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The last issue of *Risk Insights* provided an introduction into Expected Utility Theory (EUT) and how the *homo oeconomicus*, with a perfect understanding of preferences, uses unblemished rationale to maximise benefit. However, real-world behaviour in decision-making differs only too often. A further dimension is added when decision-makers assess probabilities subjectively by applying educated guesses.

**Subjective assessment of probabilities**

In Part I of this two-part article series, probabilities have been treated as given. The problem of the subjective assessment of probabilities was explored by Kahneman and Tversky in a separate line of research, which became known under the header “heuristics and biases”. Kahneman and Tversky discovered that when people assess the probability of uncertain events, they rely on a number of heuristics (rules of thumb) that reduce this potentially complex task to a simpler, judgemental operation. The heuristics Kahneman and Tversky identified were: similarity (or the rule of typical things), availability (or the example rule) and anchoring. Though generally useful, these heuristics can lead to systematic errors and biases, which are considered in further detail for the similarity heuristic and the availability heuristic.

**Similarity**

When we are dealing with such questions as the probability of object A belonging to class B, or the probability of event A originating from process B, we typically resort to the similarity heuristic, in which probabilities are assessed by the degree to which a given scenario resembles another. To see how this can be prone to error, consider the following experiment in which subjects were given a brief personality description of a woman called Linda. Kahneman and Tversky designed the description to strongly match people’s image of an active feminist. The subjects were presented with a list of professions/activities and were asked to rank from most to least likely according to the extent to which the activities fitted the personality description given. The following two items on the list were of particular importance:

A. Linda is a bank teller
B. Linda is a bank teller and is active in the feminist movement

The results showed 89% of respondents ranked B higher than A despite the fact that, according to probability theory, the conjunction of “is a bank teller” and “is active in the feminist movement” must be less likely than A (being at least a bank teller). Obviously, respondents were intuitively guided by the similarity heuristic, according to which B resembles the initial personality description much more than A.

**Availability**

The availability heuristic is used to predict the probability of something happening according to the ease with which an example of such an event can be brought to mind. It is a useful clue because instances of significance are usually recalled better and faster than those with less significance. Incorrect evaluations occur because the ease with which we can retrieve or imagine significant events does not always reflect their actual frequency. More often than not, the emotional vividness with which events come to mind lead to an overestimation of their probability, just as much as the lack of retrievable instances results in an underestimation of their probability. The ups and downs that followed the media attention of the recent H1N1 pandemic hype are a telling example.

**What is left of rationality?**

So far, we have considered risk decision-making from both a descriptive angle (prospect theory) and a practical point of view, adopting EUT as a standard by which our logic may be judged. What does all this tell us about human rationality? Is it a fanciful concept caught in a shadowy realm between rationally derived ideals and those conclusions we
draw from our experience? Or does rationality have a practical use in day-to-day coping with reality, in the sense that using its rules – in a broad sense the rules of logic, probability theory and so forth – helps us achieve our objectives?

This topic is under continuous discussion among psychologists and philosophers. Another is the question of whether deviations from rational behaviour only occur because our decision problems are framed in terms of modern, abstract concepts – concepts very different to those our cognitive apparatus had to develop in the conditions that prevailed during the greater part of our evolutionary history and that are not comparable with most of the challenges we face today. To explore this further, let us consider one of the hypotheses in this line of reasoning, according to which the ability in humans to detect a cheat has been highly adaptive, a result of our evolutionary past. One would therefore expect that if tasks, on which performance has been poor, are rephrased in a “cheat’s” version, the results will significantly improve. There appears to be evidence that this is indeed the case. The test as depicted in Figure 1 provides an intuitive idea of what this is all about.

**Figure 1 – Example of a selection task problem**

Each card shows a letter on one side and a number on the reverse side. Shown are four cards, two with the letter side up, and two with the number side up.

| E | C | 5 | 4 |

The task is to identify the cards that need to be turned over to determine whether the following claim is correct:

“If a card shows a vowel on one side, then the other side shows an odd number.”


The correct answer for the task in Figure 1 is card E and card 4.

Now consider the following selection task depicted in Figure 2.

**Figure 2 – Another example of a selection task problem**

Four cards are given. Each card contains information about a person sitting at a table. While the one side of the card tells what a person is drinking, the other side shows the person’s age.

| Drinking Beer | Drinking Coke | 25 years old | 16 years old |

The task is to identify the cards that need to be turned over to determine whether the following law is broken:

“Only people aged 21 years and older are allowed to drink beer.”


The correct answer for the task in Figure 2 is “Drinking beer” and “16 years old”.

From a purely logical point of view, the problems in Figures 1 and 2 are identical. However, the cheater version in Figure 2 makes it much easier for most of us to derive the correct solution. This has also been confirmed in a number of experiments.

EUT and prospect theory – as outlined in Part I of this series – suggest that human beings are unable to cope with risk in an entirely rational way, where “rational” is supposed to denote “reasoning according to the rules of mathematics, logic and probability theory.” Moreover, recent psychological research appears to undermine the traditional notion that rationality excludes all emotion. “A theory of choice that completely ignores feelings such as the pain of losses and the regret of mistakes is not only descriptively unrealistic; it also leads to prescriptions that do not maximise the utility of outcomes...”

**Conclusion**

Which lessons can insurance professionals draw from the above account? One salient feature appears to be the fact that ideal solutions are difficult to achieve in the presence of many pitfalls. Rather than wasting time on searching for the perfect decision, one should instead make sure that internal processes allow for constant adjustments of past actions and risky choices. Hampering such efforts is a tendency to frequently succumb to the so-called confirmation bias. This, for instance, makes a majority of people, who play the game set out in Figure 1 above, choose card 5 instead of card 4.

Last but not least, intuition or gut feel appears to play a valuable role in decision-making under risk. A cautious overall approach to anything new, especially when it involves significant risks, intuitively makes a lot of sense. Even the most refined mathematical models should not be allowed to invariably overrule our gut feeling. After all, you would not invest all your money in the St. Petersburg Gamble (see Part I), would you?

**Endnotes**


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Time was when shopping for food and other household requirements meant visits to several independent retailers: the butcher, the fishmonger, the draper, the iron-monger and so on. In most markets this picture changed during the last decades, and the number of self-service shops and supermarkets increased to meet increasing customer demand and expediency.

Today, shoppers can obtain almost everything they might need from a single “food” retailer. Increasingly, the supermarket giants responsible for the development of the modern-day convenience store are also well-placed to increase their penetration of the financial services market, including life insurance. They have the distribution network, the loyalty of customers and the financial muscle.

