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Gen Re has completed a comprehensive experience investigation of Individual Disability Income (DI) business in New Zealand. The study covers the calendar years 2004 to 2008. The results of the investigation were presented individually to the participating companies, and to the industry as a whole, at seminars held during August 2010 in Auckland and Wellington.

The high-level findings were:

- Claim experience has improved for white collar occupations and deteriorated for blue collar occupations relative to prior study.
- Higher sums assured show worse experience than lower sums assured.
- The difference between Agreed Value and Indemnity experience is as expected, but the underlying causes of this difference are interesting.

New Zealand market

New Zealand DI is available in two types each with a distinct benefit calculation at time of claim. Agreed Value policies pay the sum assured irrespective of income at date of claim, while Indemnity policies pay the lower of either the sum assured or 75% of income at date of claim. Indemnity contracts pay a lower amount where a policyholder’s income has fallen since policy inception and date of claim and are therefore less expensive than equivalent Agreed Value contracts. In both types, other sources of continuing income, such as statutory benefits and other insurance policies, are offset from the claim amounts paid.

The country has a relatively small population of just over 4.3 million people, of which 2.1 million are employed. The current unemployment rate is 6.4% (September 2010 quarter), having fallen from a high of just over 7% in the latter half of 2009. The unemployment rate in 2006 and 2007 was under 4%, and so unemployment remains at high levels subsequent to the global financial crisis.¹

The insurance market is characterised by strong competition, evidenced by high levels of upfront commission. For lump sum insurance, these levels are as high as 240% of first year premium, while for DI, it is lower at around 180%.

The retail insurance market is represented by the benefit classes shown in Figure 1.

**Figure 1 – New Zealand insurance market**

![Figure 1](image)

**Source:** ISI statistics.

Participation

Seven companies representing 88% of the DI market in New Zealand contributed data to the study (Figure 2). The total number of claims over the four-year period was just over 4,500, and there was over 650,000 life years’ exposure.

**Figure 2 – Participation rate by premium income and company**

![Figure 2](image)

**Source:** Investment Savings and Insurance Association of New Zealand, based on in-force annual premium as at 30 June 2010 for replacement income risks.
Claim summary
A high level summary of the demographics of the 4,531 claims shows:

Gender 74% male, 26% female
Occupation 57% white collar, 43% blue collar

For females, 89% of the exposure and 82% of the claims were from white collar occupations, while for men, white collar occupations represented 66% of the exposure and 48% of the claims. As expected, men have a far higher proportion of both exposure and claims in the blue collar occupations.

Smoker 86% non-smoker, 14% smoker
Benefit type 68% Indemnity, 32% Agreed Value

86% of claims have either a 30-day or a 90-day waiting period, with the 30-day version being the most popular. 73% of the claims are payable to either age 60 or 65, while the other 27% are paid for a maximum period of either two years or five years.

Cause of claim
It is interesting to examine cause of claim by occupation class. As expected, for blue collar occupations, the major cause of claim is accident accounting for almost half of the total claims (Figure 3), whereas for white collar occupations, accident represents only one-fifth (Figure 4). Much of this difference is gender related, as accident represents 40% of all claims for men and the blue collar occupations are male-biased.

For white collar occupations, the commonest cause of claim is mental health disorder. This includes stress, anxiety and depression.

Figure 3 – Cause of claim amongst blue collar occupations

Figure 4 – Cause of claim amongst white collar occupations

Experience
In order to analyse the claims experience, the investigation broke down the claim costs into its component parts, namely:

- Incidence rate (number of new claims divided by exposure)
- Claim duration (the period from date of first payment to date of last payment)
- Paid ratio (the ratio of the amount of claim actually paid to sum assured)

The total cost of the claim is the product of the three components.

The analysis compared the expected claims, derived from the IAD89-93 table\(^2\), to the actual claims in the data.

Incidence rates
The overall incidence rate was 72% of expected. This is an improvement of 9% when compared to the previous study for the period 2000-2002. This improvement is entirely driven by the white collar occupations, where the improvement in incidence was 20%. For blue collar occupations, experience actually worsened by 11% over the same period.

Claim duration
While incidence rates have improved, the average claim duration of 141% of the expected table has remained constant since our previous investigation. This figure does not change significantly by gender or occupation class.

It is interesting to note that 85% of all claims will have terminated before two years, and 69% by the end of the first year. This demonstrates the value of DI in protecting income for health events from which policyholders recover quickly. This is in contrast to Total and Permanent Disability cover, a lump sum insurance that only pays a claim for disability that is deemed to be permanent.

Paid ratio
New Zealand has a statutory no-fault accidental DI benefit, which represents a significant offset from insured disability income benefits. For accidental causes, the paid ratio is 53% of the sum insured, while for sickness causes it increases to 75%, giving an overall paid ratio for the investigation of 67%. This is a 4% improvement from our previous study.

Total claims cost
Taking the above into account, a 13% improvement in total claims cost has been caused mainly by lower incidence rates and to a lesser extent by a lower paid ratio. This is good news for an industry beset by cost pressures as a result of high levels of sales commission and the recent introduction of a tax code resulting in higher tax payments.

Total cost is 68% of the expected cost. This number in isolation does not say much, except perhaps that the benchmark table IAD89-93 is not representative of the industry’s experience, but it is useful to compare this percentage over different policy groups.
As an example, if we look at white collar experience by sum assured band, we get the following result, noting that the expected table does not use sum assured as a rating factor:

Table – White collar experience by sum assured band

<table>
<thead>
<tr>
<th>Sum Assured Band (monthly benefit), current exchange rate: NZD1.3 per 1USD</th>
<th>Total actual cost as a percentage of expected cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than NZD2,000</td>
<td>60%</td>
</tr>
<tr>
<td>NZD2,000 - NZD3,999</td>
<td>74%</td>
</tr>
<tr>
<td>NZD4,000 - NZD5,999</td>
<td>74%</td>
</tr>
<tr>
<td>NZD6,000 or more</td>
<td>88%</td>
</tr>
</tbody>
</table>

This represents close to a 50% worsening of experience between policyholders with low sums assured and those with relatively high sums assured. After breaking these overall claims costs into their component parts, our analysis showed that the worsening was driven by increases in incidence rate while claim duration and claims cost remained almost constant. Therefore, DI policyholders with higher insured benefit levels claim more often, albeit for the same amount of time and with the same percentage offsets, than policyholders with lower sums assured.

This trend is also visible in the blue collar occupation classes, although the worsening of 30% is not as severe.

Claims costs by occupation

It is standard practice to price DI by taking into account the policyholder’s occupation, with blue collar occupations paying up to triple the risk rate charged to white collar occupations. This is common in many markets globally and can easily be seen in the experience.

Figure 5 shows the total cost for each detailed occupation class as a percentage of the occupation class denoted Class A.

The classes are defined as:

Class A professional, managerial and executive
Class B administrative, clerical, mainly office environment
Class C light manual duties, sales, skilled technicians, supervisors
Class D moderate manual duties, tradesman
Class E heavy manual duties, hazardous work

This data shows that the heavy manual category has a claims cost of 323% of the professional category. This is in line with current industry pricing parameters.

