

LIFE INSURANCE AND HEPATITIS C IN AUSTRALIA

Introduction

IFSA is the national not-for-profit organisation representing the life insurance industry to Government, regulatory agencies, consumers and the community.

This fact sheet explains how life insurance works in Australia and includes information on the implications of being hepatitis C positive for future applications you may make for Life, Disability or Trauma Insurance.

Who has life insurance?

The life insurance industry in Australia has operated for over 120 years, providing financial security for individuals and families.

Currently about 6.3 million Australians are protected by individual life, disability and trauma policies. Australians purchase life insurance because it provides an affordable way of collectively sharing the financial burden due to unexpected death, disablement or sickness that are too great for them to bear as individuals. Each of these unexpected events, if not covered by some form of insurance, could cause severe financial hardship, the depletion of savings, and ultimately reliance on the government's social security safety net. A survey of 15 life insurers in 2003 showed that over \$1.2 billion is paid out in claims each year.

How does life insurance work?

A life insurance policy is a contract that sets out the responsibilities of the life insurance company and the person who is taking out the insurance. The consumer, known as the insured, agrees to pay premium/s, and the insurance company agrees to pay out an agreed amount/s in the event of a certain event/s occurring. Please refer to the Glossary for the details of the types of products available.

In Australia, life insurance is voluntary. People choose whether or not to purchase life insurance and how much to insure for. The main exception to this relates to members of some superannuation funds who automatically obtain life insurance via group life insurance while they are working and a member of the fund.

All premiums are paid into a 'risk-sharing' pool. Claims are paid from that pool.

Under the law it is the duty of the life insurance company to give potential customers all necessary details about the products you may wish to purchase. In turn it is your responsibility to provide the life insurer with all information about you that may affect the risk you are asking them to accept.

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How does my age and health affect the cost of my insurance?

When you apply for insurance, the insurance company may ask you to complete an application form and medical questionnaire. The medical questionnaire asks for details about your personal medical history, as well as information about any disease or disorders that are likely to increase the probability of a claim. It also asks basic questions about your family medical history as this can indicate whether you may be at an increased risk of developing a hereditary disease.

- Age is one of the main factors used to determine how likely it is that you will make a claim. For example, older people are generally at a higher risk of death than younger people. Within any age group, the probability of claiming may be greater for some applicants than for others.
- Gender (women tend to live longer than men), smoker status and occupation are factors that also affect the chances that you will make a claim.
- Personal medical history (past and current) as well as family history are also important.

The insurance company takes into account all the information on your application form and medical questionnaire to assess your likelihood of making a claim.

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The process of assessing the risk of the insured making a claim is known as underwriting. The purpose of underwriting is to ensure that the cost of insurance is proportional to the risk involved, and that people with the same or similar risk pay the same premium rates. Underwriting relies on the extensive use of statistical data and actuarial estimates.

Unlike car or house insurance, once a life insurance policy has been issued, the insurance company cannot cancel or increase the price of just your policy because of deterioration in your health. Insurance companies only get one chance to fully assess the risk – that is why so much emphasis is placed on assessing your risk at the beginning of the policy. Generally in Australia premium rates are not guaranteed and a life insurance company can increase or decrease the premium rates applying to all policies of a particular class.

In Australia, approximately 93 per cent of all applicants for life insurance obtain policies at standard prices. A further 5 per cent are classified as having additional risk, and therefore may pay either higher premiums or have some conditions excluded from their policy. The 2 per cent who are refused cover have serious health impairments, extremely hazardous jobs, or other high-risk factors.

To insure someone who is already quite ill or knows they have a terminal illness would be equivalent to selling home insurance to someone whose house is already on fire. The cost of paying their claim would inequitably fall on the rest of the people in the pool, without the ill person having contributed their fair share to the pool.

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

Life insurance is very competitive, so it is advisable to shop around for the best price. If one company declines to offer you insurance, another company may be willing to grant cover.