**Brand value and Shopassurance**

Reputation, loyalty, favourable core financial performance indicators, regulatory compliance, and high-quality customer services based on trust, are key factors when selling an intangible product, such as insurance. Whether “the reputation of many retail banks has all but evaporated” or the trust level has at least halved may be moot, but clearly, the ongoing economic crisis has severely damaged confidence in financial services. In such an environment, insurance companies may want to review their strategy of selling insurance products through bank branches (Bancassurance) and look at the possibilities in the grocery retail sector as an emerging and novel distribution channel (Shopassurance).

Successful strategies for exploiting this channel will differ by participant and market. In China, India and South Africa, for example, banks have maintained a good reputation throughout the global financial crisis, while elsewhere insurance and banking are so closely interwoven as to make it seem impossible to consider supermarkets selling life insurance.

Furthermore, traditional distribution channels – including Bancassurance – have found difficulty in fully developing certain segments, including low revenue products, micro-insurance and sales to consumers living in rural areas. Shopassurance is of particular interest where cost-effective distribution is unachievable through traditional channels. Taking this further, retailers could be the dominant distribution channel in rural areas, where Internet connectivity is low and policies must be issued over the counter.

If there was ever a favourable time for retailers and supermarkets (Shopassurers) to enter the financial services sector, it is perhaps now, while the banks work hard to restructure following the global financial crisis. To enter this market with simple and transparent products on the back of a well-known brand may prove a recipe for success. Opportunity exists for Shopassurers to pick up where the Bancassurers left off. Can retailers and supermarkets achieve what banks took a long time to work out – the mutual beneficial relationship between having the regular contact with consumers and insurance sales? Can the face of food and fashion be combined with the selling of insurance?

According to the 11th Annual Harris Interactive U.S. Reputation Quotient® Survey conducted in early 2010, the retail industry is one of the sectors with the most positive perceptions, as shown in Figure 1.

![Figure 1 – Industry sector reputation: 2008 and 2009 positive ratings in percent](image-url)
Reputation, quality and value of money are the three top primary reasons for choosing the most trustworthy retailer in the UK according to one survey. In general, the trust score correlates with the market share as shown in Figure 2.5

Figure 2 – Trust by “Market Share” correlation (UK retailers are depicted as diamonds, supermarkets as circles)

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Financial services offered by retailers and supermarkets

Many UK retailers and supermarkets offer a suite of financial products – including car, home, travel, pet, dental and health insurance – alongside their savings, loyalty schemes, credit cards and loans. Life insurance is also available, although it remains under-developed currently.

The retailers and supermarkets marked orange in Figure 2 above have not only entered the financial services sector but also offer life insurance products and quotations, namely Marks & Spencer, Tesco, Asda, John Lewis and Sainsbury’s. Argos, UK’s largest general-goods retailer, uses its website to redirect potential buyers of an over-50 plan to a partner life insurer, and redirects buyers of other plans to a comparison website, earning fees and commission.

What began in some stores with cash withdrawals (cash-back) continued with supermarkets offering credit cards (with the opportunity to earn loyalty points) and later offering savings and simple insurance products. Retailers have experimented with financial services over a number of years, often changing insurance or bank partners. The banking crisis has accelerated this development. Royal Bank of Scotland sold to Tesco its 50% joint venture share of Tesco Personal Finance, a company regulated by the Financial Services Authority, and “a move which will enable Tesco to develop an already very successful financial services offer towards the objective of becoming a full-service retail bank”.” This represents a part of Tesco’s plan to provide 10% of the UK’s financial services market within the next ten years.

Tesco is the UK’s seventh largest credit card provider with balances of more than GBP2 billion, and it offers savings accounts.7 Despite banks applying a conservative mortgage lending strategy after the crisis, the retailer plans to enter the mortgage market by the end of this year.4 And while UK retailers increase their number of stores, banks, in contrast, are closing branches across the country. This contraction in traditional banking sector outlets and services may create a gap which the supermarkets will fill.

Each site offers the retailers an opportunity to engage with customers on multiple occasions and possibly for long periods of time. As more and varied goods are available for sale, additional services, such as food snacking, photo printing and pharmacy care, serve to increase customer stay time.

Tesco is already an established international retailer with businesses in the UK, Ireland, Hungary, Poland, Czech Republic, Slovakia, Turkey, Thailand, South Korea, Malaysia, Japan, China and the U.S., with plans to enter the Indian market. With nearly half of the more than 4,500 stores being located outside the UK, it is not difficult to see that the idea of Shopassurance will become widespread. French supermarket chain Carrefour already offers life insurance products in various markets, including Brazil and Thailand.

How to seize the opportunity?

Does a banking crisis, added to the good reputation of retailers and supermarkets, automatically lead to opportunities? UK research showed only 10% of those surveyed said they’d be “more likely” or “much more likely” to bank with a supermarket in the future, and 55% of people said they were “neither more or less likely”.10 Besides loyalty and trust, the most important assets for retailers are the traffic and time that shoppers spend with them, as well as shopping details and preferences collected via loyalty cards.

It is well understood that a significant proportion of retail purchases is based on impulse. How can this shopping behaviour work for the sale of life insurance? Can a display of brochures and leaflets offering life insurance be a successful sales vehicle in a supermarket environment? Tesco, for example, uses multiple sales channels, including in-store, by telephone and online. Approximately 60% of new sales come through online.11

Shopassurers do not currently provide financial advice in connection with life insurance, and their marketing material is purely factual, although some do offer help in finding an independent financial adviser. The risk of mis-selling is thus a problem for Shopassurers. It is not surprising to read such important information in leaflets as “Depending on how long you live, the amount of the premium you pay may be greater than the cash sum paid out in the event of your death” — a scenario that could arise after a 15-year premium payment period for a 60-year-old male taking out a guaranteed acceptance life plan with a monthly premium of GBP10, for example. Whether such a sale of insurance is an active or passive event has created an interesting debate in the German market, and is described in a separate article of this issue of Risk Insights.

Currently, UK retailers offer basic level Term Assurance, providing a fixed amount on death during the term of the policy, and Decreasing Term Assurance designed to pay off a standard repayment (capital and interest) mortgage with a lump sum that reduces every year in line with the mortgage. Often the benefit is accelerated in case of Terminal Illness (TI). In some cases, a Critical Illness (CI) benefit may also be available as a rider benefit. Simplified products aimed at buyers between the ages of 50 and 75 or 85 are also sold. For such plans, the premiums are generally low (e.g., up to GBP50 per month) in...
return for a fixed sum assured, with the added advantage that no medical underwriting is required. Their design is most likely to incorporate a two-year moratorium, during which only accidental death is covered, in addition to a return of premiums (sometimes up to 150% of paid premiums) in case of natural death. Policyholders cease premiums typically at age 90, although their plan remains in force. Term policies may be single or joint life, and premiums are varied by sex and smoking status. It is typical for the full quotation and underwriting process to be undertaken online or over the telephone. Supermarkets’ financial services websites advertise affordable cover, quick quotations and cover — available in minutes. Shopassurers may offer incentives to potential buyers in the form of points added to loyalty card schemes, discount vouchers or gift tokens.

