INSTITUTE AND FACULTY OF ACTUARIES

EXAMINERS' REPORT

April 2014 examinations

Subject SA1 – Health & Care
Specialist Applications

Introduction

The Examiners' Report is written by the Principal Examiner with the aim of helping candidates, both those who are sitting the examination for the first time and using past papers as a revision aid and also those who have previously failed the subject.

The Examiners are charged by Council with examining the published syllabus. The Examiners have access to the Core Reading, which is designed to interpret the syllabus, and will generally base questions around it but are not required to examine the content of Core Reading specifically or exclusively.

For numerical questions the Examiners' preferred approach to the solution is reproduced in this report; other valid approaches are given appropriate credit. For essay-style questions, particularly the open-ended questions in the later subjects, the report may contain more points than the Examiners will expect from a solution that scores full marks.

The report is written based on the legislative and regulatory context pertaining to the date that the examination was set. Candidates should take into account the possibility that circumstances may have changed if using these reports for revision.

D C Bowie
Chairman of the Board of Examiners

July 2014

General comments on Subject SA1

Candidates who approach the questions, especially the more substantial elements of each question, in a methodical and detailed manner are far more likely to pass the subject. Candidates will gain few marks if they do not address the question asked but merely write around the topic of the question. The mark allocation for each question part gives an indication of the relative length of answer or number of points to be made to gain full marks. It is often helpful to use subheadings when answering long part questions.

Comments on the April 2014 paper

Overall the paper was relatively straightforward and well-prepared candidates scored well across most of the whole paper. As in previous diets, questions that required an element of analysis or application of knowledge were less well answered than those that just involved repeating bookwork. The comments that follow the questions concentrate on areas where candidates could have improved their performance. Candidates should include these areas in their revision.

1 (i) **Need for cover**

There is generally a very low awareness of the IP product amongst consumers. People do not understand it, and its features and benefits and hence are unlikely to go to the website proactively to buy.

Complexity

The terms and conditions of the product are complex, and may be very difficult to understand. For example, there are complex restrictions on the sum insured in relation to income and salary to avoid over-insurance, restricting the amount of benefit available. In particular, this can be highly complex for the self-employed or people with many sources of income.

The cover has complex interactions with employer provided benefits and State benefits for long term sickness. If misunderstood, this can lead to over-insurance and hence restriction of benefits at claim stage. Hence it may be better to use a distribution channel that offers advice.

Underwriting

Financial underwriting needs to be performed.

Health underwriting can be complex and take a long time so the insurer may need to simplify the underwriting procedure. Customers are unlikely to understand the initial underwriting stages of the process; for example, the use of exclusions. There may be a greater risk of non-disclosure.

Underwriting at the claim stage may also be difficult for the customers to understand. Misunderstandings can lead to ombudsman rulings, lawsuits and reputational damage.

The insurer may not be able to obtain reinsurance at affordable rates or at all.

Product design

There is a wide variety of products which are not directly comparable between companies. Some products offer additional services, e.g. rehabilitation services. It can be difficult to assess which one best meets customer needs.

Similarly the customer has to make a variety of choices, for example occupational claim definition (e.g. own v. any), deferred period, waiting period. Customers are unlikely to understand these, and may choose something that is not optimal for their circumstances leading to accusations of mis-selling or problems with Treating Customers Fairly.

Price

The product tends to be expensive and therefore needs to be sold, rather than customers proactively buying it.

Small changes to the product, for example change of deferred period, can lead to large changes in price (and customers are unlikely to understand that).

Market coverage

Most providers do not offer the product directly hence the customers would struggle to compare the products and make the best choice.

(ii) The insurer could simplify the application form.

Underwriting could be simplified, for example by declining more customers rather than assessing special terms, introducing some initial predictive/automated underwriting e.g. based on answer to one question, choose which question next to ask.

Have basic financial underwriting at application stage only or make further restrictions and automated checks on income and salary to avoid over-insurance.

