The Impact of Gender Equalisation on the EU Health Insurance Industry

Peter Banthorpe, Emile Stipp

20 October 2011

Agenda

- Brief Background
- What we don't know
- Is this important?
- Implications
- The philosophy of neutralising premiums for risk factors

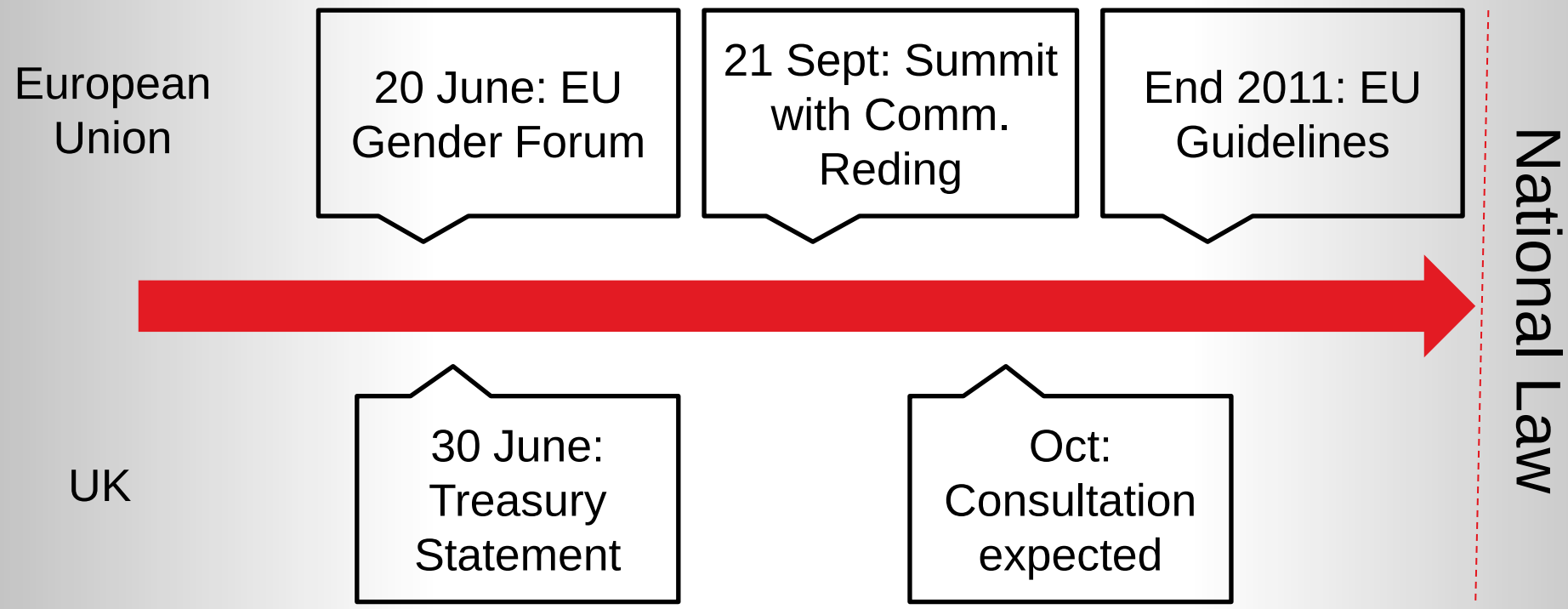
Brief Background

The ECJ Ruling – 1 March 2011

- European Court of Justice (ECJ) ruled that use of gender in determining price and benefits in insurance should be prohibited from 21 December 2012;
  - overrules the original gender directive which applied from 21 December 2007;
  - decision is drawn on narrow legal grounds, so significant practical uncertainty remains;

- The appendix contains more on the Background prior to the ruling.

Post Ruling


European Union
20 June: EU Gender Forum
21 Sept: Summit with Comm. Reding
End 2011: EU Guidelines
National Law
UK
30 June: Treasury Statement
Oct: Consultation expected

What we don’t know

Fundamental Uncertainties

Uncertainty	Anticipated Outcome
The process for implementing the ruling;	No amendment to Gender Directive – national implementations needed.
Can gender still be collected by insurers?	Yes – providing it does not result in gender based pricing.
Does the ruling apply to contracts written before 21 December 2012 and still in force?	No

Key Points To Be Resolved

- Extent of application of Indirect Discrimination legislation;
- Application to Business to Business Relationships (e.g. Reinsurance);
- Sales from Non-EU insurers;
- Treatment of Mid-Term Adjustments and Renewals;
- Application to Medical Underwriting;

Medical underwriting

- Some disclosures are inherently gender biased:
  - Definitely biological – e.g. Prostate / Ovarian / Cervical conditions;
  - High level of biological influence – e.g. family history of breast cancer;
  - Some biological influence but other factors also important - eg Hypertension / BMI ratings;
- To what extent can these lead to different rates for men and woman?

