The Insurance Institute Of Ireland

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EXAMINATION PAPERS

FOR

PMI C

INCLUDING

√ Sample paper

√ May 2009

√ October 2009

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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 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. 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;

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- 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.

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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.

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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?

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- 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.

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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.

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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.

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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.

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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.

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PMI C

THE INSURANCE INSTITUTE OF IRELAND
MAY 2009 EXAMINATION PAPER

PMI C
PMI – LEGAL, REGULATORY AND BUSINESS PROCESSES

Two hours are allowed for this paper, which is in two parts.
The whole paper carries 150 marks.

Answer any **SIX** questions in Part I.
Each question in Part I carries 10 marks.
60 marks are available.

Answer any **TWO** questions from Part II.
Each question in Part II carries 45 marks.
90 marks are available.

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PART I

Answer any SIX questions in Part I.
All questions carry equal marks.

Note form is acceptable (in respect of Questions 1 – 8) where this conveys all the necessary information.

1. Outline the specific Act that introduced Private Medical Insurance (PMI) to Ireland and the effect it had on the market.

2.
   a.) Briefly describe the “Register of Healthcare Benefits Undertakings”;

   (5 Marks)

   b.) Outline the two types of health insurers covered under this register.

   (5 Marks)

3. The **Health Insurance (Miscellaneous Provisions) Bill 2008** has a new system of tax credits for those over 50 years paying PMI. List the specific tax credits proposed in each of the age brackets over 50 years.

4. Outline any THREE reasons why regulation within the Private Medical Insurance market is important.

5. Briefly describe the authorisation process followed by the Financial Regulator for insurance intermediaries.

6. Outline what is meant by the term “Privity of Contract” citing relevant case law as part of your answer.

7. Outline how existing and potential PMI customers are protected by current legislation in Ireland when considering the underwriting of PMI business.

8. Briefly describe how the Health Insurance Authority (HIA) ensures that consumers’ rights are protected in the Irish PMI market.

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PART II
Answer TWO of the following FOUR questions.
All questions carry equal marks.

9. Underwriting of PMI policies is constrained by virtue of the regulatory environment in Ireland.

   (a) List THREE alternative underwriting methods used outside of Ireland; **(9 marks)**

   (b) Describe how each method works. **(36 marks)**.

10. In July 2008 the Supreme Court in Ireland found that the existing system of Risk equalisation was not based on the correct legal interpretation and must be set aside.

    (a) Explain what the Risk Equalisation scheme was trying to achieve in the Irish PMI market; **(25 Marks)**

    (b) Justify whether you feel it should be maintained (in a different format) for the future. **(20 Marks)**

11. The system of PMI in Ireland is quite different to the typical risk rated markets found in other developed countries. The specific provision in legislation of "minimum benefits" is one area of difference. Discuss the rationale behind the Minimum Benefit Regulations for Irish PMI policies and what they try to achieve.

12. The Financial Regulator's Consumer Protection Code came into effect in August 2006 with its full provisions becoming effective from July 2007. Fully explain the requirements of an insurer with regard to claims processing.

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PMI C – LEGAL, REGULATORY AND BUSINESS PROCESSES
MAY 2009
SUGGESTED SOLUTIONS

The answers set out below show the main points to be considered by the candidates in answering the questions. In some cases a well reasoned alternative view could earn appropriate marks.

PART I

1. From a private health insurance point of view, in Ireland prior to July 1994, the provision of private health insurance was subject to the terms of the **Voluntary Health Insurance Act 1957**. This Act established the Voluntary Health Insurance Board and required other bodies engaged in the business of health insurance to be licensed by the Minister for Health. Under this system, Vhi Healthcare developed as a virtual monopoly because other private health insurance schemes were confined to individuals sharing a common vocational or occupational group and their dependants (restricted undertakings).
   Ref: Ch. 1, Section A

2. (A) Under Section 14 of the **Health Insurance Act, 1994**, any health insurer carrying on the business of health insurance in Ireland is required to register with the Health Insurance Authority (HIA). The HIA is responsible for the maintenance of The Register of Health Benefits Undertakings (*'the Register'*). This necessitates application to the HIA for inclusion on the Register on an annual basis and the provision of details of any health insurance scheme in operation to the HIA. The scheme is examined to ensure that it is compliant with all relevant legislation. Upon the HIA being satisfied that the scheme is compliant, a certificate is issued confirming that the health insurer may offer private health insurance in accordance with the terms of its rules and with legislation. There is no fee charged for the issuing of this certificate. In addition, any health insurer which has ceased operating in the previous 12 months must notify the HIA in order that the health insurer will be removed from the Register. **(5 Marks)**

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(B) The Register consists of two types of health insurers :

i. **Commercial:** These are health insurers such as QUINN-healthcare, Hibernian Aviva Health and Vhi Healthcare which must accept all consumers who wish to obtain private health insurance i.e. open enrolment. This is subject to certain terms and conditions being fulfilled.

ii. **Restricted:** These are schemes that are mainly vocational schemes, membership of which is restricted to employees of particular organisations. Examples include ESB Staff Medical Provident Fund and St Paul's Garda Medical Aid Society. These schemes are also subject to particular terms and conditions. **(5 Marks)**

Ref: Ch. 1, Section G

3. The tax credits will be as structured as follows:

AGE (ON 1 JANUARY IN THE RELEVANT YEAR OF ASSESSMENT IN WHICH THE PAYMENT CONCERNED WAS MADE TO THE AUTHORISED INSURER)	**TAX CREDIT**
Aged 50 years and over but less than 60 years	€200
Aged 60 years and over but less than 70 years	€500
Aged 70 years and over but less than 80 years	€950
Aged 80 years and over	€1,175

Ref: Ch. 2, Section A6E

4.

