ABI Statement of Best Practice for Critical Illness Cover

2005 review consultation paper

Contents

1. Executive Summary

1.1 The Statement of Best Practice for Critical Illness Cover was first drafted in 1999 following an Office of Fair Trading report on health insurance. The Statement introduced standard definitions and wordings and allowed for a full review every three years. This consultation paper sets out options for changes to the statement designed to achieve the following aims:

- Help ensure critical illness (CI) insurance is sustainable and continues to meet consumer needs
- Further improve clarity for consumers

1.2 We are conducting this review at a time when advances in medical science are continuing to change the way illnesses affect us as well as improving the way some illnesses are diagnosed and treated. One of the key roles of the ABI CI Working Party is to anticipate and monitor major medical developments and their impact on CI insurance. This time we aim to be more proactive in anticipating medical advances and this consultation paper considers how CI policies need to evolve to ensure that customers continue to get meaningful, understandable cover that meets their needs at an affordable price.

1.3 We are consulting with Insurers, Reinsurers, Distributors, Trade Bodies, Consumer Groups, Regulators and medical experts on the following changes to the Statement of Best Practice:

1.3.1 **Improving clarity** – we are consulting on additional measures to help consumers fully understand what they are covered for and what they are not. This includes introducing more descriptive illness definition headings and on options to help consumers understand that only the listed conditions are covered.

1.3.2 **Future-proofing** – we are recommending changes to improve the degree of future-proofing the model illness definitions have against the effects of medical and other advances while maintaining broadly the same level of cover as far as possible. This should result in fewer changes in the future. We have included a new set of definitions for consideration.

1.3.3 **Introducing two levels of cover for cancer** – we are consulting on whether to introduce a new, more restricted cancer definition which could be offered alongside the existing cancer definition or on its own. This would allow insurers more flexibility to offer restricted or staged cover at an affordable price. This would be a major development for the industry and the consultation paper examines the advantages and disadvantages of such a development for consumers.

1.3.4 **Other changes to the Statement of Best Practice** – we are recommending a number of additional measures to improve clarity. These include simplifying the structure of CI by removing the confusion around the use of the terms “core” and “additional” illness categories, extending the number of model illness definitions and generic terms.

Replying to this Consultation Paper

1.4 Views are invited on this consultation document. Please send your responses to arrive by 30th November 2005 to Richard Walsh, Head of Health, at one of the following:

- Post: Association of British Insurers, 51 Gresham Street, London EC2V 7HQ
- E-mail: richard.walsh@abi.org.uk

1.5 The full list of questions for which we are inviting responses is as follows:

Q1: Do you agree there is a need to change the current Statement of Best Practice to improve clarity?

Q2: Do you support the principle of changing the product name? If so, which new name do you prefer? Do you have an alternative suggestion?

Q3: Do you support including a generic description of the product in product literature? Do you have comments on the proposed wording?

Q4: Do you support the principle that headings should be more descriptive?

Q5: Do you have any comments on the proposed definition headings? Do you have alternative suggestions?

Q6: Do you agree there is a need to change the current Statement of Best Practice to improve the degree of future-proofing in the model illness definitions?

Q7: Do you have any comments on the proposed definition wordings? Do you have alternative suggestions?

Q8: Do you support the principle of a having a second cancer definition?

Q9: If we introduce a second cancer definition, do you agree with the ABI recommendation to manage the gap?

Q10: How could the communication of the breadth of cover be made easier for advisers to explain and for consumers to understand?

Q11: Do you support the principle of streamlining the illness categories?

Q12: Do you have any comments on the proposed wordings or headings for these new ABI definitions? Do you have alternative suggestions?

Q13: Do you support the principle of linking the generic terms to the definitions?

Q14: Do you have any comments on the new proposed generic term? Do you have an alternative suggestion?

2. Introduction

Background and brief history of CI

2.1 CI insurance has been a very successful protection product. It was first launched in the UK in 1986 and until recently sales of the product have increased year on year. Initially there were many differences between the products that were available and this made them difficult to compare, particularly in the IFA sector. However the introduction of some standard definitions for six illnesses in 1992 created greater consumer and IFA confidence in the product.

2.2 Since it was introduced to the UK, the number of people covered has increased to around 12 million adults and children with more than an estimated £450 billion sums assured. Even though CI insurance is a long-term contract where we expect most claims to be paid later as customers get older, we estimate that insurers have paid over £1.6 billion in critical illness claims since the start of 2000.

The Statement of Best Practice and previous reviews

2.3 In 1998, the Office of Fair Trading (OFT) published a report on health insurance. Amongst its conclusions, it said that there were too many different definitions between companies and this was causing consumer and adviser confusion. It called for the industry to reduce consumer detriment by adopting standard illness definitions and a common format for product literature for CI. In response, in 1999 the Association of British Insurers (ABI), in consultation with OFT, published the Statement of Best Practice for Critical Illness Cover.

2.4 The Statement helps consumers in three important ways:

- **Security** – provides consumers with the safeguard that appropriate minimum standards of cover are used across the industry**.**
- **Comparability** – makes it easier to compare CI insurance from different insurers.
- **Clarity –** helps improve understanding about what each product does, and does not, cover.

