Continuous Mortality Investigation

Working Paper 40

Changes to the Coding Guide for CMI 'Per Policy' data

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August 2009

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1 Introduction

In December 2005, the CMI published version 1.0 of the Coding Guide for 'Per Policy' data for the CMI Life Office Mortality and Critical Illness investigations alongside Working Paper 19. This followed an earlier consultation exercise with life offices on the feasibility of fundamentally revising the basis of data submissions to the CMI.

It was anticipated that the Coding Guide would require amendments and additional clarification as offices began to submit data using the new guide and four subsequent versions have been issued to date.

This Working Paper is being issued alongside a draft version of an updated Coding Guide (version 1.6) to provide some additional explanation on the changes in the latest version and to consult data contributors, in particular, on these changes. Responses are requested by 30 September 2009. The CMI intends to release version 1.6 in October 2009 unless the consultation demonstrates clear objections to the proposed version 1.6.

In addition section 6 contains a brief note regarding the CMI's treatment of Terminal Illness claims within the life office mortality investigations. This does not relate specifically to Per Policy data but is included here for completeness.

The areas on which we are seeking feedback, in particular from data contributors, are set out in section 7 of this Working Paper.

2 Background to 'Per Policy' data submission

'Per Policy' data involves collecting an individual record per life for each in-force benefit and exit. Previously the CMI collected mortality data from life insurers in what was referred to as a 'Scheduled' format, where data is tabulated by investigation type, age and duration. The highly aggregated data, under the old format, limits both the checks that can be applied to the data and the analyses that can be produced from it.

The principal aims of the move to Per Policy data, as set out in the covering note to Working Paper 13 that initiated the consultation on the detail of the move, are:

- It will allow more detailed and accurate analyses to be carried out.
- A better analysis of amounts data will be possible and the CMI will be better able to track select periods.
- Policy data can also be aggregated in different ways allowing the possibility of new investigations being carried out on the data already held.

- Data and analyses for additional risk factors can be easily accommodated, for example by sales channel.

The results of that consultation are summarised in Working Paper 19, which was released in November 2005, alongside version 1.0 of the Per Policy Coding Guide. It was anticipated that the Coding Guide would require amendments and additional clarification as offices began to submit data using the new guide and the CMI sought to process the data. Four subsequent versions have been issued to date.

There are many differences between the approach taken for Per Policy data and Scheduled data, including:

- With Per Policy data, the CMI will no longer use a 'Census' approach to the investigations. Instead we are seeking to capture sufficient information in the end-year data submission to allow exposure to be calculated more accurately. One particular consequence of this is that Per Policy data submissions must include details of cases that have exited (by any means) during the investigation year.
- The Coding Guide applies to data for the Critical Illness investigation as well as the Life Office Mortality investigation.
- Data is no longer collected under specified 'Investigation Numbers'. Instead the product information is used to allocate policies to particular investigations that can be amalgamated or separated as appropriate by the CMI without offices needing to alter their data submissions.
- The approach to notification of claims (including cessation of benefits on annuities) has changed:
  - Under the Scheduled coding guide, offices were asked to provide data on deaths occurring during the investigation year but to wait at least 6 months after the end of the year before submitting data to take account of late notification of deaths. There was no guidance provided to offices as to whether all reported or only settled claims should be submitted. This meant that depending on the approach used by the offices, deaths that were reported to or settled by them more than 6 months after the end of the investigation year in which the death occurred were excluded from the investigations. Indeed the coding guide for Scheduled data explicitly states that offices should not re-submit updated data as they learned about such deaths. Informally, the CMI has been informed by one office that in data submitted under the Scheduled coding guide up to 10% of deaths may be omitted (depending on the investigation).
  - With Per Policy data, claims should be included according to the date that they are accepted as valid by the office (i.e. the date when the office's systems are updated), with delayed claims reported in subsequent years when they are accepted as valid by the office.
- A number of additional data fields were added, including distribution channel and postcode.

3 Changes in version 1.6 of the 'Per Policy' Coding Guide

The key changes in version 1.6 of the Coding Guide (compared to version 1.5) are:

- The removal of the impairment codes that were previously contained in Appendix B.
- Analysis of data submitted to date has highlighted some inconsistencies in previous versions of the Coding Guide pertaining to dates of exit, including for claims. We hope that these issues are resolved through the additional guidance and additional codes for certain fields in version 1.6.