- A particular feature of insurance is that of the **serious financial harm caused to customers** who do not receive the claim payment due to them and in the case of health insurance the payment of a claim either directly to the member or hospital concerned. This has been a traditional reason for regulating the insurance market.
- A huge impetus for better regulation of the insurance (including health) market in recent years has been created by the need for a **high standard of consumer protection** in terms of the protection of rights, fair treatment of customers and the provision of a competitive and stable market.
- The **failure of insurance providers** can harm the **economy's macroeconomic stability**. One insurer's problems may easily spread to other insurers, reinsurers and banks that are involved with the troubled company and indeed, in the case of health insurance this could also affect Government.

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- On a larger scale, a **general loss of confidence in insurance providers** undermines the basic system on which any economy runs. This is especially important for health insurance in Ireland when you consider that nearly 52% of the population are actually insured.

Ref: Ch. 2, Section B1

5. The process for authorisation requires the proposed intermediary to submit an application to the Financial Regulator (FR), in prescribed form, with prescribed documentation and individual questionnaires for directors, shareholders and senior management. The FR will require details of:

   - the applicant's legal status (whether a company or partnership), and if a company a copy of the memorandum and articles of association;
   - if a company, details of the shareholdings, if a partnership, details of the partnership composition (the regulator is required to be satisfied as to the identity and good standing of each holder of 10% or more of an applicant's share capital);
   - the applicant's head office, principal business address and any branch offices;
   - the business to be transacted by the applicant and the arrangements for handling this business, including details of the insurers from whom appointments will be held, the numbers of employees at particular levels and the organisation of the business;
   - cash flow projections for at least the first 12 months;
   - details of the arrangements proposed to be adopted by the applicant to ensure compliance with its obligations under the 1995 Act and with the Handbook and Consumer Protection Code applicable, including details of its compliance officer;
   - individual questionnaires completed for each director of the applicant.

   This documentation must be submitted to the Financial Regulator, which reviews it and may call for further information. It is usually a good idea to approach the Financial Regulator prior to completing the application forms and request an informal meeting at which the applicant's proposed business operations will be discussed and the Financial Regulator's views on these requested.

   Ref: Ch. 3, Section D

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6. Privity of contract is a doctrine which restricts the rights and duties created by a contract to the persons who originally made it. Under this doctrine, a contract between A and B cannot confer any legally enforceable benefit on a third party and cannot impose any duties on the third party. *'Only a person who is a party to a contract can sue upon it',* Lord Haldane in ***Dunlop v. Selfridge (1915).*** In this case, the plaintiffs sold tyres to Dew and Co. on the condition that they would not be re-sold below a certain price and that Dew and Co. would only sell to customers who themselves agreed not to sell below the list price. Dew and Co. sold tyres to Selfridge's on this condition, but Selfridge's broke their agreement with Dew's by selling the tyres below the list price. Dunlop's sued Selfridge's but the court held that they could not enforce the price maintenance agreement between Dew's and Selfridge's because they were not a party to it.

   Ref: Ch. 4, Section I

7. From a legislative point of view the Irish PMI market is heavily regulated in favour of the existing and potential PMI customer who is in a very strong position considering that:

   - they cannot be refused cover regardless of age at joining or medical history;
   - one price for all customers picking a given level of cover regardless of age, sex, medical history etc.;
   - premium cannot be increased based on an individual's claims experience;
   - a person has 13 weeks in which to effect a transfer to any other health insurer and at the same time preserve the waiting periods already served with their current insurer);
   - all insurance policies must provide a minimum level of cover.

   Ref: Ch. 5, Section A

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8. The HIA states that in respect of consumer interests :

"The interests of consumers of private health insurance are of paramount importance to the Authority. We assess the effect of any regulations or new legislation on consumers.

The Authority aims to ensure that:

- *consumers are aware of their rights;*
- *consumers are aware of the effect of community rating, open enrolment and lifetime cover and the maintenance and advocacy of these principles;*
- *policies and publicity material describe cover in a fair and comparable way; and*
- *health insurance providers have appropriate procedures for dealing with consumers.*

In pursuing these goals, the Authority carries out public information campaigns, and may promote a voluntary code of conduct or recommend new regulations."

Ref: Ch. 6, Section A

PART II

9. **(A)** Underwriting in the PMI market in Ireland is constrained by (age adjusted) Community Rating as well as by Open Enrolment and Lifetime Cover. In other countries, there are a number of alternative methods of underwriting in the PMI sector which are outlined below.

The key features of the principal underwriting methods are as follows:

- use of standard or general exclusions;
- moratoria underwriting;
- declared medical history. **(9 Marks)**

(B) USE OF STANDARD EXCLUSIONS

The majority of policies impose exclusions that apply to all members. These are known as standard exclusions or sometimes referred to as '*general exclusions'*. Insurers limit their exposure by the implementation of standard exclusions. The following standard exclusions apply to most types of PMI policies outside Ireland:

- pre-existing conditions;
- attributable to Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS);
- alcohol, solvent or drug abuse (must be covered in part under minimum benefits in Ireland);
- cosmetic surgery;

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- drugs and dressings other than those prescribed by the specialist during inpatient / day case treatment;
- war, invasion or civil riot.

The above list is neither exhaustive nor specific to any one insurer. Each insurer will structure their products in such a way as to offer an apparent competitive advantage over products available from their competitors. Chronic conditions (i.e. long-term medical conditions) are included as a standard exclusion in most PMI policies written in the UK, as PMI insurance is designed to offer short-term treatment for acute conditions, whereas in Ireland chronic conditions tend not to be excluded from cover with insurers protected in the most part by the 180 day maximum stay rule per membership year.

Whenever more information becomes available on the risks presented by the general incidence of particular medical conditions, insurers will consider whether to add or remove those medical conditions from its range of standard exclusions. Such decisions are based on their estimation of the risks and the ability to price the products accordingly. For example, in the late 1980s, the increasing frequency of AIDS cases and associated media sensationalisation led to concern about the future of the life and health insurance industry. It is now generally accepted that some of the wilder predictions on the expansion of AIDS were pessimistic and that insurers no longer need to be so cautious. For example, the current health insurers in Ireland will cover a member's treatment for AIDS or any resulting condition, provided the condition did not arise during their first five years of membership of their scheme.

