Underwriting

Mental Illnesses

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SCOR Global Life

Underwriting Mental Illnesses

1	Introduction and definition
2	Basic concept
3	Classification and Diagnostic Criteria
4	The Challenges
5	Glossary
6	Case studies
7	Q & A

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WHO Definition of Health

Health is a state of

complete physical, mental and social well-being

and not merely the absence of disease or infirmity

Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States
(Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.
The Definition has not been amended since 1948.

WHO Definition of Mental Health

Mental health is defined as

a state of well-being

in which every individual realizes his or her own potential,

can cope with the normal stresses of life,

can work productively and fruitfully,

and is able to make a contribution to her or his community.

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Mental Health facts

- Around 20% of the world's children and adolescents have mental disorders or problems
- Mental and substance use disorders are the leading cause of disability worldwide
- About 800,000 people commit suicide every year
- Mental disorders are important risk factors for other diseases, as well as injuries
- Stigma and discrimination prevent people from seeking mental health care
- There is huge inequity in the distribution of skilled human resources for mental health
- Financial resources to increase services are relatively modest

http://www.who.int/features/factfiles/mental_health/mental_health_facts/en/

Mental Disorder

A clinically significant psychological or behavioral syndrome that causes significant

- *Distress (subjective)*
- *Disability (objective)*
- *Or loss of freedom*

which is not merely a socially deviant behavior or an expected response to a stressful life event.

Mental Disorder

Should be a manisfestation of

- *Behavioural*
- *Psychological*
- *And/or biological*

dysfunction.

Normal Mental Health

1. Reality orientation
2. Self-awareness and self-knowledge
3. Self-esteem and self-acceptance
4. Ability to exercise voluntary control over behavior
5. Ability to form affectionate relationship
6. Pursuance of productive and goal-directive activities

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Classification

- Syndromal approach
- Enable communication
- Facilitate comprehension of the underlying causes
- Aid in prognosis

Classification

Chapter V
Mental and behavioural disorders
(F00-F99)

Incl.: disorders of psychological development

Excl.: symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)

This chapter contains the following blocks:

F00-F09	Organic, including symptomatic, mental disorders
F10-F19	Mental and behavioural disorders due to psychoactive substance use
F20-F29	Schizophrenia, schizotypal and delusional disorders
F30-F39	Mood [affective] disorders
F40-F48	Neurotic, stress-related and somatoform disorders
F50-F59	Behavioural syndromes associated with physiological disturbances and physical factors
F60-F69	Disorders of adult personality and behaviour
F70-F79	Mental retardation
F80-F89	Disorders of psychological development
F90-F98	Behavioural and emotional disorders with onset usually occurring in childhood and adolescence
F99-F99	Unspecified mental disorder

Asterisk categories for this chapter are provided as follows:

F00*	Dementia in Alzheimer disease
F02*	Dementia in other diseases classified elsewhere

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Challenges

- For a large majority of mental illnesses, no distinct aetiology is known
- Absence of objective and specific diagnostic test
- Diagnostic criteria application might not be consistent
- Diagnostic criteria could overlap
- Non-disclosure, misrepresentation is common
- Regular follow up is exception rather than the rule

Multi-axial classification

The Five Axes of DSM-III to DSM-IV-TR

AXIS I: Clinical Psychiatric Diagnosis

AXIS II: Personality Disorders and Mental Retardation

AXIS III: General Medical Conditions

AXIS IV: Psychosocial and Environmental Problems

AXIS V: Global Assessment of Functioning

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Glossary of some important terms

- Affect : The outward expression of the immediate (cross-sectional) experience of emotion at a given time.
- Anhedonia : Inability to experience pleasure
- Confabulation : A false memory that is believed to be true
- *Déjà vu* vs *Jamais vu*

Glossary of some important terms

- Delusion : A false, unshakable belief which is not amenable to reasoning, and is not in keeping with the socio-cultural and Educational background.
- Hallucination : A perception that occurs in the absence of a stimulus
- Illusion : A misinterpretation of stimuli arising from external object

Schizophrenia

- Arguably the worst disease affecting mankind
- “Cancer of mental illness”
- Systematic study is only a century old
- 1896 Emil Kraepelin : Dementia praecox vs MD illness
- 1911 Eugen Bleuler renaming as Schizophrenia
- 1959 Kurt Scheider “First rank symptoms”

