Institute of Actuaries of India

Subject SA1 – Health and Care Insurance

October 2014 Examination

INDICATIVE SOLUTION

Solution 1:

Advantages of Cashless system from insured's perspective:

Cashless settlement of claims has allowed beneficiaries to avail the medical treatment at a panel of networking hospitals of insurance company without bearing the financial burden of treatment cost.

Hospitals have started publicizing the cashless facility, which has increased the awareness.

Less administrative work in cashless facility compared to reimbursement from policyholders perspective.

It also assures the insured about the quality of the service provider.

Disadvantages of Cashless system from insured's perspective:

Insured may be offered exhaustive and extensive medical treatments which may be unnecessary even though very moderate treatment could have cured his illness. It may also mean longer hospitalization than usually would be required.

Insured should always be aware of the latest list of network providers to enjoy cashless facility. Otherwise, he/she may end up paying the hospital bills first and then reimburse the same from the insurer. Insured also may have to keep smart card/identity card issued by insurer/TPA safely to receive cashless facilities to avoid last moment hitch.

List of networking hospitals may restrict insurer's choice. Commuting could pose a challenge if networking hospital is not at nearby location. It may pose a serious problem especially in the case of an emergency.

Pre-authorization is required, which may not be liked by the insured.

Due to compliance requirement of responding within a defined time frame, insurer/TPA under TAT pressure, may reject the Cashless request and ask the insured to submit the case under Reimbursement mode.

Advantages of Cashless from insurer's perspective:

Pre-negotiated tariff with networking hospitals may help the insurer to control the claim outgo. It may help insurer to maintain a competitive pricing framework in the market. As per IRDA health regulations, for cashless facilities, legal MOU must be signed between the insurer and the network hospital. If any network hospital is found to be doing fraud, then dealing legally with the hospital becomes operationally easier due to signed legal MOU.

Due to legal MOU, it is easy for insurer to get better accessibility to hospital MIS and administration.

If insurer is not happy with the services of the hospital network, then as per the provision mentioned in the MOU, it can cancel the agreement.

As per MOU, insurer can inspect the premises of the network provider at any time without prior intimation. It reduces the chance of fraudulent claims.

Early intimation through Pre-authorization gives the following benefits to the insurer:

- Opportunity to investigate live case, hence less chance of fraud
- Chance to negotiate with networking hospital, if the proposed surgery does not belong to the pre-defined package list
- Ability to direct the insured to a cheaper networking hospital without compromising on the medical facility
- Ability to reject at the outset in case of any doubt

Disadvantages of Cashless from insurer's perspective

Under cashless facility, there may be fraudulent cases and treatment cost might have been deliberately inflated by some network provider hospitals. This may lead to higher claim outgo from insurer's perspective.

More administrative work is involved from insurers perspective like negotiating with network provider hospitals on the applicable tariff for various medical treatments, development and maintenance of IT and administration system of directly paying the claims to the network provider's bank account etc. It also leads to additional cost.

[8 Marks]

Solution 2:

i)

a) In an employer employee Group policy, generally the Employer purchases the Insurance policy as a service benefit for its employees and pays the premium either in full or in part. Here, master policyholder is the employer and the employees are **beneficiaries**.

In the customized group policy (non-employer-employee), generally the members of the group pay the premium and they are **insurance beneficiaries** and the organizer/administrator/manager (in this case, the Bank) is the holder of the group policy (Master policy holder).

b) In compulsory employer- employee Group policy, the employer may issue confirmation of insurance protection to individual employees with clear reference to the group insurance policy and securing the benefits of the employees.

In the customized group policy, certificate of insurance is required to be issued to the members of the group. Such certificate of insurance contains information on the

schedule of benefits, the premium charged to the individual member and important terms and conditions of the contract.

c) In employer- employee group policy, an employee (and his/her dependents) can be the only beneficiary.

