

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

## **PMI C 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. State the EU directive that lead to the introduction of competition in the Irish PMI market and the corresponding Irish legislation introduced to enable competition in the PMI market.
2. Outline the typical medical conditions and treatments that are excluded from PMI policies in Ireland.
3. List the distribution channels for health insurance in Ireland and briefly explain any one of these.
4. Outline how the Health Insurance Authority (HIA) is funded.
5. Outline the difference between a Multi-Agency Intermediary (MAI) and an Authorised Advisor (AA) in the eyes of the Financial Regulator?
6. With respect to Contracts, describe two circumstances where a contract can be deemed “illegal”.
7. Briefly describe what is meant by Medical History Declaration (MHD) and explain if this form of underwriting is used for PMI policies in Ireland.

8. The Financial Regulator's Consumer Protection Code sets out how a regulated entity should act when advising consumers. Outline how a regulated entity is supposed to deal with premium rebates.

**PART B – THIS PART OF THE PAPER CARRIES 90 MARKS**

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

9. The regulations for a Non-Life insurance company to receive authorisation from the Financial Regulator to conduct business in Ireland are contained in the **Non-Life Framework Regulations 1994**. Discuss the requirements a Non-Life insurance company must meet in order to achieve authorisation and describe how this process is complicated when the insurer is a PMI provider seeking authorisation.
10. The Health Insurance Authority (HIA) was established in February 2001. Describe its main functions in the Irish PMI system?
11. The Irish system of PMI is very different to most PMI systems in the world mainly due to the community rating of premiums. One advantage of this is that the processing of application forms from new customers is less cumbersome for the PMI insurer. Briefly describe why this statement is true and outline the main questions asked on an application form for PMI in Ireland.
12. The Financial Regulator Consumer Protection came into effect in August 2006 with its full provisions becoming effective from July 2007. This is a statutory code which must be followed by regulated firms and is intended to ensure greater transparency and professional advice in the insurance market as a whole. Outline and discuss the requirements of an insurer with regard to the provision of information to a consumer.

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. The introduction of the **EC Third Non-Life Insurance Directive** led to the formulation and passing of the **Health Insurance Act 1994** in Ireland that was designed to bring about the opening up of the Irish market to private health insurance competition. It provides that any non-life insurance company which is authorised to transact insurance business in an EU Member State must be allowed to transact the same classes of business in any other Member State.

However, the Directive also recognises that an EU Member State may adopt and maintain specific legal provisions to protect the '*general good*'. It was this concept of the '*general good*' that allowed the Irish Government to maintain essentially the same type of private health insurance system as had been in place since 1957 and ensure that any new entrant to the market would be required to write health insurance business on the same terms as the VHI (community rating, open enrolment, lifetime cover etc).

2. As with any insurance type, contract exclusions apply in PMI contracts. Each insurer lists the medical conditions and treatments which are not covered by the contract. It also states the position on those conditions and treatments which are contractually excluded, but for which the insurer may consider making discretionary benefit payments, in exceptional circumstances.

For example the main exclusions in a PMI contract in Ireland include:

- vaccinations and routine or preventative medical examinations, including screenings and check-ups;
- treatment which is not intended to cure or alleviate a medical condition or long-term nursing care;
- routine hearing or sight tests, hearing aids, spectacles, contact lenses, dentures or orthodontic appliances;
- treatment to correct short-sightedness, long-sightedness or astigmatism;
- treatment which is in any way related to eating disorders or weight reduction experimental treatment and drugs;
- any charge made by a doctor for a medical report;
- treatment of illness or injury necessitated directly or indirectly by war or civil disturbance; and
- treatment, the main purpose or effect of which is to relieve symptoms commonly associated with any bodily change arising from physiological or natural causes such as ageing, menopause or puberty and which is not due to any underlying disease, illness or injury. However, where medical diagnosis, treatment, cure or alleviation of symptoms of illness or injury arising from bodily changes is necessary, benefits are paid for appropriate health services.