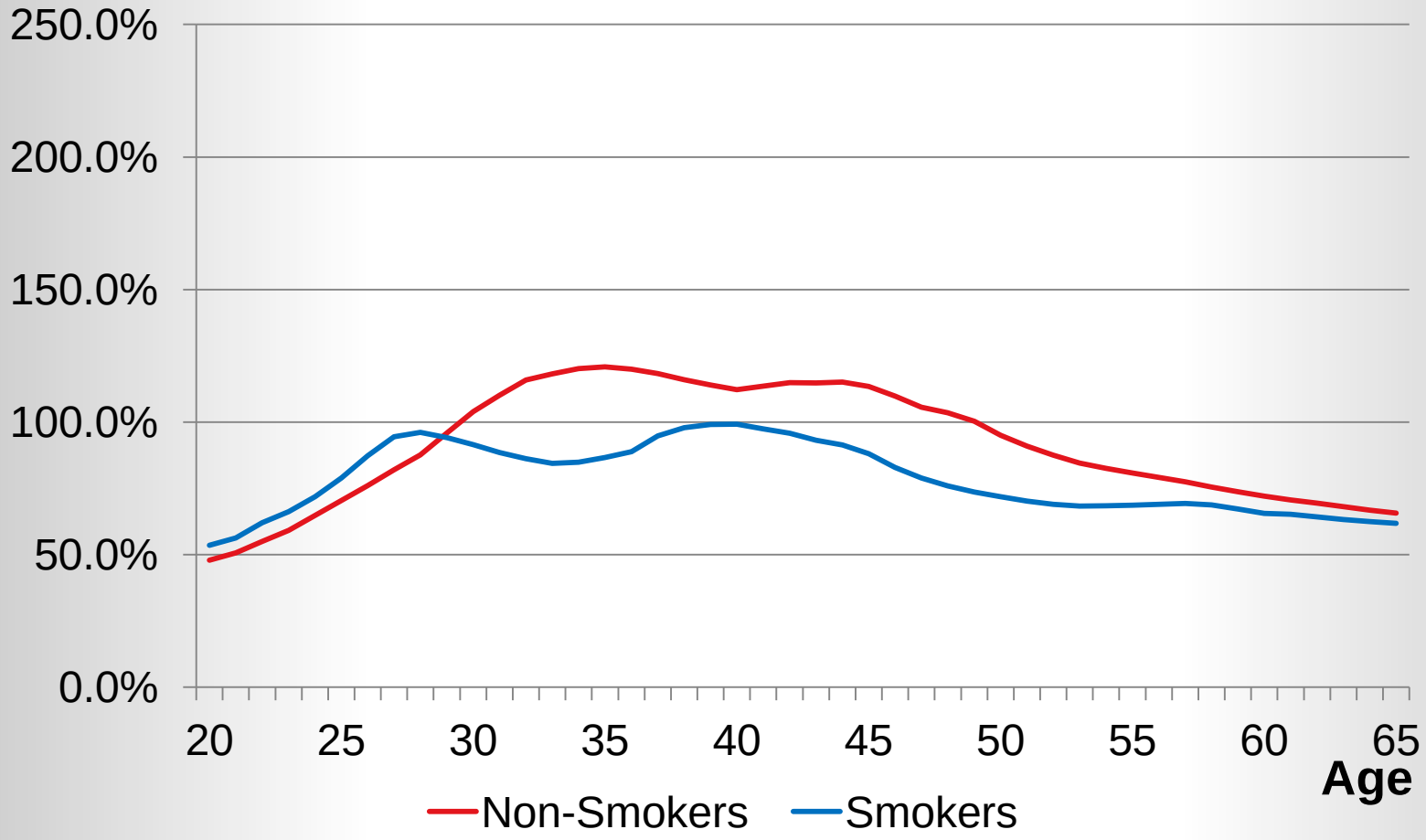
Is this Important?

Is this important?

