Investment & Financial Services Association Ltd

Submission in response to Productivity Commission Issues Paper & Review of Disability Discrimination Act 1992

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1.1 Investment and Financial Services Association

The Investment and Financial Services Association (IFSA) is the not-for-profit national peak body representing the superannuation, investment management, and life insurance industries. IFSA has over 100 member companies who invest over $640 billion dollars on behalf of more than 9 million Australians.

IFSA's mission is to play a significant role in the development of the social, economic and regulatory framework in which our members operate, thereby assisting members to serve their customers better.

IFSA acts as the collective voice of its members when they deal with governments, media and the community. It works closely with legislators, regulators and other key stakeholder groups to promote industry efficiency and ensure an effective and workable regulatory environment.

1.2 Introduction

The Investment and Financial Services Association (IFSA) welcomes the opportunity to participate in the Productivity Commission (PC) review of the Disability Discrimination Act 1992 (DDA) and submits this document to the Inquiry.

This submission is in response to the issues paper released with the announcement of the Inquiry on the 7 February 2003. This response primarily focuses on voluntary life insurance products that protect individual consumers against the risks of death, disability and trauma and collectively known as 'individual risk' products issued by life insurers.

Life insurers may also issue 'group risk' products to employers, associations and superannuation funds that provide their employees and/or members, compulsory life insurance automatically while they are in the active employment with the employer or an active member of the association or superannuation fund. Mention will be made of these products where they differ from individual risk products

Products issued by general insurance companies such as travel insurance or sickness and accident are outside the scope of this submission.

- Section 2 provides an overview of the Australian life insurance industry, the principles of insurance and provides an overview of the underwriting process.
- Section 3 contains specific responses to the questions raised in the issues paper that are relevant to the life insurance industry.
- Section 4 addresses industry experience with the DDA.

- Section 5 gives a detailed overview with examples of how family medical history is underwritten.

2 Overview of Australian Life Insurance Industry

This section defines and explains the purpose of life insurance, and provides an overview of the industry in Australia.

2.1 What is Life Insurance?

Life insurance protects consumers against the risks of death, disability (both permanent and temporary) and trauma, and in the case of annuities, longevity. Some life insurance products can also be used as a means of long term saving.

The life insurance company (the Insurer) contracts to pay an agreed amount upon the happening of a particular event, in return for the consumer (the Policyowner) agreeing to pay premiums as they fall due.

The purpose of life insurance is to provide protection against those events where the actual occurrence and ultimate timing of the event is unpredictable. Without insurance, if and when such an event occurs, the financial loss to the Policyowner could be severe.

2.2 Individual Risk Products

The major categories of individual risk life insurance products are described below.

2.2.1 Term life insurance

Term life insurance provides for the payment of an agreed lump sum on the death of the life insured within the term of the policy. The life insured can be someone other than the Policyowner.

The premium charged usually depends on the age, sex, health, occupation, hazardous activities or pursuits and smoking status of the life insured at the commencement of the policy. Policies are issued as guaranteed renewable, which means that the Insurer must offer to renew cover up to the end of the term of the policy automatically, regardless of any change in the insured's risk profile. The Insurer retains the right to review the premium rate for all policies of a particular class if experience so warrants. The insurer cannot alter the premium of an individual policy once that policy has been issued unless it is due to a change in premium rates for a class of polices to which it belongs. The decision to renew the policy is in the hands of the policyowner.

The most common form of term insurance purchased is yearly renewable term where the premium is paid on a stepped premium basis and changes each year on renewal according to the then current age of the life insured. Policies may also have premiums that are stepped less frequently than annually (eg every 5 years) or that are level for some or all of the term of the policy.

Common additional features include:

- Automatic indexation of the sum insured to inflation;
- The prepayment of the sum insured on diagnosis of a terminal illness where the life insured is expected to survive for a year or less;
- The option to add total and permanent disablement benefits to the base policy, either as an advance payment of the benefit amount, or as a payment in addition to the death benefit;
- The option to add trauma benefits to the base policy. This type of insurance is discussed in more detail below.
- Covers all causes of death, except suicide in first 13 months of the policy's start date or reinstatement or where there has been non-disclosure or misrepresentation of a condition that existed at the commencement of the policy and resulted in the death, such as to give the insurer the right to void the policy in accordance with the Insurance Contracts Act 1984 (s.29).
- Options to increase cover without underwriting on the happening of particular events (eg birth of a child) regardless of the life insured's state of health at the time.

The approximate average level of cover[1] for term insurance is $235,000.

2.2.2 Total & Permanent Disablement (TPD) cover

TPD insurance is provided as an optional additional benefit under a term life or trauma policy and provides for the payment of an agreed lump sum when the life insured is totally and permanently disabled within the term of the policy. It is available in several forms and definitional variations but primarily focuses on the ability to be gainfully employed.

Common eligibility criteria include one or more of the following:

- Suffer the total and permanent loss of the use of both hands, both feet, the entire sight in both eyes, the entire sight in an eye and the total and permanent loss of the use of a~~n~~ hand, the entire sight in an eye and the total and permanent loss of the use of a foot or the total and permanent loss of the use of a~~n~~ hand and a foot ("Lord Nelson clause")~~;~~

- Has been unable to follow his or her own occupation for a continuous period of 6 months and is unlikely to ever be able to follow his or her occupation ("own" occupation definition)

- Has been unable to follow his or her own occupation for a continuous period of 6 months and is unlikely to ever be able to follow his or her occupation or any occupation he or she could be reasonably suited to by education, training or experience ("any" occupation definition)

[1] Average levels of cover have been calculated based on in-force data provided by 13 of the 19 IFSA members asked to contribute in November 2001, representing 70% of market share (by risk annual premiums in force).

- Has a permanent inability to perform at least two of the "activities of daily living", without assistance, has ceased gainful employment and is unlikely to ever be able to follow any occupation he or she could be reasonably suited to by education training or experience, where the activities of daily living are:
  *——bathing/showering
  *——dressing/undressing
  *——eating/drinking
  *——using the toilet to maintain personal hygiene
  *——getting in and out of bed, a chair or wheelchair or moving from place to place by walking, a wheelchair or with a walking aide (ADL definition)

- Is unable to perform his or her usual unpaid domestic work for 6 continuous months and:
  *——is diagnosed by a registered medical practitioner as having a permanent disability
  *——is permanently confined to home
  *——receives regular medical attention from a registered medical practitioner (Household duties definition)

- Is diagnosed as having less than 12 months to live (terminal illness definition)

The payment of the benefit may either be an acceleration of the death benefit or a payment in addition to it.

The choice of which definitions to include in this benefit will in part depend upon the employment status of the life insured (it is usual that only white collar / professional occupations are offered "own" occupation TPD) and cover for "own" and "any" occupation usually ceases at normal retirement age (age 65) and may taper off over the last 5 years of cover. Not all companies offer all forms of this cover.

In addition, where the cover is provided under a superannuation fund it is possible for the life insured to meet the TPD definition under the policy and be eligible for the benefit but for them to fail to meet the criteria under superannuation law for early access to their superannuation and so the benefit must be invested as per other superannuation monies and preserved until retirement age.

2.2.3 Trauma /Crisis /Critical Illness insurance

Trauma insurance provides for the payment of an agreed lump sum on the diagnosis of the happening of defined medical events or conditions, such as a heart attack, cancer or stroke within the term of the policy and meet the policy's definition and diagnosis requirements.

Over recent years there has been a large increase in the number of events and diseases covered.

This type of insurance is offered as both a stand-alone product and as an additional benefit to term insurance policies that provide death cover.

Trauma insurance is also issued as a guaranteed renewable contract and is most commonly offered as yearly renewable.

Common additional features include:

- Automatic indexation of the sum insured to inflation;
- The option to add total and permanent disablement benefits to the base policy
- Covers for certain conditions such as cancer and heart attack does not commence until 3 months after the commencement or reinstatement of the policy
- Does not cover events or conditions where there has been non-disclosure or misrepresentation of a condition that existed at the commencement of the policy, such as to give the insurer the right to void the policy in accordance with the Insurance Contracts Act, 1984 (S.29).

The purpose of this type of product is to provide a lump sum that allows an insured person to fund the necessary lifestyle changes needed as a result of the happening of the insured medical event.

The approximate average level of cover[2] for trauma (crisis) insurance is $165,000.

2.2.4 Income Protection / Disability Income insurance

This type of insurance provides for regular, usually monthly, income benefits to be paid whilst an insured person is unable to work in their current or similar occupation because of sickness or injury. The maximum allowable income insured is usually equivalent to 75% of income (net of business expenses) earned (replacement ratio).