3. The traditional distribution channel for health insurance has been selling directly to the customer (direct approach) with a growing proportion of business (only to Corporate Group schemes) over the last 10 years being through employee benefit consultants. The other avenue (i.e. via insurance intermediaries (MAIs / Authorised Advisors being remunerated by commission)), which has been used by the general insurance market for years, was not introduced into Ireland for health insurance until the launch of VIVAS Health (now Hibernian Aviva Health) in October 2004.

### **DIRECT APPROACH**

Insurers have available to them a number of options in their efforts to distribute their products directly to customers. These include having sales consultants; using the mail, television, radio and Internet to reach potential customers, and employing people in call-centres to deal with the resulting new business enquiries.

### **INTERMEDIARIES / EMPLOYEE BENEFIT CONSULTANTS**

In Ireland, insurance intermediaries are normally registered with the Financial Regulator as either a Multi-Agency Intermediary (MAI) or and Authorised Advisor (AA). Employee benefit consultants (especially those who specialise in health insurance) are only found in the larger corporate intermediaries who seek to provide an all-inclusive consultancy service to their clients. These corporate intermediaries normally have AA status.

Both work independent of the health insurer and the principal value of this is the impartial advice that they provide to their clients regarding the best cover to suit their needs. The main benefit of using intermediaries to distribute insurance products is that they represent a ready-made channel of distribution to a large number of individuals who are already clients of the intermediary. The product will be endorsed by the intermediary; someone known and trusted by the client. However, they do bear their own commercial costs and risks. Dealing with intermediaries can also be very cost effective for the insurer, since they do not need to be supported by expensive television and newspaper advertisements. This can lead to a reduction in the cost of the product which will make it even more competitive.

### **GROUP SECRETARIES**

Group arrangements, whether company funded or voluntary, usually appoint a Group Secretary who is responsible for liaising with the insurer on all aspects of the Group Scheme. Group Secretaries are involved in advising insurers of additions and deletions to those covered and in the completion of the annual scheme renewal. They also act as unpaid promoters of the private health insurance company, especially with new employees or with those employees experiencing a *'change of status'* e.g. marriage or job promotion.

4. Section 17 of the **Health Insurance Act 1994** provides for a levy on registered undertakings (QUINN-healthcare, Vhi Healthcare, Hibernian Aviva Health etc.) to be introduced by regulation to fund the operations of the Authority. This was introduced in the **Health Insurance Act, 1994 (Section 17) Levy Regulations, 2001** and all registered undertakings are obliged to submit details of premium income and numbers of insured persons in their schemes. The regulations introduced by the Minister for Health and Children in 2001 set the rate to be paid at 0.14% of premium income payable on a quarterly basis.
5. The difference between a Multi-Agency Intermediary and an Authorised Advisor is that the Financial Regulator restricts an MAI from providing advice in relation to insurance policies other than those provided by insurance undertakings from which the intermediary holds an appointment (agency), whereas an authorised advisor is expected to provide advice on the whole range of policies available on the market - thus this category would classically be suitable for an independent broker, whereas that of an MAI is classically suitable for tied agents and for insurance agents holding a relatively limited number of appointments.
6. Contracts which directly involve committing a legal wrong should obviously be discouraged. Such contracts are termed '*illegal*'. They are generally void in law and the court will not assist a party to the agreement in any way. The contract therefore cannot be enforced and, furthermore, money or goods delivered under it cannot usually be recovered by an action in court. (A person who has transferred money or property under a void contract that is not illegal will generally be able to recover it). Examples of illegal contracts are :
  - **Contracts forbidden by Statute** e.g. gaming and wagering contracts.
  - **Contracts which are contrary to public policy (or illegal at common law)** e.g. contracts tending to sexual immorality, contracts in restraint of trade, contracts to deceive public authorities, contracts to corrupt public life and contracts which pervert the course of justice.
  - **Contracts interfering with the administration of justice** e.g. contracts to compromise criminal proceedings.
7. The initials MHD may stand for '*medical history disregarded*' or '*medical history declaration*'. One of the most popular methods of underwriting within PMI is via the medical history declaration.