In the customized group policy, there should be clearly evident relationship (non-insurance based) between the master policyholder and the members covered under the group policy. In the current context, only the customers (and his/her dependents) of the bank (only when they become customers of the bank due to some non-insurance relationship, e.g. Bank account holders/ loanees) can be insured beneficiaries.

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ii)

Anti-selection:

It will be very important to understand the sales model. It is important to understand if the bank will still continue to offer both the products (retail PMI product and customized group policy) and if so, how they will differentiate the target segment. Unless there is a clear understanding, it is safer to assume that customers will have a choice between two policies.

In such scenario, Insurer will be exposed to selection risk. Pricing of the proposed group policy is most likely to be higher than that of the retail product in lieu of the waiting period waiver and medical test requirement triggering from the age of 55 (instead of 46). On average Healthier risks, will apply for retail product due to price differentials. Customers, who have higher propensity to claim, will opt for the proposed group policy. Poor disclosure rate in proposal form may compound the problem.

Needy people may open bank account in order to participate in the group insurance policy.

Lapse & re-entry risk in retail policy:

Those Bank customers, who have recently purchased the retail policy (subject to waiting period restriction) and who are in poor health, may lapse their retail policy and opt for the group policy. It compounds the selection risk.

Due to this kind of selective lapsing, Insurer may not recoup some of the initial expenses (e.g. pre-acceptance medical check-up cost) which might have been spread over several policy years in pricing assumptions of the retail product.

Pricing assumption and data risk:

Proposition is voluntary with PEDs being covered from day one and mandatory pre-acceptance medical test requirement kicks only from the age of 55 (as opposed to the age of 46). Insurer may not have experience of such kind of portfolio. Pricing assumptions are associated with high level of uncertainty and risks.

High contingency margin in pricing due to above factors may lead to an unattractive proposition to the members. Moreover, there is a high chance of difference between actual and expected experience.

Volume risk:
Higher contingency margin in pricing may lead to only needy people opting for the policy. Actual volume could be much smaller than assumed at the outset. Pricing assumptions may not hold true in such scenario.

The attractive propositions of waiting period waiver and higher age of pre-acceptance medical check, may lead to a higher volume than expected. This may put administrative pressure on the insurer.

Expense risk:
Lower volume may lead to insurer not being able to recoup its initial fixed expenses like system development cost, training cost and marketing cost.

Higher than expected volume may increase the administration cost, e.g. recruitment of additional man-power, increasing the scalability of the system etc.

There is a general risk that actual expenses are higher than assumed in the pricing.

Miss-selling/policy disclosure risk:
Applicants may not be explained properly the need of true disclosure in the proposal form. It may be intended to avoid the hassle of pre-acceptance medical test and risk of losing business. Insurer loses the right of underwriting an application, which might have been declined due to health condition.

Reputation risk:
If claims are repudiated due to non-disclosure of material fact in proposal form, customers may complain of mis-selling. It may lead to bad publicity. It may also strain the relationship between Insurer and bank.

Competition risk:
Need to find out if there is any other insurance company in the competition. Need to consider the pricing of the competitor while quoting.

Capital consideration:
If the potential volume is very large, it becomes important to assess the capital requirement, specially the economic capital requirement if actual experience turns out to be worse than expected. Need to consider the solvency position of the company in the worst case scenario.

Challenges in processes like certificate of issuance, concentration risk (if bank is a small regional bank), business & claim administration need to be recognized as well. Relationship with the Bank will be an important factor to consider.

[10]

iii) Anti-Selection:

- Have dialogue with the senior management of the Bank and reach an agreement with the Bank on the business model. Two likely solutions: a) offer the Group policy to a particular segment of Bank customers only (e.g. loanee profiles) b) only offer the Group policy going forward (stop selling the retail PMI policy).
- Reduce the contingency margin in the pricing. Try to make the price of the group policy in line with retail product offered by the company. It will remove the price differential thereby addressing selection risk and ensure a large portfolio which is expected to be a mix of good and bad risks.
- Offer a Co-pay or Deductible.
- Train the Bank employees (who will be responsible to present the Group policy to customer) to ensure that customers are guided and encouraged to disclose any past medical history in the proposal form. Customers also need to be sensitized about the consequence of hiding material fact in the proposal form. Tighten the policy wording as well.

