Investment & Financial Services Association Ltd

Second Submission to Productivity Commission Review of Disability Discrimination Act 1992

29 September 2003

Level 24,44 Market Street Sydney NSW 2002
Tel : (612) 9299 3022 Fax : (612) 9299 3198
Email : ifsa@ifsa.com.au

Contents **Page**

1		**Executive Summary**	**1**
	1.1	Introduction	1
2		**The Provision of Life Insurance**	**2**
	2.1	Equity versus Equality	2
	2.2	How much Differentiation?	2
	2.3	Cost/Benefit Trade-off	3
	2.4	Limited by Design	4
	2.5	Limited by Time	5
	2.6	Limited by Timing	5
3		**Disability Insurance**	**7**
	3.1	TPD Cover	7
	3.2	Income Protection	8
	3.3	Recent Market Experience	9
4		**Insurance Products**	**11**
	4.1	The Nature of Insurance Products	11
	4.2	Availability of Insurance for those Already Disabled	12
	4.3	Industry Initiatives	13
5		**The wording of Section 46**	**14**
	5.1	What is Insurance?	14
	5.2	The Two Arms to the Exemption	14
	5.3	Refusal To Offer Cover	14
	5.4	Offering Cover under Modified Terms and Conditions	16
	5.5	Other Relevant Factors	17
6		**Complaints and Enforcement**	**21**
	6.1	Alternative Providers	21
	6.2	Independent Review	21
	6.3	Acceptable Basis	22
	6.4	Competitive Market Practices	22
	6.5	Ability To Make A Complaint	22
	6.6	Alternative Models	22

1 Executive Summary

1.1 Introduction

This is a further submission by the Investment and Financial Services Association (IFSA) to the Productivity Commission's (PC) review of the Disability Discrimination Act 1992 (DDA) This response principally addresses some of the issues raised during IFSA's attendance at the public hearing held in Sydney on Thursday, 17 July and also provides comment on issues raised in other submissions to the inquiry to the extent that they address life insurance matters.

- Section 2 provides some more background on life insurance underwriting and product design and development.
- Section 3 provides some more detail on disability insurance products offered as life insurance business
- Section 4 considers the nature of insurance products and the life insurance market
- Section 5 looks at the wording of Section 46
- Section 6 considers the complaints process

2 The Provision of Life Insurance

2.1 Equity versus Equality

One of the most common misconceptions evident in complaints about the ability to obtain or the cost of obtaining insurance is the confusion between equality and equity. Where a product or service is seen to be for the public good and essential to the maintenance of society it is important that all members of that society have equal access to that product or service. The public health system, public transport and policing are all examples of services where equality is held paramount and where failure to provide equal opportunity or access may be grounds for challenge under the DDA.

The provision of insurance is not a public service but rather a commercial exercise where individuals are able to decide if, when and how much insurance cover to apply for. If an individual is twice as likely to experience an event that may result in a claim then the principle of equity implies that they should be charged twice the cost. There are many products and services where the ability and/or cost of obtaining them, varies by some factor – this differentiation is based on equity, rather than equality, between individuals.

The basis for the confusion between equity and equality when it comes to insurance is usually because the focus is on the need. Everyone recognises the need to protect against adverse circumstances and the right to a prosperous future reflecting individual endeavours. When the focus is changed to the relative risk and the likelihood of suffering adverse circumstances more people recognise the importance for equity rather than equality when the service is provided through a free market.

2.2 How much Differentiation?

The challenge for the free market is to identify the extent that people are willing to support differentiation in price (that is, what rating factors are commercially viable and considered socially acceptable) and to what extent they are willing to cross subsidise the higher risks by paying a premium rate that does not differentiate between some risks.

One example is the differentiation in premium rates based on sex. Indeed at the turn of the 20th century premium rates didn't differentiate by age, by sex nor did they consider any factors that lead to a substandard risk. These have been developed in response to actuarial analysis and statistical evidence as well as consumer and legislative acceptance of the differentiation.

Another example of changes reflecting medical knowledge and societal views over the last 50 years or so, has been the advent of premium rates that differentiate between smokers and non-smokers. Up until the 1960's, rates were not differentiated by smoker status but these days very few products exist without such differentiation in rates. Despite medical evidence to support the differentiation this has not progressed to the point of charging different rates for life-long non-smokers versus those who have given up smoking for at least 12 months. It may be the case that the market would not support such differentiation despite the actuarial analysis and statistical evidence to support it.

This market non-acceptance has also been evident in Australia with the failure of 'preferred life' underwriting products to gain acceptance in the local market despite attempts to development and market them. These products offer lower premium rates to those lives exhibiting certain characteristics consistent with lower mortality / morbidity experience. In the US these products are commonplace and well accepted and there is clear evidence of the actuarial basis to support the pricing differentiation. Despite this the combination of distributor resistance, the costs of underwriting, the size of the market and the lack of consumer demand for such products has meant that there is no commercially viable justification for such products.

Consideration of societal views is also evident in Australia with the advent of research into the human genome and genetic testing. There is clear medical evidence that shows that individuals with differing genetic characteristics have different relative risks for a number of medical conditions that would become claimable events under various types of insurance policies. Despite this however, it has been recognised that society respects an individual's 'right not to know' and life insurance companies have agreed that they will not require those individuals whose family medical history and / or personal statements of health indicate a potential predisposition to those medical conditions, to undergo a genetic test. Thus despite actuarial and statistical evidence to support the testing, such discrimination is seen as not being acceptable to the marketplace.