2.5 To achieve these three objectives - of security, comparability and clarity – the Statement includes a common format for how insurers should present CI in product literature and model definitions for the illnesses most commonly covered. These are set at an "appropriate minimum standard" so that insurers have to use that definition, or may modify the definition in prescribed ways to offer at least the same cover. A common definition of what a CI product actually is was also required and this was agreed as the following: "Critical illness insurance pays out on meeting the definition of a listed critical illness where the list of illnesses includes cancer, heart attack and stroke."

2.6 The Statement allows for a full review every three years ensuring that it remains up to date, for example, with legislative and market changes and advances in medical science. The last full review was in 2002, when we made changes to the definitions for cancer and heart attack in the light of medical advances and, again, we consulted the OFT. There was an interim review in 2004 to introduce the changes required by protection product regulation.

2.7 Another full review is therefore due in 2005 and we have set out our proposals in this consultation paper.

Market environment of current review

2.8 To date, industry studies have shown that claims experience for CI insurance overall has been broadly in line with expectations based on population studies. Since we last updated the model definitions in May 2002 concerns about potential and unpredictable increases in future claims due to advancing medical science – especially more screening to diagnose cancer earlier and better diagnostic techniques – have risen. In particular:

- Medical advances mean that illnesses will be diagnosed earlier and at younger ages. This is likely to lead to earlier claims, especially for cancer, and potentially many more claims where previously the diagnosis would not have occurred at all within the policy term.
- Medical advances in treatments are likely to mean that the impact on a person's life is lower than previously when these conditions were life-threatening.

2.9 Cancer is the dominant issue because these claims account for roughly 50% of CI claims.

2.10 These concerns have caused significant changes in the CI market in the last 3 years. Companies have usually responded by:

- Increasing the premiums for new guaranteed premium CI policies.
- Pulling out of the guaranteed premium market because (in their view) it is impossible to price the risk over the long term. Typically such companies now only offer reviewable rate CI.
- Removing conditions where treatments have become routine: for example, angioplasty.

2.11 As a result guaranteed CI products are now less affordable, CI products offer less cover, and there is less choice for consumers.

2.12 Industry data shows that while premiums for reviewable rate products have remained fairly constant from 2002 to 2004, guaranteed rate premiums rose by about 60%. While prices in the CI market are starting to level off, concerns remain about the future of the product, i.e. there could be a further round of premium increases – possibly to the extent of guaranteed premium products at best being unaffordable and at worst not being available at all.

2.13 Most claims for CI are paid promptly and, as the people who are now covered get older, we expect more claims to be paid in the future. Inevitably, some claims are declined. In some of these cases, questions have been raised about consumer understanding about what is covered by a CI policy and what is not. Despite the mandated text in current key facts documents ("*Please remember that the heading of each critical illness is only a guide to what is covered. For example, some types of cancer are not covered…*") some customers may not remember this at the time of claim and might turn to the headings of the cover offered and might, for example,

assume that all cancers are covered. This suggests that the industry should consider what more can be done to improve the clarity about what CI products are and what they cover.

The Current Review

2.14 It is important to note that the definitions of critical illnesses in most policies cannot be changed after the start of the policy. It is therefore important that the definitions used are appropriate for the full term of the policy which may run for many years into the future. We have therefore tried to be more proactive in anticipating possible future changes, for example, in medical advances.

2.15 Advances in medical science change the way illnesses affect us as well as improving the way some illnesses are diagnosed and treated. This means that CI policies, and the definitions of the illnesses they cover, also need to evolve as medical science improves, to ensure that customers continue to get meaningful, understandable cover that meets their needs at an affordable price.

2.16 Our overriding aim is to retain the security, comparability and clarity described in 2.4 above to enable consumers to continue to access products that are affordable and offer meaningful and understandable cover.

2.17 We also recognise that insurers can only provide CI insurance if the premiums are expected to cover at least the amount they are likely to pay out plus the cost of providing appropriate financial reserves. The amount paid out in claims depends largely on what illnesses are covered and, crucially, insurers need to be able to estimate the likely amount paid out in the future to be able to set premiums.

Conclusions

2.18 We are consulting with Insurers, Reinsurers, Distributors, Trade Bodies, Consumer Groups, Regulators and medical experts on the following changes to the Statement of Best Practice:

2.18.1 **Improving clarity** – we are consulting on additional measures to help consumers fully understand what they are covered for and what they are not. This includes introducing more descriptive illness definition headings and on options to help consumers understand that only the listed conditions are covered.

2.18.2 **Future-proofing** – we are recommending changes to improve the degree of future-proofing the model illness definitions have against the effects of medical and other advances while maintaining broadly the same level of cover as far as possible. This should result in fewer changes in the future. We have included a new set of definitions for consideration – see Annex 1.

2.18.3 **Introducing two levels of cover for cancer** – we are consulting on whether to introduce a new, more restricted cancer definition which could be offered alongside the existing cancer definition or on its own. This would allow insurers more flexibility to offer restricted or staged cover at an affordable price. This would be a major development for the industry and the consultation

paper examines the advantages and disadvantages of such a development for consumers.

2.18.4 **Other changes to the Statement of Best Practice** – we are recommending a number of additional measures to improve clarity. These include simplifying the structure of CI by removing the confusion around the use of the terms "core" and "additional" illness categories, extending the number of model illness definitions and generic terms.

