Guidelines

Insurance and the Human Rights Act 1993

Aratohu

Inihua me te Ture Tika Tangata 1993

Human Rights Commission
Te Kāhui Tika Tangata

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Foreword

Access to insurance is essential for all New Zealanders. It provides security, peace of mind and a safety net in difficult times. If people cannot access insurance, they may struggle to get a mortgage, to travel or to ensure their families are adequately provided for if they fall ill.

The Human Rights Act 1993 seeks to balance the right of people not to be unfairly treated when purchasing insurance with the industry's right to charge premiums commensurate with risk. It does this by making it unlawful for companies to refuse to provide insurance on the grounds on which discrimination is prohibited under the Act. Recognising the significance of sex, age and disability in assessing risk, however, Parliament allowed insurance to be provided on different terms and conditions on these grounds if the difference could be justified by relevant actuarial or statistical data.

Despite the fact that New Zealand has had human rights legislation for almost 30 years there are very few court decisions and therefore little guidance locally on the relationship between insurance and human rights. In 1997 the Human Rights Commission developed guidelines under section 5(2)(e) of the Act[1] on the relationship between the Act and the provision of insurance.

Those first guidelines proved a useful resource, but after 10 years it became clear they needed updating. In 2006, as a result of factors such as an increase in reported mental illness, developments in the area of human genetics and relevant case law from other jurisdictions and — perhaps most importantly — experience of the practical application of the legislation, the Commission decided to review the 1997 guidelines.

In developing the new guidelines the Commission consulted widely and successive drafts were circulated for comment. The guidelines reflect a process which involved collaboration between the Commission, representatives of consumer groups, individuals and the insurance industry. The Commission is grateful to all those who made submissions and shared their experiences and expertise.

A number of matters raised during the consultation process cannot be dealt with by the guidelines. These include a need for greater transparency and communication by the industry and better promotion of the Commission's own complaints process. Some questioned the present law and proposed amendments. The Commission will consider these issues in its broader work programme.

1 Section 5(2)(e) of the Act allows the Commission to prepare guidelines "for the avoidance of acts or practices that may be inconsistent with [the] Act".

The Commission has welcomed a proposal by the insurance industry to establish a group made up of consumer representatives, the insurance industry and the Commission as a way of promoting dialogue and providing a forum for addressing human rights issues as they arise.

These guidelines will help insurers and consumers understand their rights and meet their responsibilities under the Human Rights Act. They will assist in developing best practice throughout the industry so nobody in New Zealand is unlawfully denied insurance.

Rosslyn Noonan
Chief Commissioner
Te Amokapua

How insurance works

Insurance involves pooling contributions or premiums from a group of people and using the resulting pool to pay members of the group who make a claim. The financial impact on individuals is reduced by spreading the loss across the group.

When people apply for insurance the company sets a premium which involves deciding how likely it is that a person will make a claim and how soon that claim is likely to be. Effectively, the company decides what the risk is that the applicant will make a claim against the pooled contributions. To do this, insurers rely on information that people provide such as sex, age, health and family history. The company then makes an assessment of the level of risk using statistics based on worldwide experience. If too many people who are a high risk and too few people who are low risk took out insurance, companies would need to increase premiums to ensure that the amount collected covered the cost of claims.

While most applications for insurance are accepted at standard rates, some applicants have pre-existing conditions which a company cannot cover or terms and conditions are imposed to balance the extra risk. In such cases policies are offered on different terms and conditions and may involve a higher level of premium or cover, or provide cover with an exception clause, or modify the terms of the policy by, for example, limiting or deferring cover until the results of medical tests are available.

Insurance and the Human Rights Act 1993

The Human Rights Act 1993 makes it unlawful to discriminate in certain areas including the provision of goods and services and "facilities by way of insurance". Insurers cannot refuse to provide insurance to people, or treat them less favourably, by reason of any of the prohibited grounds of discrimination in s.21 of the Act.

As insurance is essentially about the classification of risk and some of the grounds in the Human Rights Act are particularly relevant to how risk is classified, the Act includes an exception that allows distinctions on the grounds of sex, disability and age if they are rationally related to insurance underwriting criteria. Insurers can therefore treat applicants differently on the grounds of sex, disability and age if the treatment is based on actuarial or statistical data on which it is reasonable to rely. In the case of disability, if no data is available, the different treatment must be based on reputable actuarial or medical advice or opinion.

The relevant provisions of the Human Rights Act 1993[2]

Section 44 makes it unlawful for an insurer to refuse or fail on demand to provide someone with insurance or to treat them less favourably in the provision of insurance by reason of any of the prohibited grounds of discrimination.

The grounds are found in section 21 and are sex, marital status, religious or ethical belief, colour, race, ethnic or national origin, disability, age (over 16), political opinion, employment status, family status and sexual orientation. Under section 21(2) these grounds apply to a person's past, present or assumed circumstances. For example, it is unlawful to discriminate against someone because they have an infectious illness, had an infectious illness in the past, or are incorrectly assumed to have an infectious illness.

Section 48 allows insurers to provide insurance on different terms and conditions for sex, disability and age if the treatment is based on actuarial or statistical data relating to life expectancy, accidents or sickness which it is reasonable to rely on. If no data is available in relation to disability then insurers can rely on reputable medical or actuarial advice or opinion whether or not it is found in an underwriting manual, provided the application of the data, advice or opinion (together with any other relevant factors) is reasonable in the circumstances. In deciding whether this is so, the Commission can require justification for the data, advice or opinion relied on — and the different treatment that results. It can also seek the views of the Government Actuary on the justification.

