

CHANGES TO THE SYLLABUS AND CORE READING FOR SUBJECT ST1 FOR THE 2008 EXAMINATIONS

1 Changes to the Syllabus and their impact on Core Reading

There have been no changes to the Syllabus.

2 Changes to Core Reading

Listed below are changes other than those of a typographical or grammatical nature.

UNIT 1

This has been revised and is attached.

UNIT 2 SECTION 2.2

The phrase “control cycle” has been replaced by “product cycle”.

UNIT 2 SECTION 2.3

The “typical period of sickness covered” has been shortened from two years to one year.

UNIT 3 SECTION 1.1.6

The point in relation to UK guarantees of IP and CI has been deleted.

UNIT 3 SECTIONS 2.3.1, 2.3.2, 2.3.3, 2.3.4 and 2.3.5

These sections relate to underwriting as risk management and have been moved to Unit 12 Sections 6.5.1, 6.5.2, 6.5.3, 6.5.4 and 6.5.5 respectively.

UNIT 3 SECTION 6

The Financing requirement bullet now reads:

- Financing requirement — Unless the company has substantial capital resources, it will want the benefits and charges to be designed to minimise its financing requirement. There is more scope under unit-linked products to adjust the design to achieve this than under non-unit-linked products; unit-linked versions can for example vary the nil-allocation period to reduce the length and amount of financing strain. Guarantees may have a big influence on the level of reserves that have to be established at the outset and hence the financing requirement.

UNIT 4 SECTION 2.1

The second bullet has become:

- Restrictions on the premium rates or charges that can be used for some types of contract. (see section 10 of unit 6 for more detail)

UNIT 6 SECTION 8.2

Final paragraph added:

In some territories, the regulator has given guidance as to what aspects of the premium rate basis may be considered in order to justify a change in reviewable premium rates.

UNIT 6 SECTION 11.1

The final paragraph now reads:

Any of the above services which are deemed to have a cost i.e. situations where the direct monetary gain is exceeded by the reduction in premium, the actuary should include this as an item in his costing basis. Note that further discussion of the role of reinsurance can be found in unit 11.

UNIT 7 SECTION 1.1

This has been brought forward from 2.3 originally.

UNIT 7 SECTION 2

Subsections have been subject to a restructuring.

UNIT 7 SECTION 3.1

The first paragraph now reads:

The starting point for reserving assumptions will be the expected future experience. The principles involved in deriving these assumptions will be equivalent to those used in deriving assumptions for pricing purposes — assuming that premiums are costed on a best-estimate basis. It is then necessary to apply margins to these expected values so that the probability that the resulting reserves will prove to be inadequate is below an acceptably low figure. What is “acceptably low” will depend upon the reason for valuing the contracts and any relevant legislation.

UNIT 8

There has been an amount of reordering in this Unit.

UNIT 10

There has been an amount of reordering in this Unit.

UNIT 11 SECTION 5.3

A final paragraph has been appended as follows:

Examples of the above might be a chemical explosion (a single event) giving rise to a number of claims which together might exceed an insurer’s retention, though individually they would not, or claims arising from the discovery of a new method for diagnosing heart

disease prompting surgery (common peril), which again in combination necessitates reinsurance payout.

UNIT 12 SECTION 6.5

Additional Subsections have been added (moved from Unit 3) as follows:

Section 6.5.1 was formerly Unit 3 Section 2.3.1

Section 6.5.2 was formerly Unit 3 Section 2.3.2

Section 6.5.3 was formerly Unit 3 Section 2.3.3

Section 6.5.4 was formerly Unit 3 Section 2.3.4

Section 6.5.5 was formerly Unit 3 Section 2.3.5

UNIT 14 SECTION 3.3.1

This Section now reads as:

The data would ideally be analysed, where relevant, by:

- type of contract
- age
- sex
- duration from entry (or from start of claim for sickness terminations)
- smoker/non-smoker status
- underwritten status
- source of business
- occupation or industry for group business
- benefit conditions, for example length of deferred period

In addition, for PMI, the following factors might be considered:

- hospital band
- amount of excess
- NCD level
- geographical location
- size of group (for company contracts)

UNIT 14 SECTION 3.11

This section has been deleted and Section 3.12 renumbered accordingly.

END

UNIT 1 — PRINCIPAL TERMS

Syllabus objective

- (a) Understand the principal terms in health and care.

Note — Terms which are marked **(UK)** are deemed to be examinable under Subject SA1 only.

ABI (UK)

The Association of British Insurers, is the trade association for insurance companies in the United Kingdom.

Accelerated critical illness benefit

This benefit is provided when a policy pays the sum insured upon death or diagnosis of a critical illness, whichever occurs first. If the life assured suffers a critical illness, then the sum assured is paid and the policy is terminated i.e. payment of benefit is “accelerated” forward from payment on death. Some policies accelerate a portion of the sum assured in which case the contract stays in force and pays the *balance* of the sum assured upon subsequent death. Most policies accelerate 100% of the sum assured.

Access to Medical Records Act (UK)

This legislation sets down the rights that an individual has in relation to the disclosure of the information contained in their medical records. It applies to reports obtained for insurance purposes (i.e. underwriting and claims) or in connection with employment.

