RGA Global Claims COVID-19 Pulse Survey **2021**

RGA

The scale of the COVID-19 pandemic is unprecedented in our lifetimes, and it has significantly disrupted the business of health and life insurers over the last two years. Conservative estimates put total life insurance and reinsurance losses from COVID-19 at US$40 – US$60[1] billion, but to-date balance sheets have proved resilient to the impact. However, in addition to the financial impact and business continuity plans, insurers have had to adapt to other challenges as a result of the pandemic - including difficulty obtaining official documents and medical reports or the ability to arrange medical reviews or examinations to confirm disability. This paper examines how claims managers responded to these challenges.

RGA conducts surveys as part of our commitment to our clients and their efforts to better serve their markets. We sincerely appreciate your support.

Marilda Kotze
Global Head of Claims, RGA
mkotze@rgare.com

[1] Reinsurance News Articles: https://www.reinsurancene.ws/covid-19-insurer-reinsurer-loss-reports/
https://www.artemis.bm/news/covid-19-insurance-reinsurance-industry-loss-estimate-berenberg/

About this Survey

RGA conducted the survey online globally from July to September 2021. Responses were requested from the claims functions within the insurance companies. The 61 companies who responded are located all around the world, and the survey was administered in three languages. Survey findings reflect insights and data collected from 2020 experience.

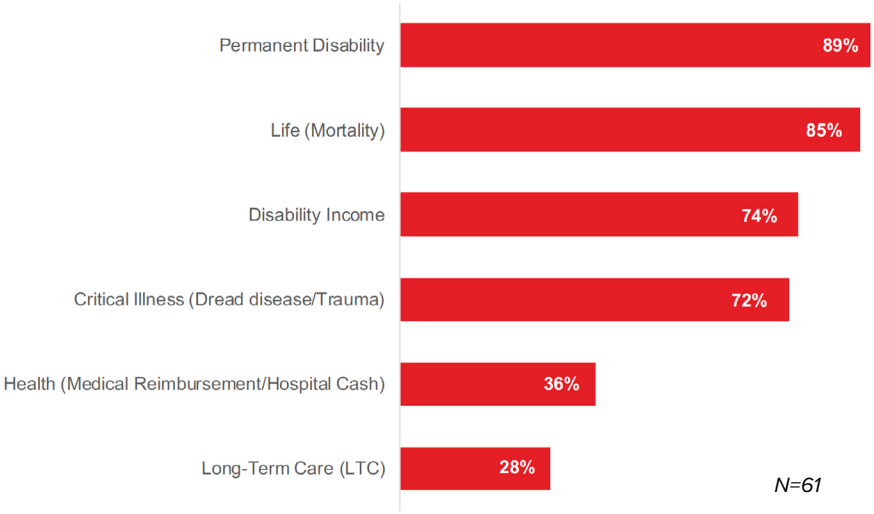
RGA would like to thank all the respondents for participating in this survey. Based on this initial study, RGA may conduct this survey again in the future, pursuant to online industry trends. A full list of participating companies can be found in Appendix A.

Claims Management in a COVID-19 world

Benefits and General Trends

To put our survey into context, as indicated in Figure 1, there was a broad mix of benefits managed by respondents, with Life and Permanent Disability being most common.

Figure 1.
Benefits Managed by Claims Team



Based on data and experience, RGA is aware that the vast majority of claims to date have arisen in mortality benefits, with Health and Disability Income accounting for almost all the rest. The number of Permanent Disability, Critical Illness, and Long-Term Care claims has been minimal.

70% of respondents reported that the number of claims they managed had increased during the pandemic, with 36% indicating a significant increase in claims volumes.

The survey findings in Health claims are mixed, with 32% reporting an increase in claims and 37% reporting decreasing claims. The remaining 31% reported no change in volumes. This appears to be very country-specific with no consistent regional pattern across North America, EMEA, or Asia Pacific.

36% of companies who manage Disability Income benefits reported an increase in average durations of claims. We will explore this more closely when we look at some of the impacts COVID-19 has had on evidence gathering.

Overall acceptance rates increased, which was likely due to several factors. A majority of claims were mortality related. The pandemic led to streamlined processes and reduced evidential requirements, particularly early on in

the pandemic. Also, non-disclosure of a history of COVID-19 was unlikely, even where policies might be relatively new. 12% of respondents observed increased fraud activity, but this was specific to writers of Disability Income.

