JOURNAL OF INSURANCE MEDICINE

J Insur Med 2023;49:1–3

OPINION

Critical Illness at 40: Still a Thorn in the Medical Director's Side

Timothy Meagher, MB, FRCP(C)

Critical illness insurance was introduced 40 years ago. Medical directors continue to be challenged and frustrated with the complexities that critical illness claims offer. This article provides insights into the continued issues and possible solutions.

Address: 1000 Rue de la Gauchetière Ouest, 20e étage, Montréal Québec, H3B 4W5; 514-392-5069; tmeagher@munichre.ca.

Correspondent: Timothy Meagher, MB, FRCP(C); Vice-President and Medical Director, Munich Re, Montréal; Associate Professor of Medicine, McGill University, Montréal, Québec.

Key words: Critical illness insurance, medical directors, insurance claims, disease definitions.

Received: August 8, 2022

Accepted: August 25, 2022

Critical Illness insurance will be 40 years old next year. One might have hoped that after 40 years medical directors would have mastered all the complexities that a critical illness claim could offer. Not so! Critical illness claims continue to challenge and frustrate. Repeated efforts to improve critical illness contracts have not had the desired effect. If anything, the adjudication of claims has become more challenging, and dissatisfaction abounds.

DEFINITIONS, DEFINITIONS, DEFINITIONS

So, what is amiss? Disease 'definitions'—the contractual descriptions of covered conditions such as heart attack or cancer— are the culprit. Over time, these have become longer and more complex. To wit: the Canadian 'benchmark' definition of cancer in 2008 was 100 words long; its 2018 descendent numbered 504! Similarly, the definition of multiple sclerosis increased from 98 to 373 words, benign brain tumor from 195 to 337, and stroke from 111 to 224. The goal of longer definitions was to describe which claims would be refused, thus providing clarity for the buyer. Lengthening would also correct the flawed original definitions, which failed to emphasize the 'critical' aspect of a covered condition and permitted payouts for minor or innocuous illnesses.

To achieve this goal, 'exclusions'—situations where a claim would be refused—were written. As more exclusions were added (in Canada, definitions were modified in 2008, 2013 and 2018), definition length increased. Success was marginal, as exclusions are a two-edged sword. They may limit payments for innocuous conditions. But they do not reduce the number of claims, as claimants and their physicians may simply judge that a claim is warranted. Thus, claim denials increase, causing client dissatisfaction and generating a reputational black cloud. Indeed, a recent Quebec financial regulator reported a 20% claim denial rate and suggested, albeit with limited evidence, that insureds were being unfairly treated.[2]

MEDICAL DIRECTORS STRUGGLE

In this somewhat fraught setting, medical directors—whose job is to pronounce whether a definition has been satisfied—must juggle competing interests: definition language, clinical commonsense, and, at times, even the notion of 'critical.' Falling back on a precise definition is the ready default. However, medical directors know that this can be unfair to the claimant: a clinical diagnosis may be clear-cut, yet the insurance definition is not satisfied, word for word. Or the corollary: the list of exclusions is incomplete, the disease is innocuous, but the definition is satisfied.

How can this be? Unfortunately, despite best intentions, insurance definitions are simply incapable of covering all clinical situations and attempts to do so are predictably Sisyphean. Further, medicine is messy; diagnostic grey zones are aplenty, and they constantly shift. Not surprisingly, evidence provided to support a claim may be far from clear-cut. For example, pathology reports may be nuanced, reflecting uncertainty. Elevated troponins may be readily explained by conditions other than myocardial infarction. The evidence for 'definite' multiple sclerosis may be equivocal. A 'residual neurological deficit' may be present, following a stroke, yet defy objective proof. And on and on.

Not surprisingly, therefore, disagreements at claim time are common, and they are multidirectional. Adjudicators may disagree with medical directors; medical directors may disagree with each other. Medical directors may disagree with treating physicians, who are befuddled by insurance definitions and will always advocate for their patient. Squabbles may develop between reinsurer and client company. Everyone will feel they are right. And, maybe they are!

DEFINITIONS ARE NOT THE ONLY PROBLEM

While definitions can be easily tagged as the root problem, perhaps they are just the tip of the iceberg? The original purpose of critical illness insurance was to protect the buyer from the consequences of a 'dread disease,' the product's original South African moniker. Its founder wrote: critical illness protection "provides you with money when you need it the most …when you are unable to work and provide for your financial needs."[1] This description is clear: the illness is so severe that work is impossible, and solvency is in peril. But surely the inability to work is the remit of disability insurance? One might reasonably ask: why purchase critical illness insurance if one already carries disability insurance? One might also ask: in countries where healthcare is readily accessible, is insolvency due to medical bills a significant threat?

Thus, in prosperous countries the role of critical illness insurance is less evident. Consequently, it requires extensive explanation to the buyer, who needs a clear understanding of its merits and an accurate understanding of its limitations. A sale based on a simple "if you get this disease, you will get X dollars" statement, is profoundly misleading. On the flip side, the message "even if you have a stroke, there is a reasonable chance that your claim will be refused," while entirely accurate, may cause sales to plummet. Yet, this is

the correct description. Failure to understand that critical illness insurance provides limited insurance against a restricted list of diseases, is the recipe for contentious claims. The addition of exclusions —which are often couched in highly technical medical language— cannot fix this problem. If anything, it makes it worse.

IS THERE A SOLUTION?

There are many solutions. One might simply accept any claim that is provided by a treating physician. One might accept, without question, a diagnosis in a hospital discharge summary. Or one could simply remove all exclusions. Such solutions would certainly simplify a critical illness policy and facilitate the adjudication of claims. However, they are unappealing, as they would substantially increase cost, which is already considered high. The creation of 'severity categories,' wherein payouts are reduced when a condition is deemed less severe, has been adopted in some markets, with variable success. On the positive ledger, a claimant is more likely to be indemnified, rather than left emptyhanded. However, problems remain: each severity category requires clear definition, in many respects emulating the North American exclusion model, with all its warts. Further, the categorization of 'critical' into 'mild,' 'moderate' and 'severe' (or into 'grades') distances the product from its original intent, with the consequences described above. It is also semantically bizarre.

Whatever solution is chosen, its goal should be to restore the 'critical' to critical illness insurance. This begins with accurate and realistic marketing, continues through informed sales, and is supported by clear disease definitions, that a lay person can understand. If this goal were reached, the informed consumer would purchase for valid reasons, would understand the product's limitations and be more likely to understand a denied claim. Squabbles would be less common.

Utopic? Probably. Forty-year-old habits tend to stick. The collective will that is needed to chart a new course for critical illness is not yet at hand. While waiting, tinkering with definitions will continue. No sign that that thorn will move just yet.

REFERENCES

1. Barnard M, CoverTEN August 2007, p 13-14. Available at: https://web.archive.org/web/20110719150446/http://db.riskwaters.com/data/cover/pdf/cover_supp_1007.pdf
2. Critical Illness Insurance Supervisory Report. *Autorité des Marchés Financiers*. December 2021. Available at: https://lautorite.qc.ca/fileadmin/lautorite/grand_public/publications/professionnels/assurance/2021_Rapport_surveillance_maladies_graves_an.pdf

Authors Queries

Journal: **INSM**
Paper: **INSM-49-04-03_1XO**
Title: **Critical Illness at 40: Still a Thorn in the Medical Director's Side**

Dear Author
During the preparation of your manuscript for publication, the questions listed below have arisen. Please attend to these matters and return this form with your proof. Many thanks for your assistance

No Query