INSTITUTE OF ACTUARIES OF INDIA

Subject SP1 – Health and Care Principles

May 2024 Examination

INDICATIVE SOLUTION

Introduction

The indicative solution has been written by the Examiners with the aim of helping candidates. The solutions given are only indicative. It is realized that there could be other points as valid answers and examiner have given credit for any alternative approach or interpretation which they consider to be reasonable.

Solution 1:

i) Reasons for issuing Professional guidance:

Guidance notes provide a way of ensuring that interests are protected. The main aim is to give a framework for issues that need to be considered in carrying out professional responsibilities.

This helps,

1) To ensure consistency e.g. various approaches to pricing and reporting
2) To maintain professional standards
3) To provide standards on the strength of which disciplinary actions against members can be taken.
4) Essential to protect public interest and to maintain trust between insurer and policyholders.
5) Encourage individuals to take out health care insurance that suits their needs.
6) It will add weightage to actuaries argument if they want to resist pressure from various stakeholders to protect the interest of policyholders.

(1/2 mark each, Max 2 marks)

ii) Broad areas the guidance to cover:

Guidance notes typically covers,

1) Detailed methodology for calculating reserves and capital requirements.
2) Design and pricing of health care products.
3) Ways of distributing profits
4) Ways to calculate the guarantees and options while pricing/valuing.
5) Guidance on interpretation of the regulatory guidelines; generally, regulations are made in a general way, expecting actuarial associations to provide detailed guidelines and interpretations of the same.

(1/2 mark each, Max 2 marks)

iii) Reasons for public tables becoming out of date frequently, out of date due to,

1) Advances in medical science, e.g., genetical editing technologies opened up new treatment options for genetical illnesses.

2) Changes in the nature of work, e.g. shift from manual jobs to sedentary jobs, lead to work-related stress and thereby more mental illnesses than physical illnesses.

3) Changes in the nature of food e.g. More junk foods compared to traditional food & having food late at night leading to many physical health issues.

4) Changes in time over opinion about illnesses and ability to work, e.g. Earlier when undergoing some treatment for psychiatric illnesses was thought the person wouldn't be able to work, however, nowadays, with medical advancements these became a part of work.

(1 mark each, Max 3 marks)

[Max 7]

Solution 2:

i) Ways to regain market share.

1. To reduce the premium from current levels
2. To increase the benefit levels for the premium
3. Claim definitions may be relooked/relaxed from current levels.
4. Can provide options to the policy, mainly at nominal cost or no cost e.g., providing options to continue the cover at the end of contract term on non-guaranteed terms.
5. Guarantees may be added; for e.g. Guarantee that premium on renewal cannot exceed a given percentage.
6. The insurer may pay higher remuneration to the sales force from the existing levels.
7. Can explore selling through some new channels.
8. May come up with new product design for e.g. with accelerated cover or benefit payments at installments based on stages of illness or having tiered CI options where benefits payments can continue even after settlement of benefits under one tier.
9. Simplified product at competitive price
10. Simplified on boarding procedures for taking out insurance.
11. Simplified underwriting, relaxing the medical grid may attract more customers to take health policies.
12. More branding and creating awareness through health campaigns.
13. Incentives such as yearly free health check-ups, smart watches to monitor health or some applications to guide policyholders to maintain their health.
14. Policy terms and conditions can be revisited e.g., reducing the waiting period/survival period.
15. Better after-sales services e.g. Reducing the claim settlement period.

(1/2 mark each, Max 5 marks)

ii) Reasons & actions can be taken when premium is uncompetitive.

Reasons why repriced premium is still uncompetitive:

- Morbidity rates:
  Actual experience of insurer may be heavier than that of industry due to
  1. Weaker/less underwriting
  2. No differentiation on premium based on habits for e.g., sample premium for smoker and non-smoker.
  3. Different target market
  4. Different sales distribution channels
  5. More CIs covered.
  6. Loose policy wordings on claims and hence more expectation on claim payments

  (Max 2 marks)
- Expenses:
  1. May be higher than competition.
  2. May be paying higher commission/remuneration to sales force than market rates.
  3. Lower Volumes/productivity from sales force might have led to higher per unit cost.