For example, a person earning:

- $50,000 per annum could insure themselves for up to $3,125 per month or
- $75,000 per annum could insure themselves for up to $4,688 per month

Benefits are paid whilst the life insured is unable to work in their current or similar occupation because of sickness or injury for up to a defined maximum period (the "benefit period"), which may be for a fixed term (e.g. 2 years) or until a particular age (e.g. age 65). Policies are also subject to a period that must elapse after the disabling event first occurs before payment of the benefit start (the "waiting period"). Most common waiting periods are 14 or 30 days but can be as long as two years.

The premium charged depends on the benefit amount, benefit period and waiting period chosen, as well as the age, sex, occupation, health, hazardous activities or pursuits and smoking status of the life insured at policy commencement.

Policies are typically issued as guaranteed renewable, however some, a significant minority, on only the higher risks, are issued as cancellable. This means that the Insurer has the right

[2] See 1

not to renew the policy or to vary the terms of the policy having regard to the claims experience of the individual insured.

Usually, premiums vary on renewal according to the then current age of the life insured. Policies may also have premiums that are stepped less frequently than annually (eg every 5 years) or that are level for some or all of the term of the policy.

In Australia the majority of the income protection business written is sold to self-employed persons on an agreed-value basis. This is where the benefit payable is agreed at underwriting stage as opposed to indemnity based where the benefit payable is based on the income in the 12 months prior to claim (subject to a maximum of the sum insured). This is starting to change as companies are charging more for agreed value policies due to the experience showing there is higher claims costs associated with them.

Examples of common features include:

- Automatic indexation of monthly benefits up to the maximum replacement ratio;
- Increasing benefit payments during the claim period; and
- Payment of rehabilitation and other additional benefits.
- Payment of partial benefits whilst not fully recovered.
- Payment of benefits during the waiting period and/or for minimum durations for specific injuries (fractures etc) and/or trauma like medical conditions

The approximate average level of cover[3] for Disability Income Insurance is $3,700 per month.

2.2.5 Business Overheads insurance

This type of insurance provides for certain of the life insured's business expenses to be paid, up to the level of the monthly benefit, for up to one year whilst an insured self-employed person is totally disabled and unable to work because of sickness or injury. This allows the life insured to maintain their business in the short term, to reorganise their finances and business arrangements over the medium term and to possibly sell the business or make other appropriate arrangements.

2.2.6 Direct Marketing

Term life, TPD, trauma and disability income policies as sometimes sold via direct marketing. These products are similar to the individual risk products mentioned above but are of a more simplified nature. They are usually of a small size and limited in their options to make the issuing and administration simpler so that they are still cost effective.

Another common direct-marketed product is Accidental Death Benefit cover that provides for the payment of a lump sum when the death of the life insured is due to 'accident'. As the

[3] See 1

cover is purely accident based it is usually offered without any underwriting but is otherwise similar to a direct-marketed term life policy.

Because the Insurer selects the individuals to whom the cover is to be presented (rather than the individual choosing to purchase the cover) there is less likelihood of an individual selecting against the Insurer (purchasing insurance because of an existing condition) and so more limited underwriting is undertaken. This is usually of the form of a limited number of YES/NO questions.

Further because the process of additional investigation can be costly and these products have limited margins in their premiums to cover expenses, these policies are usually presented on the basis that an unsatisfactory response to one of the YES/NO question will usually result in no offer of cover being made. Individuals not offered cover in this way are free to seek fully underwritten cover.

Because less than 100% of the lives offered cover take up the offer (there is still some self selection) and due to the more limited underwriting, on average the lives insured under these products will not be as healthy as fully underwritten insured lives. This means that the assumed mortality or morbidity experience assumed in their pricing will lie between those of 'insured lives' and 'population' experience, resulting in an expected higher claims cost.

The above products are collectively referred to as "individual risk" products.

2.3 Group Risk Products

The group insurance market can be segmented into three distinct segments although there is some blurring between them:

- Corporate
- Master Trust
- Industry Funds

Group insurance covers a number of lives under the one policy with a common structure to the benefit design and eligibility criteria. The policy owner is the employer, association or superannuation fund. The product offerings in all segments are basically similar to the major categories of individual risk life insurance products with industry funds being the closest comparison to individual business. Although it is available in the market, little Group Trauma has been sold, with the majority of business being Group Life and TPD (total and permanent disablement) and Group Salary Continuance (similar to Income Protection but the benefit is indemnity based as it is directly linked to current salary / wages).

The distinguishing feature of group risk business is that to varying degrees the buying decision is taken out of the hands of the life insured and the premium rate charged is based on the group of lives covered. The pre-determined benefit design and eligibility criteria mean that individuals have limited opportunity to 'select against' the insurance company by seeking to maximise their cover when they are most likely to claim.

As group schemes cover a number of lives that are associated together there is little chance of the good risks leaving and bad risks remaining, either the whole scheme will move or stay and any new insurer will consider the past experience of the group in determining the appropriate premium rate (somewhat like looking at an individuals claim history when considering offering a no claims discount when they apply for motor vehicle insurance). This means that the experience of the group can be spread across the premium charged for each life. For Corporate business it is common for the premium to be paid by the employer and so all individual premiums are aggregated into a single amount.

The result of this is that with group insurance schemes where there is a predefined benefit design and eligibility criteria such that members cannot choose when and how much cover to take out but rather have it allocated to them, then there is less need for underwriting as there is limited likelihood for anti-selection or over insurance and given that the individual must be at work performing all of their usual duties in order to be eligible to become a member, they must have an adequate level of health at the outset.

Thus there are different issues when it comes to pricing and underwriting group business and these mean that any person who can obtain permanent employment and/or become a member of a superannuation fund can normally access a limited amount of life insurance cover at a standard premium rate that reflects the risk of the group without the need for the individual to be underwritten.

2.4 Industry Structure

Life insurance in Australia is operated on a mutual, risk-rated basis. Generally, consumers choose whether or not to take out life insurance.[4]

Life insurance is offered by Insurers who enter into a contract with the Policyowner. Insurers in turn may seek to manage some of the risks they have accepted, by passing some of the risk to reinsurers through a process known as reinsurance.

Except for a minority of income protection insurance policies, once effected, life insurance is guaranteed renewable, so the underwriting of risk done at the commencement of the policy is based on long-term considerations. This sets life insurance apart from general insurance products, where the Insurer can decline to renew, or vary the terms of the policy depending on the claim history or the circumstances in existence at the time of renewal.

With life insurance if circumstances have changed in favour of the Policyholder they can choose to apply for a new policy, which may provide better terms than their existing policy but if circumstances have moved against the Policyholder the Insurer must continue to renew the policy on the terms it was originally issued until the end of the term of the policy.

[4] As mentioned previously this is not the case with group insurance – where compulsory life insurance cover may be provided automatically (and without the member having the option of declining to be insured).

Both insurers and reinsurers are commercial enterprises seeking to make a reasonable return on capital. Consequently, the life insurance industry in Australia is a highly competitive and dynamic industry.

The Australian Prudential Regulation Authority (APRA) currently supervises forty registered insurers, which includes 6 reinsurance companies. Not all registered life insurers or reinsurers are currently active and several do not operate in the risk markets.

Life insurance is distributed through a range of channels – including agents, brokers, financial planners, salaried advisers and directly by telephone, through newspaper advertising and other media. It is estimated that there are 15,000 individuals selling life insurance in Australia.

Insurance agents may have agreements with one or more direct insurers to sell their products (they are known as 'multi-agents'); they act as the agent of the Insurer.

Insurance brokers act as the agent of the purchaser, and in order to find the most suitable product for their customer, may recommend the products of many different insurers.

Financial planners look at the total financial needs of their clients including their life insurance needs and make recommendations based on the needs identified.

2.5 Industry Statistics and Trends

2.5.1 Total Industry Premiums

The following premium information provides an overview of the size and composition of the Australian life insurance industry (note this does not include data for Group Salary Continuance business):

Table 1: Industry Premiums $m[5]

Product	Year end December 2000			Year end December 1996		
	In Force Annual Premium	New Single Premium	Total Premiums	In Force Annual Premium	New Single Premium	Total Premiums
Risk[1]	3,559	38	**3,597**	1,911	54	**1,965**
Bundled[2]	596	0	**596**	789	0	**789**
Savings[3]	3,549	32,635	**36,184**	5,342	16,189	**21,531**
Total	7,704	32,673	**40,378**	8,042	16,243	**24,285**

Notes:

1. 'Risk' business includes individual Term Life, Trauma and Total and Permanent Disablement, Disability Income and Group Life business. See Table 2 for more detail.
2. 'Bundled' business includes Whole of Life and Endowment business.
3. 'Savings' business includes investment products, annuities and post retirement products, and not having any underwriting component, are outside the scope of this submission.

[5] APRA Statistics, December 2000; Rice Kachor Research July 1997 statistics ending December 1996

2.5.2 Total 'Risk' Product Premiums

Detailed statistics for risk business (note: does not include data for Group Salary Continuance business) are shown below.