Only 13% of respondents had a pandemic risk exclusion in their policy terms, and all but one applied the exclusion throughout the pandemic. The one respondent who did not apply their exclusion did so as part of an industry agreement within their jurisdiction.

Most insurers developed specific reporting related to COVID-19 claims and shared those results with management and/or a dedicated Pandemic Risk Team, and 13% of respondents created dedicated teams to assess COVID-related claims. 15% of respondents produced no specific reporting of COVID-19 claims, including in France, Italy, and the United States—a surprising finding for countries with high COVID-19 rates.

Claims Management

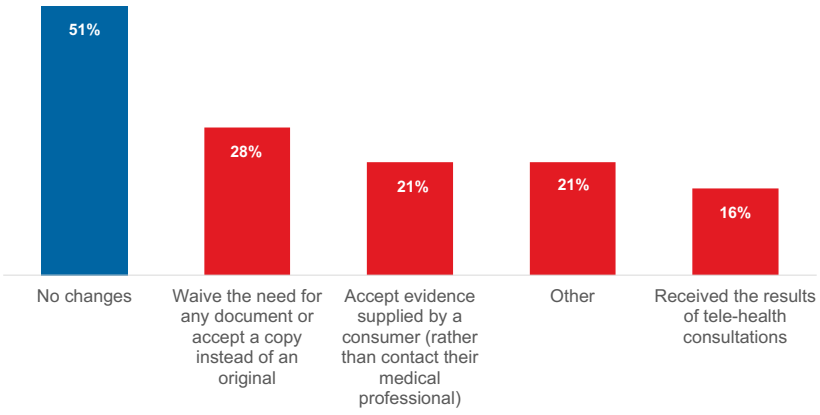
We asked participants whether they amended claims processes as a result of COVID-19. The following demonstrates the breadth of changes made by companies in managing claims during the pandemic. In addition to the areas we identified, there were also many changes made at a company level that didn't meet these criteria. Many of these items are covered below where we discuss evidential standards.

Figure 2.
Amended Claims Processes Due to COVID-19

Earlier we mentioned that durations on Disability Income claims increased during the pandemic. Figure 2 shows that one of the key process changes adopted during the pandemic was an extension of in-payment review periods, which is almost certainly the key driver of the increased durations. Although other factors, such as the difficulty consumers faced in visiting healthcare professionals, contributed to the extended durations, the results demonstrate the need to return to timely claims reviews as soon as circumstances permit.

We also surveyed respondents if the standard of evidence required was reduced due to the pandemic. Although just over half of respondents indicated they made no changes to the evidence required for a claim, the remainder used a combination of approaches to reduce the evidential requirements:

Figure 3.
Standard of Evidence Removed or Reduced for Case Assessment



Interestingly, some participants observed that, even though the way the evidence was obtained changed, the standard was not reduced and, as a result, led to no additional risk.

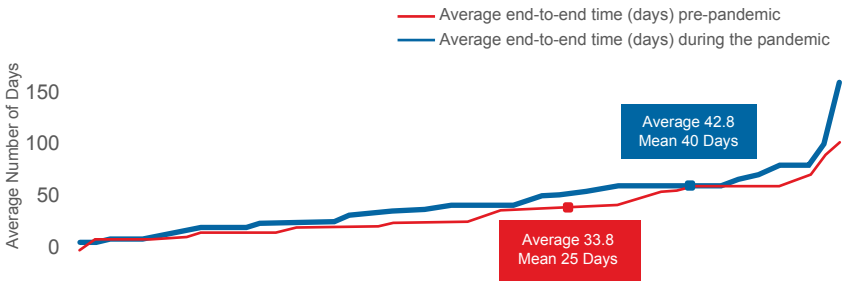
Of the companies who made changes to their claims' management practices or evidential requirements, 86% indicated that these changes were temporary and subject to review, with 19% setting a time limit. However, 14% indicated that the changes they had made would be treated as permanent.

48% of respondents indicated that the changes they implemented were exclusively a business decision taken within their own company. 20% indicated that the changes resulted exclusively from regulatory directives and 5% as a result of an industry agreement. The remainder is a mix of all three items, with some changes purely commercial and others driven by regulation or by industry agreement.

57% of respondents consulted their lead reinsurer prior to amending their process or evidential requirements, which is consistent with the fact that many of the changes were made as a result of a regulatory directive or industry agreement where reinsurers would likely be involved in the broader discussions.

