



**HEALTH FUNDS ASSOCIATION
OF NEW ZEALAND INC.**

HFANZ Guidance Note : The Human Rights Act 1993 and Health Insurance Premiums

1. Introduction

- 1.1 The Health Funds Association of New Zealand Inc (HFANZ) is the professional body representing the health insurance industry in New Zealand.
- 1.2 The HFANZ has the power to promulgate industry guidelines, and to require compliance by members of the Association under the conditions of membership.
- 1.3 This Guidance Note has been approved by the Executive Committee of the HFANZ, and endorsed by the membership.
- 1.4 This Guidance Note is effective from 2003

2. Purpose and Scope of this Guidance Note

- 2.1 This Guidance Note explains the different approaches that health insurers may adopt when pricing premiums, and the complex issues facing the industry. It makes recommendations on premium pricing, disclosure requirements, and the meaning of “other factors” in terms of the Human Rights Act 1993 (the Act).

3. Stakeholders

- 3.1 This Guidance Note has been prepared by the HFANZ for the guidance of its member health insurers. However, it is acknowledged that other stakeholders share an interest in this issue including the Human Rights Commission, NZ Society of Actuaries, the Government Actuary, Age Concern, Grey Power, and importantly the many customers holding health insurance policies.

4. The Human Rights Act 1993

- 4.1 The provisions in the Act most affecting health insurance are sections 44, 48 and 65
- 4.2 **Section 44** provides that it is unlawful for health insurers –
- (a) to refuse or fail on demand to provide any other person with health insurance ; or
 - (b) to treat any other person less favourably in connection with the provision of health insurance than would otherwise be the case, by reason of any of the prohibited grounds of discrimination.
- 4.3 **Section 48** provides an exception in relation to insurance (1) It shall not be a breach of section 44 to offer or provide annuities, life insurance policies, accident insurance policies, or other policies of insurance, , whether for individual persons or groups of persons, on different terms or conditions for each sex or for persons with a disability or for persons of different ages if the different treatment-
- (a) is based on –
 - (i) actuarial or statistical data, upon which it is reasonable to rely, relating to life expectancy, accidents, or sickness; or
 - (ii) where no such data is available in respect of persons with a disability, reputable medical or actuarial advice or opinion, upon which it is reasonable to rely, whether or not contained in an underwriting manual; and
 - (b) is *reasonable* having regard to the applicability of the data or advice or opinion, and of any *other relevant factors*, to the particular circumstances.
- 4.4 **Section 65** provides a breach of the Act for indirect discrimination; where any practice has the effect of treating a person or a group of persons differently on one of the prohibited grounds of discrimination of Part II of the Act, that conduct is unlawful unless the health insurer can establish good reason for it.
- 4.5 In practice, the provisions of the Act are construed to mean :
- Health insurers cannot refuse to provide cover to applicants, but they can defer for a period of time if there is insufficient information on which they can make an informed decision.
 - Excluding pre-existing conditions does not contravene section 44 because there is no refusal to insure nor is there less favourable treatment.
 - Health insurers are permitted under Section 48 to offer different terms and conditions to applicants on the basis of sex, disability, and age, however the different treatment must be able to be justified.
 - Younger persons who are charged substantially higher premiums than their risk profile may be discriminated against under Section 65, unless health insurers have good reasons. Belonging to a community rated type scheme justifies this different treatment

5. Methods of Premium Pricing and Treatment of Pre-existing Conditions

- 5.1 Health insurers have adopted varying approaches to setting premiums. Health insurance policies have traditionally been priced either by age banded risk rating, or by a community rating type approach. Often, in practice a combination of both methods has been used.
- 5.2 *Community rated type schemes* typically do not adjust their premiums according to the insured person's age or medical condition. People between the ages of, for example, 19 and 65 typically all pay the same premium for coverage. In community rated type schemes premiums are set at the average cost of the wide age group, so that younger people typically pay more than their average risk and older people typically pay less than their average risk. The benefit of this approach is that the premium will not increase due to the increasing age of the insured within the group (but premiums will increase to meet medical inflation and increased claims costs of the group overall). However, younger people are becoming less willing to purchase and remain in community rated schemes.
- 5.3 *Age banded risk rated schemes* charge premiums based on age, and sometimes on gender and other characteristics. Age bands, commonly five year age bands, are used to group together people of a similar age and risk, so that they pay the same premiums. Age banded risk rated schemes are becoming more popular, particularly with younger people, who usually pay lower premiums than they would under a community rated scheme. However, their premiums will increase regularly as they move through the age bands with premium costs more accurately reflecting the true health costs of each age band. This means that health insurance premiums for older persons are usually more expensive in risk rated schemes in comparison to community rated type schemes.
- 5.4 *Excluding pre-existing conditions* which individuals have when they apply for insurance does not contravene the Human Rights Act 1993. Once a medical condition arises, the insurer can no longer insure against the risk of the consumer contracting that particular illness or condition. Health insurers will therefore usually exclude pre-existing conditions, or sometimes they will adjust premiums to meet any higher health risks. Health insurers do not reunderwrite, so that consumers with a pre-existing medical condition will be covered for new medical conditions which arise or are acquired after the health insurance contract is entered into.