The product could be simplified, for example by reducing or eliminating choices available to the policyholder such as deferred periods, waiting periods or claim definition.

The insurer could offer only a basic limited benefit / budget plan version of the product.

The terms and conditions could be simplified by using plainer language, to be more easily understood.

An educational campaign could be run to improve understanding of the product and raise brand awareness.

A telephone advice team could be created that could answer questions.

Automatic referral to an advisor/ broker if the benefit requested exceeds a certain level could be instated.

(iii) Age
Basic lifestyle question e.g. smoker status
Amount of drinking
Hazardous pursuits (or suitable alternatives)
Location
Employment status
Occupation
Current income including salary
Single / joint life policy
Sum insured
Claim type (own/any occupation)
Deferred period
Waiting period

Basic underwriting questions on health status e.g. family history
Own medical history
Pre-existing conditions (or other alternatives)
Premium payment frequency
Term of policy/retirement age

(iv) This could encourage buying based on price and not on need, leading to higher lapses or reputational risks if mis-sold. This could lead to lower future new business.

This could introduce price pressures in the market to offer the lowest price to generate sales which might reduce profit margins and could even make products loss making.

If the company aims to offer the best service to consumers or better terms and conditions it may lose out as the website may not fully reflect the terms and conditions of the product or make clear all of the additional features provided. This may lead to misleading comparisons and the customer may not have purchased the best available product. Hence there are risks of accusations of mis–selling which can lead to ombudsman claims / lawsuits / regulatory fines.

There will be additional operational risks; for example internal systems and external website systems need to be compatible, and be able to "talk to" each other. There may be additional risks relating to data security.

There is a risk that the data captured by the comparison site is not sufficiently detailed or accurate.

There is a risk that premiums change upon asking additional questions, etc.

There is a risk of selling higher than expected additional new business through the comparison site channel (compared with what would have sold directly anyway) with consequent implications for admin capacity and/or capital strain.

There is also a risk of selling lower than expected additional new business through the comparison site channel (compared with what would have sold directly anyway) so the initial costs/investments of setting up the arrangement may not be recouped e.g. costs to set up system links, etc.

There is an expense risk arising of greater than expected increases in the charges levied by the price comparison website.

There is additional counterparty risk arising from reliance on the third party comparison site e.g. counterparty IT issues leading to a loss of sales and related reputational risk from association with the comparison websites if they gain bad publicity (e.g. from sales of other types of insurance).

The insurance risks may differ if the target market (e.g. by socio-economic group) differs between those using comparison websites and those who would go direct to an insurer.

There may be an increased risk of non-disclosure if customers perceive the comparison sites to be relatively detached from the insurance company.

Parts (i) and (ii) were generally well answered with candidates providing a wide range of relevant points, although relatively few candidates considered underwriting implications in any detail. Some candidates did not restrict their answers to what had actually been asked (i.e. why this particular product may not be suitable), instead writing more generally about the pros and cons of online distribution.

Part (iii) was relatively straightforward and most candidates did very well on it.

Part (iv) was also generally well answered with candidates making the points about encouraging buying on price alone rather than other aspects of a product, the counterparty risks and the issues that might arise if a large or low volume of new business were to arise. Fewer points were made relating to operational risks.

2 (i) (a) An acute condition is a non-degenerative disease, illness or injury that is likely to respond quickly to treatment and for which a full recovery is reasonably expected.

A chronic condition is a disease, illness, or injury that is degenerative and/or generally incurable. The purpose of treatment for such a disease is normally palliative.

(b) PMI normally only covers acute conditions as chronic conditions are viewed to be the responsibility of the State healthcare system (e.g. in the UK). This means that PMI providers are able to limit their claims outgo and therefore provide PMI at more affordable premiums. It is also more difficult to estimate ultimate claims costs for chronic conditions.