  (Max 1 mark)
- Lapses:
  1. May be higher than that of competition.
  2. Persistency may be poor due to different target market/sales channels.

  (Max 1/2 mark)
- Profit target:
  1. May be higher than that of competitors.

(Max 1/2 mark)

Actions that can be taken by the insurer to reduce the premium rates:

- Morbidity rates:
    1. Tighten the underwriting.
    2. Can introduce differential rates e.g., smoker and non-smoker to attract non-smokers and thereby to reduce anti-selection.
    3. Strengthen the claim management process.
    4. Tighten the policy wordings and get it aligned with the market so that claims underwriting can be strengthened.
    5. Analyzing the target market further and identifying the areas from where more claims are incurring and blacklisting the same.
    6. Analyzing and taking actions on the distribution channels where claims are higher.
    7. Target sales channels with better experience on morbidity
    8. If the portfolio is not reinsured, taking help from reinsurer so that, Lower morbidity rates can be used in pricing, which can be justified and targeted in near future with the help of reinsurer.
    9. Looking at various design options by which premium can be lowered such as,
    10. Introduce Premium reviewability and not fully guaranteed premiums, so that margins built can be reduced.
    11. Increase number of exclusions
    12. Reducing the number of Cis from current levels
    13. Reducing the benefit payouts e.g. making CI definitions more severe (to reduce number of claims) & making definitions clearer (to reduce claim disputes)

    (Max 2 marks)
- Expenses:
    1. Can reduce the commission levels if currently we are paying higher than on the market.
    2. Try to reduce the sales costs and increase salesforce productivity.
    3. Improving administrative efficiency by using AI & technology

    (Max 1 marks)
- Lapses:
    1. Try to improve persistency from current levels.
    2. Analyzing experience channel wise and taking steps to improve the same.

    (Max 1/2 mark)
- Profit target:
    1. Reduce margins in pricing.
    2. Can reduce the target profitability from current levels, which helps to lower premium.

    (Max 1/2 mark)

(Max 8 marks)

[Max 13]

Solution 3:

CI with premium reviewability for every 5 years

i) For the company:

Advantages

1. Reviewable premiums provide the insurer option to reprice in case, actual experience turns out to be worse than pricing assumptions, For example, morbidity, mortality, expense, lapse experience.
2. As the product is not priced with too much guarantee for long term margins in pricing can be lowered
3. Also, it will result in lower initial premium.
4. The lower initial premium helps to
    a. Increase the volume of business.
    b. Higher sales leads to higher profitability
    c. Increase market share in competitive environment.
    d. Lower reserving requirement
    e. Lower capital requirement
5. Reviewable premiums also provide the insurer the mechanism to pass the benefits of favourable experience back to the policyholders if actual experience turns out to be better than pricing assumptions.
6. If actual experience turns out to be better while reviewing premiums can be further lowered which as well will lead to
    a. Better policyholder satisfaction
    b. enhanced brand value
7. Offering reviewable premiums may be more aligned to market / industry practice.
8. Reviewability also gives Company X the opportunity to align the premium to changes in its own practices, e.g., its claims control procedures.
9. It may allow Company to offer cover for new risks at reasonable price even if it does not yet fully understand future claim experience for the risk.
10. Getting reinsurance support for guaranteed CI products may be limited / not available.
11. The reinsurance terms offered by reinsurers on reviewable premium business could be better than those on guaranteed premium product.

(1/2 mark each, Max 5 marks)

Disadvantages

1. CI product with reviewable premiums would create additional administrative burdens such as,
    a. Performing regular review which is time consuming.
    b. Require more frequent experience investigations.
    c. Updating the revised premiums in IT systems and ensuring the premium charged are appropriate.
    d. Proper communication to policyholders and dealing with the complaints/queries on the same.
    e. These investigations and/or procedures to implement increases the cost of the company.