Discrimination

When a person is refused a benefit or service because of one of the prohibited grounds and is disadvantaged as a result, this is considered to be direct discrimination.

Discrimination may also be indirect. Indirect discrimination is said to occur when a policy or practice that appears to treat everyone the same includes requirements or conditions that have a detrimental effect on one of the groups protected by the Human Rights Act. Indirect discrimination is addressed in section 65 of the Act and allows a defence of good reason if the person or organisation that is discriminating can show that the requirement or condition is reasonable in the circumstances[3].

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2 The relevant sections are set out in full in Appendix 1. Human rights legislation has been described as having a "special character" not "another ordinary law of general application. It should be recognised for what it is, fundamental law": *Insurance Corp. of British Columbia v Heerspink* [1982] 2 SCR 145,158. An interpretation should therefore be adopted that has the effect of advancing the broad purposes of the legislation rather than a literal or technical one: *Coburn v Human Rights Commission* [1994] 3 NZLR 323 per Thorp J.

3 For practical examples of how the concept of indirect discrimination applies see *Northland Regional Health Authority v Human Rights Commission* [1998] 2 NZLR 218; *Wheen v Real Estate Institutes Licensing Board* (1997) 4 HRNZ; *Vallant Hooker & Partners v Proceedings Commissioner* [2001] 2 NZLR 357

The Guidelines

One of the functions of the Human Rights Commission is to publish guidelines to avoid acts or practices that may be inconsistent with, or contrary to, the Human Rights Act[4]. In 1997 the Commission published guidelines to assist the insurance industry and the public to understand the relationship between the Human Rights Act and insurance. The guidelines did not claim to be exhaustive (for example, they did not address mental disability or genetics) and the Commission indicated that further guidelines would be issued as the need arose.

In 2003 the Commission, together with the New Zealand Society of Actuaries and the Health Funds Association of New Zealand, issued guidelines on the criteria for setting premiums in relation to health insurance[5].

In 2006, as a result of factors such as the rapid advances in the knowledge of human genetics, an increase in reported mental illness, a greater demand for income and mortgage protection insurance and — perhaps most importantly — experience of the practical application of the legislation, the Commission decided that the 1997 guidelines should be updated and some aspects amended.

> The guidelines are not legal advice. They represent the Commission's views on how the Act should be interpreted and provide guidance for the Commission and parties to a complaint when complaints are received by the Commission. Where there is an inconsistency with the legislation, the Act will prevail.

1. INSURANCE CONTRACTS WHICH PREDATE THE INTRODUCTION OF THE HUMAN RIGHTS ACT 1993

1.1 Retrospective application

The Human Rights Act 1993 does not apply retrospectively. This means that terms negotiated when it was legal to discriminate on the grounds of disability and age are not unlawful.

The Human Rights Act 1993 amended and repealed the Human Rights Commission Act 1977. The 1977 Act made it unlawful to discriminate on the grounds of sex, marital status, religious or ethical belief, colour, race and ethnic or national origin.

As with its successor the 1977 Act applied to insurance but the exception was limited to different terms and conditions for sex. Section 24(6) provided an exception which allowed insurance to be provided on different terms and conditions for each sex if the

4 Section 5(2)(e) HRA 1993

5 *Health insurance premiums and the Human Rights Act 1993* can be obtained from the Human Rights Commission. The guidelines were negotiated as a result of the settlement of litigation involving the Human Rights Commission and a number of health insurers. The litigation was commenced following a significant number of complaints relating to an increase in premiums by reason of age.

different treatment was based on actuarial or statistical data and it was reasonable to rely on that data. Although the 1977 Act was repealed in 1993, it may still apply to policies issued between September 1978 (when it came into effect) and January 1994.

The changes to the 1977 Act are still relevant to policies that lapse and are renewed, or varied by mutual consent.

1.2 Terms of insurance contracts

The terms on which insurance policies are offered and accepted apply for the duration of the contract.

Many life insurance contracts are long term contracts which come into existence when the applicant accepts the insurer's proposal. Unlike general insurance, the payment of regular premiums does not constitute renewal of the contract. Once a product is priced the conditions remain the same for the duration of the contract. It follows that a condition which manifests itself or is identified — for example as a result of improved medical testing — after a contract has been entered into will not affect the terms of that contract.

Other forms of insurance may be for a fixed term. In such cases the renewal amounts to a new contract and the terms of the contract must comply with the Act.

1.3 Variation

If the terms of a policy are varied then the variation must comply with the Act.

Many policies are written allowing for changes or additions to the original policy — for example, the right to increase the level of cover on certain terms after a specified time. In such cases the variation does not constitute a new policy. Where a contract does not allow for variation but is varied by mutual consent, then it amounts to a new contract and must comply with the Act.

1.4 Reinstatement

An insurance contract may lapse and need to be reinstated. In some cases reinstatement may amount to a new contract. If the original contract predated the introduction of the Human Rights Act 1993, the new contract will need to comply with the Act.

A contract may provide for reinstatement under certain conditions. If those conditions are met then the contract will be considered not to have lapsed. For example, a contract may allow for reinstatement within a specified period if any missed premiums are paid. However, where a contract has not provided for reinstatement, it will lapse and a new contract will have to be negotiated.