The increasing number of insurers and the variety of PMI products available mean that, for a suitable increase in premiums, cover may be provided for treatment and conditions which usually appear as standard exclusions.

MORATORIA / MORATORIUM UNDERWRITING

Moratoria underwriting (often referred to as '*point of claim underwriting*') enables the PMI policy to be purchased with a minimum of formality. The member can purchase a private medical insurance policy without being required to complete a detailed medical questionnaire. The costs of treatment for pre-existing conditions are excluded for a certain period of time (just like the way health insurance is currently sold in Ireland).

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Moratoria underwriting lends itself to direct selling, as applicants may be covered immediately rather than being subject to underwriting of their medical history. For the insurer, it is administratively easy, as underwriting a new application is not required at the point of joining. Most PMI Insurers in the UK now offer a choice of either moratoria underwriting or full medical history declaration.

The Association of Medical Insurance Intermediaries in the UK defines Moratoria Underwriting as follows:
"With moratorium underwriting, the insurance company will take on each individual covered by the policy, but will exclude any medical condition where medical advice, medication, or treatment has been sought in a given period, usually five years before joining the plan.

Once the individual has been free of all medication, treatments, consultations and symptoms for that condition, or any related condition, for a given period after joining the plan, usually 2 years, they will automatically be covered for that condition.

There are some pre-existing conditions, such as heart problems, cancer and psychiatric conditions that will never be covered by the plan, as the member will have regular checkups and/or medication."

Whilst ease of administration is an attraction for the insurer, there are also disadvantages. For example, it is not always clear what is covered under the policy and the limitations that apply to pre-existing conditions may lead to disputes at the point of claim when costs may already have been incurred by the member. It is the responsibility of the insurer to ensure members are aware of the cover available and the issues that might arise at the point of claim.

Moratoria underwriters argue, however, that they make it very clear what the moratorium clause means, producing special leaflets which explain exactly how it works. They also argue that the typical problems which occur at point of claim due to pre-existing conditions equally apply to underwritten contracts due to non-disclosure.

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Where a member is aware of, or has had treatment for, a pre-existing condition within five years before commencing their PMI policy, cover may be given, provided that they satisfy a qualifying period (e.g. two years, although the length of the qualifying period can vary). The cover is dependent on the member not seeking medical advice or treatment for the pre-existing condition during the stated period, in which case cover will be provided for that condition, if the policy is renewed for a third year. However, if medical advice, or treatment, is received during the qualifying period, the full qualifying period will recommence from the date on which that advice or treatment was given. This is generally referred to as a *'rolling moratorium'.*

The definition of treatment includes obtaining medical advice and regular check-ups. Someone with heart disease who has regular six-monthly check-ups but no other treatment is therefore unlikely to ever fall out of the rolling moratorium.

To assist moratoria underwriting, insurers encourage members to seek authorisation of claims prior to treatment being received. This process is commonly referred to as '*pre-authorisation*'. This process enables any exclusions or pre-existing conditions to be identified and the member advised of their benefit entitlement before costs are incurred. Insurers will usually offer a helpline facility for use by members wishing to pre-authorise their treatment.

As discussed above, due to the nature of PMI in Ireland and the relevant legislation, this type of underwriting is not practiced in Ireland.

MEDICAL HISTORY DECLARATION (MHD)

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.

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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?

It should be noted that some insurers ask much more specific questions which point the applicant to the answers required. These insurers believe that asking specific questions helps the applicant in recalling previous medical events. This helps to prevent unintentional non-disclosure which can have precisely the same effect as intentional non-disclosure when a claim is made. Consumer protection law may, in the future, make these more specific questions a requirement.

The underwriter will usually also consider other factors such as:

- Age;
- Gender;
- start date of illness, duration and severity;
- frequency of symptoms;
- nature and effectiveness of treatment received;
- present state of health.

Note again, that within the Irish PMI market such data cannot be used 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.

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An exclusive special condition may also include a proviso that the underwriter's decision may be reviewed in the future (normally expressed as a number of years) when the medical outcome would be clearer. Similar decisions also need to be taken in order to reflect the risk for medical conditions which are of a non-permanent nature (e.g. broken bones / fractures).

Assessing risk from the information provided is a skilled job. The profitability of an insurer's product portfolio often depends on the ability of its underwriting staff to assess the risk correctly.

Whilst there is actuarial and statistical data available to assist in assessing the risk, much depends on the medical knowledge and experience of the underwriter. At the same time, underwriting procedures must be sufficiently flexible to ensure that the flow of new business is maintained and that potentially good quality business is not declined on account of excessively strict underwriting policies.

With increasing complexities of treatments and changing prognosis of conditions, the role of the PMI underwriter is gaining focus and prominence. Underwriters have access to medically qualified staff to obtain expert opinions and maintain the quality of their decisions. Many underwriters may have previous medical knowledge (e.g. paramedic or nursing experience).

(36 Marks)

Ref: Ch. 5, Section I

10. (A) Whilst Risk Equalisation in its current form has indeed been set aside by the Supreme Court Ruling (16th July 2008); nonetheless, it is important for students to understand the background to this mechanism and also the process that was to be applied had the legislation been implemented in full.

Risk Equalisation (RE) is a process that aims to equalise differences in health insurance claims rates that arise due to variations in risk profile. Risk Equalisation results in cash transfers from insurers with lower risk members to insurers with higher risk members. It involves transfer payments between health insurers to spread some of the claims costs of high risk members amongst all the private health insurers in the market in proportion to their market share.

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The **Health Insurance (Amendment) Act 2001** puts it this way:

"Risk Equalisation means the sharing of prescribed costs of registered undertakings between the undertakings by means of payment made by, or to, such undertakings in accordance with the terms and conditions of the scheme". (Source: **Health Insurance (Amendment) Act 2001,** Section 3F)

It may be helpful to decipher this. The key points are:

- Prescribed costs (i.e. not all costs, although the majority of costs are captured within the Risk Equalisation Scheme (RES) calculations).
- Undertaking (in effect, a PMI insurer).
- Between undertakings (i.e. between PMI insurers).
- By means of payments (these are made to the HIA by insurers with stronger risk profiles and by the HIA to insurers with weaker risk profiles).
- Terms and Conditions of the Scheme (i.e. a risk equalisation scheme, which is set out by the Minister in Regulations and provides the template within which the Health Insurance Authority (HIA) operates in respect of its role in the risk equalisation process).

