MEDICALLY UNDERWRITTEN BULK ANNUITIES

A User Guide

June 2016

FOREWORD

The use of medical and lifestyle data to underwrite life expectancy is not new. It has been common for over 10 years within the retail annuity market with hundreds of thousands of retail annuities purchased by consumers on this basis.

The use of medical and lifestyle data to help price bulk annuities was first introduced in 2012 and its usage has grown consistently each year since then. In total there have now been over 50 medically underwritten bulk annuity transactions with around 20% (by number) of all bulk annuity transactions in 2015 being medically underwritten. What this means is that the understanding and experience of Medically Underwritten Bulk Annuities (MUBAs) across the pensions industry has increased substantially over the last few years and so Trustees that do choose to go down this route are following a well-trodden path followed by many previous pension schemes.

The February 2013 report by the Pensions Institute, entitled “A Healthier Way to De-Risk”, signposted the need for a Code of Conduct and guidance to ensure consistent, safe and efficient practice in this new area of underwriting in relation to defined benefit scheme de-risking, MUBA. The paper also expressed a need for information for stakeholders and a number of practitioners agreed that guidance in this area could be helpful. We started on this journey in 2013, but the sudden introduction of pension freedoms in 2014 and its impact on annuities forced us to step back to consider the longer term effects before continuing. With resurgence of interest in such solutions, we picked up the baton again in 2015. A follow up report entitled "The Good, the Bad and the Healthy: The medical underwriting revolution in the defined benefit de-risking market", was published by the Pensions Institute in January 2016.

Different Insurers have slightly different preferred approaches to the MUBA data collection process and there is a risk that generally the differences relative to traditional bulk annuities are not appreciated. While Insurers and Consultants should be free to develop products and approaches to maintain competitiveness, it is essential that Trustees and other users understand enough of the general concept and the process to be able to ask appropriate questions of their Consultants. This Guide has been written to help provide a firm basis of understanding of MUBAs in general terms as well as an appreciation of the variety of approaches and how those approaches may affect outcomes. It is factual, practical and impartial and is not sponsored by any firm. It does not promote medical underwriting or provide guidance on whether or not it is the right option for any particular pension scheme, but endeavours to explain medical underwriting in terms that users will understand and to provide an overview of the options available, how it may be undertaken, share current best practice and the aspects that should be considered.

The Guide does not cover the bulk annuity process in general, simply the elements relevant to medically underwritten transactions, nor does this Guide replace the need for schemes and sponsors to obtain advice, where they feel it is appropriate to do so. For background on bulk annuities, the reader may wish to refer to the ABI/PLSA guide to Bulk Insured Pensions, published in September 2011 or to the many articles written on the subject in the pensions media.

This Guide has been written by a Working Group of key contributors representing Insurers, employee benefit consultants, legal advisers, data collection specialists and trustees, who are listed on page 6. I am very grateful to all of them for giving their time to write this

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Chairman of Working Group

CONTENTS

MEDICALLY UNDERWRITTEN BULK ANNUITIES ... 1
A User Guide ... 1
ACKNOWLEGEMENTS ... 6
1. INTRODUCTION ... 8
1.1. What is a MUBA? ... 8
1.2. Assessing life expectancy ... 8
1.3. How a MUBA works ... 9
1.4. How to get started ... 10
1.5. Pricing considerations ... 10
2. THE PROCESS ... 13
2.1. Typical MUBA process ... 13
2.2. Collecting medical data ... 13
2.2.1.Telephone interviews ... 14
2.2.2.GP Reports ... 14
2.2.3.Who collects the data? ... 15
2.2.4. Selecting the members to medically underwrite ... 15
2.2.5.How long does it take? ... 16
2.2.6.Maximising participation ... 16
2.3. Selecting a Data Collector ... 18
2.3.1.Services & experience ... 18
2.3.2.Operating a fair tender ... 18
2.3.3.Working with Insurers ... 19
3. LEGISLATION & DATA PROTECTION ... 20
3.1. Terms and conditions ... 20
3.2. Compliance with legislation ... 20
3.3. Data Protection ... 20
3.4. Who sees the data ... 20
3.5. Keeping the data secure ... 21
4. CASE STUDIES ... 22
Introduction ... 22
Case study 1: “Top-slice” approach involving four Insurers ... 23
Case study 2: Pensioner buy-in involving three Insurers ... 25

Case study 3: Full scheme buyout involving one Insurer 27
GLOSSARY OF TERMS..29

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1. INTRODUCTION

1.1. What is a MUBA?

All annuity contracts require the Insurer to make an assumption about how long the person(s) covered by the contract will live for. This assumption feeds into the Insurer's price for the contract. The longer the person(s) is expected to live, the higher the price will be, because the benefit is expected to be paid for longer.

