



OFFICE OF FAIR TRADING

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HEALTH INSURANCE

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The Office of Fair Trading's first report on Health Insurance is available by calling 0870 60 60 321 (National call rate)

GLOSSARY

ABI	Association of British Insurers
CIC	Critical Illness Cover
CII	Critical Illness Insurance
FSA	Financial Services Authority
IFAs	Independent Financial Advisers
IOB	Insurance Ombudsman Bureau
IPI	Income Protection Insurance
LTCI	Long Term Care Insurance
PECs	Pre-existing Conditions
PHI	Private Health Insurance
PIA	Personal Investment Authority
PIAS	Personal Insurance Arbitration Service
PMI	Private Medical Insurance

FOREWORD

by the Director General of Fair Trading

The needs of consumers are generally best met by competitive and efficient markets. Intervention is only called for when there is market failure, and great care is needed to ensure that the cost of such intervention is recovered in the benefits it brings. Two important sources of market failure are:

a failure in competition, when suppliers resort to anti-competitive agreements, decisions or practices, or abuse their dominant position;

consumer detriment, when consumers suffer shortfalls in the information they can obtain or assimilate about goods and services.

A failure in competition can be addressed by seeking behavioural undertakings from suppliers and by structural changes to the market. Both are possible under existing powers and under the powers to be conferred by the Competition Bill. Where such remedies are ineffective, it may be necessary to resort to some more explicit form of regulation. This may, as in the case of utilities, require primary legislation to create and empower a suitable regulator .

Consumer detriment can arise even in markets where there is strong supply side competition and can be just as damaging to consumers' interests as a monopoly. Not only can consumers pay too much for particular goods and services, but also they can buy goods and services that are inappropriate to their needs. Consumer detriment can also result in some groups of consumers being excluded from purchasing certain goods and services, even though, with better information, such goods and services would have been highly valued, or perhaps even essential. Powers exist to redress some forms of shortfall in information (for example, under the Consumer Credit Act 1974), but generally, powers to remedy consumer detriment are lacking. There is, however, a valuable solution: self-regulation.

Self-regulation is possible when an industry sees the potential for consumer detriment and takes steps itself to ameliorate the situation. A number of measures are possible, including the agreement of voluntary codes of practice linked to redress and compliance procedures, monitoring by the relevant trade body and the publication by the industry of relevant information, the imposition of minimum training standards, and improvement in the quality of information and education provided to consumers.

Insurance is an industry where self-regulation has been implemented with some success. Most of the recommendations in my 1996 report on *Health Insurance* sought, in effect, to build on this success by inviting the health insurance industry to improve its self-regulation. I was, therefore, disappointed that, on the whole, it responded negatively to my suggestions while failing to come

up with convincing alternatives.

Where self-regulation proves inadequate, there may be no alternative but to introduce some form of statutory regulation. Indeed, in my 1996 report I called for statutory regulation of Long Term Care Insurance (LTCI), a matter that the Royal Commission on Long Term Care will doubtless be addressing.

As part of my fresh examination of health insurance my Office has conducted new research into the vexed question of moratorium underwriting of such policies, a subject upon which the industry itself is known to be divided. While my views on the dangers associated with this form of underwriting are, if anything, reinforced by the resultant findings, I can see that there might well be a place for it to suit the particular needs of certain consumers. Accordingly, I have recommended a series of regulatory measures to safeguard consumers when purchasing such policies.

In this second report, I call for the reserve powers which are to be included in the Financial Services Regulatory Reform Bill to enable the Financial Services Authority to regulate the conduct of general insurance business to be employed to regulate moratorium underwritten health insurance. My other recommendations remain, however, directed towards improving self-regulation in this sector. If the health insurance industry wishes to retain a wide measure of self-regulation, it should, in my view, carefully consider, and then act upon, the recommendations in this report.

John S Bridgeman
Director General of Fair Trading

SUMMARY

In this report, we look again at the recommendations in our 1996 report on *Health Insurance* in the light of the response of the industry to that report and other developments that have occurred since in the industry and elsewhere.

Two of the more significant recommendations in the 1996 report were for the introduction of 'benchmark' products and the discontinuance of moratorium underwriting of health insurance.

In this report, we identify the essential features of what we now refer to as 'core term products' for Private Medical Insurance (PMI), Permanent Health Insurance (PHI) and Critical Illness Insurance (CII) and invite the Association of British Insurers (ABI) to bring forward its own recommendations, to be defined in appropriate codes of practice, no later than 30 September 1998.

On moratorium underwriting of health insurance, we have reviewed our 1996 recommendation that the practice should be discontinued. We now conclude that moratorium underwriting may be acceptable provided there is effective regulation requiring the insurer to:

establish the consumer's need for the policy;

explain, orally, and then in writing, the essential features of moratorium underwriting of health insurance, paying special attention to the extent to which pre-existing conditions (PECs) are covered, before the consumer enters into a contract;

stress the inadvisability of foregoing medical advice in the period before PECs are covered; and

monitor the sales process to ensure that the above procedures were adhered to and to provide evidence in cases of dispute.

The regulator should, in our view, monitor the experiences of consumers following purchase and carry out research into the extent to which medical advice may be systematically foregone by consumers in the moratorium period.

The reserve powers which are to be included in the Financial Services Regulatory Reform Bill to regulate the conduct of general insurance business now provide a means of achieving this. We therefore recommend that moratorium underwriting of health insurance need not be discontinued provided that these powers are employed as soon as they are available and the Financial Services Authority (FSA) commit itself to the proposed monitoring.

In this report we also reaffirm the recommendation in the 1996 report that the selling of Long Term Care Insurance (LTCI) should be regulated in a way analogous to regulation under the Financial Services Act 1986. As the Director General notes in his Foreword, this is a matter that will doubtless be addressed by the Royal Commission on Long Term Care.

Many of the recommendations in the 1996 report were directed at improving the clarity of health insurance products, and will become less significant if our recommendations for core term products and moratorium underwriting are implemented. We do, however, recommend that every health insurance policy be accompanied by a clear summary, in standard format, showing what the policy does, and does not, cover. In any event, the terms and text of the policy itself should be expressed in plain and intelligible language in line with the Unfair Terms in Consumer Contracts Regulations 1994. We also recommend that consumers should receive a more comprehensive warning about the likely increase in PMI premiums, supported by reliable data on average increases over the last five years, which we invite ABI to publish. This would be facilitated by implementing the recommendation on core term products. Moreover, the need for clarity in the presentation of possible premium increases extends to any health insurance product where premiums are reviewable or guaranteed only for a fixed period, as in many PHI and LTCI contracts. Consumers cannot be expected to make rational choices on the basis of limited information about future costs.

1 INTRODUCTION

- 1.1 In July 1996 we published a report on Health Insurance (the 1996 report). This follow up report assesses the response to the 1996 report and identifies what additional action may be needed.
- 1.2 The 1996 report described four principal types of health insurance.
- **Private Medical Insurance (PMI)** insures against the cost of short term acute conditions in a private hospital or as a private patient in an NHS ward. It does not usually cover the cost of routine health, dental and eye checks. Some policies include additional benefits such as payment for home nursing or alternative medicine.
 - **Permanent Health Insurance (PHI)** replaces some or all of the income lost when a person becomes sick or disabled and unable to work. This replacement income is normally paid up to retirement age. PHI is increasingly known as Income Protection Insurance (IPI).
 - **Critical Illness Insurance (CII)** provides a lump sum in the event of a serious illness. It can be used to pay for medical care, to repay a mortgage, or to provide a replacement income. Although some policies are stand-alone, others are linked to life insurance or to mortgage protection policies. It is also known as Critical Illness Cover (CIC).
 - **Long Term Care Insurance (LTCI)** covers the cost of long term care for those who become unable to look after themselves. This is most likely to happen in old age.
- 1.3 Both reports concentrate on sales to individuals rather than to companies (so-called group insurance). Nevertheless, a number of the recommendations in this report are also relevant to the group market. For example employees who have health insurance benefits provided by their employers are entitled to receive the same clear information about the extent of their cover as those who are subscribing for themselves.
- 1.4 The recommendations in the 1996 report in respect of each of the four types of health insurance are summarised in Appendix A. The more significant recommendations tended to apply to more than one type of health insurance. They were:

- that ‘moratorium’ underwriting, whereby the policyholder’s medical history is not enquired about and pre-existing conditions are not covered for typically two years, be discontinued (PMI and PHI); and
- that the industry, with the assistance of the ABI, should draw up a benchmark product (PHI, CII and LTCI) or otherwise make policies more comparable by employing an industry-wide common core product (PMI).

