



New draft Statement of Best Practice for HIV and Insurance: response to consultation and suggested ways forward

June 2004

SUMMARY

In September 2003, the ABI sent out an open consultation paper to insurers and stakeholder groups, asking for views on a proposed new Statement of Best Practice for HIV and Insurance. The new draft Statement updates substantially the existing guidance, which was first published in 1994, and revised in 1997. It sets out requirements and guidance for insurance industry professionals for use when dealing with applications for insurance where HIV may be an issue.

We received a large number of responses (**see Annex A for list of responders**) reflecting the public interest in insurers' actions and perceived attitudes towards those who apply for insurance and to those who are asked to take an HIV test.

The industry is committed to fairness and treating people with respect and this review of best practice is intended to ensure that the industry is up to date in its assessment of HIV risk and AIDS. **This document is a summary of responses to the ABI's initial consultation, along with suggested ways forward.**

ACTION

Views are invited on this document. Please send your responses to me, Richard Walsh, Head of Health, Association of British Insurers, 51 Gresham Street, London EC2V 7HQ or e-mail Richard.Walsh@abi.org.uk by 23 July 2004.

Subject to views received, the ABI will issue the final version of the Guidance with an implementation date for industry compliance.

RESPONSES AND SUGGESTED WAYS FORWARD

Listed below are the questions in the September consultation document, a summary of the responses and our proposed ways forward.

Question 1 – are the five principles the right ones and do you have any comments on them?

The Statement is prefaced by a list of five key principles. The principles raised important issues for almost all respondents, particularly in the area of information (Principle 4). All agreed that it was completely unacceptable to assume an increased HIV risk based on a person's occupation.

The overwhelming majority accepted the principles. It is clearly important to the industry that it responds positively to the world in which we live and that it reflects modern views and attitudes.

A number of industry and stakeholder bodies were keen to encourage some form of information sharing to ensure that the statistics used were as up to date as possible. Stakeholders were keen that the industry should make use of all available data, and expressed concern that this might not currently be happening. Companies were also very aware of their reliance on reinsurers' manuals. No company thought it was reasonable to commit reinsurers to an annual exercise to update their manuals: three yearly updates were suggested.

One respondent suggested a working group be set up and we have had further discussions with several stakeholders about this. It is clearly important that ABI reviews and industry practice is informed by the best possible information on HIV infection and societal change and drivers.

ABI proposal: Insurers should continually review HIV incidence rates and statistics, with a view to updating company policy on HIV/AIDS every three years. Where possible, these updates should follow ABI's three-yearly updates of the Statement. Insurers should also use the sources of information suggested in the Statement (an agreed list of sources updated in line with comments received from responders). Most insurers rely on reinsurance manuals for data on HIV/AIDS. Reinsurers should update their manuals every three years.

The ABI will set up and support an independent multidisciplinary working group comprised of key experts and opinion formers to inform further policy development. Issues likely to be addressed are:

- The evidence base for HIV risk
- Changing cultural attitudes and encouraging responsible behaviour
- Rational and respectful decision making
- Fair ratings

We intend to announce the group's membership and terms of reference at the end of this consultation process.

Question 2 – do you agree passing information to an applicant's GP should not be allowed unless the applicant has given explicit consent?

Almost complete agreement. Respondents singled out the importance of not revealing sexuality to an individual's GP and not asking GPs to speculate on whether the applicant is at higher risk of HIV infection or non-clinical issues (such as sexuality). A number of respondents repeated the importance of Principle 2, that insurers should not ask speculative or unnecessary questions.

ABI proposal: accept paragraphs 3.1 to 3.3 for inclusion in the revised Statement of Best Practice (SoBP).
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Question 3 – do you agree with the wording of the questions that appear on the application form to begin the process of establishing risk of HIV infection?

This question (about standard questions on application forms as opposed to supplementary questions) produced substantial replies from nearly all respondents. We have therefore grouped the responses.

(a) Have you ever tested positive for HIV, Hepatitis B or C or are you awaiting the results of such a test?

Some respondents were concerned that asking about test results which were awaited could violate insurers' commitment not to ask about negative test results. Dealing with this concern is of growing importance given the increasing number of tests carried out by the NHS during targeted screening programmes, for example of pregnant mothers.