(ii) Cancer cannot be easily categorised as either an acute condition or chronic condition. This leads to difficulties for the PMI provider when it comes to marketing, claims management and pricing as it is not always clear cut and may lead to some inconsistencies.

Benefits for Marketing

Providing full cover will remove uncertainty on what policyholders will be covered for (related to cancer). This will provide policyholder with peace of mind. Cancer is a disease that everyone is well aware of and receives lots of publicity, so this reassurance is likely to be important.

By providing full cover, the PMI provider avoids negative publicity where in some cases it may have declined a particular claim or treatment. It also makes the product more marketable e.g. distinguish it from competitors' products.

This cover may already be offered by competitors or distributors may be applying pressure to offer this.

There may be increased consumer demand e.g. following a celebrity cancer awareness campaign, or a decline in State provided cancer care e.g. longer waiting times, reduction in quality of services or withdrawal of free cancer services.

It could increase new business volumes provided the extra premium is perceived to be good value for the additional coverage.

Existing customers will feel more valued and more likely to remain loyal customers, possibly reducing non-renewal rates and increasing take-up of other products offered by company.

Overall, the main reason is likely to be to increased profits. The providers of capital may want increased returns.

Benefits for claims management

This will provide clarity (and removes some subjectivity) around the acceptance of cancer claims.

The overall additional cost for providing this benefit may not be significant. For example because when chronic conditions relating to cancer cover were excluded, the PMI provider would likely still have paid some claims related to or caused by cancer or due to medical advances in cancer care.

Providing full cover will allow the PMI provider to be more involved in the overall treatment. The PMI provider may hence be able to reduce overall claim cost by providing more effective treatments early on or at regular intervals.

The claim underwriting process will be simpler and therefore the costs associated with this may reduce.

Providing effective treatment for cancer may also reduce claims outgo on other policies (e.g. income protection) that these policyholders may also have with the company.

Benefits for Pricing

Providing clarity means that cover for cancer can more accurately be allowed for in pricing.

Other

The insurer might be deciding to do this now because the quality of available data on cancer (for pricing) may have improved significantly or there may have been regulatory changes that make the inclusion of cancer more attractive/feasible.

The insurer may have deals with specialist cancer health care providers.

Reinsurers may now be willing to cover cancer-related claims.

Offering this to both new and existing policyholders helps to demonstrate fair treatment of customers.

(iii) Claims cost risk may be greater. In particular, there is an increased risk of very large claims including claims which may continue for a long time (longer than 10 years). Medical inflation risk may also therefore be increased. The risk of unanticipated changes to claim costs due to medical advances might also be greater for cancer.

The insurer might not have had previous experience of costs related to cancer.

The risk of anti-selection could be greater; in particular, the risk of policies being taken up by policyholders who may be more likely to have cancer leading to high overall claim costs. There may also be an increased risk of non-disclosure of cancer related illnesses, and increased selective withdrawal risk.

There may be reputational issues arising from declining cover. There is a related risk that customers do not understand the cancer claim definitions correctly.

There is a moral hazard risk relating to choice of treatments, where applicable, by the insured or provider (e.g. higher cost treatments provided or higher claims as lives are prolonged).

There is a minor risk of "lapse and re-entry". However, this is only a very small risk as the new cover will be offered at renewal and policyholders attempting to do this should be considered carefully in terms of anti-selection risk.

There is increased pricing/data risk due to the company not having previously covered cancer and so it does not have its own experience.

The product may be attractive to different market segments once cancer is included so there is risk that the mix of new business sold changes which could lead to lower profits to the extent that there are cross-subsidies within premium rates.

There is a risk that the amount of new business sold with the cancer inclusion is much lower than expected and does not recover the development expenses incurred. There is a related risk that competitors will follow and capture market share.

There may be lower renewals than expected, if premiums increase by more than the cover is valued, unless it is sold as an option - in which case there may be more selection.