Table 2: Risk Business Statistics $m[6]

Risk Product	In Force Annual Premium		New Business	
	Year ended Dec 2000	Year ended Dec 1996	Year ended Dec 2000	Year ended Dec 1996
Term Life[1]	1,837	850	415	209
Disability Income	841	587	182	169
Group Life[2]	881	475	246	139
Total	3,559	1,911	843	51
Number of Insurers	31	46	31	46

Notes:

1. Term Life business includes Yearly Renewable Term, Level Term insurance, Total and Permanent Disablement insurance and Trauma insurance.
2. Group Life insurance includes Group Life and Consumer Credit Insurance, but excludes Group Salary Continuance.

The major trends for risk business over the last 10 years have been:

- Steadily reducing term life insurance premium rates reflecting improved life expectancy.
- Steadily increasing disability income premiums reflecting an increase in the number and duration of disability claims. Premium increases were necessary in order to restore profitability after a number of years of incurring significant losses across the industry.

2.6 Regulation

The life insurance industry is heavily regulated, in order to ensure the ongoing viability of the industry and to afford consumer protection.

A brief description of the relevant legislation and industry codes is provided below:

2.6.1 Life Insurance Act 1995

Administered by the Australian Prudential Regulation Authority (APRA), this Act provides for the prudential regulation of life insurance companies in order to ensure both the ability of individual companies to pay claims as well as their long-term viability. This Act was a rewrite of the previous Act that had been in existence since 1945.

[6] Ibid

2.6.2 Insurance Contracts Act 1984

Under Australian insurance contract law, both parties enter a contract of 'utmost good faith'. The applicant has a duty to disclose all material information to the Insurer before the contract is made. The insurer has a duty to advise the insured of important obligations and to meet claims promptly.

This Act stipulates both the obligations of the parties entering into the insurance contract and the remedies for either party failing in their obligations, including remedies affecting the contract itself for the non-disclosure and material misstatement (omissions) by the applicant.

The Act is administered by the Australian Securities and Investments Commission (ASIC).

2.6.3 Insurance Agents and Broker's Act 1984

This act regulates the activities of insurance intermediaries, including registration of insurance brokers. These provisions are being replaced by provisions in the Financial Services Reform Act (FSRA) over a 2-year period that commenced on 11 March 2002.

The consumer protection provisions of this Act are administered by ASIC.

2.6.4 Disability Discrimination Act 1992

Under this Act, insurers are permitted to assess applicants and either refuse insurance or offer insurance on terms according to demonstrated risks based on actuarial or statistical data or any other relevant factor on which it is reasonable to rely.

The Human Rights and Equal Opportunity Commission (HREOC) administer the Act.

The Sex Discrimination Act 1984 and other Acts at State and Federal level embody similar provisions for insurance.

2.6.5 Trade Practices Act 1974

This Act includes prohibitions against collusion amongst industry players. The Act is administered by the Australian Consumer and Competition Commission (ACCC).

2.6.6 Australian Securities and Investments Commission Act 2001

This Act incorporates those consumer protection provisions from the Trade Practices Act prohibiting misleading, deceptive, or unconscionable conduct by providers of financial services. It is administered by ASIC.

2.6.7 Financial Services Reform Act 2001

The Financial Services Reform Act commenced on 11 March 2002 and will apply a unified set of consumer protection laws to the investment, superannuation, banking and insurance industries. There will be a 2 year transition period for many of its provisions, after this period the whole financial services industry will be subject to a single licensing and product

disclosure regime which imposes rules in relation to conduct and disclosure by providers, complaints handling and compensation.

The Act is administered by ASIC.

2.6.8 Privacy Amendment (Private Sector) Act 2000

High standards for handling and using personal data already exist in the insurance industry. On the 21 December 2001, the provisions of the Privacy Amendment (Private Sector) Act 2000 came into force, imposing strict controls on the way personal information is handled when collected in the private sector for business related purposes.

2.6.9 Health Record (Privacy & Access) Act 1997

The Australian Capital Territory Act was introduced to allow individuals to see their medical records and to also take a copy. Other Australian States are considering similar legislation while Victorian introduced the Health Records Act 2001, which commenced on 1 March 2002.

2.6.10 Life Insurance Code of Conduct

The Life Insurance Code of Conduct was introduced in 1995 and primarily focuses on sales practices and other conduct by life companies. Compliance with the Code is monitored by ASIC. This code is being replaced by provisions in the Financial Services Reform Act.

2.6.11 IFSA Code of Ethics and Conduct 1999

Insurers who are members of IFSA are subject to the IFSA Code of Ethics and Conduct, which guides the conduct of its member companies. These standards are designed to assist and inform investors and policyowners.

2.7 Principles of Insurance

There are a number of fundamental principles that underlie the provision of insurance in a voluntary risk-rated system. These are:

- Spreading risks across large groups
- Charging a premium that reflects the risk
- Pooling of similar risks
- Equal access to information

These principles ensure the stability and long-term viability of the system by:

- Ensuring fairness to consumers;
  i.e. the price set is fair relative to the likelihood of the loss and lower risk customers are not required to subsidise higher risk customers

- Protection of insurer's financial soundness.

The following subsections discuss each of these principles, and the implications of not adhering to them.

2.7.1 Spreading Risks Across Large Groups

Life insurance provides protection against financial loss occurring as a result of death or disability.

Insurance spreads these risks across a group of individuals by pooling their resources (premiums) and using them to cover the financial loss suffered by members of the group (claims). The premium to be paid is calculated based on the expected level of financial loss for an equivalent group of lives.

Spreading risks across large groups of individuals provides an affordable means of protection for people against the financial impact of early death or unexpected disability provided the group is large enough. This is because for a large group, the expected level of loss from year to year is reasonably predictable and will not vary greatly from the expected level whereas it is not possible to accurately predict when these events will occur at an individual level.

These groups, or pools of insured lives need to be large so that the relative impact of individual claims and the variation in claims from year to year remains small so that individual premiums remain affordable. Where the variability in claims experience is large additional margins need to be added to premiums to ensure that there are adequate funds to deal with adverse experience. This is why some risks remain uninsurable as the volatility in experience is such that premiums are not economic.

2.7.2 Charging a Premium that Reflects the Risk

Life insurance in Australia is provided through private enterprise, and is neither guaranteed nor subsidised by the Government. Due to the long-term nature of the contracts, the industry must be viable over the long-term to continue to be able to pay claims in the future.

In order for an insurer to remain profitable, it must receive premiums at least sufficient to cover the cost of both claims and expenses and to provide an adequate return to shareholders on the capital they have invested in support of the business. Therefore, the premiums received together with interest earned must be sufficient to cover the current costs and to set up adequate reserves to cover expected future costs if they are likely to exceed future premiums.

Examples of the impact of not charging adequate premiums, either as a result of regulatory restriction, or through industry competition or for other reasons, include:

- The US individual disability income market incurred large losses in the late 1980s and 1990s, resulting in 29 companies exiting the market and ceasing to write new

business in the period between 1988 and 1999[7]. There are currently approximately only ten major players underwriting new business[8].

- The State based personal auto insurance market in the US is a further example. In a number of States in the late 1990s, regulations restricting changes to premium rates have led to underwriting losses and subsequent withdrawal of many insurers from the market.[9]

- In New South Wales, the government introduced the 'Green Slip Scheme' in 1991 for Compulsory Third Party (CTP). This was supported by 15 general insurance companies at its inception. The average cost of green slips with de-regulation in 1993 for all vehicle classes was $193 and rose to $419 by June 1999. During this period, claims costs soared (largely due to judicial decisions on settlements) creating large insurer losses and the withdrawal of one third of the original insurers from this market.

  If changes had not been made to the Motor Accidents Act (1988) in 1995 to reduce the impact of rising costs then premiums would have continued to soar.

These examples illustrate how legislation intended to protect consumers can have precisely the opposite effect by requiring insurers to participate on uncommercial and unsustainable terms. They also illustrate how charging inadequate premiums, for regulatory or other reasons, ultimately reduces competition, which forces premiums up.

2.7.3 Pooling of Similar Risks

Some individuals are more likely to make a claim than others. Insurers are not able to accurately predict when each individual will make a claim, however they are able to identify factors which indicate an increased probability of a policyowner making a claim.

Risk-rated insurance is based on the concept of pooling similar risks. Each applicant for insurance is placed in a pool of similar risks. All lives insured in that pool are charged the same premium rate consistent with the predicted cost of claims for that pool.

This means that an applicant that is twice as likely to suffer the insured event as the average individual should pay a premium that is twice the average individual premium.

