Toby Stubbs,
Financial Conduct Authority,
12 Endeavour Square,
London E20 1JN

29 April 2019

Dear Toby,

AFM Response to FCA CP19/8, General Insurance Value Measures reporting

1. I am writing in response to this consultation paper, on behalf of the Association of Financial Mutuals. The objectives we seek from our response are to:

   - Comment on the proposals in the consultation; and
   - Highlight shortcomings in the approach and concerns about the implications for insurers and their consumers.

2. The Association of Financial Mutuals (AFM) represents insurance and healthcare providers that are owned by their customers, or which are established to serve a defined community (on a not for profit basis). Between them, mutual insurers manage the savings, pensions, protection and healthcare needs of over 30 million people in the UK and Ireland, collect annual premium income of £19.6 billion, and employ nearly 30,000 staff[1].

3. The nature of their ownership and the consequently lower prices, higher returns or better service that typically results, make mutuals accessible and attractive to consumers, and have been recognised by Parliament as worthy of continued support and promotion. In particular, FCA and PRA are required to analyse whether new rules impose any significantly different consequences for mutual businesses[2] and to take account of corporate diversity[3].

[1] ICMIF, https://www.icmif.org/publications/market-insights/market-insights-uk-2016
[2] Financial Services Act 2012, section 138 K: http://www.legislation.gov.uk/ukpga/2012/21/section/24/enacted
[3] http://www.legislation.gov.uk/ukpga/2016/14/section/20/enacted

4. We welcome the opportunity to respond to this consultation. The genesis of FCA's work in this area, which centred on add-on purchases, was not directly relevant to AFM member companies, who do not sell such products. However the proposals in this consultation are much broader, and around 60% of our member companies are actively involved in providing products in scope, with a customer base between them of around 5 million people.

5. The stated objectives for the consultation are to address concerns about suitability and performance of some GI products, centred on 'addressing poor product value and quality, and to reducing the risk of unsuitable GI products being bought or sold'. FCA also seeks to improve transparency, encourage product improvements and to provide an additional tool for supervisors.

6. We agree that these objectives are broadly consistent with the statutory aims and obligations of the FCA. We are not convinced however that the proposals in the consultation are the right solutions to the issues FCA is seeking to address, nor that the degree to which FCA is potentially seeking to alter the competitive environment is compatible with its statutory objectives. In particular, we consider that the potential market distortion that may result, will potentially raise prices and reduce choice for consumers.

7. The nature and type of claims paid is a competitive advantage for some products and for some insurers. Publishing this data may have a damaging impact on the business: if an insurer offers certain features and benefits that create a larger volume of claims, or if the insurer is inclined to pay benefits that are non-contractual, as is often the case for mutual organisations, this will distort the statistics shown.

8. In some cases, as we have seen with claims management companies elsewhere, having a tendency to pay lots of claims draws in a larger number of invalid claims or claims that might reasonably not otherwise be pursued. Given the commoditised nature of some insurance products, and the low levels of profitability, this may undermine the viability of the product or organisation: where customers are price inelastic, an insurer may be forced to withdraw the product if it is constrained in raising prices.

9. We are equally concerned that FCA has not demonstrated it has the knowledge of general insurance products to report data in a meaningful and accurate format. We see numerous errors in the current pilot reporting, as well as variations in data published that are so significant as to provide no useful comparison between firms.

10. In cases such as these, consumer choice is reduced and prices will increase: this appears at odds with the FCA's desire to stimulate competition.

11. In summary, we see significant evident that claims handling is a competitive advantage for mutuals compared to the insurance industry as a whole; however as a result of the concerns we express above and elsewhere in our response, we do not agree that the proposals in this consultation will deliver better customer outcomes.

12. We attach our responses to specific questions raised in the consultation, and would welcome the opportunity to discuss further the issues raised by our response.

Yours sincerely,

Martin Shaw
Chief Executive
Association of Financial Mutuals

AFM responses to specific questions raised in the consultation

Q1: Do you agree with our proposals for the product scope?

