

# CHANGES TO THE SYLLABUS AND CORE READING FOR SUBJECT ST1 FOR THE 2009 EXAMINATIONS

## Changes to the Syllabus and their impact on Core Reading

### Objective (n)

The last bullet point has been changed from “customers’ PRE” -> “treating customers fairly”.

## Changes to Core Reading

### UNIT 2

#### Section 3.5

Second para: Delete “with 60 currently being the most common”  
Second para: sportsmen -> sportspeople

#### Section 3.8

Second para: mollifying -> reducing

#### Section 3.12, 3.12.1, 3.12.2

These sections moved to 7.2, 7.2.1, 7.2.2

#### Section 4.1

First para: Phraseology -> term

#### Section 4.8

Has been left here in error. It also appears (more correctly) in 7.3

#### Sections 4.9, 4.9.1, 4.9.2, 4.9.3

New material on tiered benefits as follows:

### 4.9 Tiered benefits

This is a variant to the standard CI policy, in which for one or more of the illnesses covered the payment of the sum assured is linked to the severity of the disease. Thus a proportion of the full benefit is paid out, a proportion that depends on the progress or extent of the illness at the time that the claim is made.

Further claims may be lodged if the disease advances and further payments made from the balance of the sum insured to reflect the increasing impairment.

The levels of severity (and proportions attaching) will be clearly specified in the policy documents using objective medical definitions. There are often four severity levels but some policies may have conditions with up to seven levels.

Premiums do not typically reduce with any proportionate claim payment.

#### **4.9.1 Reasons for offering tiered benefits**

- The CI product becomes more comprehensive; a benefit is offered at levels of disease progression which would not have triggered payment under a more standard CI contract.
- The payments, part or whole, more closely matches financial need, reducing the incentive for anti-selection and for "exaggeration" of symptoms at the claims stage.
- Multiple claims are possible which enhances policyholder satisfaction and retention.
- As a variant on the standard product, it permits the insurer to differentiate itself from its competitors.
- It makes comparisons more difficult (and the insurer's product potentially more profitable).

#### **4.9.2 Areas of difficulty**

- Finding statistics for the current (single payout) definitions is difficult enough, with insured experience still in its infancy. Having to find four times as many rates for severity levels and transition intensities between them, for all ages, both sexes and possibly smokers and non-smokers is going to be challenging with any degree of accuracy.
- The underlying incidences and transitions will change may be frequently in the future, before credible own-experience data emerges.
- There will be many overlaps between related illnesses which will make pricing more complex and the picture for the policyholder more confusing. The cross-correlation between diseases will give rise to greater potential for disallowed claims and customer dissatisfaction at various levels of proportionate benefit.
- It is going to be difficult to define the additional stages of disease that trigger benefit that are both legally and medically objective while being understandable to the consumer. Weaknesses in definitions could result in more claims even if the probabilities are as anticipated.
- The actuary faced with these pricing risks is likely to prefer the absence of any guarantees, significant margins in the assumptions and co-operation with a knowledgeable reinsurer.
- The underwriter is faced with the prospect that the bringing forward of potential claims situations is going to increase the importance of any pre-existing conditions and change the seriousness of any material non-disclosure.

- The claims manager is going to be faced with considerably more claim forms, with complex definitions and significant policyholder (and possibly insurance advisor and general practitioner pressure) to “upgrade” to a higher level of benefit. Initially at least, there may be no market consistency of approach.

### **4.9.3 Meeting customer needs**

- A closer fit possibly to medical distress and financial needs.
- May be deemed more comprehensive and more fair.
- A lot will depend on whether the policyholder has to pay more, less or the same amount in premiums than for a standard policy covering the same illnesses.
- It is undoubtedly a more complex product and one that is difficult to compare with other (tiered or level) CI products; this may reduce its appeal to the prospective policyholder or to his/her financial advisor.
- The potential is there for a higher degree of claims dispute.

#### **Sections 5.3, 5.3.1, 5.3.2, 5.3.3**

Section 5.3.2 has moved to 7.4.1. Section 5.3 has been moved to 7.1. Other sections deleted.