Table 1 provides an overview of the current offerings in regard to life insurance, including the financial services arm used in facilitating the offerings as well as the regulatory status these entities have according to the UK Financial Services and Markets Act 2000.

Typically, Shopassurers badge protection products from life insurance companies, but it may prove tempting for them to consider whether their customers would accept a retailer’s “own-brand” life insurance, whereby the retailer is also the ultimate risk taker, in future. UK retailers that currently offer protection cover do so with the support of established life insurers; however, all retailers use their own brand name and brand colours in their offering, so there is no doubt in the consumer’s mind about who is the active seller.

UK customers who accept a Shopassurance quote for life cover are then typically asked to disclose lifestyle, build, medical and family history, plus details of medication, in a secure, password-protected environment. Tele-interviewing is offered as an alternative route for providing disclosure. Where possible, terms are offered immediately, but traditional medical evidence, including a doctor’s report, paramedical (nurse screen) or full medical examination may be obtained. Some applications will be vetted by underwriters at the home office. The entire process is usually supported by a telephone support line in case of difficulty. In short, a full and modern underwriting basis is being applied.

Table 1 – Overview of UK retailers offering life insurance

<table>
<thead>
<tr>
<th>UK Retailer</th>
<th>Financial Services Company</th>
<th>Ownership of Financial Services Company</th>
<th>Life Insurance Offered</th>
<th>Risk Taker (insurer)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tesco Stores** (100% Tesco)</td>
<td>Tesco Personal Finance* and</td>
<td>100% Tesco</td>
<td>Term life, TI, CI</td>
<td>Friends Provident</td>
</tr>
<tr>
<td></td>
<td>Tesco Personal Finance Compare*</td>
<td></td>
<td></td>
<td>Compare as broker arm</td>
</tr>
<tr>
<td>Marks &amp; Spencer**</td>
<td>Marks &amp; Spencer Money* and</td>
<td>100% HSBC Group, M&amp;S provides brand name</td>
<td>Term life, TI, accidental death</td>
<td>HSBC Life</td>
</tr>
<tr>
<td></td>
<td>Marks &amp; Spencer Life Assurance*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asda***</td>
<td>ASDA Financial Services***</td>
<td>100% Asda</td>
<td>Term life, CI, IP</td>
<td>Acts as an introducer only</td>
</tr>
<tr>
<td>John Lewis/ Waitrose**</td>
<td>Greenbee**</td>
<td>100% John Lewis Partnership</td>
<td>Term life, TI, WoP</td>
<td>Friends Provident</td>
</tr>
<tr>
<td>Sainsbury’s Supermarkets**</td>
<td>Sainsbury’s Bank*</td>
<td>50:50 partnership between retailer and</td>
<td>Term life, TI, CI</td>
<td>Legal &amp; General</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lloyds Banking Group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Argos*** (owned by</td>
<td>Home Retail Group Insurance Services*</td>
<td>100% Group</td>
<td>Term life, WL, IP, CI</td>
<td>Acts as a broker and provides link to Sun Life Direct (AXA)</td>
</tr>
<tr>
<td>Home Retail Group</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Authorised (to carry on a regulated activity)
** Appointed Representative (agent of an authorised firm that has accepted responsibility)
*** Introducer Appointed Representative (appointed by a firm whose scope of appointment is limited to a) affecting introductions, and b) distributing non-real time financial promotions)

(IP = Income Protection or Long-Term Disability cover, WoP = limited Waiver of Premium, WL = Whole Life insurance)
Summary

Shopassurance is more than simply offering insurance for sale in-store. It aims to take advantage of the frequent contact that exists with a wide range of consumer groups. Retailers can use their brand name and increasingly diverse offerings to provide simple financial services products. As with groceries, the life insurance on offer must be convenient to purchase and consume. Leaflets at checkout points or next to in-store ATMs create repeated contacts with impulse buyers. The use of loyalty schemes – often combined with retailer-branded credit cards – provide retailers with key information to use in making successful direct marketing via telephone and mail to their customers. As consumers increasingly opt to order groceries online, retailers use this medium to advertise and offer insurance products as conveniently as they currently do milk, sugar and bread.

Shopassurance is also a means to reach insurance customers deemed previously inaccessible. This may be particularly true in quickly developing countries such as India, China, Indonesia, Vietnam and Brazil, to name a few.

The exploitation of the alternative distribution channel, Shopassurance, will result in a higher penetration rate of life insurance cover in both developed and developing markets. More individuals having protection cover is good, but buying personal insurance without advice has its problems; for example, CI cover should not be sold in the same way as pet insurance. Providers of life insurance in supermarkets need to find methods to prevent sales of unsuited products and of giving the impression of sufficient cover, when this is not the case. So-called “money centres”, kiosks for financial services products already established within some hypermarkets, may provide the solution.

Features of current Shopassurance offerings are quick issuance, low premium and sales support through different media. Underwriting must fit these criteria. For insurers, retailers offer an attractive alternative distribution channel that may not replace Bancassurance or other forms of traditional distribution channels but would complement a distribution strategy and extend their reach to more consumers. Most insurers have sufficiently simple products, but a review of the products will be needed to reflect the required underwriting approach and to ensure that low premium levels are achievable. However, as it stands, an insurer’s brand will be at best a backdrop to the offerings provided by the retailer.

Endnotes

2 Between 2007 and 2010 in selected Western countries, according to the Edelman Trust Barometer 2010 and based on the question: “How much do you trust banks to do what is right?”.
3 Based on a citation from Michael Lafferty from the Lafferty Group, a retail banking research house, published in “Cash and Carry”, Financial Times, 20 July 2009.
10 The Insight Survey, May 2009, Retail Insights, www.theINSIGHTSurvey.co.uk.

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Whether aiming to retain market share, expand into new market segments or simply to remain competitive, insurers are continually looking to expand the reach of their products through new and innovative sales channels. With this in mind, it is not surprising to see insurance products promoted for sale in supermarkets and other retail venues. Insurance products first appeared in German retailers in 2001, when a retail chain selling coffee and a wide range of other products formed a partnership with an insurer to offer motor liability insurance. This innovative sales outlet idea was soon followed by a book club, a petrol station chain, a chemist chain and a clothing store. After a while, however, most of these retailers ended their co-operations with insurers, as their financial expectations could not be met.