It is unclear on what basis FCA has determined scope. The range of products bears no comparison with those in the pilot work, which itself was closely targeted and based on a careful market assessment.

The scope includes products for whom no previous work by FCA suggests poor value or the risk of mis-purchase.

If the FCA decides to take this initiative forward, we conclude the scope should remain narrow at this stage, and continue with products highlighted as problematic in the previous Market Study.

We note that FCA proposes to exclude 'commercial products' but has not clarified whether this includes products purchased by SMEs on a group basis, but with individual policyholder benefits. This includes a majority of private medical insurance and health cash plan products purchased in the UK.

Q2: Do you agree with our proposals on reporting responsibility?

We agree that the reporting responsibility should remain with insurers.

We agree it is important to collect data from EEA and Gibraltar based insurers, since the small number of FSCS referrals from insurers have largely been from insurers based in small countries outside the UK. We agree that introducing rules that require firms to report this data is important.

Q3: Do you agree with our proposal to require data to be split by the largest distribution arrangement?

We agree that any data reported needs to clearly relate to a specific product. Over many years, AFM members have reported their income protection claims statistics, where there is a measurable difference in claims compared to non-mutuals. We have seen an increase in recent years of PLC insurers seeking to disguise this, by publishing data on all protection products.

The proposal to capture data based on the five largest distribution arrangements and all remaining business, appears to suggest that claims experience will vary according to the sales channel used. That would suggest the objectives are a little blurred, and that FCA has particular concerns about particular channels. That being the case, it may be difficult to get the kind of data in a clearly and unambiguously presented form that a customer would understand.

To illustrate, one insurer might report data from sales through a price comparison site that contradict others. Should the consumer be wary then of the sales channel, of the insurer or of the product? Where FCA is concerned about the fairness of particular distribution channels, we suggest that is treated as a different exercise, and that the data here is single and consistent.

FCA appears to recognise the need for specific focus on distribution chains in GI with the launch of a thematic review in April (TR19/2). We suggest further consideration of this area is parked in the meantime.

In any event, most AFM members in scope of the proposals sell direct to customers. Where they do rely on third party distribution, the volumes may be very low: if the sales through a particular channel fall below the FCA threshold, should that channel be excluded, or should if fall into the 'other' category?

Q4: Do you agree with our proposals for the treatment of add-ons and optional extras?

We have no detailed comments on this issue, since add-on products are generally not provided by our members. We not though, as illustrated by our response to Q9 below, that the data tables provided for the 2018 pilot exercise, generate no clear and helpful data to consumers.

Q5: Do you agree with our proposals on granularity, reporting periods and frequency?

This initiative should only be conducted on an annual basis. Whilst FCA indicated it proposals to collect data for the calendar year to coincide with insurers' activities, it is not the case that all insurers financial years are on a calendar basis, so those firms with a September or March year end will be at a greater disadvantage.

Q6: Do you agree with our proposals for reporting thresholds?

The proposed thresholds are very low indeed. Most AFM members offer a single or narrow range of products, so for a health cash plan provider, by way of example, their entire book of business will be via a single product. Where the average premium of a cash plan product is around £100, a minimum volume for reporting purposes of 3,000 policies will constitute a very small organisation, where the costs of reporting would be completely disproportionate for an organisation with less than £1 million in premiums.

We suggest that whilst there is a product threshold, there is also a company threshold and that reporting excludes all non-directive insurers.

Q7: Do you agree with our proposals on the value measures metrics?

In general terms, we agree that price is a poor proxy for value in general insurance. The reason many of our members do not appear on price comparison sites is because they consider there is a tendency to disregard key features of a product through an overt focus on price. That increases the risk where a consumer buys the cheapest product on a website only to find that it fails to meet their needs.

Claims data is a better proxy for value, but not a perfect one. The nature of most insurance is that consumers generally hope not to have to make a claim: however, they gain a great deal of comfort by knowing the insurance is there.