Acute illnesses

Illnesses or conditions of a non-degenerative nature where a cure is a reasonable prospect. In the UK, PMI generally only covers surgery and other treatment for illnesses deemed acute.

Additional conditions

The critical illness conditions, apart from the core conditions and total permanent disability, for which model wordings are available.

ADLs

Activities of Daily Living, a number of functional tests against which disability can be measured.

Affinity group

A group of people with something definitive in common, often membership of a particular organisation, but not common employment.

Age-at-entry pricing

This phrase relates to the practice in some PMI markets of calculating premiums with due allowance for the increasing age of the policyholder over the prospective period of cover (often to age 65). The insurer usually retains the right to increase premiums subsequently to allow for medical inflation or medical inflation in excess of levels assumed in the original calculation.

AIDS exclusion (UK)

Virtually all companies writing individual IP business have some form of AIDS exclusion. Since the introduction of the Disability Discrimination Act there has been a move away from the cancellation type clause. There is a wide variety of wording. In practice, many of the terms used are defined at length to ensure that clauses are legally watertight and provision is usually made elsewhere in the contracts for appropriate blood testing.

There are two broad categories of AIDS exclusion found within the individual IP market:

CATEGORY 1: Companies which exclude disability “caused” directly or indirectly by HIV infection.

CATEGORY 2: No benefits are payable once HIV infection has been established.

AIFA (UK)

The Association of Independent Financial Advisers. This is a trade body set up (previously known as NFIFA) to advance the interests and status of IFAs.

Anti-selection

People will be more likely to take out insurance contracts when they believe their risk is higher than the insurance company has allowed for in the premium. This is known as anti-selection.

An example in critical illness cover may be where an individual begins to suffer pains in the chest. He takes out a policy without mentioning the chest pains and then goes to the doctor to see if the pains are due to heart disease. If they are, then there is a greater likelihood of a claim for benefit.

Anti-selection is also recognised in the tendency for sick or sub-standard lives legitimately to renew policies or take up options providing additional cover without evidence of health.

Assessment period

The period during which the insurer will assess a condition before making a decision on whether or not to accept a critical illness claim. The assessment period will not normally be longer than 12 months, as long as all the evidence needed has been provided. Also, the assessment period should only apply to claims for the conditions which must be permanent for cover to apply.

Asset share

The asset share is the retrospective accumulation of past premiums, less expenses and the cost of cover, at the actual rate of return on the assets. The accumulation could be done for a single contract or a group of contracts. It is also referred to as the earned asset share or the retrospective earned asset share.

Bancassurers (Bancassurance)

This term is generally used to describe companies who offer financial services that encompass both banking and assurance operations. A major objective is to cross sell the products of one operation to the customers of the other.

Benefit limitation

Benefit limitation is required so that the claimant with an IP policy retains a financial incentive to return to work.

Many companies impose more stringent limitations for higher salaries in excess of specified limits and many companies have an overall maximum benefit. When calculating the amount to be paid to the policyholder, many companies deduct any other income that the claimant may receive if benefits are up to the maximum. The effect on income net of tax is also very relevant as there may be certain circumstances where the benefit permitted by the formula is more than that required to maintain a claimant's net income at his or her pre-disability level.

Benefit limitation (UK)

A comprehensive guideline on benefit limitation is included in the ABI Statement of Best Practice. The guideline covers monetary maxima, percentage limitations and offsetting other sources of income. The move away from a formula based on 75% of gross pre-disability income has continued since the Budget in November 1995 in which individual IP benefits became tax-free.

Budget policies

Cheaper policies (generally PMI policies) with restricted cover. Examples of these are PMI policies with excesses (the insured bears the first tranche, a pre-specified fixed sum, of each claim), policies contingent on public service waiting periods (cover is only provided where the official waiting list is longer than a pre-specified time, often six weeks) and policies that provide in-patient cover only.

The term can also apply to CI policies (restricted list of diseases covered) and IP policies (limited benefit period)

Bulk rate or Unit rate

These refer to a premium rate applied uniformly per head on large schemes across a membership type (independent of actual members' ages or sex).

Burning cost

Typically burning cost is the estimated cost of claims in the forthcoming insurance period, calculated from previous years' experience adjusted for changes in the numbers insured, the nature of cover and medical inflation. The term can also be used to describe the historic cost of claims only.

Capitation

This term relates to the practice of charging for cover by forecasting the likely claims on an individual basis and charging this, adjusted for expenses and profit, as the premium. In effect, the insurance company "carves out" a set of medical benefits (such as dental claims or mental health claims) and passes this risk onto the provider, by giving a proportion of the insurance premium for each person managed to the provider up-front rather than an amount per claim.

Capitation (UK)

It is found in the UK in the field of dental covers where the dentist anticipates the costs incurred by his/her patient.

Career break

A career break clause allows the policyholder to resume his or her coverage after a break in employment, subject to time restrictions. Career break is becoming an increasingly common feature of IP contracts.