(Max 1 mark)

2. Sales force needs to be properly trained to explain the reviewability clause the point of sales, else it will lead to
    - mis-selling
    - Reputational loss / Damage to brand name
3. Frequent change in premium rates may not be liked by the policyholders.
4. Increase in premium rates may not be accepted by policyholders, which could lead to policyholder complaints and high lapsation.
5. Generally, these lapsations will be mostly selective and the people willing to continue the policy may be of poor health and it may further increase the morbidity experience of the company.
6. If industry is having guaranteed rates only then reviewability will not be an acceptable feature for policyholders, and it will affect sales.

(Max 2 mark)
(Max 8)

ii) For the policyholder:

Advantages:

1. As initial premiums may be cheaper compared to guaranteed product, this attracts policyholders to take the cover.

2. It may allow existing customers to increase the available coverage.

Disadvantage:

1. Premiums after 5 years are not certain in case of reviewable product; it may move on either side.
2. Policyholder may not be comfortable as the guarantee of premium for the term is removed.
3. If premium increases during review, then good lives might not be attracted to continue the cover and may lapse the policy.

(Max 2 marks)
[Max 10]

Solution 4:

i) Inflation:

1. inflation may erode the real value of benefit paid under health and care insurance product so that it will not fully meet the need for which it was purchased.
2. product design solutions include,
   a) having short term policies so that benefit levels can be revisited frequently.
   b) having product designs with indemnity benefits instead of fixed benefit designs
   c) under long-term contracts,
      i. include pre-determined fixed benefit escalation every year.
      ii. options to increase the benefit payment at frequent intervals.
      iii. having index-linked benefit increase

(Max 3 marks)

ii) Why persistency is necessary for product pricing.

1) In long term contracts, the insurer is bound to pay surrender value (SV) and whenever the SV is higher than the proxy asset share, the company may incur a loss.
2) at initial years, the asset share may be negative, and it may happen the SV needs to be paid; if surrenders are also high then it will increase the loss to the insurer.
3) if asset share is higher than SV< then company makes profit out of surrender
4) persistency rate is important in projecting the future in-force business.
5) higher lapses would mean that less profit expected from the portfolio in later years of the policy term, as less number of policies would be still in-force.
6) further renewal rates are needed to evaluate the extent to which initial expenses can be spread over the renewals under short-term products.
7) the volume will impact the spreading of overheads and fixed one-off expenses such as product development.
8) also, insurer will incur additional expenses when the policy is lapsed & the same also needs to be factored in pricing.
9) when a policy is getting lapsed, in reality insurer may not be able to recoup the higher initial expenses already incurred such as higher commission pay outs; if commission

claw backs are available then this is not much of an issue but in many cases the commissions are not clawed back.

10) further in many cases the lapses are selective, which means the healthy customers tend to lapse the policy compared to an unhealthy policyholder leading to worsening the morbidity experience than expected.
11) hence, the pricing morbidity assumption should take into effect the impact of selective lapses/surrenders as well.
12) if the persistency is incorrectly allowed in pricing, then it will lead to incorrect profitability estimation of the contract.
13) this will also affect the competitiveness of the product and business volume.

(1/2 mark each, Max 5 marks)

iii) Change of distribution channel & persistency

1. the person who initiated the sales will affect the persistency.
2. if the sale is initiated by policyholder, then persistency is expected to be better.
3. across channels the sales practice may be different which causes the persistency experience to be different across channels
   a. when sales channel sells based on pure need of the customer understanding his premium paying ability, then persistency may be better.
   b. when sales channel has put lot of pressure to the customer to buy the policy / to buy a higher cover than needed then persistency will tend to be poor
4. poor sales practice may exist particularly in places where the reward/commission to the salesperson is initial commission instead of renewal/level commission.
5. different target markets of the clients lead to different perception about the value of money for the contract purchased and it leads to different persistency behaviours.