Further the total premium received must reflect the total risk insured. If premium rates are not sufficiently segmented to take account of factors that predict the level of risk then a change in the risk profile of the individuals in the group may not cause a change in the

[7] Milliman and Robertson Disability Newsletter, "Selling Your Individual Disability Income (IDI) Inforce", R Beal, March 1999, page 3

[8] Milliman and Robertson Disability Newsletter, "Non-Can DI: 1999 Financial Results", M Seliber, W Kidwell, July 2000, page 3

[9] The Wall Street Journal, "Like a Good Neighbour", Editorial, 27/08/2001, pg A14;

The Boston Globe, "Auto Insurers Seek 7.8 per cent increase", Scott Bernard Nelson, 11/08/2001, pg E1

premium payable. This might occur if a standard premium per person is charged based on previous experience but the new group membership consists of several members that have a higher underlying risk which is not adequately accounted for in the premium rates.

2.7.4 Equal Access to Information

The consumer and the insurer must have equal access to information regarding the risk to be insured. This is the principle of 'utmost good faith' embodied in the Insurance Contracts Act 1984. Its purpose is to ensure that both the insurer and consumer are equally informed, so that the consumer can be assigned to the appropriate risk pool and a fair premium charged.

The process of assessing the risk of an applicant for life insurance is known as "underwriting". Gathering a wide range of information including the applicant's occupation, financial circumstances, recreational pursuits and medical history helps in risk classification. The underwriting process is considered in detail starting at 2.7.

The insurer is able to underwrite, and hence classify risks once only, at the beginning of the contract. Life insurance products are long-term contracts by their very nature, and can run for as long as the lifetime of an individual. If an inappropriate assessment is made initially or if the insured life's health deteriorates over time, the insurer cannot reclassify the risk nor cancel the policy but only change the premium rates for all the lives insured in the same category as the insured life. Therefore appropriate risk classification is very important at the outset.

The potential alternative approach of life insurance being short-term - with periodic assessment and underwriting, potential re-rating and/or cover restriction or denial of cover – could prove extremely adverse for consumers. It would deny them security, certainty regarding availability of cover when it is most required. Hence life insurance needs to be provided and underwritten on the basis that, once the insurers provide cover, the policyowner has long-term entitlements and that premium rates should only be reviewed for a group of lives where it is appropriate to do so for the whole group.

If all the information required to assess the risk of claiming is not available to the insurer, the insurer will not be able to correctly assign the individual to the appropriate risk pool. If this occurs then the spiral of decline described below may begin.

If the consumer has greater access to information regarding their likelihood of claiming than is available to the insurer, this could influence their decision to apply for insurance. The insurer might underestimate a consumer's risk of claiming and charge a premium lower than that appropriate to the risk due to the lack of full information. In this situation the consumer who is aware of the information would find insurance a financially attractive option and would be more likely to take out insurance, perhaps at a higher level they would have otherwise considered.

This imbalance in knowledge about the existing risk may result from either non-disclosure or by reason of a material misrepresentation (by misstatement or by an omission) in the application for insurance. The impact on the company where a policy is taken out in these circumstances it is known as 'anti-selection' or 'adverse selection'.

There are two main reasons why the preceding four principles are followed.

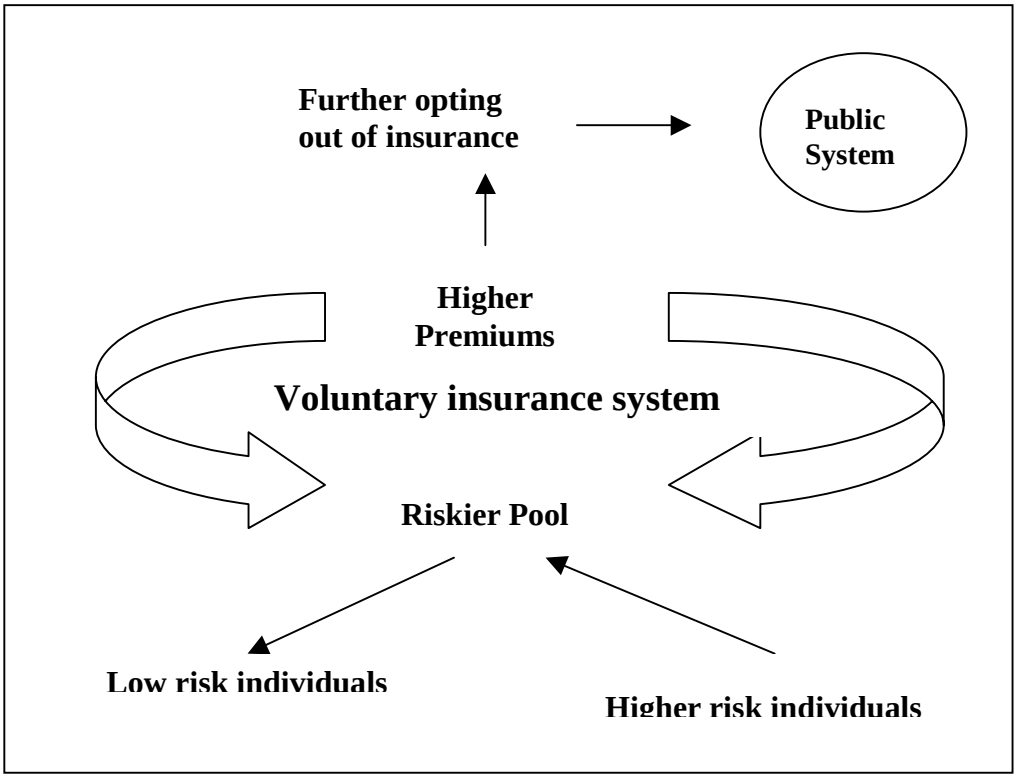
1. Fairness for individuals
   Differentiation between individuals with different risk characteristics is necessary to provide insurance at equitable and reasonable prices. Charging the same price to individuals with very different risk profiles would mean that low risk individuals would be subsidising high-risk individuals. The current system of voluntary individual life insurance in Australia is one that is based on mutuality unlike the community rated health system, which is one of solidarity.

2. Financial soundness of voluntary insurance system
   If the four basic principles are not followed then the system can become destabilised. If low risk individuals are classified within the same insurance pool as high-risk individuals and charged the same premium rate, the low risk individuals would eventually conclude that the risk product is overpriced and thus will reduce their insurance or withdraw completely. However individuals with a high level of risk relative to the price they pay would retain their insurance and possibly increase their cover.

   This could lead to an increase in the risk profile and thus the cost of claims for that pool as a whole. In order to be able to meet the increased claims costs for that pool, the insurer would need to increase premiums. These higher premiums would further drive low risk individuals out of the pool, and could eventually drive the majority of individuals to opt out of insurance altogether as they find the cost of cover no longer economically viable. The predictability of the risk profile of a pool of risk products could become so uncertain that they would be considered financially unsound and insurance providers would withdraw from the risk market increasing the burden on the public system. Adverse selection would also contribute to the first step in a spiral of increasing premiums and withdrawal from the market

   This is illustrated in the diagram below.

This vicious cycle has been seen before in the insurance industry. For example:



- [10]Historically life insurance companies did not differentiate premium rates by smoker status. Those companies that did not differentiate began to lose non-smoker consumers to their competitors who provided benefits to non-smokers for a lower cost. Those companies that didn't differentiate their rates retained the higher risk individuals leading to increased claim costs and hence driving their premiums further upwards. Ultimately all companies had to differentiate by smoker status to prevent having to exit the market, and/or prevent financial failure.

- Prior to 2000, private health insurance was not risk-rated in any way, with cover offered at the same rates regardless of individual risk factors. This encouraged more applications from individuals more likely to claim, whilst those who judged themselves healthy opted out of the system. A cycle of increasing premiums and reduced participation by healthy lives resulted. See tables below[11].

1. Increase in average hospital cover premiums in relation to CPI 1990-1996.

	Hospital Cover Average premiums	Consumer Price Index (CPI)
Increase over 1990-1996	75%	18.7%
Increase per annum	9.8%	2.9%

2. Some evidence of low risk individuals opting out of the health system at a faster rate than riskier individuals, over 1990-1996.

	Hospital Cover coverage

[10] Genetics in Society 2001, Institute of Actuaries of Australia

[11] Private Health Insurance Administration Council Annual Reports 1990 - 2000

Population aged <= 64	Fell by 33%
'lower health risk'	
Population aged >= 65	
'higher health risk'	Fell by 12%

The disappearance of market participants and insurance products in the private sector is not socially desirable, as individuals would become more reliant on the public sector to ensure their financial security.

The possible consequences of any regulatory restriction on access to relevant underwriting information is considered in section 2.8.

2.8 Overview of the Underwriting Process

The purpose of underwriting is to assess the relative risk of a potential life insured suffering a condition such that the policyholder may make a claim so that the policy can be assigned to the appropriate risk pool and the appropriate premium charged for the risk.

This section discusses the:

- Process of underwriting;
- Information used in underwriting;
- Results of the underwriting process.

It also discusses important consumer issues such as:

- Privacy and confidentiality of information; and
- The process for lodging and addressing complaints.