2.3 Cost/Benefit Trade-off

Underwriting risks is an expensive exercise. Obtaining medical reports, conducting examinations and requiring blood tests takes both time and money as does the the management of the administration system tracking those reports and results. Evaluating the responses to a long list of medical questions and obtaining more information where those responses indicate a possible factor that might impact the individual's relative risk also adds to the cost. This cost, just like the cost of claims, must be funded from the premiums charged.

As with all commercial undertakings, underwriting is subject to cost-benefit analysis. Does the cost of obtaining this information exceed the benefit obtained from it? If so, then there is no commercial justification for obtaining that information. This is the basic principal that underlies the concept of 'medical limits'. The other major factor that impacts the setting of medical limits is competition – if a company has significantly higher requirements than its competitors, applicants and/or their financial advisers will choose to purchase from companies that are 'easier to do business with'.

Medical limits are the criteria that determine at the outset of an application what the base medical requirements will be. Usually, dependant on the type of benefit payment criteria sought, the age of the applicant and the amount of the sum insured, the medical limits will state whether an individual is required to undergo a specialist medical examination, a blood test, an ECG, authorise a personal medical attendant's report or simply just provide a personal statement of health.

Where the base requirements indicate a potential risk factor, further medical or other evidence (such as financial justification for the amount of cover sought) may be requested. The underwriter must make a call as to whether the cost of obtaining additional information is more than offset by the benefit obtained (ability to more accurately price the risk) from that further evidence. Historical data, company guidelines, reinsurer advice and underwriting expertise all go into determining when further information should be obtained.

At the point where the cost/benefit trade-off is reached, the underwriter must then make a judgement call on the evidence before him or her as to how significant the individual's condition is and where they stand in terms of their relative risk. This is done for each and every factor that is considered in the process of underwriting and aggregated by means of a numerical rating process resulting in a final relative risk factor on which the premium will be based.

The decision points on when to obtain additional information and when to make a judgement call on the available information are other factors that are relevant in considering whether the discrimination is reasonable, particularly in those products where those decision points are set at very limited levels.

2.4 Limited by Design

There are many distribution channels that life insurance companies employ to offer products to the market. Some of these are designed in such a way that they limit the opportunity for 'selection against the office', that is, for individuals who are higher risks to purchase larger amounts of cover or to obtain cover at a price that does not take into account their higher risks. The design of these products depends on the ability to limit to whom the products are offered and the means of selecting which risks are acceptable.

One common example is the limiting of underwriting costs by design.

This is where a product is offered usually through direct marketing to a group of lives that have something in common such as being customers of a particular institution or some other list that would represent a cross section of the community in terms of risk profile (lists such as residents at a nursing home, members of a motorbike racing club or social security recipients would not be appropriate groups). This group are then screened using selection criteria that seek to minimise the proportion of potential bad risks (selection based on age, income, employment status, postcode or other possible socio-economic factors that are available on the list (if any) which have correlations with risk status). These lives are then offered set amounts of life insurance cover (rather than the ability to choose any amount they want) and are required to answer usually about 5 YES/NO questions.

The underwriting criteria is set so that ANY life that cannot answer ALL these questions in the acceptable way is denied cover under this policy. The premiums have been based on this criterion, i.e. there is no allowance in the pricing structure to incur additional underwriting costs to obtain further evidence as to whether the 'unacceptable' response to one of the questions is a material risk factor or not. Some of the unacceptable responses will definitely have higher risk factors and there is no alternative simple way within the products design to differentiate between those with higher risks and those without.

Thus this product design limitation, which is commonly available in offers made through credit card facilities and in non-life products such as travel insurance, is another relevant factor that is appropriate to recognise.

2.5 Limited by Time

Another factor that impacts on underwriting decision making is not only the availability of information and the cost of obtaining it but also its credibility and predictive value. When looking at an individual's medical history an underwriter needs to consider how long ago an event occurred, and whether their condition stabilised to the extent that its severity can be appropriately and adequately judged. A number of conditions also are strongly impacted by the individual's lifestyle and their maintenance of a treatment or medication regimen and having regular reviews and checkups. Without an adequate period to demonstrate compliance with that regimen it is not possible to adequately evaluate relative risk into the future.

Underwriting life insurance is a once only action. The assessment made by the underwriter determines the risk relativity that is applied to standard premium rates for the life of that policy. Under the terms of the life insurance contracts offered in the market the life insurance company is obliged to continue the cover for as long as the premiums are paid as they fall due (These contracts have often been referred to as guaranteed renewable). The standard premium rates may be altered for a particular class or group of lives but cannot be individually adjusted for a particular policy.

Although not a specific term of the life insurance contracts in the market, the life insured is able, at any time, to apply to the life insurance company to have any loading or exclusion on their policy reviewed. Failing that they can apply to any life company at any time for a new policy and should they obtain better terms, they can cancel their existing policy. This fact coupled with the "guaranteed renewable" nature of the policy is a significant issue in determining what constitutes a 'material risk factor' in the context of the ongoing prudential viability of the life insurance business of the company when developing underwriting guidelines. It is not enough to make a 'best estimate' judgement where there is equal chance of being too generous or too conservative, rather it is appropriate for the life insurance company to take a conservative stance in its risk assessment to protect the interest of the existing members of its statutory fund, tempered by the competitive pressures of the voluntary mutually rated market.

