P64 – Private medical insurance practice

Diploma in Insurance

October 2017 Examination Guide

SPECIAL NOTICE

Candidates entered for the April 2018 examination should study this Examination Guide carefully in order to prepare themselves for the examination.

Practise in answering the questions is highly desirable and should be considered a critical part of a properly planned programme of examination preparation.

P64 – Private medical insurance practice

Contents

Published February 2018

Telephone: 020 8989 8464
Fax: 020 8530 3052
Email: customer.serv@cii.co.uk

IMPORTANT GUIDANCE FOR CANDIDATES

Introduction

The purpose of this Examination Guide is to help you understand how examiners seek to assess the knowledge and skill of candidates. You can then use this understanding to help you demonstrate to the examiners that you meet the required levels of knowledge and skill to merit a pass in this unit.

Before the examination

Study the syllabus carefully

This is available online at www.cii.co.uk or from Customer Service. All the questions in the examination are based directly on the syllabus. *You will be tested on the syllabus alone*, so it is vital that you are familiar with it.

There are books specifically produced to support your studies that provide coverage of all the syllabus areas; however you should be prepared to read around the subject. This is important, particularly if you feel that further information is required to fully understand a topic or an alternative viewpoint is sought. The reading list which can be found with the syllabus provides valuable suggestions.

Read widely

It is vital that your knowledge is widened beyond the scope of one book. *It is quite unrealistic to expect that the study of a single study text will be sufficient to meet all your requirements.* While books specifically produced to support your studies will provide coverage of all the syllabus areas, you should be prepared to read around the subject. This is important, particularly if you feel that further information is required to fully understand a topic or an alternative viewpoint is sought. The reading list which can be found with the syllabus provides valuable suggestions.

Make full use of the Examination Guide

This Examination Guide contains a full examination paper and model answers. The model answers show the types of responses the examiners are looking for and which would achieve maximum marks. However, you should note that there are alternative answers to some question parts which would also gain high marks. For the sake of clarity and brevity not all of these alternative answers are shown.

This guide and previous Examination Guides can be treated as 'mock' examination papers. Attempting them under examination conditions as far as possible, and then comparing your answers to the model ones, should be seen as an essential part of your exam preparation. The examiner's comments on candidates' actual performance in each question provide further valuable guidance. You can purchase copies of the most recent Examination Guides online at www.cii.co.uk. CII members can download free copies of older Examination Guides online at www.cii.co.uk/knowledge.

Know the structure of the examination
Assessment is by means of a three hour paper.

Part 1 consists of 14 compulsory questions, worth a total of 140 marks.

Part 2 consists of 2 questions selected from 3, worth a total of 60 marks.

Each question part will clearly show the maximum marks which can be earned.

Read the current Diploma in Insurance Information for Candidates
Details of administrative arrangements and the regulations which form the basis of your examination entry are to be found in the current Diploma in Insurance Information for Candidates brochure, which is *essential reading* for all candidates. It is available online at www.cii.co.uk or from Customer Service.

In the examination

The following will help:

Spend your time in accordance with the allocation of marks

- The marks allocated to each question part are shown on the paper.
- If a question has just two marks allocated, there are likely to be only one or two points for which the examiner is looking, so a long answer is a waste of time.
- Conversely, if a question has 12 marks allocated, a couple of lines will not be an adequate answer.
- Do not spend excessive time on any one question; if the time allocation for that question has been used up, leave some space, go on to the next question and return to the incomplete question after you have completed the rest of the paper, if you have time.

Take great care to answer the question that has been set

- Many candidates leave the examination room confident that they have written a 'good' paper, only to be surprised when they receive a disappointing result. Often, the explanation for this lies in a failure to fully understand the question that has been asked before putting pen to paper.
- Highlighting key words and phrases is a technique many candidates find useful.
- The model answers provided in this Examination Guide would gain full marks. Alternative answers that cover the same points and therefore answer the question that has been asked would also gain full marks.

Tackling questions

Tackle the questions in whatever order feels most comfortable. Generally, it is better to leave any questions which you find challenging until you have attempted the questions you are confident about. Candidates' should avoid mixing question parts, (for example, 1(a)(i) and (ii) followed by 2(b)(ii) followed by 1(e)(i)) as this often leads to candidates unintentionally failing to fully complete the examination paper. This can make the difference between achieving a pass or a narrow fail.

It is vital to label all parts of your answer correctly as many questions have multiple parts to them (for example, question 1(a) may have parts (i), (ii) and (iii)). Failure to fully distinguish between the separate question parts may mean that full credit cannot be given. It is also important to note that a full answer must be given to each question part and candidates should not include notes such as 'refer to answer given in 1(b)(i)'.

Answer format

Unless the question requires you to produce an answer in a particular format, such as a letter or a report, you should use 'bullet points' or short paragraphs. The model answers indicate what is acceptable for the different types of question.

Where you are asked to perform a calculation it is important to show **all** the steps in your answer. The majority of the marks will be allocated for demonstrating the correct method of calculation.

Provided handwriting is legible, candidates will **not** lose marks if it is 'untidy'. Similarly, marks are not lost due to poor spelling or grammar.