The individual annuity market has used medical underwriting for many years when pricing annuity contracts. Insurers regularly collect medical data about each individual and use underwriting processes to assess that individual's life expectancy and price the annuity. That is particularly the case where the individual thinks they have a shorter life expectancy than an Insurer might assume without using the medical information and so hopes to benefit from more favourable pricing based on what are known as "impaired life" terms.

In a MUBA the Insurer looks at medical and lifestyle information for the specific individuals covered by the bulk annuity policy in a similar way to individual annuities. The Insurer uses that medical and lifestyle information to form a more informed view of the life expectancy of the people covered by the contract and prices the contract accordingly. It should be emphasised that a MUBA project does not necessarily mean the annuity price will be lower. There are many factors which affect contract pricing, for example assumed asset returns and profit requirements. All else being equal, however, having access to more information about life expectancy could lead to a lower price, but it could also lead to the same or a higher price.

1.2. Assessing life expectancy

For individual annuities, if an Insurer prices annuities without using medical information, you will have some individuals winning and some losing, depending on whether they are expected to live longer or shorter than the average term an insurer would typically assume in the absence of medical information. The extent to which individuals may "win or lose" is expected to be reduced with medical underwriting.

When using averages for pricing an annuity, individuals can be broken down into certain groups with similar characteristics. Groups can be identified in a number of ways:

- demographic factors – people of same sex, age and marital status
- socio-economic factors – people who live in similar areas with similar levels of income
- health factors – people who have similar medical histories and/or existing conditions.

For bulk annuities the assessment of average life expectancy traditionally uses a group approach, but typically assumptions are individually derived from demographic and socio-economic factors overlaid with scheme level factors. The assumption is that individuals who have worked for the same employer doing the same job, with similar remuneration,

will experience similar life expectancy and this is supported by evidence based on statistical modelling. Until recently the actual health and lifestyles of individuals within the scheme has been ignored. Instead Insurers have refined averages by applying broader scheme factors, such as postcode data, type of industry or job type and, for large schemes with good quality data, the scheme's actual mortality experience.

To some extent this approach relies on the law of large numbers reverting to average, which is normally reasonable when a larger number of members are involved in the annuity transaction However, in recent years this practice has been challenged and some Insurers are using individuals' health and lifestyle data to inform pricing decisions for bulk annuity transactions.

It is generally accepted that for an individual member, the use of their own specific health and lifestyle data can provide a significantly better estimate of life expectancy to that seen under a traditional pricing approach. This could lead to a decrease or an increase to the individual's life expectancy depending on how that member compares to their broader comparable Group.

Statistics would imply that the health of the scheme's population is expected to trend towards the average as the number of members included in the transaction increases. However, even the largest pension schemes may have a group of members (e.g. the pensioners with the largest pensions, who account for a large proportion of the longevity risk in the scheme) that could be suitable for a MUBA even though the remaining members are not. This is an area where MUBA can be deployed to offer significant risk reduction, which is a matter on which Trustees should take advice from their Consultants.

1.3. How a MUBA works

Compared to a traditional bulk annuity, a MUBA project incorporates two additional elements. The first is the process by which medical data is collected on individuals. The second is the use of that data to assess the individual's health and lifestyle to make an estimate of their longevity in order to price the bulk annuity.

There are a number of different ways to collect medical data for a MUBA project. These are summarised in section 2 of this Guide. What is appropriate for any particular project will depend on factors such as the number of members involved, the general characteristics of the membership and ultimately the data requirements of the Insurers involved.

One of the key decisions in relation to a MUBA project is deciding which members to involve in the medical underwriting exercise. It is often not necessary to carry out medical underwriting for all members and a cost/benefit analysis is needed to work out which members to include in the process. The choice of how many members to underwrite, or not, can influence whether some Insurers will quote. This is worth considering when designing the process.

