EXAMINERS' REPORT

June 2020 examinations

Subject F101 — Health & Care Fellowship Principles

INTRODUCTION

The attached report has been prepared by the subject's Principal Examiner. General comments are provided on the performance of candidates on each question. The solutions provided are an indication of the points sought by the examiners, and should not be taken as model solutions.

QUESTION 1

Candidates tended not to provide sufficient points for this question and did not properly consider how a formula approach works. For example, many candidates referred to sensitivity tests or option pricing as not being possible with a formula approach which is not true. Points needed to be properly explained to get full credit.

(i) -The formula approach does not allow for:

- Proper timing of events
- The accumulation of reserves
- Capital needs
- The impact of net negative cashflows
- Separate inspection of premium-related or claim-related cashflows
- The variation of assumptions over time

[Max 3]

(ii)

PMI:

- The product is short term in nature and annually reviewable. This means that a long-term projection of capital and solvency requirements is not necessary.
- Similarly, there shouldn't be a need to vary assumptions over the term of the policy given that it is a short-term product.
- While a lot of thought will go into calculating the expected level of claims, it is unlikely that the insurer will need to separately inspect the claims related cashflows. Similarly, premiums will not vary over the course of the month given that it is a group product.
- Therefore, a formula approach could be utilized for pricing this type of product.

Critical Illness.

- Critical illness products do not have significant capital requirements.
- And given the low incidence of claiming they are unlikely to have significant reserving requirements.
- The product has a simple trigger, and a defined sum assured. Therefore, the claims-related cashflows do not necessarily require detailed inspection.
- However, given the longer term nature of the product it may be necessary to consider how assumptions change over time.
- In addition, the option to continue cover without underwriting requires a more detailed approach to consider the impact of the option and of anti-selection.
    - More sophisticated techniques required for pricing options, e.g. stochastic modelling, conventional method or North-American method
- Timing of event (if happens at all) is important
- Therefore, a formula approach is not appropriate for pricing this product.

Long Term Care

- Pre-funded Long Term Care products are expected to have a significantly long term of reserve building before payment starts
- And have significant capital requirements for those offering indemnity benefits.
- The accumulation and release of reserves are a key component of this product
- Given that the product will likely go through a premium payment state, a paid-up state and a claiming state through its life cycle.
- This means that there will be a need to vary assumptions depending on the various states in which the policy is
- Timing very NB as it significantly affects the value of reserves build-up and length of claiming state, and will have a large impact on pricing
- This means that a formula approach will not be appropriate for pricing this type of product.

[Max 9]

[Total 10]

QUESTION 2

This question was well answered overall. For part (i) some candidates merely listed factors and did not explain how the change in the particular factor mentioned could have led to higher specialist claims experience. The performance for part (ii) question varied. Candidates who considered risks relating to the insurer, providers (GPs and specialists) and the policyholder generally scored well. For part (iii) the idea behind the question is to identify risk mitigation for the specific risks identified in (i), not just general "issues with healthcare utilisation". Part (iv) was bookwork – mostly well answered.

(i)

- A change in the distribution of **ages**
    - A proportionate increasing in the number of policyholders in middle- to pensioner-aged groups. On average, higher ages experience higher claims on average in these age groups.
    - A proportionate increase in the number of new born babies/children beneficiaries
        - E.g. Children under 2 need comparatively more pediatrician visits
- A different **gender** mix, e.g. more females in childbearing ages and less younger males in this age group
    - More maternity claims (all else equal) lead to higher gynecologists claims
- Change in **burden of disease**
    - I.e. higher chronicity/co-morbidities (sicker population)
        - E.g. more policyholders with diabetes will mean more endocrinologist visits
        - E.g. more policyholders with cancer will mean more oncologist visits

(ii)

