RGA

Global Claims Views

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Welcome to the first edition of *Global Claims Views* - a newsletter for our clients from RGA's International Claims Team.

This newsletter will feature short, topical articles about important claims issues in markets around the world, written by RGA Claims experts.

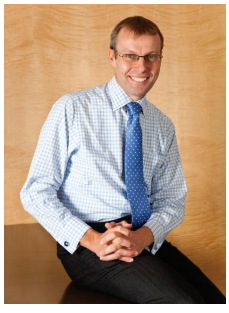
For this first edition, we are featuring articles from:

- **U.K.:** Interpreting the heart attack definition for critical illness
- **North America:** 2012 surveys – trends in group and individual disability case management
- **South Africa:** Training initiatives for assessors and advisors
- **Australia:** The growing tension between the insurance industry and mental health groups
- **Hong Kong:** Healthcare reform

RGA today has a global network of offices in 25 countries, and clients throughout North America, Europe, Africa, Asia (including Australia), and South America.

We hope you find *Global Claims Views* interesting, informative, and helpful! If you would like more information on any of the articles here, to suggest a topic for a future edition, or competitive information on any market issue, please contact your local RGA representative. We are as always available and keen to help and share our expertise.

Our global network of claims experts can help you with questions on claims both inside and outside your local market. Please contact your local RGA Claims Team if you would like information about a particular claim and the practices that would apply to a specific market.



Kind regards,

Peter Barrett
Vice President, Head of Claims for International & Global Mortality Markets

United Kingdom: Interpreting the critical illness definition for heart attack

Simon Grant DLDC (AMUS)
Claims Manager - RGA UK

The definitions for the core critical illness conditions in the U.K. are governed by a Statement of Best Practice for Critical Illness Cover, issued and updated periodically by the Association of British Insurers (ABI). The Statement is mandated for ABI member companies that offer CI cover, and provides a minimum standard definition for any condition present in at least 75% of policies available in the U.K. market. This includes heart attack, one of the main causes of claim under a CI policy in any market.

The current ABI definition is set out below:

Heart attack – of specified severity
Death of heart muscle, due to inadequate blood supply, that has resulted in all of the following evidence of acute myocardial infarction:

- *Typical clinical symptoms (for example, characteristic chest pain).*
- *New characteristic electrocardiographic changes.*
- *The characteristic rise of cardiac enzymes or Troponins recorded at the following levels or higher:*
  - Troponin T > 1.0 ng/ml
  - AccuTnI > 0.5 ng/ml or equivalent threshold with other Troponin I methods.

The evidence must show a definite acute myocardial infarction.
For the above definition, the following are not covered:

- *Other acute coronary syndromes including but not limited to angina.*

This has been the model definition since 2006, and was the first to introduce a severity-based measure in the form of a minimum required value for Troponins. Those familiar with the medical definition of heart attack will notice the insurance definition requires a specific level of Troponins for a valid claim.

This is a talking point for U.K. insurers for two main reasons:

- The advent of high-sensitivity assays for Troponins tests and the variance in reporting units, which means units can be expressed in ng/ml, ug/L or ng/l.
- Difficulties relying upon a dynamic test whose results rise and fall over time.

The effect of these two issues is that U.K. providers of CI insurance are seeing an increasing number of presented claims for heart attack where Troponin levels are below the ABI definition's required threshold with some uncertainty around when in the diagnostic process the test was done, and a lack of clarity as to the unit measurement the hospital used.

RGA Claims issued a Guidance Note in July 2012 to its U.K. clients that set out clearly how to identify and understand the differences in Troponin unit measurements. If you struggle to understand the difference between ng/ml, ug/L or ng/L please get in touch and we'll send you a copy.

Most U.K. insurers do not take a strict, literal approach to the interpretation of the ABI definition, and will consider claims where Troponin levels are close to the threshold if other mitigating factors about the claim exist. The problem, of course, is: how close is 'close enough'? And, are insurers consistent as to what the mitigating factors should be? The simple answer is: not enough consistency. The industry through the ABI and the Health Claims Forum (a U.K.-based industry body), are currently working together to help insurers achieve a common understanding.

North America: 2012 survey findings and observations

Mark C. Taylor, MS, CCM, CDMS
Executive Director, Claims

Specialty Rehabilitation Services (SRS)

In November 2012, Kathy Thiesen, Manager of RGA's Group Risk Research team in Minneapolis, published the results of a major global survey (a collaborative effort among multiple RGA offices) on Specialty Rehabilitation Services and the impact their utilization can have on individual and group disability insurance claims.

These services seek to minimize disability's impact on claimants and allow speedier return to work (RTW), thus improving overall insurer RTW outcomes. Results on SRS availability and utilization rates came from the U.S., Canada, the U.K., South Africa and Australia, with a total of 66 insurer participants.