One approach for pension schemes is to enter into a MUBA contract for just the "top slice" of members – typically meaning the group of members with the largest pension liabilities in the scheme. These members have a high concentration of longevity risk for the Insurer and so using medical underwriting can have the biggest impact in terms of better estimating longevity in the annuity price. Case study 1 on page 20 is an example of a top slice

approach. It is worth noting that even though some members will create a material concentration of risk for a scheme, for most Insurers the impact is less material in terms of their overall business. This means pricing can appear more attractive for the risk reduction achieved. Top slicing is not exclusively a medical underwriting solution, although it is common for top slice transactions to involve medical underwriting.

An alternative process is to collect medical data after the transaction, with the medical data being used to refine the price offered by the selected Insurer.

In all cases, the insurance contract applies to all the members, or the selected subset of the scheme, not just those that take part in medical underwriting.

1.4. How to get started

A number of Consultants and Data Collectors have now completed MUBA projects and have good experience of running MUBA projects. They work closely with the participating Insurers and Trustees to agree a process and documentation which suits the needs of each pension scheme.

Insurers have different views on the best process to use. The process may therefore be different depending on the Insurers selected and whether you are inviting more than one Insurer to quote.

Your Consultant should be able to advise you on how to structure your project and the best approach to use for your scheme.

Health and lifestyle data is, by its nature, very personal to scheme members. Yet medical underwriting can only impact the price of a transaction if members are willing to provide their health and lifestyle data and if it can be obtained in a timely manner. There is no way to compel members to provide their medical data, and in any exercise it should be recognised that there could be individuals for whom collecting medical data will not be possible. However, the process needs to be structured in a way which is likely to achieve the best level of member engagement in the project.

Few Trustees have experience of collecting health and lifestyle data. If medical underwriting is determined to be appropriate for your scheme this Guide will hopefully assist in explaining how best to approach the project. However, you are likely to need advice from Consultants and Data Collectors who are experienced in the design of efficient data collection processes.

1.5. Pricing considerations

So far, we have only talked about the impact that medical underwriting has on estimating life expectancy. All things being equal, a lower life expectancy will lead to a lower annuity price. However, annuity pricing depends on a number of other factors, including: other demographics, anticipated investment returns, expense allowances, expected inflation costs and cost of capital (or profit margin). Different Insurers will have different views on individual and scheme life expectancy as well as the other various assumptions used to

determine price. Some assumptions remain relatively stable, while others may change to reflect changing conditions, for example as a result of changing financial market conditions or in the case of longevity following experience analysis or the findings of new research.

As with the traditional bulk annuity market, such changes in assumptions lead to changes in the relative competitiveness of prices between Insurers. Not all Insurers offer MUBA transactions and it is important to remember that relative pricing differences between Insurers can outweigh the pricing impact of going through a medical underwriting exercise. Similarly, pricing changes over time - particularly with movements in financial markets - and a delay in transacting whilst you collect medical data can have an impact on the price you end up paying for your bulk annuity. To help address this, some Insurers have developed their proposition such that the medical underwriting exercise can be carried out after the transaction.

Starting a medical underwriting exercise needs careful consideration, given a transaction may not always be seen through to completion. If you have collected medical data and it has been used for pricing, the overall life expectancy priced may be higher or lower than under a traditional bulk annuity price. Once you have collected medical information, you will be obliged to make any future insurers aware that you carried out a medical underwriting exercise. This means that once you go down the medical underwriting route it is unlikely you will be able to get a bulk annuity on standard rates for a period of time. This is because traditional Insurers will perceive a risk that, having gone through the exercise, you would only choose the standard rate if it turned out your members were healthier than a traditional scheme level assessment. Whether to follow a medically underwritten approach or standard approach is therefore a fundamental part of the design process for any bulk annuity project.

If a transaction does occur, Insurers are unlikely to offer worse traditional pricing for other parts of the membership as a consequence of using medical underwriting if you completed a MUBA project using a top slice approach. As long as you can demonstrate that the members included in the top slice project were selected based on objective measures such as liability size (rather than based on factors which might suggest a shorter than average life expectancy, such as ill-health retirees), and communicate openly with the Insurers, traditional Insurers are still likely to offer standard terms for the rest of the membership.

