Below is a sample examination paper which is indicative of an actual PMI D examination paper. The student should use this to test their knowledge and to become familiar with the way in which the material contained in this textbook is examined. The solutions appear directly after the sample examination paper.

PMI D SAMPLE EXAMINATION PAPER

INSTRUCTIONS TO CANDIDATES

Two hours are allowed for this paper, which is in two parts.

The paper carries 150 marks.

PART A

Answer **6** questions in Part A.

Each question carries 10 marks.

60 marks are available.

PART B

Answer **2** questions from Part B.

Each question carries 45 marks.

90 marks are available.

PART A – THIS PART OF THE PAPER CARRIES 60 MARKS.

ANSWER 6 OF THE FOLLOWING SHORT QUESTIONS. EACH QUESTION CARRIES 10 MARKS.

1.

a. State what responsibility the **Health Services (In-Patient) Regulations 1991** confer onto the Minister for Health and Children. **(5 marks)**

b. Outline the Government's intentions towards the future charges for public hospital fees. **(5 marks)**

2. Outline what cover is typically provided by a Permanent Health Insurance (PHI) product.

3. List any FIVE medical expenses which qualify for tax relief from the Revenue Commissioners.

4. Briefly describe the "Upgrade Rule" associated with Private Medical Insurance (PMI) products.

5.

a. With regard to claims payments in Private Medical Insurance (PMI), state what a "Direct Settlement" is?

(5 marks)

b. Outline THREE advantages of "Direct Settlement" for the parties involved? **(5 marks)**

6. Outline what is meant by Arbitration in a dispute resolution scenario.

7. List any THREE benefits of Proportional Reinsurance.

8.

a. Briefly outline the reason for the introduction of the **Health Insurance (Miscellaneous Provisions) Bill 2008**. **(5 marks)**

b. State the main purpose of the **Health Insurance (Miscellaneous Provisions) Bill 2008**. **(5 marks)**

PART B – THIS PART OF THE PAPER CARRIES 90 MARKS

ANSWER 2 OF THE FOLLOWING ESSAY QUESTIONS. EACH QUESTION CARRIES 45 MARKS.

9.

a. The current waiting period and pre-existing rules with regard to joining private medical insurance are designed to protect the PMI providers. Outline the current waiting periods and pre-existing rule timeframes by each age category currently in force in Ireland; **(30 marks)**

b. Discuss, whether in your opinion, these pre-existing rules are fair? **(15 marks)**

10. Pre-authorisation of claims is not currently common practice with the PMI system in Ireland but it is believed will become common place in the future. Explain what Pre-Authorisation means in the PMI context and outline the reasons for its use.

11.

a. In 2004 the Financial Services Authority of Ireland Act established the Financial Services Ombudsman Bureau (FSO). Outline the main functions of the FSO. **(5 marks)**

b. The FSO has a clearly defined set of procedures which it follows when investigating a potential complaint. Describe these procedures. **(40 marks)**

12. The use of reinsurance arrangements by PMI providers in Ireland is not common practice with only one insurer (Hibernian Aviva Health) currently using reinsurance arrangements. Discuss in your own words the need for reinsurance in all classes of insurance including PMI.

SUGGESTED SOLUTIONS

Students should note that the solutions below contain the text material which should be included in an examination answer. The solutions, however, do not reflect the style of answer to be provided by the student. The key word in the examination question (e.g. differentiate, state, outline, discuss etc.) indicates how the material should be presented by the student. For example, a question which asks the student to *'Describe ……..'* would require a detailed account of the main features with examples, while a question which asks a student to *'Define …..'* would require the student to state in precise terms (quote legal definitions if appropriate) or provide a summary of all essential elements with no interpretation. The provision of the answer in the format requested by the key word is strongly linked to the awarding of full marks.

PART A

1.

a. The **Health Services (In-Patient) Regulations, 1991** specifies that all hospital beds in public hospitals must be formally designated by the Minister for Health and Children as being for the use of either public or private patients. Private patients must, except in cases of emergency, be accommodated in only designated private beds. The regulations were introduced to ensure equality of access to public hospital beds. Designating a public hospital bed as private does not however oblige insurers to automatically recognise the facilities concerned. **(5 marks)**

b. The Government has indicated that it intends to raise this charge to the full economic rate and indeed in successive years the charge has increased with 1 January 2009 seeing the last increase of 20% which will most likely contribute towards an increase in private medical insurance premiums. **(5 marks)**

2. Commonly known as 'income protection' or 'incapacity benefit', these are life assurance products designed to provide a replacement income if your income suddenly stops due to an accident, illness or injury. Whilst they have traditionally been referred to as permanent health insurance, this term is misleading as they are not designed to cover the cost of healthcare related expenses.