When using the medical history declaration, full medical history information and current state of health are obtained from the applicant, usually as part of the application form. The questions asked seek to determine the severity of any pre-existing medical conditions and, although they may differ between insurers, will generally include the following:

- Have you, or any of your dependants to be included in the policy, any physical defect, infirmity or medical condition?
- Have you, or any of your dependants to be included in the policy, been admitted to a hospital or nursing home or consulted a specialist during the last five years?
- During the last twelve months have you, or any of your dependants to be included in the policy, consulted a GP? Please include details of any repeat prescriptions.

- Have you, or any of your dependants to be included in the policy, any foreseeable need for treatment or for consulting any medical practitioner?

The Irish PMI market cannot use MHD to risk rate products. It can be used to ascertain the commercial viability of a Plan which must then be community-rated. The information, noted above, is used to assess the likely risk of conditions reoccurring, or related conditions emerging, and enables a decision to be made as to whether it should be excluded by imposing an exclusive special condition.

#### 8. **PREMIUM REBATES**

- A regulated entity must transfer a premium rebate to a consumer within 5 business days of the rebate becoming due;
- An insurance intermediary may handle premium rebates due to consumers only where an express agreement regarding same exists and the insurance intermediary acts as agent of a regulated entity;
- An insurance intermediary must transfer a premium rebate to a consumer within 5 business days after receiving payment of such rebate amount from a regulated entity or being notified by a regulated entity that such premium rebate is due to the consumer, as applicable;
- An insurance intermediary must transfer the rebate amount to the consumer in full. Any charges that the consumer may owe the intermediary must not be recovered from the rebate amount due to the consumer without the prior written agreement of the consumer.

## PART B

9.

The regulations for this process are contained in the **Non-Life Framework Regulations 1994** and state that an insurance undertaking shall not carry on the business of non-life insurance unless it is the holder of an authorisation. This authorisation shall be valid throughout the Member States and shall allow an undertaking to carry on insurance business there by way of services and by way of establishment. Non-life insurance companies must be established as companies limited by shares or guarantee or as unlimited companies.

In general, an application for authorisation will take approximately 6 months from initial submission to final authorisation. Authorisations can be granted subject to conditions.

An applicant for authorisation is required to:

- submit details of its directors, managers and authorised agents for approval of their qualifications (the undertaking must be effectively run by persons of good repute with appropriate professional qualifications and experience);
- submit a scheme of operations (including nature of risks to be covered, reinsurance principles, items constituting minimum guarantee fund and cost estimates);
- possess the prescribed minimum guarantee fund;
- provide a plan setting out three year's financial estimates (income and expenditure, reinsurance acceptances and cessions, a forecast balance sheet and estimates for the cover of its underwriting liabilities and solvency margin);
- agree to limit its business to non-life insurance activities and to operations arising directly there from;
- possess a minimum paid-up share capital of €634,869;
- inform the regulatory authorities of the identities of shareholders with qualifying holdings; and
- possess a solvency margin of 150-200% of the EU minimum (to be decided by the Financial Regulator).

The specific process for regulation of a private health insurance company in Ireland takes a bit longer as having been approved by the Financial Regulator, a company must then seek approval from the Health Insurance Authority to gain their health insurance undertaking status.

Basically, any insurance company that is authorised by the Financial Regulator, or a counterpart regulator in another EU member state, to provide health insurance is entitled to be entered on the HIA's register of health insurers. A registered health insurer is obliged to ensure that its insurance products and processes comply with health insurance legislation in Ireland. This obligation applies equally to all registered health insurers whatever their EU home state for insurance regulation purposes and the HIA does actively try to assist companies who wish to enter the Irish market with all aspects of health insurance regulation.