In making the decision as to whether to collect medical data, trustees should weigh up the following:

- The number of lives in the scheme
- The potential benefits to the price from medical underwriting (for example, the Trustees may have general knowledge about the health/lifestyle of members being covered)
- The impact on the selection process and the Insurers involved
- The implications if the price increases because members are, on average, healthier than expected
- The data collection process and any impacts on timescales

- If the members being considered for inclusion are just a subset of scheme membership, how the market will view the selection of those members.

2. THE PROCESS

Medical underwriting is the process of interpreting health and lifestyle information on individuals in order to assess their longevity. It has evolved over many decades in the Life Insurance industry.

Data Collectors and Insurers have agreed their own standard medical data collection and underwriting processes that have been successfully used and taking account of member sensitivities and meeting data protection requirements. While these processes are not cast in stone, any variation requires careful consideration, as they may have legal, pricing and data protection implications.

2.1. Typical MUBA process

The MUBA process is essentially the same as the traditional processes with the following additions steps:

1. Select and formalise appointment terms for Data Collector
2. Discuss and agree data collection process with all parties (Data Collector, Consultants and Insurers)
3. Agree the member communication process and draft member communications
4. Collect medical data using the agreed collection methods
5. Provide secure access to medical data to Insurers for medical underwriting and factoring in to their pricing.

Medical data can be collected shortly before the quotation broking process. If this is undertaken, then consideration should be given to the time period between the medical data collection and the tender. The trustees may wish to appoint a Consultant to help with this process.

2.2. Collecting medical data

There are a number of methods for collecting health and lifestyle information. Those currently used in the MUBA market are set out below:

Method	**Description**	**Suitability**
Simple paper questionnaire	A one-page questionnaire, with simple Yes/No questions	Easy and cost effective to include with an initial letter to the scheme member. Useful as an initial screen to identify if a Telephone-Interview or GP Report is appropriate

Table 1

Paper questionnaire	A 15-page questionnaire following the Common Quotation Request Form (CQRF) that is standard in the individual annuity market	Presently only used sparingly in the MUBA market and only if requested by the scheme member, as an alternative to the Telephone-Interview
Telephone Interview	An interactive interview over the phone	A quick and cost effective way to collect information in a sensitive manner from scheme members More detailed medical information can be collected if the call is conducted by a Medically Trained person
GP Reports	A report from the members' GP on their health	A good source of independent and objective medical information

2.2.1.Telephone interviews

One medical data collection method comes from direct telephone interviews with members. When done well, this leads to the receipt of good quality medical and lifestyle data. However, it is a sensitive process and needs to be carefully handled. A telephone interview service might include:

- A discussion to assist the member to recall their specific health history
- Voice recording systems and the ability to index the interview recordings
- Procedures and controls when speaking with scheme members and, where relevant, their spouses
- Robust methods for checking identity
- Quality checking, audit processes and reporting, including the ability to check and validate volunteered information
- The production of reports from interviews, to reduce the number of calls that Insurers feel they need to listen to.

In all cases, the individual carrying out the interview should have sufficient training in medical issues, the scheme background and the requirements of a MUBA underwriting exercise.

2.2.2.GP Reports

The collection of medical records from a member's GP must comply with the Access to Medical Records Act 1988. This legislation has specific requirements for the notices given

to the member and the requirement for their consent. It also sets out requirements for how consents are passed to the GP.

In addition, there is guidance from the Association of British Insurers and the British Medical Association on the process for obtaining GP Reports. It is advisable that this guidance is also complied with by medical data collectors.

2.2.3.Who collects the data?

There are two ways medical data is collected in the MUBA market:

1. In a brokered bulk annuity process, where several Insurers tender for the contract, the medical data collection is undertaken by an independent company (see Case Studies 1 and 2). The trustees will select the Data Collector

2. Alternatively, for a project where a single Insurer is selected to provide medically underwritten pricing, the medical data collection and underwriting may be undertaken in a process run by the selected Insurer (see Case Study 3). That Insurer will decide whether to collect the medical information themselves or use a third party (at their expense).

Collecting individual medical data obviously involves additional cost. For a brokered process, the Trustees employ and pay the Data Collector, when the work is undertaken. If the bulk annuity transaction goes ahead, the winning Insurer may reimburse the Trustees for the costs, but are only likely to do so if the Insurer has approved the medical underwriting process and the costs prior to starting the process.

For a single Insurer process, the Insurer will usually meet the costs of the medical underwriting process. It should be remembered that in all cases (brokered or single Insurer) the Insurer will factor any such costs into its contract pricing.

