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WWW.ACTUARY.EU**24 October 2026**

Response to European Commission Targeted Consultation

Targeted consultation on fair access to financial services for cancer survivors (right to be forgotten)

Introduction

The Actuarial Association of Europe ('AAE') welcomes the opportunity to respond to the European Commission's targeted consultation on fair access to financial services for cancer survivors. We share the objective that people who have overcome cancer should not be treated unfairly when they seek access to financial services, including life insurance that guarantees the repayment of a mortgage or professional loan.

The AAE is the umbrella organisation for the actuarial associations in Europe. Actuaries assess, price and manage the risks covered by life insurance. We believe the profession can help design frameworks that improve access for cancer survivors while preserving the benefits of risk pooling. This response builds on the AAE's Key Messages on the Right to be Forgotten, published in December 2023, and on actuarial work in this area. This includes a 2023 study by the Society of Actuaries in Ireland on the potential impacts of a right to be forgotten ('RTBF') framework for cancer survivors applying for life insurance.

Fairness in insurance can be understood in different ways. Under risk-based fairness, applicants with the same expected risk are offered the same terms. Social fairness may lead society to decide that certain information should not be used, even where it remains relevant to the risk. Both views are legitimate, and where the balance lies is a choice for policymakers.¹ The role of actuaries is to assess the risk and to make the consequences of that choice transparent. A RTBF framework is consistent with risk-based fairness where past medical history is no longer a material indicator of future risk. Where a framework requires insurers to disregard information that remains materially relevant, the cost is shared across the wider pool of policyholders. This may affect premiums and the availability of cover. For this reason, our response emphasises evidence-based parameters, national calibration, transparency and monitoring.

¹ For a discussion of these two views of fairness in the context of the RTBF, see Heck, C. (2026), 'Understanding inclusive insurance markets: a broader perspective', The European Actuary, No 47, September 2026, pp. 23 to 26.

1. A right to be forgotten in national frameworks of EU member states

Q1. Do you consider that all EU Member States should have at national level a framework for a right to be forgotten for cancer survivors covering areas beyond the Consumer Credit Directive?

Answer: Yes

Please elaborate on your answer to question 1:

We support national frameworks that give cancer survivors fair access to relevant financial services beyond the scope of the Consumer Credit Directive. National frameworks are best placed to reflect differences between Member States in insurance markets, public healthcare and social protection systems, medical practice, available evidence and the role played by private insurance.

Each framework should reflect how essential the cover is in the national context. For example, life insurance linked to a mortgage is required or commonly expected in some markets. In others it is not mandatory and plays a less decisive role in access to housing. We suggest that these differences are assessed explicitly when setting the scope, parameters and proportionality of a national framework.

National frameworks should be evidence-based, transparent and capable of being updated as medical and actuarial evidence develops. They should improve access for cancer survivors while also taking into account affordability, product availability and the interests of the wider pool of policyholders.

Q1.1. Do you consider that this framework should be enshrined in: national legislation, self-regulatory measures, other, or don't know / no opinion / not applicable?

Answer: Other

Please specify where you consider this framework should be enshrined, and elaborate on your answer to question 1.1:

In our view, the appropriate instrument depends on the national market and on how essential the insurance cover concerned is. Legislation may be appropriate where binding and uniform consumer protection is needed. In other markets, a stable and transparent self-regulatory framework, or established market practice, may achieve the objective more proportionately and allow faster adaptation to medical and actuarial developments.

Whichever instrument is chosen, we consider it important that it provides legal and operational clarity, consistent treatment of applicants, clear definitions, appropriate governance and effective monitoring. Core parameters should be clearly settled, so that applicants, insurers and claims handlers can apply the framework with confidence.

Q2. Do you agree that the priority areas in which a right to be forgotten for cancer survivors should be implemented are in relation to access to life insurance policies that guarantee the repayment of mortgage and professional loans?

Answer: Yes

Please elaborate on your answer to question 2:

We agree that initial implementation could focus on life insurance linked to mortgage and professional loans. These products have a clear connection to access to housing and to economic activity. There is also comparatively greater practical experience and actuarial understanding of the insured risk, the underwriting process and the potential impacts on consumers and portfolios.