The objective of RE is to replace an insurers' actual claims rates by what they would have been if the distribution of its policyholders with regard to factors affecting risk were precisely the same as that of the total insured population. It seeks, in effect, to replace an insurers' cost of claims by those applicable to the total market.

The intention of RE is, therefore, to put a health insurer in the position of experiencing the claims rates of the total insured market while experiencing its own cost of claims. However, the Risk Equalisation Scheme (RES) does not take into account the premium incomes received for these claims and only neutralises the claims rates without considering incomes.

(25 Marks)

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(B) Students will be expected to give their own opinion on this issue and justify their thoughts.

(20 Marks)

Ref: Ch. 2, Section A6

11. All health insurers are required to provide cover for a statutory minimum schedule of benefits as laid down in the **Health Insurance Act 1994 (Minimum Benefit) Regulations, 1996**. The rationale for this is:

- The provision of restricted cover, at a price reflecting such restrictions, could undermine community rating by attracting low-risk lives, leading to an increase in the price of cover for older / higher-risk lives.
- People might under-insure, through, inter alia, lack of information.
- The minimum benefit available from insurers should correspond to at least that which is generally available under the public system.

The Regulations require that a minimum level of benefit must be paid in respect of a broad range of investigative and medical interventions, which are regarded as appropriate and necessary and are provided on an in-patient or day-patient basis. The minimum benefits schedule in force corresponds broadly with the cover provided under: the QUINN-healthcare Essential and Essential Starter; Vhi Healthcare Plan A; Hibernian Aviva Health *Me* plans. Although in a number of areas all these plans do exceed the minimum benefit requirements.

Within this structure, health insurers are permitted to determine whether or not it is appropriate to pay benefits on an in-patient, day-patient or out-patient basis rate.

TREATMENT IN AN APPROPRIATE SETTING

If an insurer considers that treatment provided on an in-patient basis could have been provided on an out-patient basis, it is required to pay only the statutory minimum day patient or out-patient benefit (as appropriate). Equally, treatment provided on a day-case basis which could, in the insurers view, have been provided on an out-patient basis must be remunerated only at the statutory minimum out-patient basis.

MINIMUM BENEFIT IN RESPECT OF INPATIENT PSYCHIATRIC TREATMENT

Health Insurance contracts need to provide, under the minimum benefit regulations, for an entitlement to payments for 100 in-patient days.

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PREFERRED PROVIDERS

Insurers may also specify healthcare providers in respect of whose services the insured person is covered. The objective is to facilitate arrangements by insurers with preferred providers so as to contribute to cost containment without compromising the quality of care and, thereby, support the affordability of PMI. Each health insurer publishes a list of hospitals with whom it has negotiated an arrangement to provide services. A health insurer may exclude an individual health service provider from the scope of its cover if the same service is available from another provider specified in the contract.

Ref: Ch. 1, Section L3

12.

CLAIMS PROCESSING

- A regulated entity must take reasonable steps to verify the validity of a claim before making a decision on its outcome;
- Each regulated entity must have in place a written procedure for the effective and proper handling of claims;
- An insurance intermediary who assists a consumer completing a claim must, on receipt of the completed claims documentation, transmit such documentation to the relevant regulated entity without delay;
- Where there is a requirement to engage the services of a loss adjustor and/or expert appraiser the regulated entity must inform the claimant of the contact details of the loss adjuster and/or expert appraiser it has appointed and that such loss adjuster and/or expert appraiser acts in the interest of the regulated entity;
- The regulated entity must inform the claimant that they may appoint a loss assessor to act in their interests and that any such appointment shall be at the claimant's expense;
- A regulated entity must be available to confer with the claimant in relation to the claim and to discuss assessment of liability and damages during normal office hours or outside of these hours if agreed with the claimant;
- A regulated entity must advise the claimant in writing of the outcome of the investigation explaining the terms of any offer of settlement. If the claim is denied, the reasons for the denial must be provided to the claimant in writing;
- Where the policyholder will not be the beneficiary of the settlement amount, the policyholder must be advised in writing by the regulated entity of the final outcome of the claim including any details of the settlement amount paid;

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- A regulated entity must provide a claimant with written details of any internal appeals mechanisms available;
- A regulated entity must pay all claims to the claimant within 10 business days once the prescribed conditions have been satisfied (this does not apply to PMI claims where a hospital direct payment agreement is in place).

Ref: Ch. 6, Section D1C

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PMI C

THE INSURANCE INSTITUTE OF IRELAND
OCTOBER 2009 EXAMINATION PAPER

PMI C
PMI – LEGAL, REGULATORY AND BUSINESS PROCESSES

Two hours are allowed for this paper, which is in two parts.
The whole paper carries 150 marks.

Answer any **SIX** questions in Part I.
Each question in Part I carries 10 marks.
60 marks are available.

Answer any **TWO** questions from Part II.
Each question in Part II carries 45 marks.
90 marks are available.

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PART I

Answer any SIX questions in Part I.
All questions carry equal marks.

Note form is acceptable (in respect of Questions 1 – 8) where this conveys all the necessary information.

1. Briefly describe the current required Minimum Guarantee Fund for most types of non – life risks and the monetary amount prescribed.

2.
   - Outline the concept of "Community Rating". (6 marks)
   - State which act legally introduced this concept into Irish law. (4 marks)

3. List and briefly describe the THREE traditional distribution channels used for health insurance in Ireland.

4. (a) Explain the role of the Health Insurance Authority (HIA) in Ireland. (6 marks).

