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Developments in mental health underwriting

Access, language and the telling of tales

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Presented by webinar: Wednesday 5 June 2019 at 15.00

Agenda

- Changing perception of Mental Health
- Mental Health epidemic – the evidence
- Definitions in Mental Health
- Assessment of risk at underwriting
- Access to Insurance
- Case studies
- What more can we do?

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Generation stress:

- **4 in 5 Brits could be suffering burnout as a result of stress**

- Britain is in the grip of a stress epidemic, with 82% of Britons feeling stressed at least some of the time during a typical week

- https://www.axa.co.uk/newsroom/media-releases/2017/generation-stress-research/
- https://www.cigna.co.uk/assets/docs/news-room/cigna-360-wellbeing-survey-7027.pdf?WT.z_nav=business%2Fwhy-Cigna%2F360-health-and-well-being-results.html%3BBody%3BDownload%20our%20whitepaper

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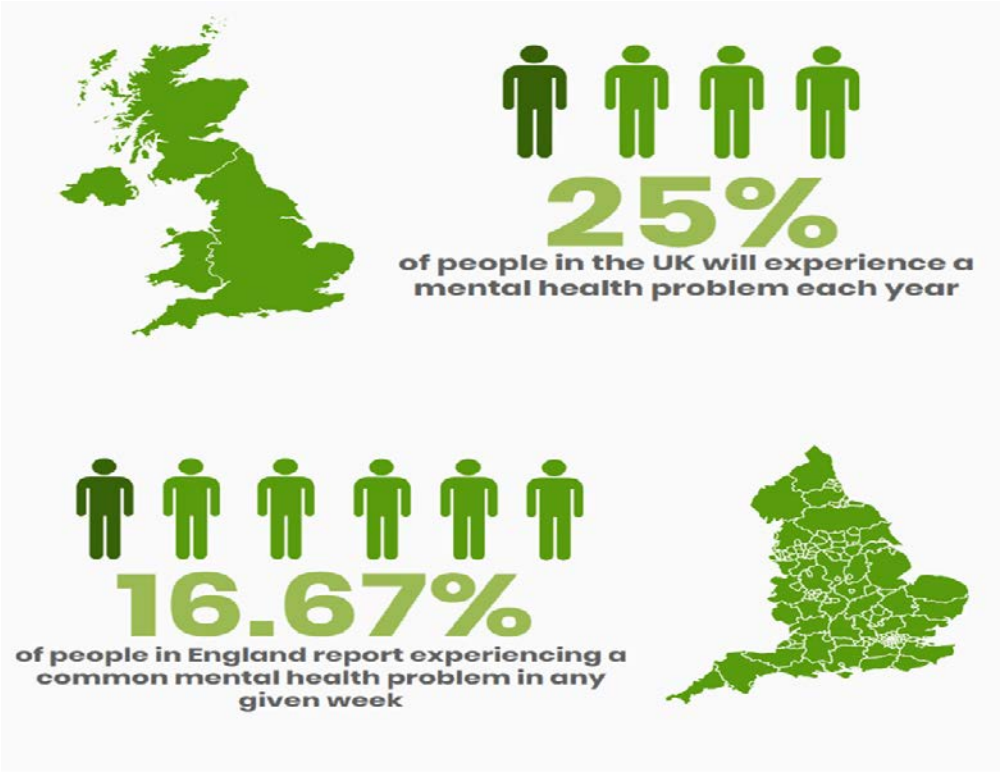

