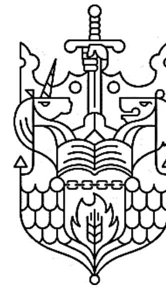

Chartered Insurance Institute

P64 – Private medical insurance practice

Diploma in Insurance

April 2018 Examination Guide

SPECIAL NOTICE

Candidates entered for the October 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

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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
The majority of candidates achieved over half of the marks available on this question.

Question 2
Some consistently good marks were achieved on this question although a minority of candidates incorrectly focused on product features or providers of medical services.

Question 3
Part (a) of this question was not well answered with many candidates explaining the features of individual intermediaries rather than the collective benefits offered to intermediaries that join forces to form a network. In part (b), candidates did mention the advantages of intermediaries remaining in contact with their customers for the longer term and not simply during the period up to the purchase of a policy.

Question 4
Many candidates gained high marks on this question.

Question 5
Only a few candidates mentioned that the target market for long-term care insurance (LTC) is the aged, elderly and infirm. Some confused LTC with permanent health, critical illness or personal accident and sickness insurance. In part (b), a few candidates referred to periodic payment of premiums. Overall, most were familiar with the assessment mechanism of activities of daily living and the way they are used to trigger a policy payment.

Question 6
Many candidates thought that the Insurance Act 2015 has its main importance in the fields of medical reporting, data protection or taxation, rather than its fundamental bearing on disclosure and fair presentation. For part (b), ‘screening’ was incorrectly attributed to ‘point of claim’ underwriting rather than fraud detection and non-disclosure. Candidates correctly answering part (a) would probably have noticed the related importance of screening of claims.

Question 7
Most candidates displayed a good understanding of genetic testing and what it sets out to achieve. However, not all candidates could expand their answers to include the current lack of availability of this form of testing to private medical insurance underwriters.

Question 8
Overall, this question was reasonably well answered. However, some candidates did not describe what was meant by the treatments captioned as directed by the question. For part (a), a few candidates mentioned the apparent shortage of National Health Service (NHS) dentists which was not necessary and came to the incorrect conclusion that dental treatments were not often available on the NHS.

Question 9
The majority of candidates described the components that insurers expect to accommodate when pricing private medical insurance business. For part (b), ‘own’ and ‘external’ data was widely recognised although the mark awarded for government data was not often achieved.

Question 10
This question was well answered by most candidates.

Question 11
This question was reasonably well answered with many candidates achieving close to or more than half of the marks available. However, there were some answers that went onto unnecessarily mention insurer's vulnerability at the point at which the policy was sold.

Question 12
This question was not answered particularly well with candidates focusing too heavily on an overstretched National Health Service, rather that the fundamental causes that prevent free on demand treatments being available to all.

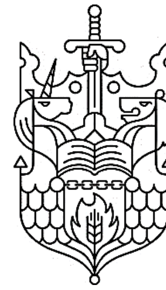
Question 13
The majority of candidates correctly described the organisations providing private medical insurance products. A few mentioned reinsurers which was not required to answer this question. For part (b), candidates were able to successfully expand on why direct distribution channels are popular with insurers.

Question 14
Few candidates gained high marks on this question.

Question 15
Part (a) of this question was answered proficiently with many candidates able to offer an understanding of the steps needed to set up the scheme. For parts (b) and (c), some candidates confused the requirements of these question parts. Part (d) produced lower marks than expected, mainly because candidates reported on the steps the administrator would take to renew the existing scheme or to transfer to a new insurer, but not often both. As a consequence, the marks available for comments on ensuring continuity for outstanding claims and updating members during any transition were rarely achieved.

Question 16
Many candidates provided alternative answers that were relevant in a way that was not expected, for example, full medical underwriting under part (a) (II), although positive marking ensured that these candidates were not disadvantaged. Some high marks were obtained by the better prepared candidates. For part (b) (i), several candidates were incorrectly under the impression that insurers are prevented from having premium structures that recognise risk factors increase alongside age. As a result, maximum marks were rarely obtained. Parts (b) (ii) and (b) (iii) were answered to a much higher standard with candidates recognising how the Equality Act 2010 deals with matters relating to gender and disability.