3. Proposals for Consultation

Improving clarity

Product name – should we change it?

3.1 Clarity has always been at heart of the statement. However, we are always seeking ways to further increase consumer understanding of CI insurance. As there are some illnesses that are not covered, the title alone could raise an expectation that all critical illnesses are covered by the product.

3.2 It has been proposed that a more descriptive title could be created for the product – for example: Specified Critical Illness Cover or Listed Critical Illness Cover. This would be in the consumers' interests for the following reasons:

- Consumers should be able to understand better exactly what CI is all about
- Improve consumers' understanding of what is covered by CI policies and what is not.

3.3 However, we also accept that changing the name could add confusion, especially given the huge number of consumers who are now protected by critical illness insurance. An alternative would be to keep the name "Critical Illness" but require insurers to include a standard product description in Key Features/Key Facts documents and other marketing literature and websites. This might be as follows:

- "Critical illness insurance pays out on meeting the definition of a critical illness listed in your policy. Other conditions are not covered."

3.4 Accordingly, we are consulting on whether the product name should be changed and, if so, what would be the most appropriate name to adopt.

Q1: Do you agree there is a need to change the current Statement of Best Practice to improve clarity?

Q2: Do you support the principle of changing the product name? If so, which new name do you prefer? Do you have an alternative suggestion?

Q3: Do you support including a generic description of the product in product literature? Do you have comments on the proposed wording?

Definition headings

3.5 In addition, it has been proposed that the industry introduces a more descriptive heading for each illness, which adds even more clarity about what is covered and would better set consumers' reasonable expectations. For example, replacing the current heading "multiple sclerosis" with "multiple sclerosis with persisting clinical symptoms" to better explain the scope of the cover.

3.6 You can find a full list of the suggested definition headings (with the proposed set of revised definitions) in Annex 1.

Q4: Do you support the principle that headings should be more descriptive?

Q5: Do you have any comments on the proposed definition headings? Do you have alternative suggestions?

Future-proofing

3.7 Future-proofing aims to protect the model illness definitions, as far as possible, from the effects of medical and other advances. We recommend introducing wordings that are less likely to need changes if there are, for example, advances in diagnostic techniques or better treatments. Whilst we believe that it is not possible to create definitions that are totally future-proof, our aim is to develop wordings that should last for a considerable time.

3.8 Future-proofing means that we aim to introduce definition wordings that will maintain the current level of cover in line with the original concept into the future with less need for further changes in the future.

3.9 Future-proofed definitions are in the best interests of consumers because:

3.9.1 There should be fewer future product generations. Each time the model definitions change there is a new generation of policies with slightly different definitions. Future-proofed definitions should lead to less future change, greater and sustained understanding amongst advisers and consumers about what is covered and what is not, and, eventually, fewer cases of different policies with different claim outcomes.

3.9.2 There could be a reduced pricing allowance for adverse trends and shocks – this should help to make cover more affordable.

3.9.3 It may encourage new entrants to the market – a more robust product structure should increase confidence in the long-term sustainability of CI and therefore encourage new entrants to the market. This means more consumer choice, more competition and therefore a healthier market.

3.10 Some definitions have been updated for reasons of consistency and clarity but without changing the level of cover. A summary of the main changes is as follows but the full set of proposed definitions are set out in Annex 1, together with a brief rationale for the change:

- **Blindness** – Cover extended to loss of vision measured at 3/60 (currently 'total loss').
- **Cancer** – future-proofing changes with broadly no change to what is currently covered. Now excludes Binet stage 1 chronic lymphocytic leukaemia (a condition without symptoms) and makes clear that non-malignant conditions that can become malignant would not be covered unless and until they do so. These may become

increasingly common with improved screening and earlier diagnosis. Exclusions for cancers related to HIV have been removed for clarity. Insurers remain free to exclude HIV/AIDS but, if they do, this should use a specific policy exclusion which would then need to be clearly disclosed in sales literature.

- **Coronary artery by-pass surgery** – future-proofing changes to maintain the original concept covering median sternotomy (division of the breastbone) as this is a major surgical procedure. Minimally invasive procedures where the post-operative recovery time should be less are not covered.
- **Deafness** – cover extended to loss of 65db (currently 'total loss').
- **Heart attack** – cover is clarified to include other supporting clinical symptoms.
- **Heart valve replacement or repair** – future-proofing changes to maintain the original concept requiring median sternotomy (division of the breastbone) as this is a major surgical procedure. Minimally invasive procedures are not covered as the long-term prognosis is more favourable and the post-operative recovery time should be less.
- **Loss of limbs** – now covers loss of hands and feet rather than loss of the limbs from above the elbow or knee joints.
- **Major organ transplant** – future-proofing changes to maintain the current level of cover in line with the original concept (the transplant of complete organs). Does not cover injections of cells.
- **Motor neurone disease** – future-proofing changes requiring symptoms of the illness to support diagnosis to maintain the current level of cover in line with the original concept.
- **Parkinson's disease** – future-proofing changes requiring symptoms of the illness to support diagnosis to maintain the current level of cover in line with the original concept.
- **Stroke** – clarity and future-proofing requiring persisting symptoms of a stroke. Major head injuries are now covered under a separate new definition (see Annex 1).

