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SCOR The Art & Science of Risk | Life

Bridging the gap between actuarial theory and claims reality

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22 May 2017

Multi-disciplinary approach

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Agenda

- Claims experience by insurer
- Impact of regulation
- Pay as many claims as possible?
- Unclaimed claims
- Company claims philosophy
- Suicide
- Heart attack

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Claims CI Experience – by Insurer

- CMI Working Paper 89 shows the variation in CI claims experience by insurer
- The GLM A/E shows the variation in results after allowing for differences in other factors (sum assured band, distribution channel, product category, commencement year, calendar year)

Office	Full A/E	Modelling A/E	GLM A/E
Minimum	72.4%	82.3%	83.9%
Maximum	121.3%	108.9%	111.5%
Weighted Average	101.0%	101.1%	100.2%

TABLE 3 *Source: Working Paper 89/Table 5.1*

- Experience period up to 2010 calendar year. Majority of newer conditions added to contracts wouldn't impact results yet

→ Not just business mix and policy CI conditions driving claims experience

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Treating Customers Fairly

- Jump in CI claims experience in calendar year 2008 – potentially a result of introduction of TCF rules (and ABI Code of Practice)

Table 5.6: Full A/Es, Modelling A/Es and GLM coefficients by calendar year

Calendar year	Full A/E *(Number of Claims)*	Modelling A/E *(Number of Claims)*	GLM coefficient
2007	100.0% *(3,668)*	94.7% *(3,243)*	95.9%
2008	104.6% *(5,157)*	104.8% *(4,802)*	104.4%
2009	99.5% *(5,076)*	99.4% *(4,678)*	99.2%
2010	97.7% *(5,386)*	99.2% *(4,814)*	98.9%

Source: CMI Working Paper 89, Table 5.6

- 2009-2010 claims levels settle back down at roughly 3% higher than pre-TCF levels

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ABI Code of Practice

- Does application design sufficiently consider how mis-representation will be treated at claim? What more could it do?

Category	Explanation	Outcome
Innocent	- Customer acted honestly and reasonably in all of the circumstances - In the circumstances, a reasonable person would have considered that the information was relevant to the insurer.	Pay the claim in full
Careless	- Misrepresentation resulted from failure to exercise reasonable care. - This includes anything from an understandable oversight or an inadvertent mistake to serious negligence. - In the circumstances, a reasonable person would have considered that the information was relevant to the insurer.	Apply a proportionate remedy *(note could still be a decline)*
Deliberate or reckless	- Only applies where the misrepresentation was deliberate or reckless. - The customer knew, or must have known, that the information given was both incorrect and relevant to the insurer, or the customer acted without any care as to whether it was either correct or relevant to the insurer.	Void the policy (decline the claim and cancel the policy from inception)

ABI Code of Practice (April 2013)

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ABI Code of Practice

- In assessing claims, insurers should consider all of the circumstances, including:
  - How clear and concise the relevant questions were
  - Where the insurer asked a clear question, presumption is that customer realised it would be relevant
  - Not much weight should be given to ‘catch all’ or ‘memory test questions’
- The sales process and its effect on the customer – for example:
  - Whether or not an intermediary was involved and if the customer had opportunity to check answers
  - The warnings given and whether these were adequately prominent
- Intermediated sales
  - Insurers should always try to establish the facts and credibility of allegations that misrepresentation arose as a consequence of failures during the sales process and their effect on the customer
  - If the intermediary was acting on behalf of the insurer, and information was properly disclosed to that intermediary, then the insurer cannot claim that the information was not disclosed to it.
  - If the intermediary was clearly acting on behalf of the customer, for example, an independent financial adviser, the intermediary (as opposed to the insurer) should be accountable for any misrepresentation resulting directly from the intermediary’s action or omission

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Do we understand the FOS approach?

