# TERMINAL ILLNESS IS PAIN ENOUGH!

## A REPORT ON TERMINAL ILLNESS INSURANCE CLAIM FAILURES

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Unless evidenced as such, the views expressed within this report are those of Peter Bull and not the APPG TI.

This report was compiled by Peter Bull as an independent contribution to the All Party Parliamentary Group for Terminal Illness (APPG TI).

# INTRODUCTION



**Peter Bull**

Surviving TI Claimant

The British Insurance Industry is a world leader, it produces thousands of great products that most of us just cannot do without.

Some may begrudge the cost, but overall, our insurers do a surprisingly good job - most of the time.

But what happens if they make a mistake, and that mistake, creates unnecessary misery and distress for thousands of people at the very worst time in their life - when they are diagnosed as terminally ill?

Would the insurers own up to such a mistake?

Could the Financial Ombudsman Service (FOS) ensure fair play?

Would the regulating body, the Financial Conduct Authority (FCA) sort it out?

The answer may be yes to all the above, but only if terminally ill claimants are mentally well enough to complain, and they live long enough to reveal the size of the problem.

The All Party Parliamentary Group for Terminal Illness (APPG TI) and the Marie Curie organisation have made great strides in improving the lives of those unfortunate enough to receive a 'terminally ill' (TI) diagnosis.

The work of the APPG TI has quite naturally been focussed on what is perceived to be the biggest issue. The fairness, efficiency and sensitivity afforded to those claiming TI related DWP benefits.

Unfortunately, a parallel issue exists in the private sector; the true size and nature of which is concealed. As such it may not be perceived, understood, or prioritised correctly by the relevant regulators.

If it has not already done so, the tragedy surrounding these Private Sector claims, may well exceed that of the 17,000 TI claimants who have died before receiving DWP benefits since 2013. [1]

TI Insurance is different; it has the highest potential to create human distress and suffering. Yes, other categories, such as property, motor and business insurance have the potential to cause misery if not paid, but mostly, if things go wrong, the claimant has time to learn, and fight another day.

Even end of life cover, although always associated with sadness, clearly pays out on death, and does the job it was supposed to do.

Those receiving a TI diagnosis do not have the benefit of time. They are often unable to work, support themselves, or their dependants. The failure of a TI insurance claim involves a life changing sum of money and a huge blow to someone already under extreme stress.

Given the above it becomes impossible to argue with the fact that insurers, who make big profits from TI policies, also have a heavy moral responsibility to minimise suffering wherever possible.

The APPG TI has worked diligently to eliminate poor TI practice in the public sector. If it is not acceptable there, then why should it be allowed to continue in the name of profit?

## THE ISSUES

### TI CLAIM ASSESSMENTS

A significant proportion of TI insurance claimants drop their claim when told they do not fit the insurers profile of a qualifying terminal illness (QTI).

Most new TI claimants are encouraged by their insurers to be assessed at the outset over the phone. At this stage, the assessor is guided primarily by the QTI and their own judgement. They will not have had sight of detailed clinical notes and are unlikely to be clinically qualified to understand the significance of any critical complications.

Incredibly, given the above, within 7 minutes of a claim call starting, a genuinely terminally ill claimant can be told '*I don't think there is going to be anything definitive to accept a claim on*'. The claimant may then be invited to '*consider deferring their claim*' until the condition worsens. A troubling example of one such call can be heard here [2]

The listener can easily determine, that unless the claimant is persistent, the insurer may decline the claim without ever having seen the clinical notes. It is worth remembering that most claims are for life changing amounts. The claimant in this case has just been refused a pay out of £150K, the average for 2019 was over £81K [3]

Given that it is the threat of the condition worsening that drove the claimant to make the call in the first place, such rejection can only promote more distress and uncertainty for the claimant and their dependants.

Note that claimants who defer their claim in this way are not included in the insurers statistics of rejected TI claims. However, if they go on to die within the policy term, they are included in the company's successful life insurance pay out statistics.

In this way the true size of the problem is masked, and the insurers claim statistics look fair to both potential new customers and regulators alike.

The true scope of the issue is difficult to ascertain as Insurers seem reluctant to divulge such figures.

The Association of British Insurers freely publishes claim rejection rates for all types of insurance but not life and terminal illness. Why is this?

On asking the ABI specifically for TI claim rejection data [4] The ABI responded '*the ABI does not hold this level of data for life insurance policies and terminal illness cover*' [5]
The FCA has responded similarly. [6]

Given that this issue has been in the public domain at least 6 years [7] Is it not reasonable to expect them to have investigated and hold current data?

## THE ISSUES

### PROOF OF MORBIDITY

Claimants who do decide to proceed with their claim have to prove that they are likely or expected to die within a given period; usually 12 months. [8]
Tragically many fail due to the problems already highlighted by the APPG TI. [9]
In 2015 a leading global advisor to the insurance industry completed a TI tracing exercise of 200 claimants who had made successful claims.
The following is an extract of that data.

| Survival Period after claim | Survived % | Died % |
|---|---|---|
| Up to 3 months | 75% | 25% |
| Up to 6 months | 54% | 46% |
| Up to 12 months | 29% | 71% |

It is important to remember that these figures represent the survival period of those claiming successfully, not those whose claims were rejected. They have been included to give an indication of how much insurers are mitigating their risk, given that 25% of claimants died within 3 months and a huge 71% died within the 12 month period. [10]

Further, given that life policy terms range from 1 – 40 years it is reasonable to consider that a majority of rejected TI claimants are likely to die within the policy term; with the result that the insurer would have to pay out anyway.