   (b) State the year and the act which established the HIA. (4 marks)

5. Explain why it is important for those who provide advise on insurance products (including PMI) to establish a clients needs in advance of any recommendations.

6. With regard to the general law of contract, briefly differentiate between a "warranty" and a "condition".

7. List any FOUR standard exclusions that are typical to Private Medical Insurance (PMI) policies outside Ireland.

8. Describe briefly what is meant by the term "Chinese Walls" when considering regulation and consumer protection.

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PART II
Answer TWO of the following FOUR questions.
All questions carry equal marks.

9. The imposition of waiting periods on Private Medical Insurance (PMI) contracts in Ireland is standard and designed to protect the community pool of funds.

   (a) Describe the concept of the "Pre-existing" waiting period and list what period of time must elapse before a 52 year- old can avail of benefits under the "pre-existing" rules.
   (15 marks)

   (b) Explain the position with regard to "Pre-existing" waiting periods if a person moves insurer.
   (15 marks).

   (c) Briefly outline the "upgrade" rule and how it could affect a person moving insurer.
   (15 marks)
   (Total 45 marks)

10. In a competitive market the pricing of goods or services is extremely important and this is no different in the Private Medical Insurance (PMI) market in Ireland. Therefore the task of setting the premium rate for a PMI plan is important.

    Identify and outline the major components which help determine the level of, and changes in PMI premiums.

11. The system of PMI in Ireland is very heavily regulated in favour of the consumer.

    (a) List the key aspects of the Health Insurance Act 1994 and explain their purposes.
    (30 marks)

    (b) Describe the risks to the market of PMI in Ireland if there was no such regulation in place.
    (15 marks)

12. The Financial Regulator's Consumer Protection Code came into effect in August 2006 with its full provisions becoming effective from July 2007.

    (a) Outline any SEVEN of the General principles of this consumer protection code.
    (35 marks)

    (b) State what is meant by the term CPD. (10 marks)

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PROMOTING PROFESSIONALISM SINCE 1885

PMI C – LEGAL, REGULATORY AND BUSINESS PROCESSES
October 2009
Suggested Solutions

The answers set out below show the main points to be considered by the candidates in answering the questions. In some cases a well reasoned alternative view could earn appropriate marks.

PART I

1. The amended first directive provides for the maintenance by insurers of a minimum guarantee fund. This fund must be maintained at a level equal to one third of the required solvency margin and it must be maintained in specified types of assets (paid up share capital and free reserves). The minimum guarantee fund cannot be less than an amount prescribed by the directive, irrespective of the level of business underwritten by the undertaking. Currently, the required amount of the minimum guarantee fund is €3 million for most types of non-life risks.

Reference: Chapter 1, Section B12 **(10 marks)**

2.

- *'Community Rating means that all persons regardless of age, gender, sexual orientation or medical history will pay the same premium for a specific level of health insurance cover. It is the cornerstone of the Irish (Private) Health Insurance system. In the absence of Community Rating, today's healthy individual could become tomorrow's uninsurable risk. The very existence of Community Rating, therefore, represents a broad protection to the community as a whole in terms of individual insurance rate stability and equitable access to insurance cover'.* (Government White Paper on Private Health Insurance, 1999, paragraph 3.2) **(6 marks)**

- The **Health Insurance Act, 1994** (S7) requires that, for a health insurance contract for a specified level of benefit, an insurer must charge the same premium in respect of all such contracts, irrespective of age, gender, sexual orientation or current or prospective health status of the insured lives.

Reference: Chapter 1, Section L1 **(4 marks)**

Total – 10 MARKS

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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))

DIRECT APPROACH

Since the inception of private health insurance in Ireland in 1957 with the launch of the Voluntary Health Insurance Board, the direct sales approach has been the main selling tool of the business in Ireland.

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.

Insurers in many other market sectors have set up direct marketing and telesales operations to maximise the use of customer information in cross-selling other products to members as well as for acquiring new customers directly, thereby avoiding payment of commission to intermediaries. Marketing database systems, using sophisticated data analysis techniques, are increasingly used to maximise sales opportunities. These systems and techniques may also be used to provide customer data for direct mail sales campaigns, with prospective customers receiving incentives to join directly.

In Ireland, the use of the Internet by the current health insurers is becoming very sophisticated with not only very specific health insurance product information being available, but also for, for example:

- access to a wide range of health related information;
- weight loss programmes;
- selling of different health related insurance products e.g. travel insurance;
- access to purchase health related products e.g. fitness equipment and contact lenses for instance;
- purchase of health insurance policies without need of application form;
- access to claims information on-line and in some situations the ability to register a claim on-line;
- access for member to update details e.g. address, date of birth etc;
- management of Group schemes.

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INTERMEDIARIES

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.
Employee benefit consultants normally work on a fee-for-service basis with large corporate clients who provide health insurance to their employees as a fully or partially subsidised benefit.

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.

Since the introduction of VIVAS Health (now Hibernian Aviva Health) in October 2004, the market has changed in that Hibernian Aviva Health has taken a decision to use the insurance intermediary channel and pay commission for the placing of business. This is a new departure in Ireland and Hibernian Aviva Health claim that it has proven to be highly successful for them in both the corporate and individual market with a significant percentage of their portfolio coming from the intermediary market. Some insurance intermediaries however, have stated that in order to remain independent, they will continue to work on a non-commission basis. QUINN-healthcare has also commenced distributing its health insurance for a particular product package through select intermediaries – only time will tell how this will effect overall market distribution. There is evidence now of an increasing number of intermediaries seeking new agencies with Hibernian Aviva Health as they see healthcare as a potential new source of income from their client banks.

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.

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They therefore act as a *'sales person'* for a given insurer within a company and act as trusted parties when employees have questions about the type and level of health insurance to choose.