1.5 Two other significant recommendations related, however, to specific types of health insurance:

- that the selling of LTCI should be regulated. This reflected the quasi-investment nature of such policies and our view that they should be regulated by the relevant financial services regulator in a similar way to other forms of investment; and
- that consumers should be forewarned about likely future increases in PMI premiums.

In making these recommendations, account was taken of the regulatory framework for health insurance that was then in place. Different regulatory regimes were involved, depending on whether the health insurance product in question might contain an investment element. The selling and prudential regulation aspects also required different forms of regulation. Essentially, the prudential regulation aspects are overseen by the Friendly Societies Commission and by the Department of Trade and Industry’s Insurance Directorate, whereas selling regulation was the province of the Personal Investment Authority (PIA) and thus now of the FSA regarding conduct of investment business, if any be present under the Financial Services Act 1986. The selling of other health insurance products was subject to self-regulation, largely through the medium of ABI’s codes, statements and advice to members.

In addition to these requirements, the Control of Misleading Advertising Regulations, monitored by the Advertising Standards Authority and enforced by the Director General of Fair Trading, were applicable to health insurance, and the Unfair Terms in Consumer Contracts Regulations, monitored and enforced by the Director General of Fair Trading, had come into force in 1995.

Agreements to pay annual premiums by monthly installments may come within the

Consumer Credit Act 1974. In general, this regulatory framework persists, but, as described in Chapter 3, a number of changes have subsequently been made or announced.

2 HOW THE INDUSTRY RESPONDED TO THE 1996 REPORT

- 2.1 ABI responded to the 1996 report in May 1997, commenting that the industry accepted that *some* health insurance products were difficult for *some* consumers to understand. According to ABI, the industry recognised this as a ‘failure of communication’ on its part, but they argued that consumers’ needs were often complex and varied. ABI considered that problems arose more from the inherent complexity of the products than from any lack of competitiveness in the market. Indeed, it was the fierce competition between suppliers that led, in their view, to the huge variety of products. The proposed benchmark products could have a ‘restrictive effect, stifling product innovation’. ABI considered that there were advantages to moratorium underwriting but acknowledged that the industry could not reach a consensus.
- 2.2 ABI suggested that improved consumer education could help surmount the perceived problems with moratorium underwriting and the difficulties over the different definitions in use in the industry. A need for improved signposting of the questions a consumer should be asked before entering upon a health insurance contract was acknowledged, and attention was drawn to some new leaflets explaining each of the four types of insurance. These would be distributed to prospective customers of ABI members and also made available through Citizens Advice Bureaux.
- 2.3 ABI indicated that the 1996 report had given added impetus to the revision of existing codes and statements of practice. The principal revisions brought to our attention were the release on 1 December 1997 of an Abstract on *Applying the Statement of General Insurance Practice to Health Related Insurances* and the publication, also in December 1997, of a *Guide on the Selling of Private Medical Insurance*. ABI also indicated that they would be willing to have further discussions with us, but, in view of the delay of some 10 months in receiving their initial response, the fundamental differences in view over benchmarking, and the absence of a consensus amongst ABI members over moratorium underwriting, we chose to approach insurers directly for further information as described in Appendix B.
- 2.4 Individual suppliers responded to the 1996 report in a variety of ways. Few made any specific changes to their practices, but two of the largest health insurers (BUPA and Prime Health) told us that they were trying to introduce their own version of a benchmark product. The Insurance Ombudsman Bureau (IOB) reported a move by some insurers to include tables comparing products within the specific insurer’s range.
- 2.5 A few insurers (WPA and PPP) discontinued moratorium policies, but some, including Norwich Union and Prime Health, continued to sell them. Overall, positions have

become entrenched. Suppliers of moratorium policies argue that the consumer benefits, while suppliers who have foregone this practice argue that they face unfair competition and will be forced to revert to selling such policies unless they are banned altogether.

- 2.6 Some improvement has been made by insurers with regard to the use of plain and intelligible language as recommended in the 1996 report. The Consumers Association reported a move by some insurers to make their literature more accessible and transparent, and one insurer (WPA) produced a video tape to support its sales literature. Some insurers now provide a single booklet listing all their health insurance products, making reference and comparison easier for the consumer.
- 2.7 The importance of clear literature on health insurance was confirmed by a report in March 1997 by CHF (a federation of charitable hospitals) stating that 63% of their patients had based their choice of scheme **solely** on literature. It also reported that many patients still did not know the extent of their cover (see Chapter 6).
- 2.8 The cost of PMI continues to increase in real terms. A simple measure of PMI price inflation is the rate of change in subscription income per subscriber. According to *Laing's Review of Healthcare*, over the period 1986-1996, year on year PMI inflation was generally above the RPI, averaging 3.5% in real terms. Such figures should however be treated with caution. This is an average figure and hides significant deviations (see Appendix B, Schedule B). There were several years in this period when PMI price inflation was significantly above the RPI, over 5% in real terms. In addition, year on year figures may not be directly comparable as the range of products available in the market grows.
- 2.9 An information sheet issued by ABI on *Selling of Private Medical Insurance to Individual Purchasers* requires consumers to be given a 'full and clear explanation of...the fact that premiums...may vary on renewal'. Accordingly, some PMI suppliers now state in their literature that 'premiums can increase more than inflation', but we are not aware of any providing quantification in terms of either past experience or future expectation, as recommended in our 1996 report. ABI claimed that it was impossible to plot accurately how claims had risen because individual policies rarely lasted five years before undergoing major change.
- 2.10 Other more detailed responses by ABI and by particular suppliers to the proposals in the 1996 report are described in Appendix B.
- 2.11 There have been other developments in the industry and its practices not specifically related to the recommendations in the 1996 report.

- Four major PMI suppliers have introduced ‘network initiatives’. These require policyholders to use a limited number of private hospitals, enabling the insurer to control costs more tightly. Excess capacity could thereby be limited and the efficiency of the industry might be increased. Consumers are thus offered restricted access to a range of hospitals in return for reduced premiums or additional benefits. Industry commentators suggest, however, that smaller hospitals which are not on one of the major health insurers preferred lists will struggle to stay in business. There are potential problems for the patient if a consultant to whom they have been referred by their GP does not have admission rights in a hospital on such a network, or considers that a non-network hospital is more suitable for the proposed treatment. There can also be problems for the policyholder if the consultant charges more than the insurer’s scale of benefits. Also, if a consultant recommends a stay in a hospital that is not covered by the insurer, the policyholder may be required to pay all or part of the bill.
- There has been increasing linkage of the various health insurance products, for example, between PHI and CII. Such policies reduce administrative costs, but the Consumers Association has pointed out that they can make it harder for consumers to compare and assess different products.
- Information on health insurance on the Internet has continued to grow. Insurers such as PPP and BUPA have put PMI product descriptions on the world wide web for overseas consumers.

2.12 In conclusion, positive responses to OFT’s 1996 report have been made by insurers, but only individually. Some insurers have abandoned moratorium underwriting, benchmarks have been introduced by others, and others still have made their literature simpler and more understandable, but the industry has not been led from the front. Consequently, there has been little progress made by the industry as a whole. Our recommendations were meant to be adopted universally in order to be truly effective.

3 DEVELOPMENTS BEYOND THE INDUSTRY

3.1 Since the 1996 report, there have been some wider changes which have implications for the industry, and our recommendations from 1996.

- In the July 1997 budget, the Government withdrew tax relief on PMI contributions for people over 60 years old. Industry commentators suggested that this might encourage a switch to less comprehensive products rather than a reduction in overall demand.
- Changes and prospective changes to the regulation of financial services. In particular:

In October 1997, the Government launched the FSA, charged not only with taking over the regulation of financial services from the PIA and other self-regulatory organisations but also assuming responsibility for insurance and banking supervision. The FSA will have a statutory responsibility for protecting the interests of consumers in these sectors. On 7 April 1998, Helen Liddell, the Economic Secretary, announced that the draft bill to reform the structure of financial services regulation will contain reserve powers to extend statutory regulation to non-life insurance business.

In December 1997, the FSA published a consultation document (number 4), entitled *Consumer Complaints*, proposing the merger of the various ombudsmen schemes relating to personal investment, insurance and banking. We welcome this proposal, which should further strengthen the redress mechanisms provided by the ombudsmen. A speedy and efficient independent means of redress is vital for all insurance business. The two largest healthcare insurers, PPP and BUPA subscribe to the Personal Insurance Arbitration Service (PIAS) and remain outside any ombudsman scheme, but the Financial Services Regulatory Reform Bill, will bring PIAS within the ambit of the Financial Services Ombudsman Scheme.