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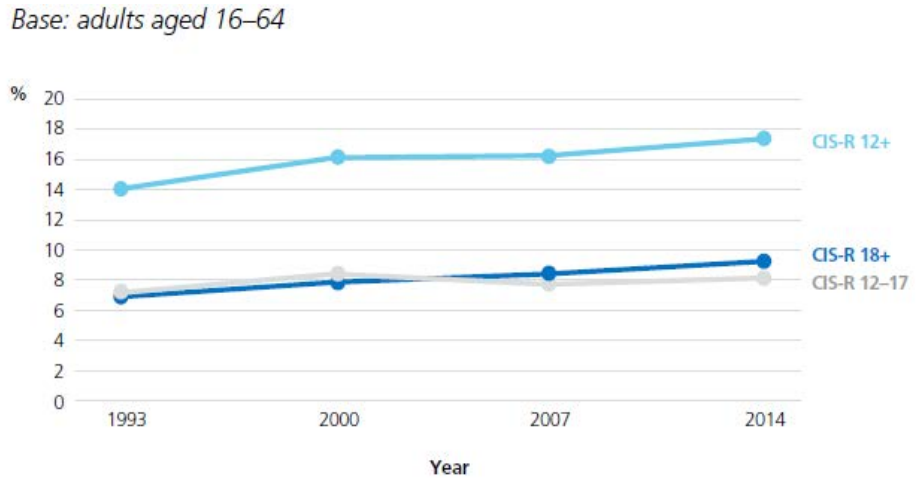
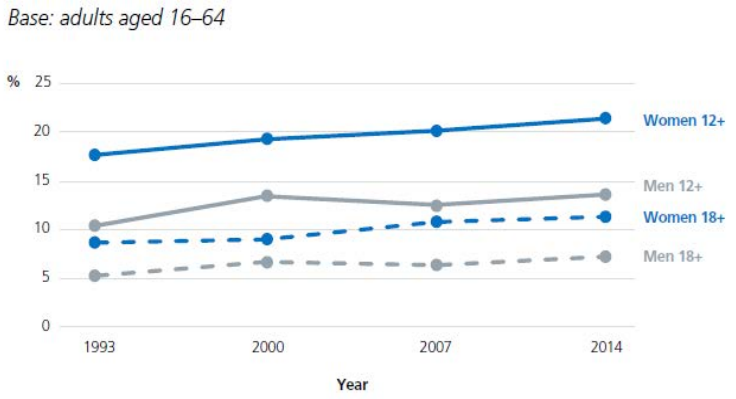
Mental Health Epidemic? UK



CIS-R score 1993-2014



CIS-r score by sex 1993-2014

http://digital.nhs.uk/catalogue/PUB21748

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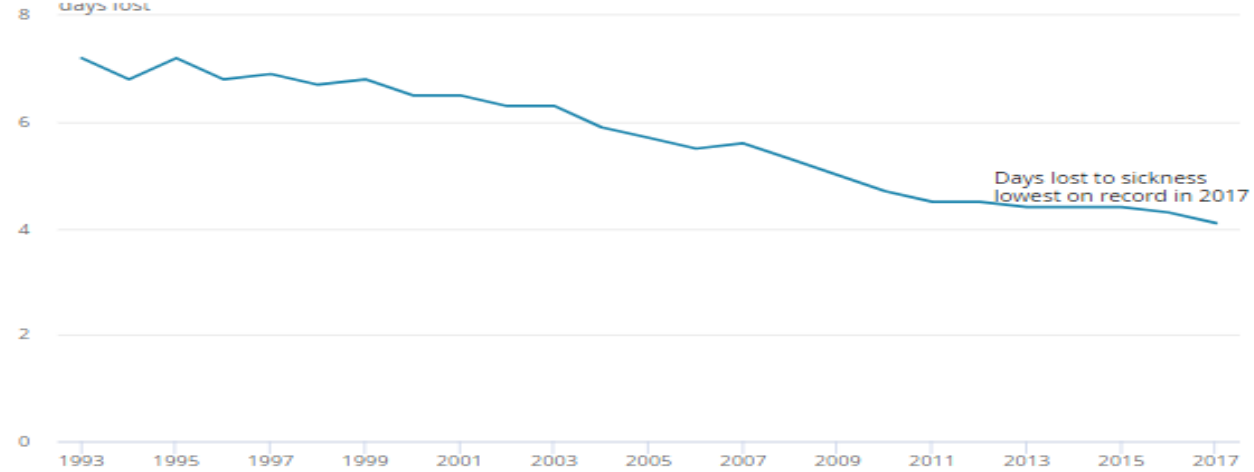
UK sickness absence levels 1994 - 2017

Number of days[1] lost through sickness per worker[2 3], 1993 to 2017, UK



Source: Labour Force Survey person datasets, ONS

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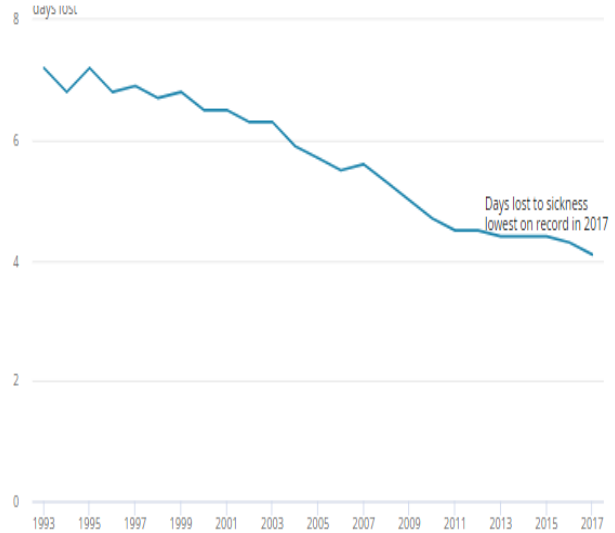