Question 17
This was the least popular of the Part II questions. Some good answers mixed in with some that were less impressive. Besides some informed explanations there were too many candidates that did not go beyond repeating information provided in the question. Only a small number of candidates displayed sufficient knowledge to achieve more than a few of the total marks available.



P64

Diploma in Insurance

Unit P64 – Private medical insurance practice

April 2018 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. Outline the checks that a private medical insurer will make when it receives an individually-insured patient's claim for treatment. **(12)**

2. Describe briefly **four** categories of buying groups within the private medical insurance market. **(8)**

3. Outline, in connection with intermediated sales:

(a) **four** features of an intermediary network; **(4)**

(b) **four** reasons an intermediary would want to maintain contact with its customer after a private medical insurance product has been purchased. **(4)**

4. State **eight** policy benefits that would normally be included in a comprehensive private medical insurance policy purchased by an individual. **(8)**

5. **(a)** Explain briefly what is meant by an immediate needs long-term care (LTC) insurance plan. **(2)**

(b) Explain briefly how an immediate needs LTC insurance plan is funded. **(2)**

(c) State the assessment criteria insurers would normally use to determine whether a claim under an immediate needs LTC insurance plan is valid. **(7)**

6. **(a)** Explain the relevance of the Insurance Act 2015 to employers of groups applying for private medical insurance. **(8)**

(b) Explain briefly why, and when, claims are 'screened' by insurers under group-rated private medical insurance policies. **(4)**

7. Explain briefly genetic testing and its significance to private medical insurance. **(9)**

8. Outline what is meant by the following treatments and the extent to which they are provided by the National Health Service (NHS) and covered by private medical insurers.

(a) Dental treatments. **(4)**

(b) Maternity treatments. **(4)**

(c) Alternative and complementary treatments. **(4)**

9. **(a)** Outline **three** components that make up the basic premium when insurers set a price for private medical insurance. **(6)**

(b) State **three** types of data an insurer would collect and study in order to determine that its premium structure is set at the correct level. **(3)**

10. Describe briefly **seven** ways in which the individually-paid market is segmented by private medical insurers. **(14)**

11. State **five** ways in which private medical insurers are vulnerable to fraud when claims are received. **(10)**

12. Identify **seven** reasons preventing free on demand State provision of all aspects of healthcare in the UK. **(7)**

13. **(a)** Identify and describe briefly **four** types of organisations underwriting private medical insurance products. **(8)**

(b) Outline **seven** reasons why such organisations might prefer to distribute their products directly to potential customers rather than using intermediaries. **(7)**

14. State **five** ways in which the Financial Reporting Standard (FRS 102) impacts insurers and employers purchasing private medical benefits for staff. **(5)**

PART II

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

15. Claire is the group company secretary for a large corporation that intends providing its staff with employer-paid private medical insurance. She will become the administrator for the private medical insurance scheme.

(a) Outline the steps that the insurer and Claire would take to set up the scheme. **(4)**

(b) Describe Claire's role in relation to the scheme once it has commenced. **(8)**

(c) Outline the membership related changes that would be communicated through Claire during the lifetime of the scheme. **(10)**

(d) Describe the functions that Claire would have to oversee at the policy anniversary, to renew the policy for a further year, or to transfer the scheme to a different insurer. **(8)**

16. Insurer Z is a leading provider of individual-paid private medical insurance offering moratorium and full medical underwriting.