Cash Plans or Hospital Cash Plans

These products pay a pre-specified cash sum on the occurrence of certain medical events (hospital stays, physiotherapy, need for spectacles, etc.). Typically the benefits paid are low relative to the true cost and represent cash in hand not indemnity rather than indemnity benefits.

In the USA, "hospital cash plan" is the term used for an indemnity product.

Change of occupation

A requirement on IP and possibly CI insurances is that the insured must notify the insurer of a change in occupation, possibly resulting in the insurer reclassifying the policyholder to a different occupation class and so revising premiums or disability definition.

Change of occupation (UK)

This has now largely been dropped in the UK.

In the UK, the ABI Statement of Best Practice says that where the insurer periodically writes to the policyholder because of the need to review premium rates or to increase premiums or benefits, it should bring to the policyholder's attention his or her duty to notify any change of occupation.

Chronic illnesses

Chronic illnesses are degenerative and/or generally incurable. The purpose of any treatment is palliative.

Chronic illnesses (UK)

In the UK, PMI does not generally cover treatment for chronic illnesses, although some insurers will offer treatment for cancer which includes palliative care.

Claim escalation rates

This is the rate at which claims, in the course of payment, escalate under IP or LTC policies. Unless otherwise stated, they compound annually.

Claim escalation rates (UK)

In the UK, escalation rates for claims fall into three specific categories:

- benefits increase in line with the Retail Price Index (RPI)
- benefits increase in line with National Average Earnings (NAE)
- the policyholder is offered a choice of set percentage increases

Increases may be subject to a maximum or minimum rate. The majority of escalating policies today in the UK link to an index and benefits increase both prior to and during claim payment.

Claim notification period

In order to improve claims handling procedures, many companies require that claimants notify them of potential claims at an early stage. Currently the notification requirements of companies fall into two broad categories:

- The insured is required to notify the company a set time after the incapacity begins, irrespective of the deferred period.
- The insured is required to notify the company at a set time before the end of the deferred period.

The purpose of this period is twofold. First, to ensure valid claims are ready to be paid at the end of the deferred period. Second, for the purposes of early intervention from a claims management perspective.

Claim notification period (UK)

In the UK, the ABI Statement of Best Practice includes a Guidance Note on claim notification period.

Claims — late notification (IP)

To protect itself from financial disadvantage, an insurer will set up rules for dealing with claims that are notified very late (i.e. notification occurs after the end of the deferred period).

Practice on the late notification of a claim varies greatly.

The options might be:

- Back-date the claim to the end of the deferred period if supporting medical evidence can be provided.
- Subject all claims to individual consideration.
- Treat the date of notification as the date benefit becomes payable.
- Assume that incapacity started at a set period prior to notification. The set period is normally in line with the claim notification period required.
- Assume the commencement of disability to be the date of notification.
- Postpone the commencement of the deferred period.
- Do not backdate benefits, so that benefits will be lost.
- Reduce the benefit payable.
- Delay benefit payment if notification is not received within six months of the end of the deferred period.
- Refuse claims where written notification is not received within 90 days of the end of the deferred period.

Claims paid, claims incurred

When certain group insurance policies are to be renewed, prospective insurers are given information on claims history over previous scheme years. This comes in one of two forms:

- Claims paid, where the amounts actually paid by previous insurers in each scheme year are totalled, or
- Claims incurred, where the amounts relative to all claims that commenced in a particular year of insurance are totalled; this equates to amounts paid plus outstanding reserves.

Claims paid or incurred will also be integral components in many forms of reporting e.g. the assessment of profitability in management reports and appropriate usage is important

Claims pre-authorisation

Some PMI insurers require (others recommend) that intended courses of treatment or surgery be approved by them for policy coverage before costs are incurred. This process can often provide opportunity for the insurer to manage care provision or reduce after-the-event claim denials.

Coinsurance

The general term given to a PMI policy condition whereby the policyholder is required to pay, at least in part, for medical expenses incurred, maybe on a percentage basis (see also *Excess*). In other contexts, coinsurance also refers to the situation where two insurers share the contract with the policyholder and also may refer to reinsurance on an original terms basis.

Community rating

Community rating most often refers to the practice of charging all policyholders or a significant subset of the persons insured the same premium rate irrespective of rating factors such as age, sex and medical history.

Community rating sometimes refers to the process of applying tabular rates to applicants irrespective of claims history.

Comprehensive cover

The standard or comprehensive PMI cover provides for full reimbursement of all medical costs incurred in hospitals within the appropriate bands and for such other treatments as the policy stipulates. Occasionally some high policy limits will apply (per year or per section of risk).

Continuation option

A continuation option describes a benefit under an insurance policy whereby the insured can choose, without having to provide evidence of health, to continue to avail of the cover provided by the policy under circumstances where the policy cover has otherwise ceased. Such circumstances might apply where the individual has left his place of work and is thus no longer covered by an employer-sponsored scheme or where an individual policy has expired. The terms under which the option is effected are those applicable to a healthy life for the age at the date when the option arises.

Continued Personal Medical Exclusions (CPME)

This is a variant of No Worse Terms acceptance whereby the new PMI insurer promises only to carry forward such cover for medical conditions as existed under the previous insurance policy.