- In cases where the GP refers the patient to a specialist anyway, costs are incurred both at the GP and at the specialist, rather than just at the specialist
- May compromise the quality of care provided to patients e.g. where GP does not have same level of expertise as specialist.
- It may aggravate policyholders if they feel that they should direct access to specialists.
- Specialist providers may resent external parties imposing clinical protocols on them and influencing the way in which they practice medicine
- Administration costs for setting up and monitoring GP-referral system

(iii)

- Certain disciplines can have exemptions, e.g.
    - maternity
    - oncologists if the patient has cancer
    - specialist to specialist referral
    - in order to avoid instances of GP-referral where specialist visits were truly necessary
- Implement a high-quality GP network of providers.
- Ensure healthcare providers are also familiar with the insurer's protocols.
    - Incorporate providers' input (e.g.. engaging various medical societies) in setting up the protocols.
- Communicate clearly to policyholders/brokers how they will be affected by the implementation of the protocol.
    - Also, communicate to policyholders/brokers about the benefits of coordination of care to aid the understanding in rationale for protocol change
    - … e.g. reducing contribution increases in the longer run

(iv)

- Implementing preferred provider networks
    - Implementing a GP network (restricting access to a select network of GPs)
    - Implementing a specialist network (restricting access to a select network of specialists)
        - Can ensure network has enough providers
        - Can negotiate on price (preferential charging structures, contracted rates, co-pay outside network)
        - Can do profiling and have outlier provider engagements to reduce unnecessary specialist spend
- Implementing disease management programmes
- E.g. diabetes/maternity/conservative back & neck programmes

- Try and prevent specialists driving hospitalisation
- Medicine formularies
- E.g. where specialists dispense medicine
- only fund generic in full (e.g. oncology medicine)
- Alternative Reimbursement methods & Risk Sharing
- Negotiate on global fees for certain procedures
- Remove incentives from away from over servicing in a fee-for service environment

(v)

- Reducing the **rand limit** for specialist consultations or implementing an upper rand limit for specialist consultations (if there wasn't one before)
    - If the limit is "per family" can also consider introducing a "per beneficiary" sublimit
- Giving a **maximum count of visits** (e.g. max 2 specialist visits per beneficiary)
- Introducing a **co-pay (rand or % of amount)** per specialist visit
- **Excluding** certain specialist disciplines and/or specialist procedures from the benefit design.
- Introducing a **self-payment gap**, i.e. the insurer only starts paying for the specialist claims after the policyholder has paid a certain amount towards specialists.

QUESTION 3

Overall this question was well answered with most candidates being able to generate a variety of points for each part.

Part (i) was a straight bookwork question. It was surprising how many students were unable to define the four elements of indemnity cover and often just repeated costs in full in different ways.

Part (ii) This question was reasonably answered. This question required candidates to clearly differentiate their proposed three strategies. Candidates who performed poorly failed to outline only three strategies and so didn't explain why a strategy would mitigate risk in sufficient detail.

Part (iii) This question was well answered with many students being able to think broadly and apply themselves to the question. Students who performed poorly often repeated points.

(i)

Indemnity cover is where the insured life's (or policyholder)full costs of your loss (or where the cover restores you to same financial position as in prior to the health event/loss)due to poor health or a health event, in line with the benefit rules, is covered by the product.

[Max 2]

(ii)

QualiMed could make use of the following to help mitigate some of the risk:

