

**Submission to the
Human Rights Commission
on the
Review of the Guidelines on Insurance
and
The Human Rights Act 1993
Discussion Paper
By the New Zealand Society of Actuaries**

INTRODUCTION

Thank-you for the opportunity to comment on this Discussion Paper. We believe that this document raises important issues and questions, and appreciate the opportunity to comment on them.

Our comments on the specific issues raised in the discussion document are below.

2. THE RELATIONSHIP BETWEEN INSURANCE AND THE HUMAN RIGHTS ACT 1993

LANGUAGE

Should outdated language be replaced with more appropriate terminology?

We agree that the industry and Commission should work together to continue to review and replace any outdated language.

We would comment that some of the industry has already made some changes to its language, for example by avoiding using terms such as 'substandard' that are likely to be found to be offensive.

INFORMATION NECESSARY TO JUSTIFY AN EXCEPTION

How important is it that a link is established between the data provided and the facts in individual cases when deciding whether data is reasonable?

A proper analysis must consider the facts around individual cases to determine where in the possible range of assessments an individual falls.

When determining the significance of the available data to an individual case, it is necessary and important to consider the relevance and composition of the population of people covered by the data, and whether there are variances that apply to different subgroups within the data. Studies will often identify both the average experience, as well as those factors that could have a positive or negative impact.

ii. Other relevant factors

When justifying an exception how important – or difficult - is it to ensure data or advice is tailored to individual situations?

As noted above, it is necessary to properly consider the facts around individual cases to determine the reasonable range of assessments for an individual case, recognising that there is no single correct answer.

Wider data and studies give the framework for the range of assessments available for a particular condition. The information is unlikely to apply precisely to any particular applicant and it is expected that the underwriter will use judgement to tailor the assessment for the individual situation.

iii. Medical advice or opinion

What type of medical advice or opinion should be necessary to justify an exception if there is no actuarial or statistical data available?

Most assessments are a combination of data and advice or opinion. There is generally some data or studies that can be used as a basis, but it is rare to find data that fits perfectly to any individual assessment. As judgement and interpretation of data is involved, there is generally a range of acceptable assessments for any one case, rather than a single correct answer.

Those who prepare the underwriting manuals (generally doctors, underwriters and actuaries) aim to sub-divide the information so that it is as specific and useful as possible for different sub-groups within any impairment, consistent with the information available for any sub-group remaining both reliable and useable.

The underwriter relies on the best information that is available, but also uses judgement, and reputable advice or opinion to determine the final assessment. Indeed, many of the ratings in the underwriting manuals are based on a combination of data, advice and opinion.

The medical advice or opinion provided to the underwriter should be from a doctor who has the experience and training in the relevant area of practice. The extent to which this is practical will depend of the extent to which the opinion is being relied on and how common is the particular medical condition. The CMO of an insurance company usually does not have a specialist understanding of all areas of medicine but has a good understanding of insurance medicine that has been gained over time, as well as a network of colleagues in different specialities that can be consulted when necessary.

What is a reasonable length of time to defer a decision about pricing a product?

It is appropriate that decisions are deferred:

- whilst the insurer is waiting for specific information, such as the result of a test or specialist appointment, or
- until a condition stabilises to a point where the risk is quantifiable.

In some cases it may be possible to offer to provide cover before all the required information is available, but in such circumstances the term of the cover will be restricted. More permanent cover can then be considered later.

It is often the uncertainty around a risk, rather than the extent of the risk that makes it initially uninsurable. For example the outlook can be very uncertain immediately following the diagnosis of a heart attack, but is likely to become clearer over time once the condition has stabilised.

The length of time in deferment would be based on medical advice and available data.

5. REFUSAL TO INSURE: EXCLUSIONS AND PRE-EXISTING CONDITIONS

i. Exclusion clauses

What information is necessary to justify blanket exclusion clauses?

A blanket exclusion should only be used where the condition cannot be effectively priced and covered.