(a) Explain the purpose and effect of these underwriting methods at the:

(i) point of sale; **(9)**

(ii) point of claim. **(9)**

(b) Outline the effect of the Equality Act 2010 on Insurer Z's treatment of proposers of different:

(i) age; **(4)**

(ii) gender; **(4)**

(iii) disability. **(4)**

17. Insurer X is an established provider of private medical insurance and related healthcare products in the UK.

(a) Identify the bodies whose remit includes the statutory regulation of healthcare insurance and describe how Insurer X's activities are likely to be impacted. **(10)**

(b) Explain briefly how the purchase of reinsurance can assist Insurer X in providing the security demanded by the regulators in relation to:

(i) capacity; **(3)**

(ii) capital; **(3)**

(iii) spread of risk. **(3)**

(c) Insurer X has noted a significant reduction in renewal take-up, and customer exit surveys indicate that self-funding of treatments, in preference to renewal of its product offerings, is a key reason for this.

Discuss the advantages of self-pay strategies for Insurer X's ex-customers. **(11)**

TEST SPECIFICATION

April 2018 Examination – P64 Private medical insurance practice	
Question	Syllabus learning outcome(s) being examined
1	2 – Understand private medical insurance products and principles 4 – Understand the application of claims and policy administration
2	2 – Understand private medical insurance products and principles
3	6 – Understand the distribution of private medical insurance
4	2 – Understand private medical insurance products and principles
5	2 – Understand private medical insurance products and principles
6	4 – Understand the application of claims and policy administration
7	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
8	1 – Understand the relationship between public and private medical provision 2 – Understand private medical insurance products and principles
9	3 – Understand the application of pricing and underwriting for private medical insurance
10	2 – Understand private medical insurance products and principles 3 – Understand the application of pricing and underwriting for private medical insurance
11	4 – Understand the application of claims and policy administration
12	1 – Understand the relationship between public and private medical provision
13	6 – Understand the distribution of private medical insurance
14	5 – Understand legislation and regulation in relation to 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 6 – Understand the distribution of private medical insurance
16	2 – Understand private medical insurance products and principles 3 – Understand the application of pricing and underwriting for private medical insurance 5 – Understand legislation and regulation in relation to private medical insurance
17	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 5 – Understand legislation and regulation in relation to 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

The insurer will check, assuming the claim has not already been pre-authorised, that:
- The patient is covered by the policy.
- The treatment is medically necessary and clinically appropriate.
- The treatment is covered by the policy.
- The treatment has been agreed by a general practitioner, consultant or specialist.
- Premiums have been paid covering the period of the treatment.
- The condition is not pre-existing or otherwise excluded from cover.
- National Health Service waiting periods are greater than the agreed time if benefit is conditional or dependent on waiting times.
- The amount claimed is within the benefit structure and limits of the policy.
- The charges made by the hospital are within the terms of the contract between the insurer and treatment provider.
- The hospital is part of an approved network recognised by the insurer.
- The claimant's consultant is recognised by the insurer.
- Surgeons' and anaesthetists' fees do not exceed the specified maxima or, if no specific limit is applicable, are covered by the reasonable and customary assumptions of the insurer.
- A policy excess or deductible may need to be applied per claim or policy year.

Model answer for Question 2

Any four of the following:
- Individuals – persons not having access to or not wishing to access a group scheme, that buy insurance in the person's own name.
- Voluntary groups (employee paid) – groups of employees outside of a company scheme or clients of a particular intermediary.
- Company (employee paid) – some employers are prepared to set up and administer a group scheme but require employees to pay the premiums in full.
- Company (part employee paid) – some employers are prepared to set up and administer a group scheme but require employees to contribute to part of the premiums.
- Company (employee pays for dependants only) – where the employer is prepared to set up, pay for and administer a group scheme but requires employees to pay the premiums applicable to the individual employee's dependants.
- Company (employer paid) – where the employer is prepared to set up, pay for and administer a group scheme and pay the premiums applicable to all aspects of the cover including those relating to the individual employee's dependants.
- Affinity groups – groups of individuals sharing a common social or sporting interest that purchase cover utilising the buying power of the group.

Model answer for Question 3

(a)
- Intermediary networks bring together groups of small intermediary firms under an umbrella organisation.
- The umbrella organisation provides compliance and business services.
- Intermediary networks offer scale economies to its members.
- It may be possible for the network to secure better cover from providers at a more competitive price and attract increased rates of commission.