PIAS has changed its complaint procedures. We welcome the change whereby consumers no longer need the consent of their insurer to complain to PIAS and are no longer bound by PIAS's decision. We remain, however, concerned that PIAS still does not publish an annual report nor disclose the amounts that insurers have been required to pay following decisions against them. We are also concerned that PIAS does not issue explanatory leaflets and trust these omissions will be corrected when PIAS becomes absorbed within the overall Ombudsman scheme.

- The announcement on 8 July 1997 that we are to investigate care homes. The resultant report is expected to be published in late summer 1998.
- In 1997, the Joseph Rowntree Foundation published a report by John Hills and Tania Burchardt on *Private Welfare Insurance and Social Security: Pushing the Boundaries*. This examined the implications of the reduction and withdrawal of social security in a number of areas, including primary health care and medical and other care for the aged. Hills and Burchardt argued that PHI was a niche product targeted at the highly paid which did not have the potential adequately to fill the gap left by a reduction in the level of primary health care provided by the state and that LTCI did not have the capacity to substitute efficiently for reduced levels of medical and other care for the elderly as, given the uncertain nature of risks covered, it could not be reliably priced.
- In August 1997, we published a research paper on *Consumer Detriment under Conditions of Imperfect Information*. This paper confirmed that the ‘inherent complexity’ of products, even when the result of ‘fierce competition’ by suppliers, could indeed result in consumer detriment, which was identified with the difficulty experienced by consumers in obtaining and assimilating the information they need.
- On 4 December 1997, the Government announced a Royal Commission on Long Term Care charged with examining the short and longer term options for creating a sustainable system for funding long-term care of elderly people. A report is expected by December 1998. The recommendation in the 1996 report that LTCI should be regulated is likely to be one of the issues that will be addressed. Without such a move, the market is, in our view, likely to remain under-developed - there are currently only about 30,000 consumers of the product. Other significant changes in LTCI, whether initiated by the authorities or by suppliers, are also, in our view, likely to be deferred until the Commission has reported in December 1998 and the Government has considered its recommendations.

4 CORE TERM PRODUCTS

- 4.1 In the 1996 report, we recommended that insurers, perhaps through ABI, should create a benchmark or core term product. This met with a disappointing response. ABI commented that the industry accepted that *some* health insurance products were difficult for *some* consumers to understand: ‘people’s needs are often complex and differ considerably from one individual to another’. The industry, according to ABI, recognised that this was a ‘failure of communication’ on its part, but ABI considered that it arose more from the inherent complexity of the products than from any lack of competitiveness in the market. Indeed, it was the fierce competition between suppliers that led to the variety of products. Benchmark products, proposed in the 1996 report, could, in ABI’s view, have a ‘restrictive effect, stifling product innovation’ and it has, as acknowledged elsewhere, produced a series of consumer leaflets describing healthcare products to assist in consumer education. Some insurers expressed interest in the concept of core term products, but without an industry-wide consensus, no practical progress could be made.
- 4.2 Our proposals have been designed to take account of these arguments. We are recommending core term products only as a means of facilitating comparison between products. Some standardisation of definitions is an essential element of this. What we are proposing is, in effect, a template of coverage and some standardisation in terminology. We welcome product innovation, but not if it simply results in increased product complexity. Innovation may give the appearance of fierce competition, but needs to go hand in hand with clear and precise information for consumers to benefit from it. What we are proposing is to put the information in a way that it is understood by consumers and so that they can compare one product with another. As our research paper on *Consumer Detriment under Conditions of Imperfect Information* argues, consumer detriment can arise in just this situation. In the absence of a clear idea about what different policies cover, and of agreed definitions, consumers are unable to compare one policy against another. As a result, they may pay more than is necessary and inevitably purchase, on occasion, inappropriate policies. Furthermore, the absence of the information needed to explain products and to enable comparisons to be made can lead to ‘exclusion’, the situation where consumers fail to buy particular goods or services even when it would be in their interest so to do. ABI argued that the health insurance market, taken as a whole, was comparatively ‘underdeveloped’. We agree and conclude that it is likely to stay that way unless these information related problems are addressed.
- 4.3 Some core benefits are common to nearly all policies, although the ways in which suppliers describe and explain them can differ significantly. The 1996 report recommended that insurers should find a way of describing such core benefits and have ‘extras’ and exclusions listed afterwards. A subsequent large scale survey conducted by

a major insurer confirmed that customers are generally more concerned about the nature of these core terms than with the more peripheral benefits.

- 4.4 We are aware that it may not be in the commercial interests of any one insurer to change the way products are specified and explained to consumers. We are also aware of interest and involvement by a number of practitioners in the industry, but ABI, representing its constituent members, may not be well placed to take such an initiative. We have therefore sought to 'kick start' the process by commissioning consultants with long experience in the industry to devise by way of example a series of templates which illustrate how the core terms for PMI, PHI and CII could be defined. The definitions and design elements from a range of products were assessed, and used as a basis for the sample core terms. The essential features are described in Appendix C and the full detail is published on the Internet on <http://www.oft.gov.uk>. In view of the establishment of the Royal Commission, LTCI has been omitted from these studies. We should emphasise that the specification of the core terms products for PMI, PHI and CII has been devised purely as an illustration. It has not been the subject of a significant editing process on the part of the Office and is presented with this report as a basis for discussion and further development.
- 4.5 The consultants' overall conclusion is that the notion of a core term product, with the specific variations required by insurers being noted as additions to or subtractions from the core product, is feasible. Much of the variation in policy definition, general conditions and exclusions would thereby be eliminated. Our consultants speculated that some of this variation might have arisen from market pressures to make products hard to compare. Furthermore, the existing products could be compared with this core term product by trade journalists and advisers, and appraised for a wider public.
- 4.6 Our consultants' view, with which we concur, is essentially that consumer detriment would be reduced if such core term products were available. We therefore recommend that ABI carry this work forward, building on our suggestions to make it easier for a consumer to understand the scope of products and make comparisons between competing products. ABI should aim to bring forward its own recommendations to be defined in appropriate codes of practice, no later than 30 September 1998.

5 MORATORIUM UNDERWRITING

- 5.1 With moratorium underwriting, the consumer does not make a medical declaration, fill in a health questionnaire or undergo a medical examination, and, for a period, any PECs are not covered. Moratorium underwritten health insurance policies typically state that any relevant PEC which has been incurred in the five years before the policy was taken out will become eligible for treatment two years from the policy start date, provided that, in the interim, the policyholder has not consulted a doctor about that or any related condition, nor otherwise sought advice about it (including related check ups), nor taken medication for it (including drugs, medicines, special diets or injections).
- 5.2 Moratorium underwriting was, and continues to be, common for PHI and PMI. While we acknowledged in the 1996 report that, in some circumstances, moratorium underwriting could have advantages for consumers, we were concerned that many consumers failed to understand its potentially adverse implications. Our concern was apparently shared by two major PMI insurers, WPA and PPP, who indicated to us before the 1996 report was published that they intended to abandon the practice. This they duly did. In their response to the 1996 report, ABI, however, told us that the industry could not reach a consensus on the matter, and the majority of insurers who had previously issued moratorium policies continued to do so.
- 5.3 The significance of our conclusion that consumers failed to understand the implications of moratorium underwriting was heightened by the subsequent publication of our research paper on *Consumer Detriment under Conditions of Imperfect Information*. This identified two forms of information shortfall confronting consumers:

an actual information shortfall, experienced when the information available to and assimilated by the consumers is less than that needed by a rational consumer seeking to maximise his or her welfare; and

an institutional shortfall, occurring when alternative institutional arrangements would offer the potential to reduce the difference between the information needed by a rational consumer, given the existing institutional framework, and all the relevant information that exists on the products and its alternatives.

Both forms of shortfall were identified with *consumer detriment*, which arose when the resulting loss in consumer welfare exceeded the cost of obtaining further information, including, where appropriate, the cost of modifying institutional arrangements. Consumer detriment was not only associated with the welfare lost by the individual consumer as a result of buying the 'wrong' product or the 'wrong' quantity. It was also associated with any resultant welfare losses incurred by the consumer and by society at large arising from

such sub-optimal decisions. The concern expressed in the 1996 report that consumers were unable to obtain and assimilate the information they needed with regard to moratorium underwritten health insurance products can, therefore, now be seen as a concern that moratorium underwriting results in consumer detriment.

- 5.4 The potentially adverse implications of moratorium underwriting include the following points.