- Least significant rating factor for many health insurance products;
- Most markets should be able to manage given change should affect all market participants;
- For long-term guaranteed rate products significant potential loss if applied retrospectively;
- Loss of ability to differentiate by disability and age would be a significantly larger issue;

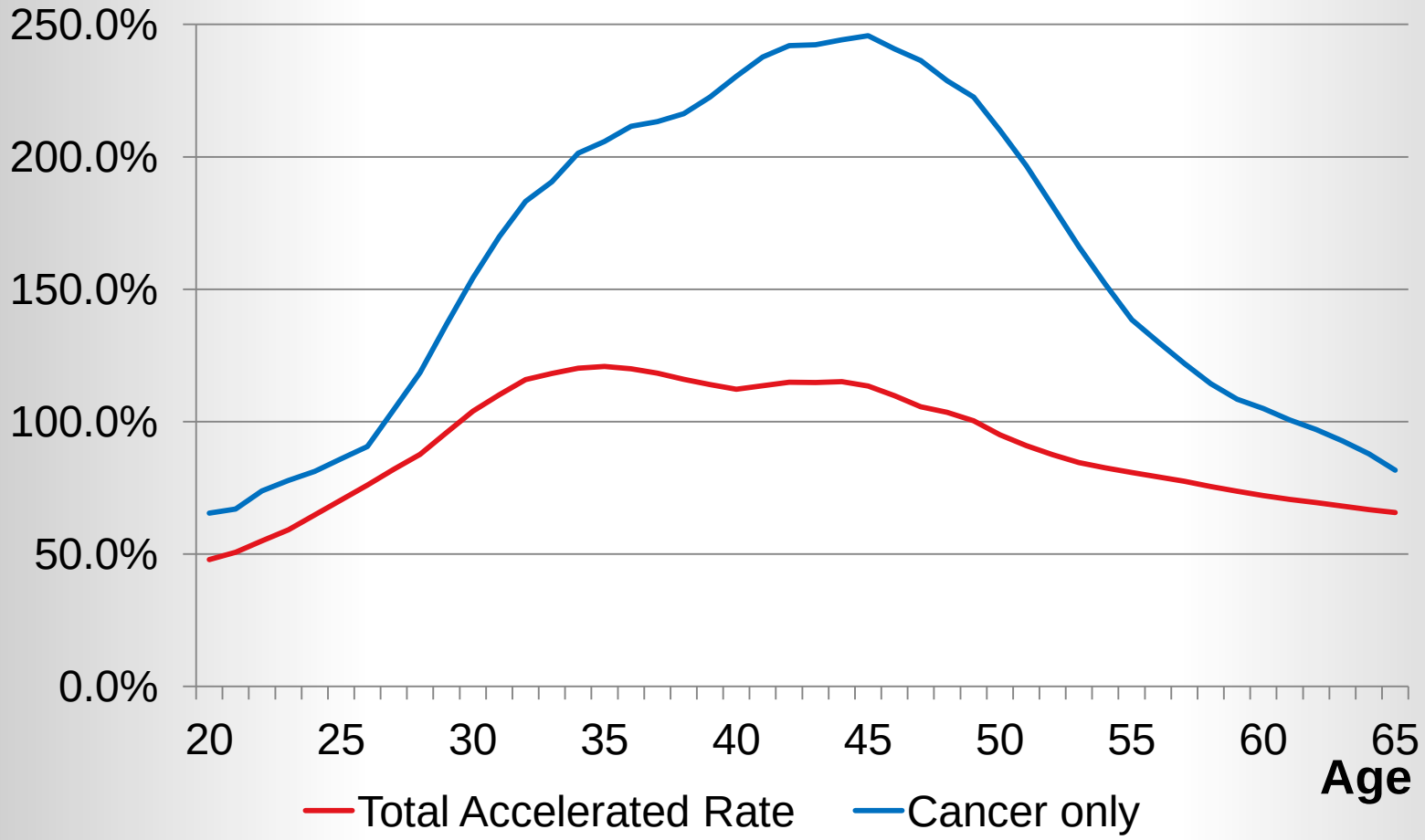
What are the gender differentials?

Critical Illness Insurance – UK ACL04 Tables, Female to Male Ratio, Ultimate Duration, Total Accelerated Risk Rate



What are the gender differentials?

