Chartered Insurance Institute

P64 – Private medical insurance practice

Diploma in Insurance

April 2019 Examination Guide

SPECIAL NOTICE

Candidates entered for the October 2019 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

Important guidance for candidates 3
Examiner comments 7
Question paper 10
Test Specification 16
Model answers 17

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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. 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 obtain free copies of the most recent Examination Guides online at www.cii.co.uk.

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 Qualifications Brochure, which is *essential reading* for all candidates. It is available online at www.cii.co.uk.

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.

EXAMINER COMMENTS

Question 1
Most candidates achieved high marks on this question, although not all were familiar with the role of Healthcode Limited in the development of electronic data interchange.

Question 2
The question produced reasonably strong answers, although there were some exceptional answers too. Candidates were more comfortable dealing with the specification that insurers would draw up to define the features of an intended product but were less certain on how the developing product would be introduced to the market.

Question 3
Part (a) was not well answered by the majority of candidates. In part (b), candidates' answers were stronger.

Question 4
Many candidates outlined each role well, although the tactical function of the finance department was sometimes confused with the more strategic role of a finance director.

Question 5
Few candidates gained high marks on this question. Many candidates incorrectly interpreted the question as requiring a protracted list of the benefits available under international private medical insurance and how this would contrast with cover that is standard in the UK.

Question 6
The majority of candidates were familiar with switch underwriting and successfully compared it with other similar concepts known as 'no worse terms' and 'continued personal medical exclusions'.

Question 7
Candidates needed a stronger understanding of the role and aims of the National Institute for Health and Care Excellence (NICE), and its impact on private medical insurers, in order to gain higher marks on this question. Part (a) was reasonably well answered with some understanding that NICE made decisions on what drugs and treatments should be made available under the National Health Service. Part (b) answers rarely went beyond the difficult choices that have to be made between offering treatments required by patients and consideration of the costs involved to the taxpayer. When answering part (c), some candidates incorrectly thought that NICE is a regulatory body that oversees the activities of private medical insurers.

Question 8
Part (a) was answered quite well with most candidates understanding that a 'basic' policy involves a trade-off between limitations on available benefits and the cost of the product to the customer. For part (b), the characteristics of a 'six-week' policy were less well understood. The policy offers cover if National Health Service waiting lists exceed six weeks. Some candidates incorrectly believed that cover was similar to a six-week short period policy or an annual contract only providing cover for the first six weeks of a required period of treatment.

Question 9

Few candidates gained high marks on this question. For part (a), some candidates tried to speculate the scope and purpose of the Association of British Insurers consumer guide 'Health Insurance Explained'. Many candidates suggested that it is a policy prospectus and others thought it provided a guide to the proposer's duty of disclosure. For part (b), a significant number of candidates provided definitions of cancer in terms of abnormal or malignant cell growth without mentioning the explanation that needs to be made to potential customers.

Question 10

Most candidates correctly recognised that limiting benefits to older employees could be discriminatory. However, only a few identified that younger employees could also be discriminated against. A minority of candidates mentioned other forms of discrimination apart from age.

Question 11

The majority of candidates achieved high marks on part (b). Part (a) was worth two marks and those candidates that did not recognise the bespoke nature of an exclusive special condition were not unduly penalised. Similarly, part (c) was worth two marks. Most candidates correctly mentioned that general exclusions are introduced by insurers from time-to-time to deal with situations where current premium levels are unable to fund the treatment of newly-emerging treatments or the increasing frequency of known conditions.

Question 12

Part (a) was reasonably well answered. When answering part (b), a large number of candidates incorrectly thought that private medical insurance is known as 'short-tail' business because policies are issued on an annual basis, and not because claims are advised and usually settled quickly.

Question 13

Both parts of this question were answered reasonably well.

Question 14

Many candidates correctly stated the basis on which International Classification of Disease (ICD) codes were set-up in their answers to part (a). For part (b), some answers focussed more on the wider and inclusive aspects of electronic data interchange rather than the discrete nature of ICD codes.

Question 15

Part (a) was answered reasonably well with most candidates describing the steps that an insurer would take to ensure the cost-effectiveness of treatments without compromising the quality of care customers are entitled to expect. Part (b) required candidates to give an outline of the role of quality assurance networks on managed care and most answers gained at least one of the three marks on offer. Part (c) required a description of differing perceptions of the effects of managed care within the individual-paid and group-paid segments of the private medical insurance market, and a large number of candidates correctly justified its greater acceptance in the group-paid market.