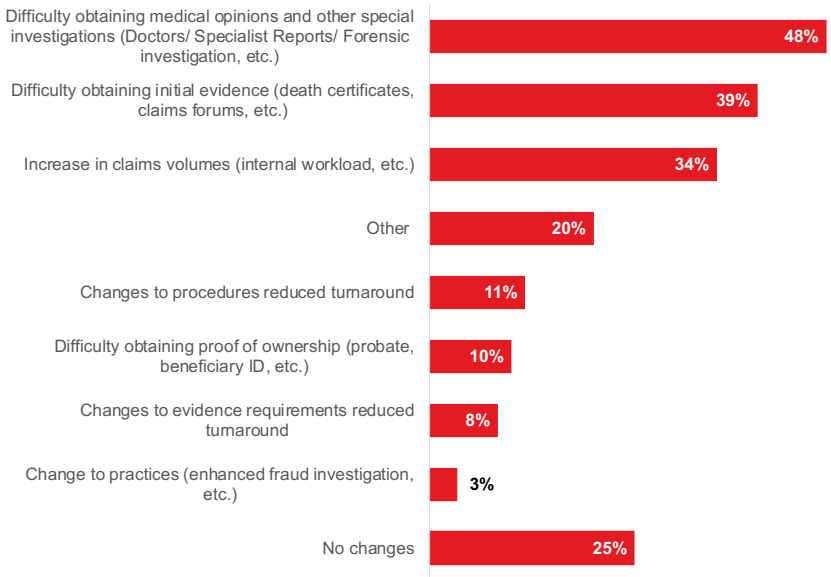
Despite the changes discussed above, the average end-to-end ("E2E") time for claims increased from 34 days pre-pandemic to 43 days during the pandemic, reflecting a 26% increase in the average E2E. Given this outcome, what additional future solutions might we consider to ensure consumer outcomes are not impacted to this extent?

Figure 4.
Average End-to-End Time (from claim notification to final decision)



To understand this in more detail, we looked at the key drivers of changes to the E2E times. Figure 5 shows that across the industry the positive impact of the changes to procedures and evidence were not sufficient to offset the difficulty obtaining important documents or evidence, coupled with the pressure of increased volumes on internal resource.

Figure 5.
Drivers for Changes to End-to-End Turnaround Times

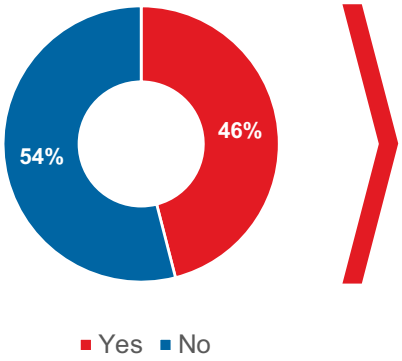


Long-COVID Claims

Almost half of respondents have received Long-COVID claims during the pandemic, with respiratory impairment, fatigue, and mental health problems most commonly reported. Notably, Long-COVID featured in almost all markets surveyed. These claims have arisen almost exclusively in the Disability Income space, with very few claims arising in the Critical Illness or Permanent Disability benefits.

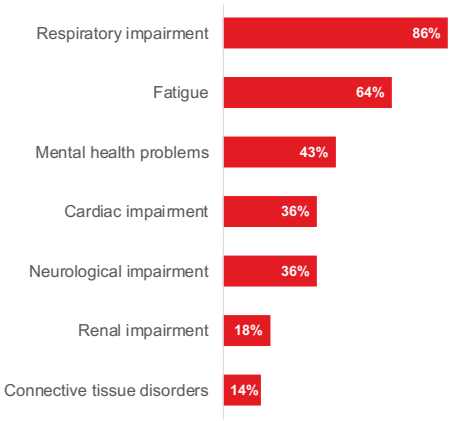
Figure 6.