2. NEW CONTRACTS

2.1 Refusal to insure

Insurers cannot refuse to insure people or treat them less favourably by reason of any of the grounds in the Act.

The Act does not permit insurers to refuse insurance but they can offer policies on different terms and conditions in relation to sex[6], disability and age. Insurers often define the scope of the product they are offering by relying on exclusion clauses or restricting coverage of pre-existing conditions on these grounds. It is unlawful to refuse or offer policies on different terms and conditions on any of the other grounds in the Act as they are deemed (for the purposes of the Human Rights Act 1993) to be irrelevant in the provision of insurance.

2.2 Deferral

A decision about the terms on which a policy is offered may be deferred for a reasonable time to quantify and assess the risk. Ideally a decision based on the best evidence available following reasonable enquiries should be able to be made within six months but the time may vary from case to case.

Insurers often defer making a decision about the terms and conditions that will apply to a product if the risk is difficult to quantify at the time the application is made. Deferral is not unlawful, but should not become a substitute for refusal.

Deferral should be for the minimum time necessary for the risk to be quantified and assessed. Depending on the condition, it may be possible to provide cover with a temporary exclusion for the particular condition or restrict the benefit term with an option to reassess after a specific time has elapsed.

Deferring the right to claim for a specified period does not contravene the Act if it is applied uniformly to all applicants. For example, if an insurer provides insurance without requiring evidence of an applicant's health on the understanding that no claim is made for two years, this does not constitute deferral or provision of a policy on different terms and conditions.

Whatever the reason is for the deferment, the process that is followed and the criteria for resolution should be explained to the applicant.

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6 Human rights law is interpreted broadly to ensure it achieves the purpose of the legislation. The definition of sex in the HRA is therefore not limited to just biological differences but includes gender identity.

2.3 Cost of assessment

The cost of assessment of high risk applications could be offset by a higher loading initially which may be reduced when information about the actual risk becomes available. Alternatively, the fee could be waived if the information would be of benefit to the company in assessing future claims.

Researching and assessing high risk applications can be costly. Many applicants who pose a high risk do not proceed when the application is finally assessed and they are advised of the cost of the insurance. If the applicant does not proceed the cost of the assessment is likely to be borne by the wider pool of people insured.

Some of the information obtained in assessing such applications increases the insurer's understanding of a condition and can be useful in assessing similar applications. Insurers therefore need to distinguish between costs that increase its general understanding and can be reasonably borne by the wider insurance pool and the costs attributable to assessing individual risk. Some judgement will be needed in attributing costs but individuals should not have to meet the costs attributable to a wider understanding of a condition. While it is permissible to charge for an assessment, the cost should not be at a level that effectively acts as a deterrent and could be perceived as a refusal to insure.

3. STRUCTURE OF THE CONTRACT

3.1 Wording of proposal forms

It is not unlawful for proposal forms to include questions that appear to infringe the Human Rights Act 1993.

The Human Rights Act 1993 is neutral on the issue of questions in a proposal form. Some provisions in the Act, for example those that apply to job advertisements, prohibit the use of language that could be reasonably taken as indicating an intention to discriminate[7].

While it is not unlawful to include questions relating to characteristics that relate to the prohibited grounds in questionnaires provided to insurance applicants[8], care should be taken to comply with the Act. Insurance companies need to be aware that a particular pattern of questioning may indicate an intention to discriminate.

3.2 Blanket exclusion clauses[9]

Policies that are designed with exclusion clauses that apply to all policy holders are not unlawful.

Blanket exclusion clauses are a way of defining cover, clarifying what a policy does (and

7 s.23 HRA 1993
8 *Lombardo v Tower Life Insurance* (2000) EOC 93-088
9 The term is used here to refer to an exception that applies to all policy holders.

does not) cover and alerting potential applicants to what they are buying. Policies with blanket exclusion clauses are not unlawful because everyone is treated the same. The policies apply equally to all applicants when they are issued and as all policy holders are in the same position — they all run the risk of developing an excluded condition in the future — no one is treated unfavourably.

As policies with blanket exclusions are offered with little or no underwriting, they are less expensive and therefore an affordable option for applicants who may find it difficult to obtain reasonably priced insurance otherwise. Blanket exclusions are a necessary trade-off for reasonable cover. If it were not possible for insurers to design products with exclusion clauses then many products would be withdrawn from the market because it would no longer be viable for insurers to offer them. Ideally, insurers should be able to demonstrate that claims experience for a particular condition has a material effect on premium costs and could lead to premiums becoming unaffordable for the consumer.

If certain conditions or eventualities are not covered, as a matter of best practice this should be made clear to consumers — before they take out the policy — so they are aware of the scope of cover.

3.3 Pre-existing conditions

While excluding cover for conditions that people have when they apply for insurance is a legitimate practice[10], whether a condition is designated as pre-existing should take into account individual circumstances.

As the purpose of insurance is to protect against future events, insurance policies often do not provide cover for conditions which an applicant has at the time they purchase insurance. The ability to exclude pre-existing conditions is a necessary tool for the insurer to limit adverse selection[11] and provide cover at a reasonable cost.

The exclusion of pre-existing conditions can be justified legally because there is no refusal to insure. Insurance is provided, but on terms which exclude conditions that already exist — effectively distinguishing between people who have a condition at the time the contract is taken out and those who develop a condition after the insurance has been purchased. Although some conditions may be excluded a person still gets value from the contract because it provides cover for conditions other than those which are excluded.