These costs should be reviewed in the context of potential savings that a MUBA could bring to the premium.

2.2.4. Selecting the members to medically underwrite

There is a need to balance the potential price implications from having the best possible medical data for the relevant members against the cost of the medical data collection exercise. Rarely do you need to collect medical data on all members. It is therefore important to select the right membership group required to participate in the underwriting process.

It is crucial that Insurers are happy with the selection criteria. This is for two main reasons:

1. To satisfy the Insurers that there was no bias in the selection

2. To ensure that the Insurers have the right data for key members.

For “top slicing” projects, the selection of members for Medical Underwriting is based on the size of their liabilities (or pension). For other projects, you will need to agree your own sample criteria with the Insurers – typically excluding small liabilities.

You should never try to target those of a particular health status. This may not be so critical for the MUBA Insurer, but such selection would become a problem later for a non MUBA Insurer looking at the population you don’t insure. Insurers want to ensure that the choice of members is objective to avoid selection against them. Trustees are encouraged to use objective criteria, such as age and liability size.

Your Consultant will advise you on the most suitable data collection methods for your project. Typically, this will be influenced by:

- The particular requirements of the Insurers tendering
- The amount, numbers and profile of the liabilities of the scheme members
- How receptive scheme members may be to different approaches.

Your Consultant should discuss the proposed method with the tendering Insurers and Data Collector to ensure they are happy with it.

The method will usually vary depending on liability size of the members being contacted, with typically a more in depth process for members with the larger liabilities, which may involve spouses being included in the underwriting process.

Typically all selected members are sent a simple paper questionnaire. From that, the ones who indicated a medical condition that may materially impact life expectancy are then contacted for an interview and/or a GP report is requested. For certain members, the Insurer will want to also obtain further information on the spouse. This communication to members is also a useful opportunity to confirm certain personal details, for example marital status and spouse’s date of birth.

2.2.5.How long does it take?

The time it takes to collect medical data does vary greatly. Experience to-date has shown that a “cut off” date of around 8 weeks should yield around 70% of the cases returned. If there is a high proportion of GP Reports required, then 10-12 weeks is more appropriate. The Insurer and Consultant would typically undertake other relevant work whilst the medical data is being collected which means that the end to end transaction timescale for a MUBA does not need to be materially different to a traditional bulk annuity.

2.2.6.Maximising participation

The aim of the exercise is to collect good quality data on targeted members and to maximise responses from those members.

Participation of scheme members is voluntary and as a result, participation rates vary. Experience suggests that very few scheme members consciously do not want to participate.

Trustees should therefore discuss with their Consultant the best approaches to use.

The quality of the available member contact information will have an impact on the level of member engagement. Obviously if you cannot contact a member you will not be in a position to obtain their medical data.

For some schemes there are formal or informal social groups among the membership which can have a big impact on the level of member engagement in the process. Approaching just a proportion of those in the group, knowingly or otherwise, can have a negative impact on response rates as other members of the group, who are not contacted, may feel excluded and criticise the exercise. On the other hand, if all members of these groups are engaged in the process, it can have a beneficial impact on response rates.

A clear benefit is to have Trustee involvement in the project. For smaller projects a Trustee or influential member can be interviewed early in the process, and can hence promote the process from experience. This type of Trustee involvement was used successfully in Case Study 1.

Every scheme is different but these are some tips on what has been found to help and hinder participation:

Do

- Consider previous experience of communications with the scheme members
- Consider the attitude of the scheme members to the Company and Trustees
- Provide clear, easy to read communication to the scheme members
- Consider different communications for employees, pensioners, deferred pensioners and spouses
- Provide full contact information and phone numbers where available
- Provide letters on trustee or company letterhead
- Make clear that the information provided by the member will not be shared with the trustees or the company, but will just be available to the Insurers for the purposes of this underwriting exercise only
- Explain that the process will not impact the level of members' benefits in the scheme
- Explain why members should participate (e.g., explain that if the process is successful there will be a reduction in risk for the scheme).

Don't

- Run a MUBA project alongside another project communicating with the scheme members as this is likely to confuse them
- Provide lengthy legally worded documentation
- Include any "opt-out" options on letters, as this actively encourages members to exclude themselves from participating. However, some Trustees may prefer to have an opt out option available to members.