ABI proposal: The current guidance on negative test results will be strengthened. Insurers will include on forms a reassurance that negative test results will not, of themselves, result in any increased premiums. Where applicants are awaiting the result of a test, insurers will make it clear that disclosure of a test, which proves to be negative, will not be held against the applicant.
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(b) Have you ever tested positive or been treated for any disease which was transmitted sexually during the last five years?

A number of respondents expressed concern at a possible conflict between this question and the ABI/BMA guidelines on medical information and insurance.

The guidelines, which concern the kinds of information GPs can pass to insurance companies with their patient's consent, state: "insurers should not request, and doctors should not reveal, information about an isolated incident of an STI that has no long-term health implications, or even multiple episodes of non-serious STIs, again where there are no long-term health implications."

The current wording invites disclosure of irrelevant information – such as lice infestation.

A key issue is whether or not an individual (as opposed to a doctor) can be expected to know whether or not an STI has a long-term health implication. There may also be doubt about the infection route. Our preferred option is to list the relevant conditions. We recognize that this will not cover all situations but at least customers will be clear about what they do and do not have to disclose. The suggested option set out in the box below.

“Any” should be replaced by “a”, and other changes as above

Have you tested positive or been treated for a disease, with long term health implications, which was transmitted sexually during the last five years?

No/Yes – if yes please give details

See [x-ref] for a list of relevant diseases.

We would welcome advice on which diseases should be included in the list

(c) **Option 1 – Have you ever visited, or been a resident of, a country which has a much higher level of HIV infection compared with the UK?**

Option 2 - Have you lived in or visited for more than [X] weeks a country outside Western Europe, North America, Australia or New Zealand in the last [X] years? If so please list which countries.)

Neither option was satisfactory. Option 1 would require applicants to have a detailed knowledge about HIV prevalence in different countries. Expanding it to list the countries which had high HIV prevalence would mean yearly updating of application forms which would be impractical for many companies.

Option 2 does not take account of the enlargement of the EU and Western Europe and would be difficult to define. There was also concern that low prevalence areas (e.g. the Middle East) would be included in a ‘high risk’ category. For this reason, some respondents wanted to know that this question alone would not result in medical tests and/or increased premiums. One respondent suggested a timeframe: more than four weeks in the last 10 years. Currently the highest growth rate of HIV incidence is in people who have been resident in countries outside the UK with high HIV prevalence and have acquired the infection there. In the future this pool of people with HIV infection now resident in the UK could result in spread of HIV in the UK through a range of transmission routes.

Insurers already ask a residence question, and some answered that this usually provides all the information they needed.

ABI proposal: **Have you been resident in a country outside the UK in the last ten years?**

If yes please list the country or countries

If you have been resident of a country outside the UK we will check the country against the latest information on HIV prevalence rates and any other serious diseases. If the country has a higher HIV rate than the UK we may ask you to take an HIV test and pay more for your cover. A list of the countries we apply this to can be obtained from our Head Office.

(c) Do you practice safe sexual behaviour?

No insurer or reinsurer said they would be willing to ask all applicants this question. It was described variously as “sensitive”, “not capable of verification” and “safer” sexual behaviour would be more accurate. Whilst the majority of stakeholders agreed, a few were supportive. A preference for a direct approach was however displayed in many answers to questions 4, 16 and 17 – see later discussion.

ABI proposal: this question should not be included in the standard questions (see also responses to question 17 – supplementary questions)

Question 4 – are these the right trigger questions for considering whether an applicant should be invited to take an HIV test? If not, please suggest alternatives and amendments.

A number of stakeholder responses rejected the concept of high risk groups altogether, preferring the concept of high risk behaviour. **This was echoed in responses to question 17, see later.** Two asked for a definition of ‘high risk group’ to be included in company policy

One stakeholder respondent said: “These questions are not very sensitive when trying to detect HIV infection in well individuals. If there were an easy set of questions, clinicians would be using them”. This was echoed by an industry response: “The trigger questions are probably the best that can be used in an imperfect world unless you are going to do away with the so called high risk groups and reduce dramatically your HIV testing limits and apply them universally across the board”.