Question 16

In part (a), candidates were required to identify and describe the key types of independent intermediary and most successfully did this. A small number of candidates unnecessarily went on to refer to tied agents and direct sales staff. For part (b), the important stages of the independent intermediary's sales process were mostly correctly identified and described. Part (C) was answered to a high standard although a small number of candidates referred to advantages and disadvantages from the viewpoint of the customer. The answers to part (d) were reasonably strong. Four marks were available for part (e), and not all candidates mentioned the essential role that a relationship manager would probably play. Overall, this question was answered well with candidates averaging over half of the available marks.

Question 17

Part (a) required candidates to explain why the insurer would look for a minimum number of members within any one scheme, and issues surrounding spread of risk and anti-selection were correctly identified. In part (b), candidates selected two of the three methods most often encountered, namely 'experience rating', 'cost plus' and 'community pricing'. Part (c) was mostly answered well, although a few candidates incorrectly identified 'profit' as a cost. In part (d), occupation, location and the scale of cover selected were among the most popular answers given. This question was answered reasonably well with candidates averaging over half of the available marks.

Chartered Insurance Institute

P64

Diploma in Insurance

Unit P64 – Private medical insurance practice

April 2019 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. **(a)** Outline how electronic data interchange (EDI) is used in the transaction of private medical insurance up to the point that a claim is accepted. **(5)**

(b) State **six** benefits that EDI has on the direct settlement of claims payments between private medical insurers and healthcare providers. **(6)**

(c) Outline the role of Healthcode Limited in the development of EDI. **(2)**

2. Explain the concept of prototyping and its attraction to a private medical insurer when adding to its range of products. **(10)**

3. **(a)** State how the pooling principle affects buyers of private medical insurance. **(3)**

(b) Outline the relevance of the Consumer Insurance (Disclosure and Representations) Act 2012 to those buyers. **(7)**

4. Outline the role of a private medical insurer's:

(a) managing director; **(4)**

(b) chief medical officer; **(4)**

(c) finance department. **(4)**

5. Identify **six** factors that would encourage people permanently living outside the UK to buy private medical insurance. **(6)**

6. **(a)** Outline the advantages that 'switch underwriting' offers an individual who is considering changing to a different private medical insurer at their policy anniversary date. **(3)**

(b) State **five** considerations that would affect an insurer's decision to offer switch underwriting terms to an individual. **(5)**

7. **(a)** Describe briefly the role of the National Institute for Health and Care Excellence (NICE). **(5)**

(b) State **two** ways in which NICE can be negatively perceived by the UK public. **(2)**

(c) Outline NICE's impact on private medical insurers. **(2)**

8. Outline the main characteristics of **each** of the following types of private medical insurance policy.

(a) Basic policy. **(6)**

(b) Six-week policy. **(6)**

9. In connection with the Association of British Insurers:

(a) outline the scope and purpose of its consumer guide 'Health Insurance Explained'; **(3)**

(b) list **five** cover limitations, in respect of cancer, that insurers must explain to potential customers. **(5)**

10. Outline **six** ways in which an employer providing private medical benefits to its staff could be guilty of age discrimination under the provisions of the Equality Act 2010. **(12)**

11. **(a)** State **two** characteristics of an exclusive special condition that a private medical insurer might decide to apply when issuing a policy. **(2)**

(b) List **ten** general exclusions imposed by private medical insurers. **(10)**

(c) Outline why insurers would consider introducing new general exclusions from time-to-time. **(2)**

12. **(a)** Describe briefly the Solvency II Directive and how private medical insurers are affected. **(4)**

(b) State why private medical insurance is regarded as 'short-tail' business. **(3)**

13. **(a)** Outline the characteristics of an incurable condition. **(4)**

(b) Explain briefly a private medical insurer's likely response when a claim is made under a comprehensive policy for a newly acquired illness which later becomes incurable. **(6)**

14. **(a)** State the basis on which International Classification of Disease (ICD) codes were set-up. **(2)**

(b) Outline **seven** reasons why a private medical insurer would use ICD codes as part of its claims assessment procedure. **(7)**

PART II

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

15. **(a)** Explain the principles of managed care when applied to claims made under private medical insurance policies. **(20)**

(b) Outline the impact of quality assurance networks on managed care. **(3)**

(c) Describe the effect that managed care can have on a private medical insurer's relationship with its group-paid and individual-paid customers. **(7)**

