ABI Statement of Best Practice for CI +

ILAG 29/04/2014

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Agenda

- Team and timetable for the Statement of Best Practice (SoBP) for Critical Illness 2014
- Principles and objectives of the SoBP
- Changes to General principles
- Changes to conditions covered
- Key Feature Document (KFD)
- Other future relevant regulation or legislation for CI
- Questions

Team and Timetable

Critical Illness Working Group	
Karen Evans (ABI)	Helen Morris (Aegon)
Craig Butler (Hannover Re)	Richard Perriss (Swiss Re)
Phil Cleverley (SCOR)	Paul Reddick (Pacific Life Re)
Christopher Jewson (RGA)	Roger Wells (Legal and General)
Jackie Kerwood (Friends Life)	Michael Whyte (Aviva)
Chris McNab (LV=)	Andrew Wibberley (Swiss Re)

- August 2013 - First consultation to Protection market
- December 2013 - Draft document consultation to all stakeholders
- May 2014 Final release of revised Statement
- Companies will be given 1 year to implement

SoBP Review - Principles

- Full reviews every 3 years
- Having a common format for the way Critical Illness Cover is described to potential buyers at the point of purchase
- General principles, common Generic terms and KFD guidance
- The use of Model Wordings for Critical Illnesses and Exclusions which meet **appropriate minimum standards**
- To attain ABI recommended wording
  - Conditions have to be included on at least **75%** of CI policies
  - Exclusions have to be included on at least **50%** of CI policies
- No new conditions are exclusions to be added

Enhancements to model wordings (ABI+)

1.25 If an insurer is claiming a definition exceeds the model wording then the definition must provide additional cover **and** result in additional claims being paid by the policy as a whole. For example, the removal of a definition exclusion where cover could be claimed under an alternative definition would not be regarded as providing additional cover.

1.26 The removal of [x] from a definition would not be regarded as providing additional cover as the model wordings do not stipulate actual criteria.

Additional/Partial payments

2.5 Additional and partial payments

Where policies provide different levels of cover depending upon the specific medical conditions, surgeries or disabilities, the following terms should be applied:

Additional payment – this is where a claim payment made under a definition does not reduce the amount of benefit remaining.

Partial payment – this is where a part payment made under a definition does reduce the amount of benefit remaining.

Where covered conditions may be either “additional” or “partial” dependent upon different circumstances as seen with products with multi-level benefits, these terms may be reasonably modified to enhance consumer understanding.

Permanent neurological deficit with persisting clinical symptoms

~~Symptoms of~~ Dysfunction in the nervous system that is present on clinical examination and expected to last throughout the insured person's life.

~~Symptoms that are covered~~ To include numbness, hyperaesthesia (increased sensitivity), paralysis, localised weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty in swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, seizures, , ~~lethargy,~~ dementia, delirium and coma.

The following are not covered:

- An abnormality seen on brain or other scans without definite related clinical symptoms
- Neurological signs occurring without symptomatic abnormality, e.g. brisk reflexes without other symptoms
- Symptoms of psychological or psychiatric origin.

Heart attack – of specified severity

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

- Typical clinical symptoms (for example, characteristic chest pain).
- New characteristic electrocardiographic changes.
- The characteristic rise of cardiac enzymes or Troponins recorded at the following levels or higher;

  - Troponin T > 200 ng/L (0.2 ng/ml or 0.2 ug/L)
  - Troponin I > 500 ng/L (0.5 ng/ml or 0.5 ug/L)

The evidence must show a definite acute myocardial infarction.

For the above definition, the following are not covered:

- Other acute coronary syndromes or angina without myocardial infarction

Cancer – excluding less advanced cases

Any malignant tumour positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue.

Etc.

For the above definition, the following are not covered:

Etc.

- All tumours of the prostate unless histologically classified as having a Gleason score of 7 or above or having progressed to at least ~~clinical~~ TNM classification T2bN0M0.