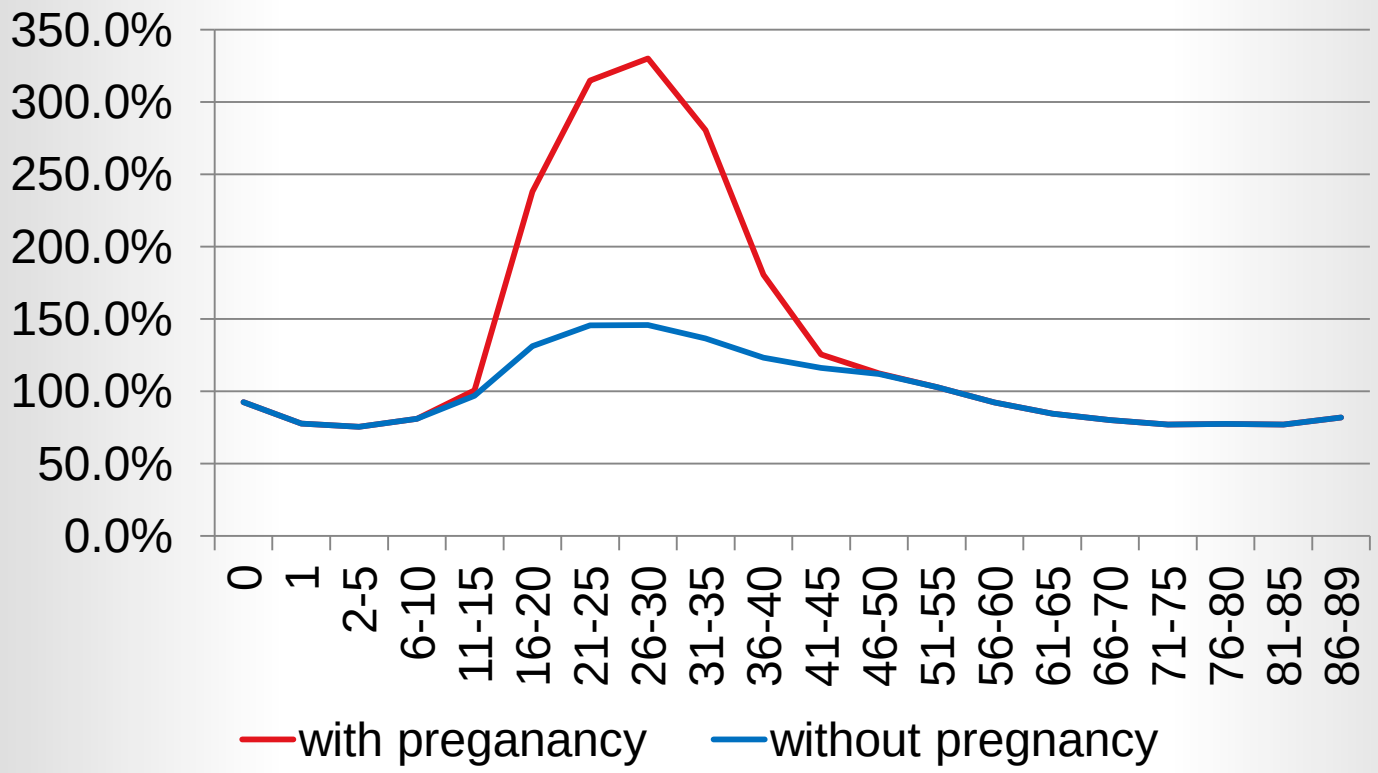
Critical Illness Insurance – UK ACL04 Tables, Female to Male Ratio, Ultimate Duration, Non-Smokers Only



What are the gender differentials?

Private Medical Insurance / Medical Expenses Cover

- Much of EU already use unisex rates;
- Ratio of Female to Male UK HES Records per 1000 of population , 2005-2008:



Age and Disability Discrimination

- Proposed EU Directive on Age and Disability is currently blocked in Council – seems unlikely to proceed in short-term;
- Lobbying ongoing to protect insurance industry position – e.g. CEA letter, September 2011;
- Insurance “carve-out” structured as a derogation, as per Gender Directive, so in current form same legal risk would seem to exist;

Insurance Market Models

- Risk Rating vs Community rating
- Compulsory vs Voluntary;

- Different markets in the same country can be structured differently, for example:
  - In France mortgage holders have to purchase matching life cover and rates were age + gender neutral but most other products are just gender neutral.
- Voluntary markets, especially community rated markets, are at risk of anti-selection;
- Risk Equalisation schemes maybe needed to maintain community rated markets.

Implications

In this section....

- Consumer Behaviour
- Pricing
- Operational Issues
- Product features and marketing
- Capital
- Sales Force Behaviour

Consumer Behaviour

- Change in timing of purchase:
  - Low risk groups accelerate purchase
  - High risk groups delay purchase.
- Purchase of substitute goods;
- Perception of bad value for low risk groups;
- Lapse and re-entry concerns for High Risk groups
  - In particular, note German Health market where new tariffs need to be offered to existing policyholders without underwriting.

