

Risk Matters



Dear Reader,

Government excise figures reveal the significant extent of alcohol availability in the UK. Alcohol continues to be freely sold at low prices and remains socially acceptable despite growing concerns about the effect on the health of people who consume levels in excess of the limits recommended by health authorities.

Increasing levels of ill health and antisocial behaviour directly caused by alcohol have brought calls for stricter controls and higher prices. The negative impact on long-term health resulting from uncontrolled alcohol consumption spans all age groups.

This edition of Risk Matters looks at the evidence of excess alcohol consumption and considers if improved underwriting techniques could have a positive impact on claims management.

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*Claire Henshall
Claims Manager
Gen Re Life/Health UK*

*Lynn Baillie
Senior Underwriting Specialist
Gen Re Life/Health UK*

Drinking Habits and the Implications for Insurance

Unlike drug taking, drinking alcohol is generally perceived as an acceptable and sociable method of relaxing in our society. Moderate use is condoned and alcohol is freely available at society events, parties and in the work context. Unfortunately, some people are unable to tolerate the effects of alcohol. This group can also find it hard to avoid alcohol given the social factors that facilitate regular exposure to and use of alcohol.

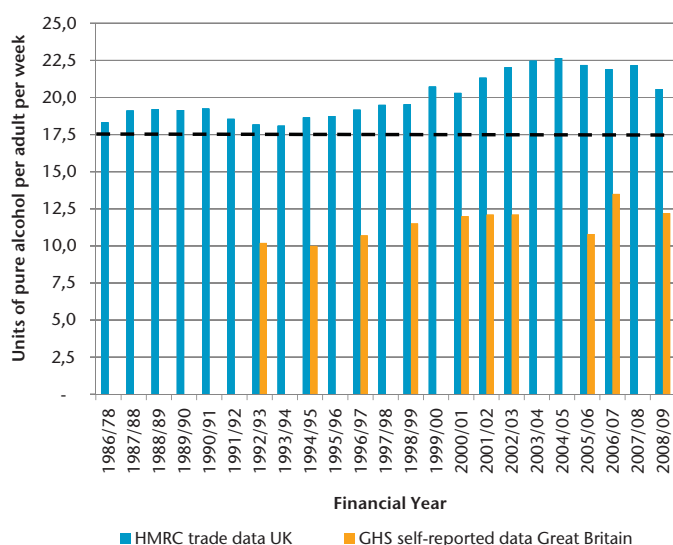
Queries about alcohol consumption are included in the UK's annual General Lifestyle Survey (GLS). Respondents are asked to record their daily intake during one week. This is in line with the Government's advice on sensible drinking that is based on a daily unit of alcohol benchmark. Regular consumption of 3 - 4 units per day for men and 2 - 3 units for women does not carry a significant health risk, but consistently drinking above these levels is not advised. The findings reveal that alcohol use is common in the UK and that many consume in excess of the levels recommended by Government guidelines.¹ Furthermore, those found to have higher than average consumption include young and middle aged men, high earners and people working in managerial or professional roles – the very groups most likely to purchase life and health insurance products.

Consuming high levels of alcohol is detrimental to health in a number of ways that concern insurance risk managers. Alcohol is a factor in 1 in 5 of all deaths for males below 45.² National Health Service statistics reveal that in 2009/2010 there were 1,057,000 alcohol related admissions to hospital. This represents an increase of almost 12% on the 2008/2009 figure (945,500) and is more than twice the total in 2002/2003 (510,800).³ The admissions could be the result of an accident or physical health problems. For example, the metabolic effects of alcohol can lead to obesity or malnutrition. Equally, admission may have occurred as a result of diminished social and psychological function – for example, depression or aggression – and the effects of these.

Measuring the problem

Obtaining good data to determine the extent of the problem and thereby to price adequately for the insurance risk is extremely difficult. Most people do not maintain an accurate record of how much alcohol they drink. The “official” guidelines used to define consumption (i.e., units of alcohol) are confusing to many as they do not correspond to the glass sizes in which drinks are normally served, especially in the home environment. It is therefore quite plausible that people understate their consumption to researchers. An example of this possible contradiction is revealed by comparing the quantity of alcohol purchased in the UK from HM Revenue & Customs trade data records⁴ to the stated alcohol consumption of individuals in the GLS. Large discrepancies appear between what people admit to drinking when compared to how much they seem to be buying (see table).