One obstacle to the success of these ventures proved to be the strict German regulations on the qualification of insurance intermediaries and on the provision of information and advice to potential policyholders. In recent years, these regulations have become even tighter, to the extent that it is debatable whether they can be adhered to fully when selling insurance products in the retail sector. Unsurprisingly, there have already been some legal disputes in the recent past as well as first judgements that could point the way forward.1 It is worth noting that the plaintiffs were not consumer protectors, as might be expected, but actually an association of insurance brokers and agents, as well as a group for the protection of fair competition. There is speculation that resistance from the association was ultimately motivated by concern for their own market shares and, by implication, recognition of the potential in the business model of offering insurance products in shops and department stores.

The judgement2 in the following case certainly caused a storm. A supermarket chain offered for sale a bundled insurance package covering personal accident, legal expenses for a victim of a criminal case and an accident and breakdown cover. The product literature was made available to customers in boxes costing EUR49 each, including documentation, an application form and a PIN number to facilitate the purchase. Customers choosing to purchase the product did so by postal application, facsimile or online registration, with the certificate of insurance being mailed. The initial purchase price was offset against the required insurance premium. If the customer changed his mind and decided not to go ahead, a refund of the purchase price was available on return of the box and receipt to the supermarket.

The plaintiff argued that the supermarket had been brokering insurance without the necessary licence. In its defence, the supermarket responded that it was acting merely as an introducer (making a suggestion) and therefore required no such permission. According to the German Trade, Commerce and Industry Act (Gewerbeordnung), which in this regard is based on the EC Directive on Insurance Mediation (Directive 2002/92/EC), an insurance intermediary is defined as an insurance broker or an insurance agent who commercially arranges the conclusion of insurance contracts or assists in the administration of such contracts. Any such person is subject to a licence requirement and has to follow considerable obligations. The obligations include, inter alia, that of offering information on whether mediation is performed exclusively for one insurer only and, prior to the conclusion of a contract, providing reasons for any given advice on an insurance product based on a needs analysis. Thus far these requirements have regularly not been fulfilled via supermarket sales. An introducer, on the other hand, is a person who simply passes details of interested insurance buyers on to intermediaries. Where only such an opportunity to conclude an insurance contract is identified, the law recognises just an act of initial preparation and not mediation, because there is not yet a particular product recommended. In addition, a customer would generally not expect to receive any financial planning advice under these circumstances.

The judges sided with the plaintiff’s point of view. It was their conclusion that a specific insurance product had in fact been made a focus as the supermarket, making the product pack available for purchase, had collected EUR49 to be offset against the insurance
premium and had received a sales commission. Furthermore, by collecting the purchase price from the potential customer, the aim had in fact been to get a contract-concluding statement from him, so the probability that the customer would conclude the insurance contract was thereby increased. If the customer did not wish to proceed, he had to go back to the supermarket and request a refund of the purchase price. This was deemed to be associated with an effort on the part of the consumer, which he might try to avoid by simply concluding the contract – despite possibly harbouring doubts about its content and suitability. The supermarket chain could therefore no longer consider itself as merely an introducer due to its clear contribution to the initiation and potential conclusion of an insurance contract. Instead, it fulfilled the requirements of an intermediary, whose aim is to bring about the conclusion of insurance contracts.

Given this judgement, it is worth considering what other options might exist for insurers and German retailers to cooperate legitimately.

The obvious solution would be for a retail company to register as an insurance intermediary with the relevant authority and thus being regulated and allowed to sell insurance products.

While seemingly attractive in principle, this solution is less likely to prove easy in practice. Fundamentally, the relevant principles associated with authorisation and compliance are designed to be fulfilled by individual persons and not by a corporate entity. It is the legal representatives of corporate entities, including retailers, who must fulfil the authorisation requirements. This is not an insignificant demand of time and cost upon the retailer and, more significantly, on the legal representative, since permission is granted only once appropriate knowledge of the subject has been demonstrated by means of a corresponding test from the Chamber of Industry and Commerce. There remains an option to delegate the necessity to provide the appropriate knowledge to a nominated person other than the corporate legal representative who has been authorised to represent the company in this capacity. However, it is questionable whether the time and financial cost of the training required are worthwhile in relation to the possible profits that could be achieved from insurance brokering in the retail sector.

An alternative solution could be to create a situation whereby permission and authorisation are not required.

This is the case where the mediated insurance contracts are complementary to the main product offered. An example is covering the risk of breakdown and loss or damage of the goods, such as motor policies in a car dealership or insurance for glasses at an optician. However, for most retailers, such a limited offer is not sufficiently attractive.

Exemption from the permission requirement could also be granted if the retail company partnered with a single insurance company that is willing to assume unlimited liability for the mediation activities of the retailer. Then again, in a recent case, a retailer was prohibited from conducting this kind of business activity by way of a temporary injunction, so there is no legal certainty in this respect either.

A third way of achieving an exemption from authorisation is for the retail company to operate only as an introducer. In this case, the insurance product should not carry the retailer’s brand and the retailer may not collect premium payments. Nonetheless, it would be acceptable to display information leaflets on the insurance product or to set up a sales and advice kiosk of the insurer within the premises of the retail company. It is questionable whether this would do enough to attract the attention of potential customers at all or whether it would be sufficiently compelling for them to pick up only product information from the retailer and still have to seek out an insurance intermediary to finalise getting a contract. Additionally, from a cost perspective, operating a kiosk may not be financially viable as sales and advice staff need to be present anyway.

In summary, we can conclude that there are no simple solutions in sight for the German retailers, despite a range of possible approaches. Careful consideration of the complex legal situation is essential for insurers and retail companies that see opportunities to generate new sales through co-operation. The scope of regulations to be taken into account – from the insurance contract law to the intermediary law to the competition law – is considerable.

The German Federal Financial Supervisory Authority (BaFin) has issued a statement on the matter but did not give clear guidance on how to proceed. Fortunately, it did not prohibit such business activity altogether. In its notice of March 6, 2009 it merely establishes that the quality of insurance mediation is a very important objective and that the insurance companies are therefore required to do everything in their power to guarantee it.

It remains to be seen whether there will be any more legal precedents on the matter that could shed light on other aspects of the discussion. At the time of writing, a claim from an association for the protection of fair competition, supported by an association of brokers, is currently pending before a German district court.

Endnotes
3 Berlin District Court; Reference: 103 O 25/10; with related note from lawyer Dietmar Goerz in AssCompact, April 2010.
The World Health Organization predicts the prevalence of diabetes will increase to 366 million people worldwide by the year 2030. Their region by region predictions show an increase over 2000 levels of 180% for Eastern Mediterranean, 160% in Africa, 155% in South East Asia and 99% in Western Pacific. Meanwhile prevalence in the Americas is projected to increase by 102% and 44% in Europe. The Center for Disease Control (CDC) advised that from 1980 to 2007, the prevalence of diabetes in the U.S. has tripled from 5.6 million to nearly 24 million with 10.7% of the population aged over 20 and 23% above age 60 suffering the disease.