#### **Sections 7, 7.1, 7.2, 7.2.1, 7.2.2, 7.3, 7.4 and 7.4.1**

These have all been moved as described above.

#### **Sections 8, 8.1, 8.2**

These are moved from Unit 3 sections 4, 4.1 and 4.2.

## **UNIT 3**

### **Section 1**

The subsections of this chapter have been restructured so that each of the four main products is considered under the five headings “To meet specific needs”, “To provide cash”, “To allay fears”, “Simplicity and clarity” and “Guarantees and reviewability of premiums and benefits”

#### **Section 1.1**

This is new:

“General

The benefits offered need to be attractive to the market in which the contract will be sold. From a customer viewpoint thus, it should meet needs, it should be clear in purpose (in risks covered and in benefits payable), it should have a charging structure which the

customer finds appropriate (e.g. the addition of options and guarantees), and, above all, it should have a premium level which makes the customer happy to buy.”

### **Section 1.1.1**

This section is a compound of former sections 1.1.1, 1.2.1, 1.3.1 and 1.4.1, with appropriate deletions to eliminate overlap.

### **Section 1.1.2**

This section is a compound of former sections 1.1.2, 1.2.2, 1.3.2 and 1.4.2, with appropriate deletions to eliminate overlap.

### **Section 1.1.3**

This section is a compound of former sections 1.1.3, 1.2.3, 1.3.3 and 1.4.3, with appropriate deletions to eliminate overlap.

### **Section 1.1.4**

This section is a compound of former sections 1.1.4, 1.2.4, 1.3.4 and 1.4.4, with appropriate deletions to eliminate overlap.

### **Section 1.1.5**

This section is a compound of former sections 1.1.5, 1.2.5, 1.3.5 and 1.4.5, with appropriate deletions to eliminate overlap.

## **Section 2.1**

The following has been added as a final para: “A company will want to ensure that the premiums charged for contracts will be sufficient to cover the benefits provided and the expenses in most foreseeable circumstances, with, for proprietary companies, a surplus to reward shareholders whose capital has been risked in support of the company”

## **Section 2.2**

The following has been inserted as a penultimate para: “Consideration will need to be given to the acceptability of the level of risk associated with a proposed contract design. The level of risk acceptable will depend upon the company’s ability or willingness either to absorb risk internally or to reinsure it.”

## **Section 2.9**

“, maybe” has been deleted from the third para

## **Section 2.10**

“hot potatoes” -> “sensitive”. The word “political” preceding this should have been changed to “politically” but has not been.

### **Section 3.1**

Fourth line: Probity -> integrity

### **Old sections 4, 4.1 and 4.2**

Moved to Unit 2 sections 8, 8.1 and 8.2

### **Section 4**

New para: "These factors are not necessarily independent. Meeting one objective may prejudice the meeting of another, and so a compromise must be struck"

### **Section 4.1**

Fourth para added "A company needs to decide on the extent of any cross-subsidies between for example large and small contracts. The marketing advantage of a simple premium or charging structure may conflict with a desire to avoid cross-subsidies"

### **Section 4.3**

First line: apply -> applies.

### **Section 4.6**

A second sentence has been added to the final para: "The system requirements of a new product may limit either the benefits to be provided or the charging structure to be adopted".

### **Section 4.8**

This has been derived from the old section 6 third bullet

### **Section 4.9**

This has been derived from the old section 6 fourth bullet

### **Section 4.10**

This has been derived from the old section 6 tenth bullet. The old section 6 has otherwise been deleted.

## **UNIT 6**

### **Section 1.6.2**

First para now reads: "There are two conflicting aspects in comparing population data and the experience of insured lives. The latter should be healthier and less prone to claim because they have been underwritten and the less healthy declined or loaded. If the policy is deemed non-essential. the population proposing for insurance are arguably doing so because they expect to gain from the contract. Those not expected to claim will keep their money in their pockets and not buy a policy"

### **Section 1.6.3**

Final sentence now reads: “In particular, the actuary will adjust for the specifics of his company’s underwriting and claims management, which may not be known to the reinsurer.”

### **Section 4.1.2**

Sentence added to final para: “The Actuary needs to recognise that the available data may not permit this degree of sophistication of the method in practice.”