Other suggestions were made, including:

- Possibility of anti-selection if a sum assured is named – insurers prefer “high potential payout”;
- Intravenous drug-use and blood transfusions are also risk factors which insurers wish to take into account;

ABI proposal: Companies must have a clear policy on trigger questions for HIV tests, as set out in Principle 5, and make this available on request to applicants. The policy should include whether a test will normally be triggered by:

- Having been diagnosed with a sexually transmitted disease with long term health implications
- Being resident of a non-UK country with high HIV prevalence – and a list of countries
- An application for an insurance with a high potential payout
- Intravenous drug abuse
- blood transfusions or surgery
- responses to supplementary questions (give details **see question 17**)

Question 5 – have you any suggestions on alternative arrangements which would make it more certain that the applicant has been given the consent form before being invited to take an HIV test?

There were substantive differences in responses on this question:

- Some respondents would like customers to have consented to an HIV test before a doctor or medical agency is sent any papers to arrange the test. An alternative was for the applicant to arrange their own test (see question 21).
- Others were broadly happy with the process as proposed, under which customers would be sent a consent form before a doctor or medical agency is sent any papers to arrange the test. The consent form does not have to have been returned before the test is arranged. In this scenario, the consent form is part of the pre-test information letting customers know that they are going to be contacted to arrange a test.
- A small number of insurers wished to issue consent forms to customers and papers to testing centres simultaneously to avoid delay.
- Two insurers implied that they currently wait for customer consent before issuing papers to a doctor or medical agency.

ABI proposal: customers should receive their pre-test information before the test centres receive order papers - there should be a delay of at least a week between information being sent to the applicant and the test centre to give the applicant the opportunity to terminate the process. Exceptionally, for example for urgent loan cover, it may be inappropriate to delay matters in this way. The consent form is part of the pre-test information and does not have to be returned before the administrative process of arranging testing can begin – indeed it is usually completed at the time of the test (see question 22). The test cannot happen unless consent has been given. Consent forms should be signed in accordance with the procedures in Annex C of the Statement.

Question 6 – should the applicant be given the option of nominating another person to be contacted should the test prove positive or should this be a condition of proceeding with the test?

Question 7 – should the nominee be restricted to medical practitioners? If not should any restriction be applied?

Again, there were substantive differences in responses to this question:

- Some considered that nominating another person to be contacted in the event of a positive test should be a condition of proceeding with the test.
- Others saw no need for a nomination to be a pre-condition or that it would be unethical to do so: since the doctor administering the test has an ethical responsibility to inform the individual of the result there was no need to inform another doctor. In the event of no nomination a number stated that it would be unethical to deliver positive HIV test results any way other than face-to-face.
- Respondents mostly replied that a nominee should either be a medical practitioner or experienced at giving test results in some other way (e.g. an HIV counsellor).

ABI proposal: offer an enhanced choice to applicants (i.e. nominate your own GP, or a GUM clinic, an HIV counselling service or another relevant professional service) as a pre-test condition. In the event of no nomination explain that the test centre would be the point of contact.

It would be unethical for the industry to take on this role. Insurers need HIV test results solely for underwriting purposes: they cannot normally become involved in patient care.

Question 8 – where the applicant has a partner, what arrangements should be made to ensure the partner knows the result of an HIV test in the event of it being positive?

Confidentiality was the over-riding concern of the vast majority of respondents. A number of correspondents said that it would be illegal for insurers to inform partners of applicants testing positive for HIV.

Responsibility for partner notification lies with the infected person, or their nomination or the test centre if there are grounds to believe that the partner will not be told. Under these circumstances, the GMC advises that the doctor *may* disclose information to a person who is at risk of serious harm (see GMC guidelines on Serious Communicable Diseases at <http://www.gmc-uk.org/standards/serious.htm>).

Respondents also made other comments on the treatment of information about positive test results. For example:

- underwriters should not receive positive test results;
- insurers should not receive test results before applicants do;

ABI proposal: insurers have no role in notifying partners of positive test results. Company CMOs should receive positive test results. If any ethical dilemmas arise they should be dealt with by CMOs in accordance with the GMC guidelines. To relieve uncertainty, all test results (positive or negative) should be communicated to the applicant as quickly as possible.

Question 9 – is it right to ask the applicant to take another test if the first one was invalid? Previous industry practice was to explain that the test was inconclusive and treat the result as negative for underwriting purposes. The change is proposed because an individual in such circumstances is likely to want to know their HIV status and have a test independently. If the test were positive and the contract was not yet in force, they would have to declare it anyway under the continuing obligation to disclose. Is it also right that not pursuing an application in such circumstances should not be held against the applicant for future applications?