Core conditions (critical illness) (UK)

The core conditions are cancer, coronary artery by-pass surgery, heart attack, kidney failure, major organ transplant, multiple sclerosis and stroke (stipulated by ABI).

Cost plus

Many of the largest group PMI schemes will self-insure. Some of these will seek to limit the possible downside by insuring against an extreme experience. Insurance will be arranged to cover the excess of a pre-agreed claims fund. Such an arrangement is called Cost Plus cover or Stop Loss cover

Creditor insurance

This is a form of cover that is effected to protect a loan or mortgage. It may consist solely of life assurance that will repay the outstanding loan if the borrower dies before it is repaid. Often cover is extended to pay off the loan following a total and permanent disability and, more recently, critical illness. Cover can also be effected to cover repayments during temporary disability or unemployment.

Day case admissions

This term relates to the increasing practice of treating the more straightforward operations in hospital surgical units on the day of admission, occupying a bed but being discharged the same day.

Deferred period

This is a term most often encountered in IP insurance. The meaning is given as “the period of incapacity before any benefit is paid”.

Deferred period (UK)

In the UK, deferred period is a generic term under the ABI Statement of Best Practice. Terms such as “waiting period” and “elimination period” should no longer be used for this concept.

The Statement also includes a Guidance Note on deferred period.

The standard deferred periods offered by companies are 4, 8, 13, 26 and 52 weeks or their equivalents in terms of months i.e. 1, 2, 3, 6 or 12 months (see *Waiting period* below). Group schemes may offer 28 weeks deferment.

Definition of incapacity

The majority of companies effectively have a standard definition of incapacity which means “totally unable through sickness or accident to follow own occupation and not following any other for profit or reward” although the exact words used are by no means the same. This definition is normally applied throughout the duration of the contract.

Some companies amend their definition of incapacity after a certain claim period has elapsed (usually two years).

Most companies reserve the right to apply an alternative definition of incapacity depending upon the occupation of the insured.

Some companies have introduced a definition of incapacity based on an abilities test. Under this plan, benefit payments are limited to a maximum of 24 months if the person is incapacitated under the mental health section. The mental health limit of 24 months can, in theory, be applied to any product. It is not a requirement of a contract with an ADW trigger (and many ADW plans do not have the 24-month limit)

Companies will also generally use different definitions of incapacity when cover is offered to housepersons and where cover is maintained on a restricted basis during a period of unemployment. For more information see the sections *Housepersons* and *Unemployment*.

Definition of incapacity (UK)

In the UK, the ABI Statement of Best Practice includes a Guidance Note on Definition of Incapacity (own occupation) under IP policies.

Direct marketing

The marketing of products directly to the potential customers with no intermediary or sales person involved. This could be via the mail, by advertising in newspapers or periodicals, by telephone, email or the internet. In all situations the customer is invited to apply for the product, usually directly to the insurance company.

Direct sales force

An insurance company that employs the services of sales people to sell only their products directly to the customer is said to operate a direct sales force. The sales people may operate on a self-employed basis.

Earned premium

Earned premium is the proportion of premiums written and received that relates directly to the expired period of cover.

For example, consider:

- A policy commencing on 1 October 2007 with an annual premium of £300. This £300 would contribute £75 to earned premiums in the year 2007 and £225 to earned premiums in the year 2008. The second annual premium would contribute £75 to earned premiums in 2008 and £225 to those in 2009 etc.
- A policy commencing on 1 October 2007 with a single premium of £800 for two years' cover. Such a policy would contribute £100 to earned premiums in the year 2007, £400 to earned premiums in 2008 and £300 to earned premiums in the year 2009.

Elective surgery

Surgery that is deemed non-emergency.

Excess, Deductible

These terms (the latter more often in the United States) are used to describe the policy condition whereby the insured is responsible for the first £x or \$x of any claim. The excess/deductible may also operate not on individual claims but on the aggregate of claims over a policy year; it may also be applied per life or per policy.

Exclusions

These are causes of disability (or “perils”) that are explicitly excluded from the cover provided by a policy.

The most common exclusions are:

- War, terrorism, acts of violence, civil unrest and such things
- self-inflicted injury or attempted suicide
- drugs
- alcohol
- hazardous past-times or sports
- aerial activity other than as a fare-paying passenger
- criminal acts
- failure to seek or follow medical advice
- complications of pregnancy
- AIDS/HIV

Experience rating

Experience rating is the process by which partial or full credibility is given to the past claims history of the risk in assessing the premium payable at renewal.

Facultative

Meaning optional, is a process of reinsurance where there are no obligations on either the insurance company or the reinsurer to offer and accept risks. The insurance company offers facultative business when and where it chooses, and the reinsurer can decide whether or not to accept it.

Fixed price surgery

This phrase relates to an agreement between a PMI insurer and a hospital (or hospital chain) whereby all surgical procedures of a particular type will be charged at a particular cost per case rate, regardless of the individual complexity. These rates are commonly referred to as “case rates” or “procedure pricing”.

Free cover

This term refers to a benefit level in a group risk arrangement, below which the member is not subject to individual underwriting. Free cover is usually a function of the number of members or aggregate of benefits provided.