The survey asked 24 questions, which focused on:

- Use of SRS in disability claims management
- Examination of SRS referral processes and case volumes
- Outcome metrics for cases where SRS is used
- Factors influencing SRS economic impact and success

Key observations:

- SRS is cost-effective. For every $1 spent on SRS, disability insurance providers save $15 to $20 in claim expenses.
- Claimant motivation is the primary factor for successful SRS referral outcomes.
- Less than 40% of the respondents calculate the return on investment (ROI) for SRS expenditure.
- Types of SRS referrals from group and individual insurers generally included: Return-to-Work Assessments, Early Intervention, Occupational Therapy, Vocational Counseling and Functional Capacity Evaluations.

Key insights:

- The key to cost-effective claim management and positive RTW outcomes is a robust mechanism for early identification of claimants and rehabilitation needs.
- Measurement of outcomes can further improve case management.
- Management of both savings and expenses for SRS appears to be key to understanding its value relative to the financial impact for insurers and employers.

Key challenges to achieving positive outcomes with SRS across all markets:

- Lack of claimant engagement and/or motivation.
- Reluctance by employers and claimants to accept SRS and pursue RTW.
- Referrals late in the claim cycle to SRS.

Successful SRS utilization emerges from:

- **Motivation** of claimant and employer.
- **Early identification** of claimants.
- **Early referral** to SRS.

In 2012, we conducted three additional industry surveys in the U.S. and Canada markets: Here are some of the insights:

CANADA: Creditor insurers are strict with disability claims management

- Seventy-five percent of respondents noted that disability benefits would cease upon *any* return to work (employment hours), even gradual/part-time transitions.
- Average caseload for claims examiners: 105 active cases/month/examiner.
- For claims submitted beyond the filing deadline date, carriers were more likely to deny disability claims than they were to deny life or critical illness claims submitted beyond the deadline.
- Very few insurers use automated claims systems.

CANADA and U.S.: Handling early disability claim submissions

We posed the following question to our clients: 'Your Company has received a disability claim for an eligible member in advance of the onset date of disability (i.e., elective surgery, etc.) How do you handle it?'

- For claims received more than 30 days in advance of the date of disability, and those received 7 to 30 days in advance, Canadian insurers are more likely to manage these claims by setting them up in the system upon receipt, whereas U.S. insurers were more likely to manage them differently (e.g., putting these claims on hold vs. set up on the claims system).
- In most cases, early claim submissions were initiated upon receipt, then closed or pended until the actual start date of the disability. Several companies noted the claimant needed to resubmit the claim after the actual date of disability had occurred.

U.S.: Long-term disability case management

We asked our client companies whether they manage long-term disability (LTD) cases defined as complex in a separate claims unit.

- Fifty-three percent of respondents indicated they currently have, or have previously used, separate LTD complex claims units.
- For these units, 'complex' claims are defined in several ways. Common factors were diagnosis, occupation, and expected duration.
- Outcomes from having these units: experienced staff to deal with specific challenges and multifaceted issues of these claimants; and smaller caseloads per staffer, enabling closer attention to each case.

South Africa: Industry training initiatives for assessors and advisors

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A number of current claims training initiatives in South Africa are impacting claims assessors.

Industry training for Claims Specialists to be introduced

In 2011-2012, an industry course for underwriters was introduced by ASISA (Association for Savings and Investments of South Africa). The course was originally developed with the intention of providing underwriters with an accredited qualification.

http://www.asisaacademy.org.za/index.php/programmes/life-insurance-underwriters-programme.html

The ASISA claims standing committee is currently developing a similar course for claims assessors, to formalize their training and enhance their careers with a qualification.

A sub-committee has been established to provide input on the curriculum, following a format similar to the underwriting course with modules addressing claims-specific issues such as case management. The training course will consist of various modules, classroom activities and assignments. It is hoped that the first course will be presented in 2014.

Spotlight on Advisors

There is currently much focus in the South African market on the rights of the consumer, particularly in relation to insurance policy sales and advice. In an effort to protect consumers and 'professionalize' the advice given to them, advisors are required to pass regulatory examinations from South Africa's Financial Services Board. (http://www.fsb.co.za)

These regulatory examinations cover roles, responsibilities and accountability of financial advisors as well as product-specific information. It is hoped that the examinations, in conjunction with the Treating Customers Fairly principles recently introduced into South Africa, will go a long way to ensuring South African consumer receive appropriate advice from advisors, and that advisors are better able to assist claimants with the benefit queries that can arise during the claims stage. The process of taking these examinations continues to be rolled out countrywide.

Initial ASISA claims and underwriting conference

- ASISA is hosting an Underwriting and Claims conference 6-7 May 2013 in Johannesburg.
- Both local and international speakers will be presenting on a variety of topics dealing with pertinent underwriting and claims matters.
- Plenary sessions will be held both mornings, followed by function-specific workshops in the afternoon.

For more information, please go to http://www.asisa.org.za/index.php/ucc-home.