The consequences of restricting information

By foregoing the information that medical checks can provide, the consumer is making a decision on less information than would otherwise be available. This, by definition, results in consumer detriment unless there are sufficient countervailing benefits. The insurer, of course, also relies on less information than would be available with a fully underwritten policy resulting in generally higher premiums due to the fact that high-risk individuals may prefer this type of insurance. In addition, those who would be lower risk on the basis of full information would pay higher premiums than they needed to. It is also possible that the fraudulent may prefer moratorium underwriting, again increasing premiums for everyone, although this is by no means self-evident.

Inhibitions on switching policies

Whereas a consumer with a fully underwritten policy can readily switch to another insurer provided the necessary health checks and inquiries are undergone, a consumer with a moratorium underwritten policy essentially makes an ‘investment’ in the first two years which yields a return in subsequent years by providing cover for PECs that might otherwise not have been insurable. The benefit of this ‘investment’ is foregone on switching, even when the consumer switches to another moratorium underwritten policy.

The consequences of deferring medical attention

There is a danger that consumers with PECs will forego necessary medical advice or treatment during the first two years of a policy. If even routine medical checks relating to a PEC are undergone, cover for that or any other related illness may be lost. Our concern here was increased when we discovered that patients recovering from serious illnesses have been sold moratorium policies, even though regular medical check ups are advised as part of their treatment. In the case of transmittable conditions, this could, of course, have adverse affects not only on the individual but also on public health. We agree with ABI that the definition of ‘seeking advice’ in connection with determining if a condition is pre-existent is in need of further clarification.

Uncertainty

Consumers may remain uncertain about whether particular risks will be covered until a claim is made.

As we recognised in 1996, there are advantages for some consumers.

Avoidance/deferral of medical inquiries

Consumers avoid the need to fill in questionnaires or attend medicals. The equivalent will, however, be required when a claim is made (hence moratorium underwriting is sometimes referred to as ‘underwriting at the point of claim’).

A simplified sales process

Moratorium underwriting enables the sales process to be streamlined. In consequence, moratorium underwritten health insurance can be less costly to administer than fully underwritten products. These benefits should, in a competitive market, be passed on to consumers. The scope for simplifying the full underwriting process is, however, also considerable, and there could be scope for providing moratorium underwritten cover on a temporary basis while the necessary inquiries for full underwriting are undertaken.

Cover can be obtained for some pre-existing conditions

As PECs can be covered once the moratorium has expired, cover might be obtainable with moratorium underwriting in situations where this would not be possible with a fully underwritten policy. ABI has, however, advised that it is important that consumers do not take out moratorium underwritten policies in the expectation that medical conditions will be covered more quickly than will be the case, and some conditions will never be covered.

- 5.5 We have come across nothing in the course of analysing the responses to the 1996 report, and in undertaking further work, to cause us to revise our view that, for many consumers, the potential advantages are insufficient to outweigh the disadvantages, particularly the primary disadvantage that the decision is being taken with less information than can often be readily obtained.
- 5.6 Those who argue that there should be no restrictions on the employment of moratorium underwriting point to research that indicates that consumers tend to like this type of product when it is objectively and dispassionately explained to them. Our view is that consumer surveys and focus groups which explore the attitude of consumers in this way are of limited interest as they fail to replicate the consumer’s level of understanding at the point when they actually make the decision to purchase the product. Moratoria might indeed have some desirable characteristics which, when properly explained, could make them attractive to some consumers, but we can find insufficient evidence that this is

happening.

- 5.7 In regard to the perceived failure of consumers to understand moratorium underwritten health insurance, ABI suggested that improved consumer education could help surmount any problems. In December 1997 they published an Abstract on *Applying the Statement of General Insurance Practice to Health Related Insurance*. This indicated that insurers could continue to use moratorium underwriting provided the implications were explained in ‘very clear and simple language in all relevant documentation’. ABI also recognised a need for improved signposting of the questions a consumer should be asked before being sold health insurance, and drew attention to some new leaflets explaining each of the four types of health insurance. These would be distributed to prospective customers of ABI members and made available to non-ABI members at Citizens Advice Bureaux. Finally, ABI indicated that there would be further guidance on selling insurance over the telephone.
- 5.8 We agree with ABI that tighter controls of selling practices and improved information for consumers would render moratorium underwritten health insurance more acceptable. The initiatives described by ABI, however, fall far short of what is required. The ‘relevant documentation’ referred to by ABI is that provided when selling general insurance. The small print in such documentation is notorious for being largely disregarded by consumers, even when it is clear and simple. Furthermore, the Director General has never formally supported any of the ABI’s guidance under our *Guidelines for Support of Individual Codes* (1991). Also, as described in our *Report on Raising Standards of Consumer Care* (1998), there exist significant weaknesses in the present regime of trade association codes of practice.
- 5.9 If the provision of moratorium underwritten health insurance is to continue, it is essential, in our view, that sales practices and the provision of information are subject to tighter regulation than the ABI’s codes and guidance can currently provide. We recommend that there should be effective statutory regulation that requires the insurer to:
- establish the consumer’s need for the policy;
 - explain, orally, and then in writing, the essential features of moratorium underwriting of health insurance, paying special attention to the extent to which PECs are covered, before the consumer enters into a contract;
 - stress the inadvisability of foregoing medical advice in the period before PECs are covered; and
 - monitor the sales process to ensure that the above procedures were adhered to and

to provide evidence in cases of dispute.

Furthermore, the regulator should, in our view, monitor the experiences of consumers of moratorium underwritten health insurance and carry out research into the extent to which medical advice may be systematically foregone by consumers in the moratorium period.

- 5.10 The reserve powers that are to be included in the Financial Services Regulatory Reform Bill to regulate the conduct of general insurance business provide a means by which this could now be achieved. We therefore recommend that moratorium underwriting of health insurance need not be discontinued provided that these powers are employed as soon as they are available and the FSA commits itself to the proposed monitoring and research.

6 OTHER RECOMMENDATIONS MADE IN 1996

- 6.1 Many of the concerns in the 1996 report (summarised in Appendix A), including those about the lack of clarity of products, would be eased if our recommendations for core term products and moratorium underwriting were implemented. The scope for improving the quality of sales literature would, however, remain. According to the 1997 report by CHF, 63% of patients still base their choice of scheme **solely** on literature. That report goes on to say that 79% of patients were unaware that their insurer would not pay the cost of drugs dispensed for use at home following discharge from hospital and that their policy would not provide cover for chronic (incurable) conditions. This suggests that there is considerable scope for improving current terminology and communicating its meaning clearly to consumers. There would also be a need to ensure that policies that did not conform to the core term criteria could still be compared with them.
- 6.2 In 1996 we identified the need for clearly written, easily understood policies. This need still exists. We recommended that every health insurance policy should be accompanied by a clear summary, in common format, showing what the policy does and does not cover. Examples of how this can be achieved include book format tables of standard benefits using recognised terms, allowing the consumer to choose the most suitable policy. We are aware that health industry consultants are also examining this approach. The terms and text of the policy itself should be expressed in plain and intelligible language in line with the Unfair Terms in Consumer Contracts Regulations 1994, ensuring that jargon and technical terms are either avoided or adequately explained.
- 6.3 We recommended in 1996 that there should be a warning about likely increases in PMI premiums, possibly taking the form of a general statement explaining that premiums had increased significantly faster than RPI, together with a statement of the increases experienced over the previous five years and an illustration of how actual premiums might increase over the next five years. Our concerns on this issue have not been alleviated, either by a decline in the rate of increase in premiums or by any initiative by insurers to bring this fact to the attention of consumers. We do, however, recognise ABI's arguments that it might not be practicable to trace premium increases in premiums for particular policies. Given the high quality of ABI's published statistics on insurance matters, it should, however, be possible to publish reliable data on the average increase in premiums for PMI for particular insurers over the last five years and to draw this to the attention of consumers before the product is sold. We therefore invite ABI to examine this possibility and publish the relevant data, with recommendations for use, by 30 September 1998, and to consider how their codes, statements and other guidance might be amended to ensure that consumers are aware of the matter. Moreover, the need for clarity in the presentation of possible premium increases extends to any health insurance product where premiums are reviewable or guaranteed only for a fixed period, as for

example, in many PHI and LTCI contracts. Consumers cannot be expected to make rational choices on the basis of limited information about future costs.