Price – business mix

- Assume pricing will be weighted average of male and female rates;
- How do you weight the rates?
- At what level of granularity is business mix determined;
- Potential issues for annually reviewable contracts for insurers with adverse existing mixes;
- Need to avoid inconsistent pricing;

Price – business mix risk loadings

- Short-term shocks expected from consumer behaviour;
- Providing gender can be collected and repricing flexible then loading should be minimal:
  - 2% loading on rates...
  - ...protects against 9% error in business mix estimation...
  - ...when there is a 25% margin between genders

Price – new rating factors

- Need to be very careful about indirect discrimination;
- Looking for proxy rating factors for gender very likely to cause issues;
- Could drive more preferred lives approaches;
- Re-examine joint life pricing perhaps;

Final Price

- Determined by competitive pressures – in competitive markets;
  - Business mix risk loadings likely to be eroded away;
  - Long-term price likely to be slightly below price for highest risk group now in competitive markets.

- Insurers need to be wary of reputation risk:
  - Consumer associations likely to be looking for “profiteering” by insurance companies;
  - Beware other factors impacting price at the same time (e.g. Tax changes in the UK)

Operational Issues - Pricing

- When to switch:
  - Driven by competitive environment but no clear first mover advantage in absence of retrospection;
  - 21 December 2012 is last working day before Christmas;
  - Can all pricing be switched in a single day?
  - How to manage quote guarantee periods and new business pipelines?

Product features and marketing

- Gender specific products should still be allowed provided made available to both genders (at the same price!)
  - e.g. Standalone maternity / pregnancy / complication covers

- Can marketing approaches or product differentiation provide sufficient “barriers to purchase” for high risk group to establish a sustainable advantage?

Operational Issues – Administration / Systems

- If no retrospection and gender can still be collected then impact may be limited;
- Need to ensure all discriminatory coding in new business systems is removed;
- When do we alter provision of forward looking information prior to change?
  - E.g. Pension projections

Operational Issues - Underwriting

- Review ratings
  - Gender neutral ratings needed;
  - Current ratings relative to gender specific rates;
- System changes:
  - New ratings in expert underwriting systems;
  - Not provide gender information to underwriters(?)

Capital

- Providing gender information can be used for reserving, then impact “claim risk” capital should be minimal;
- Lapse risk scenarios will need careful thought e.g. For term assurance:
  - “High risk groups” will show low profitability
  - “Low risk groups” with show high profitability
  - More anti-selective lapsing from “low risk group”
- Generally, more uncertainty in the short-term

Sales Force Behaviour

- To what extent can insurers influence this?
- Commission thought to be outside of scope of legislation:
  - Differential commissions by policy, providing these can’t be used to drive differential prices between genders?
  - Reward brokers providing high proportions of low-risk group?

Disclaimer

The information presented here is RGA's current view of the implications of gender equalization, based on the review and interpretation of a range of sources, which is presented as information not advice.

There is considerable uncertainty in all aspects of this topic at present and RGA acknowledges that a range of different views are held around the industry. If readers need advice on the information presented here please seek independent advice.

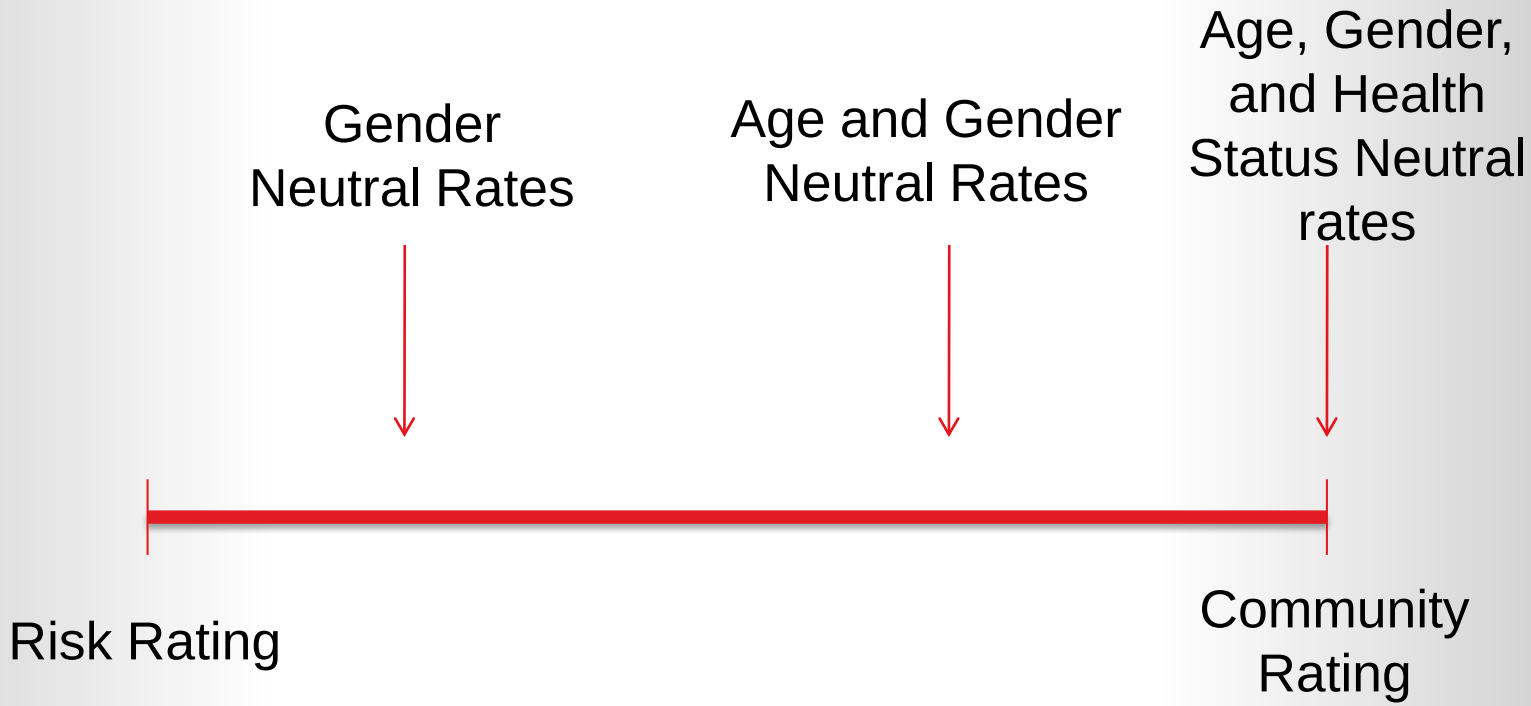
No liability will accrue to RGA in the event that a user suffers loss as a result of reliance upon RGA's information.