- FOS approach not always a legal approach
- The recent case of Insurer R v Financial Ombudsman Service discusses and reaffirms the position that the Financial Ombudsman is not bound to follow the law when making its determinations but must instead make decisions that are “fair and reasonable in all the circumstances”
- Mr M took out a TA policy with Insurer R but (due to an impairment of his mental state brought on by early onset dementia?), he did not disclose to Insurer R that he had already been referred to a doctor to begin investigations into his possible dementia.
- Dementia diagnosis confirmed, Mr M claimed
- Insurer R declined on the basis that the illness was pre-existing at outset and had not been disclosed.
- Court agreed that Insurer R acted correctly in accordance with the law in declining claim.
- Despite that, the ombudsman made an award in Mr M’s favour on the basis that it was not reasonable to expect him to have made the proper disclosures to Insurer R given the illness from which he was suffering.

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Do we understand the FOS approach?

"Have you ever suffered from any; mental or nervous disorder (including anxiety, depression or stress), ear or eye disorder (excluding long or short sightedness), arthritis or any back, spine or other recurrent joint disorder, asthma, bronchitis or other chest complaint, mole or freckle that has bled, become painful, increased in size or been removed, numbness, tingling or temporary loss of muscle power, blurred vision, double vision or optic neuritis?"

- Mrs XXXX said she felt it unreasonable that she be expected to remember every visit to a doctor for minor matters which had not caused any concern. She also felt the second question to be unclear.

- I share the adjudicators view that the second question was a "catch all" type. It included a long list of unrelated questions, making it easy for certain conditions to be missed or overlooked.

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So just pay as many claims as possible?

- Industry focus on improving paid claims statistics and driving down decline rates

> **Are the number of successful claims for Critical Illness insurance rising?**
> Yes, this year's figures illustrate that the number of Critical Illness insurance claims being paid has risen. The percentage of claims paid is 93.1% in 2015, an increase from 92% the previous year. This has increased considerably since 2005 when it was 80%. This increase is largely due to the ABI's Code of Practice on non-disclosure which was first issued in 2008. This document clarified which medical information customers needed to share with insurers and how insurers would treat non-disclosure (also known as misrepresentation) when a claim is made. This clarification has led to a marked increase of claims being paid rather than declined.

ABI 2015 Claims Statistics Press Release (April 2016)

- Improves perception of insurer and industry but there are costs
  - All customers being treated equitably by paying claims that don't meet condition or have mis-representation?
  - Increased claims payouts → increased claims and/or reinsurance costs → increased customer premiums

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‘Unclaims’ (the Unclaimed Claims)

- We can see long IBNR periods, particularly on CI
  - Do your claims team ask how the claimants knew they had a claim or why it took so long to claim?
  - What impact may there be if more people realised they had a valid claim…or submitted a claim more quickly?

- What is your policy on paying interest on delayed claims?
  - Pay from diagnosis/death date to settlement date?
  - Pay from notification date to settlement date?
  - RPI? Fixed rate? Base rate?
  - A delay of six months from diagnosis date to settlement date could add 1.5% to claims cost if using RPI

- Example:
  - Claim amount £300k
  - Customer notified 3 years after the claim event, settled 3 months later
  - Pay interest at RPI (3.1%) from diagnosis date
  - That’s extra 10.4% in interest to pay i.e. £31k extra

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Do you know your company's philosophy?

Condition	Example
Terminal Illness	
Terminal Illness near end of term	
Ex-gratia claims	
Child claims	
Heart attacks	Changing definitions
Claims on multiple CI policies	What if the condition wording is different between policies? Or reinsured by different reinsurers? Or different information provided by customer at outset?
Symptoms arise before end of term	
Claimable event before lapse	Claimable event occurred after a missed premium but still in grace period
Suicides – policy has no exclusion	Death by suicide where life assured had stated intent to take out life insurance in order to provide pay out when he committed suicide
Suicide	What is death by suicide?

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Suicide

- What is a suicide?
- Which claim causes would be considered as a suicide in your claims philosophy?
  - Are these consistent with the reinsurer's understanding?
- Is the policy wording strong enough to support the philosophy?

