges, where they are treated by the client's normal dentist; and
- dental accidents and emergencies including treatment by other dentists.

The benefit of a capitation scheme is that it allows people to budget for their dental costs rather than having to pay the costs as they are incurred. One downside is that a capitation plan usually involves a dental examination by the dentist beforehand to ascertain the dental work likely in the coming year. True dental insurance is more commonly available through group policies and will pay dental costs in part or in full.

Many plans will pay a maximum benefit that may be below the charge made by the dentist, particularly where the patient elects to have more expensive treatment. For example a dentist may offer a range of fillings costing say £50–£120, depending on the materials used and the end appearance of the tooth.

Some dental plans are sold as add-ons to PMI, whilst others are sold (often through dentists) as standalone plans or as part of an employee benefits package.

Question 9.6

What benefit does a hospital cash plan provide?



F Payment protection insurance

F1 Overview

Payment protection insurance (PPI) is similar to MPPI in terms of its structure and purpose, but may be taken out in conjunction with non-mortgage credit agreements such as unsecured car loans or other non-specific loan. In addition a form of PPI has traditionally been offered with many store cards or credit cards. Under this form of PPI, the level of cover was usually restricted to the level of the minimum payments on the card and for a fixed period of, often, twelve months.

F2 Payment protection insurance mis-selling

Over recent years, PPI has attracted considerable criticism with widespread mis-selling having been identified. Whilst the CML suggest as many as 55% of mortgage holders would benefit from MPPI, the benefit of PPI for many is less clear. In putting together their 2005 report, entitled Protection Racket, the Citizens Advice Bureau (CAB) found instances of PPI costs ranging from 13% to a staggering 56% of the loan amount. The CAB estimated the market to be worth as much as £5 billion with 20 million policies in force. The key findings of its report were:

- significant cost often adding to customer indebtedness;
- poor product design – often including sweeping exclusions such as mental health problems or back conditions;
- high pressure, inappropriate sales processes resulting in sales of products that the customer neither wanted nor needed;
- bureaucratic and insensitive claims handling, with a disproportionate number of claims failing.

At the same time as the CAB published its report, the FSA began to take an interest in the area, suggesting that PPI posed a risk to its consumer protection objective.

In August 2010, the FSA published a consultation paper which recommended that banks should compensate customers to whom policies had been mis-sold. The British Banking Association (BBA) appealed and requested a judicial review, resulting in a temporary hold on payments. In April 2011, the banks lost their appeal and a month later decided not to take the case to appeal. Since then, banks have been working through a backlog of complaints at a cost of billions of pounds. PPI has now become the most complained about financial product ever.

On 6 April 2012 new rules for PPI sales came into force which prevent PPI from being sold in the vast majority of cases until the later of seven days after the loan sale, or the point at which a personalised illustration is provided.

Given the mis-selling scandal that accompanies it, it would be easy to draw the conclusion that PPI is a product without merit, however, there are still a number of insurers who offer PPI as a standalone product and in the right circumstances, for the right customer it can offer peace of mind and security. The FCA advise customers to shop around and to carefully check the terms of the contract they are entering into.

G Adviser considerations

G1 Long-term versus short-term policies

Both long-term policies (such as IPI and CIC) and short-term policies (like ASU, MPPI, PPI and PAS) have a place in financial planning. All provide valuable, but very different cover.

Long-term policies offer the most comprehensive cover and should generally be considered the first option for the adviser in making protection recommendations. IPI provides the opportunity to protect income until retirement age, whilst CIC can ensure a significant lump sum at a time when it is needed the most. The advantages of long-term insurance are clear, but there are also disadvantages. Given the nature of the risk to the insurer, long-term policies are subject to extensive underwriting and given the high level of cover, cost can be equally high.

Short-term policies offer another option. The application process is quick and easy, and the cost can be modest compared to the more comprehensive long-term option. In addition, short-term policies can be used to protect against periods of unemployment and may also suit those who have an expectation that any needs are likely to be short-term. This, however, is balanced by the annual nature of the policy allowing for cover to be terminated or premiums increased at any renewal date.

Whichever type of policy is recommended, it is important that the customer understands the nature of the policy and the relative advantages and disadvantages associated with it. Some customers will require the adviser to educate them in a number of areas, including:

- various risks they face and the possible for cover;
- different policies available to meet their needs; and
- individual advantages and limitations of different covers.

Where the ultimate solution is for a short-term policy, it is vital that the customer understands the annual nature of the contract and the limited nature of any payment.