Benefit is typically capped at 75% of your net income (subject to other limits) and is normally payable after a deferred period (13, 26 or 52 weeks) until one of the following occurs;

- the insured recovers and is deemed fit to return to work,
- the policy ceasing date; normally at 55, 60 or 65 years of age,
- you reach retirement age.

Due to the extensive benefit payable, this cover is heavily underwritten at the point of sale and many occupations are specifically excluded (farmers, hauliers) or are loaded (tradesmen). It is important to note that to be eligible to make a claim, you must first be at a loss of income as a result of your injury. If this is not the case, then no benefit is payable.

(10 marks)

3. Allowable health expenses are expenses incurred in healthcare which represent the cost of any of the following;

- The services of a medical practitioner / GP or consultant;
- Treatments / Items, where these are carried out or supplied on the advice of a medical practitioner or dentist;
- Maintenance or treatment in a hospital or in an approved nursing home;
- Speech and language therapy carried out by a Speech and Language Therapist for a qualifying child;
- Educational psychological assessments carried out by an educational psychologist for a qualifying child;
- Certain items of expenditure in respect of a child suffering from a serious life threatening illness;
- Kidney patient expenses (up to a maximum amount depending on whether the patient uses Hospital dialysis, Home dialysis or Continuous Ambulatory Peritoneal Dialysis (CAPD);
- Transport by ambulance;
- Specialised dental treatment;
- Routine maternity care;
- In-Vitro fertilisation (IVF). **(10 marks)**

4. Where an individual upgrades their level of cover, an insurer may impose a waiting period of up to 2 years for those under 65 years and 5 years for those over 65 years, during which benefits are payable only at the rate applicable to their previous level of cover. This essentially means that a person cannot selectively choose to change their level of cover in the knowledge that they will require specific treatment that may not be adequately covered by their existing plan. This rule can also apply when a person changes insurer. **(10 marks)**

5.

a. All insurers in Ireland have direct settlement agreements with hospitals and consultants. As claims are approved for payment, these will be held against the provider's record and will be incorporated into the next periodic payment to the provider. This may be on a daily, weekly, fortnightly or monthly basis. Direct settlement became feasible through the contracting process which insurers set up with hospitals in the late 1980s. Prior to direct settlement, payment was sent to the member who was then responsible for forwarding payment to the hospital or consultant. **(5 marks)**

b. Direct settlement began to change the nature of claims processing within the PMI industry as it brought with it a number of advantages for the insurer, providers and members:

- Members who were recovering from treatment did not need to be concerned about arranging payments to the hospital or consultant, particularly as in most cases, they are assured of a full refund provided they occupied a hospital bed within the terms of their policy.
- In the 1990s, there was an increasing problem with bad debts arising from non-payment of accounts by members. Direct settlement ensures that hospitals and consultants are guaranteed reimbursement of eligible costs (up to the benefit limits detailed in the member's policy).
- As it improves the hospital's cash flow, insurers have used this method of payment to exert further influence on hospitals to reduce their costs. **(5 marks)**

6. The insured (and insurers) may choose to refer their disputes to arbitration rather than to litigate as this enables them to have their disputes resolved in private by a person or group of people who have been chosen for their experience in that particular class of business. Arbitration avoids a public hearing in an open court by a judge who may have no particular expertise about the insurance / reinsurance matter in dispute, and who will, therefore, simply have to choose between the conflicting views of each sides' expert witnesses. Arbitration also enables the parties to decide the procedure the arbitrator will be following and what their powers will be, because this is primarily governed by the terms of the Arbitration Agreement.