General Practitioner (GP)

This phrase refers to the individual's own doctor, who provides primary medical care and is normally the first port-of-call for all health concerns. The GP may or may not hold all individual health records pertinent to that person.

GP referral

Normal medical protocols would involve the patient being referred for secondary care after an initial consultation with his or her general practitioner.

GP referral (UK)

Most UK PMI policies require a GP Referral as a pre-condition to cover.

Group business

Insurance covering a number of individuals under a single policy document. The members of the group are linked in some way (e.g. employees in the same company or holders of the same credit card) and there is often a sponsor (e.g. employer) who facilitates in the payment of premiums and administrative matters. Membership may be compulsory or voluntary.

Guaranteed premium rates

This describes the situation where the benefit/premium relationship is set from the outset for the duration of the policy.

Health Maintenance Organisation (HMO)

A form of health organisation akin to insurance which combines a range of coverages in a group basis. A group of doctors and other medical professionals offer care through the HMO for a monthly subscription. However, only visits to professionals within the HMO network are covered by the policy. All visits, prescriptions and other care must be cleared by the HMO in order to be covered. A primary doctor within the HMO handles referrals. They are more common in the US.

HES (Hospital Episode Statistics) (UK)

Collection of statistics concerning personal, medical and administrative details of all patients admitted to, and treated in, NHS hospitals in England.

Hospital bands

The PMI insurer generally splits the hospitals permitted under the policy into categories (by price of treatment), known as hospital bands, usually three in number. The policy premium is generally scaled in line with the policyholder's choice of hospital group.

Hospital bands (UK)

A typical UK classification would be:

- Band A — London teaching hospitals and other top-ranking establishments
- Band B — other London hospitals and certain hospitals in other large cities
- Band C — other provincial hospitals

In the UK, many insurers are moving away from this classification and using more sophisticated methods of rating, such as geographical rating factors.

Hospital Cash Plan

See *Cash Plans* above.

Housepersons

People who are not in paid employment but whose contribution to a family might be measured in financial terms.

The majority of IP insurers also provide housepersons cover.

Two categories have been identified by reference to the definition of incapacity, as follows:

- CATEGORY 1: Ability to perform certain activities of daily living (ADLs).
- CATEGORY 2: Confinement to home or hospital or inability to perform normal household duties.

ICD (International Classification of Diseases)

A classification of diseases and surgical operations, by both coding and wording, in order to maintain an international standard. Most countries classify diseases using ICD-9 or ICD-10 codes.

IFA (UK)

This is an abbreviation for Independent Financial Adviser. These people are independent of any particular financial services company (contrasted to a member of a direct sales force above). They select and recommend the products they consider the best of their type using various criteria. They are known in some territories as brokers.

Incapacity

The term “incapacity” should be used instead of the term “disability”, in particular as regards the definition of disability clause in the policy contract, which should be called the definition of incapacity clause.

Increase options

There are two types of option under which increases in the benefit can be secured without formal underwriting.

The first covers those options whereby the increases in benefit are incorporated in the original contract and operate automatically.

They may be subject to pre-ordained premiums, which may:

- be level throughout the lifetime of the policy
- increase in line with the benefit
- increase by some other specified pattern

Alternatively, increments may be costed as they arise. The increase can be a fixed money sum, or be in line with a fixed percentage or some form of earnings or prices index. This second type of option is that which includes a periodic opportunity for the policyholder to increase the benefit by a fixed percentage, with the new policy being costed in the normal way, based on the then-current age and outstanding term. Increase options are found under critical illness and income protection policies.

Incurred But Not Reported (IBNR)

This term relates to claims that have commenced but for which the insurer has yet to receive notification. The insurer is required to hold reserves against such events when assessing results or submitting accounts for a particular period.

Individual business

Insurance covering an individual under a single policy document. Where the insurance additionally covers immediate family members on a joint life basis, this is also considered to be individual business.

In-patient

A person who is admitted to hospital and occupies a bed overnight.

Insurance Premium Tax (IPT) (UK)

Insurance premiums are exempt from VAT in the UK, but most general insurance premiums are subject to an insurance premium tax (IPT), currently (May 2007) at the rate of 5%.

Investigative surgery

Surgery that is undergone in order to advance the diagnosis (nature and extent of the complaint). It is generally covered under PMI products but may not be so under MME products.

IP insurance

Income Protection insurance (formerly known as Permanent Health Insurance (PHI)) provides cover against incapacity. Benefit is paid as an income (usually monthly) for as long as the disability exists up to a pre-defined age, usually 60 or 65, or retirement, if earlier.

Irreversible

Cannot be cured by medical treatment and/or surgical procedures at the time of the claim.

Key Features document (UK)

This was first introduced as a legislative requirement for regulated plans in 1995. It aims to give a “short and punchy synopsis of the product which is easy to read and capable of being understood by the investor”. It sets out the required information such as aims and purposes of the policy, nature of the policyholders’ commitment, a description of the risk factors and illustrative projections.