Source: Labour Force Survey person datasets, ONS

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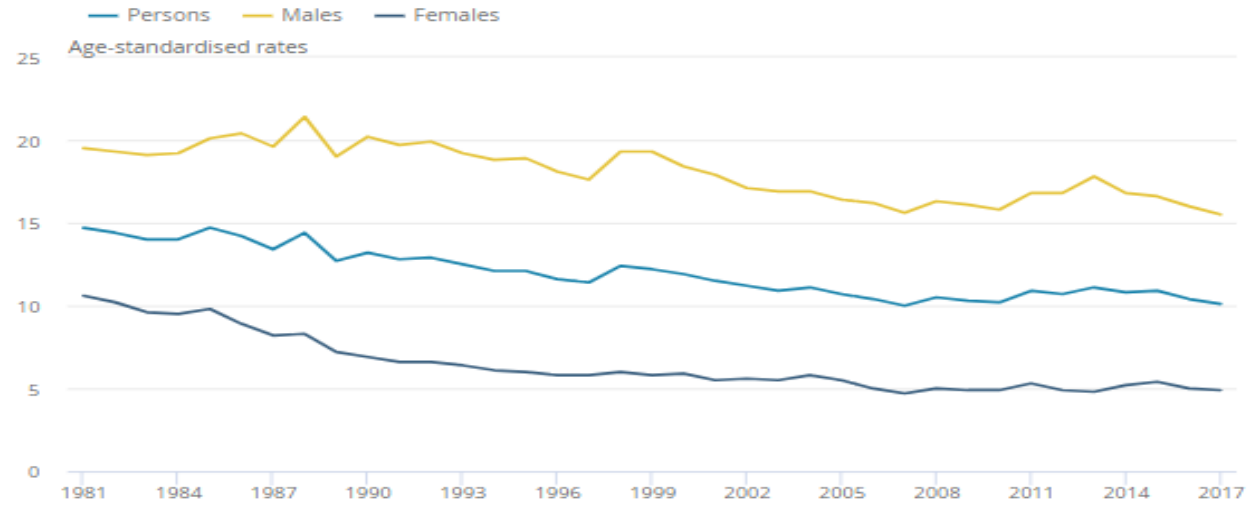
GB Suicide rate

Figure 1: Age-standardised suicide rates by sex, for the UK, registered between 1981 and 2017



Source: Office for National Statistics, National Records of Scotland and Northern Ireland Statistics and Research Agency

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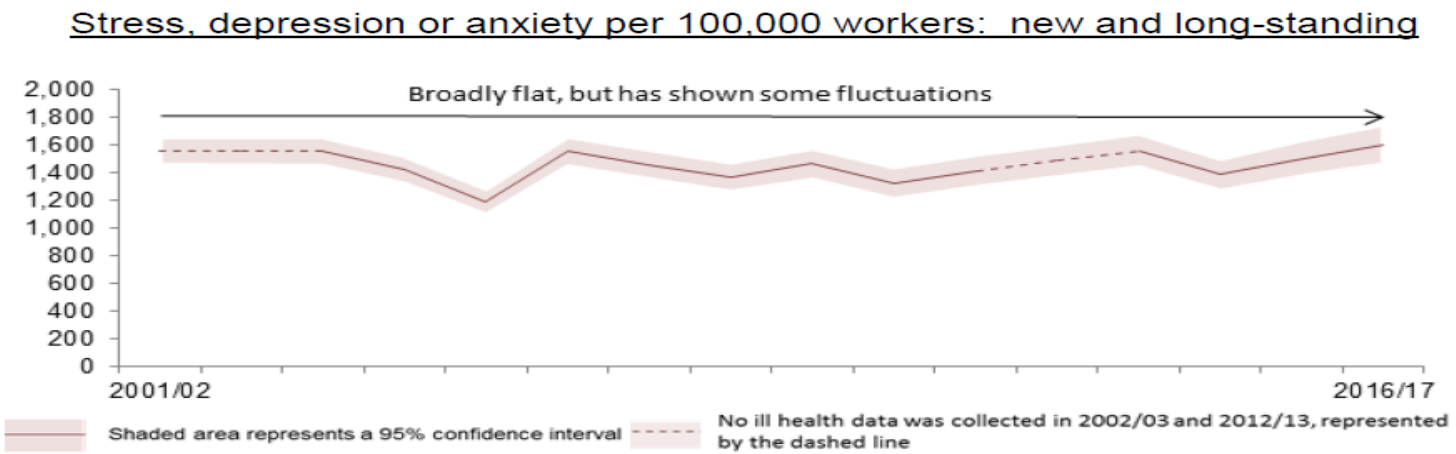
Self-reported stress over time