It is interesting to note the insignificant difference between Class C and D, which could be a result of slightly different occupational codings between these categories amongst insurers. There may also be an element of occupational creep between these categories as their definitions are highly subjective.

Claims cost by benefit type

The Indemnity type policies are expected to have lower claims costs as they pay a lower benefit where a policyholder’s income has reduced since policy inception. Therefore, we expect this reduction in claims cost to be driven by the paid ratio. Figure 6 illustrates the cost components of Agreed Value and Indemnity as well as the ratio of Agreed Value to Indemnity in the right hand chart cluster. It shows the total claims costs for Agreed Value is 8% higher than Indemnity, more or less as expected.
However, Figure 6 demonstrates that the lower claims costs for Indemnity is driven by the incidence rate and not by the paid ratio. While this may seem odd, it could be as a result of either:

- Agreed Value policyholders being more likely to claim, as some could be over-insured by the time they claim.
- Self-employed people being more likely to purchase an Agreed Value contract, as they are more at risk from future salary decreases than people employed in a corporate environment. They may represent a higher risk due to the nature of their work, therefore driving up the incidence rate for Agreed Value contracts.

Indemnity contracts have all the same offsets as Agreed Value, plus an additional offset for reducing income. As the paid ratio end up the same, it must be the case that Indemnity contracts have lower offsets than Agreed Value, ignoring the reducing income offset. While this could be the result of any number of factors, two of which were mentioned above, it certainly is not the result that was expected.

Conclusion
This investigation adds to previous Gen Re studies undertaken in New Zealand, in Australia and other markets for either or both the DI and Critical Illness lines of business. Gen Re believes these studies are important contributors to the health of the insurance industry because they provide the industry with a better understanding of the forces that drive the pricing of the products that are sold, and as such are critical to holistic risk management practices and the fair treatment of policyholders.

This brief article has provided a summary of the most significant findings but the potential for examining the data is almost endless. In some instances, the results confirm what is already known and in others they challenge the assumptions and force risk managers to reconsider business practices.

Endnotes
1 www.stats.govt.nz.
2 Developed by the Institute of Actuaries of Australia based on the Australian disability income experience for this period.

Since joining Gen Re’s South African office in 2001, James Louw has held a multi-faceted role spanning technical responsibilities, account management and group business pricing. Since 2008, he has been based in Sydney as the Head of Account Management for Gen Re in Australasia, with responsibility for product development and client management. James is a Fellow of the Institute of Actuaries. He can be reached at Tel. +61 2 8236 6206 or jlouw@genre.com.
A recent innovation in the German market: enhanced accident cover
In most markets, different types of protection products coexist, although some become more established than others. This stems from local market peculiarities, such as the social security system, public awareness, marketing strategy and the availability of alternative successful products. Increasing competition and marketing pressures can cause products to evolve quickly over time in many markets, and some may broaden to offer coverage beyond the original concept. The variety and positioning of products may shift in the future, which raises interesting questions about how the trend of convergence will play out.

One example of this trend is enhanced accident cover (also known as “functional” disability cover), which has recently gained some visibility in the German market. Life insurers have also developed other ideas to limit the scope of coverage of traditional disability income plans. For some time now, personal accident insurers in Germany have been adding new benefit features to products that are not directly linked to an accident, e.g., cover for serious illnesses. Coverage extensions range from small add-on benefits to completely new product approaches with extensive benefits that go far beyond pure personal accident insurance. For certain target groups, these products offer an affordable alternative to the disability covers offered by life insurers.

CI, DI and PA in Germany
The first critical illness (CI) product in Germany was launched in 1991, but thus far, it has remained a niche product. The relatively comprehensive healthcare system and the availability of successful disability income (DI) products are plausible reasons for this. Few companies sell CI as a basic policy, while others offer small CI add-on covers. By the end of 2008, close to 113,000 CI policies were in force, compared to 17 million DI policies (inclusive of WOP riders), a ratio of about 1:150.

Stand-alone personal accident (PA) is a well-established and attractive line of business in Germany and is sold via tied agents’ and brokers. Unlike CI and DI, due to regulatory requirements, PA is classed as non-life business in Germany. PA accounted for about €6.4 billion gross premium in 2009, which represents almost 12% of total non-life premium. Premium volume continues to increase moderately although sales growth has started leveling off in recent years, as shown in Figure 1.

Figure 1 – PA premium volume (gross) versus claims, Germany

Many companies are actively addressing the problem of slowing sales growth by incorporating innovative features within their products, such as assistance benefits or cover against serious illness. Overall, there has been a drive to offer more comprehensive coverage in PA, especially in the broker market.

Inclusion of illnesses
In line with the definition of an accident as a “sudden external event acting on the body”, certain serious illnesses such as a heart attack or stroke can be
perceived in general terms as “accidental”, inasmuch as they may occur suddenly and unexpectedly. Such disease events are therefore obvious candidates to extend the scope of PA, but there are different ways of including them. Basically, a distinction is to be made between the following:

• small CI add-on covers that provide for a single lump-sum benefit in the case of specified severe illnesses, and
• combined products (“functional” disability covers) which offer annuities when either an accident or a severe illness result in a pre-defined medical impairment, essential ability or long-term care.

Small CI add-on covers have been available in the German market for some time. Conditions covered vary between policies. Some offer cover against only heart attack and stroke or only against specific cancers, while others add larger groups of illnesses and include coronary artery bypass operation, kidney failure and multiple sclerosis. As the benefit concept is linked to the diagnosis of certain illness events without any requirement for permanent disability, claim benefits are paid as a lump sum. The benefit paid is much lower than the basic sum insured under the PA cover, typically around 10%. This means that these extensions are classed as small add-ons that have no effect on the characteristics of the basic product.

Combined products are newer products, positioned as “functional” disability cover that will pay an annuity in the event of a severe medical impairment, which is the same as the accident annuity. The ethos of the product is therefore shifted quite radically from that of classic PA protection towards a product closer to mainstream disability cover (although falling short of the mainstream’s comprehensive level of protection).

Issues to consider when developing the combined style product include policy and benefit design, pricing, underwriting and claims management, marketing and sales. They will be addressed in more detail below. (Questions also arise regarding taxation and legal requirements, although these are not dealt with in this article.)

Some features of “functional” disability products

These products pay an annuity in the event of the insured being medically impaired to a degree that renders them unlikely to be able to generate an income. Claims are evaluated based on medical criteria that are pre-defined in the policy conditions. These criteria are not linked to specific occupational requirements, as they are in a classic DI policy, nor do they follow the classic CI definitions. They were developed using a novel evaluation basis called “organ system” whereby entitlement to benefit is defined by the impairment of various bodily functions and organs, such as the heart, kidneys and lungs. (See Figure 2 for examples of current products on the market.)

Benefits are designed to provide a lifelong annuity, or one that runs until normal retirement age, with the exception of cancer where the benefit duration is restricted to a set number of years depending on the severity level. The insured may also choose benefit indexation and certain other increase options. Some companies offer an option to enhance coverage to “occupational” disability and special children products with similar options to enhance cover.