Nearly all respondents agreed that inconclusive or void results should be followed up with a further test. A number stressed the importance of being honest with applicants, and providing a detailed explanation of the reasons for requesting a second test (e.g. the sample had been delayed on its way to the lab and could not be tested as it was too old, or the sample had been tested, but it had been impossible to obtain a result). Some insurers wanted the freedom to decide against requesting a second test and wanted the option of explaining to applicants that their HIV status had not been tested.

ABI proposal: insurers should normally arrange for another test if the first one is invalid. Insurers should relieve uncertainty by explaining the reason for a second test. Alternatively they may give the choice to the **applicant**. They should make it clear to applicants that, where they choose not to have a second test, the applicant's HIV status remains unknown but that the insurer is treating it as if it were negative.

Question 10 – if the life assured in a company scheme is in an occupation where a positive HIV status could endanger others, for example a doctor, their professional occupational guidelines will have made them fully aware that they need to disclose the result to their employer. As such, the insurer has no responsibility for notifying the employer. Is this correct?

The majority agreed that insurers have no role here. This is a matter for the GMC. (see GMC guidelines on Serious Communicable Diseases at <http://www.gmc-uk.org/standards/serious.htm>).

ABI proposal: insurers must not disclose test results to employers without the consent of the individual. This applies to individual and group schemes. Doctors are, in any case, bound by the GMC. Company CMOs (see question 8) may advise insurers should ethical dilemmas arise.

Question 11 – do you agree that fax and e-mail notifications of test results are inappropriate? Are there alternatives, for example a secure designated e-mail or fax number?

The majority of respondents, both from insurance and reinsurance companies, and from stakeholder groups, preferred post to other methods of communication. Few wished to use e-mail, but some said that secure fax machines were as safe as the post for delivering negative results from medical test centres to insurance companies.

ABI proposal: insurers should only accept positive test results by post. Negative test results may be received by post or secure fax only.

Question 12 – are there other sources of information that insurers should be aware of?

A number of respondents pointed out that the Public Health Laboratory Service is now the Health Protection Agency (www.hpa.org.uk). Other sources were also suggested. For example, one respondent preferred www.eurosurveillance.org to www.ceses.org. The World Health Organisation and the Department of Health were also suggested.

ABI proposal: The suggestions should be included in the revised SoBP. Insurers should continually review incidence rates and statistics, with a view to updating company policy on HIV/AIDS every three years. Where possible, these updates should follow ABI's three-yearly updates. Insurers should also use the sources of information suggested in Annex A1. Most insurers rely on reinsurance manuals for data on HIV/AIDS. Reinsurers should update their manuals every three years: this recommendation will be added to Annex A1. See also question 1.

Question 13 – is the HIV/AIDS exclusion warning still correct?

The vast majority of respondents accepted the wording. One grammatical change was suggested: "if it is caused directly or indirectly from", should be changed to "if it is caused directly or indirectly by".

ABI proposal: The wording, subject to the small grammatical change, should be accepted in the revised SoBP.

Question 14 – do you agree that where HIV/AIDS exclusions are applied to income protection or long-term care insurance, questions relating to the risk of HIV infection should not be asked?

Question 15 – should the principle in question 14 apply to other types of insurance, for example critical illness insurance? If so, which ones? And how can insurers be confident that diagnoses will exclude HIV/AIDS and indirect but related claims?

Stakeholder respondents were overwhelmingly against asking such questions for policies where exclusions apply. Insurers, however, were concerned about writing inappropriate contracts with people who already were, or thought they might be, HIV positive. This is however largely covered in the standard questions on the application form. They also mentioned the use of combined application forms for long-term insurance, which would make it difficult to separate out term life insurance from CI or LTCI.

ABI proposal:

For standalone policies – where exclusions apply - questions about **risk** of HIV (as opposed to positive diagnosis) should not be asked

For menu/multibenefit products – if any part of a policy does **not** include an HIV exclusion - the HIV risk questions may be asked on the combined application form

Question 16 – do you have any comments on the wording of the covering letter to the supplementary questionnaire?

Very few respondents were happy with the recommended wording. The wording did not include reassurance that negative HIV tests would not be taken into account. Some also mentioned that sending a supplementary questionnaire to some applicants would amount to illegal discrimination unless insurers based the decision on reliable and relevant information. A number of insurers were unhappy with the final paragraph as it might encourage non-disclosure. Some were also concerned about wording on high-risk groups. From a practical point of view, some insurers would prefer not to add an extra piece of paper to the application process and would prefer to have the wording as part of the application form (but see question 17).