2.6 Limited by Timing

The process of underwriting in the provision of life insurance is also subject to the facts, as they exist at the time of proposal. Because life insurance policies are guaranteed renewable, the insurance company is obliged to maintain cover for as long as premiums are paid regardless of what other changes may have occurred.

This differs from general insurance where most contracts are cancellable or annually renewable where the general insurance company has the ability to re-underwrite the application at each anniversary and can choose to cancel the contract if the claims experience or risk factors affecting the applicant become to great.

Where an individual suffers a condition, or an event occurs, after a policy has commenced for which there was either no history or risk factor, or any such history or risk factor was fully disclosed in the proposal, then the cover they have in place must continue on the same basis even where that condition or event is not normally insurable.

For example an individual who is involved in motor racing would normally not be able to obtain insurance cover that would cover the risks associated with motor racing (normally an exclusion for motor racing would be placed on any policy applied for). But if at the time of applying for insurance an individual was not involved in motor racing and had no intention of taking up motor racing then no such exclusion would be placed on their policy. If that person at some later stage takes up motor racing then they would be covered so long as they maintained their previous policy.

Similarly if an individual with life cover is involved in a motor vehicle accident that leaves them severely disabled with significantly reduced life expectancy their cover cannot be cancelled by the life office but must be maintained according to the terms and conditions established at outset. Their existing cover, if not claimable due to the event, would continue on the same basis as existed at outset.

An individual who chooses not to take out life insurance when they are young, fit and healthy but later finds when they are older and suffering from several conditions that makes them such a high risk that they are uninsurable, is not being discriminated against unfairly. Insurance is there to protect against unforseen events in the future and not a means of funding inevitabilities. This is discussed later in the section on the nature of insurance.

3 Disability Insurance

One of the submissions to the inquiry[1] questioned the availability of what was described as long-term disability insurance. It was considered appropriate therefore to provide some additional information on the forms of disability cover available within the gambit of Life Insurance.

As was mentioned at our public hearing there have been instances where a life insurance company's product has been challenged as being health insurance as the benefits were becoming specifically related to hospitalisation costs and indemnification of medical expenses. The result of the challenge was that the Minister for Health at the time amended the definition of 'health insurance' in the National Health Act to make it extremely broad with very limited carve out based on the life insurance products available at the time of the modification of the regulations. There are significant monetary penalties for the provision of health insurance if not a registered health insurer.

Life insurance products provide 'disability insurance' by way of either a lump sum benefit or by way of a replacement of income in the event that an individual becomes disabled under the policy definition applicable.

3.1 TPD Cover

The oldest and most straightforward example of this is in the provision of "Total and Permanent Disability Cover". This type of benefit can be added to a policy for life insurance cover and typically provides for the pre payment of the death benefit in the event that the life insured suffers an event that has resulted in them being unable to work in their usual occupation for the past 6 months and they are unlikely ever to be able to work in any occupation for which they are suited by education, training and experience.

There are variants on this definition based on either;

- the individual's specific occupation ("own" occupation definition) or;
- any income earning enterprise ("own" occupation).

Appropriately this style of cover is only available to those individuals in gainful employment (or gainfully self employed) up to normal retirement age.

More recently there have been developments based on;

- an individuals ability to perform actions collectively described as the activities of daily living[2] ("ADL" definition) or;
- to continue to undertake the duties required to maintain a home ("homemaker" definition).

Both of these provide more scope for cover to those not gainfully employed or those undertaking domestic duties.

[1] Jack Frish, Submission 196

[2] Bathing, toileting, dressing, eating/drinking, moving from place to place

Other common inclusions in the definition provide for the benefit to be paid where:

- the life insured is diagnosed as terminally ill with less than 12 months to live ("Terminal Illness" definition) or ;
- the life insured suffers the complete and permanent loss of the use of two limbs, the sight of both eyes or the one limb and sight of one eye ("Lord Nelson Clause")

The life insured chooses at the outset of the policy how much cover they want (subject to each companies maximum cover guidelines) and can choose to have that amount indexed in line with increases in the Consumer Price Index (CPI). At claim time, once the validity of the claim is determined, the lump sum is paid out and the amount of life cover to which the TPD is attached, may cease.

3.2 Income Protection

The other main form of disability insurance available in the Australian market is one where an income benefit is payable whilst the life insured is disabled (whether permanently or not). Whilst commonly called disability insurance, it is more accurately described as income protection or salary replacement cover.

Under this form of insurance the applicant applies at the outset of the contract for a specific waiting period and benefit period as well as the amount of cover that will be provided.

The waiting period represents the amount of time from the event causing the disability, that the life insured must continue to be disabled before any benefit is payable. Waiting periods may be as short as 14 days, but are more commonly 30 days or 90 days and may be up to two years (to integrate with superannuation funded benefits).

The benefit period represents the maximum duration from the end of the waiting period for which benefits will be payable. Should the life insured cease to be disabled before this time then the benefits will also cease at that time.

It is possible for a life insured to claim multiple times on an income protection policy, as unlike lump sum cover, the payment of income protection benefits does not cancel the policy. For each disabling event there is a waiting period (reoccurrence within 6 months of the same event does not restart the waiting period) and benefit period. Benefit periods vary and may be as short as 1 year, but more commonly 2 years (maximum duration for provision under superannuation) or 5 years, and may as long as to the life insured's 65th birthday (normal maximum retirement age).

The maximum benefit amount that insurance companies will offer is an amount equivalent to 75% of the life insured's income from personal exertion. This limitation is because there is a recognised correlation between the rate of recovery from disability and the proportion of pre-disability income that is replaced (replacement ratio) as well as recognition that a proportion of income earned is spent in the exercise of earning that income.