Long-COVID Claims (Beyond Short Disability Income Claims Due to Acute Infection)



61 Respondents

Main Long-COVID Impairments for Claims



28 Respondents

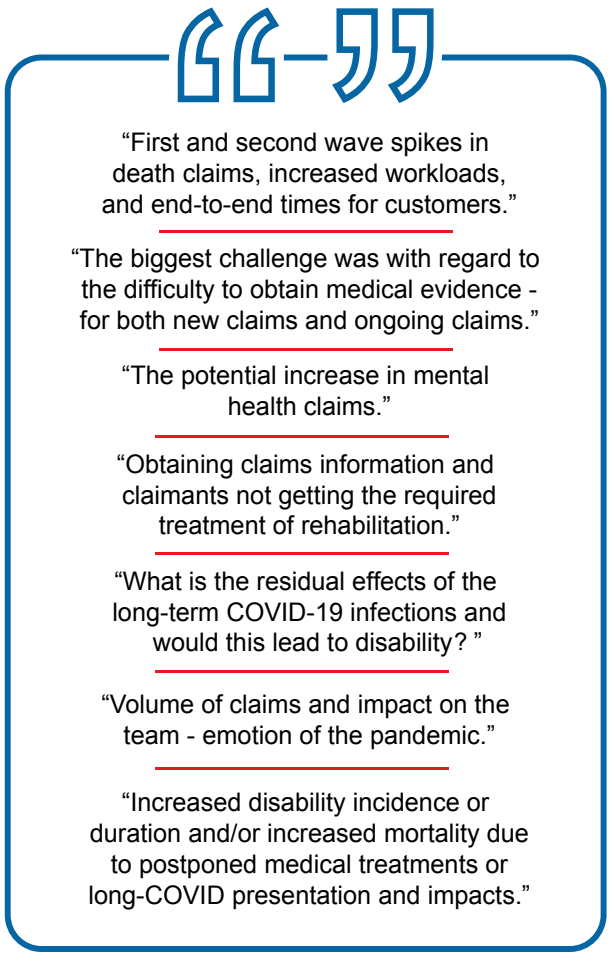
Challenges and Concerns

We asked respondents to discuss the key challenges and concerns they had as a result of the pandemic, as well as how prepared they felt they were when it arrived. We also asked them to consider the changes they made as a result of the pandemic and what impact those changes had on their level of preparedness for future events.

The key challenge identified was increased volume of claims, while difficulty obtaining evidence to assess claims was also widely mentioned. This word cloud shows the challenges indicated in our survey.

The impact of Long-COVID and mental health impacts were seen as key concerns. Also, claims managers were concerned about the long-term impact of the pandemic where people had been unable to obtain appropriate medical intervention for other diseases and what that might mean in terms of future claims.

Here is some of the specific feedback from clients:



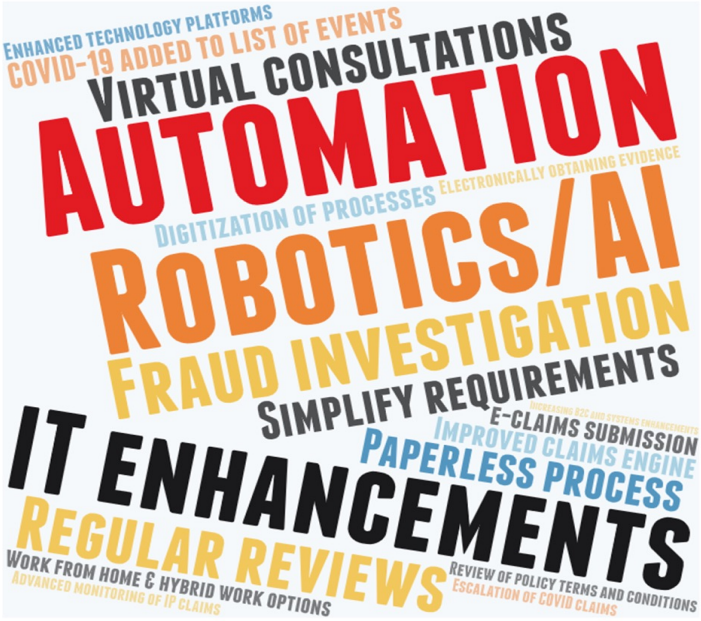
Preparedness

Overall, companies believed they were well prepared for the pandemic, assigning themselves a grade of B (on a scale of A+ to F), with 24 respondents giving a result of at least A-. However, 11 respondents scored themselves as C+ or lower with 2 rating their preparedness for the pandemic with an F.

Looking forward companies believe they are now better placed to deal with future events, and overall preparedness increased from B to A. This improvement was across the scale, with only one firm indicating they were at C+ or below and 44 giving a result of at least A-.

Other Operational Changes

All respondents are considering additional changes to their claims approach, and many are looking to introduce fully digital claims services—including Claims Engines, virtual consultations, and electronic evidence collection.