2.8.1 Data Gathered

From the initial underwriting information gathered, the underwriter gains an appreciation of the risk and determines whether additional information is required. Once this has been received and evaluated (or if no further information is needed) the underwriter develops an overall understanding of the risk profile of the applicant. The underwriter is then able to make an assessment of the impact of any increased risk factors on the applicant's probability of claiming together with any offsetting or compensating factors and determine the acceptance terms. All the information collected is used in making this assessment.

2.8.2 Basic information gathered

The basic information required by the underwriter to assess the risk is collected from the consumer via the completion of an application form. This information varies according to the type of policy, but may include the following:

- Personal and insurance information
  E.g. Age, sex, type of policy, amount of insurance, other insurance coverages held

- Medical and health information
  E.g. State of health, height and weight, lifestyle, results of medical tests, medical reports, and individual and family medical history

- Non-medical information
  E.g. Occupation, residence, hazardous pursuits

In most cases, this basic information received via the application form is sufficient for the underwriter to assess the risk of claiming and assign the applicant to the appropriate pool. In these cases, no further information is required from the consumer.

2.8.3 Further information gathered

Further information may be required in two circumstances. Firstly, when the level of cover applied for is above a certain amount, and secondly, where the information provided in the application form indicates there may be a risk that requires further investigation to assess it fully.

1. The level of cover applied for is above a certain amount.

   As the collecting of additional information is a costly exercise, it is only once the benefit obtained from the information, in terms of differentiation of relative claim probability, exceeds the cost of obtaining it that it becomes economic to request it. Thus there are different levels for blood tests, medical reports (personal medical attendant – ~~that is~~ie usual doctor), medical examinations (by an appropriate insurer nominated specialist) and ECG's. It is also common for these levels to vary by age and type of cover applied for.

   The information obtained from these additional sources allows greater differentiation of risks as the differences start to have material impact on the;
   - total premium charged due to the size of the premium at the level of cover applied for (a 5% difference becomes material when the premium is thousands of dollars per annum), and;
   - variability of claims experience as the risk becomes a larger proportion of the total pool.

   The table below is indicative of the amounts of lump sum life insurance cover that can be obtained without the automatic requirement for a medical examination, or other medical test (these may still be required if the basic information provided in the application form indicates a medical history or condition that may have a material impact on the risk and therefore warrants further investigation). These amounts are set by each company and may differ between companies.

Age Bands[12]	**Sum Insureds above this requires medical examination**

[12] RGA Reinsurance Company of Australia Limited Underwriting Limits Survey 2001

Up to age 40 next birthday	$500,000
Between 41 & 50 next birthday	$300,000
51 & 55 next birthday	$200,000
56 & 60 next birthday	$100,000
61 & Over next birthday	$ 10,000

Note:
The sum insureds shown are conservative amounts, and consumers will find that some companies' non-medical limits are considerably higher than those shown.

In a recent survey of life insurers the average size of a term life policy[13] taken out in the last twelve months was $235,000 which means that the majority of applicants under age 51 next birthday were not required to undergo a medical examination, or other medical test as part of their initial application. Statistics are not readily available to determine at an industry level what proportion of business has a medical examination or further medical test requested as a result of information disclosed in the proposal but anecdotally less than 15% of business overall have this requirement.

Similarly the average size of a trauma (crisis) policy[14] taken out in the last twelve months was $165,000 therefore the majority of those under age 55 next birthday would not have been required to undergo a medical examination, or other medical test as part of their initial application and anecdotally more than 75% of business overall would have received a policy without the need for any medical tests.

2. The information disclosed may indicate a risk and further information is required to assess it fully.

   As mentioned above, the applicant may have disclosed current or past medical conditions (e.g. diabetes, asthma, depression, removal of cancerous growth, history of back problems etc) that require further investigation through specific questionnaires, a report from their current doctor or a medical examination, or a specific medical test in order to give the underwriter a clear picture of their state of health. It is important to note that in accordance with the IFSA Standard No 11, which has been approved by the ACCC, companies will not require individuals to undergo genetic tests.

2.8.4 Basis for Using Information

The information outlined above is used in underwriting because statistics and research have shown that certain characteristics of individuals impact their likelihood of making a claim. The data gathered is focussed on understanding these characteristics fully.

The risk of making a claim is impacted by both current medical conditions as well as conditions that may develop in the future. Further personal medical history and family medical history can each provide indicators of changes in the likelihood of the condition developing in the future.

[13] IFSA recent survey of 19 direct writers of whom 13 responded. This represented 70% of the market share in terms on risk annual premiums in force at 31/12/00.
[14] see 10

Medical factors (eg blood pressure and cholesterol tests) as well as non-medical factors (eg smoking status) are recognised as valuable in assessing an individual's risk of developing medical conditions in later years.

Life insurers have used an individual's family history for many years as a means of assessing longevity. In addition family medical history is a valuable indicator of the likelihood of an individual developing a familial or inherited condition in the future.

Certain family medical histories are highly predictive of an individual acquiring a particular disease or disorder. For example, Huntington's Disease is known to follow a pattern of autosomal dominant inheritance in families, so that there is a 50% chance that a child of an affected parent will inherit the condition. Other family medical histories indicate an increased risk of a disease or disorder, for example, families with history of breast or bowel cancer.

Where possible, the relationship between individual characteristics and the risk of claiming is based on statistical data gathered from the experience of groups of individuals with similar risk characteristics. In some situations underwriters rely on the results of medical research and the advice of medical experts in assessing the nature of the risk and the likelihood of claiming.

A valuable source of information and research is multinational reinsurance companies. Their access to aggregated data and medical research, and their combination of actuarial and clinical skills, allows them to research statistics and medical information and convert this into assessments of the additional risk of claim for a range of characteristics. Consequently, reinsurance underwriting guidelines and ratings manuals are used regularly by underwriters, either in isolation or in conjunction with a Life company's own underwriting manual based on experience and research

The industry has actively responded to changes in medical science and improvements in treatment in evaluating the impact of risk factors. For example, with general population mortality improvements in breast cancer over the last ten years, there has been a corresponding reduction in life insurance ratings.

Not only have the extra premium ratings improved, but also in some instances, after treatment for breast cancer, the deferral period for offering insurance has reduced from a minimum of four years to just one year.

The criteria for assessing breast cancer risk have also become more sophisticated, as clinical prognostic indicators for the disease are more widely understood. For example, we now include measurements such as histological subtype and grade in evaluating the insurance risk.

2.8.5 Results of Underwriting

The vast majority of applications are accepted at normal ('standard') premium rates. However, if as a result of the underwriting process an applicant is found to present a higher than average risk, the outcomes of the underwriting process may be as follows:

- The application is accepted, but with higher than standard premium rates.
  For example, an applicant with high blood pressure may be assessed as having double the normal mortality for persons of the same age, and be offered cover for twice the standard premium.

- The acceptance is subject to an exclusion clause.
  For example, someone regularly engaged in skydiving may be offered a policy that would cover him or her for every cause of claim except skydiving.

- The underwriting decision is deferred. The current application is declined but will be reviewed in the future if the applicant reapplies and provides additional information / evidence
  For example, the applicant may have an operation pending, in which case the underwriting decision may be deferred until their health stabilises following the operation.

- Insurance is offered on modified terms, that is, where a different type of policy might be offered from that applied for.
  For example, a consumer with a family medical history of Huntington's disease may be offered standard rates for a term up to age 50 (i.e. for a term which expires prior to the expected age for onset of symptoms of the disease).

- Insurance is declined.
  This would typically apply to applicants with serious health impairments or extremely hazardous jobs or where the risk is unable to be accurately identified or measured or where the premium is uneconomic such as someone who has been diagnosed with a terminal disease.

In Australia, approximately[15]:

- 93% of all applicants for life insurance are issued policies at standard prices;
- 5% are classified as having additional risk, and therefore may pay higher premiums or have some conditions excluded from their policy; and
- 2% are refused cover.

The percentage of applications accepted for disability insurance is somewhat smaller as the likelihood of claim is related to a wider range of factors and more people may be excluded from cover due to non-medical factors (for example, occupational risks).

2.8.6 Communicating the Results of Underwriting

Insurers recognise the need for transparency in the underwriting process and therefore reasons for particular underwriting outcomes are communicated with the underwriting decision. The Insurance Contracts Act contains requirements about the communication of underwriting decisions.

[15] IFSA survey August 2000

However, insurers also acknowledge that they are not necessarily the appropriate party to pass on specific medical information to the applicant. For example, the applicant may not currently have a sound understanding of how their medical conditions may impact their future health. It is also possible that the individual is not aware of the medical condition revealed in the information provided, as it may be the first time all the information has been gathered together, and the correct disclosure of the condition should include appropriate counselling and treatment advice.