- Approved/preferred provider networks– QualiMed could select certain providers based on the quality of care they provide and their reimbursement structures as part of a preferred provider network. This will better help control costs, while ensuring quality of care. If a policyholder seeks cover outside of this network, QualiMed will be able to cap the claim amount or impose a co-payment even for these regulatory conditions.
- Treatment protocols – defining specific methods of treating each defined conditional may help control the costsand also reduce the degree of uncertainty of the total cost . This will also ensure the appropriate care is provided without any wastage that could be costly.
  Pre-authorisation– QualiMed can better control the number of treatments around these conditions by requiring pre-authorisation. This will allow QualiMed to ensure the treatment is medically necessary and all the information provided is correct. It also notifies QualiMed in advance as to the expected claims in the system that need to be allowed for.
- Reinsurance– reinsurances can assist with expertise and data in understanding the claims experience and other impacts of the new conditions. They will also be able to help share the costs of the claims, thus reducing volatility and smoothing results. Reinsurers may cover high cost claims thus providing caps to QualiMed's claims experience. Lastly, reinsurers are also able to provide financial reinsurance to assist with high strain in the beginning when adjusting to the changes.
- Underwriting– this provides QualiMed with an opportunity to identify substandard livesand thus charge an appropriate loading for their risk or apply a waiting period. Thus helping to curb any anti-selection where people join just for the cover and then lapse. This also helps QualiMed understand the new risks coming onto the book and any subsequent adjustments that may be required.
- Case management – this will assist QualiMed with identifying and managing any high risk cases with very high costs associated. It will be a way for QualiMed to ensure to correct care and quality of care is being provided, and that it is in line with benefit rules and treatment protocols. It will act as a notification mechanism so QualiMed can allow for these claims costs in advance.
- Global fees– this will help control the costs by defining a basket of care with an associated agreed cost. This will stop any claims costs outside of this defined basket and thus provide better claims cost control for QualiMed.
- Wellness programs and preventative screening– help with early detection of at risk members to ensure precautionary steps can be take now to prevent costly medical conditions later.

[Max 6]

(iii)

- The investigation would need to split up into:
    - New conditions not previously included
    - Existing conditions no longer included
- There may also be changes to the treatment protocols associated with each of the defined conditions which will need to be investigated
- Will need to collect data either internally or from external sources that will need to be of sufficient volume for credible analysis as well as relevant in terms of time period
- Investigation for the new conditions:
    - Collect data on the number of lives currently with the condition (expected incidence rates)
    - Collect data on the expected costs paid from risk in respect of the condition, which includes data on the costs that were not previously paid but would be required to be covered going forward
    - Adjust costs for medical inflation, IBNR and seasonality
    - Make an assumption about any changes to additional utilization expected due to supply and member behavior in light of new regulations
    - The total additional cost could be worked out as an expected PLPM cost (burning cost) by taking the incidence with cost and dividing by all lives on the policy
    - QualiMed would need to account for any changes in the capital loading requirements, an/or profit margin requirements
    - QauliMed would need to investigate the impact on adequacy of reserves (factoring any regulatory requirements for reserves)
- Investigations for conditions that are no longer on the list:
    - There may be potential cost savings here if previously unnecessary amounts were being billed to take advantage of the ruling…
    - …there may be unhappy policyholder's if suddenly they are having to fund some costs out of pocket as a result which could impact QualiMed's lapses/withdrawals
    - There may be a delay as to when controls/changes can be put in place
    - …which may further impact the pricing if it continues beyond the expected timeline for change
    - Any measures put it place may not yield the cost saving estimated in pricing…
    - …there may be unforeseen costs to factor in for the initiatives put in place
- Other investigations may include:
- May also need to investigate altering and updating QualiMed's benefit rules; guidelines; benefit guides and promotional material
- QualiMed may need to update their marketing messages and retrain staff
- QualiMed would need to investigate the expenses relating the changes required as well as if the current expense loading per policy is still sufficient given the change in volume of business expected and added costs
- QualiMed may need to update their underwriting process, so they need to check if it is still relevant and effective as intended

- QualiMed can investigate the systems changes required and if they have the capabilities to make timely updates and changes in order to comply with the new regulations
- QualiMed should investigate how their competitors are responding to the changes and whether or not their adjusted premiums are still competitive
- QualiMed may need to reassess their benefit offering if there are gaps in cover in light of the new conditions and how competitors are responding
- QualiMed may need to investigate their reinsurance arrangements to check if they extend to the new conditions (and changes) or if any changes are required
- QualiMed should monitor the experience post all the changes to investigate the actual versus expected
- If QualiMed isn't compliant it could impact its going concern basis

[Max 8]

QUESTION 4

Part (i) was reasonably well answered. For part (ii) candidates who took a structured approach scored better. The question specified that the product was a conventional pre-funded product and yet many candidates referred to immediate needs cover and unit-linked products. For part (iii) many candidates set out a generic list of considerations without any reference to the specifics of the product or the market conditions. Credit was only given for points related to the specified scenario rather than for the regurgitation of a list of generic product development points.