Not all conditions or illnesses that a person has suffered from in the past will qualify as

10 *QBE Travel Insurance v Bassanelli* [2004] FCA 396 at para [19]; (2004) 137 FCR 88

11 Adverse selection is used to describe the situation when a person takes out insurance knowing they have a particular condition or there is a strong possibility they will develop that condition. The insurer cannot charge a premium that reflects the full risk because they don't have the necessary information. Should this occur too often it will adversely affect other policyholders because premiums will increase overall. See *Xiros v Fortis Life Assurance Ltd* [2001] FMCA 15

a pre-existing condition and a decision to exclude a pre-existing condition should take into account information about an individual's particular circumstances[12]. Many medical conditions — and consequently the probability of a claim — can vary greatly depending on individual circumstances. Decisions about exemptions should involve consideration of information or data that is current, relevant and from a source which it is reasonable to rely on. For example, the fact that an applicant is currently well, with or without treatment, or the extent to which a person's past history indicates the likelihood of a condition recurring, should be taken into account.

As the extent of the cover is linked to a pre-existing condition, any exclusion should be as specific as possible. Furthermore any link between the condition itself and any other condition that the insurer seeks to exclude as a result will need to be justified under s. 48. In other words, it will be necessary for an insurer to establish that it is reasonable to exclude the other condition by reference to applicable data and other relevant factors.

4. THE SECTION 48 EXCEPTION

Section 48 applies where a person alleges they have been treated less favourably in the provision of insurance[13]. It permits different treatment on the grounds of sex, disability or age if the treatment is based on actuarial or statistical data. Where no such data exists in relation to disability the section allows the use of medical or actuarial advice or opinion — even if it is not found in underwriting manuals — as well as other "relevant factors" to be taken into consideration provided the use is reasonable in the "particular circumstances". This means that insurers can take into account a variety of material that they have traditionally relied on in calculating premiums.

4.1 "Reasonableness"[14]

In deciding whether treatment is reasonable, the information or data relied on should be relevant to the individual applicant. Insurers should be prepared to explain the basis for their decision.

At times it can be difficult to decide whether the data or advice provided to justify different treatment is reasonable both substantively and in how it is applied.

There is no relevant case law locally but similar issues have been considered by the courts in other countries, most recently by the Federal Court of Australia in the case

12 See *Bassanelli* (supra fn 10)at para [85]
13 S.44(1)(b) HRA 1993
14 The guidance note by the New Zealand Society of Actuaries (attached as Appendix 3) may be of use. The note is not mandatory but an actuary will be expected to have considered it even if she or he comes to a different conclusion.

of *QBE Travel Insurance v Bassanelli*[15]. Bassanelli establishes that reasonableness is an objective test and that it is not acceptable for an insurer to simply assert that actuarial or statistical data is reasonable and justifies an exception. The insurer must establish that the data or advice is reasonable in relation to the circumstances of the individual applying for insurance[16]. In Canada, in *Zurich Insurance Co. v Ontario (Human Rights Comm.)*[17], the Supreme Court added an extra qualification to the reasonableness test holding that a discriminatory insurance practice will be reasonable if it is based on a sound and accepted insurance practice and there is no practical alternative.

Section 48(1) consists of two parts:

1. Under section 48(1)(a)(i)(ii) it is not unlawful to provide insurance on different terms and conditions if the different treatment is based on certain types of data and the decision maker has relied on that information in reaching its decision. It therefore focuses on the decision making of the insurance company.
2. Section 48(1)(b) then directs the inquiry to the reasonableness of the insurance company in relying on the data in those circumstances. This is an objective test and it is not solely up to the insurer to assert it has been met[18]. The reasons given and the material provided by the insurer will be considered but whether it is reasonable will be a matter to be decided by balancing the views of the applicant and the insurer.

It will not always be possible to identify exact data in all cases. For example, the data may not relate to local conditions. Generally the use of generic data will be reasonable but as a general principle an effort should be made to tailor decisions to individual cases and conditions. Insurers should be prepared to explain why they have arrived at certain decisions and acknowledge any limitations of the data on which decisions are based.

4.2 Medical advice or opinion

The advice or opinion must be relevant to the applicant's disability. It should include information provided by the person's medical practitioner with their consent. In situations where the condition may potentially be subject to dispute, such as mental illness or back pain, it may be appropriate to seek the advice of a specialist.

15 [2004] FCA 396; (2004) 137 FCR 88. Ms Bassanelli had breast cancer. She applied for travel insurance but did not seek cover for any event arising from the cancer. Her application was refused. The company claimed that it was not economically viable to provide her with cover as they had been subject to a number of high cost claims in the past where it had been difficult to distinguish between the claimant's medical condition and the conditions they suffered while travelling. Ms Bassanelli obtained insurance from another insurer and challenged QBE's refusal. At first instance the Federal Magistrate concluded that the discrimination was not reasonable, the company appealed but the appeal was dismissed.

16 See also *Waters v Public Transport Corporation* (1991)173 CLR 349 and *Xiros v Fortis Life Assurance Ltd* [2001] FMCA 15

17 [1992] 2 S.C.R 321

18 This view is supported by the s.48(2)(b) which allows the Commission to request the views of the Government Actuary if necessary.