CI component dominates pricing

While premium adjustments and even changes to terms and conditions are permissible in German PA insurance, they are generally avoided by most insurers because of fear that many policyholders will cancel their policies as a consequence of a change. The age dependence of the claims experience of PA insurance has been a topic of increasing discussion in recent years. Companies tried to address the problem of increasing risk for older-aged people with tailor-made senior tariffs, or by offering gimmicks as assistance benefits or LTC benefits to give older people an incentive to switch to these more adequately priced products. Nevertheless, premium calculation continues to be undertaken on a short-term basis of predominantly one year. This issue is now being brought into focus as a result of the dominating influence of covered serious illnesses on claims expenditure. The incidence rates of many illnesses rise sharply with increasing age and in many areas are also significantly higher than those for PA cover. Also, annuity payments do not cancel out this effect, except for the last years before termination of cover where the present value of benefits goes down very quickly.

Challenges of medical complexity

At first sight, the “organ system” approach appears to be a comprehensive form of disability cover. However, a closer look at the benefit definitions does not confirm the first impression. One of several severity criteria for heart disease is the ejection fraction (EF), which is a measurement of the proportion of blood pumped out of the heart during each contraction. A healthy EF is between 55% and 70%, but this is reduced when the heart muscle is damaged. The EF can be measured using various imaging methods, including echocardiography. Typical products use an EF of 30% or below as a cut-off, but just how restrictive is it to base the benefit on this threshold?

<table>
<thead>
<tr>
<th>Organ System</th>
<th>Essential Ability</th>
<th>Long Term Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart</td>
<td>Vision</td>
<td>Care level 1</td>
</tr>
<tr>
<td>Lung</td>
<td>Hearing</td>
<td>(lowest level)</td>
</tr>
<tr>
<td>Kidney</td>
<td>Communicating</td>
<td></td>
</tr>
<tr>
<td>Liver</td>
<td>Orientation</td>
<td></td>
</tr>
<tr>
<td>Psyche</td>
<td>Hand functions</td>
<td></td>
</tr>
<tr>
<td>Brain</td>
<td>Walking</td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td>Standing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Driving</td>
<td></td>
</tr>
</tbody>
</table>
In a heart attack the EF is measured below 30% in only 8%, and below 40% in only 24% of all cases (see Figure 3). Despite the necessity to incorporate severity criteria within a policy, using a threshold value of 30% therefore appears restrictive. Furthermore, the survival rate is particularly low for heart attack patients recording an EF below 30%. More than 10% of these patients die within the first six months post-heart attack. Because of the medical terminology used in the sales literature and policy wording, sales staff and consumers are generally unaware of the fact that only a small proportion of all heart attacks will trigger an insurance payout.

Adding in serious illness cover enhances the value of an otherwise simple protection policy, but at the expense of increased product complexity. Transparent product design is therefore important as consumers must understand the scope of the cover and be able to compare it to other disability products. Compared to DI, these products provide only limited protection for neurological and mental disorders. Thresholds built into the extended cover are more restrictive than those typically used in CI. Therefore, “functional” disability covers fall well short of the protection level of “occupational” disability covers offered by life companies.

What is best advice?
Assessing the meaning of individual benefit restrictions and exclusions is also difficult for financial advisers. The classic PA product they have been familiar with for decades has undergone fundamental changes, and explaining this adequately to applicants puts pressure on intermediaries (and insurers) who have the responsibility to offer best advice. In the current environment of enhanced consumer protection and intense scrutiny of the advice given by intermediaries, these new “functional” disability products may be open to some negative attention, particularly if policyholders’ reasonable expectations are not met at claim stage.

Similarities and differences in underwriting and claims management
While underwriting is important in classic PA insurance, it is not comparable to the underwriting process used for CI. The inclusion of serious illnesses in PA requires more detailed medical underwriting, which goes beyond the simple health questions otherwise common in PA insurance. Despite this inevitable expansion in underwriting complexity, brokers demand the simplified process they are already familiar with from the basic product concept. This challenge can be mitigated using a point-of-sale underwriting system ensuring applications are processed quickly, consistently and professionally. Such a system should be capable of meeting a wide range of requirements for different types of products, as well as tailor-made solutions for combined products like “functional” disability products which, from an underwriter’s perspective, require the assessment of a blending of PA, CI and DI risk.

When assessing illness-related claims under “functional” disability products, more information and considerable medical knowledge are required. Such information would include progress and course of disease and comparison with information disclosed during the underwriting process. Definitions of diseases are significantly more complicated than in classic PA, and claims assessors may not have experience of working with them. In many cases, the input of a medical doctor may be required to complete a claim assessment.

Targeted marketing – Why are “functional” disability products attractive?
Classic PA insurance is a well-established product with consumers and sales intermediaries alike. However, the impact of stagnating sales and increased competition forces insurers to find new features that can be added to the basic accident cover and that will be attractive to consumers. Product differentiation geared to consumer needs can make a significant contribution to developing new customer segments and increasing market share.

But which consumer segments are these new types of combined products targeting? The product concept positions itself at the interface with DI. The target group therefore includes occupation groups, for which classic disability cover appears expensive. For these consumers, the “functional” disability products may offer a more affordable solution but they provide less comprehensive protection. Furthermore, the new products are also attractive for young people and students, especially if the policy conditions include an option to enhance cover to “occupational” disability without additional underwriting at a later date. Most importantly, coverage should match a potential policyholder’s life situation and needs. This makes it especially apparent how important it is to have clear delimitation from the DI products already on offer and thereby avoiding cannibalisation effects. In affiliated insurance groups, the trade-off between the product ranges of life and personal accident insurers is therefore a central issue.
International perspective

Looking at markets around the world, we can find some other approaches to “functional” disability products that are similar to the enhanced accident covers available in Germany. These products also provide cover against being severely disabled due to accident or on the basis of objective and medical criteria. Alongside these similarities there are also significant differences. As enhanced accident covers are positioned at the interface with DI, it seems obvious that a similar scope of cover can be obtained not by “upgrading the PA cover” but by “downgrading” the benefit trigger for DI protection and by limiting the scope of coverage to certain causes of disability.

However, some issues require consideration when developing a carve-out cover providing protection against “severe” disability only. While it may seem a sound idea to exclude certain common causes of disability, such as mental or musculoskeletal disorders, taking the exclusion clause route limits the level of clarity and transparency of the benefit trigger, pricing and claims assessment. Disabled persons are more likely to develop multi-morbidities. This makes a clear delimitation on basis of causality of the impairment difficult. It may even result in imbalances between customer expectations and the actual scope of cover, which could put the insurance company in an uncomfortable position when declining claims. Furthermore, the issue of multi-morbidity must be addressed in the pricing, as its effect means that excluding certain disorders does not automatically imply a proportional reduction in price. Having said this, the overlap caused by multi-morbidity is extremely difficult to assess. There are also issues that can impact on intermediaries. While comprehensive, standard products are marketed as a cover for “any” eventuality, intermediaries must advise applicants of differences in “functional” versus standard disability covers (best advice), particularly exclusion of certain causes of disability. Due to marketing aspects it is also preferable to have a more transparent benefit trigger defined in a positive way.