(i)

Possible reasons include:

- Insurer sees a market opportunity.
- First mover/competitive advantage.
- Increasing demand from customers because of ageing population. Can plan for their long-term need. And not be a burden on their family.
- Increasing demand from distributors on the insurer to provide innovative sales/products.
- Increased need for such cover in the future due to increasing life expectancy but not increasing healthy life expectancy.
- Policyholder need - concerns over Government future provision of basic LTC due to resource or political willingness.
- There may be Government incentives. E.g. Changing tax rules for prefunded LTCI may increase its attraction to customers.
- Increased sales as pre-funded cover cheaper than immediate needs policy.
- Improve insurer's brand image.
- Changing social circumstances – e.g. increasing number of older generations who are divorced or have no dependents to provide informal care.

- Insurer may have experience in selling long-term care in other territories and can use this experience to launch a LTC in this country.
- Insurer expects to sell more profitable business.
- Alternatively, may be used as a loss leader.
- May allow cross-selling of other products.

[Max 4]

(iii)

(a) Benefit Structure

- The level and form of the benefits must meet the needs of customers.
- Could be a lump sum or regular income.
- The term of the benefits – are they payable for the rest of the policyholder's life or for a fixed term e.g. 2 or 5 years.
- The policy could cover the costs of care throughout the remainder of life, i.e. indemnify against long term care costs.
- This would give rise to very uncertain benefits so the financial risk is large.
- Providing fixed benefits or benefits that increase in line with an index removes the degree of benefit uncertainty and so financial risk is greatly reduced.
- Fixed non-indemnity benefits are administratively simpler
- But need to consider carefully any index used.
- The level of benefit could depend on the level of disability; this could reduce the cost to the customer whilst still meeting their needs as they change
- Although this might lead to increased complexity of definitions, misunderstanding of benefits and reduced sales.
- Mis-selling risk if the benefits not sufficient to cover the actual cost of care.
- Index benefits may be a compromise between the fixed benefits and indemnity benefits
- …. But choice of the index problematic as no one index captures the increase in costs
- …. main costs are salary related so a salary/earnings index may be suitable but accommodation costs which is another main cost could increase at a different rate.
- Are benefits paid directly to the policyholder or the provider of care.
- Benefits should be designed to integrate with state LTC provision to maximize value for money to customers and improve affordability.
- Additional benefits may be payable such as death benefits or a surrender value.
- Consider the use of limitations on benefits (e.g. caps/excesses/limits) etc. to ensure cost of product is affordable and profitable for the insurer.

[Max 5]

(b) Claim Definition

- The claims definition needs to be well defined to avoid unanticipated claims but enable policyholders who need care to meet the definition.
- For example, the policyholder fails to meet a number of activities of daily living,

- Such as, dressing, feeding, washing, mobility, transferring.
- A mental impairment trigger may also be included.
- The definition could be a 'single event' trigger or an ongoing assessment definition, where policyholder meets the definition for a period of time.
- The former is administratively simpler. The latter is more complex but arguably better fits the customer's needs.
- Increasing the number of activities to be failed or the severity of each of the tests will limit the number of claims but may reduce the marketability of the policy.
- If the product claim trigger also meets the State benefit trigger this may reduce the amount of benefit required under the policy as they would be receiving some benefit from the State as well and hence reduce the cost.