There is a risk that the amount of new business sold with the cancer inclusion is much greater than expected putting a strain on administration leading to reputational damage, or requiring more capital. Higher reserves may be needed, possibly leading to insolvency.

There is an expense risk e.g. higher than expected project development costs or higher than expected claims management costs.

There may be a risk of adverse regulatory changes relating to cancer coverage

There may be changes in the provisions provided by the State in relation to cancer.

Systems and processes will need to be changed, so there are risks of operational failure.

There may be no established relationships with cancer care providers, so it is more difficult to control provider costs.

The insurer might not be able to get reinsurer coverage on affordable terms.

(iv) **Claims cost**

Various types of benefit limits can be introduced e.g. a cap on the amount paid in a specific policy year or in total on a specific claim, or provision of unlimited cover for the first two years of a cancer claim and only limited benefits thereafter. The latter would allow the condition to stabilise, but reduce the risk of high costs of claims that continue for many years.

The terms and conditions should be clearly worded.

Reinsurance could be used to limit the impact from very large claims. This would most likely to be excess of loss (XL) reinsurance:

Risk XL: reinsurance above a certain amount will give protection to the insurer for individual large claims.

Aggregate XL / Stop loss: provides cover to the insurer where total claims are above a specified amount. This could be used to apply to only total cancer claims or to all claims.

Reinsurers could be used to provide technical expertise.

Effective claim management such as robust provider agreements (to cover cancer treatments) could be implemented although this may not have a significant impact.

The insurer should ensure that pricing allows for expected trends in and inflation of claims costs particularly for the longer claims.

The insurer might not provide premium guarantees.

The insurer might perform regular experience monitoring and re-price accordingly.

An element of coinsurance could be included, or a system of no claims discount could be introduced.

Anti-selection

Use robust medical underwriting.

Use pre-existing condition exclusions e.g. exclude cancer cover for first two years of the policy.

Lapse and re-entry

Policyholders could be given an option to convert immediately, possibly at an extra cost.

Pricing/data

Margins for uncertainty could be included in the additional premium charged.

Data from other sources could be used e.g. reinsurers.

New business mix/volume

Market research should be carried out.

The insurer might carry out targeted sales/marketing.

Cross-subsidies in premium rates could be reduced.

To ensure sufficient volumes are sold, advertising could be increased.

The insurer would liaise with distributors.

An upper limit on new business volumes could be imposed.

The new business administration team should be sufficiently resourced.

More capital could be held or raised.

Competitor rates should be monitored, if they provide this type of cover.

Retention/renewal teams could be set up.

Regulatory change

The insurer should keep pace with proposed regulatory changes and lobby if necessary.

Operational

The insurer should have strong governance and good processes and documentation.

System testing should be carried out.

Staff training should be carried out.

Expense controls should be implemented.

Claims administration could be outsourced.

Part (i)(a) was bookwork and generally well answered, as was part (i)(b).

Part (ii) was less well answered. Many candidates made few, if any, of the points relating to removing uncertainty for policyholders or the benefits for claims management.

In contrast part (iii) was well answered, with candidates generally covering a wide variety of risks.

Candidates also generally made good attempts at part (iv), although there was a tendency to focus on management of morbidity-related risks and relatively few of the points listed above under New business and Operational were usually made.

3 (i) (a) The key concern is that if an employee is unable to work then a replacement will have to be found. As both will have to be paid, there may be significant costs in this.

The inability to work may be sudden and even if of short duration, the consequences may be significant e.g. another pilot or crew member must be found at short notice to replace them. The replacement may be in a different country.

There is a knock-on effect if the extra duty leads to the replacement pilot or crew member exceeding their hours and having to be replaced on another later shift. The sick pilot or crew member may not be in the right place for subsequent duty so there are costs of getting them back on rota.

There may also be consequential losses arising from a pilot or crew member sickness e.g. compensation to passengers if a flight is cancelled (although this may not be covered by the insurance).