In some cases, such as for PMI or cash plans, claims may be made in circumstances where the customer has not suffered claimable detriment: there may be cover for health checks, optical or dental checks etc; these would be included in claims statistics but with relatively high volumes of such events. Hence, the capacity of consumers, or FCA supervisors, to compare the value of the product will be undermined.

Insurance is in some cases impacted by external, catastrophic events. If insurers one year produce data that widely differs from the previous year, that may not be due to changes in practice, or through regulatory intervention, but to the nature of the product. Where FCA is seeking to measure differences in claims rates over time, it is not clear that the data will be useful in meeting its objectives.

Indeed, with regard to claims frequency, there are many reasons why this varies between products and between providers. Insurers that run a book of business with a higher likelihood of claims are providing a valuable service to customers, since they may otherwise be uninsured; however, the proposed data would not be able to pick up significant differences in product design or the different markets for which products are intended.

In other cases, the regularity of some claims will depend on the features in a product: a customer that buys a cash plan product and who opts to pay a higher premium to cover the cost of NHS prescriptions may as a result make 12 claims more a year than one where the customer has opted to exclude this feature. Hence the differences in claims data are entirely misleading, and could not be used reliable to judge that one product is better than another. That variance is even more apparent in the pilot data on add-ons, as we discuss in relation to Q9.

The proportion of claims paid will vary for a variety of reasons: within them are the type of differences FCA is concerned about, such as a defensive approach to

paying claims. However, there are valid reasons why a claim is not paid: in some cases, this is because the claim does not meet the terms of the product, and in others because there is no actual loss, or in other occasions because the customer has already received the full benefit payable in the year. There is a risk also that, unless there are specific definitions for each product type, the point at which there is a claimable incident will vary by product: in some cases the proposed approach may encourage insurers to reclassify some customer interactions (for example, as queries rather than claims), with the consequence that the number of recorded claims-related contacts by customers falls in order to improve their acceptance rates. This may lead to consumer detriment.

Included within the proposals for average claims payout, FCA proposes to collect data on the highest 2% and 5% of claims payouts by value. There are a number of problems with this: first, the value of claims paid out will necessarily depend on the nature of cover and the value of items covered. It will also depend on the premiums paid in some cases, since benefits from a product may be capped or subject to excesses or exclusions. In other cases, such as in health related claims, the payments may vary from less than £50 to over £100,000 and payments may run for several years. Information on average claim is therefore entirely misleading, and would misinform the customer, both in offering an exaggerated view on the typical value of claims paid, and in deciding to claim where this may impact on their no claims discount and as a result potentially increase future premiums by more than the value of the claim.

Capturing data in the way suggested here, as well as on claims-related complaints means some significant changes to insurer systems. For small insurers in particular this will have a significant effect on profitability and their capacity to remain in the market.

Q8: Do you agree with our proposals on metric definitions?

Our own experience of defining claims is such that it is difficult to define claims in a consistent and unambiguous way. AFM was not invited to participate in work within the pilot, so we cannot comment on the exercise to produce agreed definitions.

We think it would be very difficult and probably unhelpful to attempt a single definition of a claim. Whilst an incident leading to a claim on car insurance is relatively simple to define, there are a range of complicating issues for other products, particularly private medical insurance. To illustrate, FCA would need to clarify their definition to explain if a claim is the whole course of treatment for a single illness, each treatment episode or even each invoice payment. Similarly, whether a claim is accepted or not may also be ambiguous: a claim may be initially accepted for a consultation, but declined for further treatment once the diagnosis has been made.

We are also concerned that FCA has sought to redefine the point at which a customer enquiry should be registered as a claim (as per paragraph 5.13), as well as its approach to 'walkways/ walkaways' (the terms appear to be used interchangeably in the paper). The effect of this is to significantly distort the claims process: instead of a firm training staff to adopt a customer service approach, the use of punitive, complex and contrived data requirements will drive changes in staff behaviour. We consider this is likely to be to the detriment of good customer care.

Q9. Do you agree with our proposals for the publication of value measures data in bands?