  Probably a post-sale welcome call (or a personal visit) to explain the terms and conditions of the policy and re-confirming the information disclosed in the proposal form. However, associated expenses need to be considered. Sales literature should be appropriately designed. It is expected to address the mis-selling/policy disclosure part as well.
- Minimum take up rate commitment from the Bank

Lapse & re-entry risk in retail policy:

- Make an internal process where retail customers (customers of bank who have purchased retail insurance policy) can participate in the group policy only at renewal. Give them a time window during renewal of retail policy, beyond which they will not be able to convert to the group policy.
- Make those cases subject to medical underwriting (at least a tele-underwriting) or take a good health declaration from the customers.

Pricing assumption and data risk:

- Take reference from claim experience of Group policy (employer's employee) where PEDs are generally covered from day one and Medical underwriting requirement is very rare.
- Spread the initial expenses over the expected number of insurance policies to be sold / renewed in next three years (say). This will reduce the expense margin in premium, hence a more competitive premium. Get into a multi-year contract (minimum three years) with the bank.

- Try to make the premium as competitive as possible. Contingency margin should be minimal. To reduce the uncertainty part, following things can be implemented:
  - Deductible/Co-pay/cap on per claim/low sum insured could be applied(or combination of few of them) in policy design to reduce the final claim outgo, hence less uncertainty
  - Only cashless policy in preferred network hospitals (unless there is an emergency). Pre-defined package rates with hospitals will lessen the uncertainty in claim severity cost.
  - May offer family floater policy only instead of individual policy.
  - Some of the Health related pre-existing conditions could be out rightly rejected at application stage if mentioned in the proposal form. Basis the declaration in proposal form, a tele-underwriting can be performed. Design of proposal form is key here.
- Monitor the portfolio at regular interval and take corrective actions as and when necessary instead of putting additional contingency margin in pricing. This being a group policy gives additional flexibility over a retail product in terms taking corrective action (e.g. pricing revision) quickly.
- Seek Reinsurer's help. Get into a Quota share arrangement which will help the company to spread the risk and increase Company's underwriting capacity. However, availability of Reinsurance and any regulatory restriction may be an issue here.
- Reinsurer may also provide technical support in pricing, which may lower the need of putting contingency margin in pricing.

Volume risk:

- Competitive pricing will help to build a decent volume.
- Discuss with the Bank management and come up with the right marketing and selling strategy.
- Prepare a proper business plan and get the buying from the Bank management. Put a maximum cap on business volume.
- Do a monthly monitoring of the business progress and discuss with Bank management as and when required. It has to be a proactive monitoring than reactive monitoring.
- Get a minimum commitment in terms of number of lives from Bank over the next one year.

Expense risk:

- Address the volume risk to counter the expense risk.
- Have multiple round of discussions with other stakeholders to get a right level of understanding of the associated expenses.
- Monitor the on-going expenses at monthly level.
- Outsource some of the non-core activities with pre-agreed cost structure.

Capital consideration:

- If the potential volume is very large relative to size of the company, Board needs to be sensitized about the possible course of action, specially the need of additional capital infusion. Capital commitment from shareholders will be required before taking the final decision.
- Apart from reducing pricing risk, proportional reinsurance may be helpful here to reduce the capital requirement.

[10]

iv)

Morbidity experience of bank customer may differ from rest of the retail product experience. Some possible reasons:

- Possibility of concentration of risk due to possible high volume and Bank customers may have some risk factors in common, due to geography/age/marketing strategy which could be different from rest of the retail segment. E.g. concentration of lives in a particular geography which may be prone to a particular disease e.g. Dengue / Malaria
- They may belong to a particular socio-economic status. E.g. people belonging to higher socio-economic status
- If the premium charged does not take the actual risk into consideration, e.g. a different gender mix in the same age group as compared to rest of the retail portfolio
- Pressure from Bank to honour claims which are in dispute.