- 6.4 As noted in 3.1, the two largest healthcare insurers, PPP and BUPA, remain outside any ombudsman scheme, but both subscribe to PIAS. There has been a serious gap in the redress mechanism afforded by PIAS and it is essential that it is strengthened. We therefore welcome the changes to PIAS procedures whereby consumers no longer need the consent of their insurer to complain to PIAS and are no longer bound by PIAS's decision. No action has, however, been taken over our concerns in the 1996 report that PIAS does not:

- publish an annual report;
- disclose the amounts that insurers have been required to pay following decisions against them; and
- publish explanatory leaflets

These shortcomings will doubtless be remedied when PIAS becomes part of the responsibilities of the Financial Services Ombudsman Scheme following enactment of the Financial Services Regulatory Reform Bill. We nevertheless confirm our previous recommendation that these deficiencies should be remedied and suggest that this need not wait for that enactment.

References

- ▶ *Applying the Statement of General Insurance Practice to Health Related Insurances*, Association of British Insurers, 1997
- ▶ *Laing's Review of Private Healthcare*, Laing and Buisson, 1997
- ▶ *Selling of Private Medical Insurance to Individual Purchasers*, Association of British Insurers, 1997
- ▶ *FSA Consultation Paper No.4 - Consumer complaints*, Financial Services Authority, 1997
- ▶ *Consumer Detriment under Conditions of Imperfect Information*, Office of Fair Trading, 1997
- ▶ *Raising Standards of Consumer Care*, Office of Fair Trading, 1998
- ▶ *CHF Survey of Patients*, CHF . . . a Federation of Charitable Hospitals, 1997
- ▶ *Consumer Trends Q4/1997*, Office of National Statistics, 1997
- ▶ *PHI Healthcare Statistics*, LIMRA/SwissRe, 1997
- ▶ *CII Healthcare Statistics*, LIMRA/SwissRe, 1997
- ▶ *Private Welfare Insurance and Social Security: Pushing the Boundaries*, John Hills and Tania Burchardt, Joseph Rowntree Foundation, 1997

APPENDIX A - RECOMMENDATIONS MADE BY THE 1996 REPORT

Private Medical Insurance

- A.1 We recommended that:
PMI plans be presented in a common format and (like other contracts) in plain and intelligible language;

an approach be developed to enable a ready comparison to be drawn between plans.

- A.2 We recommended that PMI providers should abandon the moratorium approach to underwriting.

- A.3 We recommended that there should be a warning about likely increases in PMI premiums, perhaps in the following terms:

a general statement explaining that, because of the incidence of claims and increases in costs, PMI premiums for individual plans had increased significantly faster than RPI;

a statement of the increases for each plan over the previous five years, both in cash terms and above RPI;

an illustration of how actual premiums would rise over the next five years, both in cash terms and in real terms over a projected RPI, assuming the same rate of real increases as in the past five years.

- A.4 We recommended that all protocols or care practices should be drawn up within a common framework, under the guidance of an industry body and the Department of Health. NHS bodies and PMI companies should publicise their protocols on best practices in common formats so that comparisons can be readily made. The Royal Colleges should be invited to sponsor consensus conferences to help refine these protocols, and both NHS bodies and PMI companies should be encouraged to publish output and outcome targets and results achieved.

Permanent Health Insurance

- A.5 We recommended that the PHI industry, possibly through ABI, produce a standard definition of 'total disability' and also take steps to draw up a standard PHI benchmark product, with the key features clearly and simply described. Any additions made to such

a product by individual companies could then be compared against any resultant extra

premiums.

- A.6 We recommended that questionable promotions like '1 in 5' be dropped, and that instead PHI providers should make more effort to explain how PHI interacts with state and employer sick pay schemes.
- A.7 We recommended that the moratorium approach to underwriting also be dropped for PHI.
- A.8 We recommend that the PHI industry, possibly through ABI, tackle the problem of over-insuring, through which the PHI providers collect excess premiums. There should be a proper fact find when policies are sold. In addition, annual checks could reduce shortfalls, although a system for refunding such premiums could be a fairer solution.

Critical Illness Insurance

- A.9 We recommended that the CII industry, perhaps through ABI, draw up a CII benchmark product based on the five or so conditions which account for 95% of claims. The chances of suffering those conditions separately and overall should be disclosed - as they frequently are for marketing purposes. Any variations from that benchmark product, for example through the addition of other conditions, could then be judged by comparing the stated chances of suffering the extra conditions, and the resultant increase in premiums.
- A.10 We recommended that the CII industry, perhaps through ABI, recognise and address the problem for dependants if life cover is lost when a critical illness benefit is triggered within an accelerated benefit policy. One solution suggested was to provide the option of a higher premium to buy back life cover, as in Australia. But, in any event, everyone taking out a CII policy should be made completely aware of the basis on which cover is provided, in particular the fact that payment for a critical illness will reduce or even eliminate the benefits payable at death.

Long-term Care Insurance

- A.11 We recommended that the LTCI industry, possibly through ABI, draw up benchmark products, perhaps with one pre-funded and the other for immediate. Products with variations from the benchmark product could then be more easily judged for value for money by comparing the premiums payable.
- A.12 We recommended that sales of LTCI focus on whether prospective purchasers have family care available, whether they want to protect their assets to pass on to beneficiaries, and whether the premiums required are affordable. Sales techniques should not focus on secondary features like helplines, or care counselling.

A.13 We also recommended that, for pre-funded LTCI, prospective purchasers be given a clear indication of the likely surrender value if they prove unable to keep up the premiums.

A.14 We recommended that the selling of LTCI products be regulated.

APPENDIX B - FURTHER INQUIRIES AND FINDINGS

- B.1 After publishing the 1996 report, we continued to monitor the industry, keeping a special watch on health insurers' reactions. During the summer of 1997 we reviewed progress made by the industry and as a result of this, decided to undertake a fresh inquiry. This appendix explains the methodology behind the new work.
- B.2 In addition to the research commissioned to evolve the core term products (the methodology for which is described in Appendix C), we used a variety of methods to keep track of industry developments. As well as monitoring the trade press and examining product literature, we conducted a survey of PMI moratorium complaints statistics and met on several occasions with industry representatives and individual suppliers. We undertook a detailed re-examination of the industry during the latter part of 1997.
- B.3 This re-examination consisted of interviewing insurers and commentators, regarding the past, present and future of the industry, soliciting opinions on matters such as premium increases, moratoria and core term products. Data from the 1996 report were updated, and the conclusion was reached that the industry had not responded positively enough to the first report.
- B.4 We met with industry representatives, including ABI, on several occasions in an attempt to find common ground and to explain better our concerns. These meetings included sessions held with individual health insurance suppliers, both members and non-members of ABI.
- B.5 During the investigation insurers and commentators were approached either in person or by telephone. Interviewees were chosen carefully to ensure that there were representatives from each of the four markets - PMI, PHI, CII and LTCL. In addition any interested party wishing to contribute views was welcomed.
- B.6 First, we asked whether there had been any perceived changes to the four markets. Each respondent interpreted changes differently. One commented on consumer perception whilst another reported on market share and new entrants. A follow-up question asked whether these changes were in any way attributable to the publication of the 1996 report.
- B.7 Each respondent was asked for their views about future trends for the industry. Evidence for these views was sought. Insurers were asked whether they had made any changes to any of their products or literature since the publication of the report and commentators were asked whether they had noticed any changes. Insurers were also asked whether they

had taken any specific actions in the light of our published recommendations.

- B.8 One of the areas of contention had been the level of detriment to the consumer. There was a suggestion that we had exaggerated the size of the problem. To help resolve this, we asked each insurer for up-to-date statistics relating to product sales, lapse rates, claims ratios and complaints. Our main interest was in the complaints as the other statistics were largely available from either ABI or health insurance consultants Laing and Buisson.
- B.9 The survey into PMI moratorium complaints statistics took place in Spring 1998. Seven PMI moratorium suppliers were asked how many such bills were settled for less than the full claim. Responses to this exercise are not included in the present report as they were incomplete. Only two insurers were able to tell us how many claims were settled for less than the full amount requested and to reveal the amount for which they were finally settled.
- B.10 We then asked whether there were any further points that respondents felt they had not had the opportunity to make already, and for any other general points.

Market changes since publication of the OFT report

- B.11 There was general agreement amongst commentators and insurers that there had been little discernible change to the industry as a result of the 1996 report. Economic factors had been the main driving force behind any change. One view was that the industry was not going to make any significant changes until they saw how we responded to the ABI reply.