Schizophrenia

- Point prevalence is about 0.5 – 1%
- Incidence about 0.5 per 1000
- Diagnosis is clinical
- Several subtypes – eg. paranoid schizophrenia
- Aetiology - unknown

Schizophrenia

- Prognosis – half to two-third favorable, one third intermediate
- Treatment – pharmacological, ECT, misc.
- Suicidal risk
- Risk of other mental disorders, eg substance abuse
- Ability to enter contract
- Approximately twofold increase in overall mortality

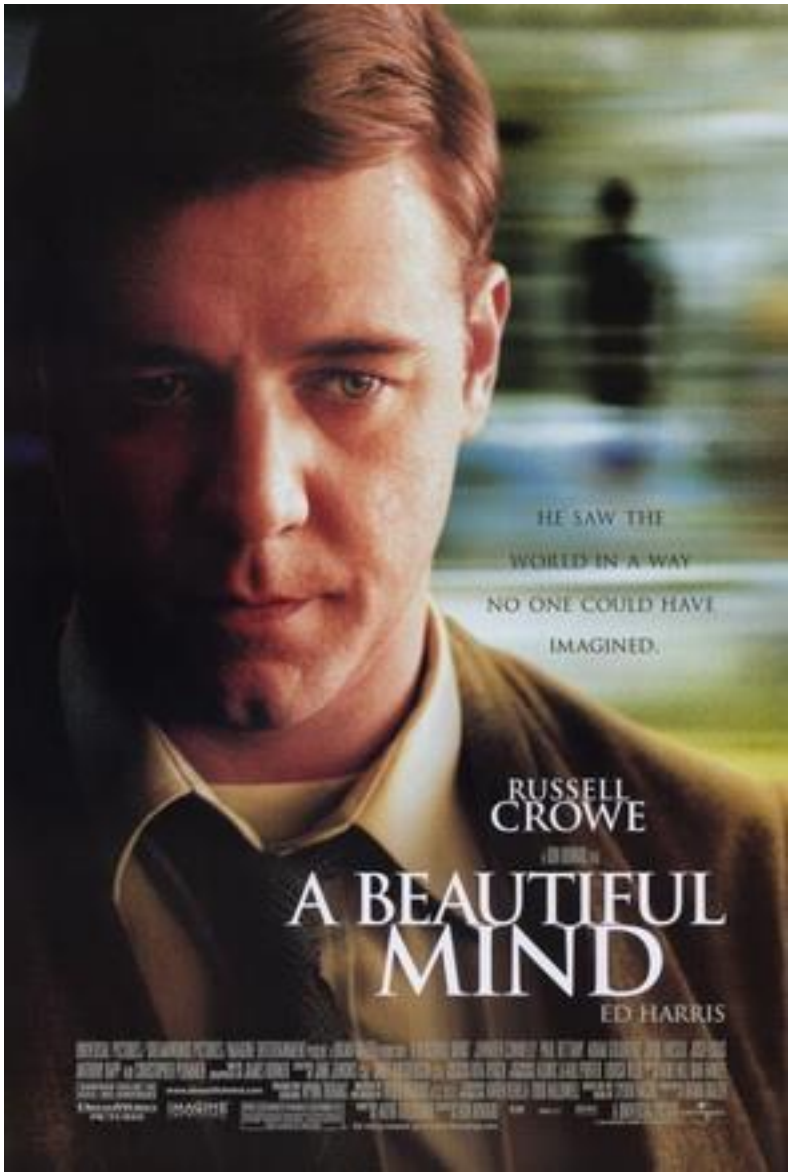
Schizophrenia

Rating

Appreciation elements		Life	Accidental Death	Income Protection (dp < 30 d)	Income Protection (dp 30-90 d)	Income Protection (dp > 90 d)	T.P.D. ADW/ADL	Critical Illness
Above information incomplete or missing	○	Postpone	Postpone	Decline	Decline	Decline	Decline	Decline
History of alcoholism or drug abuse	○	Decline	Decline	Decline	Decline	Decline	Decline	Decline
Otherwise								
Stable, well controlled and compliant with treatment								
0 - 2 years after last acute episode or hospitalisation	○	Postpone	Postpone	Decline	Decline	Decline	Decline	Decline
2 - 5 years	○	+200	+50	Decline	Decline	Decline	Decline	Decline
Thereafter	○	+150	+50	Decline	Decline	Decline	Decline	Decline
Poorly controlled, untreated or not compliant with treatment	○	Decline	Decline	Decline	Decline	Decline	Decline	Decline