A focused scope supports a manageable and evidence-based implementation. It also allows the effects on access, premiums, risk selection, claims experience, product design and the wider insured pool to be monitored before any extension is considered (see our answers to questions 11 and 12).

Q3. Do you believe there are any other areas where the right to be forgotten for cancer survivors should be implemented?

Answer: Don't know / no opinion / not applicable

Please specify and explain your answer to question 3:

We do not take a position on whether further areas should be covered, as this is a policy choice. If an extension to other products or other health conditions is considered, we suggest that it follows the same evidence-based approach and draws on the results of monitoring the initial scope. The assessment could consider, product by product, how essential the cover is, whether it is mandatory or voluntary, the relevant public provision and the effect on the wider pool of policyholders. Particular care is needed for products where cancer is itself the insured event, such as critical illness cover. If previous cancer history cannot be taken into account for such products, the risk of anti-selection is high, and there are indications that some insurers and reinsurers may reduce capacity as a result.

A framework for cancer survivors may also be seen as a precedent by people who have recovered from other serious conditions and who would still be required to disclose them. We suggest that this is considered from the outset.

Q4. When considering a right to be forgotten for life insurance policies that guarantee the repayment of mortgage and professional loans, do you think that certain aspects may be specific for individual Member States, for instance insured amount limitations, age limitations or other aspects?

Answer: Yes

Q4.1. Please indicate the national specificities you believe should be taken into account:

We suggest that the following national features are taken into account:

- the legal or practical role of insurance in obtaining a mortgage or professional loan;
- the division of responsibilities between public and private protection;
- typical sums insured and loan terms, and the age at application and at expiry of cover;

- the availability and quality of medical, epidemiological and insurance data;
- cancer treatment pathways and outcomes;
- the size and risk profile of the insured population; and
- existing legislation, codes of conduct or established market practice.

Insured amount limitations may be appropriate where disregarding relevant medical history would otherwise create a material concentration of risk or anti-selection. This reflects current practice, under which applications above certain sums insured are subject to more detailed underwriting. Any limit should be reviewed periodically and should not be set so low that the consumer protection objective becomes ineffective. Age limitations could similarly reflect the typical duration of the underlying loans and the strength of the available evidence at older ages.

Please elaborate on your answer to question 4:

We consider that important aspects of a RTBF framework are necessarily specific to individual Member States. Relevant differences include the role of public healthcare and social protection, how essential and widespread private life insurance is, whether mortgage-related cover is mandatory or customary, typical loan amounts and terms, age profiles, national insurance contract law, underwriting practice, data availability, market size and the composition of risk pools.

We suggest that national parameters have an objective and proportionate basis. They should support fair access while avoiding arbitrary distinctions, material protection gaps, disproportionate cross-subsidisation, lower maximum sums insured or the withdrawal of products.

2. Evidence-based approach

Q5. Do you consider that a right to be forgotten framework should follow an evidence-based approach whereby medical advancements in oncology, as proven by medical, scientific, and actuarial evidence, are taken into account as they emerge?

Answer: Yes

Please elaborate on your answer to question 5:

We strongly support an evidence-based approach. Waiting periods and other parameters should be based on medical, epidemiological, statistical and actuarial evidence, and updated as credible new evidence emerges.

The assessment should be granular enough to reflect material differences by cancer type, stage, age at diagnosis, treatment, time since the end of treatment, recurrence pattern, prognosis and the insured event. A single period for all cancers is simple to communicate but may not reflect these differences accurately. This is consistent with the Commission's observation that currently available scientific evidence does not support a single default waiting period.

Access to reliable, relevant and sufficiently detailed data is essential. Actuaries need to understand the risk profile of the products sold and of the insured population, assess the adequacy of pricing and underwriting, and monitor differences between expected and observed claims experience. This understanding also supports insurers' wider risk management responsibilities under Solvency II, including the Own Risk and Solvency Assessment (ORSA). We therefore suggest that any restrictions on the use of data are designed so that insurers can continue to manage aggregate portfolio risk and

meet prudential obligations. Disregarded information would still not be used in individual eligibility, pricing or contractual decisions where the RTBF applies.

The objective should be that past medical history is not used once it is no longer a proportionate indicator of the insured risk, while preserving sound risk management and sustainable pooling for all policyholders.

3. Waiting periods and reference grids

Q6. Do you consider that waiting periods set at national level are a useful tool to achieve fair access for cancer survivors?