Generally speaking, an arbitrator has similar powers to a Civil Court, they may make an order of specific performance and their findings are final. These powers can be changed by the Arbitration Agreement. Most modern insurance contracts contain a clause in the policy requiring subsequent disputes between the parties to be referred to arbitration in preference to using litigation. However this is rarely used in the PMI market. **(10 marks)**

7. The benefits of Proportional Reinsurance may be summarised as follows:

- Risks, premiums, claims and acquisition costs are shared;
- It may help to improve Solvency Ratio;
- Close relationships may be developed with reinsurers;
- The reinsurers may offer assistance in rating, policy coverage;
- It pays a share of all losses whether large or small;
- The reinsured receives a contribution towards their acquisition costs (Treaty Commission). **(10 marks)**

8.

a. Due to the failure of the **Risk Equalisation Scheme 2003** (Supreme Court ruling July 2008), the **Health Insurance (Miscellaneous Provisions) Bill 2008** which was released on the 23rd Dec 2008 as a temporary measure is currently under consideration by the Oireachtas. **(5 marks)**

b. To ensure that, in the interest of societal and intergenerational solidarity, the burden of the costs of health services be shared by insured persons by providing for a cost subsidy between the young and the old; and to provide for related matters. **(5 marks)**

PART B

9.

a. Health insurers are permitted to impose a general moratorium known as *'initial waiting period'* at the outset of a health insurance contract. During this period, the insurer is only required to pay benefits in respect of treatment resulting from an accident. The maximum initial waiting periods, which may be imposed by an insurer following the date on which the individual first enrols, are:

MAXIMUM INITIAL WAITING PERIOD

Age At Joining	Maximum Initial Waiting Period
Under 55	26
Over 55	52 weeks
Over 65	104 weeks
Maternity benefit	52 weeks

PRE-EXISTING CONDITIONS

The maximum waiting periods that may be imposed by an insurer in relation to pre-existing conditions are:

MAXIMUM WAITING PERIODS IN REGARD TO PRE-EXISTING CONDITIONS

Age at Entry	Waiting Periods
Under 55 years	5 years
55 - 60 years	7 years
60 years +	10 years

Where a person transfers from one health insurer to another, the maximum waiting period which may be imposed is that applicable to their age at the original date of entry into the contract, with full credit being given for their previous period of insurance. Moreover, where an individual's health insurance cover lapses for any reason, they are entitled to restore their cover within 13 weeks, with the same or any other health insurer, regardless of age and without liability for the imposition of waiting periods already wholly or partially served.

TRANSFERABILITY

An important feature, noted above, which it is worth emphasising from an insured person's viewpoint, is the safeguarding of waiting periods already served or partially served following a transfer by an individual from one health insurer to another. The aim is to facilitate greater choice of insurance providers for individuals. These arrangements on transferability requested insurers to require that cover has not lapsed for more than 13 weeks. **(30 marks)**

b. The student should provide their own opinion as to whether they believe these pre-existing rules to be fair or not. **(15 marks)**

10. Pre-authorisation is the process of obtaining authorisation from an insurer that the treatment is medically necessary and clinically appropriate, and covered by the policy. This intervention, usually by a team of nurses, is an example of how managed care principles are used to help control claims costs. Failure to obtain authorisation will usually result in a financial penalty and may mean that the insurer will refuse to pay towards the cost of the treatment.

There is sometimes confusion over a number of similar terms used to describe pre-authorisation (i.e. pre-verification and pre-certification). The extent to which clinical facts are taken into account varies from insurer to insurer. In some cases, the treatment will be assessed for clinical appropriateness, but in other cases the insurer will use the process to confirm that the treatment is covered rather than look at clinical issues.

There are a number of reasons for carrying out pre-authorisation:

- To promote day case surgery against a list of procedures which are routinely carried out on a day case basis.
- To manage areas such as psychiatry / addictions which often results in long periods of in-patient admission, unless monitored carefully. The hospital and consultants are required to fax / submit online details of the planned admission to the insurer prior to treatment taking place. This information includes the patient's name and membership details, the diagnosis and details of the planned treatment including the length of stay. The insurer will:
  - assess the information provided;
  - check that the member is covered for mental and addictive illnesses;
  - decide whether the treatment plan is appropriate;
  - confirm to the hospital the length of stay they will agree to.
- To check the appropriateness of procedures which may not be medically necessary.
- To identify and closely manage high cost cases to ensure that costs are controlled and to assist with discharge planning (e.g. offering home support to ensure discharge takes place as soon as possible in respect of organ transplants or cancer cases).
- To ensure that care is given in the most appropriate way. For example:
  - In-patient to day-case;
  - day case to out-patient;
  - diverting a member from a hospital which is not covered by the network to a hospital within their network.
- To enable an insurer to gather information about claims before they take place, to assist financial analysis and planning.
- If further treatment is required after the agreed period, the hospital and consultant will re-apply for further benefits and the insurer will re-assess the application.