ICD-10	Description
X60–X84	Intentional self-harm
Y10–Y341	Injury/poisoning of undetermined intent
Y87.0/Y87.22	Sequelae of intentional self-harm/injury/poisoning of undetermined intent
Notes:	
1. Excluding Y33.9 where the coroner's verdict was pending in England and Wales, up to 2006. From 2007, deaths which were previously coded to Y33.9 are coded to U50.9. 2. Y87.0 and Y87.2 are not included in England and Wales	

ONS definition of suicide in terms of ICD-10 codes

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Suicide Definitions

- Different definitions would result in different claims being refused

A: "We won't pay a claim if you die as a result of intentionally taking your own life in the first 12 months from the start date of your plan."

B: "The benefit will not be paid out if death occurs from self-inflicted injury, including intentionally taking own life."

C: "We won't pay a claim in the event that the life assured has died as a result of their own actions (whether or not at the time of such action they were sane or insane) within 12 months of the policy start date, or any reinstatement date."

D: "This policy will be cancelled if within the first year of the policy, the life assured dies as a result of:
- suicide or,
- intentional and serious self-injury or,
- exposing themselves to significant risk that is more likely than not to result in death"

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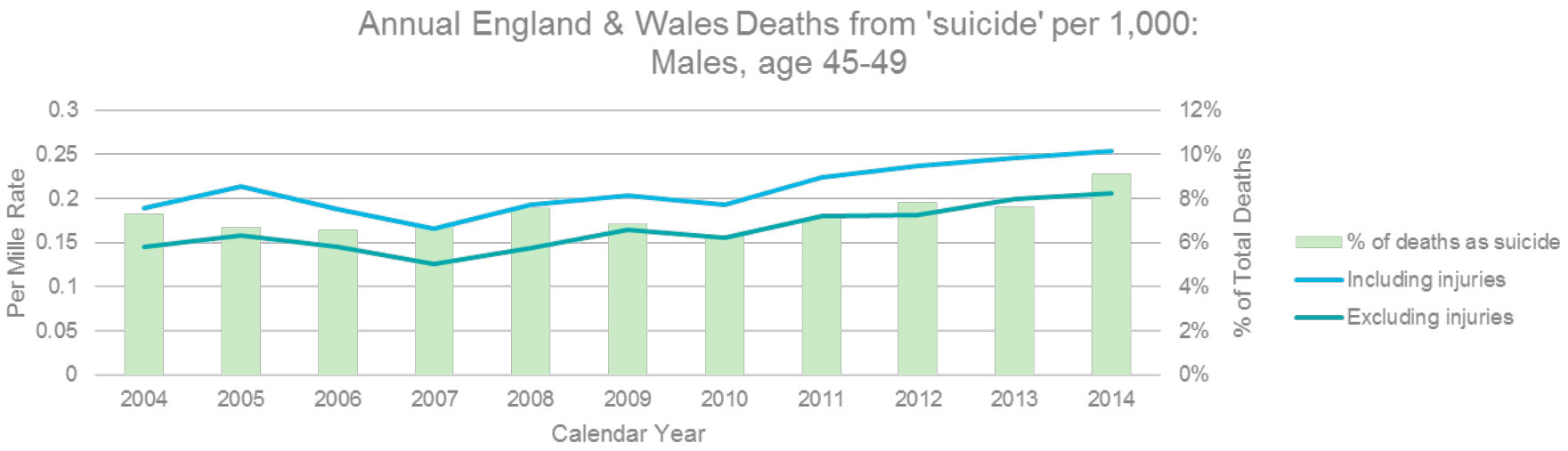
Suicide Definitions



Deaths per 1,000 in general population in England & Wales (supplied by ONS). The rate excluding injuries includes only the X ICD codes, as specified on the previous slide

- At this age group, up to 9% of male deaths are classified as suicide. The difference in classifications could impact the claims experience by up to 2% at the durations where the suicide exclusion applies