Insurer's decision on underwriting

The terms your life insurer may offer you can vary, and may include:

- Standard premium rates
- Increase the standard premium rate by either a percentage or a flat dollar amount
- A shorter period for the insurance contract
- An exclusion for one or more medical conditions
- Offer for an alternate product

In a small number of cases, however, the insurance company may decide it is unable to offer cover at all.

When a policy has been issued, any subsequent changes in your health will not impact on the coverage or the price you pay for your existing insurance contract whilst it remains in force.

The Insurance Contracts Act 1984 provides legislative protection to you as a policy owner. If any application for insurance is declined, or accepted at higher than standard premium rates, the

Act states that you are entitled to be given an explanation of the decision either directly or through your doctor.

Universal Cover – What would it cost?

It is sometimes suggested that life insurance companies should provide universal insurance coverage. Under this arrangement, insurance coverage would be made available to all persons who seek it, regardless of their age or health. It is also sometimes suggested that everyone should pay the same price, regardless of health.

Under a voluntary system of universal coverage (where individuals decide whether to have the insurance or not), healthier people will be less inclined to purchase this insurance. This is because in effect, their premiums would be helping cover the claims of those people with a higher likelihood of claiming. Premium costs would then increase over time as the proportion of healthier people insured reduces.

Depending on the degree of 'anti-selection' experiences, average premiums would have to rise as high as \$382 per annum in order to provide \$100,000 of life cover. Compare this to the average premium of about \$255 per annum per policy and you will see that the proposed premium is 50% higher.

What about my privacy?

Life Insurance companies treat hepatitis C test results with the same level of care and confidentiality as any other medical information about you.

When applying for insurance as part of your medical history any details or knowledge about your health should be disclosed and this includes hepatitis C. The life insurance industry has a long-standing tradition of safeguarding the privacy of its customers and their medical information, which is reflected by the lack of complaints against life insurance companies for breaches of privacy.

An individual's right to privacy has been reinforced with the introduction of national privacy legislation – the Privacy Amendment Act (Private Sector) 2000 – which sets down 10 National Privacy Principles. These Principles came into effect on 21 December 2001 and regulate the collection, handling, use, disclosure, transfer and management of 'personal information', which includes medical information.

This legislation, supported by the life insurance industry, provides the added protection for consumers in respect of their own personal information across all industries and provides an additional avenue to lodge a complaint. For more information on privacy, visit the Privacy Commissioner's website at www.privacy.gov.au.

How does hepatitis C influence health?

Many people with hepatitis C are completely well and unaware of any infection. Other people have symptoms including tiredness, fatigue or depression. These symptoms may interfere with their life style and capacity to work.

With advancements in medical knowledge and treatment, the prognosis or outcome following hepatitis C infection has improved considerably. About 25%¹ of those infected clear the

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infection (virus) at the time of the initial attack. The hepatitis C virus can be eradicated in up to 65%² of patients, using antiviral therapy.

Untreated, a small percentage (less than 7%) will go onto to develop cirrhosis of the liver over 20-30 years. In this group there is an additional small risk of hepatocellular cancer. Of those who go onto cirrhosis the exact natural history and expected survival is still not fully understood.

For additional information on hepatitis C contact the Australian Hepatitis Council - phone 02 6232 4257.

What is the test for hepatitis C?

There are basically two diagnostic blood tests for hepatitis C, complemented by liver function tests.

An antibody test of blood became available in Australia in 1990. If confirmed positive, the result indicates exposure to hepatitis C virus. The presence of the antibody only confirms an infection has occurred, not whether it has past, or if the hepatitis C virus is active or resolved. A confirmed positive antibody test will remain positive forever.

A PCR (polymerase chain reaction) test can determine if someone has hepatitis C virus or just antibodies from a past infection. The PCR test looks for the actual virus (hepatitis C RNA) in the blood, as opposed to the antibodies. A positive PCR indicates the virus is still present.