[3]

v)

- Proposition is voluntary and similar to a retail product. Risk premium pricing framework of retail product should be the starting point.
- Adjustment needs to be done to address the following points:
  - Actual morbidity experience of Bank customers with regard to the retail product.
  - Assess the inherent risk distribution of bank customers and compare that with the composition mix in retail product pricing assumptions (e.g. location mix/gender mix if location/gender are not considered in premium rating structure of the retail product). If there is a significant difference, do suitable adjustment.
  - Apart from the main two change requests, consider the changes in other terms and conditions and assess how they may impact the claim frequency and claim severity assumptions.
- PED waiting period waiver and no medical underwriting up to 55 years.

  Take a reference from claim experience of group policy pertaining to employer's employee segment where generally PEDs are covered from day one and there is no medical underwriting.

However, we need to keep in mind that employer's employee segment is generally compulsory in nature; hence chance of anti-selection is minimal here. This point can be addressed to an extent by making some changes in product proposition like family floater only policy, minimum lives commitment from Bank, claim underwriting & monitoring the entire sale process.

Put additional contingency margin in claim incidence rate and claim severity between the age bands 46 to 55.

- Recognize the overall need of contingency margin in lieu of the uncertainty of this unique proposition and accordingly decide on that.
- Recognize and analyse the direct fixed expenses and variable expenses with respect to this deal. Need to take a call on how much premium will contribute towards indirect fixed expenses of the company. Amortize some of the one-time expenses like promotional cost, medical check-up cost, product development cost in system etc over multiple years.
- Risk premium needs to be adjusted for future medical inflation.
- Risk premium gets loaded by contingency margin, expenses and profit margin
- Final premium needs to be adjusted in order to ensure that premium does not become too prohibitive for healthier customers to opt for this policy. It can be achieved by putting restrictions in policy design (e.g. deductible/co-pay/cap on per claim etc)
- Commitment from Bank on a minimum number of lives is extremely important here to ensure that pricing and expense assumptions don't go haywire. Keep monitoring the experience and take corrective action as and when required.
- Technical support from Reinsurer can also be sought.

[8]

[36 Marks]

Solution 3:

i) Reasons for "Care Health" to sell business:

- Care Health is unable to write new business may be due to:
    a. competition in the market,
    b. poor servicing standards,
    c. constraints on injecting additional capital,
    d. impact of recent changes in the legislation and regulations
    e. bad publicity due to some recent dispute on claim settlement
    f. Poor economic scenario
- Care Health would like to enter the new business/venture/overseas market and wants to wind up the existing business.
- Care Health might not have been generating expected levels of profits to the shareholders. Market is probably at the bottom of insurance cycle.
- Care health might not have achieved economies of scale in running the business despite being present in the market for many years.
- There could be threat on solvency and regulator might have intervened to protect the policyholders' interest. This might have forced the company to sell the business.

- There could be huge Asset Liability mismatching risk which 'Care Health' might be facing. E.g. significant level of mismatching of duration of both assets and liabilities Moreover, there could be liquidity pressure company may be facing if the claims are paid in the form of regular income to the claimant under both the plans.
- Promoters want to exit to maximize return on paid-up capital.

[4]

ii)

The following information is required to value on target business

1. **Appointed Actuary's report on proposed acquisition**
    - **a.** Structure of the company
    - **b.** Information on existing business
    - **c.** Available solvency margin
    - **d.** Experience Analysis-Mortality/Morbidity, Expenses, Persistency
    - **e.** Non-compliance and regulatory penalties in the past, if any
    - **f.** Financial conditions report
    - **g.** Valuation Report
    - **h.** Surplus Analysis
    - **i.** Reserving Methodology and assumptions
    - **j.** Methodology and assumptions used in the Embedded Value calculations
    - **k.** Movement analysis in the Embedded Value calculations
    - **l.** Any restructuring of the company in the past
    - **m.** Correspondence with Regulators
        - **i.** Proposed agreement and the communication documents for the intended acquisition
        - **ii.** Executive summary of proposed transaction