Answer: Yes

Please elaborate on your answer to question 6:

We consider national waiting periods a useful way to give cancer survivors a clear and predictable route to insurance. The period should be supported by medical, epidemiological, statistical and actuarial evidence, and should reflect the insured event and the relevant population.

We suggest that frameworks allow shorter periods where credible evidence supports them. Key concepts such as 'active treatment', 'end of active treatment', 'complete remission' and 'recurrence' currently have no commonly agreed definitions. Clear and consistent definitions would help applicants and insurers apply the framework with confidence. They would also make evidence more comparable across Member States. Commission guidance could usefully promote common definitions, while leaving the calibration of waiting periods to national level.

Q7. Do you consider that reference grids established at national level are a useful tool to achieve fair access for cancer survivors, where such grids reflect appropriate evidence-based waiting periods according to specific conditions, such as cancer type, stage, age or therapeutic treatment?

Answer: Yes

Please elaborate on your answer to question 7:

Reference grids can improve fairness by recognising that cancer is not a homogeneous risk. They allow shorter and more appropriate waiting periods for defined medical profiles. We suggest that grids are based on credible medical, epidemiological and actuarial evidence, and that they state the relevant population, outcome, observation period and uncertainty.

We recognise that reference grids differ between countries, and that many Member States do not currently have the data, institutional arrangements or experience needed to maintain them. A reference grid should therefore not be a prerequisite for a workable national framework. Where a grid is used, its methodology, governance, review cycle and limitations should be transparent.

Q8. Do you consider that national right to be forgotten frameworks should include a combination of waiting periods and reference grids?

Answer: Yes

Please elaborate on your answer to question 8:

We support a combination where a reliable reference grid is available and can be maintained. A general maximum waiting period provides clarity and certainty. A reference grid can then allow shorter periods for specific diagnoses, stages, ages or treatments where the evidence supports this.

Where no credible reference grid exists, this should not prevent a clear national waiting period from being implemented. Grids should be updated when material new evidence emerges. We also suggest that grids are not transferred mechanically between countries without assessing differences in data, treatment pathways, insured populations and market structure. Sharing evidence and methodologies between Member States could nevertheless be valuable, particularly for smaller markets.

Q9. Do you agree that for paediatric cancers diagnosed before age 21, a maximum 5-year waiting period post-treatment would be beneficial across all Member States?

Answer: Don't know / no opinion / not applicable

Please elaborate on your answer to question 9:

Whether a common maximum waiting period should apply to paediatric cancers across all Member States is a policy choice, on which we do not take a position. If such a maximum is adopted, consistent with our answers to questions 5 to 8, we suggest that it is supported by medical, epidemiological and actuarial evidence, clearly defines the point from which it is measured, is monitored (see our answers to questions 11 and 12) and is reviewed as evidence on the long-term outcomes of childhood cancer survivors develops.

Q10. For the purpose of designing or updating the waiting periods and/or national reference grids, do you consider that establishing national governance structures is relevant?

Answer: Yes

Q10.1. What features would you consider necessary for a governance structure (including composition) to ensure appropriate review and updates of waiting periods and/or reference grids in line with developments? Please elaborate your answer:

We suggest the following features:

- **Composition:** a multidisciplinary body in which the technical assessment of evidence is led by oncologists and other medical experts, epidemiologists and cancer registry specialists, and actuaries. The national competent authority for insurance, insurers, and patient and consumer organisations should also be represented, so that decisions are informed by market practice and by the experience of applicants. Actuarial expertise helps translate medical evidence into the insured outcomes, such as mortality and disability, over the term of the cover.

- **Methodology:** a clear mandate, with a documented and published methodology and rationale for each parameter.
- **Data:** access to relevant, high-quality data, including cancer registry data and aggregated insurance experience, with appropriate data protection safeguards.
- **Review cycle:** regular scheduled reviews, with the ability to update parameters earlier when significant new evidence emerges.
- **Balance and transparency:** transparent decision-making and balanced representation, so that the interests of cancer survivors and of the wider pool of policyholders are both considered.
- **Exchange:** where useful, exchange of evidence and methodologies with equivalent bodies in other Member States.

Please elaborate on your answer to question 10:

We consider national governance structures relevant. Clear governance supports the credibility, consistency and timely updating of waiting periods and reference grids.