These contracts frequently provide additional benefits that seek to recognise some of the costs associated with disability and its management. Benefits include additional funds to cover rehabilitation programs, nursing care costs, workplace modification, additional rehabilitation costs and specific amounts associated with particular injuries or sicknesses regardless of the specific amount of time spent unable to work.

The basis for the commencement of payment of benefits under these policies is that the life insured is, because of sickness or injury, unable to work in their occupation, is not working in any occupation and is under medical care. Benefits can be paid on a partial basis (usually after a period of total disability) until the benefit period expires or until the individual has returned to full income earning in their occupation.

These policies are predominately purchased by the self-employed who do not have access to sick leave or employer provided superannuation where similar style benefits are frequently provided. They therefore have employment / income earning requirements for applicants.

3.3 Recent Market Experience

During the public hearing, we indicated that there had been significant increases in premium rates for disability insurance, which the Commission expressed interest in learning more about.

Premium rates are set to cover all the costs associated with writing insurance business including those of underwriting, administration, commission, policy issue and maintenance, annual statements, premium collection, claims management and by far the most significant, the cost of claims. For income protection the cost of claims is determined by two factors:

- Claim incidence rates (how frequently claims occur), and;
- Claim termination rates (how quickly claims end)

The more frequently claims occur and the longer they last the higher the cost of claims. Since the early 1990's there have been adverse trends observed in both the incidence and duration of claims. There have been many attempts to try and identify the reasons for and causes of these trends and to attempt to predict future claims costs (as it is these costs that must be met by current and future premiums) but this has been confounded due to a number of causes including the availability of sufficient data to allow analysis, the huge variation in experience between companies and because it takes longer to identify trends in durations.[3]

It is significant to note considerable changes in the causes of claims and that approximately 30% of claims costs are now mental health related, a much higher proportion than in the past. Whilst a physically manifested condition is easily identifiable and easy to measure when an individual recovers from that disability, it is far harder to manage and measure more subjective conditions such as mental health.

[3] Papers published through the Institute of Actuaries of Australia include: D Service, Disability Claims – Does Anybody Ever Recover (2002), J De Ravin, The Management of Disability Income Claims (1998) and various regular reports by the Disability Committee (italics added)

Whilst premium rates differentiate between occupational classes the experience to date does not provide sufficient volumes or details to allow analysis on individual occupations. Anecdotally there have been indications that medical practitioners, legal representatives and insurance agents demonstrate claims experience not consistent with that expected from their occupational activities (compared to other white collar occupations) and that there may be some other factors influencing their ability or propensity to claim. As there are no available statistics or other information on which it is reasonable to reply companies are instigating mechanisms to allow greater detail in data collection to facilitate more specific analysis to see if greater differentiation in premium rates is warranted.

Growth in the market and constantly changing products as well as changes in social norms and prevailing economic conditions make past experience less than a good indicator of the future. It is the process of turning this past experience into something usable for the development of standard premium rates that is the essence of actuarial analysis..

It is not clear whether these past trends have come to an end, whether recent industry responses to these market conditions are adequate to stabilise claims costs into the future. Certainly as long as there is growth in wages, even after accounting for inflation, there will be an increase in sums insured but this will not impact on the standard premium rates (per $1,000 sum insured) if the underlying assumptions of claims incidence and claims durations are born out in experience.

One critical advantage that the Australian market has over the US that has prevented a repeat of the US experienced outlined in our first submission[4] is that in the US policies were written on a non-cancellable basis, where the standard table of premium rates could not be revised whilst in Australia business has been written on a guaranteed renewable basis where the standard table of premium rates can be revised so long as it applies equally to all in-force business of that type or class.

In-force premium rates in Australia can be increased to reflect changes in experience whereas in the US they could not. The impact of increasing premium rates however is the vicious cycle of adverse selection and increasing premiums that was outlined in our earlier submission. As we previously reported, several companies have experienced very high discontinuance rates following price increases and it remains to be seen whether it is possible to increase premiums enough to cover the increased cost of claims for the business remaining in force (premiums are not payable whilst on claim).

[4] IFSA, Submission 142

4 Insurance Products

4.1 The Nature of Insurance Products

The first step in the development of an insurance product is to identify where a need exists, the next step is then to consider whether that need can be met by the provision of insurance. In determining this there are a number of attributes that an actuary considers:[5].

- Fortuitousness:
  For a potential loss to be insurable its occurrence must be fortuitous. Where the occurrence of loss is dependant on the policyholder's behaviour it creates a moral hazard and the possibility of fraud.
- Assessability:
  It must be possible to assess the expected cost of the future loss. This means both the size, frequency and likelihood of the occurrence of the loss can be determined. Where there is an agreed sum insured the size is known but not all events are reasonably predictable.
- Affordability:
  If the cost of insuring against a loss is too high then the product will not be viable as it will not be seen as value for money and therefore there will be no demand at the price at which the insurance can be offered.
- Financial Viability:
  There is no future in offering a product that will not meet the provider's financial requirements at least in the long run. If it is not priced to meet all costs and obligations then its sale may be the beginning of a financial disaster.
- Independence of Risks:
  Insurance works by the pooling of independent risks. A pool that has a large concentration of related dependant risks contravenes this basic principle.
- Timing:
  Some opportunities remain open for a specific period. Also some risks have limited periods or conditions – the need for income protection cover ceases at normal retirement age.
- Criminal Activity:
  Insurance should not threaten the public interest and should not encourage criminal activity.
- Legal Requirements:
  The insurance should comply with all relevant legislation.