2. **Financial Statements**
    - **a.** Annual Returns and accounts
    - **b.** Embedded value calculations
    - **c.** Internal Management Accounts and MIS
    - **d.** Minutes of Board meetings and Committee meetings
    - **e.** Risk management Report
    - **f.** Investment Report
    - **g.** Reports of internal and external auditors

3. **Policy information**
    - **a.** Distribution channel
    - **b.** Terms and conditions of the policy documents
    - **c.** Sales literature and sales illustration
    - **d.** Underwriting Standards
    - **e.** Reinsurance structure
    - **f.** Claim process
    - **g.** Remuneration structure to the intermediaries
    - **h.** Premium rates and the benefit structure

i. Third Party administration
    i. Reinsurance arrangements
    ii. Agreements with care homes and nursing homes if any

4. **Operational**
    a. IT and administration system
    b. Fraud control and compliance process
    c. Corporate Governance
    d. Risk management, underwriting management, claims management
    e. Historic and future business plans
    f. Employee details and HR policy
    g. Customers complaint process
    h. Profiles of senior management team

[8]

iii)

The first step is to calculate the Appraisal Value of the "Care Health" company.

Appraisal Value is the Sum of Embedded Value and the value of expected profit from future new business.

The first step to calculate the embedded value (EV) of the business where EV is Value of in force business + shareholders' Net Asset.

If limited information on the existing business is available then it needs to set appropriate model points based on available information from the "Care Health" business. Otherwise, consider all the information and data of existing in force business of "Care Health" along with the net assets attributable to shareholders.

Also assumptions are required to be set for calculation of EV. Assumptions should be the best estimate allowing for the expectation of future trends and inherent risks and uncertainties in the projected cash flows.

Need to estimate the future new business carefully to compute expected profit from future new business for the calculation of appraisal value.

[4]

iv)

- While valuing the business of "Care Health", "Care All" might have used best estimate assumptions with some margins built in the assumptions as "Care All" is a potential buyer.
- "Care All" might have performed the EV calculations based on few model points whereas "Care Health" has performed the EV calculations on each individual in force block of business.
- "Care All" may have considered additional cost to address challenges such as system integration, integration of employee HR policy, servicing the existing policyholders of "Care Health" etc.

- Any form of acquisition is associated with some unknown level of risk. "Care All'' may have considered additional margin in Risk discount rate to address the risk.
- Shareholders of "Care all" may have different level of expectation with regard to return on Capital which may have led to assuming higher Risk Discount Rate in EV calculation. It is also possible that "Care Health" might have used Risk Adjusted Discount Rates by product types whereas "Care All" might have used single Risk Discount Rate and vice versa in the EV calculation.
- "Care all" might have estimated the actuarial assumptions-future expected mortality/morbidity, expenses investment returns, persistency rate etc. post considering the impact of acquisition on the existing policy holders of "Care Health" and their behaviour (in terms of say persistency)post acquisition.
- "Care all" might have different views of future trends in the assumptions used in EV calculations compared to EV calculations by "Care Health".
- Choice of model selection for EV calculations for both companies could be different say stochastic model vs. Deterministic model.
- EV calculation for ''Care Health'' refers to published figure which is a statutory requirement. Such form of requirement is associated with prudent margin in related assumptions. Purpose of EV calculation by "Care All'' is for acquisition purpose which reflects a different view in making assumptions.