TNM Staging for Prostate Cancer

T1	Clinically inapparent tumor not palpable or visible by imaging
T1a	Tumor incidental histologic finding in ≤5% of tissue resected
T1b	Tumor incidental histologic finding in >5% of tissue resected
T1c	Tumor identified by needle biopsy (because of elevated prostate specific antigen [PSA] level)
T2	Tumor confined within prostate; tumors found in 1 or both lobes by needle biopsy but not palpable or reliably visible by imaging
T2a	Tumor involves one-half of 1 lobe or less
T2b	Tumor involves more than one-half of 1 lobe but not both lobes
T2c	Tumor involves both lobes
T3	Tumor extends through the prostatic capsule; invasion into the prostatic apex, or the prostatic capsule is classified not as T3 but as T2
T3a	Extracapsular extension (unilateral or bilateral)
T3b	Tumor invading seminal vesicle(s)
T4	Tumor fixed or invades adjacent structures other than seminal vesicles (eg, bladder, levator muscles, and/or pelvic wall)
Pathologic (pT)*	
pT2	Organ confined
pT2a	Unilateral, involving one-half of 1 lobe or less
pT2b	Unilateral, involving more than one-half of 1 lobe but not both lobes
pT2c	Bilateral disease
pT3	Extraprostatic extension
pT3a	Extraprostatic extension or microscopic invasion of the bladder neck
pT3b	Seminal vesicle invasion
pT4	Invasion of the bladder and rectum

Low risk prostate cancer – increasing use of MRI

Table 17: Risk groups for localised prostate cancer

Level of risk	PSA		Gleason score		Clinical stage
Low risk	< 10 ng/ml	and	≤ 6	and	T1–T2a
Intermediate risk	10–20 ng/ml	or	7	or	T2b
High risk[o]	> 20 ng/ml	or	8–10	or	≥T2c

Update 2014

- Low risk prostate cancer – more likely to "watch and watch"
- Increasing use of more sensitive MRI
- Revised NICE guidelines January 2014 – greater use of MRI
- Use of "Clinical" staging be confusing
- Moving to T2b – appropriate level and "future-proofs" definition

Stroke – resulting in permanent symptoms

Death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in permanent neurological deficit with persisting clinical symptoms.

For the above definition, the following are not covered:

- Transient ischaemic attack.
- Traumatic injury to brain tissue or blood vessels.
- Death of tissue of the optic nerve or retina/eye stroke.

Benign brain tumour – resulting in permanent symptoms

A non-malignant tumour or cyst originating from the brain, cranial nerves or meninges within the skull, resulting in permanent neurological deficit with persisting clinical symptoms.

For the above definition, the following are not covered:

- Tumours in the pituitary gland.
- Tumours originating from bone tissue.
- Angioma and cholesteatoma.

Coma – with associated permanent symptoms

A state of unconsciousness with no reaction to external stimuli or internal needs which:

- requires the use of life support systems for a continuous period of at least 96 hours; and
- with associated permanent neurological deficit with persisting clinical symptoms.

For the above definition, the following are not covered:

- Medically induced coma
- Coma secondary to alcohol or drug abuse.

Kidney failure – requiring permanent dialysis

Chronic and end stage failure of both kidneys to function, as a result of which regular dialysis is permanently required.

Major organ transplant – from another person

The undergoing as a recipient of a transplant from another person of bone marrow or of a complete heart, kidney, liver, lung, or pancreas or inclusion on an official UK waiting list for such a procedure.

For the above definition, the following is not covered:

- Transplant of any other organs, parts of organs, tissues or cells.

Motor neurone disease [before age x] – resulting in permanent symptoms

A definite diagnosis of one of the following motor neurone diseases [before age x] by a Consultant Neurologist:

- Amyotrophic lateral sclerosis (ALS)
- Primary lateral sclerosis (PLS)
- Progressive bulbar palsy (PBP)
- Progressive muscular atrophy (PMA)

There must also be permanent clinical impairment of motor function.