Calculators

If you bring a calculator into the examination room, it must be a silent, battery or solar-powered, non-programmable calculator. The use of electronic equipment capable of being programmed to hold alphabetical or numerical data and/or formulae is prohibited. You may use a financial or scientific calculator, provided it meets these requirements. The majority of the marks will be allocated for demonstrating the correct method of calculation.

EXAMINER COMMENTS

Question 1
This question concerned ways in which insurers can advertise their products using 'direct' media. Most candidates gained reasonable marks.

Question 2
This question was testing the ways that private medical insurers can use the services of third party administrators (TPAs) and business aspects that are typically devolved to TPAs. Candidates provided knowledgeable answers that suggested a good awareness of the important role of TPAs within the private medical insurance sector.

Question 3
On this question some candidates wrongly interpreted 'methods of premium payment' as 'rating and risk assessment methods' – continued personal medical exclusions, full medical underwriting and moratorium underwriting which were all incorrect. Many candidates correctly identified that the question was looking for an answer based on payments by cheque, direct debit and BACS transfers. Also, candidates incorrectly mentioned cash and credit card payments. Part (b) focused on the link between salary sacrifice arrangements and 'anti-selection' but few candidates made that connection.

Question 4
This question introduced the actuarial objectives of a private medical insurer and, as these are largely generic to all classes of insurance, most candidates had probably come across them before when studying other units. As a result, the question performed well.

Question 5
Candidates mainly concentrated their answers on the taxation treatment of premiums paid and the application of insurance premium tax. The question also required comment on the taxation position of benefits and few candidates mentioned this important aspect. As a result, not many high marks were gained.

Question 6
The Health and Social Care Act 2012 and its implications were not well addressed, and several candidates did not answer this question well. However, a minority of candidates did achieve good marks.

Question 7
Parts (a) and (c) of this question were generally well answered. Part (b), which related to income protection insurance was not so well answered. Overall, the three parts of the question produced reasonable marks for most candidates.

Question 8
Provider helplines and patient helplines were sometimes confused by candidates. A few candidates mixed up 'providers' for providers of private medical insurance rather than providers of treatment. Patient helplines were more competently outlined, and the question generated good marks overall.

Question 9
This question concerned the Data Protection Act 1998 (DPA) and produced poor marks overall. Candidates tended to be confused between the remit of DPA and other statutes such as the Access to Medical Reports Act 1988 and the Access to Health Records Act 1990.

Question 10
Candidates answers displayed a good understanding of flexible benefit (flex) schemes and the way in which they operate. Part (b) required a list of examples of insurance related benefits and one example of a non-insurance related benefit found under flex schemes and most candidates correctly identify at least three examples.

Question 11
This question allowed candidates to display an understanding of how routine medical conditions would be treated by insurers when presented as claims. These were addressed reasonably well with many candidates achieving close to or more than half of the total marks available.

Question 12
Both parts of this question were answered well. Candidates were able to correctly discriminate between second opinion services and open referrals and note the distinguishing characteristics of each.

Question 13
This question concerned medical savings plans and many candidates correctly recognised key features of such plans, however, they were less successful in demonstrating how savings plans combine with conventional private medical insurance. As a result, the question was not well answered.

Question 14
This question was answered reasonably well although some candidates referred to examples of catastrophic events that were not relevant to private medical insurance.

Question 15
This Part II question was a popular choice for most candidates. Part (a) was answered well, with many candidates correctly discussing the workings of moratorium underwriting and how it would apply within the constraints of the scenario. Part (b) offered a limited number of marks for brief descriptions of discounts offered by insurers to new and existing customers and this part of the question was also answered well.

Question 16
This Part II question was not popular with candidates and, as a result, did not produce good marks. Part (a) required candidates to describe briefly the steps that Jennifer can take to achieve a diagnosis for depression. The steps that an individual would take could involve the public healthcare sector or private medical insurance, or both. Candidates tended to focus on either public or private healthcare, rather than both. For part (b), the narrow focus shown by candidates in part (a) was repeated. As a result, only a small proportion of the available marks were gained. Part (c) concerned the financial dangers of an individual attempting to self-fund treatment and how escalating costs could be damaging for the individual. Only four marks were available and very few candidates achieved more than half of these marks.

Question 17

Part (a) required candidates to display a basic knowledge of the UK regulatory regime and how a private medical insurer would be affected. Some good explanations were mixed in with some that were less strong. For part (b), candidates concentrated on underwriting and risk assessment data rather than quantitative and qualitative data as implied by the question. For part (c), candidates needed to 'drill down' to what a newly-established insurer could do to quickly build-up market share from a flat base. Reference to 'personal' and 'switch' underwriting together with 'continued personal medical exclusions' would have achieved good marks. Unfortunately, many candidates did not look beyond moratorium underwriting in answering this question part. Part (d) provided the best answers as candidates were familiar with the concept of 'anti-selection' and the problems that this creates for insurers. Part (e) offered four marks for an explanation of the rationale supporting the application of standard exclusions. Candidates that performed poorly on other parts of this question were typically able to point to the need to equalise the risk brought to the 'common pool' by applicants having a varied range of pre-existing medical conditions.