(b) *Any four of the following:*
- Provision of an ongoing service increases the chance of word-of-mouth referrals.
- Commission is likely to be earned at each renewal of the policy.
- To satisfy a regulatory obligation to review the suitability of the policy at each renewal.
- To offer the customer a claims handling service.
- To offer an advocacy service in case the customer experiences difficulty in dealing directly with the insurer.

Model answer for Question 4

Any eight of the following:
- Inpatient treatment.
- Outpatient treatment.
- Surgeons' and anaesthetists' fees.
- Physiotherapy.
- Day patient treatment.
- Cancer treatment.
- Alternative or complementary therapies.
- Treatment for mental and addictive illnesses.
- Provision of a guest room for a parent accompanying a child during a hospital stay.
- A cash benefit for each day the patient elects to receive treatment in a National Health Service hospital.
- Maternity cash.
- Private ambulance services.
- Home nursing services.
- Dental treatment or oro-surgical procedures carried out by a specialist in a hospital environment.
- Optical care.
- International travel including repatriation to the UK in the event of a medical emergency.
- General practitioner or primary care services.
- Helpline support.
- Wellness solutions.

Model answer for Question 5

(a) Immediate needs long-term care (LTC) insurance plans aim to meet the cost of care for elderly people who are no longer able to look after themselves. The plan provides a monthly benefit which contributes to the cost of home care or nursing home care.

(b) A post-funded LTC insurance plan addresses an immediate need for care and is funded by payment of a sum to the insurer once the need for care has arisen. The insurer invests the sum to produce the maximum income to pay for care throughout the lifetime of the plan holder.

(c) Insurers assess whether benefits are payable by reference to the plan holder's ability to perform a stated number of activities of daily living, such as:

- Washing – the ability to wash in the bath or shower or wash by other means.
- Dressing – the ability to put on, take off, secure or unfasten all garments including braces, artificial limbs or other surgical appliances.
- Feeding – the ability to feed oneself once food has been prepared and made available.
- Toileting – the ability to use the lavatory or manage bowel and bladder function through the use of protective undergarments or surgical appliances, if appropriate.
- Mobility – the ability to move indoors from room to room on level surfaces.
- Transferring – the ability to move from a bed to an upright chair or wheelchair.

Model answer for Question 6

(a)

- The Insurance Act 2015 amends the principle of utmost good faith previously imposed on employers by the Marine Insurance Act 1906.
- Previously, insurers could legally and summarily reject a claim if the principle, as it affected the employer, was not strictly observed.
- Insurers should ask for information needed to assess the risk presented rather than expecting automatic disclosure of all relevant material information.
- Insurers can no longer assume that the employer will know what the insurer regards as relevant.
- Nevertheless, the duty of 'fair presentation' imposed on employers requires disclosure of either; every material circumstance known, or should be known, that would influence the judgement of an insurer in deciding what terms to impose; or sufficient information to put a prudent insurer on notice to make further enquiries about potentially material circumstances.
- If the employer's answers to requests for information are dishonest or reckless the insurer can refuse to pay a claim and retain the premium paid.
- If the employer makes a careless mistake the outcome will be based on what the insurer would have done had the applicant provided full and accurate information.
- The Insurance Act 2015 benefits employers in that there is less likelihood of a claim being unfairly rejected based on a technicality.

(b) Claims are 'screened' as a way of detecting evidence of non-disclosure. This is because some employers or members may withhold relevant information to avoid a medical condition being excluded from cover. Screening is especially important during the first, say, 6 to 12 months of cover being effected in order to deal with situations where cover is purchased shortly after a medical condition has already arisen.