(Max 3 marks)

iv) Why to monitor morbidity experience

1. Ensure financial viability of the product.
2. Update the future assumptions for pricing / valuation.
3. Monitor trend in the experience.
4. To provide the information to the management to take business decisions.
5. To monitor the actual and expected experience to take corrective actions.
6. Reprice the product if warranted.
7. Ensure adequacy of reserves & to strengthening reserve assumptions when necessary
8. To further identify the risk pockets e.g.., Is anti-selection in any channel/area/branch.
9. Ensure whether reinsuranace is profitable or to assess the need for reinsurance
10. Monitor the underwriting effectiveness.

(1/2 mark each, Max 5 marks)

v) Why no reinsurance?

Possible reasons why insurer decided not to have reinsurance,

1. The insurer already has credible experience.
2. The insurer has appropriate risk appetite.
3. The insurer already has proper diversification of business.
4. Cap on insurance coverage and hence large covers are not accepted by insurer.
5. Company has adequate capital available and have large free assets.
6. As insurer is doing business for long years, there may not be any requirement for technical / administrative assistance.
7. No need of financial requirements
8. Reinsurance not available at the appropriate price / unaffordable

9. Reinsurers not meeting the expectation of the insurer terms e.g., guarantees.

(1/2 mark each, Max 3 marks)

[Max 19]

Solution 5:

i) Why reinsurance for group PMI

1. This being new product, insurer have no expertise & require support in,
    a. Product designing
    b. Technical support for product pricing
    c. Underwriting support
    d. Support for setting rating factors.
    e. Setting free cover limits for different groups based on occupation/profile.
    f. Support in framing the policy terms and conditions.

(2 Marks)

2. Renewal process set up for group PMI.
3. Setting criteria for maximum cover to be allowed
4. Setting credibility factors
5. To get expertise on product design
6. To get expertise on claim management
7. Limit the exposure to risk e.g., exposure to particular group /exposure to medical cost inflation.
8. To increase the capacity to write more new business
9. To enhance the capacity to take large risks.
10. Financial assistance
11. To price the product with credibility so that margins can be lower, and prices are competitive in the market.
12. To reduce new business strain
13. Allow more diversification.
14. Reducing capital requirement
15. Tax arbitrage.

(1/2 mark each, **Max 5 marks)**

ii) Key exclusions for PMI product

1. Pre-existing conditions for a specified period
2. Currently ongoing treatments in any hospitals
3. Treatments taken overseas hospitals.
4. War, terrorism & criminal acts
5. Self-inflicted injury or attempted suicide
6. Hazardous hobbies
7. Aerial activity other than as a fare-paying passenger
8. Caused by influence of Drugs / alcohol.
9. Treatment relating to standard pregnancy, and complications of pregnancy and childbirth.
10. Out-patient drugs
11. Any surgeries which are not clinically mandate e.g., cosmetic surgery, gender change, preventive treatments.
12. Unauthenticated treatments/drugs
13. Dental procedures

(1/2 mark each, Max 5 marks)

iii) Types of reserves under group PMI

1) Unearned premium reserve (UPR) – portion of premiums received in respect of future periods of insurance that is not yet expired.

2) Unexpired risk reserve (URR) - reserves held in excess of the UPR where it is realized that the actual experience is poorer than priced basis & UPR is inadequate to meet future claims and expenses in respect of the future periods.

3) Outstanding claims reserve / Reported but not settled in full reserve - This is in respect of claims notified to the insurer but not yet fully settled / pending for decisioning.

4) Incurred but not reported - This is in respect of claims that have arisen but that have yet to be notified to the insurer.

5) Incurred but not enough reported - This is as above but where it is felt that not all detail has yet been submitted and a provision needs to be established for the remainder.

6) Equalisation or catastrophe reserves - These are reserves where it is felt that the current year is atypical, and amounts will have to be held back for abnormal events.

7) Investment mismatching reserve - This is to allow for the extent to which the assets held do not match the liabilities.

(1/2 mark each if only named & 1 mark each if definitions are correct
Max 5 marks)

iv) Possible causes and consequences of poor-quality data:

Possible causes:

A. System Weaknesses:

1. Records not stored appropriately and loss of data.
2. Human errors in the process of capturing data
3. Not having adequate controls to ensure correctness of data / reasonability of data.
4. Not having proper validations to ensure correctness of data, for example
   a. Age as per File and use boundary limits.
   b. Date of birth not after the date of entry to the scheme
   c. Sum assured as per limits.
   d. Policy term & premium paying term as per the combos permitted for the product.
   e. Missing information for important fields like occupation, smoker status, health status
5. Historical transactions not stored appropriately.
6. Systems are too old. Outdated/legacy systems.