THE CHARTERED INSURANCE INSTITUTE

P64

Diploma in Insurance

Unit P64 – Private medical insurance practice

October 2017 examination

Instructions

- Three hours are allowed for this paper.
- **Do not begin writing until the invigilator instructs you to.**
- **Read the instructions on page 3 carefully before answering any questions.**
- Provide the information requested on the answer book and form B.
- You are allowed to write on the inside pages of this question paper, but you must **NOT** write your name, candidate number, PIN or any other identification anywhere on this question paper.
- The answer book and this question paper must **both be handed in personally by you** to the invigilator before you leave the examination room. **Failure to comply with this regulation will result in your paper not being marked and you may be prevented from entering this examination in the future.**

Unit P64 – Private medical insurance practice

Instructions to candidates

Read the instructions below before answering any questions

- **Three hours** are allowed for this paper which carries a total of 200 marks, as follows:

Part I	14 compulsory questions	140 marks
Part II	2 questions selected from 3	60 marks

- You should answer **all** questions in Part I and two out of the three questions in Part II.
- You are advised to spend no more than two hours on Part I.
- Read carefully all questions and information provided before starting to answer. Your answer will be marked strictly in accordance with the question set.
- The number of marks allocated to each question part is given next to the question and you should spend your time in accordance with that allocation.
- You may find it helpful in some places to make rough notes in the answer booklet. If you do this, you should cross through these notes before you hand in the booklet.
- It is important to show each step in any calculation, even if you have used a calculator.
- If you bring a calculator into the examination room, it must be a silent, battery or solar-powered non-programmable calculator. The use of electronic equipment capable of being programmed to hold alphabetic or numerical data and/or formulae is prohibited. You may use a financial or scientific calculator, provided it meets these requirements.
- Answer each question on a new page. If a question has more than one part, leave six lines blank after each part.

PART I

Answer ALL questions in Part I

Note form is acceptable where this conveys all the necessary information

1. Describe briefly the advantages for a private medical insurer advertising its products directly to potential customers using:

(a) telesales; **(3)**

(b) the internet; **(3)**

(c) social media. **(3)**

2. **(a)** Explain briefly the advantages to a private medical insurer of using a third party administrator (TPA). **(6)**

(b) State **eight** examples of functions that could be performed by a TPA. **(8)**

3. **(a)** State **four** methods of premium payment offered by insurers to employers purchasing group private medical insurance and outline **one** advantage **OR one** disadvantage for the insurer associated with **each** method. **(8)**

(b) Explain briefly how an insurer typically would treat a request from an employer that premiums be paid by employees through a salary sacrifice arrangement. **(3)**

4. Describe the actuarial objectives that an insurer will set when managing its private medical insurance portfolio. **(10)**

5. Explain briefly the tax implications for a UK-based applicant having private medical insurance:

(a) as an individual; **(2)**

(b) as a member of an employer-paid scheme. **(3)**

6. Outline the changes made to the provision of healthcare services in England by the Health and Social Care Act 2012. **(7)**

7. Outline the additional benefits that apply when a group private medical insurance scheme is extended to include:

(a) well-being and occupational health benefits; **(5)**

(b) income protection insurance; **(5)**

(c) personal accident and sickness insurance. **(5)**

8. Outline the main benefits that private medical insurers offer under:

(a) provider helplines; **(4)**

(b) patient helplines. **(4)**

9. Describe the principles under the Data Protection Act 1998 that apply to customers of private medical insurers regarding personal information held by the insurer. **(8)**

10. **(a)** Explain briefly the operation of flexible benefit (flex) schemes within the employer benefit environment. **(5)**

(b) List **four** examples of insurance related benefits and **one** example of a non-insurance related benefit that could be included within a flexible benefit (flex) scheme. **(5)**

11. Explain briefly the likely cover available when claiming under individual comprehensive private medical insurance in the following situations:

(a) Andrew has early-stage testicular cancer that was diagnosed after his policy started and at present is treatable. His specialist has suggested that a course of experimental treatment, alongside traditional medicine, would enhance the possibility of a complete recovery. **(5)**

(b) Beth damages a cartilage in her knee when falling awkwardly during a volleyball tournament. **(5)**

(c) Charlotte develops asthma although she has no previous history of breathing difficulties. **(5)**

12. Explain briefly, in the context of claims made under private medical insurance policies, what is meant by:

(a) a second opinion service; **(5)**

(b) an open referral. **(5)**

13. Outline how the savings element under a medical savings plan combines with conventional private medical insurance when a claim is paid. **(6)**

14. Explain briefly how reinsurance can benefit a private medical insurer in achieving:

(a) increased capacity to accept and retain business; **(3)**

(b) security and stability; **(3)**

(c) protection against a catastrophic event; **(3)**

(d) improved expertise to conduct its business more effectively. **(3)**

PART II

Answer TWO of the following THREE questions
Each question is worth 30 marks

15. Hugh is considering buying private medical insurance from an insurer offering moratorium underwriting. He is currently in reasonable health despite having been unwell in the past. The insurer also offers discounts to new and existing customers.

(a) Discuss moratorium underwriting and its likely effects on Hugh and the insurer. **(24)**

(b) Describe briefly how the following discounts operate, should Hugh become a customer of the insurer:

(i) Initial discount. **(2)**

(ii) No claim discount. **(2)**

(iii) Loyalty discount. **(2)**

16. Jennifer lives in the UK and has private medical insurance. She has become troubled by bouts of depression that seem at odds with her healthy lifestyle.