The primary reasons the WHO gives for this epidemic is obesity, reducing levels of exercise but also migration from rural to urban areas and of course the effect of an aging population. Most of this increase in diabetes is due to Type 2 diabetes.

Diabetes is a metabolic disorder of insulin production and/or utilization. With Type 1 diabetes the onset is usually before the age of 30 and results from little or no insulin production. There is a sudden onset and quick progression of symptoms in Type 1, which is caused by an autoimmune destruction of insulin secreting cells in the pancreas. About 10% of diabetics have Type 1.

Type 2 diabetes usually develops after the age of 40 and is associated with obesity, hypertension and hyperlipidemia but genetic predisposition and a lack of exercise also contribute to insulin resistance. In Type 2 diabetes, the production of insulin is intact, but there is a resistance to insulin. Symptoms, if any, develop slowly. Almost 90% of diabetics have Type 2 although many remain undiagnosed. Some good news is that the Diabetes Prevention Program in the U.S. studying people at high risk for diabetes, demonstrated that it is possible to delay and possibly prevent the disease by losing a relatively slight proportion of weight (5 to 7 percent of total body weight) through half an hour of physical activity 5 days a week complemented by healthier eating.

Medical costs for diabetics are approximately 2 to 3 times higher than the medical expenditures for those who do not have diabetes. Total price for medical bills for those diagnosed diabetic in U.S. are

- USD16 billion for direct medical costs;
- USD 58 billion for indirect costs (disability, work loss, premature death);
- including expenses for undiagnosed diabetes, pre-diabetes and gestational diabetes brings the total cost of diabetes in the U.S. in 2007 to USD218 billion.

Diagnosis

The clinical signs and symptoms of diabetes are varied and may include

- frequent urination;
- excessive thirst;
- increased appetite;
- sudden weight loss; and even
- blurred vision.

The diagnosis of diabetes can be confirmed with a simple blood test for Glycated or Glycosylated Haemoglobin (HgbA1c) which results when glucose circulating in the blood stream binds to haemoglobin molecules that make up red blood cells. The level provides an estimate of the average level of blood glucose over the last two to three months.

The latest diagnostic criteria are:

- Casual plasma glucose concentration ≥ 200 mg/dl (11.1 mmol/l) with classic symptoms of hyperglycemic crisis; or
- Fasting plasma glucose ≥ 126 mg/dl (7.0 mmol/l); or
- 2-hour post prandial glucose ≥ 200 mg/dl (11.1 mmol/l) after a 75 g glucose load; or
- HgbA1c ≥ 48 mmol per mole (or 6.5%) using a test that is standardized to the DCCT assay.
From 1 June 2009 the unit of measurement of HgbA1c changed from the Diabetes Control and Complication Trial (DCCT) standard to the International Federation of Clinical Chemistry and Laboratory Medicine (IFCC) standard. The IFCC released a consensus statement in September 2007 that agreed that all laboratories would begin reporting their HgbA1c results to the new IFCC standard that requires results be expressed as millimole of HgbA1c per mole of haemoglobin (Hgb) (mmol/mol) in place of a percentage.

Complications

Diabetes may cause acute complications such as hyperglycemia, hypoglycemia, diabetic ketoacidosis and diabetic coma. In addition, there are two causes of chronic complications in diabetics. Firstly, macrovascular disease with coronary artery and cerebrovascular disease resulting from accelerated atherosclerosis. This results in 60% of diabetics dying of heart attack and 25% from stroke. In addition, this process of accelerated atheroma causes peripheral artery disease with claudication, ulceration and gangrene meaning that diabetes is a leading cause for foot and leg amputations, secondary to peripheral artery disease.

The second cause of chronic complications are microvascular and include non-proliferative retinopathy, (microaneurysms, small dot hemorrhages and exudates in the eye usually causing no visual impairment), proliferative retinopathy (fragile new blood vessel formation often causing blindness), peripheral neuropathy (pain, burning, numbness or tingling of the feet, legs or hands) and Nephropathy (causing albuminuria and renal failure).

Treatment

Treatments for diabetes include diet and exercise, oral medications and insulin injections. Use of angiotensin-converting enzyme (ACE) inhibitors may also delay the onset and progression of diabetic nephropathy and reduce other diabetic complications, such as retinopathy and foot ulcers. Angiotensin receptor blockers (ARB) can be used in place of ACE inhibitors for those who develop a cough related to the use of ACE inhibitors. Good diabetic control is defined by the American Diabetes Association (ADA) as diabetics with usual HgbA1c levels of less than 7%. Given the reporting of HgbA1c to the new IFCC standard, underwriters will need to consider good control as being represented by the range 48 - 59 mmol/mol (equivalent to 6.5% - 7.5%). The non-diabetic reference range is now 20 - 40 mmol/mol. The well-controlled diabetic group progresses to the development of eye disease (25% of patients), kidney disease (50%), and nerve disease (30%). Good control of glycemia reduces the risk of microvascular complications.

The insulin pump; an alternative diabetes treatment system

The insulin pump, also known as continuous subcutaneous insulin infusion therapy, is a viable option to provide patients with multiple daily injections of insulin. The system consists of a pump, which contains controls, a processing module and batteries. A disposable reservoir of insulin is located inside the pump. The remaining components are a disposable infusion set, including a catheter for subcutaneous insertion and a tubing system to connect the insulin reservoir to the catheter.

To receive insulin, the needle end of the catheter is inserted under the skin and attached to the pump. Insulin from the pump travels through the catheter into interstitial tissue and is absorbed into the bloodstream. The insulin pump pushes a single type of fast-acting insulin to cover short- and long-term glucose levels, using one of two types of doses. A bolus dose that is delivered to cover glucose levels for food recently eaten or to adjust a high blood glucose level or a basal dose that is pumped constantly at an adjustable basal rate to deliver insulin needed between meals and at night. There are several advantages of using the pump system. For example it eliminates the requirement to administer individual insulin injections and more accurately delivers required doses. An improvement of HgbA1c levels, less variation in blood glucose levels and prevention of hypoglycemic episodes is seen in patients who master the use of the pump successfully. Pump users find their diabetes is easier to manage and that they have more flexibility of what and when to eat. If their glucose level is high or they wish to eat, the user can simply push a button on the pump to provide a correction in insulin dose. This can allow them to take valuable exercise without needing to eat large amounts of carbohydrates beforehand. In addition, management of diabetes using a pump to provide medication can help eliminate the unpredictable effects of intermediate or long-acting insulin.

There are however some disadvantages too. Using a pump is a more expensive form of treatment. A hospital stay or full day in the outpatient center is required initially for the user to be trained in its use. They must then become accustomed to being attached to the pump for the majority of the day. They may gain weight and diabetic ketoacidosis can occur if the catheter is inadvertently removed for hours. Finally there is the possibility for the pump to malfunction.