[5] C Bellis, J Shepherd, R Lyon: Understanding Actuarial Management: the actuarial control cycle

The implications of these principles include:

- It is not appropriate to provide insurance where the ability to claim is impacted by the policyholder's behaviour. Where a major factor in determining the probability of a claim is the behaviour of the life insured (maintaining a certain medical regime or lifestyle) the risk may be uninsurable unless there is a high level of confidence in the maintenance of that behaviour – eg considerable past history of appropriate management of diabetes. Some risks that might otherwise not be insurable may become insurable once there is a substantiated behaviour.
- It is not possible to provide insurance against an event after that event has occurred. Whilst this might seem an obvious statement some submissions have commented on the inability to obtain insurance after becoming disabled without recognising that they would have been able to obtain insurance as a standard life before becoming disabled.

At the simplest level it can be recognised that in any commercial enterprise intending to make a profit, an adequate price must be charged for the service. The price paid must cover the cost of providing that service together with a suitable profit margin. Without a suitable profit margin shareholders would not receive sufficient return on their capital to warrant investment in the business. When there is uncertainty associated with the cost of providing that service and therefore the adequacy of the profit margin, that uncertainty must be allowed for in the price. Market forces will mean that there is a limit to the amount of conservatism that can be realistically incorporated as companies compete for business.

Within the standard range of insurance products there is the ability to cater for a wide spectrum of substandard risks and this is demonstrated by the high proportion of lives that are offered cover, either at standard or other than standard terms.

4.2 Availability of Insurance for those Already Disabled

At the public hearing with IFSA a concern was raised as to what extent underwriting relies upon the stereotyping of an individual's capacity to live with a disability and to what extent severity and an individual's situation is taken into account.

Individuals that provide the greatest level of information about their medical history and any exposure to risks (hazardous pursuits such as scuba diving) allow the underwriter to adequately assess their specific conditions and the risks involved and to determine an appropriate rating factor.

There may be some conditions where the risk is not able to be assessed or is so great that the required premium is so large as to be uneconomic in which case the underwriter may offer cover with exclusions for those conditions.

Where the information is not provided or not available or the cost of obtaining the information is uneconomic then the underwriter must either seek further information or make an assessment on the available data. The extent to which this imputes a specific individual with stereotypical attributes is governed by the viability of the company entering into detailed analysis by resourcing the level of communication necessary, the willingness of that

individual to provide information and by the other circumstances surrounding the case (such as what is available in the published statistics).

There will always remain risks that cannot be insurable due to some factor, in many cases this will involve a combination of factors, not all of which will be obvious.

4.3 Industry Initiatives

The increasing significance of mental health as a cause of claim and contributor to the increasing total cost of claims has been a driving factor behind IFSA's desire to work with the mental health sector stakeholders in identifying risk-differentiating factors with regards to mental health issues that treat individuals equitably, can be understood by and are acceptable to society and represent an acceptable cost / benefit trade off to industry. The Memorandum of Understanding and the underwriting and claims management guidelines are indications of the success of this endeavour.

5 The wording of Section 46

One of the specific points raised by the Commission and in a number of submissions has been in the nature of the wording of Section 46 and whether it is too broad and non-specific.

Some submissions have questioned whether there should be an exemption at all for insurance but most of these have taken the point of view of insurance being a public good rather than a voluntary mutually rated product. To the extent that some insurance represents a public good, the government provides social security benefits or has legislated for community rating (health insurance). To the extent that access to insurance is not voluntary most superannuation schemes provide a basic level of cover that does not discriminate other than to require that the individual is "at work" on the first day they are eligible for cover. IFSA believes that our earlier submission adequately covers the reasons why an exemption is appropriate for a mutually rated voluntary life insurance industry.

5.1 What is Insurance?

Of the comments and complaints made about insurance, one of the most common themes has been a lack of understanding of the distinction between the types of insurance available in the marketplace. By this we mean a lack of understanding as to what is Life Insurance, what is General Insurance and what is Health Insurance.

IFSA only represents the Life Insurance Industry and is not the appropriate body to comment on general insurance or health insurance issues. We do believe that the intentions of the DDA would be better served if there was greater clarity in respect of distinction between these three classes of insurance, but we doubt that it is practicable to deal with this concern in the legislation.

5.2 The Two Arms to the Exemption

The current exemption is structured to allow two different bases of discrimination:

- Refusing to offer a product (declining cover)
- Offering of a product on different terms and conditions (loadings, exclusions)

Each of these will be looked at separately.

5.3 Refusal To Offer Cover

In any free market there is a point at which the marginal cost of providing a good or service exceeds the marginal revenue obtained in the provision. In insurance where the basis of the provision of the service is the assessment and pricing of uncertainty, there will come a point where the risk is such that the only prudent response, in order to protect the interest of the other members of the insured pool (the statutory fund) is to not offer cover.

To properly protect the pool it is not enough to consider the likelihood of a claim (average or mean) but also the uncertainty of the estimation of that likelihood (the variance about the

mean) and to take a conservative stance on that estimation such that the chance of the total cost of claims exceeding the resources of the pool (in actuarial jargon "the probability of ultimate ruin") is very small. This suggests that there will always be some risks that cannot be offered cover and that the point at which it becomes uneconomic or imprudent to offer cover will vary from pool to pool depending in the resources available to manage the uncertainty and the size of the pool.