16. **(a)** Identify and describe briefly the roles of the main types of independent intermediary selling private medical insurance. **(8)**

(b) Describe the stages of an intermediary's sales process. **(8)**

(c) Outline **three** advantages and **three** disadvantages for an insurer when selling through an independent intermediary. **(6)**

(d) Explain briefly what is meant by competitor analysis and the role an insurer would expect an independent intermediary to have within that process. **(4)**

(e) Explain briefly how an insurer would manage interactions with an independent intermediary to achieve its sales objectives. **(4)**

17. Insurer A is to commence transacting private medical insurance business for large group schemes.

(a) Explain why a substantial minimum number of members should be specified before a large group scheme is offered to applicants. **(6)**

(b) Describe briefly **two** premium calculation methods that could be used by Insurer A. **(6)**

(c) State **six** business costs Insurer A will take into account when building a margin into its premium calculations for this class of business. **(6)**

(d) Describe briefly **six** factors that will influence the premium that Insurer A will quote for new business. **(12)**

TEST SPECIFICATION

April 2019 Examination – P64 Private medical insurance practice	
Question	Syllabus learning outcome(s) being examined
1	4 – Understand the application of claims and policy administration
2	3 – Understand the application of pricing and underwriting for private medical insurance 6 – Understand the distribution of private medical insurance
3	2 – Understand private medical insurance products and principles 5 – Understand legislation and regulation in relation to private medical insurance
4	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
5	1 – Understand the relationship between public and private medical provision 2 – Understand private medical insurance products and principles
6	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
7	1 – Understand the relationship between public and private medical provision
8	2 – Understand private medical insurance products and principles
9	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
10	2 – Understand private medical insurance products and principles 5 – Understand legislation and regulation in relation to private medical insurance
11	2 – Understand private medical insurance products and principles 3 – Understand the application of pricing and underwriting for private medical insurance
12	3 – Understand the application of pricing and underwriting for private medical insurance 5 – Understand legislation and regulation in relation to private medical insurance
13	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
14	4 – Understand the application of claims and policy administration
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
16	2 – Understand private medical insurance products and principles 4 – Understand the application of claims and policy administration 6 – Understand the distribution of private medical insurance
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

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) A hospital or clinic prepares details of the treatment provided and the related costs and fees. This claims information is entered into a computer located at its premises and linked to the insurer. The data is sent electronically to the insurer where it is processed into the insurer's claims system. Hospitals are able to view the member information held by the insurer. The scale of cover and the existence of terms and conditions can be determined by the hospital when a member is admitted for treatment. Specialists are also encouraged to use computers at hospitals to enter details of their bills.

(b) *Any six of the following:*

- Speeds up the pre-settlement claims process.
- Allows hospitals to ensure that a claim has been authorised before treatment takes place.
- Reduces clerical errors.
- Has in-built checks to improve quality of data.
- Allows insurers to understand claims patterns.
- Eliminates or reduces paperwork.
- Reduces costs.
- Accelerates payment of claims.

(c) Healthcode Limited was created to develop electronic data interchange and e-commerce internet services for the benefit of hospitals, consultants, insurers and patients. It is credited with encouraging hospitals to use one system for all claims, rather than a separate system for each private medical insurance insurer. It is the UK's official medical bill clearing company.

Model answer for Question 2

A prototype takes the form of a product specification. The specification includes anticipated business volumes comprising new business, transfers and lapses. Also included are recommended premiums, claims forecasts and expenses. Competitor analysis will be undertaken.

The insurer will consider methods of distribution, administration and marketing as well as product literature requirements.

Information and information technology system capability requirements will be assessed.

The product could initially be test-marketed through a single broker before being rolled out to the wider market as a whole. This 'soft launch' phase of prototyping involves less risk than a full product launch. The chosen broker is given the opportunity to market a product not available to other brokers. The broker could be offered some form of profit share to encourage full commitment and support.

Model answer for Question 3

(a) The buyers of private medical insurance pay premiums into a pool. The pool is then used to fund claims payments for the minority who need to claim upon their insurance cover. Buyers pay a premium determined by their relative risk to the common pool.

(b) The Consumer Insurance (Disclosure and Representations) Act 2012 (CIDRA) amends the principle of utmost good faith previously imposed on applicants by the Marine Insurance Act 1906.