The insulin pump has undergone many revisions since the first, bulky prototype was developed in the 1960’s. While by the late 1970’s an early commercial release was still the size of a house brick, today’s insulin pump can be as small as a cell phone. Most insulin pump users are Type 1 diabetics. According to estimates, approximately 400,000 (i.e. 13%) of the 3 million Type 1 diabetics in the U.S use an insulin pump.¹¹

Use of an insulin pump in itself is not an indication of a better or worse risk for life insurance. As always, the degree of control measured via blood testing is what separates the better risk from the rest of the pack. The insulin pump does provide a quicker, more efficient opportunity for the diabetic to control his glucose level. The price for just the pump ran around USD6,500 - USD7,500 in 2008.¹² Cost of supplies for the pump will be additional.
Underwriting Evidence

To determine the mortality consequences of a diabetic, the applicant’s complete medical records (Attending Physician’s Statement) should be obtained. The proposed insured’s medical records should contain:

- The date the applicant was diagnosed to have diabetes (the longer an applicant has diabetes, the greater the likelihood of diabetic complications occurring).
- The type of diabetes the applicant was diagnosed with having (Type 1 diabetics usually show higher relative extra mortality rates than Type 2 diabetics).
- Blood studies, which show how well the diabetes is controlled, and whether the applicant has any other complicating histories associated with diabetes.

An effective method to determine how well a diabetic’s blood sugar level is controlled is to obtain an HgbA1c with the routine insurance blood profile. For risk assessment purposes underwriters will use a reference HgbA1c range representing “good” control 6.1 - 6.6 and “ok” control of 6.7 - 8.0. An applicant achieving only “ok” control is generally not debited.

A microalbumin/creatinine ratio should also be requested, with a normal insurance urinalysis. An abnormal microalbumin/creatinine ratio can show the existence of kidney disease such as diabetic nephropathy. Finally, an applicant’s medical records should contain a recent ECG or treadmill to exclude underlying coronary artery disease.

Conclusion

There is a striking rise in the prevalence of diabetes globally, made worse by growing obesity levels. At the same time, an increase in testing, public awareness and a lowering of the glucose threshold considered diagnostic of diabetes has led to a significant increase in the diabetes population. An argument could be made that life insurers will experience improved mortality for diabetics as a whole and the residual population by the redrawing of the line indicative of diabetes and by increased screening.

- The acute and chronic complications of diabetes must be recognized and evaluated with each diabetic risk.
- Alternate treatment methods, such as the insulin pump, can make it easier to control diabetes and prevent complications.
- The HgbA1c is a valuable underwriting tool to evaluate diabetes control.

Endnotes

1 www.who.int/diabetes/facts/en/.
5 Diagnosis and Classification of Diabetes Mellitus, American Diabetes Association, Diabetes Care, vol. 33, Supplement 1, January 2010.
6 Consensus Statement on the Worldwide Standardization of the Hemoglobin A1C Measurement; (Consensus Committee, IFCC); Diabetes Care, vol. 30, No. 9, September 2007, 2399-2400.
The World Cup: Shattered Dreams and Broken Hearts?

The first match of the 2010 Fédération Internationale de Football Association (FIFA) World Cup will kick off on June 11 in Johannesburg, South Africa. In 2006 the football (soccer) World Cup final attracted more than twice the television audience of any sporting event that year, with over 600 million viewers tuning in to watch some part of the match in which Italy won their fourth title. With a similarly large audience anticipated this year, it is therefore timely to raise the health dangers associated with watching major football competitions and how these may trigger an increase in claims.

Several studies have demonstrated an increase in the rate of heart attacks around prominent sporting events, especially previous World Cups. It has been established that acute physical or severe psychological stressors may be a trigger for heart attacks. The release of epinephrine and other vasoactive chemicals in response to anxiety, anger or other psychological stressors increase heart rate and blood pressure and cause vasoconstriction. These factors may increase the risk of heart attack.

The 1996 UEFA1 European Football Championship, which was played in England, resulted in one of the earliest reports of increased risk of vascular events. A longitudinal population study looked at the mortality rates of Dutch men over 45 years old for the five days before and after the Dutch team was eliminated from this competition in a penalty shoot-out with France. The data showed an increase in mortality from heart attack or stroke in men on the day of the match compared to the rates with the same period in 1995 and 1997.2 However, in a separate paper studying the incidence of heart attack in France, there was no such increase.3 Perhaps this outcome confirms that “victory is everything”?

The 1998 World Cup in France, generated more reports on the relationship between heart attack and important football matches. On the day that the English team lost a penalty shoot-out to Argentina, and during the following two days, there was a 25% increase in the rate of admissions for heart attacks in England. There was no evidence, however, of a similar increase when England won or lost games earlier in the competition.4 This would suggest that losing in a penalty shoot-out is especially dangerous to health, even though one would think that English fans would have become used to this scenario over the years having lost five penalty shoot-outs in World and European football competitions since 1990!5

Also during the 1998 World Cup, there was a reported increase in the out-of-hospital cardiac arrests in four French-speaking cantons in Switzerland, compared to the same time in 1997 and 1999.6 However, a different study of rates of heart attack in France during this same World Cup did not show any increase in heart attack admissions or mortality. In fact, during the day of the World Cup final, the admissions and mortality rate was lower.7 Perhaps French supporters do not have the same degree of anxiety when watching their team? Or was it that les Blues won so easily, defeating Brazil by three goals to nil?

There are no publications reporting similar cardiovascular events associated with the 2002 World Cup hosted by Korea and Japan.

An elegant paper, published in the New England Journal of Medicine, considered daily heart attack rates in the German state Bavaria, including the city of Munich, that were reported during the 2006 World Cup, which was held in Germany. A comparison was made with the same period in 2003 and 2005, during which there had been no major international football competitions.8 On days when the German team was competing, the rate of cardiac emergencies was 2.7 times the control days when Germany did not compete. In men, this was 3.3 times the control rate and in women 1.8 times. Temperatures through June and July were exceptionally high in Munich that summer, and these figures are adjusted to reflect this.9
Figure 1 graphically shows the increases of heart attack rate amongst local residents (visitors to the event were excluded from the survey) on days when the German team was playing, and highlights the relative importance of each game. The rates of heart attack were much higher in the first two games of the competition but fell in the third game when Germany had already qualified for the knock-out stages. On the day that Germany started the knock-out part of the competition and beat Sweden, the rate increased again. The incidence of heart attacks fell during subsequent matches that had less importance for most German football fans.

Figure 1 – Daily cardiovascular events in the study population from May 1 to July 31 in 2003, 2005, and 2006

The FIFA World Cup 2006 in Germany started on June 9, 2006, and ended on July 9, 2006. The 2006 World Cup matches with German participation are indicated by numbers 1 through 7.