A group policy is likely to be cheaper than buying individual policies.

The product may cover health treatments incurred whilst overseas in a work capacity.

There may be tax efficiency or tax breaks.

As part of the overall benefit package, it may help the airlines to attract and retain staff and help to get staff back to work more quickly.

(b) It is recommended that PMI should be provided.

Key man insurance (akin to locum protection insurance) should be provided.

Health cash plans may be provided to some categories of staff (lower paid jobs).

It is recommended that income protection insurance should be provided.

Critical illness insurance may be provided e.g. if it is felt to be important for staff attraction/retention.

It is recommended that long term care insurance products should not be offered.

(ii) **Characteristics of employees**

The pricing will need to take into account the specifics of the individuals being covered. A large airline will consist of many distinct groups of employee e.g. managers, pilots, flying staff e.g. cabin crew, on-plane security, ground crew e.g. maintenance, catering, baggage handling, check in staff, in many different countries although with more in the UK. Employees may be clustered in some areas.

Each individual may be based in one particular country but may be required to undertake long or short secondments to other countries or work temporarily from another country. Some staff may live in one country but fly from another. Some of the jobs may be outsourced. The particular roles which are outsourced will vary from one country or base to another.

Turnover rates and any seasonal working would need to be considered.

Data/experience

The insurer will lack its own relevant data although it may have some similar multinational scheme experience that could provide some insight (e.g. shipping company).

The data used for pricing must be relevant to the circumstances of the airline. The insurer may initially start with UK data but would need to adjust this for countries expected to be visited. Overseas data should be considered as well. Any trends would need to be allowed for.

Estimates of the number of each class of scheme member would be needed.

Quotes will need to be tailored to the circumstances of an interested airline's expected schedule and staffing model. Renewals can be based on actual experience of the airline. These will be large groups so could profit share with the airline.

As data is built up it can be used to improve the understanding of other airlines' experience and improve quotes and reserving. There is a need to study the airline industry and to obtain data on any specific occupational illnesses with which it is linked. The insurer should investigate whether suitable data to price the product can be obtained from reinsurers or from consultants. The Civil Aviation Authority may have data e.g. on flight crew fitness and airlines will have their own staff sickness data.

Rating

Depending on group size the pricing for IP and PMI is likely to depend on the scheme's experience. This is a new scheme to this insurer so there are no data for a credibility factor. Due to the niche nature of this product there will be a greater risk in using the expected experience of a similar scheme in order to set the basic unit rate.

The profile of this scheme needs to be allowed for e.g. age, occupation profile. The insurer will need to determine the appropriate rate for each category of scheme member. Different terms and conditions may need to be applied to the different classes of scheme member. There will be a greater need to incorporate margins in final premiums, to reflect approximations/unknowns.

Claim definition

The claim definitions need to be worded very carefully. In particular, this needs to be clear whether consequential losses (e.g. compensation to passengers) are covered by the insurance. Salary may include expenses and shift allowances so the definition of pre-disability income will need to be considered carefully, also bearing in mind that income levels are likely to fluctuate.

The definition of disability for IP will have a significant impact on the length of the claim and its cost. There will be a need to consider niche definitions of disability, as inability to fly will not correspond to normal illnesses. For some roles the IP claims need to be based on own occupation (e.g. pilot).

The CAA or other body may require flight crew to take absence in certain circumstances and be passed as medically fit by a CAA examiner prior to

returning to work – so need to ensure the circumstances are understood and the costs of medical examination/re-examination are priced into the product or excluded.

Moral hazard risks from the airline need to be considered, e.g. a flight might be cancelled and incorrectly claimed that this was due to covered sickness, knowing it has cover the airline may have fewer staff on standby or relax its procedures for dealing with "away from base" illnesses.

Moral hazard by the staff also needs to be considered e.g. staff claiming sickness to avoid an unpopular trip or one at an inconvenient time, staff claiming sickness during industrial action.