Reference: Chapter 2, Section A4 **(10 marks)**

4. (a)The Health Insurance Authority (HIA), unlike the Financial Regulator, is only concerned with the health insurance market in Ireland and it is the independent statutory regulator for the private health insurance market in Ireland. The Authority monitors the operation of health insurance business and advises the Minister for Health and Children in this regard. This includes assessing the effect of any regulations or new legislation on consumers much like the Financial Regulator does in relation to insurance as a whole. The Authority aims to ensure that consumers are aware of their rights; that policies and publicity material describe cover in a fair and comparable way and that community rating, open enrolment and lifetime cover are protected and maintained. The Authority also reviews the appropriateness of the procedures used by insurers in their dealings with consumers. **(6 marks)**

(b)The Health Insurance Authority was established by Ministerial Order in February, 2001 under the **Health Insurance Act, 1994** and operates in accordance with the provisions of this Act, the **Health Insurance (Amendment) Act 2001** and the **Health Insurance (Amendment) Act 2003** ('*the Health Insurance Acts'*). This legislation provides for the operation and regulation of the business of private health insurance in Ireland.

(4 marks)

Reference: Chapter 2, Section C & C1 **Total 10 marks**

5. All persons providing insurance advice(incl. PMI) to individual or company clients need to first establish their client's needs. This will include those things that the client identifies as a requirement and those elements introduced by the advisor as being either desirable (but unknown to the client) or necessary. The Financial Regulator has indicated minimum requirements in its consumer protection code as follows:

- A general principle that a regulated firm must seek from its customers information relevant to the product or service requested; and
- A more detailed requirement that, before providing a product or service to a consumer, a regulated entity must gather and record sufficient information from the consumer to enable it to provide a recommendation or a product or service appropriate to that consumer. The level of information gathered should be appropriate to the nature and complexity of the product or service being sought by the consumer, but must be to a level that allows the regulated entity to provide a professional service. (e.g. with regard to PMI cover a person may be asked what type of hospital accommodation they would like, any specific type of hospitals they would like cover for or maybe would cover for Out-Patient expenses be important).

Although, as an agent, the intermediary's role is to take instructions from their client and execute these in an efficient manner, the intermediary is very often the party with the expertise and will usually have a much greater knowledge of the insurance market, legal requirements and regulation than the client.

Reference: Chapter 3, Section H **(10 marks)**

6. The terms of a contract can be classified into Conditions and Warranties. This classification is based on the importance of the terms and the consequences if they are broken.

A warranty (in the general law of contract) is a term that affects only some relatively minor aspect of the agreement. If it is broken, the injured party has a right to claim damages but not, in general, to avoid the contract.

A condition (in the general law of contract) is a term that relates to an important aspect of the agreement. It *'goes to the root'* of the agreement and if such a term is broken the victim has a right not only to claim damages, but also to avoid the agreement.

Reference: Chapter 4, Section C2C **(10 marks)**

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7. Insurers limit their exposure by the implementation of standard exclusions. The following standard exclusions apply to most types of PMI policies outside Ireland:

- pre-existing conditions;
- conditions developing during waiting period
- attributable to Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS);
- alcohol, solvent or drug abuse (must be covered in part under minimum benefits in Ireland);
- cosmetic surgery; (may be covered if due to medical condition in Ireland)
- drugs and dressings other than those prescribed by the specialist during inpatient / day case treatment;
- war, invasion or civil riot. **(any 4 for full marks)**

Reference: Chapter 5, Section I1

8. *'Chinese walls'* means an arrangement within the regulated entity which requires information held by the entity to be withheld in certain circumstances from other operating units / persons with whom it deals in the course of carrying on another part of its business.

- A regulated entity must ensure that there are effective Chinese walls in place between the different business areas of the regulated entity, and between the regulated entity and its connected parties in relation to information which could potentially give rise to a conflict of interest or be open to abuse.

Reference: Chapter 6, Section D1B **(10 marks)**

PART II

9. **(A)** Health insurers are permitted to impose a general moratorium known as an *'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 outlined in table below.

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The maximum waiting periods that may be imposed by an insurer in relation to pre-existing conditions are outlined in Table below.

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.

(15 Marks)

TRANSFERABILITY

(B) When an insured person moves from one insurer to another they carry with them the years of service served with their previous insurer. Eg. If a person is insured with VHI for 20 years and moves to Hibernian Aviva Health they transfer into Hibernian and are given credit of 20 years provided there is no break in cover. Therefore they do not have to re-serve any additional waiting period or pre-existing rules with their new insurer. This therefore is 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.

(15 Marks)

Reference: Chapter 1, Section L2A

(C) UPGRADE RULE

Where an individual upgrades their level of cover, an insurer may impose a waiting period of up to 2 years (for pre-existing conditions), during which benefits are payable only at the rate applicable to their previous level of cover (aged 65+, 5 years).

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. **Reference; Chapter 1, Section L2A2** **(15 Marks); Total (45 Marks)**

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10. This section identifies the major components which help determine the level of, and changes in, premiums. The starting point is that PMI providers in Ireland operate within a Lifetime Community-Rated System. This is wholly different to the experience of the Risk Rated system which exists, for example, in the UK. Also, pricing strategies require, in the first instance, robust systems for capturing and tracking claims costs. Over and above these elements, there are a number of factors which impact directly on premium pricing strategies They include the following:

1. Determination of the product content:

- Inpatient component;
- Outpatient (daycare) component;
- Outpatient (day to day) component;
- Level of care to be provided;
- The benefits structure embedded in a product has an important impact on future claims costs.

2. Prospective take-up of products

- The demographics composition, and likely claims occurrence, of categories covered by the product must be reflected in costing procedures and in premia determination:
  - Children / Adult / Family;
  - Group Schemes vs. individuals;
  - Male / Female.
- The propensity of these different categories (e.g. children vs. adults) and age groups (in 5 or 10 year cohorts) to make claims.

3. Projected use of medical services:

- The claims propensity of those using alternative as compared with conventional medicine, may be different in key areas e.g. hospitalisation;
- The uptake of screening and more generally, both of which will impact on prospective claims and, hence, on premia;
- Preventative medicine.