(a) Describe briefly the steps that Jennifer can take to achieve a diagnosis. **(4)**

(b) Discuss the cost implications and treatment options that are available to Jennifer within the public and private healthcare sectors once a diagnosis has been obtained. **(22)**

(c) Outline the financial considerations for Jennifer if she elects to pursue treatments not available in the public healthcare sector or covered by her insurer. **(4)**

17. Company X is a newly-formed UK insurer set up to transact private medical business for both individual and group insureds.

(a) Outline how the regulation of firms writing private medical insurance will impact Company X. **(6)**

(b) State and explain briefly the **two** main types of data that Company X can use to research the needs of its potential customers. **(4)**

(c) Explain how Company X can use alternative risk assessment and underwriting strategies to differentiate itself from its competitors to gain market share. **(10)**

(d) Explain briefly how 'anti-selection' arises in the context of voluntary and group private medical insurance, and the measures that Company X can take to combat it. **(6)**

(e) Explain briefly why Company X will make its products subject to standard exclusions. **(4)**

TEST SPECIFICATION

October 2017 Examination – P64 Private medical insurance practice	
Question	Syllabus learning outcome(s) being examined
1	6 – Understand the distribution of private medical insurance
2	4 – Understand the application of claims and policy administration 6 – Understand the distribution of private medical insurance
3	2 – Understand private medical insurance products and principles 3 – Understand the application of pricing and underwriting for private medical insurance
4	3 – Understand the application of pricing and underwriting for private medical insurance
5	5 – Understand legislation and regulation in relation to private medical insurance
6	1 – Understand the relationship between public and private medical provision
7	2 – Understand private medical insurance products and principles
8	4 – Understand the application of claims and policy administration
9	5 – Understand legislation and regulation in relation to private medical insurance
10	2 – Understand private medical insurance products and principles
11	3 – Understand the application of pricing and underwriting for private medical insurance 4 – Understand the application of claims and policy administration
12	2 – Understand private medical insurance products and principles 4 – Understand the application of claims and policy administration
13	2 – Understand private medical insurance products and principles
14	3 – Understand the application of pricing and underwriting for private medical insurance
15	2 – Understand private medical insurance products and principles 3 – Understand the application of pricing and underwriting for private medical insurance 4 – Understand the application of claims and policy administration 5 – Understand legislation and regulation in relation to private medical insurance
16	1 – Understand the relationship between public and private medical provision 2 – Understand private medical insurance products and principles 3 – Understand the application of pricing and underwriting for private medical insurance 4 – Understand the application of claims and policy administration
17	2 – Understand private medical insurance products and principles 3 – Understand the application of pricing and underwriting for private medical insurance 4 – Understand the application of claims and policy administration 5 – Understand legislation and regulation in relation to private medical insurance 6 – Understand the distribution of private medical insurance

NOTE ON MODEL ANSWERS

The model answers given are those which would achieve maximum marks. However, there are alternative answers to some question parts which would also gain high marks. For the sake of clarity and brevity not all of these alternative answers are shown. An oblique (/) indicates an equally acceptable alternative answer.

Model answer for Question 1

(a)
- The latest technology can be used to assist the sales process.
- Calls can be recorded to ensure quality and for training purposes.
- Sales people will be well-trained and have excellent product knowledge.
- Calls can be targeted at defined market segments.

(b)
- The internet can be used to generate leads.
- A menu of information is provided so that the prospect can access as much information as needed.
- An application form and direct debit mandate can be completed online.
- There is a cost saving – cheap advertising.
- Insurers can receive click-through and complete the sales process immediately and assume risk in a paper free environment.

(c)
- Satisfied customers can promote and reinforce the insurer's brand.
- Complaints can be quickly resolved to minimise negativity towards the insurer's products.
- Postings can be studied carefully, and the insurer's message adjusted to achieve the best returns.
- The insurer can influence the medium by actively participating in discourse.

Model answer for Question 2

(a)
- Insurers typically may want to focus on one or more specific functions of its core business leaving other aspects in the care of a third party administrator (TPA).
- TPAs offer benchmarking services allowing comparisons to be made by contracted insurers between their own products and services, and those offered by competitors.
- Members can be offered products that are competitively priced because the same TPA provides administrative back-up for more than one discrete insurer from the same location.
- TPAs achieve cost savings for the insurer.
- A TPA sets out to provide a better level of service than the insurer can achieve in-house.
- In the interaction with the insurer, the member will be unaware that he/she is dealing through a TPA, as the relationship between insurer and TPA is not transparent.
- All contact with policyholders will be handled in the name of the insurer, usually under delegated powers, and the TPA will often be permitted to settle all claims up to a pre-determined level.
- Insurers will sometimes act as a TPA.

(b) *Any eight of the following:*
- Claims.
- Underwriting.
- Customer service.
- Product design.
- Negotiating pricing with hospitals.
- Helplines.
- Market information and market feedback.
- Administration of a health trust.
- Reinsurance.