Number of claims

Compared to standard policies it is likely that there will be more claims especially under PMI if free healthcare is not available away from the UK. Pilot or crew member will be staying in hotels for short periods; if they are unwell the insurance company will need to provide access to an out of hours GP or pay the hotel doctor rates.

Pre-authorisation may not be possible.

Delays in treatment will lead to payments under the IP part of the policy and pressure to pay out from the airline.

There may be an accumulation of risk due to extensive travel, potential terrorist attack, exposure to unfamiliar germs etc. There is also a greater risk of occupational illnesses e.g. directly due to flying or from being overseas rather than at home, e.g. poor diet, stress, unsafe practices or from lifting baggage.

Investigate the level of fitness/health required for individual roles e.g. apparently minor respiratory illnesses will have more impact on flight crew than ground staff.

Size of claims

PMI claim amounts are likely to be greater for this type of business and similarly IP claim durations due to the higher level of health required to perform some of the roles. IP claims could be high for some staff (e.g. pilots)

If treatment takes place overseas the company is unlikely to have preferred supplier deals in place and there may well be a lack of contact with suppliers

Speedy treatments may be required which may be more expensive or require more administration.

It may be possible to offset some costs by using the airline's own aircraft to repatriate staff or fly out medical staff or its preferred supplier hotel rates to

accommodate staff too ill to travel or their families making "compassionate" visits.

Need to consider likely claims under keyman insurance, if provided, to reflect loss of profits and/or costs of temporary replacement.

Terms and conditions / Underwriting

Need to take into account the chosen terms and conditions e.g. benefit limits, excess levels, NCD, deferred periods and free cover limits.

Pricing will be influenced by the deferred period chosen. There may be more than one deferred period offered, at different rates.

The insurer will want to avoid very short claims but will have to meet the needs of the airlines.

It needs to consider whether the airline already provides some sick pay and whether this varies by type of scheme member and country of working or base country. If not, there may be an argument for a very short deferred period which will add to the risks e.g. potential difficulty in obtaining certification, especially as this could be overseas, and difficulty in producing an unambiguous definition of a claim inception.

Need to consider any interaction/overlap with existing travel cover.

Pricing will depend on the extent to which there is "underwriting" e.g. imposition of an "actively at work" clause and pre-existing exclusions, although these may be difficult to enforce. Some employees, such as pilots, will already be subject to strict medical checks

Pricing will also depend on whether the schemes are voluntary/compulsory and if voluntary, the likely take-up rate and on the group size i.e. whether the airline will cover all of its employees or just some membership categories. There is generally less scope for anti-selection in group schemes

Expenses will need to be allowed for in the pricing

Forecast business volumes will be needed for premium loading purposes.

Adjust to allow for anticipated differences due to the specific characteristics of this scheme e.g. increased time in administering this product and in managing claims, the increased expenses of sale, underwriting, new business processing, regulation costs.

Managing overseas claim authorization, treatment and payment will be more expensive.

Need to decide the extent to which the new schemes will be required to contribute to the insurer's overhead costs.

There may be different levels of commission if specialist brokers are used.

Include loadings for any reinsurance used. Reinsurance may be more difficult or costly to obtain.

Other factors influencing pricing

The reserves and hence cost of capital could be higher because of the uncertainties involved.

Need to consider loadings for tax.

The economic pricing assumptions are unlikely to differ for this target market.

However, renewal rates may differ. Renewal rates could be closely related to the economic cycle, since the relative profitability and success of airlines is strongly correlated to the state of the economy.

Claim rates may also be related to the state of the economy.

(iii) An appropriate balance has to be made when setting the premium rates between making profit and offering an attractive product. The insurer has to load in an adequate profit margin and make a sufficient return on capital for the providers of that capital.

The currency risk in relation to overseas claims needs to be considered.