Source: **Labour Force Survey** (Estimates of self-reported stress, depression or anxiety caused or made worse by work)

http://www.hse.gov.uk/statistics/causdis/stress/stress.pdf

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Stress: HSE formal definition

- **The adverse reaction people have to excessive pressures or other types of demand placed on them at work"**

- Stress is not an illness – it is a state
- If stress becomes too excessive and prolonged, mental and physical illness may develop
- Work is generally good for people if it is well designed, but it can also be a great source of pressure
- There is a difference between pressure and stress
- Pressure can be positive and a motivating factor, and is often essential in a job. It can help us achieve our goals and perform better
- Stress occurs when this pressure becomes excessive.
- Stress is a natural reaction to too much pressure

http://www.hse.gov.uk/stress/furtheradvice/whatisstress.htm

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% change in cause of death CDC vs SCOR (Ages 20-89)

SUICIDE	2010 - 2011-13	2011-13 - 2014	2014 to 2015
SCOR	0	0	0
CDC	-0.5	-0.2	0

http://www.scorgloballifeamericas.com/en-us/knowledgecenter/Pages/Recent-Mortality-Trends-Cause-Of-Death.aspx

Unpublished data GenRe London – 2011-2017 - Mean 4.33% claims and stable over time
Absolute numbers commensurate with the rise in total numbers of claims

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GRID: GIP claims by cause

	2013	2014	2015	2016	2017
Mental Health	24.3%	23.2%	24.0%	22.9%	24.5%
Musculo-skeletal	15.1%	16.0%	14.5%	14.8%	14.7%
IHD	4.7%	3.0%	4.5%	5.6%	4.6%
Cancer	24.7%	23.8%	23.6%	24.1%	24.2%
Neurological	6.74%	6.71%	8.3%	6.9%	6.3%

How should I feel? Is this normal?

http://www.gosocial.co/12-fantastic-facts-magic-roundabout

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Thriving at work – Stevenson/Farmer Review 2017

- ‘It is especially important therefore to be crystal clear about definitions.’
- First, **mental health** itself. By mental health we do not mean “**mental ill health**”. We mean the mental health we all have, just as we all have physical health
- This provokes the question as to what we mean by **poor mental health.**
- One in four people in England have been diagnosed with a **mental health condition** in their lifetime.
- One in six adults in England met the criteria for **a common mental disorder** in the past week
- …the full spectrum of poor mental health, from common mental health problems to more **severe mental illnesses**

- **https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/658145/thriving-at-work-stevenson-farmer-review.pdf**

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Mental Health Continuum

Self-Care and Social Support		Professional Care	
Healthy Normal Functioning	**Reacting - Common and Reversible Distress**	**Injured - Significant Functional Impairment**	**Ill - Clinical Disorder Persistent Functional Impairment**
	Irritable/impatient Sadness, poor sleep, lowered energy, difficulty relaxing	**Anger, anxiety, hopelessness, preoccupied, poor performance, social withdraw**	**Significant difficulty with emotions, depressed, overwhelmed…**

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DSM 5 Definition Mental Disorder

- A behavioural or psychological syndrome or pattern that occurs in an individual The consequences of which are clinically significant distress (e.g. a painful symptom) or disability (i.e. impairment in one or more important areas of functioning)
- Must not be merely an expectable response to common stressors and losses (for example, the loss of a loved one) or a culturally sanctioned response to a particular event (for example, trance states in religious rituals)
- Reflects an underlying psychobiological dysfunction
- Is not solely a result of social deviance or conflicts with society
- Has diagnostic validity using one or more sets of diagnostic validators (e.g. prognostic significance, psychobiological disruption, response to treatment)
- Has clinical utility (for example, contributes to better conceptualization of diagnoses, or to better assessment and treatment)

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DSM 5 Definition Mental Disorder

- A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion, regulation or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning.
- Mental disorders are usually associated with significant distress in social, occupational, or other important activities.
- An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder.
- Socially deviant behaviour (e.g. political, religious or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above.