Buyers of private medical insurance must only be asked for information needed to assess the risk presented by applicants rather than the insurer expecting automatic disclosure of all material information. If the applicant's answers to questions for relevant information are deliberately dishonest or reckless the insurer can refuse to pay a claim and retain the premium paid. If the applicant makes a careless mistake the outcome will be based on what the insurer would have done had the applicant provided full and accurate information.

CIDRA benefits applicants in that there is less likelihood of a claim being unfairly rejected due to inadvertent misrepresentation.

Model answer for Question 4

(a)
- Effective management of the organisation.
- Defining strategic direction.
- Setting and monitoring of organisational goals.
- Guiding the overall performance of the organisation.
- Reporting of medical trends.

(b)
- Advising on new drugs and treatments.
- Analysing the frequency and severity of claims patterns.
- Ensuring the confidentiality of medical reports.
- Adjudicating on complex medical cases.
- Considering complaints received from claimants.
- Resolving disputes with hospitals and consultants.
- Mentoring and training underwriting and claims personnel.

(c)
- The banking of income, including premiums.
- Payment of invoices.
- Debit and credit management.
- Ensuring robustness of systems to reduce fraud.
- Maintenance of revenue accounts.
- Forecasting of financial performance.
- Preparation of year end accounts.

Model answer for Question 5

Any six of the following:
- The lack of availability of a state-sponsored public healthcare scheme.
- Levels of dissatisfaction with the quality of state-sponsored public healthcare schemes or facilities.
- Private medical insurance (PMI) may be needed to top-up state-funded provision.
- Concerns over funding of state healthcare facilities.
- Local culture could discourage individuals to support the concept of state-assisted healthcare.
- The absence of employer-sponsored healthcare schemes.
- The availability of tax relief.
- The desire that treatment should be elective.
- The availability and cost of PMI.

Model answer for Question 6

(a) People who already have private medical insurance may find it worthwhile moving to another insurer, especially if premiums could be less expensive and for more attractive benefits.

To counter this, some insurers offer switch underwriting. If the customer is able to answer 'yes' to a small number of questions, the new policy will not impose any more exclusions than their existing policy. Switch underwriting avoids the need for customers to be re-underwritten.

(b) *Any five of the following:*

- Lack of organic growth in the individual-paid market.
- An insurer's best opportunity to expand its account is to encourage transfers from other insurers.
- When the applicant was last underwritten by the previous insurer.
- What terms were previously applied?
- Whether benefits requested by the applicant are different from, or superior to, those previously provided.
- If the new insurer is likely to be exposed to a medical condition where the applicant is already receiving treatment, or a medical condition is just starting to emerge.
- Terms and conditions offered to be set at levels that enable the insurer to expect to achieve a profit.

Model answer for Question 7

(a) The National Institute for Health and Care Excellence (NICE) attempts to match finite resources to the cost-effectiveness of available treatments. Judgements are based on evidence of clinical effectiveness measured as life expectancy or improving quality of life by assessing Quality Adjusted Life Years. High-cost drug therapies are evaluated to see if they are affordable within the National Health Service (NHS).

NICE disseminates clinical audit methodologies and information concerning good medical practice. It provides evidence-based clinical guidance and advice to healthcare professionals.

NICE sets quality standards and outcomes and carries out technical appraisals.

(b) *Any two of the following:*

- NICE puts money before health.
- NICE is slow to react.
- NICE's decision-making lacks transparency.
- NICE is subject to political interference.

(c) A private medical insurance insurer may only choose to cover drugs and treatments that are approved by NICE. It is unlikely that budget and similar policies would provide cover for non-approved drugs and treatments. Under top-of-the-range or group-paid schemes, the insurer may pay for non-approved drugs and treatments, although this involves greater and less certain costs and, potentially, more variable outcomes.

Model answer for Question 8

(a) A basic policy allows the customer access to cover at a low premium. The cover is available for only the more important and/or expensive types of treatment, such as inpatient and day care costs. Outpatient treatments are likely to be excluded unless related to an inpatient stay. Treatments are likely to have to be received at one of the insurer's network of hospitals where preferential rates have been negotiated.

Other treatments likely to be excluded include those for psychiatric and addictive disorders.

(b) With a six-week policy, there is no cover if the average waiting time for hospital treatment is less than six weeks. The average waiting time can be a difficult concept for the customer to understand when waiting times can vary in different areas or by hospital or consultant.

A six-week policy is available at a lower premium cost compared to one written without any such restriction.