Q6: Do you agree there is a need to change the current Statement of Best Practice to improve the degree of future-proofing in the model illness definitions?

Q7: Do you have any comments on the proposed definition wordings? Do you have alternative suggestions?

Introducing two levels of cover for cancer?

3.11 We are consulting on whether it would be appropriate to make a fundamental change to the structure of CI insurance products covered by the Statement of Best Practice by considering the introduction of a second, more restricted, cancer definition.

3.12 Many believe that the pace of medical advances and the unknown effects of these on cancer incidence, detection and treatment mean that even with the changes set out above the future is too uncertain to ensure that cancer could be properly priced to the current level of coverage.

3.13 Therefore, to introduce an even more robust element of future-proofing many companies now believe that they should be allowed to restrict the cancer element of cover to life threatening/more advanced cases. However such cover would be significantly less than the mandatory "full cover" provided for in the current ABI definition and thus would require extra product disclosure such as risk warnings to avoid any potential consumer detriment.

3.14 The definition of what a CI product actually is would have to change so that, as a minimum, the list of illnesses covered would be heart attack, stroke and the new, more restricted, cancer definition.

3.15 Introducing a second cancer definition would create a potential two-tier approach to cancer – with a "full" cancer definition and a "restricted" cancer definition which covers cancer arising in specific sites or cases where the cancer has spread. The proposed full definitions are set out in Annex 1 under the following proposed new headings:

- **"Full" cancer cover:** Cancer - *malignant and invasive (with exclusions)*
- **"Restricted" cancer cover:** Cancer - *specified sites or with spread*

3.16 We believe that this could be in the interests of consumers for the following reasons.

- **Consumer need** – the proposed "restricted" cancer definition covers the more serious cases where the need for financial protection is usually greater. It also covers cases where the initial diagnosis is at an earlier stage but where the cancer subsequently spreads, perhaps because the initial treatment is not successful.
- **Availability** – a more restricted cancer definition should help ensure that CI insurance continues to be available as a form of protection insurance.
- **Affordability** – CI insurance policies with a more restricted cancer definition, or offering a tiered cover approach, should be more affordable than those offering only full cancer cover.
- **Choice** – there may be a wider range of CI insurance product types available for consumers to choose from, depending on their budget and financial needs.

3.17 Whilst there are clear advantages, in making this change we need to recognise that the restricted cancer definition would provide significantly less cover. For example, early stage breast cancer would not be covered. Accordingly, insurers and advisors would need to ensure that consumers are aware of the scope of the cover they are considering so that they can make an informed buying decision. This will require clear disclosure of this information before the sale is concluded (for example, in product literature and web sites).

The gap between the two cancer definitions

3.18 There would be a "gap" in cover between the full cancer definition and the restricted cancer definition. Poor explanation of the differences in definitions in literature and by advisors could introduce more confusion into the CI sale. This "gap" therefore needs to be addressed to minimise any possible confusion.

3.19 There are several ways that companies might structure their products should we introduce a more restricted cancer definition.

3.19.1 They could offer only "restricted cover" (with consequent lower premiums) – customers would need to be made aware that other companies may offer "full cover" and the implications for themselves and their families of taking out the "restricted cover"

3.19.2 They could use a definition that offers better cover than "restricted cover" but more limited than "full cover" – this would mean three or more cancer definitions. If totally unregulated it could mean many more definitions being introduced by individual insurers – precisely the confusing situation that the OFT report and the ABI Statement of Best Practice intend to avoid.

3.19.3 They could introduce "staged products" i.e. products that pay out a proportion of benefit for early stage ("full cover" definition) cancer and the rest if the cancer meets the "restricted cover" definition. Such products are already common in South Africa – where CI originally came from. In addition it would at least offer some payout on satisfying of the "full cover" definition.

3.19.4 They could continue to offer "full" cancer cover, or in excess of "full cover", as at present.

How would we manage the gap?

3.20 To ensure that the cover gap does not cause consumer detriment we are faced with six possible options as follows:

3.20.1 Only allow companies to offer "full cover" under the CI product name – i.e. do not allow the development of a more restricted version except under a different product name. This would maintain the current position and avoid any potential consumer detriment caused by having different definitions in products described as "Critical Illness" but does not address the concerns about cover for cancer.

3.20.2 Allow only the two levels of cancer cover and insist that companies adopt a "staged" approach – i.e. force companies to give some payout on the "full cover" definition. This would preserve a degree of the existing cover but would prevent companies offering only the "restricted cover".

3.20.3 Allow only two levels of cover but do not insist on "staging" – i.e. insurers would be able to offer "full cover", the staged product or "restricted cover". This option would give significant consumer choice and would allow the market to address risk-pricing problems and still sell CI. On the other hand consumers would have to be told absolutely clearly what they were buying if they opted for the "restricted" or "staged" cover.

3.20.4 Allow the two layers of cover and allow a prescribed range of definitions between the two layers of cover. This would give further consumer choice but could lead to confusion over meanings of definitions and would be unwieldy to administer and communicate clearly.

3.20.5 Prescribe the lower level of cancer cover as the minimum standard but also publish the "full cover" definition if companies wish to use it and allow any level of cover in between, or more cover. This would give maximum consumer choice but could move to the confusion that existed prior to the OFT report on cancer definitions.