## 10.

The principal functions of the Health Insurance Authority as provided for in the **Health Insurance Acts** are -

1. to evaluate and analyse returns made to it under the Risk Equalisation Scheme 2003 and to prepare and furnish a report to the Minister in relation to:
  - (a) this evaluation and analysis; and
  - (b) matters concerning the carrying on of health insurance business and developments in relation to health insurance generally that the Authority considers ought to be included in the report as a result of that evaluation and analysis;
2. to carry out its role in relation to the Minister's decision whether or not risk equalisation payments should be commenced;
3. to manage and administer the risk equalisation process and establish and maintain the risk equalisation fund and also to make an annual report to the Minister evaluating the operation of the scheme for each 12 month period during which any risk equalisation payments are being made. Note: this function of the authority will change due to the Supreme Court Ruling in July 2008 regarding Risk Equalisation.
4. to maintain *'The Register of Health Benefits Undertakings'*
5. to advise the Minister (either at his or her own request or on its own initiative) on matters relating to:
  - (a) his or her functions under the Health Insurance Acts;
  - (b) the Authority's own functions; and
  - (c) health insurance generally;
6. to monitor:
  - (a) the operation of the Health Insurance Acts;
  - (b) the carrying on of health insurance business; and
  - (c) health insurance developments generally.

## 11.

The process of application processing of new members to a PMI provider in the Irish PMI market is not as cumbersome a task as it would be in a risk rated environment due mainly to the fact that a person does not have to answer any medical or family history questions as the premium is *'community rated'* and, therefore, the insurer cannot ask these type of questions.

Community Rating in essence means that the level of risk that a particular consumer poses to an insurer does not affect the premium paid. It is an established cornerstone of government policy in order to assure availability of cover for all. The insurer essentially works on behalf of its members to collect the premiums which are pooled together for the greater good of the insured community and tries to make sure that the pool is sufficient to meet the needs of all its members.

Under an Irish health insurance contract for any specific level of benefit, a health insurer must charge the same premium in respect of all such contracts regardless of the age, gender, sexual orientation or current or prospective health status of the insured lives.

As a result, the typical PMI application form in Ireland only asks the member to answer the following:

- Name;
- Date of birth;
- Address;
- Contact telephone numbers;
- Email address;
- Occupation;
- Group Scheme (if any);
- Payroll / Staff number if member of a salary deduction scheme;
- Preferred method and frequency of payment;
- PPS number (not in all cases);
- Name, date of birth and relationship of any other persons to be insured on policy;
- Required cover (usually a tick the box type question with plan choices clearly marked);
- Details of previous membership or existing insurer if transferring;
- Signature.

12.

#### **Information to a consumer**

A regulated entity must :

- ensure that all information it provides to a consumer is clear, timely, legible and comprehensible, and that key items are brought to the attention of the consumer;
- give notice to affected consumers, at least one month in advance, where it intends to amend or alter the range of services it provides;
- provide at least two month's notice to affected consumers of its intention to cease operations and ensure all outstanding business is properly completed;
- ensure that, where applicable, documents conferring ownership rights are given to the consumer in a timely manner or are held for safekeeping under an agreement with the consumer, in accordance with the terms of the regulated entity's authorisation;
- ensure that consumers are aware that telephone conversations are being recorded;
- provide a consumer with a receipt for each negotiable or non-negotiable instrument presented by the consumer as payment for a financial product or service provided by that regulated entity;
- acknowledge in writing, the receipt of a completed direct debit mandate or payroll deduction mandate, received from a consumer as a payment instruction for a financial product or service provided by that regulated entity;
- ensure that, where it communicates with a consumer using electronic media, it has in place appropriate arrangements to ensure the secure transmission of information to, and receipt of information from, the consumer;
- provide each consumer with the terms and conditions attaching to a product or service, before the consumer enters into a contract for that product or service, or before the cooling-off period (if any) expires.