The philosophy of neutralising premiums for risk factors

The arguments for community rating

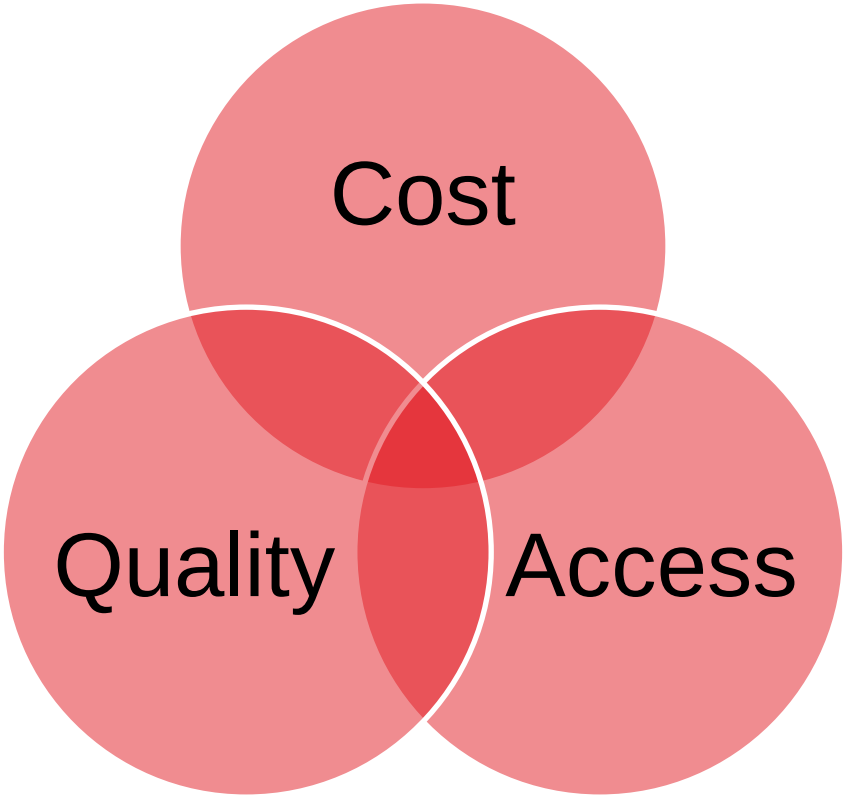
- Legislation enforcing premiums neutralised for risk factors is driven by philosophical arguments:
  - Risk rating = risk selection by excluding unfavourable risks through higher premiums
  - Which means that those unfavourable risks are dependent on the State for cover
  - And their exclusion is based on profit motives
  - And this is unfair and socially unacceptable
- Let us examine these arguments in the context of medical indemnity insurance, or personal medical insurance (PMI).....
- For the sake of argument, we are ignoring other “tools” of risk selection, such as underwriting

There are different degrees of community rating, e.g.