G2 Private medical insurance

There are a number of considerations for the adviser and customer when considering PMI. These include:

- Level of cover – budget, standard, comprehensive. The more comprehensive the cover, the more expensive it will be, but equally the greater the benefit it will provide.
- Level of excess – the greater the excess, the cheaper the cover.
- Basis of underwriting – full underwriting may take longer but moratorium underwriting may result in effectively permanent exclusions.
- Travel plans – if the customer is intending to reside abroad, an international PMI policy may be required.

Often, the form and level of cover provided will be budget-driven with customers buying the most extensive cover they can afford. The adviser will need to help the customer to understand the benefits provided and the limitations associated with their cover.



Key points

The main ideas covered by this chapter can be summarised as follows:

Personal accident and sickness policy

- PAS benefits are paid out if the insured suffers an accident or is off work due to sickness.
- Most contracts are annual but can be taken for shorter periods, e.g. to cover a business trip or a holiday.
- All PAS policies generally cover: death, permanent disablement, loss of an eye, loss of a leg, foot or toe, loss of an arm, hand, finger or thumb.
- Two other benefits can be added: medical expenses and weekly sickness benefit.

Private medical insurance

- Provides cover against the cost of private medical treatment.
- PMI is primarily aimed at acute, not chronic, conditions.
- Most PMI policies are restricted to residents of the UK and do not provide any cover for treatment abroad. Foreign treatment may be covered by a travel insurance policy, or if the individual has international private medical insurance.
- Types of PMI:
 - budget plans – premiums can be reduced if the insured pays the first part of any claim. There may be restrictions to the limits on the cost of treatment. Home nursing and private ambulances are not covered;
 - standard plans – provide a wider cover than budget plans. More choice of hospitals together with higher limits on costs of treatment;
 - comprehensive plans – claim periods can be longer with higher limits and often a wider choice of hospitals. Services such as home nursing and private ambulances are covered.
- Cost of treatment is paid directly from the insurance company.
- Taxation of PMI:
 - individual policies – cost of treatment is paid directly from the insurance company;
 - group policies – cost of treatment is paid directly from the insurance company. The employee will be liable to benefit-in-kind tax if the employer pays the premiums.
- Annually renewable and the premiums are subject to insurance premium tax.

Mortgage payment protection insurance

- MPPI aims to provide the ability to maintain mortgage payments and costs for up to a normal maximum of twelve months.
- Maximum monthly benefit of up to 125% of the mortgage payments including associated mortgage costs.
- Benefits are paid after a deferred period which is typically 30 or 60 days.
- The cover is not tied to a specific mortgage and can be portable to a new mortgage. Policies may no longer be sold at the same time as a loan. Instead there must be a gap, which can leave borrowers uninsured.
- Benefits are paid tax-free.
- Annually renewable and the premiums are subject to insurance premium tax.
- Similar policies are available for non-mortgage loans and are known as PPI. These have been the centre of much controversy over recent years and sales are now subject to tight regulation.

Accident, sickness and unemployment insurance

- ASU or STIP policies are very similar to MPPI but the insured benefit is not limited to mortgage payments.
- Monthly benefit can be linked to earnings, e.g. 50–75% or a set amount, e.g. £2,500.
- Benefits will be payable for a maximum period of two years after a deferred period which is similar to MPPI.
- A lump sum can be payable subject to conditions, e.g. loss of limb or sight.
- Taxation of ASU:
 - individual policies – benefits are paid tax-free;
 - group policies – benefits are paid tax-free and the employee will be liable to benefit-in-kind tax if the employer pays the premiums.
- Annually or monthly renewable and the premiums are subject to insurance premium tax.

Question answers

- 9.1 Household, motor or travel insurance.
- 9.2 Chronic conditions are usually incurable, whereas acute conditions are usually amenable to cure.
- 9.3 Budget, standard and comprehensive.
- 9.4 To protect a client against inability to keep up with mortgage payments due to accident, sickness or unemployment.
- 9.5 MPPI is linked to a mortgage, ASU and STIP are not.
- 9.6 A fixed cash sum for each day spent in hospital.



Self-test questions

1.	List four events normally covered by PAS insurance.
2.	To what tax are general insurance policies subject?
3.	Why is there a need for PMI cover?
4.	Describe the tax treatment of PMI group cover paid for by an employer.
5.	For what mortgages is MPPI normally available?
6.	Is MPPI subject to IPT?
7.	ASU benefit is normally limited by reference to what?
8.	Group ASU cover arranged by an employer is sometimes restricted to what?

You will find the answers at the back of the book