Average weekly alcohol consumption per adult



Implications for underwriting

Underwriters must look at the disclosures and evidence available to identify individuals with the potential to develop alcohol-related health problems. People in this group often display risky behaviour related to their alcohol consumption that may be revealed by a history of accidental injury or high levels of absenteeism. Within this category of risky individuals, are the binge drinkers, people who regularly consume at least six (for women) or eight (for men) alcoholic drinks on any one occasion on a regular basis. Currently, this sub-group cannot be readily identified by the alcohol questions included on most application forms. Another at risk group is the alcoholics, people with a level of alcohol consumption that has become an uncontrolled habit with severe health consequences. The psychological and physical effects of excess levels of alcohol on the body are evident in this group who typically will hide their problems and protect their supply. This last behaviour is sometimes shown in a lifestyle that ensures regular availability of alcohol and is often linked to choice of occupation.

Consistent identification of applicants with alcohol-related issues becomes challenging because space and time dictate that application form questions are kept brief. The majority of companies continue to ask applicants to disclose their average weekly consumption of alcohol but, as discussed above, probably obtain unreliable and understated data in return. An analysis of application form disclosures undertaken by Gen Re showed an average amount disclosed of only 7 units a week. Information to help identify these risks may not be readily available, so underwriters must look more closely to identify medical, psychological and social factors in individual's disclosures

and medical history. For example, a person with ill-health consequences of excess alcohol may disclose gastritis, pancreatitis, depression or a history of violent injury or work problems stemming from drink-drive offences. There may be clues to draw from the medical examination findings, including classic physical signs in their appearance or frank liver enlargement.

Tele-underwriting can be used to capture fuller disclosures as this gives the opportunity to drill down further into the applicant's drinking patterns. For example, an interviewer can ask the frequency of occasions when six or more drinks are consumed over a short time frame to obtain information about binge drinking. Asking questions about the psychological effects, such as an inability to stop drinking once started, or the amount of sickness absence taken around weekends are also a possibility. Such questions are much more specific and similar to the questions included in the CAGE questionnaire⁵ and the Alcohol Use Disorders Identification Test (AUDIT).⁶ CAGE is a simple screening for problem drinking and potential alcohol problems, while AUDIT helps to identify alcohol dependence and some specific consequences of harmful drinking. This would perhaps be a more effective way to accurately capture the extent of the risk.

Laboratory tests that are more sensitive and specific to high levels of alcohol intake than biomarkers that are merely suggestive of alcohol abuse, such as gamma-glutamyl transferase (commonly called gamma GT), would enable insurers to identify more problem drinkers. Elevated levels of CDT (carbohydrate deficient transferin) are associated with sustained alcohol intake and this marker is used by doctors to monitor patients they consider use excessive alcohol or are at risk of alcohol-abuse relapse.

Alcohol and claims

Alcohol use also presents challenges for the claims assessor. In the majority of cases, only the most severe forms of alcohol abuse are discovered at claim stage. This is because most alcoholics deny their own habits with respect to the amounts and frequency of drinking. Equally, patients do not readily disclose their lifestyle history to their doctor. This means that the claimants themselves are the only ones who hold accurate information on their drinking habit. Heavy drinkers are less likely to visit their doctor on a regular basis, to accept medical help or to look after their general health. Doctors are not especially trained to spot the early signs of alcohol abuse and can be unwilling to label a person as alcoholic. In insurance reports, doctors are at liberty to comment on the medical conditions that arise from a lifestyle choice, such as binge drinking, rather than make comment on the lifestyle choice itself. Research conducted to assess how newly qualified doctors felt about identifying alcohol problems in a clinical setting showed that only 4% were confident to diagnose alcohol abuse and that 3% felt that the treatment that they could then offer to patients was effective.⁷