Including CI as the principal element of the DI benefit trigger overcomes these problems. Only claimants disabled due to accident or who meet the insured level of disability after suffering a critical illness can qualify for the benefit. Critical illnesses, such as cancer, heart attack, stroke, kidney failure and multiple sclerosis – all common causes of disability – are particularly suitable for this kind of cover. Alternatively, moving away from the list of individual diseases, the benefit trigger can be defined on the basis of an evaluation system that includes pre-defined objective medical and functional criteria of disability grouped by body systems. Severity hurdles used in this approach tend to be stricter than in standard CI covers.

The resulting cover, combining elements of DI and CI, can be positioned as a catastrophic disability cover with a very clear and transparent benefit trigger. As severity hurdles refer to certain medical criteria and criteria of bodily functions (similar to the “organ system” approach used in enhanced accident covers), cover is also referred to as “functional” disability cover. Depending on market peculiarities, there are “functional” disability products that pay out an annuity in case of a claim, whereas others provide a lump sum benefit, which is closer to CI cover than the other approach. Such products have already gained some interest in various markets, including the Netherlands, Germany, South Africa, Japan and Australia, to name only a few.

Implications for the future

Will this trend of converging products continue? Considering these product approaches of “functional” disability cover that go beyond original product design, either as enhanced accident cover or “catastrophic” disability cover, one may want to say “Yes”.

PA insurers are driven by making their products more attractive and comprehensive. The inclusion of serious illnesses in accident covers may thus be a reasonable way forward. Likewise, disability income insurers are concerned about the trends in certain causes of claims. To make the premium level and the underwriting and claims process more attractive for a wider group of consumers, carving out a section of the cover from a comprehensive DI plan seems a rational development. These new advances offer new possibilities for marketing and sales to position themselves more strongly in a special customer segment and for differentiating themselves in a positive way from competitors in the market. However, the additional complexity of new kinds of products with more elaborate benefit triggers and illness definitions should not be underestimated and it is necessary to monitor their effects from outset. Many challenges are not unique to just one market. A better understanding of these challenges can assist in developing appropriate product concepts meeting consumer needs and expectations.

Endnotes

1 Financial services sales representatives who are authorised to recommend the products of one insurance company only.
3 Ibid.
4 Shiga T. et al. Sudden cardiac death and left ventricular ejection fraction during long-term follow-up after acute myocardial infarction in the primary percutaneous coronary intervention era: results from the HIJAMI-II registry. Heart. 2009;95:216-220.

Inga Kreiensiek joined Gen Re in 2006. She works in Cologne as a product underwriter in the Research & Development department where she is responsible for product development and trends in Critical Illness insurance. Inga is head of the Competence Centre for Critical Illness.

Sabine Fahrig is Head of Product Underwriting, a team of product specialists within the Research & Development unit in Cologne. During more than ten years with Gen Re, Sabine has conducted various actuarial consulting projects for international clients. Sabine has been head of Gen Re’s Competence Centre for Disability since 2008. She can be reached at Tel. +49 221 9738 150 or sabine.fahrig@genre.com.
The Individual Disability Physician Market – Is Hindsight Really 20/20?

Patricia G. Bailer
Second Vice President
Gen Re, North America

In the U.S. the physician market presents both an opportunity and a challenge to direct writers and reinsurers of individual disability (DI) products. The insurance industry has experienced a shift in DI claims patterns from this professional group. Several social factors impacting risk management are at work that may have influenced this and from which there may be a continuing effect.

One obvious factor is the distinct shift from physicians working as solo practitioners or in small practices to larger groups of doctors working together. These larger work groups generate higher levels of claims. Perhaps it is more difficult to stop working due to illness when self-employed or working as part of a very small practice. Maybe working within a large group practice serves to dilute the positive aspects of the physician offering a personal service to a particular patient. Concurrent with this shift has been the reduction in the domination of this occupation by white males in the U.S., which may also have served to alter claims likelihood. Also at work is the increasing role in healthcare of related professionals, such as pharmacists, who have been expanding their services to the point where they should perhaps be treated in the same way as physicians by DI writers. In fact, changes in specialization within medicine itself and the potential for outsourcing some tasks overseas may alter the risk profile of the group as a whole. It is also noteworthy that job satisfaction in this sector remains low, and this mood is always likely to be reflected in a higher rate of DI claims.

This article considers some of these challenges and looks at the possible links between them and emerging DI experience in the U.S.

Changes in organization

A snapshot of U.S. physicians and medical practitioners taken in the early 1980s would show an occupation largely dominated by white males. These primarily U.S.-educated physicians mainly operated as either general practitioners or internists. Physicians were prime targets for DI because they had high levels of personal income and job satisfaction, but perhaps most importantly they understood the impact of poor health and disability and therefore the need for DI coverage. Products were developed to provide them with lifetime benefits for high monthly benefit amounts, in some instances up to USD50,000. This affluent group could afford to purchase “Cost of Living Adjustments” or “Future Increase Options”; policy riders that served to enrich their coverage by increasing benefits at or even above inflation rates.

In the early 1990s, a “shake-up” of the physician market took place with the emergence of managed care. Briefly, managed care aimed to control medical costs by offering incentives to physicians and patients to select cheaper forms of care and introduced pre-authorization for more costly procedures. As a result, new bureaucratic bodies, including Health Maintenance Organizations, Independent Practice Associations and Preferred Provider Organizations, sprang up. The combination led physicians to perceive a loss of freedom to choose their working practice, their hours, their clients and fields of specialization. The impact of these changes on U.S. physicians should be set against the position of dominance that the medical profession had established. Job satisfaction plunged to an all-time low in the medical profession, and DI carriers began to experience increased claim incidences from this group. The impact caused the insurance industry to experience a mass exodus of DI carriers, especially by those who had underpriced their products or had underestimated expected loss ratios. The net result was that the number of DI providers decreased from over 100 to around 30 that exist today.
Changes in insurance practice

Disability carriers reacted in various ways. One response was to raise premium rates in particular states, while products and options were limited and tightened elsewhere. DI carriers generally began to exert stricter risk management protocols in underwriting, especially financial assessment, and in claims management. Occupation classes were adjusted to better differentiate between the various disciplines within medicine, such as physicians offering invasive and non-invasive procedures, chiropractors, podiatrists and so forth.

In the early 2000s, the pendulum began to swing back towards more relaxed practices but eventually came to rest somewhere in the middle. Disability carriers saw profitability restored as a result of exercising more disciplined risk management and pricing efforts. Gradually, carriers felt able to liberalize rates once again and to expand product offerings and occupational classes along with increased issue and participation limits. The industry’s herd mentality was resurfacing, and carriers continued to increase maximum monthly benefits back to unrealistic levels. Very few companies, however, reintroduced lifetime benefit periods, leveraging lessons learned from the past.