[Max 4]

(c) <u>Other factors</u>

- Premiums: how long will these be paid for.
    - Will they be level of increasing.
    - Will they be reviewable or guaranteed.
- Underwriting: will the product be fully medically underwritten for each life.
    - Will evidence of health be required.
    - Shouldn't be too onerous to deter applicants but needs to be thorough.
- Claims management which help insurer control future claim costs which keep prices down and so improves competitiveness,
    - …. for example an assessment period, telephone helplines.
    - The product should be designed to achieve the desired profitability of the company.
- Additional design features may improve marketability for example, addition of options and guarantees
    - …… but not too onerous that the capital required significantly affects the company's financial position.
    - The product should be designed with the risk appetite of the company in mind
    - Balancing this with the marketability of the product.
- Sources of data available to assess risks.
- Consumer demand – check acceptable price levels.
- Distribution – consider the most appropriate distribution channels;
    - Likely to be specialist healthcare brokers.
    - May need a new distribution network if the insurer does not currently use such distributors.
    - Complex product, policies can have large benefit amounts therefore require large remuneration to motivate sales.
    - May need training.
- Consider documentation/sales literature etc. required.
- Consider any admin/systems changes required.

    - For example, underwriting, claims management, admin
- Sales volumes – if too low, may not cover development costs or fixed expenses
    - If too high may cause new business strain and require additional capital.
- Consider the extent of any cross-subsidies between sexes etc.
- Simple design helpful for marketing
- So potential higher sales and reduces the administration required so lower costs.
- Consider regulatory requirements on the product design
- Consider local tax rules to assess tax efficiency of the product.
- Financing requirements - e.g. capital should be available to support initial set up cost and capital requirements
- Without higher opportunity costs on other projects.
- Sensitivity of profit
- E.g. for changes in state benefit provisions, for a fast or slow sales volume launch, for tax or interest rate changes
- Need for and availability of reinsurance and cost of reinsurance.
- Consider investment strategy and availability of assets required.
- Need to consider potential actions of competitors.

[Max 7]

QUESTION 5

Candidates seemed to struggle with structuring part (i) well and covering enough points but generally answered part ii) well. The weaker candidates did not relate the answer to the question posed and merely regurgitated benefits of reinsurance, for example. Many scripts unfortunately went off on a tangent about how to price the pandemic and mitigate against the risk when the question was specifically using reinsurance as the mitigation and candidates needed to discuss this aspect. Stronger attempts were able to systematically work through the considerations for both insurer and reinsurer and scored well.

(i)

Insurer

- Will give up any insurance profits on the book over the 1 year period. These profits could be substantial should the experience be better than expected.
- The insurer may wish to put a profit share in place to account for this.
- The reinsurance will come at a cost as the reinsurer's premium will be loaded for profit and expenses.
- There will likely be a loading for the increased risk that the reinsurer is taking on making the reinsurance even more expensive.
- 100% quota share reinsurance will completely protect the insurer against any adverse experience from the COORS-20 virus. This is especially important for the mortality benefits (funeral and death).

- A medium sized insurer may not have sufficient capital to absorb significantly adverse experience from normal assumptions
- Not all the benefits offered by the insurer are at an increased risk from COOORS-20 – the disability and CI benefits are unlikely to cover this as a claim condition and so the insurer would unnecessarily be passing on the profits of these books
- The funeral benefit in particular may be open to an increased risk from COORS-20 due to the target market being disproportionately weighted towards lower socio-economic classes and not necessarily having access to proper medical care. Reinsurance will help remove this increased risk.
- The insurer is open to default risk from the reinsurer and would still be liable for any claims if the reinsurer could not meet its liabilities, made worse if the virus turns into pandemic
- The administrative burden of reinsuring for only 1 year could prove difficult. The insurer's systems would need to be able to cope with this and switch off the reinsurance in a year's time.
- The experience could be worse or still bad in a year's time and the reinsurer would not be willing to renew the deal. This would pass the risk back to the insurer.
- Further admin of drawing up treaty/legal documentation to account for the unusual deal, and reinsurer covering all claims and getting all premium. Insurer could suffer reputational risk if the reinsurer is late on settling claim payments
- More than one reinsurer to spread risk / diversify / gain better rate
- Regulatory – will this structure be allowed
- Cost of reinsurance / price being charged is a factor for insurer
- Consider competition actions - what are other insurers doing about the impending risk