A cash benefit may be paid directly to the customer if they decide to receive free treatment as a National Health Service (NHS) patient.

Model answer for Question 9

(a) The Association of British Insurers consumer guide 'Health Insurance Explained' covers private medical insurance and health cash plans. It sets out to help consumers understand what their health insurance options are, why people buy health insurance and how it works, so they can make an informed choice when buying a policy.

(b) *Any five of the following:*

- Limits on time periods.
- Cycles of treatment.
- Maximum payments.
- The effect of a terminal diagnosis.
- Continuing care.
- Palliative care.
- End of life care.
- Circumstances in which insurers would not provide cover.
- When cover might be withdrawn.

Model answer for Question 10

Any six of the following:

- More older people continue to work, and the employer sets a maximum age beyond which cover is no longer available.
- Where younger employees are disadvantaged by the application of a minimum age before which benefits become available.
- By applying a qualifying or probationary time limit before any employee is entitled to benefit may discriminate indirectly against older members of staff who are very close to normal retirement age.
- An employer-paid subsidy covering the cost of benefits, where the subsidy increases or decreases as an employee becomes older.
- Where employees work beyond a certain age, employers should provide the same level of benefits as younger members receive.
- Exclusion of dependants over a certain age could be considered discriminatory.
- Former employees who receive benefits in retirement could be discriminated against if benefits or premiums are age-banded.
- To avoid inadvertent discrimination employers must go through an objective process.

Model answer for Question 11

(a) *Any two of the following:*

- An exclusive special condition is bespoke by nature.
- An exclusive special condition is designed to address a particular medical condition displayed by the applicant.
- There may be provision for the underwriter's decision to apply the condition to be reconsidered at some point in the future.

(b) *Any ten of the following:*

- Pre-existing conditions.
- Mental/addictive conditions.
- Pregnancy/childbirth.
- Contraception/assisted reproduction.
- AIDS/HIV.
- Unproven, alternative/experimental treatments.
- Cosmetic treatments.
- Nuclear/chemical contamination.
- War/invasion/acts of a foreign enemy.
- Renal dialysis.
- Hormone replacement therapy.
- Dental/oral surgery.
- Chronic conditions, apart from acute episodes.
- Private GP treatment.
- Alcohol/solvent/drug abuse.
- Self-inflicted injuries.

(c) Insurers would consider introducing new general exclusions from time-to-time to limit or exclude cover due to advancements in medical technology that prolong life but at the same time lead to increased levels of morbidity. Also, to mitigate the appearance of previously unknown illnesses and diseases, and to address the associated treatment costs that current premium rates are unable to sustain.

Model answer for Question 12

(a)
- The Solvency II Directive sets out to harmonise European Union (EU) insurance regulation on solvency.
- It seeks to ensure that insurers remain solvent and to minimise the risk that an insurer might become insolvent in the future.
- It consists of three pillars:
- Pillar 1 – sets out a minimum capital requirement (MCR) that insurers must meet.
- Pillar 2 – is a supervisory review process to assess whether an insurer should hold additional capital beyond its MCR.
- Pillar 3 – is the disclosure and supervisory regime requiring that certain reporting aspects are declared to the regulator and the public.
- The principle of Solvency II is likely to continue to apply after the UK has left the EU.

(b) Insurers are quickly made aware of claims and they are paid promptly. Insurers are able to quickly change their pricing if claims take on an unexpected and sustained increase.

Model answer for Question 13

(a) An incurable condition is chronic and needs on-going, long-term monitoring and control. It continues indefinitely and can only be managed rather than cured. A patient may require rehabilitation or training in order to cope. Incurable conditions are not always life threatening and sufferers may have a reasonably normal life expectancy.

(b) An initial diagnosis could also be covered if the policy covers consultations. Short-term cover may be available whilst the insurer observes how the condition progresses. Eventually the condition may be judged to be untreatable and at this point the insurer will have to decide whether to stop paying for further treatment, subject to providing the patient with a period of notice.

An acute flare-up may be covered and installing a prosthesis could also be covered. All other aspects of care are likely to be excluded.

Model answer for Question 14

(a) International Classification of Disease (ICD) codes were set-up by the World Health Organisation. They are a means of classifying impairments and are used as a universal coding system. They are regularly updated to meet developments in healthcare and diagnostics.