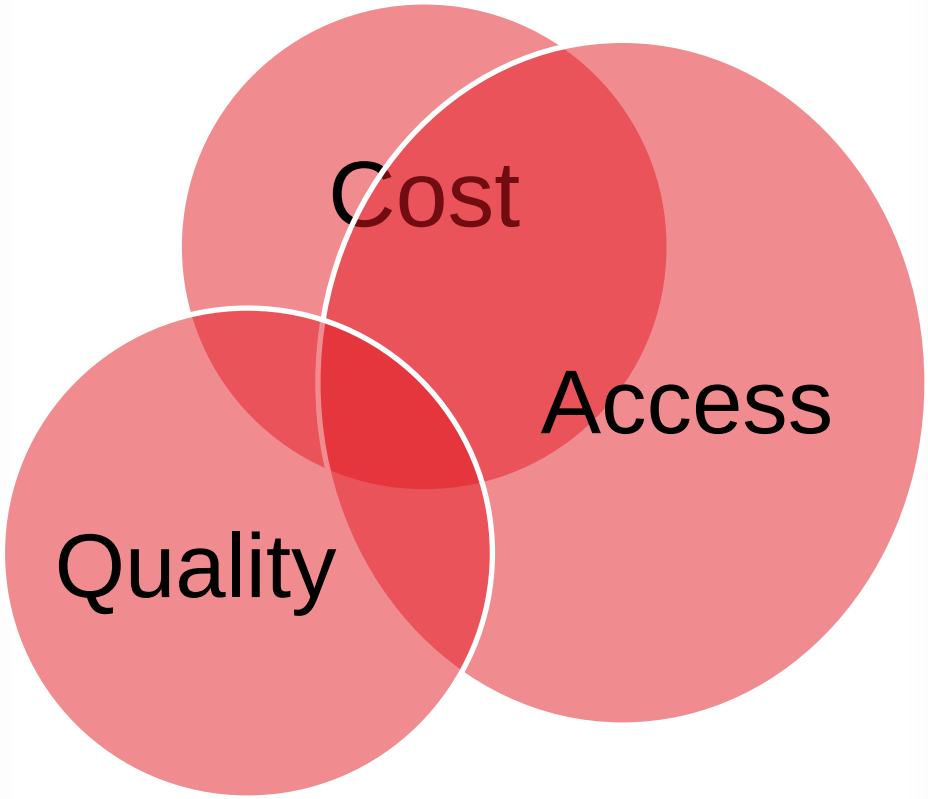
- Proposals in USA: community rating, within premium bands
- In South Africa: community rating, with premium differentiation only allowed for income, family size and level of cover

In any health insurance market….



- Policy makers have to find the optimal combination of cost, quality and access
- Community rating is typically implemented to increase access

Increasing access could imply increasing cost or quality or both….



The actuarial response

- Often emphasises that community rating only works if there is also a system of risk equalisation and mandatory cover
- Risk equalisation is needed to ensure that consumers who happen to be with insurers with worse than average risks, are not adversely affected by an actuarial death spiral
- And mandatory cover is needed to ensure that better risks don't opt out of the system entirely, thereby increasing costs for everyone
- The need for risk equalisation and mandatory cover depends on the extent of enforced community rating
- And of course risk equalisation and mandatory cover are complex to implement, and depends on the context of the cover
- And all of this is true, but there is also some basis for examining the philosophy behind the fairness arguments outlined above

The fairness argument

- The fairness or lack of fairness of risk rating clearly depends on the context of the health system:
  - Is risk rating and risk selection in respect of *essential* cover
  - And what are the alternatives to private insurance?
  - Health cover *is* generally essential
  - But, in the UK, for instance, the NHS provides essential cover to everyone
  - And PMI only provides top-up cover – it responds to a market need for cover that is not provided via NHS, or to “jump the queue”
  - It is arguable that exclusion of adverse risks is not socially unacceptable in such a context

The fairness argument

- The fairness or lack of fairness of risk selection depends on the *basis* of excluding unfavourable risks from cover:
  - Even in risk rated insurance environments, the exclusion operates mostly on the basis of anti-selection
  - In other words, unfavourable risks are not excluded *per se*, but only if they attempt to anti-select against the established risk pool
  - Anti-selection is generally a choice – people choose not to have cover until they get sick
  - In which case exclusion of unfavourable risks may well not be unfair. Policy makers then only need to ensure that cover cannot be cancelled, and that the risk rating involved in premium increases is done on a fair basis
  - Unless there were barriers to people entering the market in the first place