The sensitivity of profit to changes in assumptions should be tested. Profitability will also depend on where currently are in the economic cycle.

The insurer needs to consider how many UK-based airlines there are who would be interested in this product and the potential growth/decline of this market and therefore whether the insurer is likely to sell enough to make the required profit after taking into account set up costs. The insurer would also consider whether there is potential to sell to other airlines (i.e. non-UK based). In particular the insurer will need to decide whether the costs of tailoring existing products to meet the needs of an airline will be recouped.

The insurer should consider whether existing distributors will be willing to sell this business at an acceptable level of fee. It may need to actively engage with brokers. Other distribution methods that would be appropriate should also be considered e.g. specialist brokers.

The insurer would consider whether the business fits with the existing brand or ethos.

If there are other providers/competitors do they make a profit from this type of group cover and would this insurer be able to offer a more attractive product and still make sufficient profit. If there are no other providers, this is a niche product which could enable the insurer to make a high profit margin but it

would need to be wary of the risk of other providers then entering the market and stealing market share. The insurer might consider offering the product at a discount (or a loss leader) to gain traction in the market.

Offering this cover may provide other benefits to the insurer which could improve its bottom line profits. For example, cheaper advertising or sales of products on board or at the airport or reduced price business or leisure travel for its staff, or cross selling opportunities for individual products.

The insurer should consider whether there are any issues relating to the taxation of profits, particularly on profit repatriation.

The marketability may be linked to simplicity of the product, i.e. how easy it is to understand and for the employer to administer. It may also be linked to customer service standards and/or to other services provided by the insurer e.g. rehabilitation.

(iv) The three Generic TASs are TAS R, TAS D and TAS M. They apply to any work that is commonly (or exclusively) performed by actuaries and that falls within the scope of one or more of the Specific TASs.

The purpose of TAS R is to ensure that the reporting of actuarial work includes sufficient information to enable users to judge the relevance and implications of the report's contents, and that the information is presented in a clear and comprehensible manner.

The purpose of TAS D is to ensure that data used in the preparation of reports is subject to sufficient scrutiny and checking so that users can rely on the resulting actuarial information, and that appropriate actions are taken where data is inaccurate or incomplete.

The purpose of TAS M is to ensure that actuarial models used in the preparation of reports sufficiently represent the issues on which decisions will be based, and are fit for purpose both as theoretical concepts and as practical tools. Further, TAS M requires that models be properly documented and that significant limitations and their implications be reported.

This question was aimed at getting candidates to apply their knowledge of health and care products for a particular group of employees.

In part (i)(a) most students made the more straightforward generic Core Reading points about a group product being relatively cheaper than the purchase of individual policies to cover the same people, and the employer wanting to attract and retain staff as well as encouraging those off ill to return to work as soon as possible. However, few candidates made points about the specific needs of this particular type of employer which might be met by purchasing health and care insurance products. Most candidates did well on part 3(i)(b), which was a straightforward question on the types of health care products that it might be useful to offer.

Parts (ii) and (iii) were intended to allow candidates to relate their knowledge of health and care products and the standard factors to be considered when pricing, profit testing and marketing a new product for a specific group of employees. However, relatively few candidates commented on the specific characteristics of the employees in question or how these might affect the claims experience and the underwriting carried out. Similarly few candidates considered the problems that might arise from the fact that many of the staff would be working overseas. It was, however, good to see many candidates setting out their answers under different headings related to the main areas to be covered such as data, terms and conditions, claims experience, expenses, business volume, renewals and lapses. Candidates who used a methodical approach generally scored better than those who didn't. Candidates should note the high number of marks allocated to part (ii) of this question, which indicates that a large number of points and a lot of detail was expected, and so a high proportion of the available time needed to be allocated accordingly.

Part (iv) was a bookwork question. Although some candidates did well on this question, there were many who did not know the TASs with which a report should comply or could not describe their purposes.

END OF EXAMINERS' REPORT