4. Nature of procedures:

- Insurers specify a fixed cost for procedures as the basis for remunerating consultants;
- Complexity of procedures, which impacts on cost and, hence, on claims. PMI insurers in Ireland operate according to accepted international norms in deciding the relative complexity of procedures;
- There are also fixed cost procedures e.g. maternity, which must be factored into product planning and

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premia pricing strategies;

- The focus of treatment is also important in this regard; specifically, the progressive trend towards the use of day-case contributes to a lower cost of claims.

5. Primary Care - Referral Patterns:

- Patterns of GP referral are critical in determining claims cost. A leading authority (Boland, 1999) points out that

  "Healthcare may be viewed as a spectrum. Most people are healthy. Many more manage their own illnesses and complaints with the help of community pharmacists, friends and common sense. Those who do not, consult their GPs and others in primary care. A small proportion of these reach secondary care. Very few reach tertiary care. For all the images of crowded hospital outpatient departments, it is worth remembering that 10 times as many patients attend GP surgeries. 96% of those who attend GPs are not referred on for consultation with a specialist, 4% result in referral and 8% involve a significant laboratory investigation. If the percentage of patients cared for exclusively in General Practice were to increase from 96% to 97%, the number of patients reaching hospital would drop by 25%. This is the nature of the interface. It is vital that we put in place methods of assessing the quality of referrals with a view to continuous improvement. Any referral should be necessary, timely, and appropriately directed. All involved should be satisfied with the process and outcome. Overall, it should achieve its objectives in a cost effective manner."

- PMI insurers have, in very recent years, integrated GP services into their total product offerings. Properly structured, they provide a means of achieving a systems reduction in claims cost (since this reduces the propensity to opt for expensive inpatient treatment). QUINN-healthcare's *Health Manager*, which, in addition to hospital treatment, allows customers to claim half of their outpatient costs including GP fees, charges for tests and screening and specified dental care, with no excess, broke new grounds in Irish PMI. Vhi Healthcare, for its part, indicated in its Annual Report, 2000 (p21) that it intended to introduce a primary care scheme to cover GP's, Dental and Optical services as part of an integrated healthcare strategy, and in September 2001 it launched its *HealthSteps* product.
- The net effect of these and related initiatives will be to reduce future claim costs, as well as to add value to customers through improved preventative measures, and, thereby, impact on competitive premia pricing strategies.
- The introduction of *Stage of Life* plans from each of the insurers are also aimed at reducing the claims costs by being more preventative in their approach.

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6. Key Premia Drivers:

- Accommodation:
  - Level of accommodation;
  - Nature of hospitalisation (e.g. high tech);
  - Average length of stay (ALOS).

  Public Hospitals:
  - Bed charges for private / semi private rooms in public hospitals are determined by the Minister for Health and Children.
  - A key factor impacting on medium term costing strategy is the proposed move, signalled by Government, to so called *"full economic costing"* for private beds in public hospitals. In January 2009 an increase of 20% was imposed and further increases are expected in the near future. This has a huge impact on premiums and indeed all current health insurers have indicated that this is the main element of their current or proposed premium increases.

  Private Hospitals:
  - Bed charges paid by insurers are negotiated annually with individual hospitals, in consultation with the Independent Hospital Association of Ireland (IHAI).
  - Charges are impacted by the level of services (proxied by case-mix intensity), by specific hospital specialisms, proposed investment by hospitals in e.g. technology and other relevant factors.

  Consultants:
  - Regulations specify a minimum schedule of benefits.
  - Insurers specify a schedule of benefits by which consultants are remunerated for specified procedures.
  - Consultants who accept (99% in practice) are called *'participating consultants'*, they are paid at the maximum rate and agree not to charge any incremental fee.
  - Non-participating consultants are remunerated at a lower rate, which they generally augment by *"balance billing"* of patients.

7. Adjustments

Plans have to be adjusted to take account, so far as possible, of the likely average cost of a particular product. This requires, among other things, imputing a cost into premia calculations for children who are *'free'* and, also, for those who are charged as students (who are provided with cover at a lower cost to the adult rate) and, finally, for Group schemes for whom a 10% discount on premia is available.

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8. **Fixed costs / Administrative costs**

Potential entrants, in formulating a premia pricing strategy, must take account of initial start-up costs, of fixed costs (premises, IT, etc), variable costs and incremental costs, which accrue as the business develops.

9. **Cost of capital solvency requirements**

There is a cost to capital which must be remunerated and factored into premia pricing. Vhi Healthcare is, at present, constituted as a not-for-profit body and is exempt from EU solvency requirements but this was due to change by the end of 2008 from when Vhi Healthcare will be expected to meet the EU solvency requirements. As referenced in Chapter 1, Section F1B, this date has now been pushed out to 31 March 2009 by Ministerial order.

Any new potential entrants into the Irish market are likely to be commercial insurers who will, in determining premia, have to generate an acceptable return on capital; probably in excess of some pre-determined *'hurdle rate'*. Hibernian Aviva Health and QUINN-healthcare are regulated by the Financial Regulator and must maintain set down minimum levels of solvency. (
5 marks for each point)

Reference: Chapter 5, Section F3 **(45 marks)**

11. **A)** The Irish private health insurance market is governed by a set of rules and legislation which lays down the terms and conditions which all private medical insurers must follow when developing and bringing to market health insurance plans.

The **Health Insurance Act, 1994** enshrines the four principles of private health insurance into Irish law. These are:

- community rating;
- open enrolment;
- lifetime cover; and
- minimum benefits.

There is also an emphasis on the best overall interests of consumers which includes a reference to the need to maintain the application of community rating across the market for health insurance and to facilitate competition between undertakings. One of the functions of the Health Insurance Authority is to ensure that these principles are maintained by all registered undertakings in the Irish market.