3.20.6 Only offer the lower level of cancer cover as the minimum standard.

3.21 Following initial discussions with the FSA, if we do permit a move from compulsory "full cover", option (3.20.3) above would be our preferred option to manage the gap.

Q8: Do you support the principle of a having a second cancer definition?

Q9: If we introduce a second cancer definition, do you agree with the ABI recommendation to manage the gap?

Q10: How could the communication of the breadth of cover be made easier for advisers to explain and for consumers to understand?

Other changes to the Statement of Best Practice

Streamlining the illness categories

3.22 There has been some confusion over the use of the terms "Core" and "Additional" conditions. These terms date back to the early days of CI products when some insurers offered plans with selectable groups of illnesses. Few insurers now make this distinction so the labels "Core" and "Additional" no longer carry any meaning and, in many cases, add extra complexity which leads to confusion.

3.23 We therefore recommend that we no longer use these obsolete labels but that the requirements of the Statement remain unchanged.

Q11: Do you support the principle of streamlining the illness categories?

Extending the range of model illness definitions

3.24 We would like to thank Defaqto for conducting a survey on behalf of the CI Working Party into the breadth of cover offered by CI providers in the UK.

3.25 Their report shows that since the original Statement of Best Practice was published the number of conditions and exclusions covered by companies has increased. Consequently some conditions for which we originally decided not to draft model definitions because they were not widely available now appear on more than 75% of CI products.

3.26 Taking together this research and other recommended changes to the model definitions, we therefore propose adding new model definitions for the following conditions:

- Alzheimer's disease - *with permanent symptoms [before age x]*
- HIV - *contracted [in the UK] from a blood transfusion, a physical assault or at work [in an eligible occupation]*
- Major head injury - *with symptoms of permanent brain damage*

3.27 You can find the new definitions in Annex 1.

Q12: Do you have any comments on the proposed wordings or headings for these new ABI definitions? Do you have alternative suggestions?

Generic terms

3.28 To further strengthen the proposed future-proofing of the CI definitions we propose to link the generic terms set out in the Statement to the model definitions. This would mean that insurers would have to include the generic terms in their policy conditions, where they are used within ABI model CI definitions.

3.29 We also propose to add a new generic term that would be used in the following proposed new and amended model definitions:

- Benign brain tumour - *with symptoms of permanent brain damage*
- Coma - *with symptoms of permanent brain damage*
- Major head injury - *with symptoms of permanent brain damage*
- Stroke - *with symptoms of permanent brain damage*

3.30 The new generic term is – "Persisting clinical symptoms of permanent neurological deficit". You can find the full term in Annex 1.

Q13: Do you support the principle of linking the generic terms to the definitions?

Q14: Do you have any comments on the new proposed generic term? Do you have an alternative suggestion?

Future work

3.31 **Update the Definitions Guide** – the ABI has published a guide to the existing model illness and exclusion wordings which is available on the ABI website at www.abi.org.uk. After the new definitions are finalised following this consultation, we will update the definitions guide accordingly.

3.32 **Work on Total Permanent Disability (TPD)** – this is out of scope for this review. Whilst certain components within the definition relating to occupation and permanence are covered within the Statement of Best Practice, the benefit in its entirety is not. Given the number of providers offering TPD, we would like to consider how best to improve consumer clarity about what TPD does, and does not, cover to help reduce the number of declined industry claims for this condition.

3.33 **Radical new product design** – this is out of scope for this review. Some people believe that consumers would benefit from an entirely different approach, perhaps incorporating some elements of income protection and/or some overriding requirement for a level of disability. The work on an "Underpin" concept based on severity is ongoing to consider its feasibility.

Transitional Arrangements

3.34 Following the consultation, we will publish the revised Statement of Best Practice for Critical Illness Cover. At that time we will also publish a transition timetable to allow insurers to review and amend their policies and literature for new business as appropriate. However, given the nature of the changes, we do not expect that insurers will be obliged to make any changes before the end of 2006 although, as soon as the revised Statement is published, insurers will be free to make any required changes earlier if they wish to do so.

4. What we need from you

4.1 The full list of questions for which we are inviting replies as part of the consultation exercise is as follows:

Q1: Do you agree there is a need to change the current Statement of Best Practice to improve clarity?

Q2: Do you support the principle of changing the product name? If so, which new name do you prefer? Do you have an alternative suggestion?

Q3: Do you support including a generic description of the product in product literature? Do you have comments on the proposed wording?

Q4: Do you support the principle that headings should be more descriptive?

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Q13: Do you support the principle of linking the generic terms to the definitions?

Q14: Do you have any comments on the new proposed generic term? Do you have an alternative suggestion?

