

THE HUMAN RIGHTS ACT 1993 AND THE PROVISION OF INSURANCE.

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This paper is intended as a joint presentation. The writers have identified certain issues relating to the Human Rights Act 1993 ('the Act') and suggested actuarial solutions. Neither presenter considers that they have all the answers and they are hopeful that the comments will generate a constructive debate.

Structure of the paper

The paper includes a short introduction to the general principles of insurance that could be compromised by the application of human rights requirements. This is then followed by a number of specific issues relating to genetic testing and mental illness and suggested actuarial responses. Finally, the paper ends with a number of open questions relating to the legislation as an incentive to generate discussion.

GENERAL PRINCIPLES OF INSURANCE

For a risk to be insurable the conditions listed below must be satisfied. One way of determining how viable it is actuarially to require insurers to comply with human rights requirements is to consider to what extent these conditions are likely to be compromised as a result. If some of the issues considered later are not addressed satisfactorily, then this is likely to be the case.

- **Quantifiable**

The probability of claim must be able to be calculated with a reasonable degree of certainty.

The insurer needs to be able to classify individuals into groups with similar risk of claim and charge an appropriate premium. It does not matter whether the reasons for the risk differ, e.g if one person is loaded for build and another for blood pressure. The costs of quantifying the additional risk also need to be reasonable relative to the premium. It is important that the insurer has access to all factors that can significantly impact on the probability of a claim, and has the ability to take them into account.

- **Random**

Ideally the person insured, or beneficiary should not be able to influence whether a claim occurs.

In practice this is not always possible for living benefits, so it is important that there is no financial incentive to claim. The person insured and insurer need to have access to the same information, and to be able to take it into account when setting the premium.

- **Large number of similar independent cases**

Insurance is largely based on the put-workings of the Central Limit Theorem. That is, the level of uncertainty around a large number of independent events is significantly less than the level of uncertainty for any one event.

Customers buying insurance trade the small probability of suffering a large loss for the certainty of a small loss. Insurers charge a profit margin for this security, and for the residual risk they are taking that the portfolio as a whole performs worse than expected.

- **Objectively definable**

It must be clear to both parties whether or not a claim has occurred.

- **Affordable**

The price for the insurance must represent value to both the person insured and the insurer.

Insurance works effectively when there is a small probability of a big loss. It does not work as well when there is a high probability of claim, as there would be for example, if a person who is terminally ill applies for life cover. The price is also less likely to represent value for money when the costs of assessing the extra risk are high. In practice both parties may have to accept a reasonable estimate.

GENETICS

Many discussions in the area of genetics are premised on the idea that genetic information is so fundamentally different to other forms of personal health information that it requires a different type of legal protection that applies solely to genetics. Stand-alone legislation has been adopted in some States in the United States and in some European countries. However, it has been persuasively argued recently¹ that discrimination on the grounds of genetic status is better dealt with under existing anti-discrimination legislation subject to some amendments and safeguards.

Before consideration is given to anti-discrimination issues relating to genetics it is crucial to resolve whether the current definition of disability in the New Zealand

¹ Australian Law Reform Commission: Discussion Paper 66 - Protection of Human Genetic Information, 2002

legislation covers actual or perceived genetic status. Whether this is the case at present is contestable. Although the Act is remedial and disability is defined very widely as a result, opinion is divided on whether the definition is broad enough to include genetic defects, which predispose a person to disease.

Clearly people who have a disorder, which can be attributed to genetic causes, will fall within the definition but it is less clear whether the statutory wording (“any other loss or abnormality of psychological, physiological or anatomical structure or function”) includes people with particular genetic susceptibilities who are currently asymptomatic. There is a substantial body of opinion that argues against inclusion, principally because until a disorder actually manifests itself, predisposition alone cannot be said to equate with disability. Conversely, it has been argued that defective genes could be viewed as abnormal physiological or anatomical structures, albeit at a cellular level, which will ultimately result in clinical symptoms and this therefore would bring the term within the definition.

Even if not strictly covered, most insurers will strive to apply the principles of the Act. Any loading would therefore have to be justified under the criteria in section 48. It is axiomatic that if genetic information is considered to fall within a prohibited ground, then the exception in section 48 must apply. If, however, insurers are prevented from accessing genetic information, then these conditions are unlikely to be met since the insurer would not have access to the same information as the applicant which would allow the individual to select against the insurer.

There is a further difficulty with multi-factorial dispositions since the disorder may never manifest itself but if it does environmental factors could play a significant role. If multi-factorial dispositions were considered to be a disability, it would be analogous to suggesting that subtle environmental factors – such as diet – equated with disability. This then raises issues about whether an individual’s contribution to the development of a condition to which they are predisposed, should be taken into account if they allege discrimination, and whether any weight should be given to life style choice.

Technically the price an individual is charged should reflect both the underlying genetic information and the effects of their lifestyle on the probability of claiming. Consideration of lifestyle choices can only reflect current behaviours (such as regular screening) and not future intentions (such as the intention to reduce fat intake in the event of a heart attack).

One of the most contentious public issues surrounding genetics revolves around whether insurers should be prevented from using genetic information to determine risk and, were this to be the case, would this involve a blanket proscription against any use or would insurers be permitted to continue relying on the “primitive” tests (eg inquiries into parents’ health status) employed at present.