Keyperson cover

Keyperson products fall into 2 categories:

- Those designed to provide compensation for loss of profits.
- Life of another type policies which are taken out by the employer to cover the key employee’s salary (to facilitate the temporary recruitment of a replacement).

Limited benefits/budget plans

A number of IP providers are now offering policies where in the event of a claim, benefit payments are restricted to a certain number of years. These policies are sometimes referred to as budget plans because they are cheaper than contracts that provide benefit to the terminal age.

Linked claims

These relate to IP claims whereby a claimant, having been in receipt of claim payments, recovers and returns to work, but within a specified period (the “link period”) suffers a recurrence of the same disability, and is eligible for immediate claim payments without the imposition of another deferred period.

The standard definition refers to a linked period of 6 months.

Loss ratio

The ratio of claims incurred, including allowance for ultimate settlement amounts, to the relevant premium. In some instances, the ratio is calculated with expenses also in the numerator; but this statistic should be more properly termed the combined or operating ratio.

Major Medical Expenses (MME)

MME in the UK is a PMI product variant that pays a fixed amount (from a schedule relating to severity) to policyholders who undergo surgery of a non-investigative and non-cosmetic nature.

MME in the USA is a comprehensive PMI product type offering reimbursement for the costs of primary, secondary and tertiary care as defined in the policy.

Managed Care

Managed Care is the term given to a process whereby an insurer intervenes in the provision of medical care with the dual objective of optimising the quality of treatment for the policyholder and controlling the cost (by such means as preferred provider utilisation and claims pre-authorisation).

Medical History Disregarded (MHD)

An individual's proposal to effect insurance will be underwritten without regard to that individual's past medical history i.e. there are no exclusions for pre-existing medical conditions.

Medical inflation

This term generally refers to the annual increase in the average cost of medical treatment.

Moratorium

Certain PMI products, in place of medical underwriting, do not cover medical conditions that existed during a pre-specified period, usually between two and five years, but will then cover these conditions if no treatment, symptoms or advice takes place for a period of, typically, two consecutive years after taking out the policy. The insurer is however on immediate risk for all other conditions.

MSGP (Morbidity Statistics from General Practice) (UK)

A study carried out by the Royal College of General Practitioners, the Office for National Statistics and the Department of Health. A fourth such study took place in 1991–1992, and presents statistics on the reasons, as perceived by the doctor or practice nurse, for which people consult in general practice.

National Health Service (UK)

The NHS is the UK's public health service, originally formed to provide cradle-to-grave or womb-to-tomb free medical care, funded by general taxation. Increasingly, however, certain aspects require some individual payment at the point of claim with copays or coinsurance for prescriptions, dental care, eye glasses and other items.

No Claims Discount (NCD)

Under PMI, the insured, not having claimed in a policy year (or other specified period), will be subject to a lower premium than would have arisen if a claim had been made. An NCD system is used as own-experience proxy for more accurate risk segmentation.

No Worse Terms (NWT)

In certain circumstances, on PMI policy renewal, a new insurer will agree to offer cover at least as comprehensive and with no additional underwriting conditions as the policyholder's current policy; the renewal or "switch" is accepted on no worse terms.

Non-medical limits

Non-medical limits denote the maximum (long term) policy benefits for which one can propose without needing an automatic medical examination or PMAR.

The fact that a benefit falls within the non-medical limit is no guarantee that the proposer will not be asked to attend a medical examination. In the majority of cases the proposal will be supported by a medical report from the proposer's medical attendant, but insurers always reserve the right to call for any additional medical evidence they feel is necessary in the light of any information that they already have.

Non-proportional reinsurance

In non-proportional reinsurance, the reinsurance protection covers amounts above certain pre-defined limits, rather than splitting individual claims in given percentages. Under PMI, it will often apply to a portfolio of risks as a whole, not individual risks; the reinsurer will pay when the losses on the whole portfolio exceed an agreed limit. Examples of non-proportional reinsurance include Stop Loss and Catastrophe excess of loss cover.

Occupational classes

Occupational classes are used to rate proposers in many lines of health and care insurance. Examples of occupations that fall into different sample classes are:

Class 1 — actuary, accountant, archaeologist, astrologer, author

Class 2 — doctor, dog breeder, counsellor

Class 3 — teacher, plumber

Class 4 — roofer, Heavy Goods Vehicle driver

Occupational classes (UK)

Under IP insurance in the UK, companies use a varying number of occupational classes — ranging from 3 to 6, as well as certain special ones for particular occupations.

ONS (Office for National Statistics) (UK)

The Office for National Statistics is the Government Agency responsible for compiling and analysing many of the United Kingdom's economic, social and demographic statistics. These include the retail price index, trade figures and labour market data as well as the periodic census of the population and health statistics.

Open enrolment

Open enrolment refers to the process in some markets whereby an insurer is obliged to accept all proposers for insurance at standard rates.

Original terms

Original terms method of reinsurance is where the reinsurer has a virtually identical contract to the insurance company in respect of the reinsured portion of the risk. The reinsurer receives the same gross premiums for its share as the insurance company, except that the policy fee is normally retained in full. The reinsurer is responsible for its full proportionate share of the sum assured in the event of a claim, and, likewise, for any surrender values which are paid.