Replying to this Consultation Paper

4.2 Views are invited on this consultation document. Please send your responses to arrive by 30th November 2005 to Richard Walsh, Head of Health, at one of the following:

- Post: Association of British Insurers, 51 Gresham Street, London EC2V 7HQ
- E-mail: richard.walsh@abi.org.uk

Annex 1 – Possible New Definitions with Headings and New Generic Term

Existing definition	Possible future definition	Reason for change	Level of cover
Aorta graft surgery Undergoing surgery for disease of the aorta needing excision and surgical replacement of a portion of the diseased aorta with a graft. For this definition, aorta means the thoracic and abdominal aorta but not its branches.	**Aorta Graft Surgery** The undergoing of surgery for disease of the aorta with excision and surgical replacement of a portion of the diseased aorta with a graft. For this definition, aorta means the thoracic and abdominal aorta but not its branches. Surgery following traumatic injury to the aorta is not covered.	Clarity. Heading and definition changed to make it clear that surgery to the aorta due to injury is not covered.	Same
Benign brain tumour A non-malignant tumour in the brain resulting in permanent deficit to the neurological system. Tumours or lesions in the pituitary gland are not covered.	**Benign brain tumour - *with symptoms of permanent brain damage*** A non-malignant tumour in the brain, meninges or cranial nerves within the skull resulting in persisting clinical symptoms of permanent neurological deficit. The following are not covered: • tumours or lesions in the pituitary gland • angiomas	Clarity. Heading and definition changed to make it clear that "permanent neurological deficit with persisting clinical symptoms" required for a valid claim. Definition changed to make clear that cover extends to cranial nerves and meninges.	Same
Blindness Total permanent and irreversible loss of all sight in both eyes.	**Blindness - *permanent*** Permanent and irreversible loss of sight to the extent that even when tested with the use of spectacles, vision is measured at 3/60 or worse in the better eye using a Snellen eye chart.	1. Clarity. Heading changed to make it clear that blindness has to be permanent 2. More cover. Cover extended to loss of vision at 3/60 rather than total loss of vision.	More
Cancer Any malignant tumour characterised by the uncontrolled growth and spread of malignant cells and invasion of tissue. The term cancer includes leukaemia and Hodgkin's disease but the following are excluded: • All tumours which are histologically described as pre-malignant, as non-invasive or as cancer in situ. • All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least TNM classification T2N0M0. • All forms of lymphoma in the presence of any Human Immunodeficiency Virus. • Kaposi's sarcoma in the presence of any Human Immunodeficiency Virus. • Any skin cancer other than invasive malignant melanoma.	**Cancer - *malignant and invasive (with exclusions)*** Any malignant tumour characterised by the uncontrolled growth of malignant cells and invasion of tissue. The term malignant tumour includes leukaemia, lymphoma and sarcoma but the following are not covered: • All tumours which are histologically classified as pre-malignant, as non-invasive, as cancer in situ, or as having either borderline malignancy or low malignant potential. • Non-malignant conditions that can become malignant, including essential thrombocythaemia and polycythaemia rubra vera. • All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0. • All cancers arising in the skin other than malignant melanoma histologically classified as having progressed to at least Clark's Level II. • Chronic lymphocytic leukaemia unless histologically classified as having progressed to at least RAI or Binet Stage 1.	Clarity – removed the words "and spread" which could misleadingly imply spread beyond the site of origin and is not felt to be necessary in the opening paragraph Clarity - "or as having either borderline malignancy or low malignant potential". These are terms used to describe ovarian tumours and are histological classifications. Clarity – essential thrombocythaemia and polycythaemia rubra vera are myeloproliferative disorders which are not malignant but which can become malignant. Addition of "clinical" due to potential reclassification. Clarity - Skin cancer exclusion amended to make clear Clark Level 1 is not covered Future-proofing – Excluding "Chronic lymphocytic leukaemia … Binet Stage 1 guards against paying claims for conditions without symptoms. Removed HIV exclusions. Insurers are free to exclude HIV/AIDS but, if they do, this should be specifically excluded and disclosed in sales literature.	Essentially the same. We have removed the exclusions related to HIV but introduced an exclusion for pre-Binet Stage 1 CLL – a condition without symptoms that is likely to increasingly be diagnosed through future developments in diagnostics and screening.

There is currently no "restricted" cancer definition	**Cancer - *specified sites or with spread*** Any malignant tumour characterised by the uncontrolled growth of malignant cells and invasion of tissue that has either: • originated in the brain, gall bladder, liver, lung, oesophagus, pancreas or stomach; or • spread beyond its site of origin (spread to regional lymph nodes, involved adjacent structures and/or has distant metastases). The term malignant tumour includes leukaemia, lymphoma and sarcoma but the following are not covered: • Non-malignant conditions that can become malignant, including essential thrombocythaemia and polycythaemia rubra vera. • Chronic lymphocytic leukaemia unless histologically classified as having progressed to at least RAI or Binet Stage 1. • Lymphoma limited to one region of lymph nodes.	Future-proofing – guards against shift in diagnoses to more diagnosis while cancer is localised and which have a better prognosis. Covers cancer arising in specific sites or cases where the cancer has spread Clarity – as above	Significantly less than the existing and proposed definitions for cancer above unless used as part of a two tier approach in conjunction with above definition
Coma A state of unconsciousness with no reaction to external stimuli or internal needs, persisting continuously with the use of life support systems for a period of at least 96 hours and resulting in permanent neurological deficit. Coma secondary to alcohol or drug misuse is not covered.	**Coma - *with symptoms of permanent brain damage*** A state of unconsciousness with no reaction to external stimuli or internal needs which: • requires the use of life support systems for a continuous period of at least 96 hours; and • results in persisting clinical symptoms of permanent neurological deficit. Coma secondary to alcohol or drug misuse is not covered.	Clarity. Heading and definition changed to make it clear that "permanent neurological deficit with persisting clinical symptoms" is required for a valid claim.	Same
Coronary artery by-pass surgery The undergoing of open heart surgery on the advice of a Consultant Cardiologist to correct narrowing or blockage of one or more coronary arteries with by-pass grafts but excluding balloon angioplasty, laser relief or any other procedures.	**Coronary artery by-pass grafts - *with major surgery*** The undergoing of major surgery requiring median sternotomy (division of the breastbone) on the advice of a Consultant Cardiologist to correct narrowing or blockage of one or more coronary arteries with by-pass grafts.	Future-proofing changes to maintain the original concept covering median sternotomy (division of the breastbone) as this is a major surgical procedure. Minimally invasive procedures where the post-operative recovery time should be less are not covered.	Same compared to original concept but possibly less than today's definition depending on how widely "open heart surgery" is construed
Deafness Total permanent and irreversible loss of all hearing in both ears.	**Deafness - *permanent*** Permanent and irreversible loss of hearing to the extent that even when tested using hearing aids, the loss is greater than 65 decibels in the better ear measured using an audiogram.	1. Clarity. Heading makes it clear that deafness has to be permanent 2. More cover. Cover extended to deafness of 65 db or more rather than total loss of hearing.	More