Reinsurer

- Exposed to risk of unknown COORS-20 true mortality rate Additional profits over and above profit loading if COORS-20 turns out to be lower risk than priced for
- Additional profits from benefits which do not have increased risk – can be used to cross-subsidise the riskier mortality books
- Need data to price – 3 months of data is not enough and difficult to use past data since this would not have COORS-20 risk in it. Could use flu trends with increased mortality rates.
- Reinsurer may not be willing to enter the treaty as risk perceived to be too great
- Alternatively, the reinsurer may not be able to enter into further reinsurance agreements for this risk if perceived too great.
- Anti-selective risk exists with inbound call centre if policyholders are taking up policies (especially funeral) if they believe they are at a greater risk of infection. This will further worsen mortality experience on the book and could lead to losses
- Reinsuring whole book at 100% QS misaligns incentives between the insurer and reinsurer for new business – the insurer may relax its risk management processes if it is not taking any of the risk which would further drive up poor experience

- Reinsurer may wish to rather enter into a stop loss treaty instead to limit the risk exposure [or similar reinsurance structure that makes sense]

[Max 10]

(ii)
To be considered, a condition must:

- Have sufficient data to price– the COORS-20 only has 3months of data at best and so fails to have sufficient data to accurately price
- Clearly defined and objective / unambiguous from medical point – the COORS-20 can be tested for and identified so should be fine on this criterion
- Perceived to be serious and occur frequently– definitely perceived serious and spreading makes it frequent but the 100% payout might be too generous since long-term effects are not known. If similar to flu then full recovery is likely and CI payout might not be needed
- Limit anti-selection– the use of waiting periods for the funeral benefits and underwriting for the other benefits should reduce the risk of anti-selective behavior

[Max 4]

QUESTION 6

Overall this question was reasonably answered. It was evident that some students were short on time given it was the last question of the paper and also the longest question. Candidates who were apply to apply themselves to the question as well as think broadly scored well on this question.

Part (i) was a pure bookwork question with most candidates scoring very well. Those who missed marks were unable to explain tied agents adequately.

Part (ii) was an application question look for advantages and disadvantages of the new distribution channel. Students who performed poorly where unable to apply their points to the question and were also unable to distinguish between the risks, which is part (iii), and the disadvantages. Those who performed well were able to think broadly, avoiding repeating their points, as well as apply their points to the specifics of the question.

Part (iii) The question was well answered. Students struggled to generate and justify a variety of points, and those who performed very well were able to apply their points to the specifics of the question.

Part (iv) required a list of data needed for pricing this change in distribution channel. This question was poorly answered and often distinguished top performing students for the question as a whole. Students who performed badly often repeated the same data points and/or didn't answer the question being asked by detailing sources of data or adjustments they would make. Students who performed well only listed the data needed and were able to list distinctive points.

(i)

The insurer currently uses brokers (financial intermediaries), and is considering looking at a direct sales channel method – cellphones. Other sales channels could include:

- Own sales force - This would be where the insurer hires employees to form a team who initiate the sales via a client list of only the insurer's products.
- Tied agents – these would be independent agents who sell either the insurer's product or could also be selling other insurer's products too where the products are mutually exclusive (and do not compete).
- Other direct sales channels - could include sending out email marketing material; telephone selling; advertise via billboards or the press. This would be channels where there is no party in between the insurer and the prospective client.
- Worksite marketing – where information is handed out via the employer through emails or promotional stand.