Where there is no actuarial or statistical data available in relation to disability, an insurer can rely on reputable medical advice or opinion to justify different treatment — provided it is reasonable in the particular circumstances. Ideally the medical advice or opinion should be provided by a doctor who has experience or training in the relevant area and is aware of advances in treatment.

Not all medical practitioners will have the necessary skills to assess the risks relevant to long term products such as life insurance. At times an insurer may need to seek a second opinion from an expert or experienced medical practitioner on the information provided. Whether this is necessary will depend on the existence of relevant data and how common a condition is.

4.3 Other relevant factors

The 'other relevant factors' referred to in s.48(1)(a)(b) must be linked to the data, advice or opinion used to justify different treatment in particular circumstances.

In addition to statistical or actuarial data or medical advice or opinion, different treatment can be justified by 'other relevant factors'. The treatment must be reasonable given the data plus any other relevant factors. Whether factors are relevant is an objective decision but "any matter which is rationally capable of bearing upon whether the discrimination is reasonable could fall within the umbrella of relevance"[19].

It has been suggested that other relevant factors should include commercial concerns since, if a company's commercial viability is threatened by having to write unprofitable business, this could lead to an increase in costs across the board and disadvantage consumers generally. However, the reference to particular circumstances suggests a link to individual cases. This is not to say that commercial considerations will never be relevant but they must relate to the facts of a particular case. Applications should be analysed on a case by case basis to establish whether the factors are relevant to that particular situation.

5. SPECIFIC ISSUES

5.1 Mental Disability

Cover should be available for mental disability on the same terms and conditions as other forms of disability. Where insurers rely on an exception for mental disability then the exception will need to be justified in the same way as for other disabilities.

One of the issues raised during the consultation process was the difficulty in defining mental disability with any precision. A number of insurers have said that inaccurate diagnoses — often by GPs — have significantly increased their financial risk and they therefore rely on exclusion clauses as a way of limiting those risks.

19 *Bassanelli* supra fn 10 at para 53

While mental illness cannot be measured in the same way as physical disability, it does not follow that it is impossible to quantify the risk. Underwriters should assess mental illness in the same way as physical disability, using reputable medical, psychiatric and actuarial advice as guidance. All cases should be assessed on an individual basis taking into account information such as the treatment and who treated the applicant. While some people will have psychiatric conditions which will mean that they pose a greater risk of a claim, an increased premium or imposition of an exclusion clause should be justified and applied in the same way — and to the same standard — as for a physical disability[20].

5.2 Use of genetic information

Insurance companies can request applicants to disclose the results of any genetic tests but cannot require them to undergo genetic testing.

The present moratorium voluntarily agreed to by insurers allows them to request the results of any genetic tests that an applicant has taken but they cannot require the applicant to undergo a test. This recognises the need for insurers to have access to the same information about an applicant's health status as the applicant themselves.

Genetic information and its relationship to insurance has been — and continues to be — the subject of considerable debate worldwide. In New Zealand most people consider the current situation to be satisfactory but a number of industry representatives and some consumer groups consider the moratorium is vulnerable because of its voluntary status and it should be made mandatory. This would require a change in the law. In countries where there is legislative prohibition forbidding insurers from seeking genetic information or prohibiting genetic testing generally[21] it has raised some problems, including confusion in the definition of what constitutes genetic information and what a genetic test is. While the moratorium is effective in New Zealand there is an opportunity to monitor overseas developments and best practice internationally and to promote debate within New Zealand about future options.

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20 Recognising the difficulties in underwriting mental health conditions, the Australian Investment and Financial Services Association Ltd (IFSA) has drafted a guidance note with representatives from the mental health sector (including consumer representatives) on underwriting mental health conditions. The note suggests ways of addressing conflicting or inappropriate diagnoses and when it may be appropriate to exclude or defer cover, or charge a higher premium: *Underwriting Guidelines for Mental Health Conditions: IFSA Guidance Notes Nos. 14 & 15 (2003)*

21 For example, Israel, Genetic Information Law 5761-2000; Denmark, Insurance Contracts Act 1998; Austria, Federal Law of 1994: Regulating Work with Genetically Modified Organisms, the Release and Marketing of Genetically Modified Organisms and the Use of Genetic Testing and Gene Therapy in Humans.

5.3 Group insurance

An insurer offering a group policy is only responsible for the product it provides not any discrimination by an employer in the way the policy is offered.

Employers often provide insurance as part of an employment package. Such products are offered with little or no underwriting, the insurer providing cover up to a certain limit without requiring any medical evidence from employees. The rationale behind such schemes is that those insured represent a low risk (as they are healthy enough to be employed) and the schemes themselves are large enough to spread the risk.

Section 22 of the Human Rights Act 1993 makes it unlawful for an employer to offer or afford an employee less favourable terms of employment (including fringe benefits) by reason of any of the grounds of prohibited discrimination. There will be situations where the manner in which a policy is offered impacts on the terms of employment. For example, health insurance offered as part of an employment package that ceases at 65. Such decisions are employment — rather than insurance — related and an insurance company is not responsible for the less favourable terms and conditions that result. If the product is offered to all employees, regardless of their age, the cost of the subsidy may need to be capped or benefits restricted as people get older — in which case the treatment would need to be justified under s.48.

However, if an insurer restricts eligibility for membership, or the extent to which cover and benefits are provided under a scheme, by reference to a person's disability, for example, then they will be responsible for the resulting discrimination unless it can be justified under s.48.

6. REINSURANCE

Reinsurers are exempt from the Human Rights Act as the service they offer is to insurance companies, not to individuals.