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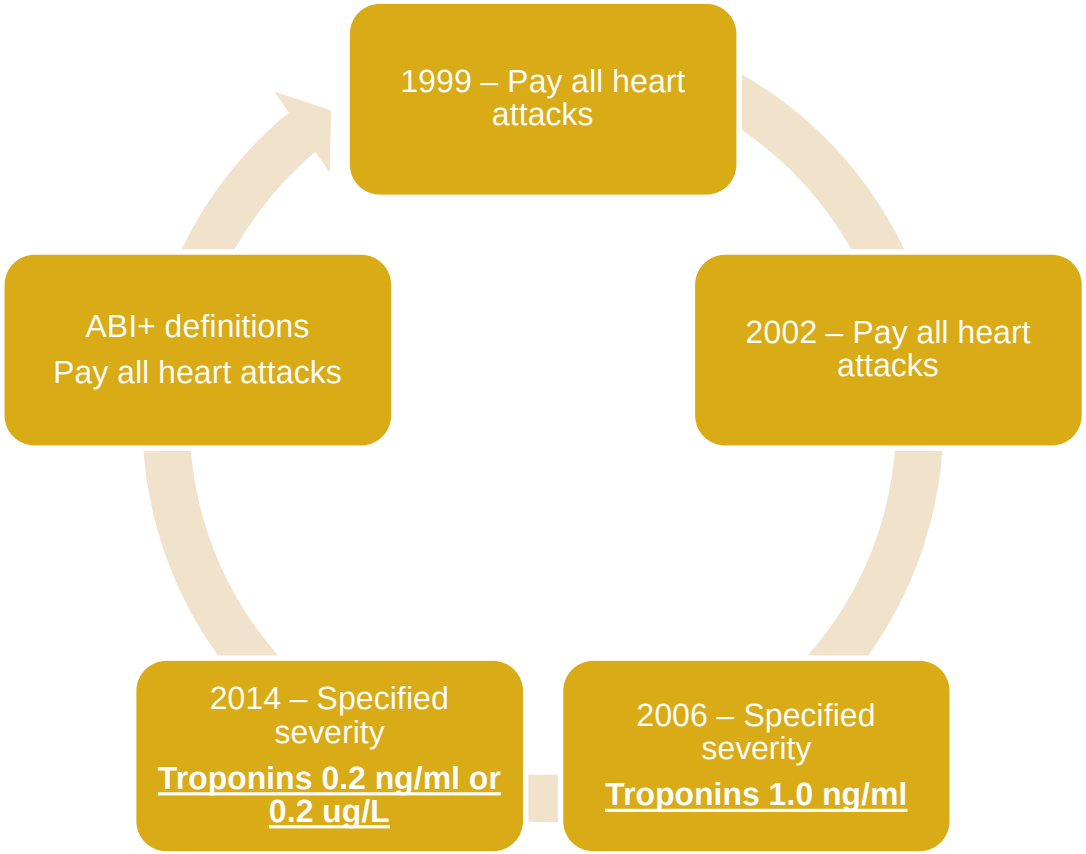
Heart Attack Definitions



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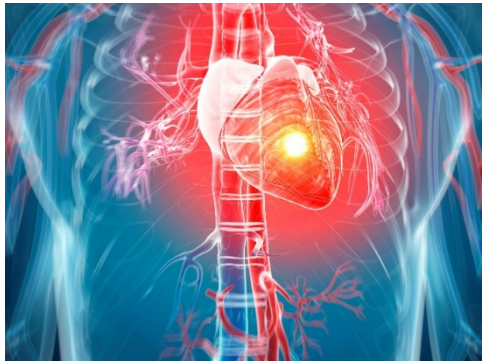
Claim Scenarios



- Mr Smith has 3 critical illness policies with insurer A
- Mr Smith has a heart attack and so makes a claim with insurer A
- All 3 policies were taken out at different times
- All 3 policies have different heart attack definitions
- 2 claims would be medically valid based on the definition it is being considered against
- 1 policy would not meet the policy definition it is being considered against

What would you do?

Policy 1

1999 – Pay all heart attacks

Policy 2

2006 – Specified severity

Troponins 1.0 ng/ml

Policy 3

ABI+ definitions

Pay all heart attacks

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Summary

- Control cycle between different departments to ensure:
  - Claims philosophy is well understood so consistent and fair approach to all customers
  - Clear approach to explain to reinsurers for best rates
  - Product design and underwriting can take account of practical difficulties
  - Marketing can use actual claims approach to help sell the products

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Questions

Comments

Expressions of individual views by members of the Institute and Faculty of Actuaries and its staff are encouraged.

The views expressed in this presentation are those of the presenters.

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