Consultants, Insurers and Data Collectors have standard and sample letters and communications that have been used on previous projects and these are a good place to start. Some Insurers have also developed their own guides and toolkits to help run a robust process.

Some early exercises offered incentives to members to participate in the medical data collection process. There have been varying degrees of success when using incentives so careful thought is needed before offering anything to members. It is important that any incentive rewards members for engaging in the process, not for the information they provide. In some circumstances, it can be acceptable to offer members something like a voucher for a shop if they agree to respond to the written questionnaire, or agree to carry out a telephone interview. However, general market practice and experience is that incentives are not necessary.

2.3. Selecting a Data Collector

In selecting the company to undertake the data collection, Trustees may like to take recommendations from their Consultant and consider the following factors.

2.3.1. Services & experience

Issues to consider are:

- Data Protection processes
- Experience of the data collector has been involved in medical underwriting for bulk annuity transactions
- Integration with the wider MUBA project and the Consultant
- Their ability to capture accurate medical data from members
- Typical response rates and quality of data received from previous exercises
- Range of services offered i.e. Telephone -interviews, GP Reports and their appropriateness for the particular project
- Reporting and management reporting for Insurers, Consultants and Trustees
- Customer service and customer complaints
- Cost.

2.3.2. Operating a fair tender

For a brokered process there are some high level obligations on the medical Data Collector that are imposed by the Insurers to ensure a fair market.

The Data Collector should share all obtained information with all the tendering Insurers. This should be shared at the same time and certainly not biased in any way to favour one or other Insurer.

The Data Collector should present the data in a neutral way. It should not try to bias the results of the data collection in any way so as to present data in a favourable or un-

favourable position. The Trustees and their Consultant should also not attempt to bias the medical underwriting exercise in any way.

2.3.3.Working with Insurers

Insurers need to rely on the medical data collected, and will be more willing to do so if the perceived risks in the collection of that data are reduced.

Insurers are encouraged if the Data Collector can provide transparency for example by granting access to voice recordings of phone calls or real-time on-line systems that the Insurers can use to see the progress of all cases.

Trustees may consider the ability of the Data Collector to liaise and negotiate a common process for the project with the Insurers.

3. LEGISLATION & DATA PROTECTION

3.1. Terms and conditions

Trustees will require an agreement with Insurers and Data Collectors to ensure that the process meets their requirements whilst complying with all necessary legislation. Standard terms and conditions are usually available. The key elements these should cover are:

- Data Protection (including use of data)
- Confidentiality
- Service specification
- Remuneration.

3.2. Compliance with legislation

Relevant legislation, including, but not limited to the Acts listed below, needs to be complied with when running a medical data collection project:

- Access to Medical Reports Act 1988
- Data Protection Act 1998
- Financial Services and Markets Act 2000
- Insurance Act 2015.

Data Collectors should be registered and authorised by the Financial Conduct Authority (FCA).

3.3. Data Protection

Contracts with Insurers and Data Collectors should include clear obligations with regard to the Data Protection Act and keeping data secure. Practically this comes down to the electronic systems and portals used and the practices within the company.

Trustees will be the data controller under the Data Protection Act of the member data used for the data collection process. That means they are ultimately responsible for the data and keeping it secure and so they need to ensure that the collection and use of the medical information for the Medical Underwriting process complies with the Data Protection Act.

3.4. Who sees the data

Typically, the sensitive and personal data on individuals is not shared with the Trustees, the Company or Consultants. This is for two reasons; first, the scheme members are more likely to divulge information if they know that their ex-colleagues will not see it, and second, as required under the Data Protection Act, personal data should only be seen by the people who need to see it. Trustees should make this clear to members in the communications.

There is an exemption to this, in that address, phone contact details, details of spouses, their date of birth and any financial dependants may be fed back to the trustees to improve the future administration of the scheme. Member communications should make this clear.

3.5. Keeping the data secure

Data Collectors will typically use secure portal systems to share the collected data with the tendering Insurers. Portals are built to manage the data and restrict access to only those who need to see it. By the nature of these systems it is difficult to change the process to accommodate individual projects and any such change risks undermining the security protections built into the standard process.

Trustees need to make sure the Data Collector and all Insurers are under a legally enforceable obligation to delete the data once the transaction is complete and such data is no longer required.