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2006 Matches involving Germany:
1 June 6: Germany 4 – 2 Costa Rica
2 June 14: Germany 1 – 0 Poland (qualified for knock-out stages)
3 June 20: Germany 3 – 0 Ecuador
4 June 24: Germany 2 – 0 Sweden
5 June 30: Germany 1 – 1 Argentina (4 – 2 after penalties)
6 July 4: Germany 0 – 2 Italy (after extra time)
7 July 8: Germany 3 – 1 Portugal (third-place match)
8 July 9: Italy 1 – 1 France (5 – 3 after penalties; Italy wins World Cup)

Most of the emergency admissions were men, for which there may be several possible reasons:

- More men watched the matches than women
- Men became more excited than women while watching football
- Due to a higher rate of underlying heart disease in men, these heart attacks were simply brought on earlier than would have been the case in normal circumstances.

Pathophysiology
It has been known for some time that acute stress may trigger heart attacks. Reported heart attacks increased after earthquakes in Athens, Greece in 1981, in Los Angeles, California in 1994 and in Kobe, Japan in 1995. A report from Israel in 1991 documented an increase of heart attacks after missiles landed from Iraq. An explosion at a chemical plant in France also produced an increase in heart attacks.

Stress causes release of epinephrine, which increases pulse rate and vasoconstriction and raises blood pressure. Platelets are released, making the blood more liable to clot. These developments may increase the risk of heart attack.

However, during football matches, other potential factors may play a part. During these competitions, behaviour changes, including:

- More alcohol is consumed and binge drinking is common. This has been demonstrated to increase the risk of vascular events in men.
- Diets change, including the consumption of fattier foods while watching the matches on television, which may make the blood more viscous.

The stress of watching an emotional football match may increase the number of cigarettes that a viewer smokes within a short period. It has been shown, however, that smoking bans in public places, such as bars, have reduced the number of heart attacks. This reduction has also been greater among non-smokers, suggesting that exposure to second-hand smoke is an important consideration. Since 2006, many countries have instituted smoking bans in bars, so this factor may be less significant in these countries in 2010.
Summary
In the past, large football competitions have been associated with a reported increase in heart attack rates in some countries. The 2010 World Cup may lead to emotionally charged situations where some people get excited possibly smoking and drinking more. We believe there may be an increase in heart attack rates associated with the World Cup, especially if there are penalty shoot-outs. We hope that the competition is a great success and that all our readers enjoy the matches without any ill effects.

Endnotes
1 Union of European Football Associations; UEFA.
5 England was eliminated from competition in a penalty shoot-out in the 1990 FIFA World Cup, 1996 UEFA European Football Championship, 1998 FIFA World Cup, 2004 UEFA European Football Championship and the 2006 FIFA World Cup.
7 Lower myocardial infarction mortality in French men the day France won the 1998 World Cup of football. Berthier F., Boulay F. Heart 2003;89:555-556.
9 www.synopvis.co.uk/weather/png/mimt200607.png.

Dr. Ian Cox qualified from Cambridge University and The Royal London Hospital in 1976. He worked in hospital medicine and research until 1985 when he moved to family practice. He has worked in Insurance Medicine for direct offices since 1993 and with reinsurance companies since 1998. He can be reached at Tel. +44 20 7426 1803 or ian_cox@genre.com.
Client Seminars

International

- **Gen Re LifeHealth, United Kingdom**, organised a Seminar in Dublin, Ireland, on March 3, 2010. The seminar considered developments in Income Protection, Group Critical Illness contracts throughout the world, the practical issues to consider when using tele-underwriting and the use of Bio-Psycho-Social techniques in managing IP claims.

- **Gen Re LifeHealth, United Kingdom**, hosted a client seminar in Edinburgh on March 17, 2010. The guest speaker from Gen Re LifeHealth in South Africa, Lauren Hulett, presented on Lower Back Pain — the Underwriting and Claims Challenges.

- **Gen Re LifeHealth Research & Development**, hosted its annual Actuarial Course from April 11 - 16, 2010 in Cologne, Germany. Participants representing 19 different countries from Asia, Europe, Middle East and South America contributed to lively discussions in the Primary Insurance Management Exercise (PRIME), a computer assisted learning exercise which demonstrates some of the decision making processes involved in operating an insurance company. Further topics discussed in presentations and interactive workshops included risk management, reinsurance, actuarial modelling, issues related to products that cover biometric risks such as disability, critical illness and long-term care as well as aspects of preferred life concepts.

- **Gen Re LifeHealth, United Kingdom**, held their fourth Risk Matters Symposium on April 19, 2010. The purpose of the event is to bring together senior opinion makers within the life insurance industry to discuss a specific issue that the industry is facing. The symposium’s keynote presenter was Dr. Patrick Nolan, Chief Economist of the independent think-tank, Reform, who gave his view on where things may be headed post the UK's general election in May 2010.

North America

- **Drew King**, President, JHA, delivered a presentation on the current Group Insurance market and offered his forecast to producers and group representatives for Sun Life in Seattle, Washington on April 27, 2010.

- The **Gen Re LifeHealth Advisory Council meeting** was held in Scottsdale, Arizona May 3 - 5, 2010. This discussion workshop with presentations is held annually for selected key clients. Representatives from 22 companies, comprised of senior actuarial and underwriting officers are participating in this year’s meeting. Gen Re LifeHealth presenters consisted of Steve Mannik, President, providing an overview of the industry and global Gen Re; Jim Greenwood, Senior Vice President discussed the Life Division’s products and services; an Actuarial panel consisted of Vadim Marchenko, Philip Velazquez and Jeremy Starr discussed mortality improvements, post-level term period findings, product trends and capital market cost, availability and outlook; Thomas Ashley, Chief Medical Director, discussed alternative medical tests. Outside speakers were Laura Bazer, Vice President, Senior Credit Analyst at Moody’s discussing the outlook of the economy and the impact on the insurance industry, and Charles J. Vinicombe, Partner at Drinker Biddle Reath, discussing the Life Settlement Industry. All attendees participated in a workshop discussing relevant topics addressing industry issues.