Changes in demographics

The physician DI writers who had survived two prior recessionary periods were poised for an onslaught of the worst recession in recent history, in part because of the emerging demographic trends in the physician market. Specifically, the primarily male-dominated profession had experienced a gender shift, with the proportion of female to total physicians more than tripling between 1970 and 2004. This pace did slow somewhat however in recent years, as shown in Figure 1. There has been a correlation between women and part-time workers, and now the medical industry is seeing similar trends. The increasing number of female physicians is affecting patient experience, influencing schedules, and foreign nationals entering the country for residency training are helping to relieve a perceived physician shortage.

Figure 1 – Proportion of female physicians in the U.S. by age and year

The physician market experienced age distribution changes and, as demonstrated in Figure 2, also increased cultural diversity with the growing number and proportion of international medical graduates (IMGs). By far most IMGs continue to originate from India (about a quarter) and the Philippines (about one-tenth).

Figure 2 – Proportionate and absolute changes in International Medical Graduates by year

IMGs comprised 17.1% of total physicians in 1970, climbing to 25.3% in 2004 and 25.7% in 2008. The physician market grew by 142.3% between 1975 and 2008, and IMGs accounted for greater than one-fourth of the increase.² For the most part, the IMGs concentrate on similar areas of specialty as the top five highest ranking specialties selected by U.S. physicians (e.g., Internal Medicine, Family Medicine, and Pediatrics). The exception being that IMGs preferred entering into the Psychiatry and Anesthesiology fields.

Changes in the role

Several career satisfaction studies have been done on the medical profession.³ The most recent was published in February 2010.⁴ Although several years passed between the surveys, the results are remarkably similar. Morale continues to be low, with increased paperwork a key factor and directly related to having less time to spend with patients, as 76% in the 2010 survey report being at full capacity or overextended, with 49% intending to reduce the number of patients they see. Universal healthcare has a lot to learn from its European and Canadian colleagues, especially as it relates to limited access to physicians in the U.S.

There are several studies currently underway regarding physician compensation and its relevance, if any, to physician satisfaction levels.³ This may help to settle the difference of opinion regarding the quality of care provided in a single provider practice versus a group or hospital-oriented practice. The Medical Group Management Association recently compared physician productivity levels in both the single provider and multi-specialty/hospital practice setting over a five-year period. Privately-owned multi-specialty groups reported a 13% increase while hospital-owned saw an 18% decrease in productivity, a statistic that may suggest generally lower work satisfaction.
Changes to the law
The physician DI market is not immune from legislative impact. For example, the Pennsylvania General Assembly passed Act 29 (also known as House Bill 1041) in June 2010. Once enacted, this amendment to the existing Pharmacy Act will serve to make lawful the current informal collaborative relationships that exist between pharmacists and physicians. Of key importance to DI writers is the wide reaching definition of the practice of pharmacy that is used in the Act and includes participation in choosing appropriate medication, drug regimen review and monitoring of medication therapy. All are tasks that overlap with those of a physician and extend beyond merely dispensing drugs on request. The challenge for DI writers will be to assess whether this represents an occupational shift that should be reflected in their risk assessment.

Meanwhile, clinical pharmacy is becoming a much wider occupation group as pharmacists are extending themselves towards non-traditional career paths. In addition to investigational research, these include consultant pharmacy (a hybrid of retail and hospital practice), field-based industrial or corporate campus-based pharmaceuticals, clinical research and drug safety. Specialty pharmacy roles include disease management and medication therapy management.

The Future
Looming issues continue to compete for the attention of those targeting the physician DI market in America. There are unanswered questions regarding what, if anything, healthcare reform will mean to U.S. physicians and others working in the medical arena. In addition to the subjects discussed in this article, further challenges exist. For example, the electronic age asks healthcare providers to manage patient information in image-full environments while technological advances require a review of how medical procedures are performed. The impact on patients of workplace ergonomics, architecture, lighting, workflow and so forth are some of the areas competing for physician time and attention. The potential for cash-only or concierge-type medical practices as alternatives to healthcare reform remains a reality as evidenced by physicians and nurse practitioners practicing in retail settings. DI writers must look at where the opportunity resides since the challenges are certainly well-established. The question remains whether improved productivity incentives are needed for the physician population and if DI underwriting guidelines need to be revisited to take into consideration all of the information discussed above. It is difficult to say with certainty while all this activity is going on whether this remains a market in transition. For those involved in DI in this or similar markets, it is important to keep a continued watching brief.

Endnotes
3 For example: University of California Davis School of Medicine and Medical Center in 2002; Seattle Survey published in the Journal of American Board of Family Practice in 2003; Patients in a Malpractice Crisis: Physician Satisfaction and Quality of Care, Health Affairs, 2004; the American Medical Association Medical Liability Crisis Map, 2007.

Patricia G. Bailer is a Second Vice President in Gen Re’s Group and Specialty Division in Portland, Maine. She is responsible for our Individual Disability underwriting and claims management team. She can be reached at pbailer@genre.com or 207 874 2261 ext. 147.
Equal Treatment of the Sexes

The Advocate General of the Court of Justice of the European Union, Juliane Kokott, has found that Article 5(2) of Directive 2004/113/EC (the Gender Directive), that permits insurers in certain circumstances to take the gender of a person into account as a risk factor in insurance contracts, infringes on the fundamental rights for equal treatment for men and women under other European laws. The opinion can have implications for insurers, in the context of differential insurance premiums for men and woman, as permitted under Article 5(2).

The opinion is the finding on the preliminary issue referred by Belgian Constitutional Court in the test case brought by a Belgian consumer organisation and two private individuals for annulment of Belgian provisions transposing the Gender Directive. The Gender Directive enshrines the principle that gender cannot be taken into account when setting insurance premiums. Importantly, however, Article 5(2) contains a specific derogation wording that allows insurers to use gender to calculate differential premiums provided that gender is a determining risk factor and that the difference can be substantiated by relevant and accurate actuarial and statistical data.

The core of the opinion is that strict standards must be imposed when dealing with fundamental rights and that differences in premium can at most be justified by clear biological differences between the sexes. Article 5(2) uses gender as a kind of substitute criterion for other factors, and differences in premium can at most be associated statistically with gender. One example given is that the life expectancy of insured persons is above all strongly influenced by the economic and social conditions of each individual, such as the kind and extent of the professional activity carried out, the family and social environment, eating habits, consumption of stimulants and/or drugs, leisure activities and sporting activities. Gender is by contrast something over which the individual has no control. Accordingly Article 5(2) infringes on the fundamental right and is therefore invalid.

Although the Advocate General’s opinion is not binding on the Court, it is likely to be influential on the Court’s determination in the test case. The implication for insurers of any finding on the invalidity of Article 5(2) is that it will impact pricing, product design and underwriting. Should the Court eventually decide that the derogation provision in Article 5(2) is invalid and should be set aside, the Advocate General suggests that there should be a three-year transition period, following which all future premiums would be gender-neutral. Accordingly, much of the work done to comply with the Gender Directive may prove to be short-lived, and by 2014 or 2015 premiums and benefits may well have to be the same for women as for men within the European Union, regardless of statistical differences in the risk proposition that each represents. Importantly, this would also have to apply to in-force contracts. The case is expected to conclude in early 2011.