Model answer for Question 3

(a) *Any four of the following:*

- By cheque – is administratively cumbersome and creates a delay in premiums crystallising in the insurer's hands.
- By variable direct debit – once set up future premium amounts can be easily changed provided the employer is given advance notification.
- By standing order – are expensive to administer and rely on the employer to instruct the bank to make regular fixed payments to the insurer.
- By electronic funds transfer through the BACS clearing system – is an inexpensive and flexible way for premiums to be transmitted to the insurer.
- The employer is offered the choice of annual, quarterly and monthly premium payments.
- A discount could be offered for annual payment as it benefits the insurer's cash flow, since all that year's premiums are paid at the beginning of the year.

(b) Insurers discourage such arrangements as a way of avoiding anti-selection. This is because employees in poor health are more likely to forego salary to purchase the best levels of cover. Salary sacrifice could however be allowed as a means of employees funding benefits for their dependants.

Model answer for Question 4

- To achieve current year and longer term profitability targets.
- To decide whether to cross subsidise between different markets, products or underwriting years.
- Whether to introduce segmentation when setting the price to be charged to individual members.
- To establish the relationship between underwriting and pricing.
- To assess the desirability of purchasing different types and levels of reinsurance.
- To assess the impact of projected business volumes on fixed and variable expenses.
- To ensure that the insurer meets its solvency requirements including its obligations under Solvency II.
- To compare the insurer's pricing structure with those of competitors.
- To match price to risk as this is important in determining whether the insurer will attract better or poorer risks.
- To be able to continue writing private medical insurance business.
- To avoid pricing the portfolio at less than cost over a sustained period.

Model answer for Question 5

(a)
- An individual paying premiums from their own net earnings will have no further tax to pay.
- No tax relief is allowed on premium payments.
- Insurance premium tax will be payable although the cost will have been included in the premium pricing.
- Receipt of benefits will be paid free of tax, even where involving a payment to the individual, such as a National Health Service (NHS) cash benefit.
- There is no value added tax (VAT) to pay.

(b)
- Premium payments made on a member's behalf by an employer will be treated as a benefit-in-kind and attract tax at the members marginal rate.
- This is done by an adjustment to the member's tax code that effectively reduces the personal allowance to take account of the additional tax liability.
- Receipt of benefits will be paid free of tax regardless of whether such benefit is paid to the member, the member's employer or the provider of medical services and need not be entered on the member's tax return.

Model answer for Question 6

- A reduction in spending on health whilst protecting frontline services.
- Giving groups of general practitioner practices and other health professionals, in the form of (clinical commissioning groups or CCGs), budgets to buy care on behalf of their local communities.
- Empowering local authorities whilst limiting political micro-management.
- Ceding greater involvement to patients through Healthwatch organisations.
- Reducing tiers of administration by abolishing primary care trusts and strategic health authorities.
- Creating a health specific economic regulator, **Monitor**, with a mandate to guard against anti-competitive practices. Monitor operates across public and private sectors.
- Moving all National Health Service (NHS) trusts to foundation trust status.
- Creating Public Health England as a new politically independent body.
- Shifting responsibilities to a newly-formed NHS Commissioning Board. This has been renamed NHS England.
- By creating streamlined arms' length bodies with fewer tiers of management.

Model answer for Question 7

(a)
- Health screens are annual or less frequent health checks that can vary from completion of a questionnaire to a full medical assessment.
- Wellbeing or healthy living programmes offer advice and assessment concerning diet, exercise, alcohol consumption, smoking and stress.
- Medical helplines can be nurse or general practitioner-led providing a consultation service.
- Face-to-face counselling services that tend to be limited to a maximum number of sessions in any one year.
- Employee assistance programmes provide a confidential service combining helplines and counselling.
- Information services are a non-interactive facility in the form of pre-recorded messages on a range of related topics concerning financial management and debt.
- Sickness management where employees can make contact if they are unable to work due to illness.
- A private general practitioner service that could include writing and delivery of necessary prescriptions.

(b)
- The policy provides a monthly income to replace lost earnings during periods of incapacity due to sickness or accident.
- The income level is limited to take account of statutory sick pay or other sums that mitigate the loss of earnings.
- A deferred period would be selected that coincides with the period that sick pay is received from the employer.
- Benefit is payable until the member is fit to return to work or any prior policy termination date.
- The insurer will not be able to cancel the policy or refuse to renew provided premium payments continue or a waiver of premium option has been purchased.

(c) A pre-agreed lump sum payable on:
- accidental death;
- permanent and total disability;
- loss of a limb, or part of a limb, or loss of use of a limb;
- hospitalisation;
- a specified bone fracture;
- temporary total disablement, which is a weekly or monthly benefit linked to pre-event income and payable for a maximum of 12 or 24 months.

Model answer for Question 8

(a) Most insurers have some form of provider helpline that treatment providers can quickly clarify with the insurer:

- that policy benefits apply in respect of the procedure or treatment recommended;
- any queries that have, or may, arise in respect of a particular case;
- details regarding the settlement of claims;
- any shortfalls where policy benefit does not extend to the full cost of treatment;
- instances where the patient has settled the treatment provider's account and the insurer should reimburse the patient rather than the hospital or consultant.

(b) Patient helplines offer one, or any combination of the following:

- Pre-recorded tapes providing information about specific medical conditions.
- Access to a qualified nurse who can give generic or specific advice on conditions affecting the customer.
- Access to an out-of-hours private general practitioner.
- A third party helpline service covering: sundry issues including stress, bereavement as well as health and lifestyle matters and problems of a practical domestic nature, such as locating a plumber or electrician.