Additional Factors

Appreciation elements		Life	Accidental Death	Income Protection (dp < 30 d)	Income Protection (dp 30-90 d)	Income Protection (dp > 90 d)	T.P.D. ADW/ADL	Critical Illness
No hospitalisation in psychiatric department	☐	-50	+0	Decline	Decline	Decline	Decline	Decline
History of hospitalisation in psychiatric department								
2 - 5 years	☐	+50	+0	Decline	Decline	Decline	Decline	Decline
5 - 10 years	☐	+25	+0	Decline	Decline	Decline	Decline	Decline
Thereafter	☐	-25	+0	Decline	Decline	Decline	Decline	Decline


HE SAW THE
WORLD IN A WAY
NO ONE COULD HAVE
IMAGINED.
RUSSELL
CROWE
A BEAUTIFUL
MIND
ED HARRIS

Mood Disorders

- *Emotions* can be described as two main types:
  - *Affect*, which is a short-lived emotional response
  - *Mood*, which is sustained and pervasive
- Depression and Mania
- Bipolar Mood Disorder – used to be MDP
- WHR 2001 estimates that 121 million people worldwide sufferring from depression

Manic Episode

- Life-time risk of manic episode is about 1%
- Episodes lasting usually 3-4 months
- Complete clinical recovery
- Future episodes can be manic, depressive or mixed

Manic Episode

- Stage I – Euphoria
- Stage II – Elation
- Stage III – Exaltation
- Stage IV - Ecstasy

Depressive Episode

- Life-time risk of depression
  - Male 10%
  - Female 20%

Depressive Episode

- Depressive mood
- Depressive ideation/cognition
- Psychomotor activity
- Physical symptoms
- Biological functions
- Psychotic features
- Suicide

Mood Disorders

- Generally better prognosis than Schizophrenia
- Complete recovery between episodes
- However, still extra-mortality

Bipolar Disorder

Rating

Appreciation elements		Life	Accidental Death	Income Protection (dp < 30 d)	Income Protection (dp 30-90 d)	Income Protection (dp > 90 d)	T.P.D. ADW/ADL	Critical Illness
Above information incomplete or missing	○	Postpone	Postpone	Decline	Decline	Decline	Decline	Postpone
Hospital admission for neuropsychic disorder or severe episode within last 12 months	○	Postpone	Postpone	Decline	Decline	Decline	Decline	Postpone
Otherwise								
Well controlled, regular follow-up, good compliance, medical treatment and/or psychotherapy								
0 - 6 months since last episode	○	Postpone	Postpone	Decline	Decline	Decline	Decline	Exclusion (1)
6 - 12 months	○	+175	+50	Decline	Decline	Decline	Decline	Exclusion (1)
1 - 3 years	○	+125	+50	Decline	Decline	Decline	Decline	Exclusion (1)
3 - 5 years	○	+100	+25	Decline	Decline	Decline	Decline	Exclusion (1)
Thereafter	○	+75	Standard	Decline	Decline	Decline	Decline	Exclusion (1)
Poorly controlled, untreated and/or not compliant with treatment and/or treated by ECT (electro convulsive therapy), and/or several hospital admissions	○	Decline	Decline	Decline	Decline	Decline	Decline	Decline

Underwriting Approach

- Underwrite overall risk profile
- Look for indicators of good mental health
  - Functionality – occupation
  - Relationship – marriage
- MER
  - Appearance
  - Grooming
- Mental Health Q/APS

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FINANCIAL REVIEW

Jun 29 2013 at 12:05 AM | Updated Jun 30 2013 at 12:47 AM

Life insurers hit by mental health claims

New criteria from the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* or DSM-5, colloquially known as the "psychiatrist's bible", could fuel an influx of healthy individuals being diagnosed with medical conditions and make them eligible for insurance claims, said Dr Doron Samuell , medical director of Corporate Health Services. He argues that the "threshold in almost every category of making a diagnosis has lowered".

Australia's life insurance industry is besieged, and conditions are tipped to worsen as insurers grapple with soaring claims, cost-conscious consumers prepared to axe their cover, and lower barriers for mental illness claims.