Out-patient

A person who attends hospital for treatment or consultation but who does not occupy a bed. In some markets this is known as “ambulatory treatment”

Pay beds (UK)

Beds or wards, within an NHS hospital, that are made available for private self-pay or privately insured patients. The patient or his insurer is billed accordingly for this accommodation and all treatment provided.

Permanent

Expected to last throughout the insured person's life, irrespective of when the cover ends or the insured person retires

PMAR

Private medical attendant's report which is sought by the insurer to provide further insight into an individual's state of health at the proposal or claim stage.

Pre-existing conditions (pec) exclusion

This is an exclusion used in non underwritten healthcare contracts. Under the terms of the exclusion, cover is not provided in respect of any of the critical illnesses listed in the policy which the life assured has already suffered, i.e. where the condition pre-existed at the commencement of cover. It is also usual to exclude cover for any critical illness where the life assured has previously suffered from a medical condition that gives a greater risk of that critical illness occurring.

Pec exclusions are also to be found in PMI and IP contracts.

Preferred Provider Organisation (PPO)

A PMI policy may restrict cover to such treatment as is carried out in certain medical establishments (with whom it has special arrangements, often financial) or may limit the scale of reimbursement outside these establishments. The premium for such policies where treatment must take place in a PPO will usually be cheaper than if the claimant had the choice of any possible provider.

Pregnancy clause (UK)

The pregnancy clause is an IP policy term covered by the ABI Statement of Best Practice in the UK. The Statement of Best Practice recommends that insurers should:

- (a) Cover claims arising from complications of pregnancy diagnosed by a doctor, or a consultant who specialises in obstetrics.
- (b) Cover such complications from the date on which they become incapacitated, i.e. without any extension of the standard deferred period.

There is currently considerable variation in practice. The most common approach is that “disability attributable to pregnancy or complications thereof is not covered unless the condition continues for more than 13 weeks after the termination of the pregnancy. The deferred period is then deemed to commence”.

Primary care

Primary care is the term given to such advice and treatment as provided by a general practitioner. This is not typically covered by a PMI policy in the UK, although elsewhere, primary care would be an insured benefit.

Private Medical Insurance (PMI)

A product under which in return for premiums, an insurer promises to pay certain sums of money on the occurrence of certain medical events. The product is generally one of a short term insurance class, the events are frequently surgical in nature (predominantly so in the UK) and the amounts paid usually indemnify costs incurred by the individual in receiving treatment.

Profit sharing

Profit sharing relates to the practice under group scheme business whereby the insurer rewards the group for better than expected experience with some share in the profit arising. This share might be expressed as a cash refund or as a discount against the future premium.

Proportionate benefit

Under IP policies, if a claimant takes up employment in an occupation that is different to the one from which he or she was originally incapacitated, it is usual for the continuing benefit to be reduced. The reduction will relate to the ratio that the gross earnings from the new job bear to those from the occupation against which disability was being claimed.

It is a standard requirement that disability from the original occupation continues whilst a proportionate benefit is being paid. Some companies require a full claim to be established before a proportionate benefit can be claimed.

Proportionate benefit (UK)

In the UK, the ABI Statement of Best Practice includes a Guidance Note on proportionate benefit. Among other things it is recommended that insurers should be prepared to adopt a flexible approach to proportionate benefits in order to reach a financial agreement with the claimant. This recognises that it is in the insurers' and policyholders' long term interest to facilitate a return to employment in some form.

The ABI Statement of Best Practice states that insurers who allow inflation proofing should include in the policy document details of the method and index used to make the proportionate benefit calculations.

Rehabilitation/partial benefit

This IP benefit is payable when a claimant is no longer totally unable to follow his or her original occupation and returns to it in a reduced capacity. The amount of benefit is usually calculated in the same way as that for proportionate benefit, as described above. Rehabilitation can also apply to the process of counselling where disability counsellors assist disabled persons with advice on practical matters to do with the benefit and their disability, to aid a return to work.

Rehabilitation/partial benefit (UK)

The comments on the ABI Statement of Best Practice recommendations for proportionate benefit apply equally to rehabilitation benefit.

Replacement ratio (or net replacement ratio)

This refers, in the context of income protection insurance, to the ratio of net (in benefit) income to net pre-disability income. A value less than one is desirable from the insurer's viewpoint, to provide a financial incentive for the claimant's return to work, especially given that expenses in disability may be less than those in normal (working) health.

Residence

This clause limits the countries in which the policyholder may be resident to make a valid claim, to ensure effective claims management.

There are almost as many variations on this clause as there are companies transacting business.

Reviewable premiums

A popular form of premium offered by the income protection and critical illness insurance providers is the "reviewable" premium. This allows the insurer to alter the premiums if the prospective claims experience (or indeed any aspect of the premium basis) for the portfolio as a whole is different from that which was originally expected. Most companies that employ reviewable rates undertake the reviews every five years, though experience monitoring is done on a regular basis.