These two areas are discussed further in sections 4 and 5 below.

Other minor changes to the latest version include:

- Additional codes (of C and D) have been added to the Pension Grouping field to separately identify buy-in and buy-out bulk purchase annuities.
- An additional code (of I) has been added to the Type of increment/decrement field to separately identify Family Income Benefits.
- Additional guidance has been provided in section 4.15 regarding the preferred treatment of increased benefit amounts, where there is no additional underwriting.
- Section 5.14 has been amended to recognise that – in the case of annuities purchased from an Income Drawdown policy – the date from which the annuity commences is not the date of retirement.
- Section 5.33 has been amended to clarify that the mortgage interest rate should be provided in the Rate of benefit increment/decrement field (not the actual change in benefit, which was previously implied) and that no value is required in this field for Family Income Benefits.

4 Impaired Lives

The CMI has collected data on impaired assurances since 1982. The investigation covers an extensive list of impairments, including Hypertension, Ischaemic Heart Disease, Cerebrovascular Disorders and Tumours, some of which are sub-divided by the degree of impairment.

The complexity of the data requirements, and the likelihood that such detail is not held on offices' principal systems, has meant that this investigation has received data from a small number of offices.

As noted in Working Paper 19, "None of the respondents who appeared to have studied the Per Policy Coding Guide in detail will be able to provide such data." As a result, the existing codes were retained in version 1.0 of the Per Policy Coding Guide to continue capturing data from those offices that currently provided it with the intention that a further consultation would be undertaken to update the investigation in due course.

Further falls in data volumes subsequently cast doubt on the continuing credibility of the results, and the CMI decided to cease collecting data in its current form for years after 2006. A consultation on a revamped future investigation into impaired lives was contained in Working Paper 36, alongside the results for 1995-2006.

Responses to the consultation from data contributors have indicated that the CMI is unlikely to be able to collect detailed data on impaired lives from life offices in the short term, beyond an indicator of whether or not a life is subject to special terms. Consequently the impairment codes that were previously contained in Appendix B have been removed in version 1.6 of the Coding Guide.

Notwithstanding this change, the CMI believes that the information yielded by an impaired lives investigation has strategic importance to the insurance industry, in demonstrating the need to underwrite, to charge additional premiums for impaired lives and also to help better understand trends in non-impaired mortality and hopes that it will be feasible to re-launch a revamped investigation in the future.

With the latest version of the Coding Guide, the CMI is continuing to request details of all policies/lives in Per Policy data submissions – regardless of whether there is a rating or exclusion applied – together with a mandatory field to indicate whether or not the benefit has been issued on non-standard terms for that life. For the foreseeable future, CMI analyses will be limited to 'standard business' and 'non-standard business' with no further analysis of the non-standard benefits, for example by type of impairment.

5 Claims and other exits in Per Policy data

Analysis of the Per Policy data that the CMI has received to date has raised a number of issues regarding the treatment of exits, including claims. In some cases these issues reflect a lack of clarity or consistency in earlier versions of the Coding Guide.

This section seeks to explain the background to the changes in the latest version of the Coding Guide and to expose a number of areas where the CMI is hoping to obtain confirmation that the data it is seeking to collect can be provided by offices. The issues are discussed below, together with the resultant changes to the Per Policy Coding Guide. The areas for consultation are then set out in section 7.

5.1 Definition of a claim

Previous versions of the Per Policy coding guide did not define what is meant by a "claim".

For assurances, they provided some guidance relating mainly to what should not be treated as claims. In particular, they indicated that only assurances where a claim benefit is settled should be treated as claims. However, some offices' systems may only record admissions, in which case it is better to use this as the basis for the definition of a claim.

Section 4.5 of the coding guide seeks to make clear that either admission or settlement can be used to decide whether a "valid claim" has occurred on assurances and hence whether a claim record should be submitted in a particular investigation year. It also contains additional guidance regarding how offices could decide to define valid claims for assurances, to seek to ensure that all valid claims are reported to the CMI and that claims that do not meet the office's definition of valid claims are not reported as claims to the CMI.

For annuities, previous versions of the coding guide implicitly regarded cessation of annuity benefits as "claims". Section 4.5 of the coding guide now specifies a "valid claim" for an

annuity to be the cessation of benefits where the death of policyholder has been notified to the office in an acceptable form (cases where death is suspected are considered below, in section 5.4). Guidance has also been added to ensure that all notified deaths are reported to the CMI regardless of whether the office has previously suspended annuity payments.