Parkinson's disease [before age x] – resulting in permanent symptoms

A definite diagnosis of Parkinson's disease [before age x] by a Consultant Neurologist.

There must be permanent clinical impairment of motor function with associated tremor and muscle rigidity ~~and postural instability~~.

For the above definition, the following are not covered:

- Parkinsonian syndromes/Parkinsonism.

Terminal illness – where death is expected within 12 months

A definite diagnosis by the attending Consultant of an illness that satisfies both of the following:

The illness either has no known cure or has progressed to the point where it cannot be cured; and

In the opinion of the attending Consultant, the illness is expected to lead to death within ~~[the earlier of]~~ 12 months ~~[and the remaining term of the cover]~~

Traumatic brain injury – resulting in permanent symptoms

Death of brain tissue due to traumatic injury resulting in permanent neurological deficit with persisting clinical symptoms.

Key Features Documents – response to FOS

Completing your application

You must do the following or your plan will not pay out:

- Answer all questions in the application honestly. We may not pay any claim, have to amend the terms of your cover or at worst cancel your cover if you don't answer the questions honestly, you should not assume that we will write to your doctor – it is your responsibility to complete the application form properly.
- You must tell us if there are any changes to your personal health, family history, occupation or residence, or if you take up any hazardous activities between completing the application form and when the policy starts

When will the plan not pay out?

We will not pay a claim for life cover or for critical illness cover and all cover under the plan may be cancelled:

- If you do not answer all questions in the application honestly, you should not assume that we will write to your doctor, it is your responsibility to complete the application form properly.
- You must tell us if there are any changes to your personal health, family history, occupation or residence, or if you take up any hazardous activities between completing the application form and when the plan starts

Your commitment

You must do the following or your plan will not pay out:

- Answer all questions in the application honestly. We may not pay any claim, have to amend the terms of your cover or at worst cancel your cover if you don't answer the questions honestly . You should not assume that we will write to your doctor – it is your responsibility to complete the application form properly.
- Tell us if there are any changes to your personal health, family history, occupation or residence, or if you take up any hazardous activities between completing the application form and when the policy starts

Summary

- Changes to General Principles
  - Greater clarity when cover is enhanced (ABI+)
  - Consistency for "Additional" conditions
- Model wordings – no conditions are exclusions to be added
- Changes made to Cancer, Heart attack and Stroke
  - Necessary to bring clarity and to future proof definitions
- Some other conditions also changed to add clarity
- Permanent neurological deficit wording changed
- KFD changes – improved guidance relating to disclosure
- New SoBP to be released May 2014 – 1 year to implement

Other Regulation or Legislation

- Council of Europe
  - Committee on Bioethics (DH-BIO) Working document
  - Draft Recommendation on the use for insurance purposes of personal health-related information in particular information of a genetic and predictive nature
  - Paragraphs 11-12, information on family history should not be collected and used for insurance purposes
  - Paragraph 17, doctors should make the judgement about what information is relevant and appropriate to pass to an insurer - Consequently, the doctor or other health professional should not pass on, without prior assessment, information contained in his or her patient's medical record
  - Doctors should never send a patient's full medical record or entire sections thereof containing irrelevant information. While technical items in the medical record may be communicated as they stand to avoid having to repeat examinations, it is not acceptable to send the entire medical record or large parts thereof without selecting those data which are genuinely relevant to the assessment of the risk

Other Regulation or Legislation

Hospital records of all NHS patients sold to insurers

Hospital records of all NHS patients sold for insurance purposes days after controversial plans to extract patient data from GP files put on hold

- Hospital episodes Statistics provided by Health and Social Care Information Centre (HSCIC)
- Particular concerns at a time when the new ‘care.data’ GP database is being produced
- Meeting with ABI/DoH to discuss how insurers use medical data
- More relevant to Pricing than Claims or Underwriting

Questions