The reader may consider, that by the insurers own statistics, there is plenty of spare risk capacity to widen their QTI acceptance list, or even consider accepting all 'genuine' TI claimants. This would remove the unworkable 'Likely/Expected to die within 12 months' clause altogether.

The insurance industry has known for many years about the problems of proving morbidity.[7]

It is also fully aware that the requirement for clinicians to prove death within 12 months is 'virtually impossible to achieve'. [10] Its use of the term 'Likely to die within 12 months' is unsuitable both clinically and contractually. The evidence of the APPG TI report supports this supposition.

The ABI issued guidance to its members as far back as 2015, that the 'likely to die within 12 months' clause should be replaced with 'Expected to die within 12 months'. This adds clarity and reduces the risk of litigation against the insurer.

However, it does nothing to reduce the burden of proof for the claimant. [11]
The average customer is totally unaware of the difficulty of proving morbidity when buying the policy. The policy may therefore be considered unfair and biased towards the insurer.

A consideration that can only be tested when the new definition of 'terminal illness' is brought into English law.[12]

## THE ISSUES

### THE ADJUDICATION PATHWAY

Is initially via the FOS, who stated that 'I know you feel strongly the definition is unfair and inappropriate and shouldn't be sold to consumers. It isn't our role to comment on this' 'It is the responsibility of the FCA to police such matters.'[13]

The FCA acknowledge receipt of complaints regarding contracts but will not respond to individuals regarding progress, opinion, or outcome. [6]

In this way the problem may never obtain resolution as too few complainants survive or are fit enough to come forward.

**Financial Ombudsman Service**

Not their job to regulate unfair terms in insurance contracts[13]

**Financial Conduct Authority**

Will not respond to individuals regarding progress, opinion or outcome[14]

## THE CURRENT SITUATION

### SURVIVING CLAIMANTS

Hundreds of surviving but genuinely terminally ill claimants may await their death; emotionally and financially compromised through no fault of their own. Even if their policy pays out on death, irrevocable financial damage may already have been done.

Many will have been forced to sell their homes and draw on their pensions and savings just to cover their basic needs until they die. By the time that happens, the ability of dependants to financially support themselves may be vastly reduced. In this way such claimants will never receive the true value of the cover they thought they had secured.

### THE HIDDEN TRAGEDY

Over 10.8 Million policies with the 'Likely or expected to die within 12 months' clause are still in circulation. [15]

Given that 30% of these policies will claim TI, and the last published ABI rejection rate was 7%; more than 42,000 TI claims have the potential to fail. [16]

That is, 42,000 people, plus their dependants, at risk of misery and financial desperation.

And of course, 42,000 people who may become new benefit claimants!

## THE CURRENT SITUATION

### RECOMMENDATIONS

The FCA should be formally asked to urgently consider whether the 'Likely to die within 12 months' and 'Expected to die within 12 months clauses are unworkable.

If found to be so, the FCA should instruct the life insurance industry and the FOS to recognise that fact and to 'fall back' on the remaining requirement, proof of terminal illness.

To minimise suffering, all surviving policy holders affected by this issue should be urgently assessed first. If effected, their policy immediately paid out with automatic accrual of interest from the time of first claim.

Those affected posthumously, should also be assessed, and if effected, their policy paid out with automatic accrual of interest (less the policy value if death benefit already paid).

All remaining policy holders with affected policies, contacted and advised of an 'improvement' in their terms and conditions i.e. There is no longer a requirement to prove death within a timescale.

The ABI and Insurers may consider approval of a dynamic list of defined terminal illnesses from an independent body such as Cancer Research.

This list to be available as a central point of reference for both private and public sector claimants.

**FCA to consider if 'Likely to die within 12 months' unworkable**

**Insurers to fall back on proof of terminal illness**

**Surviving 'failed' claimants assessed urgently**

**Review of past claim rejections**

**Existing 'faulty' policy holders advised**

**Facilitate an independent dynamic list of 'Terminal Illnesses**

## REFERENCES




1 APPG TI Report 2019, Page 5

2 Recording of telephone call Aviva to Peter Bull 17/04/2015

3 Association of British Insurers statistics 01/05/2019

4 Email Peter Bull to Emma Elson, ABI 13/08/2020

5 Email Emma Elson, ABI to Peter Bull 14/08/2020

6 Email FCA to Peter Bull 23/05/2018

7 23/10/2014, BBC Watchdog Series 34, Episode 2, Only paying out if customers guarantee they will die within a year.

8 Aviva, Legal & General, Zurich Et al

9 APPG TI Report 2019, general theme.

10 SCOR Global, Presentation to Faculty of Actuaries UK 20/05/2016

11 APPG TI Et al

12 Welfare (Terminal Illness) Bill 2019-21

13 Email from Amma Simpson, FOS to Peter Bull 01/11/2016

14 FCA email to Peter Bull 23/05/18

15 Statista, 14/08/2020
Insurers who supply TI policies extracted from UK total life policies 2019

16 ABI 2015 published TI claim failure rate. Document now removed from public access. See slide 3 of SCOR Presentation


### THE AUTHOR


Peter Bull is a former Senior Business Continuity Manger for the NHS and DH who was diagnosed as 'Terminally Ill' with an advanced cancer in 2015.

Fortunately, he had made proper financial provision for such an eventuality via a ‘Terminal Illness’ life insurance policy.

His insurers declined to pay out, because although told he could die within months; he could not prove he would die within 12 months.

In pursuing that claim with his Insurers, Financial Ombudsman Service (FOS), and Financial Conduct Authority (FCA) Peter found sympathy but no resolution.

Whilst still terminally ill, Peter feels incredibly lucky to have survived long enough, to compile the accompanying report.

He hopes his discoveries, evidence, and observations, might make a difference for the millions of people who remain compromised and seriously vulnerable.