Model answer for Question 9

- Customers have the right to access computer, paper and other non-computerised records containing structured information about them.
- There also exists a right to see other unstructured information.
- Access is allowed by certain classes of other people acting on behalf of the customer.
- Personal medical information is said to be 'sensitive' data and customers are entitled to believe that the insurer's data controller handling such data does so in accordance with the specific provisions contained within the Data Protection Act 1998.
- Customers should expect to be informed by the insurer's data controller whether personal data where the customer is the data subject is being processed by the data controller.
- Customers have the right to know who is holding their personal details, and this right extends to another party other than the insurer to whom details have been passed for the purposes of processing.
- Customers should be given a description of the purposes for which the data is to be processed by the insurer's data controller.
- If a customer's personal data is processed automatically for the purpose of evaluating matters relating to such matters as creditworthiness, reliability or conduct and this automatic evaluation is likely to contribute to any significant decision then the customer has the right to be informed by the data controller of the logic involved in the decision-making process.
- If customers believe that the automatic processing of data affected the premium offered the customer will be able to request details and be informed of how the decision was made.
- Customers can request a copy of the personal data that is held that relates to them and, if applicable, the source of that data.
- Access is generally free of charge although a fee of up to £50 can be made for copies of records.

Model answer for Question 10

(a)
- Employees can choose a benefit package to match their lifestyle.
- Each employee receives an allowance to spend and choices are made from a menu of available benefits.
- The arrangement may include core or mandatory benefits.
- There could be a cash element rebated to the employee if the allocated allowance is not fully spent.
- Conversely, the employee may be allowed to contribute if the total spend is above the allowance.
- Employees are typically required to nominate the range of benefits selected annually in advance of the scheme's renewal.

(b) *Any four of the following:*
- Private medical insurance.
- Critical illness insurance.
- Life assurance.
- Dental cover.
- Health cash plan.
- Pension benefits.

Any one of the following:
- Childcare vouchers.
- Selling or buying holiday entitlement.
- Discounts on consumer goods and services.

Model answer for Question 11

(a)
- The insurer will check if the condition or symptoms existed prior to inception of the policy.
- Oncology would be covered to a lesser or greater extent and usually includes surgical and medical treatment.
- Key cover elements relate to drugs and specialist's fees.
- If invasive surgery takes place, hospital accommodation, surgeons' and anaesthetists' fees and all other aspects of the procedure would also likely be covered.
- Chemotherapy and radiotherapy are often specified and covered within policy limits.
- Experimental, alternative or unproven treatments will normally not be covered unless expressly agreed by the insurer.
- To ensure that the best care is obtained, and that costs are controlled, cancer treatment will usually be case managed by the insurer.
- Andrew will be informed well in advance if his benefit limit is in danger of being reached.
- Due to the high cost of cancer treatment Andrew's claim may approach the overall annual maximum benefit.

(b)
- The policy will cover the cost of an initial consultation with a specialist and any tests, scans or X-rays required in arriving at a diagnosis.
- If surgery is necessary, the insurer would cover in-patient or day patient treatment, theatre fees, diagnostics, drugs and dressings, surgeons' and anaesthetists' fees, together with the cost of accommodation and nursing.
- Following, or as an alternative to surgery, the insurer will cover the cost of physiotherapy, if recommended and referred by a general practitioner and carried out by a registered practitioner.
- The number of sessions permitted is likely to be limited.
- Costs will be covered provided there is no link to a pre-existing condition.
- Most policies exclude sporting injuries suffered as a result of taking part in professional sport.

(c)
- Charlotte's asthma may be the onset of a chronic condition.
- If tests and consultations are required to ensure that the diagnosis of asthma is appropriate these will be paid.
- Chronic conditions become permanent and need an indefinite ongoing period of supervision, observation and care, and may require regular drugs to achieve stability.
- Insurers will not cover chronic conditions where ongoing treatment is required simply to stabilise the condition.
- The insurer will usually pay for the short-term treatment of an acute exacerbation or flare-up of such a condition.
- Once treatment of the condition is needed simply to maintain health, cover will cease.

Model answer for Question 12

(a)
- A second opinion service sets out to ensure that the claimant has total confidence in a specialist's recommended treatment plan.
- Medical records are reviewed independently to analyse the claimant's medical condition.
- The service is free of any excess and the cost is not deducted from the claimant's out-patient benefit entitlement.

A second opinion service makes sure that there is agreement as to the most appropriate form of treatment, alternative treatments are considered, the claimant makes the final choice regarding the course of treatment adopted and incorrect diagnosis and related costs are mitigated.

(b) An open referral is where a general practitioner's (GP) referral of the claimant does not specify a specialist, consultant or hospital. Instead the insurer decides where, and with whom, treatment of the claimant should take place. The claimant will only be referred to treatment providers who regularly undertake the relevant procedure. A better outcome could result for the claimant than an inappropriate recommendation from the GP. The insurer will endeavour to choose a treatment provider situated within a reasonable distance of the claimant's home or place of work.

Open referrals can be an effective way for the insurer to manage claims costs whilst at the same time leading to a favourable conclusion for the claimant.