Model answer for Question 7

- A genetic test is an examination of the structure of the chromosome, deoxyribonucleic acid (DNA) or ribonucleic acid (RNA) to discover if there is an otherwise undetectable disease-related genotype.
- A test may indicate an increased chance of a person developing a specific disease in the future or experiencing a reduced life expectancy.
- Some diseases are a direct result of, or are aggravated by, a familiar trait that can be identified through laboratory testing.
- Where a test is predictive it is taken before the appearance of any symptoms of a particular condition.
- Where a test is diagnostic it is taken to confirm a diagnosis based upon existing symptoms.
- The Association of British Insurers, on behalf of insurers, have agreed a voluntary moratorium with the Government whereby they will not use the results of predictive tests in their underwriting processes until at least 2019.
- Applicants will not be asked whether a genetic test has been undertaken.
- An applicant for private medical insurance cannot be asked to undergo a genetic test as a pre-requisite to obtaining insurance.
- Applicants cannot be prevented disclosing the negative results of a predictive test already taken although insurers cannot offer better terms in these situations.
- A positive result of a predictive test would indicate the likelihood of contracting an inherited disease and the insurer would be inclined to exclude as a pre-existing condition, were it not for the moratorium.
- If the insurer were to use this information, it would discriminate against an applicant that had chosen to submit to a test compared to an applicant that had not.
- An insurer may consider the results of a test that is diagnostic.
- Tests cannot confirm for certain when, or whether, a disease will occur, and an applicant can still live to an advanced age.

Model answer for Question 8

(a)
- Basic dentistry provides for oral hygiene and is available from the National Health Service (NHS) although many patients will be required to contribute to the cost of their treatment.
- Patients wanting a higher quality of treatment or better materials may be inclined to seek treatment within the private sector.
- Dental insurance can be purchased on an annually renewable basis providing a range of defined benefits.
- Dental capitation plans provide a form of budgeting where patients pay a monthly fee in return for their treatment.

(b)
- Maternity treatments include costs incurred for medical treatments occurring due to pregnancy, labour or childbirth.
- Maternity care is routinely provided by the NHS.
- Private medical insurance usually excludes cover for normal interventions.
- There is no cover for investigations into and the treatment of infertility, impotency or assisted reproduction.
- International policies may provide some cover for childbirth.
- Some types of policy could provide a cash benefit for childbirth.

(c)
- Alternative and complementary treatments are usually beyond the scope of conventional medicine.
- Acupuncture, osteopathy, chiropractic, reflexology and homeopathy or treatments for joint and muscular pain, can all be categorised in this way.
- Treatment is not usually available through the NHS.
- Such treatments are rarely offered by budget policies.
- There could be some cover under comprehensive or top-of-the-range policies or group schemes.

Model answer for Question 9

(a)
- The risk premium is intended to pay for anticipated claims for groups of similar policies.
- The expense loading contains provisions for acquisition and maintenance expenses, a return on capital, protection against statistical fluctuations and other elements, such as tax, solvency requirements, regulatory costs and reinsurance.
- The profit or surplus the insurer expects to achieve.

(b) *Any three of the following:*
- The insurer’s own data relating to underwriting, claims and marketing costs.
- Costs involved in servicing the business.
- Comparable data that is sourced externally.
- Government statistics.
- Reports on experience gained from other countries.
- Prices of competitors’ policies.
- Information obtained from third parties.

Model answer for Question 10

Any seven of the following:

- Price – the cost of cover determines the affordability of the product to low income or high net worth applicants.
- Location – insurers use postcode rating and hospital bands to reflect differing treatment costs across the UK.
- Lifestyle choices/exercise/smoking/alcohol consumption/health history – lower rates can be offered to applicants displaying characteristics associated with healthy living.
- Benefit – the level of benefit offered varies according to the targeted socio-economic group.
- Age – the policy structure is aimed at young or elderly applicants.
- Occupation – where the rating and benefit structure correlates to the level of morbidity connected with the manual or sedentary work undertaken.
- Gender – policy benefits could be aimed at women to provide cover for female-specific conditions.
- Leisure interests – cover is provided for sports injuries or to confer discounted gym membership.
- Family status – where the product is aimed at those in relationships or having families.
- Weight and height/body mass index – whether weight is within an acceptable proportion to height so that the body mass index is neither too high or too low.