### **Section 5**

Para added: “Individual policy premiums are generally higher than group premiums as the risk of anti-selection against the insurer is higher when an individual is financing his own premium.”

### **Section 5.1**

Section replaced with reference to unit 2 section 7.2.2

### **Section 5.3**

Para added: “Some form of experience rating is usually incorporated in PMI or IP group pricing, whereas individual business is normally priced on a community rate basis i.e. the premium is assessed with all other lives in the same risk cell without reference to individual claims experience.”

### **Section 5.4.1**

New section, mainly derived from old unit 2 section 5.3.1:

#### **Group PMI Pricing**

- The greater frequency of claim that applies with group PMI permits a wider usage of experience rating where full or partial credibility will be afforded to past history, depending on their number of member years that are available at the time of pricing. Some form of experience rating is usually incorporated in group PMI pricing and other at a level below that which a strict statistical approach would demand.
- NCDs are sometimes used for individual and group business in order to make some allowance for individual claims experience in the premium rates.
- Larger groups (more than 50 employees) are often flat rated according to benefit class, whereas individual business is almost always age rated.
- Large groups frequently self-insure up to a point e.g. 125% of expected claims cost, and purchase administration and stop-loss insurance from the insurer.

### **Section 5.5**

“a recent year” -> “one or more recent years”

## **Section 5.7**

Final sentence now reads: “The actuary must discover if there is a claims history available for this incoming group of lives; it might be significantly different from the experience of the host scheme.”

## **Section 6.1**

Third para: “do not reflect their” -> “are insufficient to cover the”

## **Section 6.2**

Under **North American method** *Example*: “year insurance” -> “year accelerated critical illness term insurance”

Under **Conventional method** *Example*: “year term insurance” -> “year accelerated critical illness term insurance”

## **Section 8.3**

Opening sentence now reads: ” Where a policy is sold at less than the full premium rate for the expected claims and expense outgo, for portfolio development or cross-subsidy reasons, reserves will need to be established for the extent to which the pricing basis is inadequate.”

## **UNIT 7**

### **Section 2.5**

Fourth para: “are often minimised by use” -> “may be reduced by the use”

### **Section 2.10**

“averages inserted” -> “commission levels assumed”

## **UNIT 8**

### **Section 1.1**

Second para has been deleted

### **Section 1.2**

This section now reads as:

- Reserve for policies — typically the discounted value of future expected claims, expenses and premium cash flows.
- Reserves for claims that have been incurred but not reported

- Reserves for claims that have been reported and not yet fully settled.
- Option reserves — additional costs which need to be set aside for the eventuality that a particular option “comes into the money” — becomes more valuable in its exercise than in its discard.
- In a group risk context, the concepts of unearned premium reserve and unexpired risk reserve will apply as defined in 1.4 below.

Note that when setting the IBNR reserve, the actuary needs to consider whether there have been any claims reported with abnormally long delays. These may arise in circumstances where the policyholder learns, some years after the disability itself, that his/her insurance policy provided protection against such an event and then lodges a claim. Such late notification is becoming increasingly common in critical illness insurance.

In some territories, the policy reserves are referred to as active life reserves and the claims reserves as disabled life reserves.

### **Section 3**

A bullet has been added: “to set investment strategy”

### **Section 4**

An initial para has been inserted: “Broadly, liabilities can be determined as the present value of future claims plus expenses (including commission) plus taxes (if appropriate), less premiums. The greater the margins that are employed in the assumptions (e.g. lower discount rates), the more prudent is the calculation.”

### **Sections 11, 11.1, 11.2 and 11.3**

These sections have been added as follows:

## **11 Embedded value**

### **11.1 Calculation of embedded value**

Embedded value is the present value of shareholder profits in respect of the existing business of a company, including the release of shareholder-owned net assets.

It can be calculated as the sum of:

- The shareholder-owned share of net assets, where net assets are defined as the excess of assets held over those required to meet liabilities. These assets may be valued at market value or may be discounted to reflect “lock-in”, for example if they are required to be retained within the fund to cover solvency capital requirements.