Model answer for Question 13

- The combination builds up to cover part or all the customer's medical costs.
- The insurance element may pay most of the cost of treatment with the savings element funding the balance.
- The relationship between the two elements will vary according to the size of the savings fund.
- Where many claims have been made the savings element will have little or zero residual value.
- During the first few months of the policy the savings element will, nevertheless, not have had time to accrue and additional insurance will be provided to cover any claims shortfall.
- The savings element can be cashed at agreed times, such as at retirement.
- If the sum of the two elements is insufficient to fully cover the treatment costs the customer would be obliged to resort to part self-funding.

Model answer for Question 14

(a)
- The purchase of reinsurance potentially provides the insurer with impact and market visibility when competing for business.
- Reinsurance allows the insurer to accept business it might otherwise have to decline because of concerns over solvency levels.
- Reinsurance mitigates escalating costs on its existing account arising from medical inflation.

(b)
- The purchase of reinsurance relieves the insurer of concerns over the effects of uncertainty of loss.
- Peace of mind is created for shareholders whose investments are protected and members whose policy benefits are secured.
- Fluctuations in claims costs year-on-year are reduced.

(c)
- Reinsurance provides protection against accumulated losses.
- The losses arising from an industrial accident affecting many employees under a group paid scheme would be reduced after the application of reinsurance.
- The aggregated costs associated with expensive new cancer treatments would also be reduced if reinsurance is in place.

(d)
- For a newly-formed insurer, the reinsurer can provide valuable technical expertise.
- Some functionality can be outsourced to the reinsurer, such as pricing and product design.
- The reinsurer may have a larger medical underwriting team led by an experienced chief medical officer.

Model answer for Question 15

(a) The moratorium method of underwriting would involve Hugh completing a short application form. The form will simply ask for details of Hugh's name, address and date of birth. No details of Hugh's past medical history are initially required. The insurer reserves the right to request this information if a claim occurs. Such an arrangement allows any medical declaration to initially be avoided. This makes the application process quick and easy for both insurer and Hugh, especially as Hugh has had medical problems in the past.

Moratorium underwriting is often referred to as 'point of claim' underwriting. This is because conditions are assessed for cover when a claim is presented for pre-authorisation rather than at the point of sale of the policy. Hugh cannot be certain that a condition is covered until he submits a claim. He may discover that a condition thought to be covered is in fact excluded. This is because his policy will have blanket exclusions of medical symptoms or conditions experienced during the period up to the policy start date, often five years.

An exclusion would apply even if a general practitioner had not been consulted in connection with the condition. A condition becomes covered, unless subject to a standard policy exclusion, once it has been treatment free, often for a period of two years, following the policy inception date. This arrangement reduces the number of claims the insurer must deal with during the first two years of the policy. Any new medical conditions that arise after the policy starts are covered unless they relate to a pre-existing condition.

Under a rolling moratorium, if treatment of a pre-existing condition is received during this two year period, a further treatment-free period of two years must elapse before cover applies. The moratorium is effectively renewed for a further two years and a condition receiving regular treatment will never fall out of the moratorium.

A fixed moratorium works differently. After a specified two year period excluded conditions automatically become eligible for benefit without the requirement that they are free of symptoms or treatment. A fixed moratorium may be easier for Hugh to understand but presents considerably more risk for the insurer. Where the insurer is offering a fixed moratorium, it is likely to screen Hugh by asking filter questions before acceptance.

Because of an Office of Fair Trading recommendation, insurers transacting business on a moratorium basis must also offer the alternative of cover subject to full medical underwriting, although many already did this. The Association of British Insurers' Statement of Best Practice requires that insurers clearly explain how moratorium underwriting works compared to full medical underwriting and provide examples of how both methods work in practice.

Hugh's medical history could make full medical underwriting a better option as he would know which conditions are covered and which are not.

(b) **(i)** Initial discounts are applied to the insurer's standard rates of premium and are offered to attract customers to switch from other insurers or to those arranging cover for the first time. The percentage discount offered could be tiered so that customers that switch receive a higher initial discount than those buying cover for the first time.

(ii) No claim discounts are offered to existing customers that have not claimed in the previous policy year. The discount is applied to the next year's renewal premium. A single claim in the previous year would not necessarily result in the customer losing all the potential no claims discount.

(iii) A loyalty discount is not dependent on the customer's claims record. It is offered as an incentive to renew an existing policy and is applied to the next year's renewal premium.

Model answer for Question 16

(a)
- Initially, Jennifer should visit her general practitioner expressing her concerns and fully describing the symptoms of the condition.
- Seeing a general practitioner (GP) is the first contact point for those having health concerns.
- The GP will offer an opinion and prescribe medication, if appropriate.
- At this, or some later point in time, the GP may decide that a specialist should be consulted.
- A National Health Service (NHS) referral could be arranged.
- Alternatively, Jennifer could contact her insurer's helpline to see if diagnostics are covered by her private medical insurance (PMI) policy.
- Diagnostic investigations include scans, x-rays or blood tests.
- The extent of cover will depend on the level of cover purchased.
- Only better policies will cover diagnostics, out-patient consultations and, possibly, complementary practitioner charges.