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Recognising mental illness

Levels and Filters after Goldberg and Huxley

Level One: General Population	315/1000/year
Filter One: Illness Behaviour	
Level 2: Psychological distress in primary care	230/1000/year
Filter 2: Recognition by primary care physician	
Level 3: Conspicuous psychiatric morbidity	101.5/1000/year
Filter 4: Referral to specialist care	
Level 4 & 5: Specialist clinic or hospital	23.5 & 5.71/1000/year

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Where there is a diagnosis

- All-cause mortality

Diagnosis	All-Cause mortality	Risk compared to heavy smoking	Relative Risk
Opioid use	14.7	7.7	
Cocaine use	6.0	2.4	
Anorexia nervosa	5.9	2.3	
Alcohol abuse	4.6	1.8	
Heavy smoking	**2.6**	**1.0**	
Schizophrenia	2.5	1.0	2.54
Bipolar Disorder	2.2	0.8	2.00
Depression	1.6	0.6	1.71
Cannabis use	1.2	0.5	

Pinch of Salt

MORTALITY IN PERSONS WITH MENTAL DISORDERS IS SUBSTANTIALLY OVERESTIMATED USING INPATIENT PSYCHIATRIC DIAGNOSES

- All-cause mortality risk overestimated by 15.3% using only inpatient diagnoses (adjusted hazard ratio [aHR], 5.89; 95% CI, 5.85–5.92

	Relative Risk
Inpatient	2.42
Outpatient	2.08
Community	1.90

- Suicide risk was overestimated by 18.5%
- 4.4% for substance use to 49.1% for anxiety disorders
- SMR of 2.2 for inpatients and 1.3 for outpatients
    - J Psychiatr Res. 2013 October ; 47(10): 1298–1303. doi:10.1016/j.jpsychires.2013.05.034

- *JAMA Psychiatry*. 2015 April ; 72(4): 334–341. doi:10.1001/jamapsychiatry.2014.2502 Amaddeo F, et al. Mortality among patients with
- psychiatric illness. A ten-year case register study in an area with a community-based system of care. Br J Psychiatry. 1995;166:783–788

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Critique

- Inappropriately generalising mortality estimates from clinical (often tertiary) samples.
- Usually including high levels of more severely ill subjects
- Small sample size
- Few studies included match nationally representative household surveys
- One of these studies has a HR 1.09 – over very long term follow up
- Not adjusted chronic physical disorders
- Bias inherent in using point, period or lifetime prevalence
- Publishing Bias
- Data needs to be interpreted in the light of the conversation on mental health and in particular the insured population.

https://jamanetwork.com/journals/jamapsychiatry/article-abstract/2436903Melissa

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Assessing Risk at underwriting

- One Traditional Risk Factor- What is being asked?
- Ticked “yes” to overdose / suicide attempt/ self-harm / thoughts of self-harm
- How many times have you attempted suicide, attempted to harm yourself or had suicidal thoughts – 3 episodes
- Double counting???

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Traditional Risk Assessment

Suicidal thoughts	20.6 in 100 people
Suicide attempts	6.7 in 100 people
Self-harm	7.3 in 100 peoples
Suicide rate	10.1 deaths per 100,000

Large et al (2017) concluded ‘We need to acknowledge our powerlessness to usefully classify individuals or groups of patients according to future suicide risk’.