Private Medical Insurance

- B.12 Commentators and insurers suggested that there had been a growth of about 2% during 1996. A number of insurers restated that the business remained 'marginally profitable' with claims ratios on average at about 82%. Insurers commented that there had not been much product innovation since the 1996 report.
- B.13 The Government has now withdrawn tax relief for the over-60s. Commentators and insurers suggested that this was not a surprise and was in fact a change for which they were preparing. But the industry expected a subsequent increase in lapse rates for this group. Subscribers were likely to trade down to less costly PMI products whilst insurers would try to reduce premium increases by balancing costs with other groups.
- B.14 A number of insurers considered the market to be saturated. Many applicants could not afford the premiums. The industry consultants Laing and Buisson pointed to a growth of

10% in PMI subscription income but added that the subscriber population had remained flat. Abbey National entered the market in late 1997 and the Daily Telegraph had run a promotion during 1997 selling PMI in arrangement with Norwich Union. Other commercial insurers, including pure life as well as general insurance companies, were understood to be considering entering the market.

Permanent Health Insurance

- B.15 Norwich Union continued to sell PHI moratorium policies. PPP halted their use of moratoria for PHI soon after the publication of the report as did Prime Health. Some insurers now refer to 'income protection' rather than 'permanent health' insurance policies.
- B.16 PHI business had improved. PHI sales, which had been in decline for several years, had stabilised to a discernible upward trend. There was a 9% increase in sales in 1996. Half the PHI market was generated by Independent Financial Advisers (IFAs), suggested by some to have improved their explanations of the products on offer.

Critical Illness Insurance

- B.17 For the industry, one clear success story was CII, which continued to grow. Our enquiries indicated that at the end of 1996 around 50 companies were transacting individual CII business, marketing some 150 products. Individual CII sales had stayed buoyant during the economic gloom of the previous five years and improved by 55% in 1996 to sales of over 300,000 policies. Stand alone policies were also growing but at a smaller rate than those linked with other products. Industry analysts reported that companies which specialised in this market were starting to become aware of the potential of longer standing mortgagors without critical illness cover and were beginning to make a stand alone product for them.

Long Term Care Insurance

- B.18 There had been little growth in this product. The industry is waiting and watching new developments but overall consumer interest in this product has never been more than limited.

Future market trends

- B.19 Some insurers considered that certain negative public perceptions of the NHS were

essential to PMI growth. One insurer was of the opinion that the NHS would be selling off part of its non-essential care, which would create business opportunities for PMI insurers. It was unable to predict exactly what would be sold but mentioned hormone replacement therapy (HRT) and HIV-related treatments as possible examples. The industry does not appear to have a clear vision of how the market for PMI could grow short of a major change in government policy.

- B.20 There were two major trends emerging which would affect the industry: 'network initiatives' and the linking of policies, for example, linking CII with PHI products.
- B.21 Four major PMI insurers had introduced network initiatives, designed to improve cost management. Some larger insurers intended to increase the efficiency of the independent hospital sector by reducing excess capacity. Consumers would be offered access to a restricted range of hospitals in return for reduced premiums or additional benefits.
- B.22 BUPA launched its preferred provider network in 1996. It invited consultants and hospitals to be part of the scheme. PPP Healthcare launched its network programme in April 1997 and was now claiming a success with 95% of existing customers choosing to join the network in four first phase areas. Each customer had been sent a letter explaining the benefits of joining the network, such as a premium price freeze on renewal, and informing them that they would automatically become a member of the network if they took no action. Earlier in 1997, Norwich Union announced a partnership strategy with Nuffield Hospitals and in September Prime Health launched its network. Industry commentators suggested that smaller hospitals not on the preferred lists would struggle to stay in business.
- B.23 Linking policies enables different products to be bolted together. This benefits the insurer as administration costs are reduced, but policies are likely to be more expensive. The Consumers Association commented that they were finding it more difficult to compare products as increasing numbers were being combined in this way.
- B.24 Moratorium policies continued to be used as a marketing tool by insurers to encourage consumers to switch companies and to gain new business.
- B.25 Cooperation between institutions with existing customer databases and major health insurers continued. Recent examples included Abbey National and Norwich Union.
- B.26 The Internet was considered to have a significant role to play in future policy sales. Many companies were studying closely European Directives on Distance Selling and their consequences for exploiting this medium. BUPA, along with one or two other companies, had a well-developed web site. Some insurers were now beginning to experiment with

selling PMI products over the Internet.

Changes to literature and products

Literature

- B.27 ABI had produced a guide to each of the four main types of health insurance, which was to be distributed with ABI members' product literature. The *Statement of General Insurance Practice: Health related Insurances* had also been revised.
- B.28 Consumers Association acknowledged that there seemed to be a shift by some insurers towards more accessible and transparent literature, but it was apparent that few changes to company literature occurred as a direct result of the 1996 report. Most insurers said the report had given extra impetus to changes they were considering anyway, although WPA claimed that they had produced videotapes and literature changes as a direct result of the report.
- B.29 Certain major insurers were currently redesigning their product literature to make it easier to understand. One would be providing one main booklet which contained all their products rather than separate brochures. An insurance consultant pointed out that price information was becoming less easy to obtain. Rates were not published but were available only to individual enquirers.

Products

- B.30 There had been little product innovation, but BUPA introduced its 'health fund', whereby subscribers are required to agree to receive treatment in approved hospitals. In return the savings are allowed to accumulate in the policy-holder's health fund and used to purchase other BUPA insurance services and health care products.
- B.31 WPA and PPP claimed that they had stopped the use of moratoria (although WPA had been using it for only three months) as a direct response to OFT recommendations. It was suggested that there had been a move by insurers to practise a straightforward exclusion of pre-existing conditions instead of full underwriting.
- B.32 There was a suggestion by one provident insurer that there might be a move to underwriting which took greater regard to the individual characteristics of the applicant. This was said to be as a consequence of continuing competitive pressures from 'commercial' insurers and resulted in a widening of rates.

Other changes

B.33 Insurers suggested that they considered their subscribers to be sophisticated and noted that awareness of the consequences of pre-existing conditions seemed to have increased. This is in direct contrast to the IOB, who had told us that pre-existing conditions remained the area of greatest public confusion.

Statistics

B.34 Updates of all major tables from the original report appear in schedule B.

Complaints

B.35 One of the main claims made in the ABI response to the OFT report was that the report had exaggerated the level of consumer complaint. In support of this we requested a variety of complaints statistics from insurers. Some were very willing to comply, others had a variety reasons not to provide the figures.

B.36 It is our view that referrals to the Insurance Ombudsman and his Bureau's complaint figures are not a useful guide to the level of public complaint at large. Several insurers impressed on us that they did not let cases go to the Ombudsman unless they were confident of a finding in their favour, preferring to settle 'out of court'.

B.37 There had been changes to the way that the PIAS operated since the 1996 report. Customers no longer need the consent of their Insurer to submit a complaint. Complainants are also no longer bound by any decision of PIAS and are free to take the case elsewhere if they are not happy with the adjudication. However, PIAS still did not produce an annual report, or an explanatory leaflet for customers, and were unwilling to disclose the amount that insurers were required to pay when a case was presented to them. (It is known that insurers are charged for each case submitted to the IOB). A large part of PIAS activity remains unknown. The practice of not issuing an annual report was being reviewed, however. According to current industry statistics, companies using the PIAS system of complaint represent just over 70% of all health insurance subscribers.

B.38 One insurer did suggest that they were trying to set up a new Healthcare Ombudsman, for which they were seeking the support of others.

Other comments

Commentators

B.39 Employers' representatives reported that companies had been concerned about rising costs for corporate PMI schemes, which had led to shopping around, although this no longer seemed to be such a problem. Some companies had begun to get employees to pay

towards their health insurance premiums. PMI continued to be attractive to smaller firms, whose employees enjoyed the almost tangible 'perk'. The main problem for the consumer of corporate PMI (or PHI) is that he or she is not the policyholder and has no access to redress and often a poor idea of the cover.

Other observations

Private Medical Insurance

- B.40 PPP and WPA claimed to have halted moratorium sales following our recommendation, but moratoria continued to be a significant part of Prime Health and Norwich Union's business. We heard the opinion that neither moratoria nor full underwriting was flawless and the problems of full underwriting might also be given adequate attention.
- B.41 We had expressed some concern that in order to survive the moratorium terms, consumers with pre-existing conditions might take the undesirable step of not seeking advice or treatment if that condition recurred within two years of purchasing a policy. During our follow-up enquiry, we received anecdotal evidence which supported this concern.
- B.42 In most European countries there is no tradition of selling instant cover 'off the page' and therefore no reason why moratorium selling would be an advantage. It is for this reason and the fact that none of the European health insurance markets is similar to the UK, that moratorium policies are not generally sold by European insurers. In the current debate about 'distance selling' and 'electronic trading', the general view among health insurers is that customers should have full information about the exact extent of their cover and any exclusions in force at inception or shortly afterward.
- B.43 One commentator considered that there would be a greater need for managed care, to control rising premium costs. Both PPP and BUPA were developing networks of approved hospitals.
- B.44 Although the market was said to be only marginally profitable, there was talk of other entrants to it. We were told that PMI is considered by several insurers to be a good entry level product to other insurance products. This is apparently why life insurers appear to be keen to offer at least one health insurance product in their range. Most insurers considered the market to be saturated, though one insurers' view was that there might be an eventual boom in PMI sales.
- B.45 Apparently IFAs play only a small part in individual PMI sales as the commission

element continues to be small, one insurer reporting that only 10% of its sales were through brokers and that 90% remained through direct contact.