ABI proposal: The following wording should be used as a preamble to supplementary questions when these are asked. (see questions 3 and 17). The proposed wording for the revised SoBP is:

“When we consider an application for life insurance, we sometimes require additional information to that contained in the application form. In requesting this information, we are following normal industry practice, so we can set fair

insurance premiums taking account to HIV risk.

“Any information given in your answers will be treated confidentially. We would be grateful if you would complete the questionnaire (*following questions*) and return it (*them*) in the envelope provided. If you prefer, you can answer the questionnaire (*following questions*) separately, and send your answers in a sealed envelope, marked for the attention of the Chief Medical Officer at our company.

“It is important that you be truthful in answering the questions on the application form, and disclose all relevant information. Non-disclosure may mean that you are not covered by the insurance policy.

“We may also ask you for additional medical information before making our decision.”

Question 17 – do you have any comments on the wording of the ‘standard’ supplementary questions and should they be asked for all applicants?

Insurers also wished to ask whether an applicant had been the sexual partner of anyone in the groups named. A number of both insurer and stakeholder respondents preferred that the questions be asked of all applicants. However further discussions indicate that the **new** supplementary questions suggested below are unlikely to be asked of all applicants. Instead they are likely to be triggered for high sums assured etc (see question 4).

With the increasing spread of HIV amongst the heterosexual population (mostly acquired overseas) restriction of questions to the gay or bisexual community is clearly outdated. This is reflected in the debate about question 3 and residence outside the UK.

However, as is noted in the response, insurers are, to a great extent, reliant on the information held by reinsurers for their policies on HIV and AIDS (see also questions 1 and 12, and Annex A). The Health Protection Agency notes: “Sex between men remains the group in the UK at highest risk of acquiring HIV with evidence that transmission is continuing at a substantial rate”. Full details about transmission routes are available on the internet at http://www.hpa.org.uk/infections/topics_az/hiv_and_sti/hiv/epidemiology/hars.htm. Incidentally, the slightly ungrammatical nature of this quote also points up some of the disagreements between respondents in talking about high-risk groups (men who have sex with men) and high-risk behaviours (having sex with men, intravenous drug users, or people who have been resident in countries with high HIV prevalence).

A number of both industry and stakeholder respondents preferred to ask about high-risk behaviours.

ABI proposal: the supplementary questions should be adjusted to reflect concerns about high-risk behaviour. Insurers need not ask all applicants the

questions below. Instead they are encouraged to ask them separately in line with their HIV testing limits (see question 4)

For male applicants:

Q1. Have you had sex with a man in the last five years?

For all applicants:

Q2a. Have you ever injected non-prescription drugs intravenously?

b. Have you had sex with a person who has injected non-prescription drugs intravenously in the last five years?

Q3.a. Have you ever undergone any surgical procedure outside the UK or been a recipient of blood products outside the UK? If 'yes', please provide us with the date(s), the country or countries and the reason(s) for each procedure and transfusion undergone.

b. Have you had sex in the last five years with someone who has undergone any surgical procedure outside the UK or been a recipient of blood products outside the UK? If 'yes', please provide us with the date(s), the country or countries and the reason(s) for each procedure and transfusion undergone

Q4. Have you had sex in the last five years with someone who has been resident in a country outside the UK in the last ten years?

If yes please list the country or countries

If yes we will check the country against the latest information on HIV prevalence rates. If the country has a higher rate than the UK we may ask you to take an HIV test and pay more for your cover. A list of the countries we apply this to can be obtained from our Head Office.

Question 18 – do you agree that insurers should not ask the supplementary questions listed in Annex B6?

Many respondents referred back to question 3 when answering this question, particularly when talking about sexually transmitted infections. Most agreed that these questions should not be asked. However, some argued that sometimes people facing higher premiums may wish to volunteer information about monogamy, Civil Partnership, and safe sexual behaviour, which they want insurers to take account of.

ABI proposal: subject to answers to question 3 and 17, above, insurers should not ask questions of this kind. Insurers should, however, be open to the possibility that applicants may wish to disclose information to support their application: people who wish to make such a disclosure should be treated with respect.

