Explaining underwriting decisions where an insurer offers non standard terms or is unable to offer cover

Signatories (as at March 2021)

Aegon
AIG
Aviva
British Friendly
Cirencester Friendly
DG Mutual
The Exeter
Guardian
Holloway
HSBC
Legal and General
Lloyds Banking Group
LV=
Met Life
PG Mutual
Royal London Group
Scottish Widows
Shepherds Friendly
Vitality
Wiltshire Friendly
Wesleyan
Zurich

A2I
Access to Insurance

1. Introduction

The majority of Life, Critical Illness and Income Protection policies that are underwritten by insurers are accepted with no change to the standard premium based on age and smoker status. However, for those with pre-existing medical conditions premiums may be higher or cover may be unavailable.

Work undertaken by charities and other consumer groups[1], the Financial Conduct Authority[2] and the Treasury Select Committee[3] has evidenced that consumers with pre-existing medical conditions can struggle to navigate the life and protection insurance market and obtain affordable cover. This can result in consumers with pre-existing medical conditions forgoing cover entirely or paying significantly more for policies than they could with alternative firms.

In an open and competitive market, different insurers may have different risk appetite or claims information. This means that different insurers may offer different outcomes and decisions when assessing the same risk.

In response to these findings, the insurance industry, charities and other consumer groups formed the Access to Insurance Working Group in October 2018. At its first meeting, the group committed to the following:

"We, the members of the Access to Insurance Working Group, are committed to improving access to protection insurance for consumers with chronic health conditions and disabilities. Working together, we have four key aims:

- *develop a signposting system for consumers, supporting consumer groups and charities so they can easily access guidance and advice about insurance from protection specialists*
- *improve the transparency of underwriting processes and practices around chronic health conditions and disabilities for consumers, supporting consumer groups and charities*
- *improve standards across all who distribute protection products so that we create a framework for improving access to expert underwriting advice across financial, health and charitable sectors*
- *develop a proposal for greater accessibility to insurance through the workplace".*

As part of this work, it was agreed that there should be a workstream focused on the second bullet point above to deliver the following outputs:

- Improve trust in and understanding of underwriting within advisers and charities in working group

[1] For example, see publications from Age UK, Alzheimer's Society, Macmillan, Money and Mental Health Policy Institute, NAT (National AIDS Trust) and Scope, among others.
[2] Financial Conduct Authority, 2016, Access to Financial Services in the UK. Available at: https://www.fca.org.uk/publication/occasional-papers/occasional-paper-17.pdf
[3] Treasury Select Committee, Consumers' access to financial services, 13 May 2019, HC 1642 2017-19.

- Agree methods to improve trust and understanding of underwriting within broader community
- Recommend best practice communications approach where non-standard decisions are made

2. The requirements of the Equality Act

Some consumers with pre-existing medical conditions will have a disability covered by the Equality Act 2010. These are classed as physical or mental health conditions that have a 'substantial' and 'long-term' adverse effect on someone's ability to carry out normal day to day activities. People who have a progressive condition like cancer, HIV and multiple sclerosis are covered by the Equality Act from the point of diagnosis. People are also covered by the Equality Act in relation to a disability they had in the past from which they have now recovered.

The Equality Act offers legal protection from discrimination for those with protected characteristics – including disability. However, because insurance involves an assessment of risk, it may sometimes be possible for providers of 'insurance business' to take protected characteristics into account when making decisions about whether or not to offer cover to someone or offer it on different terms - such as the price of the premium - because of their disability.[4]

In order to be compliant with the Equality Act, the action taken (either increasing the price of their premiums, applying exclusions, or refusing cover entirely) must be reasonable and done by reference to information that is both relevant to the assessment of the risk to be insured and from a source upon which it is reasonable to rely.[5]

Insurance providers do not have blanket or general policies of refusing to provide insurance or only providing insurance on certain terms, to disabled people. This would be unlawful discrimination under the Equality Act.

3. Signposting

If an insurer has made a reasonable decision to refuse cover to someone with a pre-existing medical condition based on relevant and reliable evidence alternative options for accessing cover may still be available to them. If it is an intermediated sale, the distributor should present the customer with alternative options.

An approach to facilitating consumers' access to alternative options in the wider market through signposting, which some insurers have signed up to is explained in "An agreement on access to protection insurance for people with pre-existing medical conditions and disabilities"

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[4] Specific information for financial services providers can be accessed at: https://www.equalityhumanrights.com/en/advice-and-guidance/equality-law-banks-and-other-financial-services-providers

[5] Schedule 3 (21) of the Equality Act 2010, c15. Available at http://www.legislation.gov.uk/ukpga/2010/15/schedule/3/paragraph/21 [accessed 10 December 2019]

4. The Agreement

This non-statutory Agreement sets out how the parties mentioned below will cooperate to deliver the objectives of the Access to Insurance Working Group.