Reinsurers provide services to insurance companies, not to the public. As a result, reinsurers are exempt from the application of s. 44 of the Human Rights Act.

Furthermore, as all the reinsurers that New Zealand insurers contract with are based offshore there are jurisdictional issues. The requirement to always offer cover does not apply in international markets. At times New Zealand insurers have to offer cover to individuals even though they are unable to obtain reinsurance.

Appendix 1

Relevant Sections of the Human Rights Act 1993

Section 21: Prohibited grounds of discrimination

(1) For the purposes of this Act, the prohibited grounds of discrimination are-
- (a) sex, which includes pregnancy and childbirth:
- (b) marital status, which means being—
  - (i) single; or
  - (ii) married, in a civil union, in a de facto relationship; or
  - (iii) the surviving spouse of a marriage or the surviving partner of a civil union or de facto relationship; or
  - (iv) separated from a spouse or civil union partner; or
  - (v) a party to a marriage or civil union that is now dissolved, or to a de facto relationship that is now ended:
- (c) religious belief:
- (d) ethical belief, which means the lack of a religious belief, whether in respect of a particular religion or religions or all religions:
- (e) colour:
- (f) race:
- (g) ethnic or national origins, which includes nationality or citizenship:
- (h) disability, which means—
  - (i) physical disability or impairment:
  - (ii) physical illness:
  - (iii) psychiatric illness:
  - (iv) intellectual or psychological disability or impairment:
  - (v) any other loss or abnormality of psychological, physiological, or anatomical structure or function:
  - (vi) reliance on a guide dog, wheelchair, or other remedial means:
  - (vii) the presence in the body of organisms capable of causing illness:
- (i) age, which means, —
  - (i) for the purposes of sections 22 to 41 and section 70 and in relation to any different treatment based on age that occurs in the period beginning with the 1st day of February 1994 and ending with the close of the 31st day of January 1999, any age commencing with the age of 16 years and ending with the date on which persons of the age of the person whose age is in issue qualify for national superannuation under section 7 of the New Zealand Superannuation or Retirement Income Act 2001 (irrespective of whether or not the particular person qualifies for national superannuation at that age or any other age):
  - (ii) for the purposes of section 22 to 41 and section 70 and in relation to any different treatment based on age that occurs on or after the 1 February 1999, any age commencing with the age of 16 years:

(iii) for the purposes of any other provision of Part 2, any age commencing with the age of 16 years:

(j) political opinion, which includes the lack of a particular political opinion or any political opinion:

(k) employment status, which means—

(i) being unemployed; or

(ii) being a recipient of a benefit or compensation under the Social Security Act 1964 or an entitlement under the Injury Prevention, Rehabilitation, and Compensation Act 2001:

(l) family status, which means—

(i) having the responsibility for part-time care or full-time care of children or other dependants; or

(ii) having no responsibility for the care of children or other dependants; or

(iii) being married to, or being in a civil union or de facto relationship with a particular person; or

(iv) being a relative of a particular person:

(m) sexual orientation, which means a heterosexual, homosexual, lesbian, or bisexual orientation.

(2) Each of the grounds specified in subsection (1) of this section is a prohibited ground of discrimination, for the purposes of this Act, if—

(a) it pertains to a person or to a relative or associate of a person; and

(b) it either—

(i) currently exists or has in the past existed; or

(ii) is suspected or assumed or believed to exist or to have existed by the person alleged to have discriminated.

Section 44: Provision of goods and services

(1) It shall be unlawful for any person who supplies goods, facilities, or services to the public or to any section of the public—

(a) to refuse or fail on demand to provide any other person with those goods, facilities, or services; or

(b) to treat any other person less favourably in connection with the provision of those goods, facilities, or services than would otherwise be the case, —

by reason of any of the prohibited grounds of discrimination.

(2) For the purposes of subsection (1) of this section, but without limiting the meaning of the terms "goods", "facilities", and "services" in that subsection, the terms "facilities" includes facilities by way of banking or insurance or for grants, loans, credit, or finance.

(3) Where any club, or any branch or affiliate of any club, that grants privileges to

members of any other club, branch, or affiliate refuses or fails on demand to provide those privileges to any of those members, or treats any of those members less favourably in connection with the provision of those privileges than would otherwise be the case, by reason of any of the prohibited grounds of discrimination, that club, branch, or affiliate shall be deemed to have committed a breach of this section.

(4) Subject to subsection (3) of this section, nothing in this section shall apply to access to membership of a club or to the provision of services or facilities to members of a club.

Section 48: Exception in relation to insurance

(1) It shall not be a breach of section 44 of this Act 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.

(2) In assessing, for the purposes of this section, whether it is reasonable to rely on any data or advice or opinion, and whether different treatment is reasonable, the Commission or the Complaints Division may—
   (a) require justification to be provided for reliance on the data or advice or opinion and for the different treatment; and
   (b) request the views of the Government Actuary on the justification for the reliance and for the different treatment.

Section 65: Indirect discrimination

Where any conduct, practice, requirement, or condition that is not apparently in contravention of any provision of this Part of this Act has the effect of treating a person or group of persons differently on one of the prohibited grounds of discrimination in a situation where such treatment would be unlawful under any provision of this Part of this Act other than this section, that conduct, practice, condition or requirement shall be unlawful under that provision unless the person whose conduct or practice is in issue, or who imposes the condition or requirement, establishes good reason for it.