Endnotes
2 Test-Achats.
Client Seminars

International

> **Gen Re, Mexico**, hosted a client seminar from July 14 - 16, 2010 in Playa del Carmen. Twenty key insurance professionals representing 10 countries attended this event. Dr. Winfried Heinen, member of the Board of Executive Directors, and Dr. Alfredo Fetter, Life/Health Business Unit Manager Mediterranean and Latin America, gave keynote addresses. Carmelo Galante, Regional Manager Life/Health for Latin America, presented the results of the Latin America client survey and Raul Maldonado, Life/Health Manager of the Mexico City Office, spoke on “Simplified Underwriting and Antiselection”. Two invited speakers addressed the potential of affinity marketing in the region and chaired a workshop on leadership.

> **Gen Re, China**, held the 9th Management Course in China from August 6 - 14, 2010. Twenty-nine insurance executives from China, Hong Kong, Malaysia, Singapore and Taiwan attended the course in Qingdao. The participants took part in a structured programme and benefited from the discussions in the cosmopolitan atmosphere and exchange of experience from the various markets.

> **Gen Re, Australia**, held its Life/Health Annual Seminar in Sydney, Melbourne, Auckland and Wellington from August 23 - 27, 2010. This year’s event was attended by nearly 400 risk insurance professionals from 28 organisations across Australia and New Zealand. The seminar is a unique forum for our clients and the industry to come together to share both local and global knowledge and experience that influence the underwriting, claims management, product design and actuarial thinking of our industry. Under the theme of “Global Risk Radar”, the Seminar delivered insights from Gen Re’s global research into threats and opportunities of the biometric risks. Drew King, Senior Vice President of Gen Re Portland, Maine, spoke about the U.S. employer sponsored and voluntary/worksite group disability markets while Dr. Wolfgang Droste, Chief Executive Life/Health Asia Pacific, recounted how Long Term Care insurance addresses the growing needs of ageing populations and its opportunities and challenges for insurers world-wide. Eddy Fabrizio, Chief Actuary, discussed “Climate change and the impact on life insurance”, and Eddie McEllin, Senior Actuary, presented on the “Results of Gen Re’s investigation of 2004 - 2008 New Zealand disability claims experience”. Both Adrian Mak, Account Executive, and James Louw, Head Account Management, talked about “Product development and insurance customer buyer psychology”. Matthew Ramjan, Chief Underwriter, shared the “Results of a Gen Re survey of Australia & New Zealand underwriting consistency” and Jane Dorter, Head Client Services, and Grant Tritton, Principal Claims Adviser, spoke about the “Biopsychosocial screening for disability claimants”.
Client Seminars (cont’d)

> **Gen Re, Mexico**, organised a one-week Life/Health insurance course in Panama from September 5 - 10, 2010 for Latin American client companies (X Curso de Vida y Salud). Nearly 50 participants from 15 different countries representing 27 companies attended the course. Gen Re speakers included from Cologne Carmelo Galante and Gabriela Clavijo, and from Mexico City Raúl Maldonado, Luis Enrique Garcia, Al’Nair Escalante, Rita Hernandez, and Keiko Imuro. The team held various presentations on a wide range of topics including Risk Management, Medical and Financial Underwriting, Group Life, Health Insurance, Reinsurance, trends in products and distribution channels as well as on various other topical subjects for the Latin American market.

> The **3rd Seminar on International Product Trends**, an annual Gen Re event, was hosted in Cologne, Germany, and took place from September 27 - 28, 2010. Andres Webersinke, Head of Life/Health Research & Development, and chair of this event, welcomed nearly 50 life insurance executives from 26 countries. The first seminar day was dedicated to current issues in disability insurance. The second day focused on the increasing life expectancy and its consequences for life insurance. Gen Re associates from various offices and research areas shared recent product trends and findings from international disability markets, challenges in the assessment and management of disability claims and challenges caused by the increasing prevalence of dementia. Further topics were experience with insurance products for Generation Jones and enhanced annuities. Invited speakers were Nick Kirwan, Head of Health and Protection at the ABI, UK, who shared his lost secrets of unlocking the protection market; Hans Ouwehand, Executive Director at Calder Holding, The Netherlands, presenting the Dutch approach towards welfare to work and disability; and Prof. Roland Rau from the University of Rostock presenting on the life expectancy revolution. Gen Re presenters included Sabine Fahrig, Head of Product Underwriting, Claire Henshall, Head of Claims UK, Jason Cooper-Williams, Regional Chief Actuary Southern Africa, Tim Eppert, LTC Product Specialist, Dr. Dirk Nieder, Regional Chief Actuary Far East, Dr. Chris Ball, Consultant Chief Medical Officer UK and Andres Webersinke. We look forward to continuing this series of seminars with the 4th Seminar on International Product Trends scheduled for September 22 - 23, 2011.

For more information on this seminar series, please visit www.genre.com/producttrendsseminar.
The 8th International Seminar on Risk Management, one of Gen Re’s annual events, was hosted in Cologne, Germany, and took place from September 30 to October 1, 2010. This year’s theme was dedicated to “Risk Management in the Wake of the Financial Crisis.”

Dr. Winfried Heinen, member of General Re’s Board of Executive Directors and chair of this event, welcomed 60 senior life insurance executives representing 30 countries. Topics raised included global economic developments and investment strategies, recent developments in regulatory and legal requirements, the impact of economy on biometric risks and model risk and risk/return characteristics of unit-linked life insurance products.

Invited speakers were Dylan Grice, Stratégiste Global at Societe Generale in the UK; Kai-Marjep Kosik, Head of Insurance of the Person at the CEA, Belgium; Dr. Thomas Knispel, Executive Director of the “Leibniz Lab of Financial and Insurance Mathematics” at the Leibniz University Hanover, Germany; and Dr. Jürgen Bierbaum, Head of Actuarial Research, Allianz Lebensversicherungs-AG, Germany. Gen Re presenters included Dr. Stefan Maus, Actuarial Modelling Specialist, Michael Morgenstern, Financial Controller, Andres Webersinke, Head of Life/Health Research & Development, Dr. Wolfgang Droste, Chief Executive Life/Health Asia Pacific and John Gilbert, Chief Investment Officer at General Re-New England Asset Management Inc. We look forward to continuing this series of seminars with the 9th International Seminar on Risk Management scheduled for September 19 - 20, 2011. For more information on this seminar series, please visit www.genre.com/riskmanagementseminar.

Gen Re, Singapore, organised a seminar in Kuala Lumpur (October 12, 2010) and Singapore (October 13, 2010). About 90 risk assessors and claims managers attended this event. Dr. Ian Cox, Consultant Chief Medical Officer Research & Development, presented on “Critical Illness Innovations – Implication on Claims” and “Cancer Screening and Trends”. Irene Ng, Chief Underwriter, discussed the topic “Simplified Issue” and why this does not mean simple underwriting.