- B.46 Industry representatives claimed that benchmarking would stifle competition. Some insurers, however, claimed that they were trying to introduce their versions of a benchmark product. The IOB suggested a better approach would be to promote the use of key features documents rather than benchmarks (as required by the FSA for investment products). They reported a move by companies to show tables comparing products within the insurer's range. One insurer, however, suggested that the benchmark product, though a laudable idea, was impractical and that such a move would not enable customers to take other factors into consideration, such as levels of service.
- B.47 One insurer said that its literature had been directly influenced by the 1996 report. The company was producing a new flow chart for customers which would show its whole range of products on one page with the central product representing a benchmark. Another had undertaken a customer survey and, as a result seemed likely that it would be relaunching its literature as one booklet rather than one for each product. It found also that customers considered its literature too wordy, that there was no reference to increased premiums with age and that limitations were not clearly laid out. It said customers wanted depth of cover rather than peripherals, such as a private ambulance.
- B.48 Insurers have been generally dismissive of our recommendation for indications of past rises in premium levels. Respondents said this might mislead the public since PMI products do not remain static, one commenting that even if individual plans had been in existence for five years, there might have been fundamental changes which would have materially affected the benefit levels and the price, for example the abolition of tax relief for the over 60s. There is an industry-shared view that it would not be possible to provide reliable illustrations of how actual premiums might rise over the next five years.
- B.49 We had recommended that protocols or care practices should be drawn up within a common framework and be published. There was general agreement within the industry that such a task would be an enormous undertaking, on which the NHS should take the lead if any progress is to be made.

Permanent Health Insurance

- B.50 Consumer's Association was still concerned about the use of the definition for total disability and that there was still room for misuse concerning the definition of 'usual occupation'. It was also concerned about whether PHI cover was reviewable. Could insurers simply stop cover when they wanted?

Critical Illness Insurance

- B.51 The success of CII products seems to be largely a result of policies' being added on to mortgages. Insurers suggested it was a simple product to sell. Consumers seem to know what they are likely to get. It was suggested by commentators that some CII sales may be at the expense of PHI sales as brokers apparently prefer to sell CII rather than PHI.
- B.52 Consumer's Association remained concerned over the cover claimed for many CII policies. For example, one insurer covered Alzheimer's disease but only for claimants under a certain age. Premiums are reviewed every ten years for CII. The Consumers Association was concerned about the possibility that when subscribers are older and premiums are put up they will not be able to afford cover just when they are most likely to need it.

SCHEDULE A
ORGANISATIONS CONSULTED

Insurers

interviewed in person:

Prime Health

BUPA

Norwich Union

PPP

WPA

interviewed over telephone

Legal And General

Unum

Swiss Re

Commentators

interviewed in person

The Research Department

Confederation of British Industry (CBI)

Insurance Ombudsman Bureau (IOB)

Association of British Insurers (ABI)

NHS Executive

interviewed over telephone:

Consumer's Association

Personal Insurance Arbitration Service (PIAS)

British Medical Association (BMA)

Department of Social Security (DSS)

Comité Européen des Assurances (CEA)

Other sources

Laing's Review of Private Health Care 1997

Life Insurance Marketing and Research Association (LIMRA)/ Swiss Re Study on CII and PHI
1997

SCHEDULE B

Private Medical Insurance (PMI)

	RPI Adjusted Price Inflation	RPI Adjusted Cost Inflation
1987	7.3%	4.2%
1988	2.1%	5.1%
1989	-1.2%	0.3%
1990	-1.1%	2.6%
1991	5.9%	5.1%
1992	9.8%	2.5%
1993	3.5%	-0.2%
1994	1.8%	2.1%
1995	1.1%	2.0%
1996	5.5%	5.5%
Mean	3.5%	2.9%

Source: Laing's Review of Private Healthcare, 1997

PMI MARKET SHARE BY SUBSCRIPTION INCOMES

	1985		1990		1994		1996	
	£m	%	£m	%	£m	%	£m	%
<i>Insurer</i>								
BUPA	308	59	551	50	754	45	813	42
PPP	130	25	316	29	461	27	525	27
WPA	34	7	73	7	77	5	95	5
BCWA	9	2	28	3	34	2	39	2
Other providents	5	1	13	1	18	1	28	1
Commercials	<u>35</u>	<u>7</u>	<u>124</u>	<u>11</u>	<u>333</u>	<u>20</u>	<u>423</u>	<u>22</u>
Totals	521	100	1105	100	1677	100	1757	100

Source: Laing's Review of Private Healthcare, 1997

PHI

Average benefit and premium levels

	<i>year</i>	1994	1995	1996
<i>benefit per claimant</i>	£	7833	8443	9715
<i>premium benefit per policy holder</i>	£	308	319	360

Source: PHI Healthcare Statistics 1997 LIMRA/Swiss Re

CII

CII SALES BY POLICY TYPE

<i>Type of policy</i>	<i>Sales</i>		<i>Average sum assured £</i>	
	1995	1996	1995	1996
Free-standing	53,661	79,659	52,030	50,156
Acceleration:				
term	10,321	96,701	86,249	52,997
whole of life	91,956	92,040	52,537	44,048
endowment	146,316	202,068	32,940	32,925
<i>Totals</i>	302,245	470,468	40,023	45,031

Source: CII Healthcare Statistics 1997 LIMRA/Swiss Re

APPENDIX C: CORE TERM PRODUCTS

Overview, Reliances and Limitations

- C.1 This appendix is based on the market experience of our researchers and on the desk research they carried out. The primary research inputs were the policy wordings obtained from several insurers. In view of the difficulties encountered in obtaining policy wordings, the research database was incomplete and in some cases out-of-date. Consequently, this report does not claim to represent a comprehensive current view of the individual consumer product offerings of all insurers in the UK.
- C.2 The scope of the research and the report was restricted to a selection of individual consumer products for the UK. Accordingly, the consultants did not review either group products or international products for UK residents.

Methodology

- C.3 The approach was to review literature from a selection of the leading insurers in the market, for individual consumer business. The researchers then proceeded to build a generic core term product structure that could potentially be utilised by most insurers in the UK. Although the core term product structure took account of several products presently available in the market, it is not based on any particular product. Rather, it is a synthesis by the researchers, who made their own judgmental decisions on the more pertinent product elements.
- C.4 The approach also aimed to build the core term product structure from the viewpoint of an interested informed individual who was a potential customer. The starting point was that such an individual would wish to compare the features of competing products. In order to facilitate such comparisons, it would be important to compare the policy definitions, general conditions and general exclusions as applied by competing insurers.
- C.5 It was also recognised that applicants would want to compare product prices, both now and for future years. This applies just as much to PMI as to PHI or CII. PMI policies may be annual insurance contracts but few consumers enter into them on any basis other than a long term commitment.
- C.6 The researchers commented that most of the leading insurers seemed to have developed their own preferred policy definitions, general conditions and exclusions. Although some of the reasons were historical, they suspected that competitive market pressures had encouraged some insurers to make their products difficult to compare

with those of their competitors.

- C.7 The definitions of the disability Activities of Daily Living (ADLs) conditions and medical conditions that would give rise to an eligible claim were found especially confusing, in so far as each insurer seems to have its own views on disability matters. We believe that the consumer would benefit if there was some standardisation of the technical definitions of disabilities and ADLs.
- C.8 It is hoped that this report will encourage insurers to move towards a common set of policy definitions, conditions and exclusions, if only to help consumers understand exactly what is on offer and how it compares with the competition.
- C.9 There was a focus in this work on the generic technical product design features, rather than on the commercial aspects that are subject to competitive market pressures.
- C.10 The overall conclusion is that it is possible to introduce the notion of a recognised core product, with the specific variations offered by insurers being noted as additions to or subtractions from the core product. Furthermore, existing products can be assessed against this standard, and interpreted by informed trade journalists and others, in the public interest. Given that most individual consumers are planning for lifetime coverage, albeit for PMI via annual renewals of short term products, it is important that they are in a position to make informed choices. Our conclusion is that these choices will be better informed if insurers are encouraged to present their products in terms of a common core term product.
- C.11 A summary of the core terms products for PMI, PHI and CII follows. Full details including definitions are set out in Annex 1 which is available on the OFT's web site (<http://www.offt.gov.uk>).