Appendix 2
Complaints Processes

HUMAN RIGHTS COMMISSION PROCESS
The Human Rights Amendment Act 2001 introduced a new system to resolve complaints of unlawful discrimination.

Under the previous system a person was required to make a written complaint to the Human Rights Commission. The Commission would then investigate the complaint and make a decision about whether it had 'substance' in terms of the Act.

The new process is closely modelled on the disputes resolution process set out in the *Employment Relations Act 2000*. The goal is to resolve complaints in a timely, informal and cost effective manner. The service is free, confidential and impartial. People do not have to submit a complaint in writing, although a written account may be useful if the issue is complex or long-running. Legal representation is not required, as the process is kept as informal as possible. Commission representatives facilitate mediation meetings and provide parties with necessary information about the Human Rights Act. Commission mediators are neutral and do not represent either party.

Settlements can include an apology, a reference, an undertaking to not discriminate in future, participation in training programmes and compensation, among other things.

If mediation is unsuccessful, the complainant can take the complaint to the Director of Human Rights Proceedings. The Director is independent of the Commission and can appear on the complainant's behalf before the Human Rights Review Tribunal, which can make a legally binding decision.

Human Rights Commission InfoLine
0800 496 877 (toll free) / TTY (teletypewriter): 0800 150 111
Email: infoline@hrc.co.nz

INSURANCE AND SAVINGS OMBUDSMAN
The ISO deals with complaints about personal insurance and savings products provided within New Zealand by participating companies in the ISO Scheme, including:

- fire and general insurance
- health insurance
- life insurance
- savings schemes

The ISO can consider a complaint about a company if it relates to:

- house, contents, vehicle, travel, health, income protection, mortgage protection, critical illness, life insurance and superannuation
- claims not in excess of $150,000, or $1,000.00 per week for a disability benefit (unless by agreement with the company)

- policy interpretation
- claims made by, or on behalf of, the policy holder
- the amount payable under a claim
- small business claims

However, the ISO cannot consider complaints about:

- awards of compensation or damages
- commercial or business insurance, except small business claims
- third party or uninsured losses
- premiums, charges, excesses, returns, underwriting decisions
- financial advisers and brokers
- complaints which are, or have been, the subject of proceedings in another forum e.g. a decision has already been made in the courts

The ISO can only consider complaints against companies which are participants of the ISO Scheme.

For more information go to the ISO website: www.iombudsman.org.nz or write to Office of the ISO, PO Box 10-845, Wellington

If the ISO is unable to help you, please refer to the following list of useful contacts and links:

INDUSTRY ASSOCIATIONS

The Insurance Brokers Association of New Zealand
P O Box 7053, Auckland,
Telephone: (09) 306 1734

Institute of Financial Advisers
www.ifa.org.nz

Life Brokers Association
www.lba.org.nz

CONSUMER HELP:

Citizens Advice Bureau
www.cab.org.nz

Consumers' Institute
www.consumer.org.nz

Legal Services Agency - Community Law Centres
www.lawaccess.lsa.govt.nz/law_centres.aspx

GOVERNMENT AGENCIES:

Accident Compensation Corporation (ACC)
www.acc.co.nz

Commerce Commission
www.comcom.govt.nz

Ministry of Consumer Affairs
www.consumer-ministry.govt.nz

Retirement Commissioner
www.retirement.org.nz
www.sorted.org.nz

Securities Commission
www.sec-com.govt.nz

INSURANCE INDUSTRY LINKS:

Australasian Institute of Chartered Loss Adjusters
Enquiries about loss adjusters in New Zealand and Australia
www.aicla.org

Australian & New Zealand Institute of Insurance & Finance
Enquiries about insurance industry professional qualifications and continuing education
www.theinstitute.com.au

Earthquake Commission
Enquiries about claims including earthquake, landslip and flood damage to land
www.eqc.govt.nz

Health Funds Association of New Zealand Inc.
Enquiries about health insurance
www.healthfunds.org.nz

Insurance Council of New Zealand
Enquiries relating to fire and general insurance
www.icnz.org.nz

Investment Savings and Insurance Association of NZ Inc.
Enquiries about life insurance, superannuation and managed funds
www.isi.org.nz

OTHER DISPUTE RESOLUTION SERVICES:

Banking Ombudsman
www.bankombudsman.org.nz

Disputes Tribunal
www.courts.govt.nz/tribunals/disputes_tribunals.html

Parliamentary Ombudsmen
www.ombudsmen.govt.nz

Privacy Commissioner
www.privacy.org.nz

OVERSEAS INSURANCE OMBUDSMAN SCHEMES:

Australian and New Zealand Ombudsman Association
www.anzoa.com.au

Insurance Ombudsman Service Limited — Australia
www.insuranceombudsman.com.au

Financial Industry Complaints Services Limited — Australia
www.fics.asn.au

Financial Services Ombudsman — UK
www.financial-ombudsman.org.uk

Appendix 3

New Zealand Society of Actuaries Guidance Note No.3

The Human Rights Act 1993

Paragraphs in italics are included to clarify interpretation but do not form part of the Guidance Note.

Scope and Purpose

This Guidance Note sets out considerations that bear on the actuary's professional work in providing advice or reports in relation to the exceptions allowed under the Human Rights Act 1993 ("the Act") for either Insurance or Superannuation Schemes.

Such advice may be required when launching new products, revising the terms of existing products, or in the rating of individual cases.