(b) *Any seven of the following:*

- To classify claims causes recorded on many types of health records.
- To facilitate the storage and retrieval of diagnostic information for clinical and quality purposes.
- When claims were originally processed against textual descriptions of impairments the insurer's claims assessor had to categorise the severity of the condition claimed for.
- Since the introduction of computerised claims processing in order to support accurate assessments, coded information has replaced narrative descriptions of impairments and medical conditions.
- Coded descriptions help to analyse costs and monitor trends.
- Reporting of incident rates and claims for each specific disease will be consistent across industry data.
- Relevant codes are included in invoice exchanges between insurers and hospitals to ensure consistent records.
- Data quality is improved, and errors minimised.
- Quicker payments to treatment providers can be achieved.

Model answer for Question 15

(a) Managed care is a response to concerns insurers have over the escalating costs associated with the provision of healthcare services. It represents an intervention by insurers or their third party administrators as a means of containing claims costs whilst at the same time maintaining standards of care. Any such intervention aims to ensure that procedures undertaken are necessary and that less costly alternatives are considered that could lead to an equally positive outcome without compromising the patient's speedy recovery.

Managed care looks at clinical appropriateness, the cost and quality of healthcare as inter-related matters. Insurers take a proactive interest in decisions affecting medical care given to the patient. Insurers contract with hospitals to agree fee scales.

Insurers may set-up consultant networks in order to set parameters for treatment options. This process is known as utilisation review and comprises three elements, namely:

Pre-authorisation
Before the commencement of treatment, the patient contacts the insurer to confirm that the proposed treatment is covered. There will be an assessment of the proposed treatment by doctors and other specialist medical staff acting on behalf of the insurer to be sure that the proposal is clinically appropriate.

Case management
This permits the insurer to study any complex medical treatments to check that what is proposed is being delivered in the most cost-effective way and that less expensive alternative, but equally effective treatments are considered. Tailored price agreements are specially negotiated with treatment providers.

Concurrent or ongoing review
This occurs as the patient is treated to check that the treatment remains appropriate and is the best way of achieving the most satisfactory clinical outcome. A protracted stay in hospital could be replaced with an earlier return home supported by an appropriate, but less expensive, level of home care. Guidelines and protocols are developed by insurers, and backed by the Competition and Markets Authority, to define best practice in the treatment of common complaints by determining lengths of hospital stays. They are used to review the process of managing individual cases which would otherwise be subject to a broad range of opinions over treatment options. Consequently, insurers have developed reference points which are published to the medical profession as well as having internal application.

(b) Quality assurance networks ensure that patients are treated correctly and cost-effectively. Critics say they are designed primarily to save costs at the expense of the best outcome for patients. Specialists, forming part of a network, agree to medical protocols or methods of working in return for higher fees and patient referrals.

(c) The principle of managed care is more accepted in the group market where employers, who sponsor such schemes, place a greater emphasis on cost containment. This is because they fund the cost of healthcare in full or in part on behalf of members. Any increase in claims costs will result in increased premiums for the employer who could also be adversely affected by the operation of a co-insurance clause. As a result, employers tend to be amenable to limitations that are applied within group-paid schemes.

In the individual-paid market the principles of managed care can meet resistance. Freedom to choose treatment options assumes greater importance than cost at the top end of the product range. Conversely, budget-type policies use a managed care philosophy as a means of lowering premium levels as well as limiting the range of benefits being offered.

Model answer for Question 16

(a)
- Independent financial advisers (IFAs) specialise in providing financial advice. Private medical insurance (PMI) will be one of a range of protection-based products on which an IFA would offer advice.
- IFAs advise on and place PMI business with the whole market, rather than one, or a limited number, of product providers.
- The IFA may offer the client a fee-based option as an alternative to being remunerated in the form of commission.
- Insurance brokers and other intermediaries, including networks and umbrella organisations, may specialise in selling PMI business and offer expertise to clients.
- All independent intermediaries set out to recommend to the client the best product, service and price mix that is available.
- Employee benefit consultants also have an important role in recommending appropriate products to corporate clients.