Add in supplementary question 4

Optional - have you anything to add to your declaration, which in your view,

means that you are not at risk of HIV?

Question 19 – which is the best approach to establishing risk – the direct or indirect approach? Also, given the level of risk in the whole population, should the direct question be asked for all applicants? Can you suggest any other questions, and which at-risk groups would they apply to?

The majority of respondents preferred the direct approach, but few agreed with the suggested direct question (see question 3d). A few industry respondents wished to be able to use indirect questions in special circumstances. This seems to be comparable to the desire that applicants could volunteer extra information (see question 18).

Questions about civil partnerships and adoption/fostering prompted a strong response from a number of stakeholder groups. One commented: “Another heterosexual answer to what is perceived to be a gay problem”.

ABI proposal: insurers should use the new questions in question 3 and the direct approach for supplementary questions as above.

Question 20 – are the criteria in Annex C the right ones for insurers to apply in choosing their test method and provider? Should blood or saliva tests be standard practice, and if so why?

Insurers agreed that the criteria were the correct ones, and most said that they preferred saliva tests for acceptability and convenience for customers. Some said they would use blood tests where other blood-based tests (e.g. lipid profile) were also required. One respondent pointed out that in the USA the only oral test with FDA approval for clinical diagnosis of HIV is the OraSure, oral mucosal transudate, (OMT) test.

Most stakeholder groups did not respond to this question. Those that did mentioned pre-test discussions and/or counselling. One said that saliva testing was not accurate enough to justify using that alone to give a positive result to an applicant.

ABI proposal: The criteria in C2 should be written into the revised SoBP, but should be expanded to cover the quality of pre-test care given to applicants. There should be no industry-wide agreement on the type of test but where companies had a policy to only use saliva or blood tests they should apply this principle to all their applicants regardless of their level of risk. We also invite views on the OMT test.

Question 21 – are the procedures for insurers’ arrangements with health professionals in Annexes C6, C7, and the HIV protocol, correct?

The responses were broadly positive, but some covered issues raised by question 5. A few insurers did not wish to establish customer choice over who should administer the test, preferring to use test-centres whose protocols were known. One mentioned that a request for a particular test-centre would be treated on its merits.

A number of stakeholder respondents mentioned that current thinking includes a pre-test discussion, rather than pre-test counselling, and recommended that the protocol be changed to reflect this.

ABI proposal: insurers should be free to offer a choice of testers. Whatever their policy, if an applicant requests that the test be carried out at a location of their choice the insurer should seek to take account of their preference. In the protocol, 'pre-test counselling' should be changed to 'pre-test discussions' and 'counselling letter' to 'pre-test letter/leaflet'.

Question 22 – do you have any comments on the wording of the pre-testing leaflet?

A number of comments and drafting points were made:

- change 'micro-organism' to 'virus';
- clarify 'Immune Deficiency' or 'Immunodeficiency';
- paragraph two contains sections on high-risk groups to which a number of stakeholder groups have objected;
- change 'life assurance' to 'insurance' as the consent form could be for life, CI, IP etc.;
- re question 7, clarify whether consent for disclosure to a GP, GUM clinic etc. is required for the test to take place;
- form should allow room for the name to be printed, as well as for a signature;
- the phrase "social and medical consequences" is too negative – testing is a positive step as it allows early, more effective treatment;
- should make it clear that a decision not to test will not affect future applications.

ABI proposal: Following comments, this is the revised wording for the pre-testing leaflet.

"As you are probably aware, Acquired Immune Deficiency Syndrome (AIDS) is caused by infection with a virus known as Human Immunodeficiency Virus (HIV).

"When insurers consider an application for life insurance, they sometimes require additional information about your risk of HIV. This assessment of HIV risk is designed to protect the funds held for both existing and future policyholders. Your insurance company has asked you to undergo an HIV antibody test. This may be because of answers you gave on your application form which revealed that you could be at risk of HIV, or it could be because you have applied for a relatively large amount of insurance.

you have applied for a relatively large amount of insurance.

“The nurse/doctor will take a sample of blood/saliva (delete as appropriate). The test will form a part of your medical examination and the sample will be sent to a specialist laboratory. Your test will be protected by a strict code of confidentiality, and will only be disclosed if you give your written consent to the disclosure. Your insurer asks you to consent to your test result being released to your GP, local GUM clinic or HIV counselling service, as insurers are unable to provide adequate post-test support if your test proves to be positive.