Another consideration is the fundamental difference between 'clinical' and 'insurance' medicine in that insurance medicine involves a point in time assessment of the applicant's state of health and the potential down side (20% of lives with this condition will die) whilst clinical medicine involves the ongoing management of a condition and the reassurance of the patient (80% of people with your condition will be OK).

Consider an applicant with abnormal blood test results. These results may represent an additional risk of claiming over the long term. However, in the short term, they may be of little significance in terms of impacting the applicant's current health. In such cases the medical practitioner may need to continue to monitor and review the situation over a longer time period.

As insurance underwriters do not have the primary care relationship with the client in these circumstances a written response would inform the applicant that the reasons for the underwriting decision have been passed on to their usual doctor, who they are required to nominate in their application form, with whom they should consult.

2.8.7 Privacy and Confidentiality

The industry has for a long time recognised the individual's right to privacy and confidentiality in the underwriting process.

The IFSA Underwriting Guide requires companies to:

- Have a documented set of underwriting practices in place to ensure that confidential information, including medical and lifestyle information, is accurate, complete and securely held.
- Follow guidelines for the maintenance of privacy and confidentiality when dealing with sensitive personal information.

This guide currently requires updating to reflect advances in medical technology and changes in community attitudes.

In addition the Privacy Amendment (Private Sector) Act 2000 requires high standards of all industries for handling and using personal data. All organisations will need to ensure that they conform with the National Privacy Principles set out in the Act.

Historically the life insurance industry has had access to a wide range of health information and has been recognised for using that information in an informed and responsible manner.

One example is the industry's approach to the underwriting of HIV/AIDS, which focussed on the behaviours associated with the spread of the disease rather than sexual orientation, and ensured high standards of privacy and confidentiality.

The Privacy Commissioner has noted[16] that there is general satisfaction with the handling of information by the life insurance industry.

2.8.8 Complaints

The life insurance industry recognises the need to have an effective process for handling customers' complaints. In 1979, the life insurance industry association started an Inquiry and Complaints Service. This service developed over time into the Complaints Review Committee. Its role was to resolve policyowner complaints in a fair, impartial and timely manner.

Importantly, in 1991, external controls were introduced under the supervision of the Insurance Industry Complaints Council chaired by the then Federal Minister for Consumer Affairs, The Hon. Lionel Bowen.

This external dispute resolution body became the Life Insurance Complaints Service Ltd in 1995: a company dedicated to resolving inquiries and complaints from the owners of life insurance policies. In 1999 it was extended further to become the Financial Industry Complaints Service (FICS) embracing complaints concerning funds management, stock broking, financial advice and investment products.

Thus the initiative by the life insurance industry in 1979 to create a transparent externally regulated complaints scheme has developed into a robust dispute resolution scheme that has been funded by the industry and recognised by the government from its earliest days.

The Complaints Process

All life insurers have complaints handling processes. With the advent of licensing requirements under the Financial Services Reform Act 2001, these processes will be required to meet specified minimum standards approved by ASIC and we should therefore see further consistency across the industry.

Should a customer be dissatisfied with an insurer's response then a complaint can be considered by FICS at no charge to the customer. Determinations by FICS are binding on the insurer.

FICS does not consider complaints relating to underwriting, so in the case of dissatisfaction with an underwriting decision, the complaint may be referred to the Human Rights and Equal Opportunities Commission (HREOC).

At present the normal industry practice is to provide a consumer who is not satisfied with an insurer's decision with details of the external dispute body that can consider their complaint.

[16] Privacy Commissioner, Information Paper Number 5, September 1996

3 The Issues Paper

This section contains answers to the questions raised in the issues paper that are specific to the life insurance industry.

We would also refer the Commission to Chapter 8 of Discussion Paper 66, Protection of Human Genetic Information, published by the ARLC and NHMRC joint inquiry in human genetic information. Although this chapter primarily deals with anti-discrimination law in the context of genetics it examines the current DDA and many of the issues surrounding it dealt with in this issues paper.

3.1 What have been effects of the DDA's broad definition of disability?

As indicated in section 2, life insurance protects consumers against the risks of death, TPD, disability and trauma, and in the case of annuities, longevity. Therefore in a voluntary mutually rated market it is important to have parity of information. IFSA believes that the existing definition is fundamentally correct as it addresses the need to remove discrimination that can occur from everyday activities whilst recognising the need for life insurers to correctly price its products.

The various life insurance products offered in Australia each contain their own definition of disability (be it total and permanent, temporary or partial) and the various requirements for the impact ~~of~~ and cause of the disability in order to qualify for benefits under the policy. This means that the DDA's definition does not greatly ~~e~~affect the provision of life insurance and indeed there may be individuals who meet the definition under the DDA who are able to obtain life insurance on standard terms.

Inconsistencies in the definition of disability between states and government departments does present some hurdles to the industry as eligibility for social security benefits, workers compensation and other disability related services may vary by the state of residence of the ~~e~~affected individual. This makes the pricing of contracts that offset some of these benefits very awkward as individuals may relocate following their disability in order to maximise their benefits.

3.2 Should the exemptions be added to or removed?

The continuation of the exemption in some form is fundamental to the continuation of the life insurance industry as we know it.

IFSA believes that Section 46 does give insurers the right to offer the same product to different individuals on different terms providing that the offers meet the requirement contained in the exemption.

The DDA also recognises that different insurers can offer a similar product while the underwriting terms offered to the same individual can be different. This reflects the competitive nature of the life insurance industry in Australia.

Given that there are behavioural factors as well as medical ones that can impact on an individual's relative risk and that there is limited information within the Australian context to allow detailed investigation of relativities in experience together with the rapidly changing field of medical knowledge and technology it is appropriate for the exemption to be in terms of actuarial, statistical or any other relevant factor on which it is reasonable to rely.

In view of the size of the Australian market, the number of competing life insurers and the nature of a voluntary risk-rated insurance, the existing exemption should remain. This was supported by the Anti-Discrimination Commission of Queensland who commented as follows:

> It is acknowledged that the contract of insurance is a private commercial relationship between the insured and an insurer and that insurers should not be expected to provide a social safety net for people.[17]

Should there be a recommendation to modify the wording of the existing exemption, then IFSA would welcome the opportunity to be involved.

3.3 What amounts to 'reasonable' grounds for discrimination in the provision of life insurance?

It is IFSA's understanding that although the definition is very broad so as not to exclude anyone, in order for a person to claim discrimination they would still need to demonstrate they have been discriminated against on the grounds of their particular disability. In the case of life insurance, they would need to demonstrate that an insurer has not taken into consideration data that the insurer could reasonably rely upon in making their decision.

Decisions whether or not to accept a risk when based on the underwriting manuals generally used in the market, whether produced by reinsurers or life companies should be recognised as reasonable grounds for discrimination in provision of life insurance. The cornerstones to the viability of life insurance are:

(a) the preservation of the practice of pooling 'like' risks and offering or rejecting insurance on a consistent basis to persons categorised together by those risks;
(b) the commercial and prudential basis for each individual insurer determining what 'risk' or 'level of risk' is too great to insure and the level of premium to be charged for extra risk above standard.

As long as there is statistical data in the form of professional medical or clinical research studies which support an identification of a level of risk in the underwriting manual relied upon by the life company underwriters, the level of risk itself should be taken on evidence of the 'actuarial' assessment of the risk of mortality or morbidity above standard.

If the life company in its standard practices at the relevant time, determines that the risk identified by the underwriting manual is too great to underwrite, or can only be offered on specific sub-standard terms, that should be accepted as reasonable.

Different life insurers will offer the same applicant different terms or will reject the application based on their standard prudential or commercial terms offered from time to

[17] Submission G214, 2 December 2002 to Australia Law Reform Commission Issues Paper 26

time, but the test of "reasonableness" of such discrimination should be the published internal guidelines for that company's underwriters, provided that such guidelines apply on the basis of setting a limit with respect to the rate of mortality or morbidity over the standard life on a consistent basis, regardless of the cause of the disability.

Previously guidelines provided by HREOC have confirmed that reliance on the underwriting manual was a reasonable basis for discrimination. However, in practice, the basis for confidently asserting an entitlement to rely on the exemption has required a chain of evidence showing the actual medical/clinical data relied upon, which is both time consuming and expensive.

The industry has, admitted, been slow to address the potential for reliance on the exemption to fall down because of an administrative deficiency for keeping a record of those medical clinical studies that have been reviewed for the purpose of 'rating' the risk in the published underwriting manuals. The factor associated with recompiling data used over the years as the basis for underwriting manuals is not insignificant.

The consequence in individual complaint cases has been a significant drain on professional resources associated with collating the objective statistical data that supports the rating in the manual.

Underwriting is not an exact science and the determination of premium rates for life insurance depends upon the pooling of a large number of risks and the law of large numbers. That is when the group is large enough that the average experience from year to year will be relatively consistent. This means that it is not possible to calculate an exact premium that reflects an individual's particular disability but rather an average premium rate that reflects the historical relative experience of a group of lives with a similar condition against those of an average insured group of lives.

