



Insurance

Guidelines on Insurance and the Human Rights Act 1993 – issues to consider

By BRIAN KLEE

There is a lovely saying: “Before you take down the fence around the farm, make sure you figure out why it was put up first – you don’t want to lose your entire livelihood”...

WITH TODAY’S GREATER focus on anti-discrimination, “impaired risk” underwriting means many of those “uninsurable” succeed in obtaining affordable coverage. The Human Rights Commission (HRC) has contributed to this outcome and much wisdom is required.

In January 2004, Helen Gilbert of the Mental Health Commission published a very well-researched paper “Life insurance issues for people with experience of mental illness.” The key conclusion we reached after talking with Gilbert by telephone was that the public does not have an adequate understanding of the life insurance industry. It is often viewed as a “secret society” and we must do more to clearly communicate our practices and processes.

Another working paper published around the same time by University of Wisconsin entitled “Prohibitions on Health Insurance Underwriting” stated: “Underwriting restrictions are supported by many ethicists who contend that underwriting is morally indefensible (Daniels, 1990) and by market reformers who view underwriting as a barrier to insurance for those in poor health.” We hope this view is also adhered to in New Zealand and that democracy shields the rights of ordinary people, and our government’s social welfare system manages those in poor health.

Since the Human Rights Act was introduced 13 years ago and the initial Guidelines nine years ago, insurers in NZ have cooperated well with the

spirit of the Act, and in our experience most make a conscientious effort to comply. Nevertheless, the four main issues from our viewpoint are:

- An overuse of “deferred” applications – many should be declined outright but no one wants to be involved with the first test case;
- Unreasonably long deferment periods;
- Paranoia around issuing insurance for people who have suffered stress, mental illness, etc., especially with the underwriting of income protection insurance; and,
- the dilemma faced by insurers for those claims that will not be shared by their reinsurer because they have gone outside the reinsurer’s underwriting guide.

We comment here on the first two issues.

Medical advice or opinion

As with any profession, methodologies are based on research, experience and accurate data. However, up-to-date, accurate statistical data and clinical advice or opinions are all vital components for properly assessing insurance applications.

However, we are concerned at the present use of reinsurance underwriting guides. We are reliably informed that a number of sections are

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based on very old data and medical practices, and should be updated. Also, they are not being used as actual guides in fear of audits and the risk their “partners” will take a tough line on a future claim if the original underwriting decision was in conflict with the guidelines.

For us, underwriting complex or extreme cases has highlighted that the quality and accuracy of clinical notes maintained by GPs can vary considerably and, as such, risk assessment is sometimes very difficult. Because of this factor alone, insurers will often “defer” making a decision until the evidence is improved, procedures are undertaken, risk periods lapsed, etc.

That said, some insurers and inexperienced underwriters are over-using (or abusing) “deferred” especially for applicants who should be declined outright. The proposed Human Rights Commission (HRC) complaint process would be useful to flush this out.

Reasonable data or advice

As New Zealand is leading the world in its broad-minded human rights approach and reinsurance treaties and underwriting guides are very rigid, the ability for an underwriter to “think outside the square” is very restrained. Nevertheless, it is common practice for underwriters to research risks using the reinsurers’ underwriting guides.

These guides are extensive, but they are only infrequently updated. Typically, statistical data and underwriting information become outdated and need continual upgrade. Until this happens, it will continue to remain problematic for individuals to have their risk profiles assessed thoroughly – unless of course they can afford to pay for an expert opinion from someone like us.

Some years ago, we assisted a person who had Haemochromatosis. All the insurance guides

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stated that his premium should be loaded, and – as far as disability is concerned – declined. His specialist was one of NZ's leading authorities on the condition and provided us a medical journal paper which provided evidence in support of the application. We were able to provide disablement cover with a suitable premium loading. With the internet and the availability of the latest medical opinions on an assortment of conditions, senior underwriters can and often do make decisions that contradict the reinsurers' guides.

Exclusion clauses

The information required to justify blanket exclusion clauses has to be substantial, up-to-date and relevant to the type of cover (typically, these are trauma, health and disability-type contracts). The alternative to exclusions is product warranties, such as limiting the policy term, restricting certain activities (we had one golden oldies rugby restriction for a former cardiac patient), increasing the premium, or outright declines.

Exclusions are practical and necessary, however there is a tendency to use wide-reaching conditions that some describe as blanket exclusions, for example, somebody who has suffered cancer. Is it reasonable to exclude all cancers? Or specifically the cancer that the insured has suffered? The bottom-line is it depends on the type and location.