5.2 Dates of claim

To date, the CMI has requested 5 dates of claim for Per Policy data:

- Date of exit
- Date of claim (death or diagnosis)
- Date of notification of claim
- Date of claim admission
- Date of claim settlement

The last four of these dates are requested for the Census CMI critical illness investigation, however Date of exit has been added for Per Policy data. Guidelines for each of these dates are given in paragraphs 5.36 and 5.38 to 5.41 of the coding guide. The Date of exit is considered in section 5.6; this section considers issues surrounding the other dates of claim.

The other four dates, which apply only to claims, are not all mandatory however the coding guide specifies that at least one of these must be supplied. These dates were intended to be effective dates rather than processing dates but depending on their administration systems and processes, offices may provide processing dates for these events.

In version 1.6 of the coding guide we continue to ask offices to provide at least one of the dates of death, notification, admission and settlement for claims on assurances though we have requested offices to provide the date of death on as many claim records as they can. However for annuities, both "date of admission" and "date of settlement" have little meaning and version 1.6 of the coding guide clarifies that these dates are not required for annuities but that at least one of the dates of death/notification would be required.

In Per Policy data submitted to date it has not been clear what some of the date(s) of claim provided actually are and clarification has been sought from offices, where necessary. Taking account of subsequent clarification, for the data received to date, the date of death or terminal illness has been provided for more than 98% of assurance claim records and for all annuity cessation records.

5.3 The claim process

Intuitively, the claim process for death claims under assurances is relatively clear. Following death, the office is notified of the life insured's demise; it will then admit the claim (perhaps following collection of evidence or even investigation) and finally settle the claim.

Note that for critical illness insurance, the claim process is fuzzier; date of notification can precede date of diagnosis if the definition of the critical illness event has not been adequately fulfilled at the date the claimant notifies the life office. This may also occur on Terminal Illness claims within the Life Office Mortality investigation, but should not happen for death claims.

5.4 Submission of claims data

With Per Policy data we are now explicitly providing some flexibility to offices regarding the date used to select claims data falling in the year for which data is supplied. Offices are now

also asked to select a definition of a "valid claim" based on either the date of admission or the date of settlement and to use this for all submissions. However, this means that offices may take different approaches in submitting claims data and hence the CMI needs to understand what information offices are providing so that we can properly analyse this data.

General guidance on claims data provided in paragraph 4.4 of previous versions of the Per Policy coding guide stated that "*data must be submitted on any normal claim settled in the year*", "*Claims submitted in respect of a particular year should be based, where possible, on the year of settlement*" and that "*In no circumstances should claims data be submitted in respect of claims that have yet to be settled*". Though appropriate for assurances, this is not helpful for annuities. This guidance has therefore been amended to make it clear that it refers to assurances and to reflect the flexibility now provided to offices regarding the date used to select claims data falling in the year for which data is supplied.

Assurances taken "off-risk" by offices whilst they investigate a claim

Guidance in previous versions of the Per Policy coding guide has also been unclear about the treatment in the data submitted of assurances taken "off-risk" by offices whilst they investigate a claim and of annuities suspended where the office suspects that the policyholder has died.

The CMI continues to restrict data on claims for assurances to the cases where the office has settled the claim. This is consistent with how mortality data has always been analysed and graduated by the CMI. However, an additional code (of Q) has been added to the Entry into Current Status and Type of exit fields to distinguish claims that are still being investigated from settled claims and other types of exits.

This will assist the CMI to better track policies from one year's submission to the next and to validate data.

Annuities that are suspended

Annuities may be "suspended" if the life office thinks death may have occurred but has no notification or clear evidence, and hence no date of death; for example, offices may suspend annuities automatically where annuitants reach a particular age and do not respond to the office's requests for confirmation that they are alive. The data received to date sheds no light on this practice, so how offices process such cases is an area where the views of offices are requested.

In particular it is not clear to the CMI:

- whether offices' administration systems can separately identify annuities that are suspended separately from those where the office has evidence of the policyholders' death;
- how offices treat suspended annuities in their internal analyses;
- to what extent offices update their records for suspended annuities when they receive evidence of policyholders' deaths; and
- whether offices are able to reinstate suspended annuities on receiving evidence of policyholders being alive or have to set up another annuity.