When evaluating an individual's relative risk the underwriter has to consider the current and historical medical, occupation, avocation, lifestyle, diet and other information as well as project forward the likely future situation to determine an appropriate classification. Will the individual maintain their treatment, continue to engage in preventative activities, and act appropriately or will they behave in a manner that may increase their exposure and make them a 'bad risk'?

As a case becomes more complex, it is handled by a more experienced underwriter to ensure that each case is given appropriate consideration. Underwriting in a mutually rated market is a competitive activity so each company will arrive at its decision independently.

3.4 How has the 'requests for information' worked in practice and can it be improved?

As has been outlined above, the process of underwriting involves obtaining a detailed understanding of an individual's risk factors and, for individuals with various medical conditions or disabilities in terms of the DDA; this will include obtaining detailed

information of the treatment, management and impact of the condition or disability as part of the underwriting process.

In practice IFSA is not aware that the 'requests for information', (S30) of the DDA, has resulted in complaints that our underwriting questionnaire or personal health statements may breach the Act. It is fundamental to our underwriting decision that life companies be able to seek all relevant information. Without wishing to pre-empt difficulties, it may be sensible to amend the provision to recognise insurers may be exempt from the obligation where the information is gathered in the process and for the purpose of underwriting.

3.5 What is the effect of the overlap between Commonwealth and State Territory anti-discrimination legislation?

The legislation in all states is not identical but contains considerable similarities and the way the legislation operates is also very similar. The dilemma for insurers is that they operate under the Federal Government's Life Insurance Act 1995 and the question that has arisen over many years is whether the state legislation should apply to complaints against life insurers. IFSA understands that NSW has received a legal opinion that indicated that life insurance matters should be referred to HREOC, whilst Queensland's regulator will hear complaints under the State law, as will Tasmania.

3.6 What are the advantages and disadvantages of guidelines?

IFSA members welcomed the release of the 'Guidelines for Providers of Insurance and Superannuation' by HREOC in 1998 as they provided a clear outline of the actuarial or statistical data that insurers could rely upon, while explaining the operation of the DDA.

The disadvantage is that because the law does not recognise the guideline in relation to evidence that supports an insurers decision. (i.e. underwriting manuals, census statistics or local and international experience), its usefulness is assisting the sensible cost effective resolution of complaints may be limited.

4 Industry Experience

4.1 Overlap between Commonwealth and State Territory legislation

Our experience has been that each jurisdiction differs in its approach to the administration of complaints. Perhaps by virtue of having no power to make legally enforceable determinations, the role of the President of HREOC in the enquiry conciliation and termination process has resulted in a more manageable and cost effective process of complaints handling than in State jurisdictions.

In some States, complaints, which on their facts should be resolved by submission, go to full hearing with all attendant costs. In Tasmania, it has been our experience, that the Commissioner may simply defer dealing with a discrimination complaint for 6 months, after which time the matter must revert to a Tribunal hearing automatically – an expensive and inconvenient situation.

4.2 Complaints being heard by HREOC

Over the last few years the mix of complaint types before HREOC seems to have narrowed such that the majority of current complaints are depression related where previously they covered a wider range including Hepatitis, HIV, and drug use.

This may indicate improved industry response and community acceptance of the appropriate rating of risks or the potential for highly subjective conditions such as depression to become a significant proportion of future complaints. IFSA is already working with other members of the mental health community to ensure appropriate standards for underwriting and claims management are established.

Generally, our industry experience with HREOC and some State jurisdictions is that efforts are made to conciliate complaints to great effect and with a minimum of cost. However, the derogation of the conciliation process in other States is inconsistent with the general purpose and intent of the legislation.

4.3 Evidence of 'reasonable' discrimination

Recent experience suggests that despite Section 7.3(a) of the Guidelines for Providers of Insurance and Superannuation issued by HREOC, there seems to be a tendency to request the data behind the underwriting manuals that these guidelines approve for use.

There may be value in providing more definitive guidelines or legislative recognition of these commercially produced underwriting manuals and the process to establish them as being a reasonable basis for discrimination (eg certification by the source company's Appointed Actuary) so that the process is not required to be replicated for each circumstance in which they are relied upon and to remove the current uncertainty about whether they can be relied upon.

4.4 Expertise of HREOC

Given the expertise and experience required to underwrite life insurance business, there is a need to ensure that similar expertise is available to HREOC to allow them to determine whether the information provided substantiates the underwriting decisions they are reviewing. Allowance should be made within the DDA to permit HREOC to employ actuarial and medical experts to assist in their determinations.

4.5 ACCC implications

In establishing its Standard Number 11 on Genetic testing, IFSA had to seek approval from the ACCC for what was seen as anti-competitive behaviour on the basis that it was in the public interest.

Reference material such as underwriting and claims manuals are commercial documents that reflect the best practi~~s~~ces as perceived by their suppliers. Underwriting decisions and claims management activities are commercial activities that each company undertakes independently. Although industry policies may exist they must by their nature be non-prescriptive if they are not to breach trade practi~~s~~ces considerations.

When considering any changes to the DDA, IFSA would ask the commission to be mindful of the potential impact of any changes on the competitive nature of the life insurance industry.

5 Underwriting Family Medical History

5.1 Overview

To assist the Inquiry's understanding of the use of family medical history in underwriting, outlined below is some background information in relation to this subject matter.

The use of family medical history is an integral part of the underwriting process. Family medical history has been used for over 100 years within the life insurance industry worldwide.

Family medical history can be a relevant factor in assessing the likelihood of an individual meeting the policy conditions to substantiate a claim. It is used to identify potential medical risks on the basis of the probability that the insurance applicant may be susceptible to certain risks due to a familial/hereditary link with his or her immediate family and in some instances 2nd degree relative such as grandparents and uncles / aunts.

The majority of insurers in Australia have a section in their standard application forms asking about the applicant's family medical history. The purpose of the question is to identify whether the applicant's immediate family members (biological mother, father, brother(s) or sister(s), known collectively as 1st degree relatives) have been diagnosed with, or have died from a number of medical conditions which medical research has identified as having a strong familial link or for which there is an identifiable direct genetic link (such as Huntington's disease). The insurer does not generally ask for family history information relating to the applicant's children, cousins or relatives that are not immediate family.

The following is a list of medical conditions where medical research has demonstrated potential correlations with family medical history. The list represents those medical conditions that insurers specifically ask about in their respective family medical history question in their application forms. Medical conditions under Group A relates to 1st degree relative(s) who were diagnosed under the age of 60, while those under Group B are not age related.

Group A	Group B
❑ Cardiovascular ❑ Stroke ❑ Cancer (breast, bowel etc) ❑ Diabetes ❑ High blood pressure ❑ High cholesterol	❑ Huntington's Disease ❑ Muscular dystrophy ❑ Cystic fibrosis ❑ Familial polyposis ❑ Polycystic disease, or ❑ Other hereditary conditions

5.2 Use of family history in medical practice

Family medical history has been accepted within the worldwide medical/scientific community as being a significant indicator of the likelihood of diagnosing an individual with potential medical conditions throughout their lifetime on the basis of a familial link. The importance of using family medical history in clinical practice is evident in two articles published in The Medical Journal of Australia (MJA).

The first article comments on the guidelines[18] released by the National Health and Medical Research Council (NHMRC) for health professionals, which addresses the clinical implications of cancer genetics for Australian families. The article[19] highlights that family history is widely recognised as an important risk factor for common cancers, with 5-10% of cancers considered attributable to genetic predisposition. The NHMRC document also stratifies risk categories for people with a family history of cancer such as breast, colorectal, or ovarian cancer, and assists practitioners in predicting and identifying the risk of developing such diseases.

In a more recent article[20], the MJA addresses whether clinical medical practitioners are adhering to the NHMRC guidelines that ensure high-risk patients with strong family history of colorectal cancer are referred for appropriate screening (i.e. colonoscopic surveillance). The article also commented that 10-20% of patients with colorectal cancer will eventually have a family member with the disease, and the relative risk of colorectal cancer increases with the number of relatives with the disease and the earlier the age of onset in the affected relative(s).

Both articles highlight the important impact of an individual's family medical history on an individual's future health, and potentially being diagnosed with a similar medical condition as those identified in the family.

[18] NHMRC, *Familial aspects of cancer: a guide to clinical practice*, (Endorsed November 1999).

[19] MJA, *Cancer in the family: risks and management*, MJA 2000; 172: 529-30.

[20] MJA, *Colonoscopic surveillance for family history of colorectal cancer: are NHMRC guidelines being followed?* MJA 2002; 176: 151-154.