Heart attack The death of a portion of heart muscle, due to inadequate blood supply, that has resulted in all of the following evidence of acute myocardial infarction: • typical chest pain; • new characteristic electrocardiographic changes; • the characteristic rise of cardiac enzymes, troponins or other biochemical markers; where all of the above shows a definite acute myocardial infarction. Other acute coronary syndromes, including but not limited to angina, are not covered under this definition.	**Heart attack - *with ECG changes and specified clinical evidence*** The death of a portion of heart muscle, due to inadequate blood supply, that has resulted in all of the following evidence of acute myocardial infarction: • typical clinical symptoms (for example, characteristic chest pain); • new characteristic electrocardiographic changes; • the characteristic rise of cardiac enzymes, troponins or other biochemical markers; where all of the above shows a definite acute myocardial infarction. Other acute coronary syndromes, including but not limited to angina, are not covered under this definition.	Cover is extended to include other supporting clinical symptoms	More
Heart valve replacement or repair Undergoing open heart surgery from medical necessity to replace or repair one or more heart valves.	**Heart valve replacement or repair - *with major surgery*** The undergoing of major surgery requiring median sternotomy (division of the breastbone) on the advice of a Consultant Cardiologist to replace or repair one or more heart valves.	Future-proofing changes to maintain the original concept covering median sternotomy (division of the breastbone) as this is a major surgical procedure. Minimally invasive procedures are not covered as the long-term prognosis is more favourable and the post-operative recovery time should be less.	Same compared to original concept but possibly less than today's definition depending on how widely "open heart surgery" is construed.
Kidney failure End stage renal failure presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis or renal transplant is initiated.	**Kidney failure - *end stage*** End stage kidney failure presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular kidney dialysis or kidney transplant is initiated.	Clarity. Heading changed to make it clear that only "end stage" kidney failure is covered.	Same
Loss of limbs The permanent physical severance of two or more limbs from above the *[elbow/wrist]* or *[knee/ankle]* joint.	**Loss of hands or feet - *permanent*** Permanent physical severance of any combination of more than one hand or foot at or above the wrist or ankle joints.	Clarity. The minimum standard now ensures all insurers cover loss of hands and feet rather than loss of the limbs from above the elbow or knee joints. This is in line with current market practice.	More
Loss of speech Total permanent and irreversible loss of the ability to speak as a result of physical injury or disease.	**Loss of speech - *permanent*** Total permanent and irreversible loss of the ability to speak as a result of physical injury or disease.	Clarity. Heading changed to make it clear that loss of speech has to be permanent.	Same
Major organ transplant The actual undergoing as a recipient of, or inclusion on an official UK waiting list for, a transplant of a heart, liver, lung, pancreas or bone marrow.	**Major organ transplant** The undergoing as a recipient of a transplant of bone marrow or of a complete heart, liver, lung, or pancreas, or inclusion on an official UK waiting list for such a procedure. Injections of cells into organs to generate growth are not covered.	Future-proofing and clarity that injection of cells (rather than an entire organ transplant) is not covered.	Same