This then leads to the question as to when it is considered appropriate to discriminate and not offer cover and when the refusal to offer the cover constitutes discrimination under the DDA.

There is a basis for discrimination when it is uneconomic to obtain the information (be it actuarial, statistical, or other relevant factors on which it is reasonable to rely) necessary to determine the relative risk but that the generally accepted or typical situation is that the risk is considerably greater than average.

One solution to this situation is the approach taken in New Zealand where Life Insurance companies can charge the client the cost of the research required to locate, derive or analyse the information available in order to determine the relative risk. The client is required to pay a non-refundable amount up-front to cover this cost if they want to proceed with their application for insurance. The insurer will then determine the terms and conditions on which insurance can be offered and the client has the option to accept those terms or to decline to take out insurance. This approach addresses those cases where the risk is very sub-standard and is known in industry jargon as "extreme underwriting".

This approach does lead, however, to terms that would normally be considered uneconomic such as a premium that is in excess of 20% of the sum insured so that say $100,000 of life insurance cover would cost $20,000 a year which very few people would be willing to pay.

It also means that companies are required to offer cover even where there are clearly significant moral hazards, large uncertainties or "asymmetric information" which could allow the insured to "select" against the insurer. Such a situation seems to be developing in the United Kingdom where companies that previously offered critical illness insurance on a guaranteed premium basis (the company cannot change the premium rate on policies once written) are withdrawing from the market as it becomes clear that it is impossible to offer cover on guaranteed terms when diagnostic techniques are changing so fast that future claims costs cannot be adequately predicted.

To require companies to offer products to all comers (which is similar to the requirement for Authorised Money Market Dealers to always be prepared to buy and sell government securities and thereby 'make a market') means that they are required to provide terms even in markets that they would not wish to operate or in which they have no expertise. This requirement to 'make a market' exposes companies to the risk of mis-pricing, which can have adverse impacts on the financial security of the company's statutory fund by leaving the other policyholders to cover the cost (but without access to a 'lender of last resort' as is the case in the money markets). Such a requirement is neither fair nor equitable.

IFSA believes that the correct approach is to retain this arm of the exemption whilst allowing companies to offer fee-based extreme underwriting.

5.4 Offering Cover under Modified Terms and Conditions

The current wording of the Act allows insurance companies to vary the terms and conditions under which it is prepared to offer insurance. This flexibility to tailor cover under a contract and to charge a premium that reflects the relative risk is well used by underwriters in attempting to maximise the cover they can provide and to ensure equity in the premium charged.

It is in an insurance company's interest to sell more business, provided that business can be written on a profitable basis. The flexibility offered by the Act allows this to occur rather than the offering of standard terms or nothing. Certainly market forces work to encourage participants in the market to make the offering of standard terms as broad as possible but there will always remain a proportion of the proposed risks that cannot be accepted on standard terms.

Currently underwriters have the flexibility to (and do so in practice);

- Charge an additional amount either as a percentage multiple (say 100% loading for someone considered twice as likely to claim) or a flat dollar addition (say an additional $2 per mille – that is an extra $2 premium for each $1,000 of cover – for a hazardous pursuit such as weekend motor racing) for a set period (say 3 years as the period following cancer removal or bypass surgery is an identified period of higher risk) or for the duration of the policy (where the impact of the relevant factor is unlikely to diminish)
- Exclude certain conditions identified as high risk factors (say back disorders where there is a history of back problems) or where the individual would be otherwise immediately entitled to claim (offering cover that would normally provide a benefit on loss of sight to someone who is already blind)
- Defer cover for a period until more information or post event experience is available or a period of high risk has passed (say only include cover upon full recovery from a current condition or surgery).

It should also be recognised that this full range of exercising of underwriting judgement and the modification of terms and conditions will not always be exercised but rather cover will be offered on a standard basis or not at all. As identified earlier, underwriting and evaluation is a costly process and some products are specifically designed with limited underwriting in mind. As such it is not appropriate to require that every product must be made available on modified terms and conditions but rather the nature of the product design and underwriting approach should be considered as an 'other relevant factor' when questioning the basis under which cover is offered or refused.

So long as the principle of equity is recognised as a fundamental component of a mutually rated voluntary life insurance market and it is desirable for the greatest proportion of applications to gain access to insurance then the ability to offer cover under modified terms and conditions must be maintained albeit with the same requirement that the modified terms and conditions are based upon actuarial, statistical or other relevant factors on which it is reasonable to rely.

5.5 Other Relevant Factors

Our understanding of the area of most concern with Section 46 is the breadth or rather the lack of restriction that is felt to exist in the reference to "other relevant factors".

As has been outlined in the earlier sections there are many factors that are considered when underwriting a proposal for life insurance, not all of which have clearly identifiable actuarial or statistical data. Certainly the exposure to moral hazard and the potential of an individual to impact on their ability to claim falls outside of statistical data.

IFSA is mindful however of the Commission's desire to explore as much as possible the potential for modification to this part of the exclusion in order to address the concerns of other interested parties.

In considering whether alternative wording could be developed to cover what other factors are considered in the underwriting of life insurance, IFSA sought examples from it members as to what other factors have been considered in recently underwritten business. Some of the responses are outlined below.

Case Study 1:
Application from a 27-year-old male for Income Protection with an 12 month waiting period and benefits payable to age 65.