Gen Re, China, organised the 2010 Insurance Medicine Seminar in Beijing (October 14) and Shanghai (October 15, 2010). One hundred fifty-five underwriters and claims personnel attended the seminars. Dr. Ian Cox, Consultant Chief Medical Officer Research & Development, presented on “Cancer in Critical Illness: More Than We Expected And More Are Coming” and “Changes in Diagnosis of Diabetes And Usefulness in Screening”.

Gen Re, China, sponsored the 3rd Shanghai Underwriting & Claims Club meeting on October 15, 2010. Twenty-six representatives from the major Life/Health insurers attended the meeting. Dr. Ian Cox, Consultant Chief Medical Officer Research & Development, was the guest speaker. Since 2006, the Underwriting & Claims Club has provided a platform to keep the underwriting and claims professionals abreast of the latest developments in insurance medicine and to discuss current underwriting and claims issues.

Gen Re, UK, sponsored an LTC breakfast meeting at the Association of British Insurers in London on October 15, 2010. More than 100 delegates attended representing insurers, reinsurers, care givers and old age health affinity groups. Jules Constantinou headed a five-person panel discussion about the future of long term care in the UK. Solving the funding of future care is a high priority for the new government in the UK, and the ABI is keen to stress that private insurance can be part of the solution.
Client Seminars (cont’d)

> **Gen Re, Mexico**, organised a Risk Management Seminar in Bogota, Colombia (October 19, 2010). Twenty-nine participants representing 12 companies attended this seminar. **Dr. Alfredo Fetter**, Business Unit Manager Mediterranean and Latin America, **Carmelo Galante**, Regional Manager Life/Health for Latin America, gave keynote addresses. **Raul Maldonado**, Life/Health Manager of the Mexico City Office, gave a presentation on the social and economical development of Latin America during the last two centuries.

> **Gen Re, Japan**, hosted its annual seminar and dinner for clients on October 20, 2010, at Hotel New Otani in Tokyo. Around 85 insurance professionals representing 35 insurers attended this event. During the seminar, **Dr. Dirk Nieder**, Vice President and Regional Chief Actuary, gave a presentation on “Innovation in Critical Illness Insurance”, and **Dr. Ian Cox**, Consultant Chief Medical Officer Research & Development (R&D), presented on “Cancer: Trends, Overdiagnosis and ‘New’ Cancers”.

> **Gen Re, Hong Kong**, organised the 2010 Insurance Medicine Seminar in Hong Kong on October 22, 2010. 26 underwriters, claims personnel and actuaries attended the seminar. **Dr. Ian Cox**, Consultant Chief Medical Officer R&D, discussed the topics of “Cancer in Critical Illness: More Than We Expected And More Are Coming” and “Changes in Diagnosis of Diabetes And Usefulness in Screening”, while **Dr. Detloff Rump**, Regional Chief Underwriter Asia, presented on “Childhood Obesity: Long Term Risks”.

> **Gen Re, Lebanon**, organised a Risk Management Seminar in Beirut (Lebanon) during November 3 - 4, 2010. Forty-two participants were given the opportunity to participate in Gen Re’s Primary Insurance Management Exercise (PRIME), a computer-assisted learning exercise, which demonstrates some of the decision-making processes involved in operating an insurance company. **Mazen Abouchakra**, Regional Director MENA & Cyprus, **Sascha Adler** and **Ibrahim Salam**, both Senior Account Managers for MENA & Cyprus, held the PRIME session. **Andres Webersinke**, Head of Research & Development, presented on “The Right to Underwrite”, “Questionnaires – Does It Matter How I Ask?”, “Teleunderwriting” and “Financial Underwriting” with case studies. The event was held at the building of the Association des Compagnies d’Assurances au Liban in Beirut.

> **Gen Re, China**, held an Insurance Seminar in Beijing and Shanghai on November 10 and 11, 2010 respectively. **Andres Webersinke**, Head of Research & Development, and **Dr. Detloff Rump**, Regional Chief Underwriter Asia, addressed the audience of the China market. The topics discussed were: “Evidence-Based Underwriting”, “Anti-Discrimination Legislation and Life Insurance” and “Genetics and Insurance: Are We Prepared?”. A total of 74 professionals attended the seminars.
Inside Gen Re

Client Seminars (cont’d)

> **Gen Re, Hong Kong**, held an *Actuarial Seminar* in Hong Kong on November 12, 2010. We invited international Gen Re associates including **Andres Webersinke**, Cologne, **James Louw**, Sydney, **Youjin Lee**, Korea, and **Yvonne Ren**, Shanghai, as our guest speakers. The seminar covered a wide-range of topics such as Evidence-Based Underwriting; Mortality and Dread Disease Claims Experience in China; Managing Cancer Products in Korea; Product Innovation in Australia; and Anti-Discrimination Legislation and Life Insurance. Forty-six participants attended this seminar. Special guest of this event was **Dr. Winfried Heinen**, member of Gen Re’s Board of Executive Directors.

> **The Gen Re Business School, Germany**, organised the *17th Congress on Insurance Medicine* in Cologne on November 17, 2010. **Dr. Winfried Heinen**, member of Gen Re’s Board of Executive Directors, welcomed more than 80 insurance medical officers and senior underwriters and opened the event with the handing over of the Gen Re Award for Innovation in Risk Assessment. Topics raised included diagnosis of kidney diseases; kidney and liver transplants; bariatric surgery; prevention, diagnosis and treatment of colon cancer; Gen Re’s latest findings on evidence-based underwriting; a law case review on anti-discrimination and occupational categorisation. Various speakers were invited to provide a clinical view while Gen Re representatives discussed the insurance aspects. They included **Bernhard Balg** and **Dr. Robert Ostermann-Myrau**, both members of the medical team, **Andres Webersinke**, Head of Life/Health Research & Development, **Jürgen Warstat**, Head of Underwriting Research, **Tim Eppert**, Product Specialist, and **Ulrich Pasdika**, Head of Business Unit Germany.

North America

> **Gen Re, North America**, hosted its *annual Group Life Roundtable* on November 17 at Gen Re’s Stamford headquarters. Most of the 20 companies who participated in the 2010 U.S. Group Life Rate & Risk Management Survey sent representatives to discuss key segments of the survey, including Basic and Voluntary Group Life rating, underwriting and pricing, experience rating, claims management and recent trends in the market.

> **Anthony Forte**, Vice President and Chief Underwriter, moderated a Case Clinic at the Impaired Risk Underwriting Association meeting in Clearwater, Florida on September 19, 2010.

> **Dr. Thomas Ashley**, MD, FACP, Vice President and Chief Medical Director, taught a Basic Mortality Methodology Course at the *AAIM Annual Meeting* (American Academy of Insurance Medicine) in Scottsdale, Arizona on October 23, 2010. Dr. Ashley also gave a *webinar presentation on “Bipolar Mood Disorder”* at the Gen Re’s Stamford office that was broadcast to approximately 200 underwriters at 30 client companies on November 10, 2010.
Industry Meetings

International

> **Dr. Detloff Rump**, Chief Regional Underwriter Asia, presented on October 16 - 17, 2010 at Know Your Life, a seminar organised by the Association of Insurance Underwriters, India, about “Underwriting Tumours”. About 270 participants attended this event.