4. Application and adaptation

Q11. What potential consequences of the application of a right to be forgotten (access by cancer survivors to life insurance policies that guarantee the repayment of mortgage and professional loans, impact on prices of the relevant insurance products or overall access to insurance) would you consider necessary to monitor?

We suggest that monitoring covers both the intended benefits for cancer survivors and the effects on other policyholders and on insurance markets. Monitoring should be proportionate, use aggregated data and recognise statistical uncertainty, particularly in small portfolios. We suggest the following areas:

- **Access for cancer survivors:** application volumes, acceptance outcomes, availability of standard terms, underwriting time, exclusions, loadings, restricted benefits, complaints and disputes.
- **Affordability:** premiums and terms offered to eligible cancer survivors, changes in premiums for the wider insured population and evidence of material cross-subsidisation.
- **Product availability and protection gaps:** maximum sums insured, changes in exclusions or cover, product redesign or withdrawal, and access for applicants with other prior medical conditions.
- **Risk and claims experience:** mortality and claims outcomes, expected versus observed experience, changes in the composition of the insured pool, anti-selection and the sustainability of pricing and benefits.
- **Consistency and fairness:** treatment of applicants with comparable risks, differences across insurers and distribution channels, and whether other variables are used as proxies for information that should be disregarded.
- **Prudential and operational effects:** the ability to understand portfolio risk, set appropriate technical provisions and capital, complete the ORSA, arrange reinsurance and handle claims consistently.

Experience from earlier restrictions on rating factors, such as gender-neutral pricing in the EU since 2012, shows that effects on pricing, product design and risk selection can take several years to emerge. Monitoring should therefore allow timely adjustment where the framework does not deliver the intended improvement in access, or where it has material unintended effects on affordability, cover or market participation.

Q12. Do you consider that a right to be forgotten monitoring mechanism should be in place?

Answer: Yes

Q12.1. Which aspects should be monitored and at what frequency? Please elaborate on your answer:

The aspects we suggest monitoring are set out in our answer to question 11. Core indicators could be reviewed annually during the early years of implementation. These include access and acceptance outcomes, premiums and terms, maximum sums insured, exclusions, complaints, product availability, portfolio composition, claims experience and material differences between expected and observed outcomes.

A more comprehensive review could take place once sufficiently credible experience has accumulated, for example every three to five years. Medical and actuarial parameters should be reviewed earlier when significant new evidence, treatment developments or material market effects emerge. Review intervals should reflect the long-term nature of life insurance, and firm conclusions should not be drawn from immature or statistically limited data.

Results should be reported in aggregated form, with appropriate confidentiality and data protection safeguards. Each review should state its data limitations and the degree of uncertainty underlying its conclusions.

Please elaborate on your answer to question 12:

We support a proportionate monitoring mechanism. Its purpose would be to test whether the framework improves access for cancer survivors, remains aligned with current medical and actuarial evidence, and avoids material unintended consequences for other consumers or for the sustainability of insurance products.

Monitoring should not require insurers to collect or reconstruct individual information that the framework prohibits them from using. It should rely on lawful, appropriately aggregated and protected data, and avoid duplicative reporting. Because insurers will generally not be able to identify cancer survivors within their portfolios, some aspects, such as the claims experience of those benefiting from the framework, may be better assessed through independent studies. These could, for example, link cancer registry and insurance data under appropriate data protection safeguards.

Q13. Should monitoring mechanisms involve participation of: (select as many as you like)

Answer: All five options: the national competent authorities for insurance, the relevant medical organisations, cancer patients' organisations, insurance companies, other stakeholders

Please specify to what other stakeholder(s) you refer in your answer to question 13:

- the actuarial profession, which can contribute independent expertise on translating medical evidence into insured risk and on interpreting experience data;
- reinsurers, which often hold pooled data and underwriting expertise across markets;
- consumer organisations; and
- the bodies responsible for national cancer registries and health statistics.

Please elaborate on your answers to question 13:

We see value in involving all of the stakeholders listed, so that monitoring results are credible, balanced and technically robust. Each would contribute according to its role, with medical, actuarial and statistical experts focusing on the analysis of evidence and experience data, and patient and consumer organisations on the experience of applicants, such as access, complaints and the clarity of information.