On balance, the Committee considers it would be useful to identify suspended cases separately from cessation of benefits where offices have evidence of policyholders' deaths, if this is feasible for offices. To achieve this, an additional code (of H) has been added to the

Entry into Current Status and Type of exit fields in the draft version 1.6 of the Per Policy coding guide.

To take account of further information received by offices following the suspension of an annuity – if this is feasible – the guidance in the draft coding guide has been extended to clarify that:

- If the office receives evidence of a policyholder's death, a further record is required bringing the annuity back into force and exiting on the same day, with status "D" in the "Type of exit". Appropriate information on benefit amounts and at least one of Date of death or notification should also be provided.
- If the office receives evidence that the policyholder is alive and reinstates the annuity, the suspension should be reversed (this required an additional status to be added to the "Entry into Current Status" field).
- If the office receives evidence that the policyholder is alive and issues a new annuity, then it should be requested to provide a cross-reference to the original annuity that had been suspended.

The CMI may also seek to maintain a list of suspended annuities for each office for which updates could be sought on an annual basis.

This allows the CMI flexibility on whether such cases are included as deaths in its analysis and also allows the data to be updated where offices receive further information and can provide it to the CMI.

Further, where an annuity is suspended, the Date of exit is the only claim date likely to be available and will have a different pattern of delays from the actual date of death. Hence for suspended annuities only the Date of exit will be required.

The best way to treat such cases within CMI analyses is unclear but it is likely that the CMI will treat suspended annuities as deaths. However, there is a danger that this could result in some overstatement of deaths if payments on some of these annuities have to be restarted as the policyholder had not actually died.

Note that it is not clear to the CMI how offices treated suspended annuities historically when submitting Scheduled data and it is possible that they could have been missed altogether, if the cessation of payments is not recorded as a death. Responses from offices that have contributed data are sought in the consultation.

5.5 Definition of an exit (other than a claim)

Previous versions of the coding guide implicitly defined an exit as a policy being taken out of force or "off-risk" either permanently or temporarily.

This definition has now been made explicit in section 4.2.

5.6 Date of exit

In versions of the Per Policy coding guide to date, Date of exit is stated to be mandatory and required for all exits including claims. The Date of exit is defined as "the date that the office processes the exit" – clearly the date supplied by an office will depend on its interpretation of what "processing the exit" means and what dates are available on its systems. Since the Date of exit is used for claims (including annuity cessations) as well as other types of exits such as

lapses, it is not clear that a single definition of "processing date" will be relevant to all offices for all these circumstances.

Previous versions of the coding guide state that the Date of exit "*should therefore **always** fall during the year for which data is being submitted*". Offices would normally process many events such as claim settlements, surrenders and maturities ahead of the "effective" date though on the odd occasion it may have to process them after the effective date. This would indicate that some Dates of exit would fall outside the year for which data is submitted. However, in the data submitted to date, none of the Dates of exit for any type of exit have fallen outside the year for which data is submitted.

This suggests that offices are either:

a) submitting effective dates in the Date of exit field;
b) are providing processing dates but artificially restricting them so that the Date of exit falls in to the year for which data is submitted; or
c) are providing a mixture of (a) and (b) depending on the type of exit.

It may also be the case that offices find it easier to extract effective dates rather than processing dates from their systems.

This led us to consider two options:

Option A We continue with the current definition of Date of exit but drop the requirement that it fall into the year for which data is being submitted and clarify that "the date an office processes an exit" means the date that it updates its systems for a particular event.

Option B We continue with the current ambiguity regarding the Date of exit for events other than claims and annuity cessations. The requirement for Date of exit to fall in to the year for which data is submitted would then continue.

In both cases, Date of exit would continue to be mandatory.

The Committee concluded that the second option is preferable as it allows offices to use effective dates where these are the only ones available or are more easily extracted than processing dates. Further, where the date of death is missing, it is necessary to estimate it from one of the other claim dates and using information on reporting delays for other offices. It would not be appropriate to use the date of exit for this purpose if it does not match one of the claim dates. This approach also continues to have a Date of exit falling within the year for which data is submitted which allows easier validation of data by the CMI within a year and across years.

However the Committee is keen to consult offices on this approach and also to ask offices about the processes they use to administer and analyse their business.