Australia: Mental health poses a new challenge

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Episodes of disordered mental health often pose a challenge for the life insurance industry, both at the time of application and at the time of claim. How to appropriately classify and rate a mental health history disclosed at application can be difficult for a number of reasons, including the limited information given. At the time of claim, getting agreement on the diagnosis and ensuring appropriate and compliant treatment that results in a timely return to work can all be difficult to achieve. In 2013, it seems the industry is about to face new challenges.

In January 2013, *beyondblue*, one of the organisations leading the campaign to lessen the stigma of mental health and provide support for sufferers and their families, issued a media release announcing that it would '*take a stand against the insurance industry's discriminatory policies from today in a fight for the rights of millions of Australians with a mental illness'*. The group alleges that insurance companies routinely discriminate against people with a mental illness by either refusing to offer them a range of products including life insurance, travel insurance and income protection, or rejecting their claims if they have cover.

Under Section 46 of Australia's Disability Discrimination Act 1992, originally created to protect the rights of the disabled in housing, education, and provision of goods and services, insurers can lawfully discriminate on the grounds of disability, provided it is reasonable and that actuarial or statistical data or other relevant factors can demonstrate as much.

beyondblue has expressed doubt that the industry has the necessary data to enable a lawful exemption. A 2010 survey conducted by *beyondblue* in partnership with the Mental Health Council of Australia found that people with mental health conditions do experience significant difficulty and discrimination when applying for insurance products and making claims against their policies. It asserts that insurance companies have provided no evidence that people who have experienced or who are being treated for depression or anxiety disorders pose higher risk for insurers, and has sounded an ominous warning that the group is '…*looking at various legal options, including a class action*'.

This tough stance sits in stark contrast with the harmonious relationship that has existed between the life insurance industry and mental health support groups for almost a decade. Consultation and collaboration among a wide range of stakeholders produced, in 2003, a world-first Memorandum of Understanding (MoU) for the underwriting of applications and the management of claims. The MoU was re-signed in October 2008, but lapsed in 2010.

The Financial Services Council, which represents the interests of life insurance companies, currently has a working group looking further into the issue, with a view to preparing a response.

Assertions that the insurance industry is overstating the risk of mental illness claims or is being too conservative in offering cover do not align with the industry's claims experience, where around 25% of all income protection benefits are paid in relation to mental health problems. The claims also sit somewhat paradoxically alongside lobbying by mental health groups to the Commonwealth Government for greater health funding amid dire forecasts about the increasing burden of mental illness.

A lawful exemption under disability discrimination legislation is fundamental for the life insurance industry to be able to classify and rate according to the risk each individual poses. The threat of litigation or at the very least a concerted debate fought in the public domain, may see the right to underwrite put to the test.

Hong Kong: Healthcare reform

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The public sector dominates the healthcare market in Hong Kong, especially among the elderly, to whom it provides about 80% of all inpatient services. This leads to long queues for non-emergency surgeries and a financial burden on the government which will not be sustainable in the long term. As a result, the Hong Kong Government is working on a proposed Health Protection Scheme to reform healthcare provision.

The goals of the Health Protection Scheme are:

- Increase the private medical insurance penetration rate, with a special focus on keeping the elderly population insured after retirement.
- Reduce the government's financial burden and improve the quality of public healthcare services in the long run.
- Introduce benefits packages with pre-set prices and coverages from both healthcare providers and insurers to better control medical costs, thereby making private healthcare services more affordable and provide better value-for-money.
- Improve service standard of insurers and transparency of the price level/profitability

Some features of this proposed voluntary Health Protection Scheme are:

- Standardized terms and conditions
- Voluntary participation for insurers and the general public
- Guaranteed renewal for life
- Guaranteed issue
- No claims discount
- Coverage of pre-existing medical conditions
- Portability
- Maximum premium loading on sub-standard risk (max 200% extra loading)
- Creation of a high-risk pool from all participating insurers)
- Lump-sum benefit limit for certain medical treatments, instead of traditional itemized benefit limits
- Monitoring of premium rate increase
- Claims arbitration and mediation

Now at the second stage of the public consultation, the proposal includes funding of HKD50 billion (USD6.4 billion) for the following incentives:

- Subsidy to insurers to provide No-Claims Discounts at the implementation stage of the Health Protection Scheme.
- Financial support to maintain a high-risk pool, as needed.
- Encouraging insurers to include a saving element in order to reduce post-retirement premiums and as an incentive to keep individuals insured after retirement.
- Setting aside four plots of land for building new private hospitals to offer packaged-price treatments. The hospitals must meet a certain proportion of services offered to Hong Kong residents and maintain a minimum number of beds for maternity services.

The Hong Kong Federation of Insurers supports the proposal in principle, but has major concerns on issues such as the open enrolment and the operation of the high-risk pool. Its Task Force will be meeting periodically with the Food and Health Bureau's appointed consultant on this matter to share ideas regarding the development of the proposed scheme.

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