The fairness argument

- The fairness or lack of fairness of risk selection depends on the *basis* of excluding unfavourable risks from cover:
  - It is important to note that every insurer has to balance the needs of Underwriting and Sales
  - A too aggressive risk selection policy will affect sales adversely
  - And would certainly not lead to optimal profits, as volumes would be too low
  - There is not necessarily a *direct* profit incentive involved in risk selection

The fairness argument

- There is also an argument to be made that risk rating is not necessarily unfair:
  - In PMI, people with higher risk get access to *more* cover relative to those with lower risk
  - Is it then fair that they pay the same premium for it?
  - If the same arguments are applied to transport: people should pay the same for their train tickets, regardless of how far they live from the office
  - Or, people should pay the same for their mobile phones, regardless of how often they call
  - Clearly, what is fair or not depends on how essential services are, as mentioned above....

The fairness argument

- There is an argument to be made that risk rating is not necessarily unfair:
  - ....but it also depends on whether it is their *fault* that they use services more frequently or not
  - In health care, gender is not somebody's fault, and age also not, but health status can be their fault, at least to an extent (e.g. smoking, lack of exercise?, obesity?)
  - And, again, even where risk factors are not their fault, a choice not to take up cover until the risk factors manifest in terms of higher costs, is more often than not their "fault"

Conclusion

- The arguments for community rating do not necessarily apply equally in all contexts
- Different health systems, and types of cover, and bases for risk selection, are all factors to be considered
- It is therefore hard to see how a *blanket* implementation of community rating legislation across different countries and different insurance markets and different forms of cover can be argued to be appropriate
- For gender neutralised rates across Europe, the implications are far-reaching for some forms of insurance
- And if there are moves to neutralising for age or health status, the above arguments should be given a fair hearing

Questions?

- Listener submitted questions

The next IAA Health Section Webcast will take place on December 7 on the topic of Health Insurers and Solvency II. The speaker for this webcast will be Andreas Sanner from PwC.

For more information and to register, please visit: www.IAA-IAAHS.org and click on the banner.

IAA Mini-Congress

The Actuarial Profession and Social and Economic Development

Sheraton Hong Kong Hotel & Towers
May 6-9, 2012

NOTE: Deadline to submit abstracts for papers and presentations is October 31

For more information, please visit the Mini-Congress website www.actuaries.org/HongKong2012/

The Impact of Gender Equalisation on the EU Health Insurance Industry

Peter Banthorpe and Emile Stipp

20 October 2011

Background to the Ruling

Appendix

Current EU Directive (2004/113/EC)

- Aims to combat discrimination based on gender in access to, and the supply of, goods and services – for insurance:
  - Unisex rates required but Member State opt out allowed (unless already using unisex rates) providing relevant & accurate data could be regularly published showing gender was a risk factor and premiums varied in a proportionate way - Article 5(2)
  - Applies to new insurance contracts concluded after 21 December 2007 where these are private, voluntary and separate from the employment relationship
  - 5 year review (originally) due at end of 2010 with Member State review of opt-out to follow by 21/12/2012

EU Directive: Not a “Single Market”

- All 26 countries availed of the opt-out clause:
  - 13 for all types of insurance (incl. UK)
  - Others selectively, e.g. Belgium allows for Life/annuities only
- Different requirements for what data is published and who by
- Different interpretations of relationship between pricing and data
- Different application:
  - Consumer Protection – applies to policies sold to domestic residents, e.g. UK
  - Prudential supervision – applies to domestic insurers, e.g. Belgium.

The TEST ACHATS case

- Belgium adopted the Opt out for life insurance/annuities only
- Action brought in June 2008 by Test-Achats in the Belgian Constitutional Court that law is incompatible with the principle of equal treatment for men and women embedded in constitution
- Court decided that validity of Article 5(2) of Directive 2004/113 needed to be referred to the Court of Justice of EU.

The ECJ judgment – 1 March 2011

- "Conclusion consistent with the Advocate General – No more gender discrimination in insurance
- But justification was significantly due to the lack of a time-limit for the original opt-out clause:
  - *There is a risk that EU law may permit the derogation from the equal treatment of men and women, provided for in Article 5(2) of Directive 2004/113, to persist indefinitely."*
  - *"such a provision, which enables the Member States in question to maintain without temporal limitation an exemption from the rule of unisex premiums and benefits, works against the achievement of the objective of equal treatment ... and is incompatible with Articles 21 and 23 of the Charter."*
  - *"That provision must therefore be considered to be invalid upon the expiry of an appropriate transitional period."*
  - ***"Article 5(2) of Council Directive 2004/113/EC ... is invalid with effect from 21 December 2012."***