Rider benefits

These can be described as extra benefits that can be added to a basic policy either at commencement of the cover or sometimes at defined policy anniversaries of the contract. These benefits would be underwritten at outset and would, of course, affect premium rates and possibly initial underwriting requirements. For marketing reasons, some riders are provided for the policyholder at no additional charge.

Riders (IP)

A number of additional benefits may be added to standard IP covers, such as:

- hospitalisation benefit
- lump sum TPD benefit
- critical illness benefit
- terminal illness benefit
- unemployment and health waiver of premium benefit
- death benefit
- state benefit option (this pays an additional IP benefit if you do not receive state benefits)
- fatal accident benefit
- retirement protection option

Risk equalisation

Risk equalisation applies in some markets where the profits or losses on specified policies or risks are pooled and reapportioned among participating insurers so that each shares in the average market experience.

Risk premium

The risk premium method of reinsurance is used when a long term insurer wishes to reinsure only the risk element (mortality or morbidity) of a policy. The insurer and reinsurer agree a set of risk premium factors to be applied to benefit reinsured; these factors will generally vary by age sex and smoker status. Under CI and other health contracts, these risk premium rates are often used as the basis for the insurer's office premium rates.

Secondary care

Secondary care is the term given to such advice and treatment as provided by hospitals, consultants and other specialists, usually after referral by the patient's general practitioner.

Smoker/non-smoker rates

Most companies offer different rates for smokers and non-smoker for long term contracts, reflecting the different morbidity or mortality of smokers and non-smokers. Smoker/non-smoker differentials would not apply to the pricing of larger group schemes which are fully experience-rated.

Stand-alone critical illness plans

These are policies that only provide cover against critical illness and do not provide (or accelerate in the case of a stand-alone rider) any benefit in the event of death. Following payment of the critical illness benefit, the policy terminates. Occasionally such policies may offer a nominal sum in the event of death before a critical illness is suffered.

Stop Loss

Similar to Cost Plus, Stop Loss is a reinsurance contract whereby an insurer's claims exposure will be restricted at some multiple of premium. The Stop Loss arrangement will stipulate a loss ratio above which the reinsurer becomes responsible for all or the majority of further claims.

Surplus reinsurance

Under a surplus reinsurance arrangement, the long term insurer will cede to the reinsurer all sums which exceed its retention on each individual life.

Switch

In this context, switch applies to the process whereby an existing PMI policyholder, individual or group, changes insurer on renewal, without further underwriting.

Telemarketing

The marketing of products via the telephone. Usually enquiries are generated by direct marketing (see above) with the customer telephoning the advertiser (usually the insurance company). The aim is to complete all application procedures over the telephone. The policy will then be despatched together with a direct debit instruction for completion and a copy of the completed application for signature by the applicant confirming the answers given to the underwriting questions.

Tied agents

Also known as Appointed Representatives. These are sales people who act more independently than a member of a direct sales force (see above), but sell only the products of one insurance company i.e. they are “tied” to one company. They enjoy more freedom in how they operate and may employ sales people themselves to sell the products of the selected company.

Treaty

A treaty is a formal agreement between an insurer and a reinsurer setting out the terms of a reinsurance arrangement. A treaty imposes an obligation on the reinsurer to accept automatically business ceded within the scope of the treaty. It also usually imposes a similar obligation on the insurer to pass business to the reinsurer which falls within that scope and other terms of the treaty

Unemployment benefit

Where cover for unemployment is provided under an IP policy, it is usually for a reduced benefit. The level is usually identical to that offered under the *Housepersons* benefit.

Some companies provide cover during unemployment but change to a definition of incapacity that requires confinement to the house (this may be extended to include a medical institution) or being unable to go outdoors without assistance. The student should note that this is not unemployment insurance — payment if insured becomes unemployed.

Voluntary Group

This describes a collection of policyholders for whom membership of a PMI scheme is voluntary. It may include affinity groups or employment groups.

Waiting period

This is a feature adopted by friendly societies under which sickness benefits will not be paid for a specific period after the member first joins the society. This waiting period may also be applied to any additional benefit from the date that the member buys the additional units of cover. It might also be called a no-claim period. See *Deferred period*.

Waiver of premiums

This refers to the practice whereby the premium for an IP or CI policy is covered in addition to the main benefit provided by the policy in the event of disability.

Waiver of premiums (UK)

The ABI Statement of Best Practice on IP includes a Guidance Note on waiver of premium which states that the definition of incapacity for waiver should be no stricter than that applying to the main benefit.

Waiver of premium is automatically included in the basic premium rates by the majority of IP providers in the UK. Practice is split between companies that refund premiums proportionately for the period during which a claim is paid and those that waive premium payments which fall due whilst the benefit is being paid.

WHO (World Health Organisation)

An autonomous health organisation set up in 1948, with the aim of assisting the population in the attainment of the highest possible level of health. WHO proposes conventions, agreements, regulations and makes recommendations about international nomenclature of diseases, causes of death and public health practices. It also develops, establishes, and promotes international standards concerning foods and biological, pharmaceutical and similar substances

Written premiums

In the case of regular premium business, written premiums are defined as the annualised amount of premiums for all policies commencing or renewing in a given period. Single premiums are deemed wholly written.

END