We recently challenged an insurer for an applicant who had non-Hodgkin's Lymphoma and Hepatitis C. He had applied for health insurance and the exclusions came back initially excluding all cancers plus any disease or disorder of the liver. Another insurer restricted just the non-Hodgkin's Lymphoma and subsequent related conditions, and Hepatitis C plus conditions arising from or associated with this condition. When we raised this with the original insurer who had requested the blanket exclusions, they agreed to change their offer. How often is this challenged?

Finally, insurers will not offer terms to an insured where more than four exclusions are necessary. This practice is over-simplistic and we challenge this numerical approach for justifying a decline. We feel the HRC support is required on this issue. The public needs a channel like the HRC to review over-zealous conditions, rather than have to resort to the court system.

Pre-existing conditions

The relevance of recent treatment is vital, however

this must be duly considered with all long-term implicating factors. Recent treatment is not an assurance that the applicant is cured of the ailment suffered – it could take some years to reduce the absolute risk factor. Extending these exclusions to include "associated" or indirectly related conditions is reasonable in some situations but nevertheless tempting for insurers to exploit and really minimise their risk. Periodically, we challenge insurers on this. In most cases, with a reasoned argument, we are successful in amending the original offer. Typically, these are presented by underwriters lacking experience or knowledge. The biggies are mental illness and back exclusions. We are in agreement that excessively general exclusions to limit liability must be challenged.

Other relevant factors

The insurance industry has been around hundreds of years because it has made the right commercial decisions over time. It would be like "throwing out the baby with the bath water" for any legislative authority to suggest it interfere or restrain insurers from making sound commercial judgments about premiums and policy wordings.

It is important to remember that over 90% of all applicants are issued insurance at affordable standard rates. Only 2% to 3% are regarded as uninsurable and the rest can be covered with adjusted premiums or policy wordings. Exclusions are more prevalent for some products than others. For life insurance, they are relatively rare (fewer than 5%) and these are commonly for hazardous pursuits or pastimes, or where people work in dangerous countries such as Iraq. A few are issued with permanent suicide exclusions.

In contrast, exclusions are commonplace with the more difficult "living" insurance products – that is, income protection, total and permanent disablement, trauma, health, etc. Perhaps as many as 40% or more are modified because of the more complex risk factors. The most prevalent is health insurance, where the standard "pre-existing clause" is common, though today some insurers are covering medical issues disclosed unless they must be expressly excluded, and anything "material" that is not disclosed will not be covered.

The HRC should be aware of the issues surrounding anti-selection. Insurance is designed for risks that are unforeseen and unanticipated such as premature death, accident or illness. When an applicant anticipates a premature event because of specific knowledge, known by them and not

the insurer, the insurer is being selected against. The playing field is no longer level.

With the power of the internet today giving individuals the opportunity and ability to research their medical symptoms before they consult a doctor, anti-selection is on the rise. This too is discrimination. People can and do anticipate what may be around the corner, and can go out and buy insurance when they think the worst. This is particularly an issue with trauma insurance, which pays a lump sum on the diagnosis of a specified condition such as cancer, heart attack, etc. It is all too easy to go out and buy insurance in advance before you seek medical assistance or advice.

From our experiences specialising with applicants suffering from health difficulties, though important for the insured, we know how difficult it can be to tailor the applicant's circumstances so they become insurable. Providing adequate information for an insurer so they have enough "data" to assess the risk is always our biggest challenge.

On the other hand, to assume that any policy can be priced is a mistaken belief and in practice, rarely achieved. In an article by [former AMP general manager] John Dingle in 1996, he stated: "International experience is that the limit of insurability is considered to be an extra mortality in the range of 400-500%. This is because of the reasons of cost to the applicant on one hand, and the medical uncertainty with higher rated impairments on the other hand."

We have had applicants accept cover in excess of this range but we have witnessed an insurer's offer of 1400%+ – that is, 150 times the standard premium! This extreme response is certainly a waste of everyone's time, cost and effort and was simply to comply with the HRC's requirements.

Finally, a couple of associated issues.

It would assist insurers if the HRC gave much firmer guidelines that were also supported by reinsurers. Section 44 does not apply to reinsurers, a situation which must be remedied.

The second issue is genetic discrimination. Although our genes affect almost every aspect of our lifetime health, the prognostic value of genetic information depends on so many complex factors, and it is too difficult to get a clear opinion yet. The HRC should continue to monitor overseas events and support the recommendations of the ISI and Law Commission on this subject. *fa*

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