B. Operational / Process Flow:

1. Digital onboarding systems may have weaknesses, for example lack of identity check and hence susceptible to identity theft, fraud, or customer inputting incorrect data.
2. Lack of compulsory fields creating gaps in client records and eventual gaps in valuation data
3. Lack of checks on whether data have been manipulated when data is transferred from one system to another within the company.

4. Errors in the process that create the data extraction.
5. Financial data – data obtained from untrustworthy sources.

C. Inadequate / Poor Controls:

1. Lack of regular and random comparisons of stored data and the physical copies of customer data
2. Lack of effective user access rights documentation and implementation such that individuals who are not supposed to have access to systems can make changes to data without consequences.
3. Lack of effective access control mechanisms including strong password systems
4. Lack of maker-checker system to ensure that all data is checked and validated.
5. Lack of regular independent auditing of data records and systems to ensure quality is maintained consistently.
6. Lack of checks / reconciliation between policy and claims data
7. Lack of reasonableness data checks. e.g., checks on averages.

D. Human Issues:

1. Inadequate training / incompetent staff involved in capturing of data records resulting in more data errors.
2. Lack of accountability and there are no consequences for capturing data incorrectly.
3. Presence of a poor data culture that does not recognise data as a key asset within the organisation.

Consequences:

1. Poor quality valuation data lead to incorrect financial results such as,
    a. Under/over reserving
    b. Incorrect calculation of capital requirements
    c. incorrect solvency capital workings
    d. under/overestimating of profits of the company due to incorrect reserving & capital workings
2. Issues with underestimating of reserves & capital are,
    a. higher than optimal tax being paid by the company.
    b. excessive dividends being distributed.
    c. The company may end up having insufficient financial resources to meet future claims or being insolvent.
3. On the other hand, overestimating reserves and capital may lead to inefficient use of capital / financial resources.
4. The regulator may impose fines on the company.
5. This may also result in negative assessments by credit rating agencies / financial press.
6. This could lead to damage to Company's brand name / reputation and cause negative impact on the market.
7. Reputational damage could affect Company's future persistency and new business sales.
8. Poor quality valuation date could also lead to incorrect premium rates if they are also being used for pricing purposes.
9. If premium rates are much higher than intended, this could lead to high lapse at renewals and loss in new business thereby higher per policy expenses / financial losses.

If premium rates are much lower than intended which are not sufficient to cover underlying risks, Company may end up with significant financial losses.

(Max 7 marks)

[Max 22]

Solution 6:

i) Investigations to be done:

1. The actuary would carry out an analysis of surplus.
   a. Each item that contributes to the profit and loss account of the business would be looked at, in turn.
   b. The positive cashflows for the insurer's PMI portfolio are Premiums received, Reinsurance claims & Investment returns.
2. The negative cashflows for a PMI portfolio are Policyholder claims, agents commission, Reinsurance premiums & expenses.
3. A comparison of actual experience against assumed in the pricing basis would be carried out.
4. If the experience of any of these components materialises to be worse than that assumed in the pricing basis then the portfolio will make lower profit margins or even losses.
5. As PMI is short-term business, the analysis of profit will generally involve consideration of claim and expense ratios (ratios with regards to the premium or exposure) for cohorts or categories of business
6. Comparing actual ratios against those expected in the pricing basis.
7. Experience should be analysed initially at portfolio level and then wherever required further splits should be carried out.