There is no doubt that alcohol is a compounding factor in many disability claims either as a cause of claim or exacerbating the symptoms of other illnesses. The ability to adapt and cope with illnesses is seriously impaired when alcohol is also a factor in the claim. Not only does this have an effect on claims admissions but it also has implications for the ongoing management of the claim. Even if alcohol is suspected as a factor affecting a disability claim, it is a challenge to obtain an accurate diagnosis or details about the effective treatment of the problem. Treatment is often limited to small amounts of counselling in the early stages of the disease. It is only when the alcoholism is severe that the claimant is able to access treatment. In these cases the treatment often consists of “drying out” in a clinic, attending a recovery programme or undergoing treatment with medication or cognitive therapy. Follow up and rehabilitation

aimed at helping individuals to cope without alcohol is limited and patchy. Relapse is very common. There is limited evidence to support the success of interventions to treat alcoholics and because of this it is difficult to assess if any rehabilitation can be justified in the management of claims. There is, on the other hand, plenty of research that indicates that alcohol misuse has a detrimental impact on return to work plans.

Claims challenges with respect to the investigation of non-disclosure are particularly evident when alcohol abuse is suspected. The Association of British Insurers has issued an advisory statement of good practice on treating customers fairly and on non-disclosure. This states that questions asked at application stage must be clear, relevant and concise.⁸ Insurers must also have a good reason to obtain medical information when investigating claims. In many cases the non-disclosure is deemed to be innocent because the application question was unclear, the question does not clearly and directly apply to the facts (the person was a binge drinker for example), the customers disclosed the number rather than the units of drinks or it was reasonable for the customer not to remember or disclose the information. When doctors are asked to confirm that non-disclosure has occurred, they are often unable to do so; the information is unavailable to them simply because the applicant has never revealed their drinking habits to them.

In order to manage non-disclosure, it is important to look for red flags in the claim history that may lead the assessor to suspect a problem. The questions asked at claim stage need to be clear and unambiguous and assessors should not be deterred from investigating further when alcohol is a suspected contributor.

Conclusion

Alcohol and its effects present many challenges to the insurance industry. This is evident in all stages of the risk management process. Pricing is difficult due to inaccurate data, underwriting application forms are not effective in identifying at risk drinkers and claims assessors struggle to manage claims. Trends measuring drinking habits indicate that this problem is likely to worsen. A study of drinking prevalence, trends, consumption and patterns amongst teenagers revealed 10% of 15-year-olds regularly consume alcohol 3 days a week, with 56% admitting deliberately trying to get drunk in the previous 7 days.⁹ These are our future policyholders, so we need to take action now to protect any future burden to our industry.

Endnotes

- 1 The General Lifestyle Survey, 2009; Office for National Statistics, London (statistics licensed under the Open Government Licence v 1.0).
- 2 Mortality Statistics Deaths registered in England and Wales 2001-2010: Table 8 ICD-10 codes F10, K70 – K77; Office for National Statistics, London (statistics licensed under the Open Government Licence v 1.0).
- 3 Statistics on Alcohol: England, 2011; National Health and Social Care Information Centre, London.
- 4 Alcohol Factsheet March 2010, HM Revenue & Customs, London.
- 5 Ewing JA, Detecting alcoholism – the CAGE questionnaire. *JAMA*; 1984;12; 252(14):1905-7.
- 6 AUDIT- The Alcohol Use Disorders Identification Test; guidelines for primary care, second edition, 2001, World Health Organization, Geneva.
- 7 Missed Opportunity: National survey of primary care physicians and patients on substance abuse, 2000; National Center on Addiction and Substance Abuse (CASA), Columbia University, New York.
- 8 Non-disclosure and Treating a Customer Fairly, Code of Practice 2009, Association of British Insurers, London.
- 9 Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) National Report; Smoking, drinking and Drug use among 13 and 15 year olds in Scotland in 2010.



**General Reinsurance
London Branch**
Corn Exchange
55 Mark Lane
London EC3R 7NE
Tel. +44 20 7426 1800
Fax +44 20 7426 1898
www.genre.com

Editor
Ross Campbell, ross_campbell@genre.com

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