Where it is not possible to obtain pre-authorisation from the insurer (e.g. an emergency admission), there is normally an agreement with the hospital that they will notify the insurer of the admission on the next working day. In this event, the insurer will not normally impose a penalty for failing to obtain pre-authorisation; provided the treatment is eligible.

Currently in the Irish PMI market the pre-authorisation of claims is not widely used as a tool to manage claims by insurers except in the area of dental procedures where surgery is involved or where a member may be seeking cover for treatment outside of the State. **(45 marks)**

11.

a. The Financial Services Ombudsman is a statutory officer who deals independently with complaints from consumers about their individual dealings with all financial services providers that have not been resolved by the providers. The Ombudsman is, therefore, the arbiter of unresolved disputes and is impartial. It is a free service to the complainant. The broader issues of consumer protection are the responsibility of the Financial Regulator.

The principal functions of the Financial Services Ombudsman are :

- to deal with complaints made to the Financial Services Ombudsman (FSO) by *eligible consumers* about the conduct of regulated financial services providers by mediation, and where necessary;
- investigate and adjudicate on the complaint.

(5 marks)

b. **INITIAL STEPS**

There should be a formalised complaints handling process in place in every financial service provider which is easy to access. All staff should be aware of it. A senior management person should be responsible for ensuring that the complaints handling process works in a fair and proper manner.

FINAL RESPONSE FROM THE FINANCIAL SERVICE PROVIDER (FOR OUR PURPOSES THE PMI PROVIDER)

Upon receiving written notification of the complaint and request for a Final Response from the Complainant, the Provider has 25 working days in which to try to resolve the complaint by its internal complaint procedures. If at the end of the 25 working days, a resolution has not been attained, a Final Response letter must be issued to the Complainant by the nominated member of senior management. If the Provider requires more time to review the complaint, for example if it requires the Complainant to undergo a medical examination, the FSO must be notified of same.

The Final Response letter must:

- contain a detailed account of the dispute at hand;
- address all issues outlined in Complainant's Complaint Form;
- quote the applicable loan contract terms / policy conditions / terms of business etc.;
- give details of any redress offered to the Complainant by the Provider;
- state that it is the Final Response of the Provider for the purpose of referring the matter to the Financial Services Ombudsman's Bureau;
- advise the Complainant that they have 15 working days from the date of said Final Response to refer the matter to the Financial Services Ombudsman's Bureau for investigation

REVIEW OF COMPLAINT FORM AND FINAL RESPONSE

If it is determined that a Formal Investigation is not warranted a View will be issued to both parties based on the information contained in the Complaint Form and Final Response letter. The View will confirm that the FSO is of the opinion that due to the reasons outlined, the FSO does not intend to instigate a Formal Investigation in to the complaint at hand. This View is subject to appeal and may be reviewed by the Ombudsman. If the Ombudsman then decides that a Formal Investigation is warranted, both parties will be notified. If the Ombudsman decides that a View should stand, the View becomes the Ombudsman's Finding.

INVESTIGATION AND DECISION

If it is determined that a Formal Investigation of the complaint is warranted, the Complainant will be informed that his case is proceeding to investigation. The Provider will have a maximum of 20 working days within which to comply with the FSO's request either for its full file of papers or for responses to questions posed and documents requested. Any delay in the submission of documentation to the FSO (and in the absence of a reasonable explanation for said delay) may be viewed as obstructing the Ombudsman in the exercise of his function and may lead to the Ombudsman applying to the Circuit Court for a Compliance Order.

All the circumstances surrounding the complaint will then be examined. Further information or supporting documentation may be requested from both parties. Every case is judged on its individual merits.

FINDING OF DEPUTY FINANCIAL SERVICES OMBUDSMAN

The Deputy Ombudsman, or an assigned investigating officer, may attempt to negotiate a settlement between the parties at this point. Alternatively, or in the event that no settlement may be reached, the Deputy Ombudsman or investigating officer will issue a Finding on the matter. Each party is given 15 working days to request a review of the Finding by the Financial Services Ombudsman if dissatisfied with the outcome.

Where the 15 working days have lapsed and no review has been requested by either party, the Finding becomes a Final Decision and is binding on both parties.

FINAL DECISION OF THE FINANCIAL SERVICES OMBUDSMAN

Where a review is requested by either party, the Financial Services Ombudsman will review the Finding of the Deputy Ombudsman or investigating officer and then issue a Final Decision on the matter.