Model answer for Question 11

Any five of the following:

- Policyholders take out more than one policy with different insurers and submit multiple claims for the same treatment.
- Policyholders misrepresent the date of treatment received so that it falls after, or before, the commencement or expiry dates, respectively, of the policy.
- The value of a claim is exaggerated so that a franchise is exceeded or the impact of an excess mitigated.
- Providers are guilty of mis-billing or charging for services not actually carried out.
- Providers up code resulting in a charge that is more for services than were actually delivered.
- Unbundling or charging for the same service several times and hiding it behind medical jargon.
- Misrepresentation of the facts such as performing breast enlargement and claiming that the treatment was for breast cancer.
- Multiple claims especially where the benefit is cash rather than being paid by direct billing.
- Charging for more complicated procedures than were actually being performed.

Model answer for Question 12

Any seven of the following:

- The cost of healthcare funding by the National Health Service (NHS) places a considerable burden on UK taxpayers.
- Demand for NHS services increases as people live longer.
- It is too expensive for certain aspects of care to be funded by the State, such as the provision of spectacles and some prescriptions.
- Funding shortages leads to difficulties recruiting sufficient medical professionals.
- Patients are more demanding and better informed.
- It would be impracticable to extend the scope of the NHS to non-essential services where there is no underlying medical need.
- It would be unacceptable to UK taxpayers that they should pay for routine cosmetic surgery so that individuals can enhance their appearance.
- Some secondary costs associated with obesity, tobacco usage, alcohol abuse, drug and substance abuse etc.
- The costs associated with expensive treatments such as cancer.

Model answer for Question 13

(a) *Any four of the following:*

- Mutual insurers – do not have shareholders and their ownership is assumed by policyholders. Any surplus that is achieved is used to reduce the premiums paid by its members, the policyholders.
- Commercial insurers – these organisations exist to generate profits for shareholders, who provide the capital the company needs to trade. Shareholders receive dividends based on profits and expect over time, that the value of shares held will increase.
- Friendly societies – are a form of mutual insurer and were founded when groups of individuals joined together for the common purpose of funding the cost of healthcare.
- Provident insurers – these are 'not-for-profit' organisations that are managed for the benefit of members, although the members may not actually be owners. Profits are reinvested back into the business.
- Health cash plan providers – such plans have mutual status and some market private medical insurance alongside the core product.
- Third party administrators – are not insurance companies themselves but are organisations that provide underwriting services to private medical insurers.

(b) The underwriting organisation:

Any seven of the following:

- has full control of the distribution channel;
- can avoid the payment of commission to intermediaries reducing business acquisition costs;
- can use online and social media to increase business volumes;
- can cross-sell related or other products to customers;
- can data profile to identify customer target groups;
- assumes complete ownership of the customer;
- can differentiate its service proposition from that of its competitors;
- trains its sales staff so ensuring compliance with internal and external quality and regulatory rules;
- can invest expertise into its staff, building trust and rapport with customers;
- can control business levels by expanding or contracting the size of its sales force.

Model answer for Question 14

Any five of the following:

- Employers are required to disclose details of benefits provided to employees.
- The employer must calculate the present cost and value of such provision.
- The employer's balance sheet must include the value of the future liabilities relating to the provision of free private medical insurance cover for employees in retirement.
- In doing so, the employer must have regard to an employee's life expectancy and likely future cost of providing the benefit.
- The insurer may be asked for its view of likely future premium trends.
- This would be done by reference to past claims experience or its own premium rate increases for similar schemes.
- The insurer will not be required to calculate the Financial Report Standard (FRS 102) figure itself.

Model answer for Question 15

(a) Claire would send a completed application form that would be processed by the insurer. It will be given a unique reference number and any missing underwriting, or other information will be sought. Once an underwriting decision has been made this will be communicated to the customer. If the case proceeds the policy schedule and terms and conditions will be sent to the customer. Individual members will be given a personalised certificate of insurance describing what cover has been provided, excess options that apply, and details of underwriting terms.