- The present value of future shareholder profits arising on existing business. The process of determining this amount is similar to performing a profit test, bearing in mind that some elements will not be applicable (e.g. new business expenses). The calculation may differ for different types of business. For example:
  - Conventional without profits business: the present value of future premiums plus investment income less claims and expenses, plus the release of solvency reserves.
  - Unit-linked business: the present value of future charges (including surrender penalties) less expenses and benefits in excess of the unit fund, plus investment income earned on and the release of any non-unit reserves.

For without profits business, embedded value is effectively the release of any margins within the solvency reserves relative to the assumptions used within the embedded value calculation. It is important that the reserves used in the determination of net assets are consistent with those used in the determination of the present value of future profits.

Tax is allowed for within the calculation as appropriate.

The higher the discount rate, the more prudent is the calculation.

## 11.2 Appraisal value

The starting point in valuing a long term insurance company for sale or purchase will be the embedded value. However, an important element of the price is likely to be goodwill, corresponding to the estimated profits expected from future business. The sum of embedded value and goodwill is generally known as “appraisal value”. Further consideration of goodwill is beyond the scope of this Subject.

## 11.3 The assumptions that might be appropriate

If an embedded value is being prepared for published accounts or internal management accounts, then the principles to be applied in setting the assumptions are as outlined in section 4 above.

If an appraisal value is being prepared as a sale value, then it is likely to be based on realistic assumptions without margins. A purchase value may be based on cautious assumptions that include margins.

### UNIT 9

#### Objectives

“customers’ PRE” -> “treating customers fairly”

#### Section 1

Add to third bullet “and the company’s appetite for risk”

## Section 2.4

The first para now reads:

“The regulatory framework within a country may limit what a company would like to do in terms of investment. The following controls may be implemented:

- restrictions on the types of assets in which a provider can invest
- restrictions on the amount of any particular type of asset that can be taken into account for the purpose of demonstrating solvency
- a requirement to match assets and liabilities by currency
- restrictions on the maximum exposure to a single counterparty
- custodianship of assets
- a requirement to hold a certain proportion of total assets in a particular class - for example government stock
- a requirement to hold a mismatching reserve
- a limit on the extent to which mismatching is allowed at all”

## UNIT 11

### Section 3

This is a new section inserted. Subsequent sections thus will be renumbered.

### “3 Reinsurance Commission

Reinsurance commission is used to describe a payment from the reinsurer to the insurer. For tax purposes this would typically be treated as an expense for the reinsurer and a negative expense for the insurer. If the basis of tax treatment of reinsurers and insurers differs then there may be value in structuring this payment in a different way. For example, in the UK insurers are taxed on an “Investment income minus expenses” approach while reinsurers are taxed on profits. The value of the commission payment to the insurer is reduced by the value of the extra tax that is payable. To avoid this problem the reinsurance arrangement may be structured so that the insurer deducts the commission from the premium before making the payment to the reinsurer. In this case the commission will be called a rebate and will have no impact on the tax calculation.

In the following sections the term commission can also be read to mean a rebate.”

#### Section 5.1 (formerly 4.1)

Final para: Delete “and are usually payable annually”

#### Section 5.2.2 (formerly 4.2.2)

Delete first sentence “This ... covers.”

Third para. Delete first sentence: “No commission is payable.”

Add a new para: “With risk premium structures changes in the insurer’s premium rates will not necessarily require changes in reinsurance rates. They therefore give the insurer greater freedom to respond to competitor changes in premium rates”

### **Section 5.3 (formerly 4.3)**

First sentence of second para now reads: “The level of commission offered by the reinsurer will reflect the reinsurer’s view of the expected claims.”

## **UNIT 11**

### **Section 8**

The heading now reads: “Treating Customers Fairly/Policyholders Reasonable Expectations”

#### **Section 8.1**

This now reads:

#### **“PRE/TCF as additional policy conditions**

In order to improve consumer protection many regulators impose additional requirements on insurers to ensure that they treat their customers fairly. These additional requirements can impact on the sales process, through literature provided, the claims process in terms of the claims payable as well as the whole process for managing the customer relationship. Often there will be generally accepted provisions that products of a particular genre should encompass. The insurer will avoid promising more than the scope of the product in such ways, making all product conditions clear and explicit and will accordingly monitor sales processes.”

**END**