A person's genetic makeup does have a significant impact on the probability that they will claim. From a pricing perspective, genetic information is fundamentally no different to other health information, except for the fact that the applicant can choose whether or not they find out their risk profile. In the past individuals did not have access to their genetic information. Insurers could set premium rates reasonably accurately, knowing that a certain proportion of the population carry genes that would increase their risk of claiming. Since neither party concerned knew the genetic information for any individual, selection was not possible. Family history was often used as a proxy for genetic information.

The current industry standard in New Zealand - and in many other countries - is that an insurer cannot demand that an applicant undergo a genetic test, but they can require them to disclose the results of any genetic test they have already had. This is designed to ensure that the insurer and the applicant have access to the same information while still respecting the individual's right not to have to undergo genetic tests. This works relatively effectively as long as genetic testing remains expensive and uncommon. However, the position may require rethinking as tests become more sophisticated and readily available.

One potential weakness is that there is no requirement for an individual to disclose genetic information they obtain after taking out a policy. It may therefore be good advice for doctors to recommend to any patients with a family history of a medical condition such as Huntington's chorea, who are intending to take a test, to first take out insurance. If the results of the test are positive then they can disclose the results and ask for a reassessment to standard. Otherwise they can keep the cover, knowing that it does not reflect their full risk.

The fact that an individual can decide if and when they to access their genetic information therefore sets genetic information apart from other risk factors. When genetic information becomes readily available it may be necessary to require individuals to either provide genetic tests at the point they take out a policy, or make them available if they subsequently have them done.

This raises the issue of whether individuals should be obliged to undertake tests if there is a family history of genetic disorder and whether the industry should consider developing and publishing policies on the appropriate use of family medical history for underwriting purposes. While family history is frequently used as a rough proxy for genetic information it is arguably unlawful under the Act as family status (which is defined *inter alia* as being a relative of a particular person) is a ground on which it is unlawful to discriminate. Family status is not among the exemptions in section 48. Section 48 only applies to different treatment based on age, sex or disability. A possible solution may be to argue that family history demonstrates a propensity to become disabled and it should therefore be included within disability - and therefore the exemption in section 48. Any distinction would therefore be legal if it could be justified under section 48.

Given the sensitivity of issues relating to genetic information, the Australian Law Reform Commission has suggested that insurers should review their consent forms to ensure that applicants have sufficient information to give informed consent to the disclosure of genetic information. The ideal consent form for collecting genetic information should be standardised and include a separate section with precise information about the specific nature of the test required, why and how it will be used and/or disclosed.

MENTAL ILLNESS

Some insurers offer policies that include blanket exclusions for mental disorder. It has been suggested that this amounts to a refusal to insure.

Policy design and wording is fundamental to how an insurance company can both determine the appropriate price for a risk and ensure that the risk itself is insurable. If a component of the risk such as mental illness cannot be made to meet these conditions, then the whole product may not be viable. Clearly the risk must be objectively defined, and measurable. If mental conditions are not objectively measurable then there is a strong argument that they should be excluded. Although a less extreme option might be to restrict the amount of cover that is paid for the benefit.

The cost of mental health claims is also rising and now makes up a significant component of the total claims cost. Many consumers (rightly or wrongly) do not see themselves as at risk of suffering a mental illness, and are not prepared to pay the extra premium. One alternatively currently offered by many companies is to offer an optional exclusion. This is arguably not a refusal to insure, as full cover is available at a price.

When applying an individual exclusion there is a balance between the insurer's need to make sure the exclusion is effective and the customer's right not to be excluded for illnesses that are interdependent from their previous history. Is it appropriate to exclude all mental illnesses when an individual's history may only predispose them to some particular illness?

Terms such as mental disorder that are in common use but have no specific, accepted meaning can be confusing. Yet it is essential that mental disorder is objectively defined if it is to be covered. Many psychiatrists believe that while diagnosing mental illness is less straightforward than many other areas of medicine, certain objective tests do apply. It may therefore be possible to develop some objective definitions that would permit mental illness to be covered.

But this still leaves open the question of when an insurer can take into account a history of mental disorder i.e when a disorder is considered to be a pre-existing condition and when it is cured. To be able to price a risk fairly the insurer needs to be able to take into account all relevant information. A person who has had a history of mental illness may well have a greater probability of developing a

similar condition in the future even though they may currently appear to be cured. This is the case not only for mental illnesses, but for other conditions such as cancer. What is important is that the definition of disability is broad enough to cover such situations.

DIRECTOR-GENERAL OF HEALTH

At present the ultimate decision on the applicability of section 48 and whether the difference is reasonable rests with the Government Actuary. However, the section refers to more than simply actuarial or statistical data. Reputable medical opinion can also be adduced. In order to determine whether such opinion is adequate section 48(2)(b) could be extended to include the option of referring to the Director General of Health for an opinion on whether the terms and conditions offered to an applicant by reason of their disability.

If the section is amended to include the option of referring an opinion to the Director General of Health for advice on whether the medical advice or opinion is reasonable and there is an increased probability of claiming, it should still be open to the Government Actuary to decide whether the different treatment is acceptable.

FURTHER ISSUES FOR CONSIDERATION

- How viable is community rating for health insurance?
- The present insurance guidelines allow a deferral period if a risk is unable to be quantified on application but likely to be come clearer with time. How long can an application be deferred without amounting to refusal to insure? Who should bear the cost of assessment of a deeply sub-standard risk?
- Is it permissible to distinguish between different disabilities, for example, by capping the cost of treatment for mental illness but not other disabilities?