(b) Claire's role will include being the contact point between insurer and members of the scheme. Handling queries and communications with members. Maintaining an up-to-date list of members and individual cover levels. Distributing certificates to members. Dealing with complaints and arranging payment of premiums within agreed timescales.

Claire's role could be purely administrative or involve negotiations with the insurer or broker.

Claire could be the initial contact point for potential claimants and hold supplies of claim forms.

(c) The membership related changes that would be communicated through Claire during the lifetime of the scheme include:

- Communicate details of leavers and joiners to the insurer on the agreed basis.
- Arrange continuation of cover for retirees within the limited time period specified by the insurer.
- Record changes to dependants as a result of marriage, divorce or separation.
- Where new-born or adopted children are involved advise insurer within the specified time period.
- Notify death of a member or dependant to the insurer.
- Inform the insurer of members or their dependants reaching retirement or a specified age.
- Arrange mid-term changes of cover requested by members for themselves or their dependants.
- Inform the insurer of members' changes of address if required to do so by the rules of the scheme.
- Arrange corrections of miss-spelt members' names, errors in dates of birth and incorrect dependants being shown.
- Arrange for additional dependants to complete a medical history declaration.
- Ask employees to contribute towards the cost of adding dependants.
- Wind-up scheme if the employer goes into liquidation.

(d) The functions that Claire would have to oversee at the policy anniversary include:

- Renewal terms to be reviewed when received a few weeks before renewal date.
- Competition is fierce for this type of business among insurers and profit margins narrow so the corporation's purchasing power will be used as a significant negotiation tool.
- Steps will be taken to place the insurer on notice in case there is an assumption that renewal is automatic.
- Discussions with the insurer or a broker will aim to ensure that the best terms are secured in the form of wider cover or lower premiums before confirming renewal.
- If better terms are available from another insurer cancellation instructions will be given, and an initial application form completed for the new insurer.
- Claims that are outstanding when the scheme is transferred will have to be effectively managed.
- Familiarity will be needed with the requirements of the new insurer.
- Action needed to ensure there is no gap in cover.
- Policy documents and certificates noting the insurer's terms and conditions, when received directly or from the broker, to be distributed to members.

Model answer for Question 16

(a) (i) Insurer Z's approach will be to obtain completion of an application form describing the proposer's past and present medical conditions. The objective is to limit the exposure to known risk. Limiting the extent of cover in individual cases, rather than premium differentiation, is the traditional method used to discriminate between various levels of risk.

Point of sale underwriting attempts to reduce differences in groups of proposers by excluding cover for impairments that the proposer already has. This is achieved by excluding cover for chronic conditions, or other pre-existing or related conditions which are statistically likely to recur. This is because of the higher incidence of potential claims due to the costs of treatment associated with recurring conditions. It would be inequitable to offer the same level of cover to all proposers regardless of their state of health. This puts all proposers on a consistent footing at the start of the policy.

The Insurer Z will be aware that some proposers will be a higher risk than others, such as those buying products with high cover limits or those of greater age who are more likely to claim.

Point of sale medical underwriting seeks to assess the risk posed by a pre-existing medical condition and exclude the risk by imposition of a 'special' condition to the terms of the policy. Medical information is used to assess the likely risk of conditions recurring, or related conditions emerging.

Cover for new, unrelated conditions will continue to be provided. Standard policy exclusions would still apply.

(ii) There is no need for the proposer to declare medical history when applying for cover. Instead, a moratorium clause is applied where the proposer agrees to be underwritten at the point of making a claim. At this point Insurer Z will request general practitioner records to assess whether the condition claimed for is eligible for benefit.

Time is saved by the proposer and Insurer Z at the application stage. The possibility of non-disclosure is also avoided.

Pre-existing conditions could be covered if sufficient time has elapsed since the policy inception. There is no possibility that a proposer with a poor medical history will have a premium loading or terms applied at the application stage.