The Agreement is a statement of intent and does not create legal obligations between the parties. Nothing in this Agreement should be construed as conflicting with statutory or regulatory requirements, or with other professional duties and obligations.

The language used between “will” and “should” is deliberate. “Insurers will” means that any insurer signing up to this agreement agrees they will do this in all situations. “Insurers should” means that insurers agree that this is best practice, but that they may not always be able to do this for practical reasons.

4.1. Key Principles

This agreement recognises that insurers have the same duty of care to ‘potential’ customers applying for insurance as they do to all their existing customers. It aims to ensure that people with pre-existing conditions and other potentially vulnerable customers are appropriately supported throughout the application process, as well as increasing their trust that underwriting decisions about them are being made fairly. It also aims to enable customers to navigate the insurance market more confidently and effectively and ultimately to find affordable and appropriate cover.

It is therefore designed to improve the transparency of underwriting decisions, make it easier for customers to understand them and demonstrate that they are reasonable, having been based on relevant and reliable evidence in compliance with the Equality Act.

It is also fundamental that customers will not face unreasonable barriers to accessing their data, and should be supported by insurers in any application they wish to make to a new insurance company.

These principles apply to any decision where another individual of the same age and smoker status who did not have the same medical condition would have received improved terms. Specifically, it refers to all decisions where an individual is declined or deferred cover, charged an increased premium or has a part of their cover excluded.

4.2. Details

4.2.1 Oral and written communications (with both applicants and distributors[6]) relating to underwriting decisions will always be empathetic, respectful, free of stigmatising language and appropriate. Insurers will also be mindful that communications can affect an individual's health. They should be specific to the individual customer and consider their information needs using plain and simple language and avoiding technical jargon.

4.2.2 Insurers will make available a broad explanation of what underwriting is and why it happens.

4.2.3 On a customer's request insurers will explain what information was used to make the decision and the reason(s).

4.2.4 Any exclusions applied as part of the underwriting decision will be clearly stated.

4.2.5 Where a customer is not offered cover, insurers should signpost that cover may be available from other insurers or distributors.

4.2.6 If a distributor is involved in the application, then the communication explaining the decision should refer the applicant back to their distributor for support to consider protection options and look for alternative sources of cover that will best meet their needs.

4.2.7 If the customer has made their application direct, then sources of support to find alternative cover that will best meet their needs should be signposted.

4.2.8 On some occasions, customers may need additional support to understand the reasons for the decision or to cope with the impact of it. Insurers will be particularly mindful that they may already be vulnerable. The insurer should refer the customer to other sources of information and support such as the NHS website or appropriate charities if this would be helpful.

4.2.9 A GP should not have to explain an insurer's underwriting decision. In some circumstances e.g. where there is a concern about harm to the applicant and/or where new information has arisen through the insurance application it may be appropriate for the insurer to recommend that an applicant make an appointment with their GP. It will be clear that this is to enable the GP to support the customer, not to explain the underwriting decision.

4.2.10 Where a distributor is involved, the distributor should be notified of the decision no later than the customer so they can explain the decision and help the customer in the next stage of their journey.

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[6] "Distributors" referred to throughout s.4 includes any distributor who wants to receive information in this way – most likely those who speak to the applicant. Insurers are not expected to fulfil these criteria for distributors who do not wish to receive information in this way e.g. comparison sites

4.2.11 Where a distributor is involved, they will be given the reasons for the underwriting decision if requested if they are already aware of the relevant disclosures.

4.2.12 If a customer provides explicit written consent, the insurer should discuss, in detail, the reasons for the underwriting decision with the distributor. This may include information that the distributor was not aware of when submitting the application. The insurer reserves the right to refuse this if the GP has highlighted that such information should not be shared with the customer or at the insurers discretion if it is deemed not to be in the best interests of the customer to share the information with the distributor. An insurer may also refuse this if there is any concern that this information will be misused or if there are concerns over the way this personal sensitive information will be handled. This provision does not include the sharing of medical reports with distributors.

5. Monitoring of effectiveness of agreement

A final version of this document and all initial signatories committed to it will be shared in January 2021. This agreement will apply to all signatories from December 1st 2021.

An ongoing publicly available record will be kept of insurers who sign up to the Agreement. When they do so they will be invited (but not required) to comment on their stance on any of the "should" requirements in section 4, as well as their current position on all of the "will" requirements to enable monitoring of improvements being made related to this agreement.

Insurers will reconfirm their adherence with the requirements on an annual basis.

Distributors, charities and insurance applicants should notify a representative of the Access to Insurance group of any occasions where a signatory is not felt to have fulfilled the requirements they have agreed to. The signatory will investigate the issue and decide whether the requirement has been breached, and if so what action will be taken and notify the complainant and the Access To Insurance group of the result of the investigation. For any complaint that relates to legal matters, for example the Equality Act, then the respective law applies.

In the event of repeated breaches without proposed resolution the signatory will be removed from the agreement.