The twin pressures of rising claims costs and clients cancelling ch have hit some of Australia's biggest insurers including AMP , ure – come as players struggle to find concrete solutions to their

lso been suffering from falling investment income, as interest mic levels and lower-than-anticipated long-term returns from

al models used by insurers to predict lapse rates and loss experiences have also failed to map out the severity of today's losses, University of NSW associate professor and financial services expert John Evans said.

"The bottom line is all your worse nightmares have suddenly hit at once. If you get lapse rates wrong, you end up writing off the front end commission [from sold policies], and if lapse rates jump dramatically then you're going to make a loss," he said.

Australia's first challenge to discrimination by insurers against people with a mental illness

Monday, 26 October 2015

A young Melbourne woman, in an Australian-first discrimination case, is challenging an insurance company's decision to reject her travel insurance claim after she was hospitalised with depression.

Ella Ingram, represented by Victoria Legal Aid, had no pre-existing illness when she was diagnosed with major depression in February 2012. She was 17 years old. On medical advice Ms Ingram had to cancel an overseas school trip she had booked in late 2011.

https://www.theguardian.com/business/2015/dec/18/qbe-insurance-discriminated-against-student-with-depression-says-tribunal

Insurance discrimination: your rights if you have a mental health condition

Often insurance companies do not seem to know how to deal with the complexities of mental health. They may say you present a high level of risk if you have or had a mental illness, and may not take your individual circumstances into account.

You have rights if an insurance company rejects your claim, denies you cover or asks you to pay a higher premium because of your mental health.

What the law says

Commonwealth and state laws say that it is wrong to discriminate against someone on the basis of a disability, which includes a mental illness, unless certain conditions apply.

An insurance company can *only* discriminate against you if their decision:

- is based on reasonable actuarial and statistical data and
- is reasonable, taking into account that data and other relevant factors, for example the type of illness, its severity, how much it impacts you, and your treatment or recovery plan.

Even with these laws in place, many insurance companies may not use the right data or consider the full range of relevant factors in dealing with people who tell an insurer about their mental health.

https://www.legalaid.vic.gov.au/find-legal-answers/consumer-complaints/insurance-discrimination-your-rights-if-you-have-mental-health-condition

SCOR Global Life Australia Claims Work Sheet

Claimant:	SW	
Date of Birth:	02/09/69 Male	
Claiming:	IP	$12,576.04/month, 90 day WP, Age 65
	Super	$1,676.80/month
	Total	**$14,254.84/month**
Joined Fund:	07/04/15	
Cause of Claim:	Depression and anxiety	
Date of Claim:	13/03/16	
Summary at time of Claim:	***Claim forms dated 04/04/16:*** - *DLAW 11/03/16* - *Dx, depression and anxiety in addition to relationship difficulties affecting ability to work* - *Symptoms commenced 13/03/16* - *Dx made on 17/03/16* - *Attended by Doctors of N from August 2015* - *Referred to KB, psychologist* - *Admitted to N Hospital from 13/03/16 to 17/03/16* - *RTW, partial plan includes day and outreach programs provided by the M Clinic, RTW still to be developed with T* - *Was prescribed anti-depressants from August 2015* - *Occupation, National O & M Program Manager* - *Been in role 1 year* - *Travels interstate to Sydney and Brisbane* - *RTW, part-time from 06/06/16 and full-time from 02/11/16, subject to doctors approval*	

SCOR Global Life Australia Claims Work Sheet

Claimant:	GC	
Date of Birth:	1973 Female	
Claiming:	IP	$14,613/month,
Joined Fund:	2015	
Cause of Claim:	Exhaustion	
Date of Claim:	21/10/15	
Summary at time of Claim:	***Claim forms dated 21/12/15:*** - *DLAW 21/10/15* - *Symptoms commenced 19/10/15* - *Dx made on 19/10/15* - *Symptoms include dizziness, nausea, headaches, pain in back of eyes* - *Attended Dr B on 19/10/15, known doctor for 3-4 months* - *Also consulted Dr G on 29/10/15* - *Currently undertaking a GRTW* - *Occupation, BMS Principle, been in role 6 months, works 50-60 hours per week* - *Been with Company since 2011 as a contractor* - *Can perform all her duties, just not full-time* - *RTW part-time from 16/11/15* - *Has claim with MLC IP policy*	

Terima Kasih

谢谢

Thank You

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