4. CASE STUDIES

Introduction

Three case studies are presented below to illustrate the process of carrying out a medically underwritten bulk annuity transaction:

- The first of these case studies looks at a “top slice” pensioner buy-in where four insurance companies provided quotations
- The second looks at a pensioner buy-in transaction where three Insurers provided quotations
- The third looks at a whole scheme buy-out where only a single Insurer provided a quotation.

Case study 1: “Top-slice” approach involving four Insurers

In this transaction a specific subset of the scheme membership was chosen by the Trustee, with their Consultants, to be medically underwritten prior to obtaining quotations for a buy-in policy covering just that subset of members. The individuals included in the subset were the 100 current pensioners with the highest individual liabilities in the pension scheme.

Four insurance companies were invited to provide quotations. All four Insurers agreed to provide the quotations requested.

Key features of the transaction

Number of members	100
Age profile of members	Average age 69
Liability profile	All large individual liabilities > £500k
Method of underwriting	Telephone interview followed by GP Reports for all members
Members underwritten	All 100 members and their current spouses were asked to take part
Response rate	c.80% by liability
Time to transaction	4 months from the start of medical underwriting

Since all 100 members had individual liabilities greater than £500k the trustees took the decision to seek to underwrite all 100 members (together with their current spouses).

The trustees also decided that for this group of members (who were former senior individuals within their organisation) the best quality information would be obtained by omitting the step of sending members a paper questionnaire – all members were instead asked to undergo a telephone interview.

Because four insurance companies had agreed to provide quotations, the trustees appointed a third party to gather the medical data on their behalf.

An outline of the process is as follows:

1. Two Trustees of the pension scheme undertook a test telephone interview with the appointed Data Collector
2. The 100 members were then sent a letter explaining the underwriting process and asking them to take part. The letter mentioned the fact that two of the Trustees of the pension scheme had already been through the process

3. If members were comfortable taking part, they arranged a telephone interview with the Data Collector. If any member was uncomfortable taking part in a telephone interview they were instead asked to complete a paper questionnaire

4. In all cases a follow-up GP Report was also requested (although in some cases the Data Collector asked for only a Targeted GP Report)

5. If any member did not respond to the initial letter, one "chaser" letter was issued. Where the member was known to a trustee of the pension scheme, an attempt was also made to speak with the member concerned to encourage their participation

6. If any member did not respond to either the initial letter or the chaser letter, no further contact was made with that member.

Outcome

The outcome of the underwriting process was that:

1. c80% of members (by liability) responded to either the initial letter or the chaser letter

2. Of those who responded, 2 members refused to take part, the remainder were willing to be medically-underwritten

3. Medical information was received in respect of over 70% of the subset, by liability.

Throughout the process the trustees (together with representatives of the sponsoring employer) were keen to spend time speaking with members (either over the phone or through email exchanges) to maximise member engagement. It is likely that member engagement would have been lower had the trustees (and sponsoring employer) not done so.

The time between the initial letter being sent to members, and the insurance companies providing their final quotations was around four months.

Case study 2: Pensioner buy-in involving three Insurers

This transaction related to a very mature scheme, with current pensioners accounting for over 70% of the total scheme liabilities. The scheme had concentrated longevity risk, with under 30% of pensioners representing over 85% of the pensioner liabilities. Several of the highest individual pensioner liabilities were in respect of individuals who were known to the current board.

All current pensioners were included in the buy-in policy. However, of the 33 scheme members, 24 had small individual liabilities and, on this basis, it was agreed that they would not be medically underwritten.

Four Insurers known to be willing to provide quotations on a medically-underwritten basis were approached for a quotation and three of them agreed to participate in the exercise.

Key features of the transaction

Number of members	33
Age profile of members	Average age 68
Liability profile	All current pensioner members
Method of underwriting	Questionnaire, followed by telephone interview GP Reports obtained for a number of members
Members underwritten	9 members with the largest individual liabilities, plus their current spouses
Response rate	All members; c.85% by liability
Time to transaction	5 months from start of broking process

Following a pre-agreed process and timescales, a third party was appointed by the trustees to gather the medical data and provide this to the three Insurers involved in the exercise.

In order to improve response rates, the members were written to in advance of the exercise, to provide some background to why the exercise was taking place and to ask for their co-operation with the exercise.