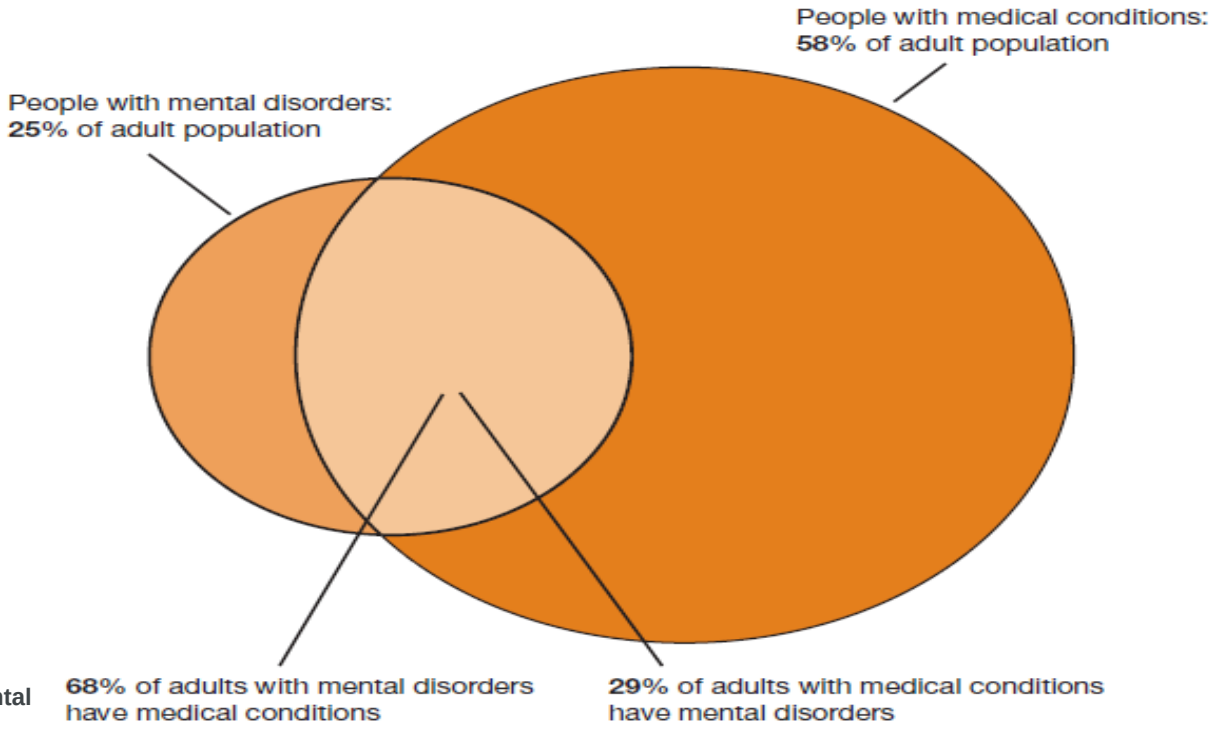
- Klonsky et al (2017) concluded ‘The majority of traditionally cited risk factors for suicide – including depression, hopelessness, most psychiatric disorders, and even impulsivity – predict suicidal ideation but do not distinguish suicide attempters from suicide ideators’.

https://www.mind.org.uk/information-support/types-of-mental-health-problems/statistics-and-facts-about-mental-health/how-common-are-mental-health-problems/#.XJJCkyj7TmY

Co-morbidities

Mental illness associated with adverse health behaviours

- smoking
- substance abuse
- physical inactivity
- poor diet



Synth Proj Res Synth Rep. 2011 Feb;(21):1-26. Mental disorders and medical comorbidity. Druss BG(1), Walker ER.

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What are we learning?

- No need to panic
- All mental health problems do not have terrible outcomes
- The data on which ratings were based need interpretation
- The question set needs to allow the applicant to give their account
- Reliance on one or two indicators will not produce a fair assessment of risk
- How much double counting goes on?
- This may cut across the grain for quick app based business but it is not impossible to develop smart systems to make these assessments.

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Perception they won't get cover

mind
for better mental health

How do I find the right cover?

Even though having a mental health problem can mean that you face certain challenges to getting insurance, there are lots of things you can do to make sure you get the cover you want. This page covers information on some things you can try:

Rethink Mental Illness.

Insurance

This factsheet explains your rights when buying insurance. It also offers an overview of the main types of insurance available. And the rules about mental illness.

- You may find that standard insurance policies will not cover you if you have a mental illness. You might have to buy a more expensive policy to get the cover you need.
- It is illegal for an insurer to refuse to give you insurance cover because of your mental health. Unless they can give evidence that you are more likely to make a claim.
- You could make a complaint to the insurance company if you feel you have been discriminated against because of your mental illness.

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Industry action - ABI

Industry action – Access to Insurance

Jonny Timpson 25.2.19

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Access to Insurance – Areas to focus on?