Following a review, the Financial Services Ombudsman may deem that the Finding issued by the Deputy Ombudsman or investigating officer is the Financial Services Ombudsman's Final Decision. The Complainant is informed of this by way of letter from the Financial Services Ombudsman.

Alternatively, the Financial Services Ombudsman may determine to alter the finding of the Deputy Ombudsman or investigating officer and issue a new and Final Decision to this effect. The Final Decision of the Financial Services Ombudsman is binding on both parties, subject to appeal by either party to the High Court within 21 days.

The foregoing process aims to ensure that cases can be resolved at the earliest stage possible. It also aims to ensure that the Financial Services Ombudsman is aware of all the facts that he has to consider before he makes the Final Decision.

The Ombudsman can direct the service provider to do one or more of the following:

- rectify or change the conduct complained of or its consequences;
- provide reasons or explanation for that conduct;
- change that practice;
- pay compensation up to a maximum of €250,000 or a €26,000 annuity;
- take any other lawful action.

The FSO must give a copy of its written finding to:

- the consumer who made the complaint;
- the financial services provider to whom the complaint relates;
- the FSO Council;
- the Financial Regulator.

APPEALS

Section 57CL(1) of the **Central Bank and Financial Services Authority of Ireland Act 2004** provides that, "*if dissatisfied with a finding of the Financial Services Ombudsman, the Complainant or the regulated financial service provider concerned may appeal to the High Court against the finding*""

In general the appeal must be commenced within 21 days after the Ombudsman issues his final decision.

(40 marks)

12. Insurers will aim to take advantage of the law of large numbers in the underwriting of personal insurances. If they can insure a large portfolio of homogeneous and statistically independent units, the variability of outcomes from those expected should be small.

The need for reinsurance of personal insurances, therefore, arises from the following three factors:

1. Variations in the size of the individual units exposed to loss. The inclusion of a few large risks, such as high value household properties or personal accident policies with large death benefits, will expose the portfolio to the risk of large losses;
2. The degree of interdependence between loss exposures e.g. the geographical concentration of a household portfolio; and
3. The need, especially for insurance companies listed on the Stock Exchange, for a relatively stable pattern of profit growth and to be able to demonstrate to the Financial Regulator a statutory minimum excess of assets over liabilities.

Reinsurance can provide protection against both large individual losses and accumulation of losses. The insurer must decide how much to retain, how much to reinsure and how to reinsure. These three factors also apply to the insurance of commercial risks. Factor two will have less of an impact on commercial risks as the large portfolio of homogeneous risks is not as prevalent. Variations in the exposure presented by individual risks, is a key issue; particularly where commercial liability risks are insured. Often commercial risks differ from personal risks in terms of sheer size (and therefore exposure for the insurer). The result of this is a much greater need for proportional reinsurance support.

LIABILITY

In the case of liability business, there is no reasonably foreseeable limit to the amount which may have to be paid; you only have to think about pollution risks to realise that indemnities of billions of Euros or Dollars can be at stake. For such forms of direct insurance, non-proportional reinsurances are more appropriate to deal with the problems presented as cover relates to the value of claims as opposed to a proportion of the risk. In addition to straightforward liability insurance, the excess of loss form of reinsurance can also be applied to the liability sections of other policies, e.g. motor.

LIFE

As might be expected, the reinsurance arrangements for life are slightly different from those in the non-life field. It is common to refer to *'reassurance'* for these long-term contracts in line with the use of the term life assurance.

PRIVATE MEDICAL INSURANCE

Private medical insurance can also benefit from the use of reinsurance arrangements just in the same way as those other areas of insurance mentioned above. Although Hibernian Aviva Health were the first PMI insurer in Ireland to use reinsurance (mainly for solvency reasons as they were a new start up) there is a growing appetite for insurers to consider reinsurance as an aid to help with solvency but also the rising cost of claims.

It has been widely accepted in the USA that major claims were on the increase in private medical insurance and although not exclusive or an exhaustive list the following are contributing factors in these increases:

- Medical inflation and advances in medical technology, especially cancer treatments, which although extremely successful and welcome are very expensive (e.g. some drug treatments can be as much as €100,000 per treatment).
- Increased life expectancy.
- Overburdened public system meaning that PMI is becoming more popular and thus putting more of a financial burden on insurers as much of what the State used to provide is transferring to the private system. **(45 marks)**