Typical PMI Benefits Summary

In-patient and Day-patient Care	
Treatment at Select Hospital	100%
Treatment in a NHS pay-bed	100%
Accommodation and Nursing	100%
Drugs and dressings (prescribed)	100%
Operating theatre charges	100%
Surgeons & anaesthetists fees	100% - within Insurer guidelines
Physicians fees	100% - within Insurer guidelines
Radiotherapy & Chemotherapy	100%
Consultations and physiotherapy	100%
Pathology and radiology	100%
Private ambulance	100%
Hospital accommodation in respect of parent accompanying an insured child under age 9	100% - <i>if sharing a room</i>
Treatment at other hospitals: Benefits as for Select Hospitals and NHS pay-beds	Lesser of the actual charge or the average cost of equiv. treatment across all Select Hospitals

<p>Home Nursing immediately following Treatment as In-patient or Day-Patient on Specialist recommendation</p>	<p>100%</p>
<p>Out-patient treatment Consultations and therapies (Chiro/Osteo/phys) Pathology and radiology Radiotherapy and chemotherapy Acupuncture and homeopathy</p>	<p>100%</p>
<p>GP Minor Surgery - defined procedure list</p> <p>Recuperative Care</p> <p>Hospice Care</p> <p>Physiotherapy, Chiropractic, Osteopathy by a Qualified therapist on GP referral</p> <p>Maternity Cash</p> <p>NHS Cash</p>	<p>£y(1) per procedure</p> <p>Not covered</p> <p>£y(2) per day, up to (3) days, max. £y(4)</p> <p>100%</p> <p>Not covered</p> <p>£y(5) per day, up to £y(6) days, max. £y(7)</p>
<p>Optional Excess</p>	<p>£y(8), £y(9) or £y(10) per insured person per policy year</p>

Permanent Health Insurance

Summary of policy

<i>Purpose of the policy</i>	▶ provide an income in the event of accident or sickness resulting in incapacity.
<i>Subject to the following conditions and exclusions:</i>	
<i>Income Replacement Benefit</i>	▶ paid if the Life Assured suffers a period of Incapacity ▶ subject to the deferred period as specified in the policy
<i>Rehabilitation Income Replacement Benefit</i>	▶ paid immediately following a benefit period if the life assured either: <ul style="list-style-type: none"> • enters into an occupation that is less remunerative than the prior occupation; or • returns to the prior occupation at a reduced level of activity and remuneration.
<i>Benefits will be payable until the first to occur of:</i>	<ul style="list-style-type: none"> • termination of incapacity • attainment of termination age of the policy • attainment of normal pension age, or • death.
<i>Benefits may be total, limited, proportionate or rehabilitation.</i>	
<i>Total Benefit</i>	▶ if you were following a gainful occupation.
<i>Limited Benefit</i>	if you were solely engaged in <ul style="list-style-type: none"> ▶ household duties ▶ a part-time occupation or ▶ you were unemployed and as a result of the incapacity you are then unable to follow any occupation and you are confined to your home or to a hospital.
<i>Proportionate Benefit</i>	▶ if as a result of the incapacity you follow a different occupation with a reduction in your normal earnings (indexed to retail prices).
<i>Rehabilitation Benefit</i>	▶ if incapacity restricts the scope of your duties and reduces your normal earnings in your normal occupation. ▶ benefit will be based on the percentage reduction of your normal earnings applied to the total benefit and for a period not exceeding twelve months in respect of any one claim.

<i>Hospital Benefit</i>	<ul style="list-style-type: none"> ▶ arises with at least seven consecutive days in a hospital during your deferred period.
<i>Payment of Benefit on Death</i>	<ul style="list-style-type: none"> ▶ where benefits are not being paid a sum equivalent to the first 12 months contributions. ▶ where are paying a sum equivalent to 12 months income replacement benefit.
<i>Automatic Increase Option</i>	<ul style="list-style-type: none"> ▶ increases the benefit by an agreed index. ▶ option may be reduced or removed at any time. ▶ where the benefits are increased, contributions will also be increased to a level sufficient to sustain the increase in the benefits.
<i>Maternity Break Option</i>	<ul style="list-style-type: none"> ▶ following the birth of her child if a woman decides not to resume any such employment or occupation. ▶ commences at the end of the statutory maternity leave period whether or not full maternity leave has been taken. ▶ benefit equal to the maximum income replacement benefit payable ▶ the original level of benefits can be reinstated.

Critical Illness Insurance

<p><i>Purpose of the Policy</i></p>	<ul style="list-style-type: none"> ▶ to provide benefits in the event of accident or sickness occurring during the period of cover which results in the life assured having a specified critical illness.
<p><i>Benefits available are subject to the benefit terms, exclusions from cover and the conditions set out below.</i></p>	
<p><i>Critical Illness Benefit</i></p>	<ul style="list-style-type: none"> ▶ payable if the life assured survives for a period of 15 days after the occurrence of one of the specified critical illnesses. ▶ no further benefits will be payable unless there is another life assured under the plan.
<p><i>Children's critical illness benefits</i></p>	<ul style="list-style-type: none"> ▶ 50% of the critical illness benefit is payable to financially dependent child or children who aged between 30 days and 18 years (including 50% of any subsequent increases if appropriate) subject to a maximum payment of £25,000. ▶ only one claim can be made in respect of each child does not cover ▶ blindness, loss of hearing, loss of limbs, loss of speech or major burns. ▶ self-inflicted injury whilst sane or insane ▶ the taking of drugs (other than at the direction of a registered medical practitioner), alcohol or narcotics. ▶ unreasonable failure by the child or the child's parent or legal guardian to seek or follow medical advice ▶ injury inflicted by a parent or legal guardian ▶ a claim for children's critical illness benefit will not terminate the plan.

<p><i>Benefit terms, exclusions from cover and the conditions are set out below</i></p>	<ul style="list-style-type: none"> ▶ a sum equivalent to the contributions paid or payable in respect of that life assured during the first 12 months of the existence of the plan. ▶ unless there is another life assured under the plan the plan will terminate.
<p><i>Income Replacement Benefit</i></p>	<p>Not available</p> <ul style="list-style-type: none"> • during the first 3 month period of incapacity • if the critical illness arises directly or indirectly from, is aggravated by self-inflicted injury whilst sane or insane, the abuse of drugs, alcohol or narcotics • unreasonable failure to seek or follow medical advice • if any contribution (or part of any contribution) is outstanding; or • in respect of the first three months after pregnancy or childbirth.
<p><i>Waiver of annual contributions</i></p>	<ul style="list-style-type: none"> ▶ if your contributions are payable on an annual basis we will treat them as being paid monthly for the purposes of any waiver.
<p><i>Automatic increase option</i></p>	<ul style="list-style-type: none"> ▶ increases the amount of the critical illness benefit payable under this plan by reference to an agreed index. (*)
<p><i>Ad hoc increases/decreases option</i></p>	<ul style="list-style-type: none"> • (at any time request) ad hoc increases or decreases to the amount of critical illness benefit payable (*).
<p><i>Contract renewal option</i></p>	<ul style="list-style-type: none"> • you may elect to renew the plan for such further period as we may agree. ▶ no requirement to provide evidence of continued good health or insurability. ▶ contributions will be reviewed and may be increased.
<p><i>Replacement option</i></p>	<ul style="list-style-type: none"> ▶ if benefit is reduced on review, allows the policy holder to take out a new plan within one month without producing evidence of continued insurability. ▶ benefit under the new plan may not exceed reduction in the existing plan.

<i>Option to change the life assured</i>	▶ this option allows you to cancel the plan and replace it with a new plan with a different life assured or alter the plan by substituting a different life assured.
<i>Special event option</i>	▶ provides for an option to increase the benefit payable on marriage, the birth of a child (or children), or legal adoption, or divorce.
<i>Mortgage increase option</i>	▶ allows the policy to be extended within 3 months of a further advance either to purchase a new home or improve on an existing home.
<i>Unit linking</i> <ul style="list-style-type: none"> ▶ the product is written as a unit linked contract, with notional investments in units and the cancellation of units to pay the risk charges and the management charges. The key features of the unit linking of the funds are set out. 	

(*) Contributions will be increased as necessary to support the increase in benefit.