(Max 3 marks)

Analysis of Claims

1. PMI business, being indemnity contract the claim amounts are neither fixed, nor increase with a specific index, the analysis should compare the amounts of claims incurred with those expected.
2. Claims might rise in line with medical inflation so the rate of increase could be analysed compared to a suitable index, if available.
3. While doing this analysis, provision must be made for the Incurred but not reported (IBNR) and claims which are reported but not settled as pending for assessment (RBNS)
4. After the analysis at the portfolio level has been completed, a deeper analysis can be performed in which the data is subdivided into more risk categories.
5. For example:
   a. type of contract
   b. age
   c. gender
   d. duration from entry
   e. smoker/non-smoker status
   f. medical/non-medical underwriting
   g. occupation

(Max 3 marks)

Analysis of New Business

1. The new business sales should be compared against volumes projected at the time of pricing.
2. check commissions paid against those assumed in the pricing bases.
3. The extant and impact of cross subsidies would be analysed.

(Max 1 mark)

Analysis of Renewals / persistency

1. If the assessment period includes historic periods, then the analysis should include the business which has lapsed (i.e., not renewed) during that period and is therefore no longer in-force.
2. Renewal rates will be compared with those assumed by region, branch, or specific agents (if they sell huge volumes)
3. The impact of lapses will be crucial to profitability where the pricing bases have amortised initial costs over a number of years of renewal.

(Max 2 mark)

Analysis of Expenses

1. The expenses incurred in writing the business will be compared against the assumptions in the pricing basis, including:
    a. administration costs
    b. underwriting cost
    c. claims management costs
2. Expense inflation would also be analysed against that expected.
   These analyses would be split into the same set of subdivisions as the claims analysis.

(Max 2 mark)

[Max 8]

ii) Reasons for deviations from expectations:

Claims:

1. The average claims paid per policy may be higher than the risk premium & it may be due to higher frequency of claims than expected.
2. The higher morbidity rate maybe due to,
    a. ageing population
    b. General worsening of health
    c. Unhealthy food habits
    d. More policyholders falling sick or having accidents.
    e. Poor underwriting leading to anti-selection.
    f. Greater awareness of the policy benefits leading to greater utilization
    g. catastrophic event
    h. Fraud
3. Average claim amount is higher than expected due to,
    a. Salaries of health and care professionals higher than expected.
    b. Medical technology has developed rapidly leading to new treatments which are more expensive.
    c. New drugs/medicines/pharmaceuticals developed which are more expensive.
    d. Private hospitals and other treatment providers have increased their charges for treatment may be due to greater demand or reduced supply.

(Max 5 marks)

Commission:

1. Typically, the agents commission would be fixed in advance of selling the business.
2. There could have been market pressure to pay more commission than priced ones leading to deficit.
3. There may have been more new business sold with higher commission.

(Max 1 mark)

Reinsurance:

1. If reinsurance is used, then the reinsurance premium may have increased more than the amount assumed in the pricing basis.
2. The reinsurance claims may be lower than assumed in the pricing basis.

(Max 1/2 mark)

Expenses:

1. Expenses of the insurer may have increased compared to the expenses assumed in the pricing basis.
2. Higher new business than expected may have led to new business strain.
3. Lower new business than expected may have led to costs not being recouped or higher expenses per policy.
4. Absolute expenses may have increased, for example:
    a. Salary inflation may be higher than anticipated.
    b. Claim management expenses may have increased.
    c. More staff may have been hired.
5. Technology (IT, telephony, software licenses, etc) may be more expensive than expected.
6. Unless the new business volumes sold had also been higher in proportion to the higher absolute expenses, then the per-policy expense loadings will be insufficient to cover the actual expenses.
7. Absolute expenses may be stable, but the volume of new business sold may be lower than planned and this would lead to the expenses been spread over fewer policies.
8. This would mean that the expense loading in the premium basis is inadequate to meet the real per-policy expenses.