The life insured had been employed in his current position for 4 months. The position involves being a project manager for building a block of units and associated administrative tasks and selling them on completion. The position is a set period contract with no guarantee of future work at its conclusion, and the life insured has no previous experience in this area.

His previous occupation was as a financial planner, which lasted 7 months.

Given the employment history, the nature of the current work and its limited time span, the application for benefits to age 65 was declined.

Employment status and history are frequently relevant matters when considering an application for insurance, particularly income protection.

Case Study 2:
Application from a 52-year-old male for Income Protection with a 2 year waiting period and benefits payable to age 65.

The life insured disclosed in his application recurrent abdominal pain, aching joints and occasional peri-anal bleeding that continued up to the time of the application. Medical investigations and various tests have been conducted to date but have revealed no known cause.

On the basis of the continuing symptoms and unknown cause the application was declined until the symptoms ceased or a definite cause was determined to allow effective management of the condition.

Case Study 3:
Application from a 30-year-old male for Income Protection with a 30 day waiting period and benefits payable to age 65.

Life insured was recently diagnosed with a potentially significant medical condition after a reasonable history of symptoms.

Application was deferred 12 months to allow adequate development of understanding, treatment and management of the condition.

Uncertainty as to the cause of symptoms and conditions can mean there is no way to identify what the relative risk for an individual is. Alternatively recent diagnosis of a condition may mean that there is not yet a good understanding of the severity or the individual's ability to manage the condition in order to consider the risk relativity adequately. Whilst not common, the development of an unknown ailment is a trigger for individuals to consider seeking insurance.

Case Study 4:
Application from a 53-year-old male for Life Insurance and Income Protection with a 90 day waiting period and benefits payable to age 65.

The life insured had a history of a growth in the cranium putting pressure on the optic nerve that had previous required surgery to manage. Upon consultation with the company's Chief Medical Officer for expert opinion the Income Protection was declined due to possibility of impending blindness and associated surgical risk / complications, life cover was offered on standard terms.

Risk assessment is dependant upon the type of risk being assessed and what may be a relevant factor for some benefits may not be significant in others. Prognosis and the uncertainties of future treatment outcomes can mean that the risk is not sufficiently containable into acceptable levels to support insurance on a commercially viable basis.

There were also a number of typical scenarios outlined by several companies that have frequently occurred in their experience.

Scenario 1:
Application from a manual worker that discloses regular consultation with a chiropractor for "maintenance" therapy over an extended period of time. No time off work and x-rays normal.

Life insured normally states no back problems exist but report from chiropractor indicates initial consultation followed an injury and because of the occupation and manual work activities ongoing management is required.

This might warrant an exclusion for back injuries, particularly if the original injury was severe and work related.

Scenario 2:
Application for Income Protection from a self employed person who indicates that they work in excess of 75 hours a week.

This may be relevant in some circumstances where there may be adverse impacts on health due to the long working periods over extended periods of time.

Long working hours also have particular relevance especially, in underwriting the self employed or commission based occupations, as a reduction in hours worked would generally be expected to have a direct impact on the income received. When someone working 70 hours a week earning $100,000 is totally disabled and then returns to work, but only resumes a 40 hour week resulting in an income of $70,000, they would be able to claim partial disability benefits (for the lost income) even though they have returned to full time work and have no intentions to work more than 40 hours a week.

The usual response to this scenario is to limit the maximum amount that is permitted to be insured such that the benefit amount insured is that which would be earned based on a 40 hour working week.

Scenario 3:
Application for a particularly large amount of insurance cover, or where the purpose for the insurance cover is related to business activities, guarantees or estate planning purposes.

It is usual in these circumstances to seek financial evidence (accounts, documents, business plans) to see whether they support the level of cover applied for to ensure that there is not an excessive amount of cover sought which may expose the company to moral hazard.

Scenario 4:
Life insured discloses a very rare disorder or a newly identified disease where there is little statistical data available, particularly to do with long-term survivorship and morbidity experience.

The life office can see if it is possible to access a renowned specialist in the particular field to obtain their educated view on the condition, treatment, expected prognosis and associated risk factors such as type of medication, treatment and other co-mortalities/morbidities such as smoking status etc. Many specialists do not look beyond the immediate circumstances so it is important they understand the need to consider factors and impacts into the future (for the length of the insurance cover).

Another alternative is to conduct an extensive search of medical information on the internet and seek as much detail as possible on the disease/condition and latest developments and understanding of the disease that may be able to be converted into an appropriate loading.

Failing these approaches if there is sufficient similarities with other recognised and understood impairments (similar symptoms, organs effected, medication taken) the correlation may be used to arrive at an estimate in an attempt to be able to offer cover.

The availability of data can be further complicated by the fact that applicants do not accept the loading or exclusion and simply do not take up insurance so there is limited ability to monitor the experience (even on an international level) to check the actual experience of this condition.

The only alternative to these less than strictly statistical approaches is to decline to insure. As has been stated before the insurance industry seeks to offer cover wherever possible whilst being mindful of its need to protect the other members of statutory funds. Whilst a conservative rather than best estimate approach may be taken in assessing the risk relativities this should be viewed as being appropriate and within the Section 46 exemption under the DDA.

As has been demonstrated there are a wide variety of situations where a whole range of information that is not considered to be 'actuarial' or 'statistical' in nature is essential to the appropriate assessment of the risk and are used in the underwriting process to determine whether it is appropriate to insure the risk and if so whether standard or modified terms should be offered. Hopefully these scenarios and case studies outline to the Commission why there is a need for a broadly worded allowance for the consideration of other relevant information.