[6]

v)

- Reason for selling "Care Health"
- Sole bidder or competing with other insurers
- Structure of bidding process- e.g. opportunity to revise bid
- How desperate is the "Care Health" company to sell the business
- Plans for workforce of "Care Health" post winning the bid
- Expertise available to run the business
- Integration plans post winning the bid
- Data quality
- Credit rating of ''Care Health''
- Cost of acquisition such as cost of the consultant, legal cost, stamp duty etc.
- Reaction of stakeholders (Stock market if the company is listed/existing policyholders etc.) if purchase goes ahead

  Reason of purchase? Potential synergy and benefit, e.g.
  - Enhancement of Distribution Channel
  - Cross selling
- Assessment of impact on distribution channels and branch network
- How easy or difficult to raise the capital for acquiring the business
- Opportunity cost of capital
- View/approval of shareholders of ''Care All''
- Legal, regulatory and taxation aspects
- Time to complete the process
- General economic outlook

- Market reputation of ''Care Health'' (e.g. number of customer complaints, cases at ombudsman etc.)

[6]

[28 Marks]

Solution 4:

i)

Advantages of introducing Group Critical Illness cover

- This cover will help to provide financial security for employees in the event of contracting a critical illness (CI).
- This will help to attract and retain the employees in the organisation.
- Using weight as one of the factors in deciding the CI cover will encourage employer to introduce gymnasium facilities at office and employee to maintain weight over time at a sensible level by taking regular exercises.
- Easier for insurer to estimate the morbidity risk under critical illness cover as group is homogeneous (employer-employee group).
- Initial expenses under group CI could be lower due to less underwriting and usually low levels of commissions to the distributors. This will help the insurer to charge lower premiums to the employer.
- Mandatory cover for all employees makes the proposition less risky for insurer.
- The CI cover formula will reduce automatically anti selection risk from those with very high weights and high aged employees.
- The formula being linked to salary reduces the risk of over insurance.

Disadvantages of introducing Group Critical Illness cover

- The CI cover formula may not be appreciated by the senior level employees (assuming they are nearing their retirement ages) as the cover for them is reducing as age is increasing (assuming constant level of salary). Also very active with muscular employees may be unfairly penalised through the CI cover formula due to weight as one of the parameters for critical illness cover..
- The CI cover formula includes only age and weight as factors for providing cover to the employees ignoring other factors. Insurer would be exposed to other sources of risk e.g. family medical history.
- Introduction of such CI cover may give extra administrative burden on employer. In particular, recording the weight of each employee at the end of every year and re-computing the CI cover for each employee. Also employee may not appreciate the variability in CI cover (due to change in salary levels, age and weight) over the years.
- Insurer may not have full control on the employee data; in particular weight might have been recorded incorrectly and hence might have covered the employee based on incorrect weight.
- Employer might find a simple CI cover structure from other competitors and hence might not appreciate the CI cover formula.
- The CI cover formula has a high multiple of monthly salary for the young employees than the old aged employees. This may not be appreciated by the employer as the

chance for claiming the CI for young aged employees could be lower compared to old aged employee.

- There is no cap on Sum assured coverage amount. In case of a very high salary (e.g. senior management), potential sum insured exposure could be very high.
- Formula can produce negative number.
- There may be misinterpretation by employer/employee with regard to CI definition. Employee may be under the impression that all form of CIs will be covered. Rejection of claim due to policy definition may impact the relationship with Insurer leading to lapse of the Group policy at renewal.

[6]

ii)

Underwriting

- It would require initial underwriting such as declaration of health status.
- Specific PEDs not covered in the policy.
- Requiring HR declaration such as employees to be "Active at Work".
- There is a set "Free Cover Limit" above which more underwriting is carried out. Moreover, premiums may have impact on level of free cover limit. Eg insurer may charge comparatively different level of premiums if the free cover limit is very high and vice versa.
- Underwriting can be performed at claims level (Back end underwriting) wherein pre-existing conditions are excluded for claiming the benefits.
- Reinsurance can also assist in designing the underwriting policy of the insurer.
- Appropriate policy wording.