(b)
- Prospecting for new customers involves advertising and raising product awareness through the use of e-mails, mailshots, letters, telephone calls, the internet and cold canvassing.
- Leads can be obtained from electoral roles or agencies that specialise in releasing lists of people thought to be interested in purchasing PMI.
- Recommendations from existing satisfied clients offer good introductions.
- Initial contact involves making an introduction in order to create interest on the part of the client or to see if there is a PMI need to address.
- A meeting is arranged to build on the initial contact and seeks to define a plan that suits the needs of the client.
- The next step is to produce an illustration of costs and benefits for the client, often by using a lap-top quotation facility.
- If the proposition is acceptable to the client, the intermediary will close the sale or arrange a further meeting with the client in order to progress matters further.
- A follow-up meeting will be arranged to discuss any future change in needs and to ensure that the client is satisfied with the arrangements made.
- Annual service meetings are often planned to take place shortly before renewal of an existing contract as this is usually the best time to consider changes to the present arrangements, or to address any further needs that have arisen since the last meeting.

(c) <u>Advantages</u>

Any three of the following:
- The insurer distributes its products without incurring direct sales costs.
- The insurer enjoys lower acquisition and administration costs.
- A price advantage can be gained over competitors.
- The insurer can gauge the success of its products from the level of intermediary support received.

Disadvantages

Any three of the following:

- The insurer cannot distribute its products without incurring substantial commission costs.
- Unwarranted lapsing of policies at renewal adversely affects insurers' operating costs.
- Loss of ownership of client.
- Potential mis-selling of its products can reflect badly upon the insurer.

(d)

- Competitor analysis will look at comparisons of common benefits and premium pricing together with trends of increasing or decreasing market share.
- Insurers expect intermediaries to indicate where their products are particularly weak or strong. For example: speed of claim payment, customer service etc.
- Insurers need to know what their competitors are doing and how competitors' products compare to their own.
- This information translates into product design.

(e)

- Management of the intermediary-led distribution channel includes payment of commissions and promotional incentives.
- Specialist PMI intermediaries need special handling as they are important in the selection of appropriate products for clients and some flexibility may be needed over price negotiation.
- The insurer could have an intermediary support team as part of its sales and marketing function as an initial contact point.
- Insurers may support aggregator or price comparison sites provided by intermediaries that allow clients to rank products by price and product features.
- Some insurers own or invest in intermediary firms and such partner firms may place all or a great proportion of their business with the insurer.

Model answer for Question 17

(a)
- Large group schemes are usually intended to cover at least 50 members.
- Because of the nature of their composition, it is usual for such schemes to include cover for pre-existing conditions.
- The insurer will wish to avoid anti-selection. This is where the insurer could discover it is covering a disproportionate number of employees in poor health.
- By insisting that all employees within a given category are covered, the insurer relies on the law of large numbers to ensure that balance is achieved that employees in good health are also included.

(b) *Any two of the following:*

Experience rating

Premiums are calculated according to the group's claims experience over the previous twelve-month period, or longer, rather than a collection of individual tabular ratings.

Cost plus

The insurer first determines the likely future claims costs. To this, they add a fee for administration and all other costs.

Community pricing

The insurer charges a premium for each member, regardless of age or gender.

(c) *Any six of the following:*
- Marketing.
- Customer service.
- Staff and administration costs.
- Risk premiums.
- Claims.
- Fixed infrastructure costs.
- Commission costs.
- Solvency requirements.
- Levies imposed by the Financial Conduct Authority.
- Reinsurance premiums such as for specific and aggregate stop loss.
- Insurance premium taxes payable to Her Majesty's Revenue and Customs.

(d) *Any six of the following:*
- The range and hierarchical status of members who are to be covered, such as employees only, or employees plus dependents.
- The age profile of the group – pricing may be based on an age banding system in the case of large groups or individual age specific pricing in the case of smaller groups.
- Scales of cover selected – benefit choices can increase or decrease the quoted premium.
- Method of premium payment – the insurer incurs greater costs the more frequently the applicant elects to pay premiums.
- The groups past claims experience as confirmed by the previous insurer.

- The area in which cover will apply by post code or the hospitals which can be included in or excluded from the scheme.
- The additional risk factors that are apparent amongst members resulting from the nature of the occupational duties undertaken.
- Product benefit variables can be introduced such as a range of different levels of excess or deductibles.
- Some customers may wish to share in the insurer's profits if their member group has low claims in a policy year. Other customers may be prepared to share in both profits and losses depending on the claims experience of their member group in any year. An appropriate adjustment is applied to the premium for these options.
- Insurers are often prepared to offer longer term contracts to customers. Customers are interested in obtaining price-stability, so longer-term contracts may be attractive to both parties where the contract runs for two to five years instead of one.
- Under co-funding arrangements, the customer pays part of each claim and insures the rest. The customer's element may be limited per claim or per policy year.