Reference: Chapter 1, Section L

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COMMUNITY RATING

'Community Rating is the cornerstone of the Irish (Private) Health Insurance system. In the absence of Community Rating, today's healthy individual could become tomorrow's uninsurable risk. The very existence of Community Rating, therefore, represents a broad protection to the community as a whole in terms of individual insurance rate stability and equitable access to insurance cover'. (Government White Paper on Private Health Insurance, 1999, paragraph 3.2)

The **Health Insurance Act, 1994** (S7) requires that, for a health insurance contract for a specified level of benefit, an insurer must charge the same premium in respect of all such contracts, irrespective of age, gender, sexual orientation or current or prospective health status of the insured lives. Importantly, in regard to the latter, the intention of Government was to ensure that insurers did not use genetic testing for screening purposes.

Reference: Chapter 1, Section L1

There are a number of exceptions to this key principle of Community Rating:

- The rate charged for children under 18 may not exceed 50% of the adult charge for the corresponding level of cover.
- The rate for students between 18 and 23 who are in full-time education and are dependent on the person with whom the contract is affected may be reduced by at least 50% of the adult rate. The White Paper allows for the extension of student rate to 23. Hibernian Aviva Health are currently the only insurer to provide a student rate to 23, both QUINN-healthcare (formerly BUPA Ireland) and VHI Healthcare currently provide a student rate up to age 21 .
- Discounts of up to 10% on premiums, which are paid through Group Schemes, are permitted.

OPEN ENROLMENT AND LIFE TIME COVER

The **Health Insurance Act 1994**, as modified by the 2001 amendment, requires that PMI providers:

- Accept all individuals. There was a provision in the 2001 Act to extend this to over 65 year olds but this was not introduced into legislation until July 2005 by means of the **Health Insurance Act 2001 (Open Enrolment) Regulations 2005.**
- Provide lifetime cover i.e. once an individual has been put on cover, the insurer may not cancel or refuse to renew such cover.

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The **Health Insurance Act 1994 (Open Enrolment) Regulations 1996**, and the **Health Insurance (Amendment) Act 2001** in respect of Open Enrolment allow insurers to impose Waiting Periods.

Reference: **Chapter 1, Section L2**

MINIMUM BENEFITS

All health insurers are required to provide cover for a statutory minimum schedule of benefits as laid down in the **Health Insurance Act 1994 (Minimum Benefit) Regulations, 1996**. The rationale for this is:

- The provision of restricted cover, at a price reflecting such restrictions, could undermine community rating by attracting low-risk lives, leading to an increase in the price of cover for older / higher-risk lives.
- People might under-insure, through, inter alia, lack of information.
- The minimum benefit available from insurers should correspond to at least that which is generally available under the public system.

Reference: Chapter 1, Section L3

The Regulations require that a minimum level of benefit must be paid in respect of a broad range of investigative and medical interventions, which are regarded as appropriate and necessary and are provided on an in-patient or day-patient basis. The minimum benefits schedule in force corresponds broadly with the cover provided under: the QUINN-healthcare Essential and Essential Starter; Vhi Healthcare Plan A; Hibernian Aviva Health *Me* plans. Although in a number of areas all these plans do exceed the minimum benefit requirements.

Within this structure, health insurers are permitted to determine whether or not it is appropriate to pay benefits on an in-patient, day-patient or out-patient basis rate. (30 marks)

Reference Chapter 1, Section L3

B)

- A particular feature of insurance is that of the **serious financial harm caused to customers** who do not receive the claim payment due to them and in the case of health insurance the payment of a claim either directly to the member or hospital concerned. This has been a traditional reason for regulating the insurance market.
- A huge impetus for better regulation of the insurance (including health) market in recent years has been created by the need for a **high standard of consumer protection** in terms of the protection of rights, fair treatment of customers and the provision of a competitive and stable market.
- The **failure of insurance providers** can harm the **economy's macroeconomic stability**. One insurer's problems may easily spread to other insurers, reinsurers and banks that are involved with the troubled company and indeed, in the case of health insurance this could also affect Government.

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- On a larger scale, a **general loss of confidence in insurance providers** undermines the basic system on which any economy runs. This is especially important for health insurance in Ireland when you consider that nearly 52% of the population are actually insured.

An insurance provider fails to meet its goals when it is unable to meet its obligations to its customers or claimants. Because the potential consequences of an insurance provider's collapse are so harmful, governments attempt to prevent such failures through extensive regulation of their domestic insurance systems, procedures and solvency. Well-managed insurers themselves take precautions against failure even in the absence of regulation, but because the costs of failure extend far beyond the company's shareholders, regulation of insurance business and practice is a priority for government departments around the world.

Ref: Chapter 2 Section B1 (15 marks) **Total 45 Marks**

12.

A) (Any seven of the below for full marks – 5 marks each)

ARTICLE I. GENERAL PRINCIPLES

A regulated entity must ensure that in all its dealings with customers and within the context of its authorisation, it:

- acts **honestly, fairly and professionally** in the best interests of its customers and the integrity of the market;
- acts with **due skill, care and diligence** in the best interests of its customers;
- **does not** recklessly, negligently or deliberately **mislead a customer** as to the real or perceived advantages or disadvantages of any product or service;
- has and **employs effectively the resources and procedures, systems and control checks** that are necessary for compliance with this Code;
- seeks from its customers **information relevant to the product or service** requested;
- makes **full disclosure of all relevant material information**, including all charges, in a way that seeks to inform the customer;
- seeks to **avoid conflicts of interest**;
- **corrects errors** and handles complaints speedily, efficiently and fairly;
- **does not exert undue pressure** or undue influence on a customer;
- ensures that any outsourced activity complies with the requirements of this Code;
- without prejudice to the pursuit of its legitimate commercial aims, **does not**, through its policies, procedures, or working practices, **prevent access to basic financial services**; and

complies with the letter and spirit of this Code. (any seven @ 5marks each 35 marks)

Reference: Chapter 6, Section D1A

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B) Continuous Professional Development (CPD)

All accredited individuals and specified accredited individuals, whether accredited through grandfathering or obtaining a recognised qualification, will be obliged to complete a number of hours of CPD each year. The content of the CPD hours must be directly relevant to the activities undertaken by the accredited individual. Therefore a person selling health insurance must gain CPD in an area associated with health insurance.

(10 marks)

Ref: Chapter 6, Section D2

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