Pitfalls of underwriting

- False health declaration could be a major risk.
- Claim based moratorium underwriting may lead to reputational risk (if claim is denied basis wrong health declaration) and employer may be forced to lapse policy at renewal. Stricter policy wording may lead to same problem.
- Insurer needs to obtain indication of ages and weights at the outset in order to allocate the member to the correct underwriting category. Insurer will also need to obtain this information at each policy anniversary for each member. It is difficult to check false statement of weights of the employees.
- Too much emphasis/reliance on HR provided information which may be wrong.
- It is difficult to set the one unique single formula for Free Cover Limit (FCL) which is applicable across all employee-employer groups.
- Medical underwriting will impose additional administration hassle. It also leads to incurring additional cost.

[8]

iii)

Advantages:

- PMI cover can be provided on indemnity basis subject to a maximum cover as per the formula mentioned. It seeks to provide compensation for cost of medical treatment. A group policy may cover in-patient/outpatient/ day care treatment, nursing at home, transportation by private ambulance etc. It provides a wider coverage as compared to Group CI cover.
- Employers can use the PMI cover not only as a perk, and also to get employees back to work and keep them healthy and productive.
- Family members (dependents) are also generally covered, which gives peace of mind to the employee.
- Insurer is expected to have higher level of confidence in pricing assumptions.
- PMI cover can be offered to employees of the large group on a "Medical History Disregarded" basis.
- As it's voluntary, scope of anti-selection is limited.

Disadvantages:

- In CI cover, the form of benefits gives the beneficiary ultimate choice over what he/she wants to do with the lump sum, whereas in PMI cover benefits must be taken in the form of treatment.
- PMI cover is expected to be more expensive for the employer.
- It leads to more administration hassle:
    - Requires expert staff and specialist systems
    - Building cashless network across Pan India
    - Managing the TPA if claim administration is outsourced
- Chance of fraud is higher here.

Underwriting:

- Requiring HR declaration such as employees to be "Active at Work".
- There is a set "Free Cover Limit" above which more underwriting is carried out. Moreover, premiums may have impact on level of free cover limit. Eg insurer may charge comparatively different level of premiums if the free cover limit is very high and vice versa.
- Putting certain restrictions in policy conditions like
    - Per day room rent cap
    - Co-payment at the time of claim
    - Co-payment at the time of claim for Parents
    - Exclude parents from coverage
    - Excess/Deductible
- Entry and exit criteria must be clearly defined e.g. new employees may be required to serve a waiting period of 3 months.
- By pre-authorizing claims (except accidental and emergency cases)
- In family plan, employees must not have option to choose dependents
- Relationship of dependent with employee must be clearly defined (e.g. Spouse, son, daughter, parents, parents-in-law)

Pitfalls of underwriting:

- Stricter terms and conditions are not liked by employer/employees
- Too much reliance on HR provided information which may be incorrect
- Collection of information like weight in order to calculate Free-cover limit will impose additional administrative pressure and risk as well due to potential error in data

[8]

iv)

- If group CI cover is offered on voluntary basis then there is a high risk of 'anti-selection'. Hence, pricing should consider this factor.
- If the cover is on voluntary basis then minimum number of participation of employees is required to spread the morbidity risk and to avoid the mismatch between actual expenses and expected expenses assumed in pricing
- Different level of "Free Cover Limit" is set of the group CI cover is on voluntary basis. Pricing will depend on the level of ''Free cover'' given.
- Premium should be competitive enough to avoid anti-selection and selective lapsing.
- Level of pre-acceptance underwriting: Whether underwriting process will be robust enough to counter anti-selection e.g. whether there will be close enrolment period for existing employees or whether new employees will be subject to an initial waiting period or a process of having form with self-declaration).

  That will also drive the level of contingency margin which will be required in pricing assumptions.
- Presence or absence of PED conditions will have an impact on pricing.
- Disclosure rate in proposal form will be a risk which needs to be kept in mind while pricing the policy.
- Volume estimation is a big risk in any voluntary scheme. If volume is expected to be lower than estimated, insurer will not be able to recoup its initial fixed expenses. It also leads to high volatility in claim experience.
- Insurer will not have a fair idea about the overall risk profile of insured beneficiaries in advance which may impact the pricing.

[6]

[28 Marks]

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