Conclusion

The survey demonstrates a willingness and ability on behalf of the industry to adapt to the unique circumstances driven by the pandemic. Working together through industry bodies and with regulators, insurers took a number steps to ensure claims were managed and paid despite the challenges of obtaining the evidence required to make claim assessments. It is recognized that E2E times increased by 26% during the pandemic. Overall, it is encouraging that all respondents are looking at the way they do business and seeking ways to simplify the process for consumers.

Although fraud was a concern for respondents, only a small number had seen an increase in fraud, which was limited to writers of Disability Income. The impact of Long-COVID is more significant, with a broad spectrum of conditions arising post-infection. These range from severe respiratory or organ impairment to fatigue and impacts on mental health.

Generally, companies felt well prepared for the pandemic and feel some of the changes they made as a result put them on a sound footing to deal with any future events. That said, it appears that the pandemic will also be a catalyst to introduce, or at least speed up, the move to greater use of technology throughout the claims process.

Appendix A: Survey Participants

RGA would like to thank the following companies for their participation in our 2021 COVID-19 Pulse Survey:

Achmea (Netherlands)

ADNTC (United Arab Emirates)

Aegon (United Kingdom)

AF LIFE (South Africa)

AIG Life Ltd (United Kingdom)

Al Jazira Takaful (Kingdom of Saudi Arabia)

AmTrust Assicurazioni spa (Italy)

April Santé Prévoyance (France)

Arca Vita (Italy)

Aviva (United Kingdom)

AXA Insurance Pte Ltd (Singapore)

BPCE VIE (France)

CBP France (France)

Cigna Worldwide (Hong Kong)

Clientele Life (South Africa)

Country Financial (United States)

Dai-ichi Life Vietnam (Vietnam)

EUROVITA (Italy)

FMI (South Africa)

Gibraltar BSN Life Insurance Berhad (Malaysia)

Groupama Assicurazioni (Italy)

Helvetia Vita (Italy)

Hollard Group Risk (South Africa)

HSBC (United Kingdom)

Legal and General (United Kingdom)

Liberty Life (South Africa)

LifeCare Assurance Company (United States)

Madison National Life Insurance Company (United States)

MAIF VIE (France)

MALAKOFF HUMANIS (France)

Manulife (Malaysia)

MCIS Insurance Berhad (Malaysia)

Metlife (Italy)

MLRe (Malaysia)

Momentum (South Africa)

Nedbank Insurance (South Africa)

Old Mutual (South Africa)

Orient Insurance, PJSC (United Arab Emirates)

PHKL (Hong Kong)

Prevoir (France)

PVA (Vietnam)

Renaissance Life and Health Insurance Company (United States)

Royal London (United Kingdom)

Sanlam (South Africa)

SBIB (South Africa)

Scildon (Netherlands)

Scottish Widows (United Kingdom)

SECURIMUT (France)

SILAC Insurance Company (United States)

Standard Insurance Company (United States)

SWISS LIFE (France)

Takaful Oman Insurance SAOG (Sultanate of Oman)

Universal Life Insurance Co. (United States)

UTWIN (France)

Voya Financial (United States)

Waard Verzekeringen (Netherlands)

Zurich Topas Life (Indonesia)

Disclaimer

This detailed, confidential summary of the survey results is being provided to each company that participated in the survey.

This report is for information purposes only. The information contained herein is not exhaustive and does not cover all the issues, topics, or facts that may be relevant to this subject.

All participating companies have agreed that the results gained from this survey will be used for internal purposes only, and will not be used in marketing, sales materials, or part of any sales activities.

Contact us to discuss your company's claims practices and ask further questions regarding the survey results to provide insights and analysis. RGA strives to enable the life insurance industry to undertake important changes managing claims processes and standards.

For more information regarding this survey, please contact:

Philip Thomas
Executive Director, Global Claims, Governance and Reporting
phthomas@rgare.com

Jennie Calder-Brown
Executive Director, Global Claims, Research, Development & Training
jcalderbrown@rgare.com

Gayle Kanchanapume
Executive Director, Global Claims, Value Added Specialist
Gayle.Kanchanapume@rgare.com

About RGA

About RGA Reinsurance Group of America, Incorporated (NYSE: RGA). RGA is one of the largest global providers of life reinsurance and the only global reinsurance company focused solely on life and health reinsurance. With headquarters in St. Louis, Missouri, and operations around the world, RGA delivers expert solutions in individual life reinsurance, living benefits reinsurance, group reinsurance, health reinsurance, financial reinsurance, facultative underwriting, claims, and product development.