> **Gen Re, Australia**, was proud to be a sponsor of the Biennial ALUCA Conference (Australian Life Underwriting and Claims Association), in October 2010 that was held at Maroochydore (Queensland) and attended by more than 370 delegates. Gen Re staff from Australia contributed five papers to this congress. **Adrian Mak** co-presented on “Australian and New Zealand Trauma Experience”, **Matthew Ramjan** co-presented on “Tele-Underwriting”, **Grant Tritton** co-presented on “Durations Management And Risk Profiling”, **Dr. John Cummins** spoke about “Evidence Based Psychiatric Risks” and **Michael Molesworth**, Managing Director, discussed “Professionalism” in underwriting and claims.

North America

> **Joseph Atamaniuk**, Vice President, Marketing, managed the Discussion on Strategic Issues for LIMRA’s Reinsurance Study Group following the Annual Society of Actuaries Meeting on October 20, 2010 in New York City.

> **Jacqueline Zenon**, a Business Unit Specialist, gave a presentation entitled “Business Intelligence and Analytics – Consolidating Disparate Data Sources” on October 21, 2010 at the annual LOMA Distribution and Emerging Technology Conference held in Ft. Lauderdale, Florida.

> **Jennifer Daigle**, Vice President, Group Life and LTD Claim Management, co-facilitated a roundtable discussion at the Claim Analytics LTD Claims Benchmarking User Group meeting held in Chicago on November 2, 2010. Companies represented at this industry gathering included Aetna, Assurant, Lincoln Financial Group, MetLife, Mutual of Omaha, Principal, Sun Life (US and Canada), and Unum.
Mark Your Calendar

North America

> James Greenwood, Senior Vice President, will speak on Reinsurance from a Global Perspective on January 23, 2011 at the Annual meeting of The Metropolitan Underwriting Discussion Group in New York City. Jim will also moderate a panel at the ReFocus conference in Las Vegas, Nevada on February 28, 2011. The panel will discuss Alternative Distribution Technology to Capture the “Mid-Market” with Bob Baranoff of LIMRA, Mike Hamilton of ReMark North America, and Moshe Tamir of Migdal.

> Also at the ReFocus meeting in Las Vegas, Dr. Thomas Ashley, MD, FACP, Vice President and Chief Medical Director, will make a presentation on March 1, 2011 on the findings from the survey on Predictive Modeling. He will also moderate a discussion on Mortality Modeling in Life Insurance Preferred Risk Selection with Dr. Andrew Coburn of Risk Management Services, Dr. Guizhou Hu of Biosignia, and Chris Stehno of Deloitte Consulting LLP.

> Gen Re’s Dynamics Seminar will be held March 2-4, 2011 in Bonita Springs, Florida at the Hyatt Regency Coconut Point. This seminar is the premier Disability and Group Life insurance event in the U.S., attracting over 325 insurance professionals and related decision makers each year. For more information on how to sign up and details on speakers, breakout sessions and hotel/travel arrangements, visit www.genre.com/dynamics.
This edition returns to cognitive problems which have proved the most difficult risk to assess and manage.

**November – Chronic Obstructive Pulmonary Disease**
Chronic Obstructive Pulmonary Disease (COPD) has become the preferred name (rather than emphysema or chronic bronchitis) for a lung disease that is a significant public health problem. It is estimated that there are over three million people in the UK with significant airway obstruction but only about 900,000 have received the diagnosis and therefore appropriate treatment. The European Respiratory Society (ERS) predicts that by 2020 COPD will account for over six million deaths annually making it the third leading cause of death worldwide.

**November – Challenging the Legality of the Gender Directive**
The recent Opinion of the Advocate General of the Justice of the European Union in the *Test-Achats* case has raised questions over the validity of the opt-out provisions under Article 5(2) of Directive 2004/113/EC (the Gender Directive) that permits differential insurance premiums between men and woman. This *Risk Matters* summarises the current position and considers the implications that this Opinion may have for insurers.

**Risk Matters Oceania**

**September** – The content of this issue is Income Protection and the Price of an Exclusion / The National Disability Insurance Scheme (NDIS) / CLUE / COMET 2010 Diary.

**October** – The main topics in this issue are The Use of Social Networking in Claims Management / Facts About Diabetes / Winner of Gen Re Annual Seminar 2010 Feedback.

**Claims Focus**
The main topics in the issue are: When Does Multiple Sclerosis (MS) Lead to Disability / MS and Disability – Case Studies / Epilepsy and Disability / Epilepsy and Disability – Case Studies / Gen Re Business School Claims Assessment Programme – Module 4 / Seminar Dates.
Publications (cont’d)

International (cont’d)

> **Topics No. 18**
> The Future of Underwriting — Between Technical Progress and Legal Pitfalls
> Underwriting is under scrutiny. Declared to be “dead” every now and then, it is still particularly significant for life insurers’ risk management today and for the foreseeable future. Although methods may change and become simpler, faster and more economical, the principle of guaranteeing insurability by means of underwriting is not going to change. Changes to the basic conditions are significant, however. Similarly, one of the greatest challenges for underwriters and managers is to be able to adapt to these comprehensively and swiftly.

North America

> The **2010 U.S. Group Disability Mid-Year Market Survey** and the **2010 U.S. Group Life Mid-Year Market Survey**, both published in September 2010. These leading industry benchmark surveys cover Traditional/Basic and Voluntary Group Term Life, Short Term Disability (STD) and Long Term Disability (LTD) sales and earned premium for the first half of the year.

> The **2010 U.S. Group Life Rate & Risk Management Survey**, the most comprehensive survey of the U.S. Group Life business, was published in October 2010.

> During October, Gen Re collected data to survey the market on the **Status of Predictive Modeling**. The report will describe the current understanding and use of predictive modeling in this market. Respondents will receive the report in December. It will be available on request after presentation at the ReFocus conference in Las Vegas, Nevada, on March 1, 2011.

> Stephen Rowlie, Vice President, published print and online versions of “Critical Illness Insurance – Keys to Success in the Worksite” in the October issue of “Life Insurance Selling”. Steve also published an article “Using Critical Illness Insurance to Increase the Value of Existing Products” in the October online edition of “Agents Sales Journal”.

> Barry Eagle, Vice President, recently published the **2010 Critical Illness Insurance Market Survey**, which provided participants with details of the product in the US market. Thirty-one Direct Writers supplied details on 48 product variations, and 12 companies looking to enter the market responded relative to their plans. In addition, the survey, in collaboration with LIMRA reported aggregate new business sales details for 38 direct writers, the most comprehensive report to date.

Our Professionals

North America

> **Stacy Varney** has joined the Group and Specialty Reinsurance division as Vice President, Marketing and Account Management. Stacy was previously at Gen Re’s subsidiary GR-NEAM where she was Vice President, New Business Development.
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.