(Max 4 mark)

Other:

1. There may have been higher reserving requirements or higher tax rates than expected.

(Max 1/2 mark)

[Max 7]

iii) Actions to be taken to reduce losses:

1. If it is believed that this tied agency sells business to higher risk lives, then increase premiums to avoid lapses.
2. Have to check the sales process whether agents encourage higher utilization of certain benefits; If this is the case then the insurer should aim to educate/train in this regard.
3. Introduce sales from other sales methods like digital or bancassurance where cost is expected to be lower than tied agents.
4. The insurer could provide training to the salesforce to help them sell to lives which more closely match the risk profile of the pricing basis.
5. It could reduce the commission to the priced levels if paid commissions are higher.
6. It could introduce (or increase) commission clawback.
7. It could be that other risk factors are more prevalent in the business, e.g., it sells in a particular geographic region which carries high risk of some diseases, or it sells to people with dangerous occupations which are not identified by the underwriting process.
8. To address this problem, the insurer could strengthen its underwriting procedures.
9. It could introduce new rating factors which would lead to higher premiums for the high-risk policyholders.
10. It could increase the premiums for existing rating factors.
11. Reduce claim frequency / costs by:
    a. introducing or increasing excesses or coinsurance

b. offer no claims discounts.
c. require pre-authorisation for any treatment.
d. restricting hospital selection through bands
e. improve deals with hospitals to reduce costs.
f. it could change the policy wording to be more strict in certain benefits.
g. review its claims handling processes to ensure that all claims submitted are valid and covered by the policy.

12. Reduce expenses by:
    a. outsourcing admin or claims functions is these could be done more cheaply elsewhere.
    b. improve efficiencies.
    c. reduce staffing levels where possible.
13. Improve underwriting to:
    a. charge fair premiums reflecting the level of risk.
    b. identify higher risk applicants and determine whether to accept and on what terms.

General:

1. It could change its marketing to encourage sales from other channels.
2. If the high claims experience from this segment is due to a particular benefit, then the insurer could redesign its product to remove or limit particular benefits.
3. Introduce a retention team to improve lapses.

(Max 7 marks)
[Max 22]

Solution 7: Special terms and their appropriateness for a mental health condition

1) The special terms that might be offered are:
   a. higher premiums
   b. lower benefit
   c. exclusions of specified perils (or illnesses)
   d. postponement of a decision to a later date
   e. a different type of contract, *e.g.* a short-term accident and sickness contract.

2) Alternatively, the insurance company might:
   f. accept the risk on standard terms.
   g. offer the risk to a reinsurer facultatively with zero retention.
   h. decline the applicant.

3) An applicant with a pre-existing mental condition may accept that he/she poses a higher insurance risk and may therefore accept a higher premium, however this might make the cover unaffordable to the applicant.

4) A higher premium may be preferable to a lower benefit, as the applicant is likely to have assessed his/her income needs and have applied for an annual benefit level to meet those needs.

5) An exclusion clause, which excludes claims resulting from the pre-existing mental health condition, may be acceptable to the applicant however this may have been the applicant's main reason for applying for cover, and as such, it might not meet his/her needs.

6) It may also be difficult to prove whether a claim is a result of the mental health condition (possibly indirectly).

7) Postponement of a decision to a later date is unlikely to be appropriate, as mental health problems are often long-term, possibly recurring, conditions however, if the mental health issues are the result of a recent event, *e.g.* depression resulting from a recent death of a relative, then postponing the decision might enable the insurance company to ascertain whether the problem is likely to recur in the future.

8) Offering the applicant a different type of contract, *e.g.* a short-term accident and sickness contract, might be appropriate depending on the applicant's individual circumstances.

9) For example, the applicant may suffer from relatively short bouts of mental health incidences, in which case a short-term policy might meet his/her needs.

10) It also depends on other factors, such as the level of employer / State benefits available and the applicant's level of savings.

11) Offering the applicant standard terms is unlikely to be appropriate, although this depends on the extent to which the insurance company deems the applicant to be a higher risk, which in turn depends on:

- the occupation of the applicant
- the severity of the existing mental health condition.

12) Reinsuring 100% of the risk on a facultative basis is likely to be appropriate for very unusual risks. This is unlikely to be the case here as there may be a number of applicants (or potential applicants) who have suffered from mental health issues.

13) Declining the applicant may be the most appropriate option if the risk is deemed to be unacceptably high. However, this might lead to bad publicity for the insurance company.

14) There may be regulation / legislation on the course of action that is permitted in certain cases.

[Max 7]

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