“A positive test would mean that you have been exposed to HIV and have developed antibodies. You should be aware of the possible consequences of testing positive. It would, however, enable you to access effective treatments earlier. If you decide not to have the test at this time, please sign the appropriate section of the enclosed declaration and ask the nurse/doctor to return it to the insurance company. You will, of course, understand that this will mean that we cannot proceed further with your application. Your decision not to test will not be held against you for any future applications.”

It will be necessary to add a further ‘consent to disclosure’ box. The wording will depend on further responses to question 7. There should be space on the form for the applicant’s name to be printed next to the signature.

Additional comments:

The role of the CMO

This was mentioned in multiple answers by a number of stakeholders. Should the CMO be the *only* person in a company to receive HIV test results? What effect do the CMO’s own medical ethics have on insurance industry policy? – **we think this is dealt with in the text earlier**

Claims and ratings procedures

Insurers will have little experience of dealing with HIV/AIDS related claims. Should the SoBP practice address this? – **the ABI cannot advise companies on medical matters but the SOBP should make reference to the need for expert medical advice and for transparency in communicating underwriting decisions**

Group cover

Is group cover adequately catered for by these recommendations? – **the document applies to group cover – see also question 10**

Occupational acquisition

Individuals who acquire HIV through their work (e.g. medical personnel) may be able to claim under policies with exclusions for other transmission routes. Does this imply discrimination and stigma? – **there are no such exemptions in the model exclusion wordings in the CI or IP Statements – Annex A6 will be amended.** That is not to say, that companies cannot arrange their own

compensation/liability schemes but these are not the subject of this consultation

Industry limit above which all applicants would be asked for an HIV test

One respondent suggested a system similar to the one in place in the Netherlands, under which all applicants for life insurance over a certain level would be asked for an HIV test. **In the UK, we believe that this would be against competition law and would therefore require Government legislation. The suggestion is beyond the scope of this consultation. The relevant legislation in the Netherlands is the Medical Examinations Act 1998. This law restricts HIV testing under the amount of EUR 150,000 (for life insurance) and EUR 30,000 for disability insurance. Five questions about HIV can be asked under these amounts:**

- do you have AIDS
- Have HIV materials been found in your blood (are you HIV positive)
- Have you had a blood transfusion abroad? If so in which country
- Have you used drugs intravenously in the past 5 years
- Have you been treated for a sexually transmittable disease in the past 5 years.

If applicants give a positive response to 3,4 or 5 insurers are permitted to ask for an HIV test. The Netherlands also has an expert working group – as we suggestion in question 1.

Legal restrictions on underwriting are common in EU countries with social insurance systems common in contrast to the UK commercial arrangements

People with HIV

The SoBP makes no mention of insurance (travel insurance, life insurance for mortgages etc.) for people living with HIV. **Travel and, in limited circumstance, life insurance is now available for people with HIV. This reflects the improved treatments that are available. We expect this trend to continue. We could also include material on insurance for people with Hepatitis B or C.**

ANNEX A

ABI HIV STATEMENT OF BEST PRACTICE CONSULTATION –

INSURANCE INDUSTRY RESPONSES

Norwich Union
Standard Life
Friends Provident
Scottish Widows
Liverpool Victoria
UISL
Zurich
Prudential
Nationwide
Munich Re
Swiss Re
Legal & General
Axa SunLife
HSBC
Natwest Life & Royal Scottish Assurance
Allianz Cornhill Life and
Allianz Cornhill Direct Life
Reviso
RGA UK Services Ltd
CIS
Bright Grey
Medicals Direct
Canada Life
MorganAsh
Isis Financial Planners Ltd

STAKEHOLDER RESPONSES

PinkFinance.com
Terrence Higgins Trust
RCGP Sex, Drugs & HIV Task Group- Lothian Primary Care NHS Trust
Genitourinary & HIV Medicine Unit, the Sandyford Initiative, Glasgow
Herpes Viruses Association
BMA
Medical Foundation for AIDS & Sexual Health
Medical Defence Union
Society of Sexual Health Advisers
HIV Special Interest Group of British Association of Sexual Health and HIV
National Aids Trust
Royal College of General Practitioners
Department of Health
Citizens Advice Bureau

INDIVIDUAL RESPONSES

Several people also responded in a personal capacity

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