An outline of the process is as follows:

1. An initial letter from the sponsor was sent to members to prepare the ground for the exercise
2. The third party Data Collector issued a short health questionnaire, consisting mostly of “yes/no” responses

3. Depending on the responses provided on the short health questionnaire, the third party Data Collector decided whether a telephone interview was appropriate, arranged at a time proposed by each member and carried out by trained nurses

4. For a number of members, the third party Data Collector arrange for the medical information provided to be verified via a GP Report (or Targeted GP Report if appropriate)

5. A chaser letter was drafted but not issued as all members returned their questionnaires promptly.

Outcome

The initial engagement with the members proved beneficial as all members responded to the individual questionnaire. All GP Reports requested were also provided within the required timescales (one from abroad).

The impressive response rate meant that the Insurers were able to underwrite virtually all members targeted – the only exception was the spouse of one of the members (who happened to be the one with the smallest liability in the underwritten group).

The entire process (broking, underwriting and transaction) took five months.

Case study 3: Full scheme buyout involving one Insurer

This transaction related to a scheme closed to new entrants and further accrual for a number of years. The trustee (with sponsor support) wished to buyout the scheme liabilities and wind up the scheme. The profile of the membership, by geographical location and industrial sector, suggested that an underwritten approach may be beneficial. The trustees had some knowledge of health and lifestyle conditions affecting a number of members with significant liabilities.

One Insurer only was approached, as they were the only Insurer able to offer an underwritten process for a population including deferred members.

Key features of the transaction

Number of members	178 deferred members, and 187 pensioners
Age profile of members	Average age 53 (deferred members) Average age 72 (pensioner members)
Liability profile	All pensioner and deferred members
Method of underwriting	Questionnaire, followed by telephone interview for some members; GP Reports obtained for a small number of members
Members underwritten	126 individuals and spouses; 62 of these being deferred members and the rest pensioners and dependants
Response rate	51% of members responded; equivalent to 42% of the scheme liabilities
Time to transaction	12 months from start of broking process

The Insurer set a minimum proportion of liability beneath which they decided that the underwriting process was not necessary. As a result, it was agreed that only a small subsection of members would be involved in the underwriting exercise.

The Insurer appointed a third party to manage the gathering of the medical data. Different correspondence and forms were used for the various member categories.

The Trustees were mindful that, as the underwriting exercise would include deferred members, particular care would have to be taken in respect of the correspondence as deferred members are normally less engaged than pensioners. Finalising the member letters took some time and goes part of the way to explain the protracted timescale before a transaction was finalised.

An outline of the process is as follows:

1. The initial letter was sent [by the trustees] and included a short health questionnaire, requiring “yes/no” responses for screening purposes
2. The Data Collector reviewed the answers to the screening questionnaires and then selected a number of respondents for telephone interviews, carried out by trained nurses
3. GP Reports were also obtained for a proportion of members where the Data Collector decided it was appropriate to do so
4. One chaser letter was issued approximately three weeks after the initial letter.

Outcome

Regardless of the effort made to tailor the member correspondence to fit the scheme membership, the overall response rate was lower than average. This is likely due to the difficulty in communicating with the deferred population. However, the Insurer was able to collect sufficient information in order to calculate an acceptable premium for the policy.

The entire process (initial broking, underwriting and transaction) took around 12 months.

GLOSSARY OF TERMS

Bulk annuity	A contract with an Insurer under which the pension benefits relating to a group of members are insured.
Consultant	The pension professional or firm which advises the trustees on the MUBA process.
Data Collector	A third party who runs the exercise to collect individual member medical data to share with the Insurers.
GP Report	A report from the member's GP on their health.
Individual annuity	A contract with an Insurer under which the pension benefits of just one individual member are insured.
Insurer	The life insurance company which is quoting to enter into a bulk annuity contract with the trustees.
Medical Data	Health and lifestyle information about scheme members and their spouses which is used in the underwriting process to price a bulk annuity transaction.
Medical Underwriting	The process by which medical data is used to estimate the life expectancy of a member covered by an individual annuity or bulk annuity so that the Insurer can give a price for that annuity contract.
Medically Trained	A person who has been sufficiently trained in medical conditions to collect relevant Medical Data.
MUBA	A medically underwritten bulk annuity
Targeted GP Report	A specific report from the member's GP on a specific medical condition.
Telephone interview	An interactive interview over the phone, usually with a medical professional.
Trustees	The group of individuals or a company which is the trustee of the pension schemes and is proposing to enter into the bulk annuity contract with an Insurer.