[Max 3]

(ii)

Advantages:

- Insurer can decide who to target
- The insurer may be able to better control the marketing message
- …which reduces the risk of any misinformation being shared (or false promises given like in the case with telesales or sales agents)
- No commission or agent salaries payable so theoretically cheaper…
- The insurer may be able to target clients who are not reachable via the other channels, such as those in rural areas…
- This will also increase the number of policies sold for the product
- May be easy to sell if the product is attractive to policyholders
- …and is competitively priced
- No need for training and extensive management required with this channel
- Because this is an untapped part of the market there may be little or no competition which increases the chance of take-up
- Increased growth through this new channel may mean more economies of scale which may improve the profitability of the product
- The new market targeted may bring some diversification to the existing risk pool
- …which may improve the overall experience of the SACI product
- May be reaching a younger more "tech-savvy" market
- Once the channel is established there is an opportunity to use it for future product developments and changes

Disadvantages:

- Need some form of database to market to…
- …and the insurer's market is limited to the list of cell phone numbers they have.
- May not be targeted marketing
- …which introduces several risks such as a selective take-up
- If the insurer is unable to reach enough volume of sales/conversion to sales, this may impact the coverage of expenses…
- …which could put additional strain on the profitability of the product.
- Given the limited amount of content you can send via the cell phone channel, the product would need to be fairly simple and/or the message may need to direct the client to a platform where more information is available
- …this may make the conversion to sale more of a longer process
- …which introduces a greater chance of lower conversions
- Because this is a new market, it may be difficult to sell the product if the insurer's brand isn't known by the market
- May have infrastructure costs and development time to consider
- Difficult to engage with client if they have any questions or need help understanding a part of the marketing message
- Limited scope for underwriting – short list of easy to answer questions at best
- ….which may mean the risk pool is worsened by anti-selection
- The insurer is dependent on cell phone network coverage in order to distribute the message

[Max 8]

(iii)

The major risks to the health insurer include:

- The insurer may get a poor mix of risks resulting in more poorer health lives taking up the product
- …which leads to poor claims experience than expected
- …meaning there may be a risk of inadequate premium coverage and losses being made
- Burden of disease (affecting extent to which people are ill) – incidence rates show considerable variation from year to year creating uncertainty about what level of claim incidence will emerge increases are going to occur
- Selective withdrawals due affordability or misunderstanding
- …may also mean economies of scale with respect to expenses doesn't get realized
- …especially if lapses occur at a point where the asset share is negative
- Too many sales may put a strain on the administration and system capabilities
- …which may lead to delays or errors causing potential reputational risks
- Anti-selection if take advantage of low level of underwriting through this channel

- …meaning that a larger number of those with a higher propensity (due to family or medical history) for certain conditions will take-up product than expected which may lead to higher costs
- New lives targeted may have much higher sum insureds leading to higher capital requirements and potential losses
- Decision relating to imprecise policy wording can create new classes of claims and introduce reputational risk (Interpretation of wording – if it is worded imprecisely this may result in claims that were never intended to be covered arising)
- Accumulations of risk – aggregation of claims triggered by a single event e.g. epidemic outbreak in the specific new target market
- The regulators may impose changes or additional requirements relating to this new channel which may mean additional costs or the channel will no longer be allowed
- The intermediaries may be unhappy about business being lost to this new channel, which could hamper the relationship with the insurer
- Competitors may enter the market once noticing the wider reach and lower cost, if their offering is better (cheaper, easier to understand, more well-known brand) this could reduce the sales volumes
- Insure may have reputational risk if those contacted are unhappy receiving marketing messages they didn't sign up for

[Max 6]

(iv)

The main data required for the insurer to assess the impact on the pricing assumptions and experience include:

- Number of sales
- Demographic profile of the new lives (age; gender; chronic status etc.)
- Conditions covered
- Sum insured
- Any tiered benefits
- Policy start dates
- Premium charged
- Policy terms/duration (dates of expiration)
- Additional costs linked to setting up distribution channel
- Any additional underwriting costs
- Inflation for benefit
- Policy management expenses
- Expected incidence rates for conditions
- Waiting periods or Survival period terms
- Changes in reinsurance premiums or recoveries (terms)

- Profit margin requirements
- Capital requirements
- Lapse or withdrawal rates expected
- Discount/interest rate
- Mix of business

[Max 6]