The Guidance Note was first issued in April 1997 and modified in August 2002. It is a Guidance Note rather than a Professional Standard as the Act is relatively recent and experience with it, its scope, and implications, along with case law, is slowly emerging.

Actuaries must take appropriate steps to satisfy themselves that the particular situations on which they are advising or reporting are covered by the exceptions specified in the Act.

If in doubt, the actuary should either seek to clarify the situation or qualify his or her advice, opinion or report accordingly.

Background

The Act prohibits discrimination on the grounds of sex, marital status, religious or ethical belief, colour, race, ethnic or national origin, disability, age, political opinion, employment or family status and sexual orientation in employment and in the provision of goods and services.

Section 65 covers indirect discrimination and prohibits any conduct, practice, requirement or condition that although not apparently in contravention of any other provision of the Act has the effect of treating any person or group of persons differently on one of the prohibited grounds unless good reason is established for it.

Sections 48 and 70 provide certain exceptions in relation to insurance and superannuation schemes respectively for discrimination on the grounds of sex, age, or disability:

Different terms or conditions may apply on the grounds of sex, age or disability if the different treatment is based on actuarial or statistical data upon which it is reasonable to rely, relating to life-expectancy, accidents, or sickness.

In the case of individuals who have a disability where no such data is available different terms or conditions may apply if the different treatment is based on reputable medical or actuarial advice or opinion, upon which it is reasonable to rely, whether or not contained in an underwriting manual.

In both cases the different treatment must be reasonable having regard to the applicability of the data or advice or opinion, and of any other relevant factors, to the particular circumstances.

Guidance

This guideline is to assist actuaries in providing advice concerning the justification for exceptions under sections 48 and 70 of the Act. In this context those that the actuary is advising may include:- the actuary's employer, a consulting client, a party justifying a difference in treatment, a party opposing a difference in treatment, the Human Rights Commission, or as an impartial expert witness.

When providing advice in relation to the Act, actuaries should take steps to ensure they are familiar with the legislation, the guidelines issued by the Human Rights Commission and case law as it develops.

There are two situations where the Act permits exceptions relating to actuarial data or opinion. These are set out below along with a discussion of the likely issues involved in a justification for exception.

(a) Different treatment based on actuarial or statistical data, upon which it is reasonable to rely, relating to life-expectancy, accidents, or sickness

The actuary should be prepared to justify his or her reliance on, and the relevance of, the data to the Human Rights Commission or in Court. The justification may be examined by the Government Actuary under the Act or an actuary acting for another party.

Justification may be required for both whether there should be a difference in treatment at all, and for the extent of any difference in treatment.

Justification should comprise both quantitative and qualitative aspects.

In setting out quantitative arguments the actuary should pay regard to relevant local experience as well as published tables and overseas experience.

The actuary should be aware, particularly in the case of disability, that not only is experience in certain areas changing rapidly but that local data collection and analysis is increasing both in quantity and quality. In any particular case the actuary can be expected to justify why available local statistics were or were not taken into account.

The actuary should have regard to the credibility of the data being used both in a statistical and in a qualitative sense. In particular the actuary should be able to quote the source of the data or table and have appropriate regard to:-

(i) the composition of the group giving rise to the data
(ii) the period to which the data relates
(iii) any qualifications on the collection or analysis of the data
(iv) the size of the data sample
(v) the construction methods employed in deriving smoothed rates from data
(vi) any projections used in the table construction

Justification should be provided as to why the actuary considers it to be reasonable to apply particular statistics or tables to a group other than that included in the underlying experience of those statistics or tables if that is the case.

For example:
(i) an actuary may use relationships between population and insured life tables in order to draw reasonable conclusions about insured lives experience at older ages;
(ii) qualitative arguments may also be required to justify the application of overseas experience to New Zealand.

Credible local, office or scheme experience or particular circumstances may be used either in their own right or to adjust published statistics or tables if the use of such data can be reasonably justified. The actuary may also wish to take account of trends in the data.

(b) Where no such data is available, different treatment may be made in respect of persons with a disability based on reputable medical or actuarial advice or opinion, upon which it is reasonable to rely, whether or not contained in an underwriting manual.

Actuaries providing advice or opinion on which others may rely for the purposes of this part of the Act may be asked to justify their advice and opinion in a similar manner to that outlined in (a).

Actuaries relying on such advice or opinion should take such steps as necessary to satisfy themselves that data as outlined in (a) is not available and should ensure, as far as possible, that the provider of such advice or opinion understands the purpose for which the advice is sought and that it may be relied on for the purpose of obtaining an exception under the Act.

Actuaries should take such steps as necessary to ensure that they are satisfied that it is reasonable for them to rely on such advice or opinion for the purposes of the Act.

If reliance is placed on information contained in underwriting manuals, care should be taken to establish that the information is up to date and can be demonstrated to be reasonable, and also whether adjustments are required to take account of local conditions and experience.

In justifying a difference in treatment, and thus an exception under the Act, it is up to the actuary to use his or her professional experience and judgement. Any justification must be documented.

It is possible that opinions on another actuary's work in this area may be required from time to time. Paragraph 16 of the Professional Code of Conduct should be adhered to in such cases.

Human Rights
Commission
Te Kāhui Tika Tangata

New Zealand Human Rights Commission,
PO 6751,Wellesley St, Auckland, New Zealand 1141
www.hrc.co.nz


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