5.3 The underwriting process: family medical history and other risk factors

The underwriting process takes into account multiple risk factors to arrive at a final decision. Family medical history is used in conjunction with an applicant's current and past medical health status and other factors such as occupation, avocation, diet and lifestyle. The following are considered important factors to be used together with family medical history in the underwriting process:

- Age of applicant;
- Age at diagnosis of the applicant's 1st degree relative(s);
- The number of 1st degree relative(s) affected by the medical condition;
- Applicant's medical status and whether there are associated risk factors to the family medical history (e.g. an applicant has a family medical history of diabetes, and also one or a combination of the following conditions: borderline hypertension / obesity / hyperlipidemia);
- Unfavourable risk factors in which the applicant may partake such as smoking or ingestion of excessive alcohol.

Family medical history in association with an applicant's current and past medical history is used by underwriters in assessing an insurance applicant's mortality, morbidity or probability of being diagnosed with a particular medical condition/disease (specific to Critical Illness/Trauma Insurance). As these risks are different they each involve different considerations and the underwriting result for each benefit may differ.

Only information provided by the applicant or obtained with the applicant's permission will be used in the assessment of the applicant. If the insurer also provides cover for other members of the applicant's family, information about those other family members obtained in their applications will not be used in the assessment of any other life. Rather it is only the information about other family members that is disclosed in the applicant's own application that is used in the assessment of the applicant. This means that if the insurer has information about another family member that the applicant is unaware of, it will not be used in the assessment of the applicant.

5.4 A positive family medical history result – what does this mean for the insurance applicant?

A positive family history of condition X does not translate to the insurance applicant being underwritten as though they themselves had been diagnosed with absolute certainty of that particular medical condition X. Rather on the basis of credible medical and scientific research data, which is publicly available, insurers and reinsurers (through actuaries) translate the medical/scientific data into mortality and morbidity loadings (factors to apply to the standard premium rate to allow for the additional risks[21]). It is these loadings, which underwriters apply to an applicant's life insurance application.

[21] There are instances where the additional risk factors are considered so significant or specific that rather than a loading the recommendation is to exclude the particular condition from the offered cover, to defer the cover

For underwriting purposes, family medical history can play a significant part in determining an individual's extra[22] mortality or morbidity. Listed below are a number of examples of how family medical history impacts on the relative risk of the applicant and how this is interpreted in the underwriting process. These are taken from one of the underwriting manuals commercially available and may differ from those recommended in other manuals.[23]

Familial Colorectal Cancer

- No family history of colorectal cancer equates to a 2% lifetime risk of developing colorectal cancer. That is 2 in 100 people will suffer this condition at some stage of their life.
- 1 first degree relative with colorectal cancer translates to a 6% lifetime risk of developing the disease. If an applicant is over 45 years of age and asymptomatic at the time of underwriting they would be assessed as:
  - borderline ordinary rates for life insurance;
  - up to +50% extra morbidity for trauma insurance;
  - borderline ordinary rates for disability insurance.
- 1 first degree relative aged < 45 years of age when first diagnosed with colorectal cancer translates to a 10% lifetime risk of an individual developing the disease. If an applicant is under 45 and asymptomatic at time of underwriting they would be assessed as:
  - up to +50% extra mortality for life insurance;
  - +75% extra morbidity for trauma insurance;
  - up to +50% extra morbidity for disability insurance.
- 2 first-degree relatives with colorectal cancer translate to a 17% lifetime risk of developing the condition. If the applicant is under 45 and asymptomatic at time of underwriting he or she would be assessed as:
  - up to +50% extra mortality for life insurance;
  - up to +100% extra morbidity for trauma insurance;
  - up to +50% extra morbidity for disability insurance.

Motor Neurone Disease

- The SOD1 mutation is evident on many occasions in individuals who are diagnosed with Motor Neurone Disease.
- A critical issue is that 80% of individuals with the familial form will not have the SOD1 mutation.
- This clearly shows that even if an applicant had voluntarily been genetically tested for the SOD1 gene mutation, a negative genetic test would not exclude being diagnosed with Motor Neurone Disease.

(decline and allow reapplication) until more information is available or the condition has developed or to decline to offer the cover.

[22] When compared to the average insured person, which is the basis for the derivation of standard premium rates.

[23] Source for risk ratings: *Gerling Global Life Reinsurance – Gerling Electronic Manual (GEM)*

Diabetes
The following example illustrates that even where a family history of diabetes exists and based on the medical /scientific data, a mortality or morbidity loading may be applicable, an applicant's favourable current and past medical status is taken into account in the final underwriting decision.

- 50-year-old female applicant.
- Family history of both parents with non-insulin dependaent diabetes
- The applicant has a normal blood sugar level and her other risk factors are all normal (i.e. normal build / blood pressure / cholesterol)
- The applicant on the basis of both parents being diabetics would warrant an extra mortality loading of +50%. However, on the basis of her advanced age, and with no other risk factors the applicant would be offered life insurance cover on standard terms.

As demonstrated by the above examples (and particularly the example on diabetes), there are many variables used in the underwriting process. Family medical history needs to be considered in association with other risk factors before the final underwriting decision is made. This being the case there is considerable difficulty in trying to develop a policy on the use of family medical history (genetic information) separately from the use of other medical and personal information in the insurance underwriting process.

5.5 Family Medical History Survey

During the month of October 2002, IFSA conducted a survey of its members to determine the prevalence and significance of family medical history in underwriting. Sixteen insurers and reinsurers participated in the survey.

The survey covered 7,949 applications for term life cover, total and permanent disability (TPD) cover, disability insurance, trauma cover or combinations thereof. Family medical history played a part in 558 (7.39%) applications. 349 applications showed a family medical history that was either not significant in the underwriting decision or resulted in a favourable underwriting decision (i.e. accepted at standard rates), when considered with other personal medical information. The remaining 209 (2.62%) applications had an unfavourable underwriting decision (i.e. resulted in a loading, exclusion, deferral or declinature of insurance), which therefore show that the insured's family history impacts on an extremely small number of underwriting assessments. In 106 of these applications the rating was exclusively attributable to the family medical history, whilst in the remaining 103 applications, the ratings were based on a combination of family medical history and other medical and personal information.

Whether the rating was specific to family medical history or a combination of the applicant's other risk factors and family medical history varied by the type of cover being requested. For example, in one case a family history of bowel cancer in one 1st degree relative had no effect on the application for term life cover (offered cover on standard terms) whilst it attracted a small loading for trauma cover, given that trauma insurance is paid on the diagnosis of certain cancers, not from possible mortality.

In another example, an individual who applied for term life, trauma insurance, TPD and disability insurance evidenced a strong family history of premature heart disease with ~~3~~ three 1st degree relatives being affected prior to age 58. While the request for TPD and disability insurance cover was declined, the applicant was still offered trauma cover, albeit with a loading, and term life cover, which was accepted as borderline standard.

A 28-year-old applicant, who is suffering from high cholesterol and already has blood pressure levels that are considered borderline, these are factors which by themselves might well qualify for a loading. When these factors are combined with a family history that both parents were hypertensive, it was considered appropriate to apply a loading of +100% extra morbidity to the premium rate for the individual's application for disability insurance, due to the higher propensity of the insured developing hypertension in time.

Another client's personal statement and medical information revealed borderline blood pressure levels as well as elevated cholesterol, which would normally warrant an underwriting loading. However given that the family history showed the father was still alive following a bypass at 87 and the mother died of a stroke at age 85, it was considered appropriate, when considering these factors with the blood test and the individual's height / weight levels, to accept term life cover, TPD and trauma insurance all at standard rates, demonstrating how family history can positively influence the underwriting assessment.

Finally, another case had a raised lipid profile that would by itself warrant a +50% loading for morbidity, but as there was no family history of cardiovascular disease and the individual was a non-smoker with a satisfactory resting ECG they were able to obtain disability income insurance at standard rates.

This survey shows that family medical history is used extensively in the underwriting process, and that while it may have no bearing or be neutral in many applications, nevertheless it does have both favourable and unfavourable impacts on life insurance. The examples together with the survey data demonstrate how complex family medical history can be and how it interacts with other medical information in determining the underwriting result rather than being a factor that can be considered in isolation.

5.6 Conclusion

Family medical history has a comprehensively documented scientific/medical basis, which is utilised extensively in the surveillance and management of individuals in the everyday clinical medicine environment.

In a competitive market place where clients can shop around for cover, it is crucial for a company to remain at the forefront of underwriting techniques to be sure to be able to correctly identify the appropriate loadings to apply to sub-standard insurance applications. This involves the use of constantly updated underwriting manuals that keep abreast of the latest medical research findings. Failure to do this would result in other insurance companies being able to offer better terms for particular medical conditions.

The need for screening and surveillance of individuals with a positive family history (of a specific medical condition) strongly supports the process of insurance companies using

family medical history in categorising and assessing an individual's relative risk position in the underwriting process to determine the correct premium to be charged. Natural market forces ensure that this process keeps up with the latest medical developments to ensure that new information is incorporated as soon as it becomes available.