- Building trust
- Education
- Application questions
- Underwriting decisions
- Communication

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Access to Insurance – Mental Health

Company 1
Most mental health disclosures are mild or self-limiting and 90% of customers are offered standard rates for life cover

Company 2
78% of mental health disclosures receive standard terms. 5% of disclosures result in a decline, where terms cannot be offered

Customers are offered terms for Life and CI
Exclusions are applied for IP

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Access to Insurance – Case Study 1

- Application form: Female 41nb, £230k, DTA, Teaching assistant
  - Ticked yes to overdose / suicide / self-harm / thoughts
  - How many times have you attempted suicide, attempted to harm yourself or had suicidal thoughts – 3 episodes
  - Ticked yes to having anxiety

Case declined by underwriting engine

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Case Study – What's the story?

- Suffered "an episode of anxiety" was in 2012 approx.
- Had CBT and prescribe medication.
- "Scary thoughts" occurred on a couple of occasions that maybe the "world would be a better place without myself" but never acted upon.
- Treated and resolved and no symptoms since

Still a decline?

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Traditional Risk Assessment

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https://www.mind.org.uk/information-support/types-of-mental-health-problems/statistics-and-facts-about-mental-health/how-common-are-mental-health-problems/#.XJJCkyj7TmY

Assessing severity at underwriting

- Diagnosis may not be clear, and can be subjective
- Symptoms and there effect on life expectancy and the risk of further co-morbidities
- Broad range of severity – risk of “over-rating” mild conditions
- No medical biomarkers for severity and prospects of recovery
- Bio-social and other markers

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Assessing severity at underwriting

- Medical diagnosis
- Impact on social life, work and family
- Extent of treatment and response
- Management of conditions
- Recurrence or relapses
- Co-morbidities – both mental and physical
- Self-harm or suicide attempts

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Access to Insurance – Case Study 2

Application: Joint life case, male, 43, £350k DTA, Lawyer,

Diagnosed bipolar disorder in 2013, current controlled on medication.

Two episodes of inpatient treatment

Medical evidence

2013: Diagnosed with severe depression, schizoaffective / bipolar disorder – **first suicide attempt**, started on meds and mood stabilisers

2015: Admitted with **second suicide attempt**, depressive episode, medication and psychology input

2016: Discharged from psychiatry follow up

2017: Work related stress, phased return to work after 3 months

Repeat meds: Venlafaxine, Fluoxetine

Case declined

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Leading causes of death by age group in England, 2015

Leading causes of death vary by age for males

External | Cancer | Circulatory | Respiratory | Other

Age	1st	2nd	3rd	4th	5th
1-4	Perinatal & congenital	Influenza and pneumonia	Brain cancer	Meningitis and meningococcal infection	Vaccine preventable disease
5-19	Suicide	Transport accidents	Homicide	Leukaemia and lymphomas	Brain cancer
20-34	Suicide	Accidental poisoning	Transport accidents	Homicide	Cirrhosis and other liver disease
35-49	Suicide	Heart disease	Accidental poisoning	Cirrhosis and other liver disease	Stroke
50-64	Heart disease	Lung cancer	Cirrhosis and other liver disease	Colorectal cancer	Chronic lower respiratory diseases
65-79	Heart disease	Lung cancer	Chronic lower respiratory diseases	Stroke	Prostate cancer
80+	Dementia and Alzheimer's disease	Heart disease	Influenza and pneumonia	Stroke	Chronic lower respiratory diseases

Public Health England

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Life insurance policy exclusions

Suicide exclusion in first year

Cover with longer self-inflicted harm exclusion

"some protection better than none"

Challenges?

- Claims management
- Involve family and beneficiaries
- Cover from mortgage in some markets

Health Insurance & Protection DAILY

Analysis: Protection and pre-existing conditions

Tuesday 05 March 2019 by Emily Perryman

LIFE/CRITICAL ILLNESS

"***Many clients I speak to with a history of suicide attempts would be more than happy to take out life insurance with a permanent suicide exclusion,"***

Kathryn Knowles, managing director at Cura Financial Services

CURA
THE SPECIAL RISKS BUREAU

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What more can we do?

- Increase awareness and engagement
- Collaboration
- Does our underwriting approach work for our consumers?
- Are we fair? Can we give options?
- How do we handle declines?

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26 June 2019

Questions

Comments

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