A disadvantage for the proposer is that there will be a lack of clarity over what medical conditions that are actually covered. Insurer Z will have to be sure that the proposer understands how moratorium underwriting actually works.

Standard policy exclusions would still apply.

(b) (i)

- Insurers are allowed to recognise that the possibility of a claim becomes greater as a proposer's age increases.
- Insurers are allowed to have age-related premium bands.
- A different price is permitted for each individual age accepted.
- A ceiling could be applied to the age at which new applications can be accepted.

(ii)

- It is not lawful for insurers to discriminate on the basis of gender. It therefore can't be used as a factor when assessing insurance risk.
- Insurers are not allowed to charge differential rates for males and females.
- No discrimination is allowed in differences in benefits. Different specific heads of cover are allowed.

(iii)

- It is unlawful to uniformly treat disabled persons unfairly or unfavourably.
- Insurers are allowed to treat the disabled less favourably that others if this can be justified actuarially or statistically.
- Insurers cannot apply blanket exclusions.
- Insurers can offer benefits on an 'accept or decline' basis.
- Insurers can state that all risks exceeding a certain level of morbidity is unacceptable since it applies to all proposers equally.

Model answer for Question 17

(a) Only authorised firms are allowed to carry out insurance business. The Financial Policy Committee sits within the Bank of England and looks out for emerging risks to the financial system and economy as a whole and provides strategic direction for the entire regulatory regime.

The Financial Conduct Authority is responsible for both the Prudential and conduct of business regulation of intermediaries and for the conduct of business regulation of all insurers. Its overarching objective is to ensure that relevant markets function well. Its three operational objectives that affect Insurer X, both directly and indirectly, relate to consumer protection, its impact on the integrity of the UK financial system and the promotion of competition.

The Prudential Regulation Authority is responsible for the authorisation of and Prudential regulation of all systemically important firms, including insurers. Its specific insurance objective that impacts Insurer X is to contribute to the securing of an appropriate degree of protection for those who are or may become policyholders.

(b) (i)

- Insurer X may have a financial limit on the size of the risk it can accept.
- There will be risk-based capacity limitations imposed by Solvency II regulations.
- Reinsurance allows a proportion of accepted risks to be transferred without affecting its ability to accommodate substantial lines of business offered by intermediaries.

(ii)

- Sufficient levels of capital need to be held to cover Insurer X's potential liabilities attaching to the volumes of business it decides to accept.
- Reinsurance provides capital in the form of commissions on reinsurance premiums.
- Insurer X can also take advantage of the solvency offered by reinsurers to meet its regulatory obligations.

(iii)

- Reinsurance allows the cost of risk to be spread both nationally and internationally.
- The impact of risk does not fall entirely upon the UK economy.
- Spread of risk has a levelling effect on Insurer X's trading performance encouraging investment and adding to its ability to pay claims.

(c) Advantages of self-pay strategies for Insurer X's ex-customers:

- There is no exposure to insurance premium tax.
- Treatments excluded by private medical insurance (PMI) can sometimes be accommodated.
- There is no time-consuming requirement to obtain pre-authorisation from the insurer.
- If the patient needs additional treatment the hospital would be unable to charge more than the fixed cost the self-funder has agreed.
- There is no potential for disputes with the insurer over benefit or policy limits.

- Although original costings quoted to the patient could include an allowance for unexpected complications, self-funded treatments could still be less expensive than an equivalent procedure under a PMI policy.
- Hospitals and clinics may offer treatments at heavily discounted rates to the self-funding patient in order to fill spare capacity.
- Highly competitive rates may be available for the most common and routine procedures.
- The cost of treatment to the self-funding patient could be even lower at off-peak times, or if the patient is prepared to travel to achieve the best deal.
- Some hospitals and clinics offer interest-free loans to assist the self-funding patient to spread treatment costs.
- All costs are agreed in advance and the total could be less than the cost of buying private medical insurance over a period of years.
- Medical tourism could lead to further savings.