The consultation paper does not set out the benefit of publication of data in bands. By necessity the bands will vary by product: for example, the average number of claims each year on a health cash plan product is around 2.5 claims per policy, whilst in other insurers, there are fewer than one in ten claims a year. It is difficult therefore to see what value is produced by banding.

In addition, it is concerning that the current reporting has some significant flaws, and that this reflects an apparent lack of understanding or challenge by FCA in the way it monitors data, and/or that the data generated offers so little valuable comparison as to be meaningless. To illustrate, in the third data set published:

- For home insurers the capacity to rank suppliers by claims frequency is not working properly: AFM member Cornish Mutual records a higher proportion of claims than other organisations, but the ranking fails.
- That same failure is apparent with Home emergency cover; additionally, either the numbers published are wrong, or the product offered by British Gas Insurance is vastly different to any other, since more than 95% of policies generate a claim every year according to FCA's data, compared to a median level of 5 to 7.4%. Even with products that offer 'free cash'- such as dental cover in a health cash plan- it is not conceivable that virtually every customer will make a claim every year, and we are concerned therefore that FCA is content to publish data that is so clearly wrong.
- Personal accident add-ons sold by NFU Mutual have a claims frequency stated of between 1% and 100%: a meaningless range in its own right, as it might mean virtually no, or virtually no, customers claim in a year. But the result is also completely at odds with the frequency of claims by other manufacturers of this product. In the same section, the average payout by Aviva is less than £500, whilst for LV= it is over £100,000, so again we must assume that the products are not comparable, or the data is wrong.

Q10: Do you agree with our proposal to add a specific requirement to our rules to cover the use of value measures data in the product oversight and governance process?

The proposals here reflect good practice generally, but they represent a valuable reminder of the kind of scrutiny an insurer should be undertaking of claims trends and data more generally, as well as the range of management actions they ought to explore if a trend becomes adverse.

We consider this is largely an internal exercise, and unlikely to benefit significantly from benchmarking data across the wider industry. We consider the Board of an insurer should be best-placed to assess what good value looks like, and should be able to articulate that clearly.

Q11: Do you agree with our cost benefit analysis?

A particular concern we have is that by its own admission, FCA has "not quantified the benefits" of its proposals and we question how that is consistent with its statutory obligations. We also concern the cost case is incomplete and misrepresents the true position.

The cost benefit case returns to the rationale for the pilot work FCA has undertaken so far. In so doing it focuses on the potential for harm in a small number of add-on and other products, but makes the dangerous assumption that some of those problems may be lurking in other product areas, without presenting evidence to support the view.

We are concerned that these proposals have been issued without any clear evidence that the pilot work so far has delivered any benefit. We would expect FCA to collect sufficient data to be able to tangibly demonstrate whether or not its objectives were being achieved with those pilot products, before it launched proposals across others. As we highlight above, FCA has the failed to present accurate data from the pilot, and this is in itself likely to lead to harmful conclusions by consumers or their advisers.

We have a particular concern that the various products cited in the cost-benefit analysis do not include healthcare products. It is unhelpful therefore that a significant business line for AFM members (and some other insurers) is included in this work without any proper consideration. As we highlighted above, there are significant differences in the nature of healthcare products that have not been considered or understood.

FCA's proposals will create significant disruption and cost to firms in the first instance, in terms of changing internal processes and procedures, training staff and making system changes. This is not properly reflected in the cost analysis,

which disappointingly give more attention to the costs for firms of reading the consultation paper than they do the complex and significant investments in time and resource needed to comply.

Some of the key costs overlooked in the analysis include:

- the IT development time needed for small organisations, who are unlikely to have the breadth of data currently required, particularly as the thresholds are disproportionately high and include many non-Directive insurers;
- the need to re-write definitions of a claim, and relevant claims procedures and processes;
- the cost of staff training on new procedures and reporting requirements;
- the impact on consumers on higher prices to readjust the economics of some products;
- the failure costs of wrong and meaningless data being published;
- the impact on consumers of the reduction in choice of products available where, as we suspect, the problems inherent in this exercise lead to the withdrawal of products.