6. NZ Health Insurance Industry Practices

- 6.1 In the health insurance market, there are a variety of organizational structures from Not for Profit and Friendly Societies through to listed companies. Some insurers are essentially restricted funds, such as the Police Health Plan whose members comprise only members (and retired members) of police and their families. Each insurer has its own separate identity and philosophy which influences its premium setting methodology and its approach to age banding and premium setting.
- 6.2 Market forces have in recent years influenced the approaches adopted by health insurers to premium pricing. With the adverse selection experienced by some of the community rated type schemes, many health insurers have moved to introduce some form of age banding. The ability for community rated type schemes and risk rated schemes to co-exist comfortably alongside each other is a significant issue facing the industry. It is in the interests of the health insurance industry that the market remain strong and viable to ensure ongoing protection for our customers.
- 6.3 Notwithstanding the more recent practices to age band in typically five year bands, many insurers group children and adolescents (for example from 0-18 years) in one band, and older persons (for example those over 65 years) into another band.
- 6.4 The grouping of children and adolescents into one band is primarily for administrative convenience to enable the marketing of family policies with standard premium rates for all children and adolescents.
- 6.5 The grouping of older persons into one band is usually due to quite different reasons, namely the smaller number of insured in these groups, the volatility of claiming patterns, and hence the need to spread the risk over a greater pool of insured. Furthermore, as people in this older age group are typically on a set income, the need to contain premium increases in this group is considered important.

7. HFANZ Recommendations

1. *Premium Pricing*

Premium pricing should normally reasonably follow the age based risk profile, both actual and prospective, of the health insurers entire book,

unless it is a community rated scheme. To price premiums otherwise is to treat some persons unfavourably. There will be circumstances when “other factors” may entitle an insurer to treat a group of persons or all of its members differently, some of which are outlined in 3. below.

2. Disclosure

Health insurers should provide clear information to their customers about how the product or portfolio is priced, and if appropriate how this may differ from other product types. If the customer is well informed, then they can confidently choose the type of health insurance policy that best suits their needs.

The marketing and promotional material used to describe health insurance policies should clearly explain the following :

- the philosophy of the health insurer and their premium setting methodology.
- the relationship between premium rates and the age of the person insured, and how this might change over time.

3. Other Relevant Factors

S.48 of the Act permits insurers to treat individual persons or groups of persons on different terms or conditions if the different treatment is based on actuarial or statistical data, or reputable medical or actuarial advice or opinion upon which it is reasonable to rely, and is reasonable having regard to the applicability of the data or advice or opinion, and of any other relevant factors to the particular circumstances.

It is considered that certain “other relevant factors” in terms of s.48 of the Act entitle a health insurer to treat a group of persons differently, including (but not limited to) the following :

- (i) *Children / adolescents* : as many families prefer to purchase family plans, it is administratively easier to charge a set premium for all children of a defined age. It is not considered that the risk profile, and hence the costs of the group are so significantly different that this treatment unfairly affects any of the persons in this group. It is therefore considered acceptable practice to group all infants, children, and adolescents in one age band for the setting of “child” or “dependant” premiums.
- (ii) *Elderly premiums* : the pricing and affordability of health insurance policies for older persons presents many difficulties for the health insurance industry. If insurers were required to risk rate all persons over 65, this could lead to large fluctuations in

premiums for the over 65 age group due to claiming volatility and small risk pools. As most people over 65 are retired and have set incomes, it can be administratively easier and more affordable for this group to be charged one base premium. It is therefore considered acceptable practice for health insurers to group (either entirely or partly) persons from the age of 65 and over, notwithstanding the different risk profiles of the various age groups over 65.

- (iii) *Restricted membership funds* : several health insurers are regarded as restricted membership funds, such as the Police Health Plan, and funds which require membership such as Manchester Unity, EBS, and IOOF. In such restricted membership funds, many policyholders stay with their health insurer for a long duration. This fact, together with the philosophy of the health insurer (which is often to share costs) can influence their approach to premium setting. Many such restricted membership funds consider that community rated type schemes best suit their members needs. It is therefore considered that restricted membership funds may offer community rated type schemes providing their customers receive full disclosure as set out in 2. above.
- (iv) *Group schemes* : may also be regarded as restricted membership funds, as only members of a particular group can join the scheme (such as groups of employees, professional groups etc). Premiums are sometimes based on the estimated claims costs of the group as a whole rather than on each individual risk, in circumstances where all members of the group have the same coverage and when the premium is paid for by one entity (normally the employer). It is administratively easier for both the employer and the insurer to set a standard premium for all members of this type of group scheme. It is therefore considered acceptable practice to group all members of this type of group scheme together for the setting a “group” premium, notwithstanding the different risk profiles of the various age groups of the insured. Sometimes members of a group scheme can elect to include their families and/or upgrade their coverage. In these situations the insurer is likely to charge an age-based premium for the additional members and/or expanded coverage.