Should the Commission feel that there is some need to more precisely define this requirement, then greater emphasis could be placed on the fact that the relevance of the 'other information' and the refusal to offer, or the modified terms and conditions offered, must be interrelated. The kind of amendment the Commission proposed was that the 'other relevant factors' might be qualified as being "factors relevant to the nature and extent of the cover" being applied for. This would prevent circumstances such as the case identified at the public hearing in Adelaide where an individual with advanced breast cancer was refused travel insurance even just for her luggage.

It is worth noting however that if the design of the product is such that the allowance for underwriting costs is for "all conditions or no conditions" to be covered (rather than setting up policy specific exclusions) then our submission would be that this would need to be accommodated as a factor relevant to the nature and extent of cover..

6 Complaints and Enforcement

As outlined in our initial submission all life insurance companies have an established process of internal complaints handling as well as an independent body to hear complaints unable to be resolved internally. Under recent reforms this process is required to meet minimum standards set by ASIC. The adequacy of these arrangements can be demonstrated by the level of complaints made and frequency of referral to external bodies.

6.1 Alternative Providers

One of the factors that assist in ensuring that an individual is not inappropriately discriminated against is the freedom they have to approach any life insurance company. They are able to make application to more than one company at a time and can choose to take up the best offer made to them.

If there is a generally consistent response between companies then this is most likely to occur due to a similar interpretation of the actuarial, statistical and other information available that are relevant to the risk.

6.2 Independent Review

In response to concerns from the consumerist movement that there was a perception that complaints were not being independently reviewed, the industry supported the establishment of the Financial Industry Complaints Service (FICS). This is an independent body set up under the Federal Minister for Consumer Affairs and recognised by the Australian Securities and Investments Commission (ASIC), as an independent dispute resolution body, which satisfies the requirements for complaints handling under the obligations life insurance companies are bound to observe under the relevant provisions of the Corporations Law for Australian Financial Services licensees.

Currently the scope of FICS does not include complaints to do with underwriting decisions, as this was believed to be adequately covered in the existing legislation for which the Human Rights and Equal Opportunity Commission (HREOC) has responsibility.

Underwriting is a specialist skill and the review of an underwriting decision equally requires the same amount of knowledge, expertise and experience to adequately consider the issues.

One concern IFSA has is that the responsibility for the review of underwriting decisions will be placed in the hands of a body that does not have the required specialist skills and which does not seek to access those skills in reviewing decisions. As these skills exist only within those who have at some time underwritten risks for life insurance, it is felt that whilst it is appropriate for reviews to be undertaken independently of the life insurance company involved it cannot occur independently of the life underwriting profession.

IFSA would support the use of independent expert underwriters in the review of any complaints regarding underwriting decisions.

6.3 Acceptable Basis

There are a number of fundamental principles, practices and data that are common across a range of complaints but which, due to the current structure of the process, are required to be presented and validated in each instance. This involves considerable time and effort on behalf of each company when dealing with each issue on a case-by-case basis.

One of the challenges is that underwriting processes, guidelines and reinsurer's manuals are commercial documents upon which companies seek to differentiate themselves so it is not always appropriate to have them treated as public documents and not possible to have them set as an industry standard (anti-competitive).

IFSA would support the ability to deem certain material, approaches or outcomes as acceptable discrimination and for the appropriate body to be able to review and certify various manuals and reference material as meeting the "actuarial, statistical or other relevant information on which it is reasonable to rely" criteria so that any underwriting decision based upon the appropriate application of these certified materials will prima facie be considered acceptable discrimination (falling within the Section 46 exemption).

6.4 Competitive Market Practices

As each company independently assesses the risks proposed to them this forms an informal process of peer review that is the essence of a competitive marketplace.

There is no requirement currently that companies must make a market for all comers so that where it is felt that there is too much uncertainty or there is not a commercially viable market opportunity they are able to decline to offer cover. If companies are required to make a market for all comers (an "insurer of last resort") what support will be provided if the provision of cover for those risks results in adverse impacts on the statutory fund thereby threatening the benefits of other individuals?

6.5 Ability To Make A Complaint

A number of submissions to the Commission have highlighted that often those individuals with disabilities, in terms on the DDA definition, that are being discriminated against (not necessarily in the insurance context) are also the ones least able to conduct a complaint through the existing complaints process.

IFSA would support the authorising of appropriate third parties to undertake complaints on behalf of individuals who are, for one reason or another, unable or unwilling to pursue the complaint on their own behalf.

6.6 Alternative Models

IFSA believes that there are a variety of mechanisms that can be, and in some cases have already proven to be, used in relation to setting acceptable standards and criteria under which discrimination can be seen to be appropriate.

As an example of self-regulation, IFSA's Standard Number 11 on the handling of genetic information addresses how genetic information must be handled and when it can be used. A similar standard is under development in regards to family history. It is worth noting however the conflict this has caused with regards to appropriate market practises and the need to gain approval from the ACCC for the standard.

The Memorandum of Understanding with the mental health sector stakeholders and the guidelines for underwriting and claims management that have come from the collaborative work of the industry with the stakeholders has shown itself to be a very effective mechanism in getting consensus between opposing parties. One of the contributing factors with this MoU is that it covers all the mental health industry allowing a single point of reference and contact. Such a tool would become unmanageable if it was done on an association by association basis as a result of the sheer number of contacts required. IFSA believes that MoU's can be very effective on a broad industry exposure level.