Motor neurone disease [before age x] Confirmation by a Consultant Neurologist of a definite diagnosis of motor neurone disease [before age x].	**Motor neurone disease [before age x] - *with permanent symptoms*** A definite diagnosis by a Consultant Neurologist of motor neurone disease [before age x] using techniques current at the time of the claim. There must be permanent clinical impairment of motor function.	Future-proofing. Guards against possibility of diagnosis being made before symptoms have manifested.	Same
Multiple sclerosis A definite diagnosis by a Consultant Neurologist of Multiple Sclerosis which satisfies all of the following criteria: • There must be current impairment of motor or sensory function, which must have persisted for a continuous period of at least six months. • The diagnosis must be confirmed by diagnostic techniques current at the time of the claim.	**Multiple sclerosis - *with persisting symptoms*** A definite diagnosis by a Consultant Neurologist of Multiple Sclerosis which satisfies all of the following criteria: • There must be current impairment of motor or sensory function, which must have persisted for a continuous period of at least six months. • The diagnosis must be confirmed by diagnostic techniques current at the time of the claim.	Clarity. Heading changed to make it clear that there must be "persisting symptoms".	Same
Paralysis / paraplegia Total irreversible loss of muscle function or sensation to the whole of any two limbs as a result of injury or disease. The disability must be permanent and supported by appropriate neurological evidence.	**Paralysis - *permanent*** Permanent and irreversible loss of muscle function, or sensation, affecting the whole of any two arms or legs.	Clarity. Heading changed to make it clear that symptoms must be "permanent". Paraplegia is a sub-set of paralysis and continues to be covered as before.	Same
Parkinson's disease [before age x] Confirmation by a Consultant Neurologist of a definite diagnosis of Parkinson's disease [before age x]. Parkinson's disease secondary to alcohol or drug misuse is not covered.	**Parkinson's disease [before age x] - *with permanent symptoms*** A definite diagnosis by a Consultant Neurologist of Parkinson's disease [before age x] which satisfies all of the following criteria: • There must be permanent impairment of motor function, with associated tremor and rigidity of movement. • The diagnosis must be confirmed by diagnostic techniques current at the time of the claim. Parkinson's disease secondary to drug misuse is not covered.	1. Clarity. Heading changed to make it clear that symptoms must be "permanent". 2. Future-proofing. Guards against possibility of diagnosis being made before symptoms have manifested. 3. Clarity. Alcohol dropped from exclusion. According to expert medical opinion you can't develop Parkinson's from alcohol misuse.	Same
Stroke A cerebrovascular incident resulting in permanent neurological damage. Transient Ischaemic Attacks are specifically excluded.	**Stroke - *with symptoms of permanent brain damage*** The death of brain tissue due to inadequate blood supply or sub-arachnoid or other intracranial haemorrhage, resulting in persisting clinical symptoms of permanent neurological deficit. The following are not covered: • Transient ischaemic attacks • Traumatic injury to brain tissue or blood vessels	1. Clarity. Heading changed to make it clear that "permanent neurological deficit" is required for a valid claim. 2. Definition makes clear that stroke caused by traumatic injury is not covered. Consumer will be able to compare products easier as some already cover traumatic brain injury separately.	Same when "major head injury - *with persisting symptoms of brain damage* " is included under new separate definition (see below)
Terminal illness Advanced or rapidly progressing incurable illness where, in the opinion of an attending Consultant and our Chief Medical Officer, the life expectancy is no greater than 12 months. *[AIDS is specifically excluded and not covered under this definition.]*	**Terminal illness** Advanced or rapidly progressing incurable illness where, in the opinion of an attending Consultant and our Chief Medical Officer, the life expectancy is no greater than 12 months. *[AIDS is not covered under this definition.]*	Delete "specifically excluded and" because words are unnecessary.	Same

Third degree burns Third degree burns covering at least 20% of the body surface area.	**Third degree burns - *extensive*** Burns that involve damage or destruction of the skin to its full depth through to the underlying tissue covering at least 20% of the body surface area.	Clarity. Heading indicates that the definition has a qualification in terms of the extent of the burns.	Same

New definitions

Alzheimer's disease [before age x] - *with permanent symptoms*

A definite diagnosis of Alzheimer's disease [before age x] by a Consultant Neurologist, Psychiatrist or Geriatrician using techniques current at the time of the claim. There must be evidence of progressive and permanent loss of the ability to:

- remember;
- reason; and
- perceive, understand, express and give effect to ideas.

Other causes of dementia are not covered.

HIV - *contracted [in the UK][2] from a blood transfusion, a physical assault or at work [in an eligible occupation]*

Infection by Human Immunodeficiency Virus resulting from:

- a blood transfusion given as part of medical treatment;
- a physical assault; or
- an incident occurring during the course of performing normal duties of employment [*from the eligible occupations listed below*][1];

and all of the following are satisfied:

- The incident causing a potential claim must be supported by a negative HIV antibody test taken within 5 days of the incident.
- The incident must have been reported to appropriate authorities and have been investigated in accordance with the established procedures.
- [The incident causing infection must have occurred in the UK] [2].

HIV infection resulting from any other means, including sexual activity or recreational drug use is not covered.

[1]Note: include specified occupations if applicable
[2]Note: include geographic limits as applicable

Major head injury - *with symptoms of permanent brain damage*

Traumatic injury to the brain resulting in persisting clinical symptoms of permanent neurological deficit.

New generic term for use with definitions

Persisting clinical symptoms of permanent neurological deficit

Persisting clinical symptoms of dysfunction in the nervous system, but the following are not included:
- Abnormalities seen on brain or other scans without definite related clinical symptoms.
- Neurological signs occurring without symptomatic abnormality (for example, brisk reflexes without other symptoms).
- Symptoms of psychological or psychiatric origin.
- Residual neuro-psychological deficit due to secondary factors such as depression and post-traumatic stress disorder.

Note: used in the following proposed definitions:
- **Benign brain tumour** - *with symptoms of permanent brain damage*
- **Coma** - *with symptoms of permanent brain damage*
- **Major head injury** - *with symptoms of permanent brain damage*
- **Stroke** - *with symptoms of permanent brain damage*