A blanket exclusion enables the insurer to exclude that part of the risk that cannot be quantified, to enable a fair price to be determined for the remaining risk. One example of a blanket exclusion is suicide in the first year, which cannot be priced as the life insured has significant control over whether or not the event occurs.

Where a risk can be priced then it need not be excluded on a blanket basis, although it is possible to offer the option of an exclusion for a lower premium. An example is AIDS. In such cases the pricing must take into account the fact that people electing to pay the higher premium for full cover are likely to have a higher incidence of the condition than the population as a whole.

ii. Pre-existing conditions

If seeking to exclude cover for a condition which existed before the policy commencement date, how relevant is it that the applicant has recently received treatment for the condition?

The underwriter will take into account all known information, which includes the person's current state of health, the treatment they are having and how they are responding to the treatment. In some cases it is necessary for a person to be on treatment for a reasonable amount of time to assess how effective the treatment will be in the long term.

One relevant factor is the extent to which a past history of a particular condition predisposes a person to a recurrence to a greater extent than a

person without that past history. This will depend on the individual's specific history and circumstances. For example the likelihood of a person suffering a recurrence of depression will vary greatly, and the underwriter would consider factors such as:

- the severity, and duration of the original depression,
- the extent of any recurrences,
- the personal circumstances of the original depression, and
- the response to treatment.

Should cover be offered for unrelated conditions?

Exclusion clauses should be as specific as possible. Where possible, the intention would be to exclude a specific type of condition, rather than the whole condition.

Taking cancer as an example, it is often reasonable to exclude testicular cancer rather than all cancers. However, in some cases, where it is difficult to distinguish between a secondary of the original cancer, and a separate unrelated cancer, a general cancer exclusion may be necessary. As medical science develops it should be possible to identify secondary cancers more accurately, leading to the use of more specific exclusions.

6. MENTAL DISABILITY

Should insurers provide cover to people with a mental disability in the same way as they offer it to people with a physical disability?

Insurers need to be consistent in their treatment of different types of disability.

Our understanding is that most companies in the industry aim to achieve consistency between different disabilities and agrees with this aim in principle. In practice, it is necessary to review what this may mean in practice from time to time, which may show there are areas where changes need to be made.

7. AGE DISCRIMINATION

Do you think that health insurance offered as part of an employment package should be available to everyone regardless of their age?

If health insurance is included as part of a salary package, then we see no reason why it should expire at a particular age.

It may be necessary to cap the cost of the subsidy, or restrict benefits at older ages. There is clear data on health costs at older ages that could be used to support this variation.

8. THE POTENTIAL FOR GENETIC STATUS DISCRIMINATION

Do you think the current moratorium on the use of genetic information is a satisfactory way of dealing with this issue?

The content of the current moratorium is currently satisfactory. The content should be constantly reviewed as the use of genetic testing develops.

Are any of the other options such as legislation, more appropriate? If so, what option is better and why?

The current moratorium is only a voluntary code, and only applies to ISI members. The moratorium needs to apply to all companies. As a first step, the Human Rights Commission could consider endorsing the existing ISI guidelines.

9. REINSURANCE

Is the Commission's current position in relation to reinsurance appropriate?

If insurance companies are to comply with the guidelines then reinsurers also need to be covered by the Act.

Most companies base their assessments on manuals provided by reinsurers. Some reinsurance treaties specify that underwriters must use the reinsurers underwriting manual. It is important that the data and the advice and opinions behind such manuals are compliant with the Act.

As the Act also requires companies to offer cover to people outside the normal range covered by the reinsurer's manual, reinsurance support should be available for these cases. This will happen if the reinsurers are required to comply with the Act.

The New Zealand Act is unique in that it requires insurers to offer cover on some terms to all applicants. It is also small in the scheme of a reinsurer's total business. Reinsurers may be hesitant to operate in the New Zealand market if they are made to comply with the Act. This would remove vital support from direct insurers, and could restrict the level of cover available. These practical considerations would need to be worked through carefully.