Note that under option B, the Date of exit for claims and annuity cessations is amended to the date used by the office to select claims data falling in the year for which data is supplied. This need not be one of the effective claim dates.

6 Terminal Illness claims

The Life Office Mortality Committee decided many years ago that – although both death and terminal illness claims are requested in Scheduled data (where relevant) – analyses would be carried out only on the death claims, i.e. terminal illness claims are ignored.

In practice, very few offices submit terminal illness claims and it is not clear to the Committee whether this is due to offices excluding terminal illness claims (even though they are requested) or recording them as deaths. As a result, the Committee cannot definitively state whether or not terminal illness claims have been included in its analyses.

The Per Policy Coding Guide continues to seek death and terminal illness claims to be recorded separately and in due course the Committee will consider producing results both including and excluding the terminal illness claims, if the number of terminal illness claims warrants this.

7 Areas for consultation

This section sets out the specific areas on which the Life Office Mortality Committee wishes to seek views. Many of the questions are only of relevance to existing and prospective data contributors; however the views of other interested parties, such as reinsurers, are also welcomed.

In relation to version 1.6 of the Per Policy coding guide, the specific questions are set out below.

General:

Q1. Please confirm whether your office is able to meet the requirements arising from the proposed changes in 1.6 of the Per Policy coding guide? If not, please explain the areas of difficulty. Please also describe any existing requirements that your office is unable or finds difficult to meet.

For assurances:

Q2. Please describe briefly your office's processes regarding claims, maturities and lapses, including the dates that are recorded on your systems and whether processing dates and/or effective dates are available.

Q3. What approach does your office use to identify valid claims on assurances for your internal analyses?

For annuities:

Q4. Please describe briefly your office's processes regarding cessations of benefits, including the dates that are recorded on your systems and whether processing dates and/or effective dates are available.

Q5. What prompts your office to suspend annuities? Can these be separately identified on your systems?

Q6. How has your office treated suspended annuities when previously submitting data to the CMI? Where these have been treated as deaths, how was the age at death for Scheduled data and date of death for Per Policy data estimated?

Q7. How does your office deal with suspended annuities (in terms of processing and systems) where a policyholder subsequently provides proof of being alive?

Q8. Please provide an indication of the number of suspended annuities (if possible, by type of annuity) at 31/12/2008 (or another specified date) together with the corresponding numbers of annuities in payment.

Q9. Assuming that offices are able to identify suspended annuities in Per Policy data submissions, should the CMI produce results allowing for:
   a) Confirmed deaths only, or
   b) Confirmed and suspected deaths combined only, or
   c) Both confirmed deaths only and confirmed and suspected deaths combined?

Q10. What approach does your office use for suspended annuities in internal mortality experience analyses?

Q11. For bulk purchase annuities, are your office's systems able to distinguish between buy-in and buy-out annuities?

We would also like offices' views on one area where there has been no change in version 1.6 of the Per Policy coding guide:

Q12. For individual annuities arising from private pensions, do your office's systems hold data allowing annuities to be distinguished between those arising from S226 policies, from personal pensions and from income drawdown arrangements? If yes, please explain how the data held allows this.

In relation to section 6, in respect of those assurance contracts that cover both Death and Terminal Illness (but not Critical Illness), the specific questions are:

Q13. Does your office distinguish between Terminal Illness claims and Death claims in the data you hold on your systems that will allow them to be distinguished in Per Policy data submissions in the future?

Q14. For data submitted to the CMI Life Office Mortality investigations in recent years have Terminal Illness claims been:
   a) Coded as Terminal Illness claims,
   b) Coded as Death claims, or
   c) Excluded?

Q15. Please provide an indication of the number of Terminal Illness and Death claims incurred (if possible, by product type) in 2006-2008.

Q16. Assuming that offices are able to submit claim records that distinguish between Terminal Illness claims and Death claims in Per Policy data submissions, should the CMI produce results for:
   a) Death only,
   b) Death and Terminal Illness combined only, or
   c) Both Death only and Death and Terminal Illness combined?

Responses on the points noted above – and indeed any other comments arising from this Working Paper or version 1.6 of the Coding Guide – should be sent via e-mail to mortality@cmib.org.uk or in writing to: CMI, Cheapside House, 138 Cheapside, London, EC2V 6BW. Responses are requested by 30 September 2009. The CMI intends to release version 1.6 in October 2009 unless the consultation demonstrates clear objections to the proposed version 1.6.