(b) Interaction between the NHS and the private healthcare sector depends on the nature of the condition. Primary care will be initiated by Jennifer's GP and provided by the NHS. The scope of treatment offered by the NHS includes the treatment of both acute and chronic conditions. The diagnosis may be that her condition is chronic, and, in this event, she will be treated by the NHS. Treatment will be free to Jennifer at the point of use. The diagnosis may be that the condition is acute, and, in this event, she can also be treated by the NHS. Treatment will, again, be free to Jennifer at the point of use.

Alternatively, cover for treatment could be available under Jennifer's PMI policy because PMI is designed to cover the treatment of acute conditions. Its primary purpose is to pay the costs associated with secondary care outside of the NHS. PMI is not designed to cover chronic conditions. Depending on the level of cover purchased, there may be benefit for day care costs only, inpatient treatments and full cost including outpatient treatments. Cover could only be available at specified hospitals or if NHS waiting lists exceed a stated threshold. Insurers may want to pre-authorise treatment before it takes place. Confirmation that the treatment is necessary would be needed from the GP or specialist. Cover could apply until Jennifer's condition is resolved. If her condition cannot be resolved and becomes classified as chronic, cover would cease. She could choose NHS treatment in which case it is possible that she could be eligible for a cash payment under the PMI policy.

(c) Electing to pursue treatments not available in the public healthcare sector or covered by Jennifer's insurer is known as self-funding, self-insurance or self-pay. It is not without risk since the treatment costs could stretch Jennifer if her financial resources are limited. Several courses of treatment within a short space of time could impact her capacity to self-pay. Both the NHS and insurer may refuse to pay if Jennifer is considering treatment from a source not recognised by or registered to an accredited body.

Model answer for Question 17

(a) Regulation of healthcare insurance was introduced by the Financial Services and Markets Act 2000 and then the Financial Services Act 2012.

Regulation of Company X will come under the auspices of the Financial Conduct Authority (FCA) and the Prudential Regulation Authority (PRA). The rules set out in the FCA's Insurance: Conduct of Business Sourcebook (ICOBS) will apply, requiring Company X to:

- pay regard to the interests of its customers and treat them fairly;
- communicate with customers in a way that is clear, fair and not misleading; and
- take reasonable care to ensure the suitability of its advice.

- Firms are required to embed the principle of fairness to customers throughout the entire customer process from product development to sales and during the entire life of the policy.
- Firms must ensure that staff are trained and are competent to a level that is appropriate to the nature of the product.
- All firms authorised by the FCA are required to report regularly under prescribed headings.

(b)
- Quantitative data – involves counting customer responses to a particular question.
- Qualitative data – involves a more in-depth survey of potential customers' views involving interviews and focus groups.

(c) Demand can be achieved by providing cover wider than that available from competitors. This can be done by introducing personal underwriting. This is a process whereby premium loadings allow cover for pre-existing conditions, rather than imposing specific exclusions. Premium loadings reflect the costs associated with the greater frequency of treatment needed.

Conversely, proposals indicating low medical risk can have a lower premium applied. This approach makes a visible distinction between the risk factors attaching to individual lives.

Personal underwriting places a price on the level of risk introduced by individual proposers. Standard policy exclusions would still apply. Medical underwriting would have to be applied to correctly price risk. This is especially true where cancer or conditions relating to mental health are involved. A detailed medical history declaration form supported by a general practitioner's report will assist what can be a complex underwriting process.

Switch or continued personal medical exclusions (CPME) terms could be offered to encourage transfers in circumstances where there would otherwise be reluctance to change insurers.

Company X's new policy will not impose any more exclusions than the existing policy. All current exclusions will carry forward onto the new policy.

Tele-underwriting would allow Company X to use a qualified nurse or underwriter to telephone proposers to ask underwriting questions, rather than simply requiring completion of a form. With 'little-t' tele-underwriting the proposer completes all medical questions on the written application form and the interviewer calls to ask any follow-up questions. With 'big-t' tele-underwriting the proposer does not answer any medical questions on the application form. The interviewer asks the relevant questions during the call.

(d) 'Anti-selection' is the likelihood of any insurer unwittingly agreeing to cover a disproportionately large number of individuals in ill-health. Company X needs to be aware of the possibility of 'anti-selection' because claims for chronic and recurring conditions could be submitted as soon as cover is granted.

For voluntary or affinity group business, members pay premiums themselves without subsidy and those in poor health are more likely to choose to insure, whilst those in good health are more likely to decide not to. When accepting voluntary business, it may be prudent to carry out full medical underwriting to ensure that members are properly rated and that appropriate terms are applied.

For company paid group schemes benefit structures often favour members defined by age, status and length of service. This can lead to older members, who statistically are more likely to claim, receiving more generous benefits. To attract large company paid group schemes, Company X may be obliged to accept on medical history disregarded terms. It would be usual to insist that all members within a stated category are included for benefit. Furthermore, Company X will likely stipulate that premiums must be company paid and not reimbursed by members under salary sacrifice arrangements.

(e) Standard exclusions equalise the level of risk each member brings to the 'common pool' and so limits exposure. This allows all applicants to be provided with cover on an equitable basis. There are certain medical conditions which cannot be covered if premiums are to be offered at an affordable level. The cost of providing cover for routine procedures would rise to an unacceptable level if all treatments were routinely covered.