- **Barry Eagle**, Vice President, Marketing, presented at three Critical Illness “Boot Camps” in Dallas, Houston and Anaheim May 11, 12 and 18, 2010 on the History of, and need for, Critical Illness Insurance as a companion sale for producers regardless of their product specialty.
Gen Re LifeHealth, South Africa, was proud to be a platinum sponsor of the 29th International Congress of Actuaries that was held in Cape Town during March 2010 and attended by more than 1,500 delegates. Gen Re LifeHealth staff contributed eight papers to this congress. Louis Rossouw, Singapore, presented a paper entitled “How much life insurance is enough? A utility-based approach”. Andres Webersinke, Germany, spoke about “The expanding role of the actuary” with particular emphasis on evidence-based underwriting. Wolfgang Droste, Hong Kong, presented “Long Term Care case studies” as well as on “Risk management in medical expense insurance”. Paul Lewis, South Africa, discussed “Data availability” and James Louw, Australia, presented the findings of “A Critical Illness experience study in New Zealand”. Disability experience and the economy were covered by two separate presentations. Eddy Fabrizio, Australia, presented on “Economic issues affecting disability” whereas Karl Schriek and Paul Lewis, both South Africa, presented on “The link between disability experience and economic conditions in South Africa”, which was awarded the “Best African Paper” prize.

North America

Cecil Ramotar and Michael Clift spoke at the April 11, 2010 meeting of the Association of Home Office Underwriters (AHOU) in San Antonio, Texas. Cecil spoke about Auto Racing and Michael spoke about Mountain Climbing. Laura Vecchione, Medical Director also spoke at the meeting about Breast Cancer.

Barry Eagle, Vice President, Marketing, spoke at the LIMRA, LOMA, SOA and ACLI 2010 Life Conference April 13 - 15, 2010 in Washington, DC on Critical Illness Insurance as a companion sale or combination sale with Life Insurance.

Barry Eagle also spoke at the Benefits Selling Expo April 19 - 21, 2010 in Washington, DC on Critical Illness Insurance as a “Gap Filler” in Benefits Programs. Barry, along with Steve Rowley, spoke at the Workplace Benefits Renaissance in Nashville March 24 - 26, 2010 on Critical Illness Insurance as a gap-filler in Worksite Marketing Programs.
Mark Your Calendar

International

> Gen Re LifeHealth, United Kingdom, will be hosting underwriting training in Bristol on June 15, 2010. Dr. Chris Ball, Consultant Medical Officer, will be presenting on “Hepatitis and Inflammatory Bowel Disorders”.

> Jules Constantinou, Head of Marketing at Gen Re LifeHealth, United Kingdom, will give a presentation on “Social Care in the UK” at the Health and Care Conference in Newport, Wales on May 13, 2010.

North America

> Steve Rowley, Vice President, Risk Management, will be presenting at the LIMRA, LOMA, SOA, DI and LTC Meeting September 22 - 24, 2010 in Orlando, Florida as part of a panel discussing the subject of Managing Existing Blocks of LTC, including reporting on a major industry survey that Gen Re has initiated looking at rate increase filings.

> Barry Eagle, Vice President, Marketing, will be speaking at the LIMRA, LOMA, SOA, NACII Forum September 21 - 22, 2010 where he will provide results of the 2010 Gen Re NACII Survey on Critical Illness in the U.S. market.

> Thomas Ashley, Chief Medical Director, will be speaking on bipolar disorder at the South Eastern Home Office Underwriter’s Association (SEHOUA) in Hilton Head, South Carolina on June 23, 2010.

> Barry Eagle, Vice President, Marketing, will be presenting on Critical Illness Insurance at the South East Actuaries Meeting June 16 - 18, 2010 in Palm Beach, Florida with the session titled “What Do Actuaries and Companies in 54 Countries Know that You Need to Know?”.

Our Professionals

International

> Paul Lewis and Karl Schriek, Gen Re LifeHealth, South Africa, were awarded the “International Congress of Actuaries (ICA) 2010 Best African Paper” prize. The paper looks at the link between disability experience and the economy. It includes a statistical analysis of the impact on South African disability experience due to changes in economic conditions.

> Dr. Detloff Rump, Regional Chief Underwriter, Gen Re LifeHealth, Hong Kong, published an article in the March 2010 issue of the Journal of the Association of Insurance Medicine of Japan entitled “Epidemiology – Changes in Disease Patterns”. It highlights the effect of changes in epidemiology and related scientific fields in four areas – infectious diseases; malignancies – metabolic abnormalities and chronic cardiovascular disorders; and examines the potential impact of future developments on the life insurance industry.

North America

> Sue Hendrix has joined JHA in South Portland, Maine as an Individual Disability Income underwriter.
Publications

International

> **Risk Matters**

**March – This LTC Quarterly Digest** concentrates upon both the non-motor symptoms, whose management can reduce the likelihood of a long-term care claim or the length of claim, and the recent research suggesting changing patterns of mortality in Parkinson’s Disease patients.

**March – Employment Support Allowance**

This issue looks at the results of the UK Government’s assessments for the Employment Support Allowance based on the Capacity of Work Assessment.

**April – Skin Sterol**

The measurement of cholesterol in the skin, or “skin sterol”, has been put forward as a candidate to eliminate the need for testing blood for lipids and avoiding the inconvenient requirement for examinees to fast prior to the test. This edition of Risk Matters examines the claims for this test and its potential for cardiovascular risk assessment.

> **Risk Matters Oceania**

**March –** This issue covers Guaranteed Acceptance Insurance – We’ve got it covered; New Zealand Trauma Investigation: A key finding; COMET Program 2010 – Protect Your Future; and Gen Re’s Upcoming Events.

**April –** This time, we draw our attention to the Australian taxation implications of Key Person Insurance; Lump Sum & DI Financial Analysis for Financial Planners as a new COMET Elective; the update of our Underwriting Guidelines and Standards 2010; What’s in the latest update to CLUE4; and the COMET courses in April - June 2010.

North America

> Gen Re LifeHealth recently released the **2009 Medicare Supplement Market Survey**, the first comprehensive survey focused on the Medicare Supplement market segment. There were 49 participating companies, representing over USD10.8 billion in annualized Medicare Supplement premium and 57% of the total Med Supp market premium as reported by the NAIC. The survey encompassed questions about each participating company’s background, experience and expectations, challenges, products and marketing, and operations. Future studies will track changes in the business over time.

> JHA, the Disability and Group Life division of Gen Re LifeHealth, North America, has released the results of the following annual U.S. benchmark research studies: **2009 U.S. Group Disability Market Survey, 2009 U.S. Group Life Market Survey** and **2009 U.S. Individual Disability Income Market Survey**. These surveys collect and report sales and inforce premium results for their specific markets. Participating companies receive the detailed reports.

> The following profit studies were also released: **2009 U.S. Group Disability Profit Study** and **2009 U.S. Group Life Profit Study**. The final reports show aggregate industry results of profitability for their respective markets. Full reports are available to participating companies only. Summary information for the JHA research is available at www.jhaweb.com.
This information was compiled by Gen Re and is intended to provide background information to our clients, as well as to our professional staff. The information is time sensitive and may need to be revised and updated periodically. It is not intended to be legal or medical advice. You should consult with your own appropriate professional advisors before relying on it.