A negative PCR test indicates the virus is no longer present, or at least not present in sufficient quantities to cause future concern, due to spontaneous clearance or antiviral treatment. Two negative PCR results, 6-12 months apart, are required to confirm this result. This is because as viral levels can fluctuate, the second test is needed to confirm the initial negative test did not coincide with a very low titre (level) of virus.

Liver function tests, in particular the ALT (aminotransferase) enzyme, are used as an indication of liver function. About one half of PCR positive people will have some alteration to liver enzymes. Liver enzymes can fluctuate hence the need to repeat the tests. Again there is a need to repeat the tests because of the known fluctuation in liver enzymes in hepatitis C.

The definitive test to assess liver damage is a liver biopsy. This is a usual requirement before the commencement of antiviral therapy. It is not done routinely in other patients, nor is it a test requested by insurers.

How does hepatitis C affect your insurance?

The terms offered by different life insurers may vary depending on each company's premium rate and product features as well as underwriting philosophy.

Applicants who have made a successful recovery through antiviral treatment, or who have spontaneously cleared the hepatitis C virus (confirmed by two negative PCR tests at 12 months interval) with no other health problems are generally acceptable at standard rates or a small premium loading for life insurance and trauma products.

Applicants with active hepatitis C infection are generally also insurable for life insurance cover subject to a premium loading. The risk to life is considerably less than first thought 10 years ago. For life insurance this has meant a continuing improvement in terms able to be offered. Acceptance terms range quite widely and are dependent on a number of factors such as age, gender, duration of infection, liver function and alcohol intake.

The most common symptom for people with chronic hepatitis C is fatigue.³ Clinically it is very difficult to predict who will be symptomatic. Even for people successfully treated and who become HCV RNA negative, fatigue continues in a substantial percentage. It is for this reason that acceptance terms (where available) for disability income insurance policies are generally very strict. Applications that represent less risk to the life insurance company (in terms of benefits and features) tend to be underwritten more favourably.

Glossary of Life insurance products

Accidental death

Accidental death provides a lump sum benefit on the death of the life insured due to an accident caused solely by violent, visible and external means, which occurs within a specified period following the accident.

Disability Income Insurance/ Income Protection

Disability Income Insurance or Income Protection cover provides for the payment of a monthly benefit, usually up to a maximum of 75% of the insured person's income, while the insured is prevented from working due to sickness or injury.

The benefit is usually payable after an initial waiting period which is selected by the policy owner and which can vary from 1 week up to 2 years.

Benefits are payable whilst you continue to be disabled for up to the policy term which again is selected by the policyowner. Generally benefit terms range from 2 years through to lifetime although the most common is to age 65.

Group Life Insurance

Group life insurance is designed to provide death cover for groups of people who are linked together through employment or superannuation. 'Group Life' is a product purchased by employers or trustees of superannuation funds to provide coverage on an agreed basis, usually a multiple of salary, for their employees or superannuation fund members.

Group Disability Insurance

Group disability insurance is designed to provide 'income protection' benefits to groups of people who are linked together through employment or superannuation. While they are unable to work, insured members receive an income stream, being a percentage of their normal salary. The payment of the benefit is usually limited to a maximum of 2 years.

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Life Cover

Life Cover provides for payment of an agreed amount in the event of the death of the life insured. In today's market the most common form for providing this cover is through guaranteed renewable term insurance.

Total and Permanent Disablement

Total and Permanent Disablement (TPD) provides for the payment of a benefit if the life insured meets the definition of Total and Permanent Disability under the policy. The TPD benefit is normally only available as an extra option to a policy providing Life Cover and the standard version provides for prepayment of the Life Cover agreed amount in the event of becoming totally and permanently disabled.

There are 3 variations to the conditions under which a benefit is payable –

Own Occupation Definition – this definition requires the insured to be disabled through injury or sickness and as a result completely unable to work at their own occupation ever again.

Own/any occupation definition – this definition requires the insured to be disabled through injury or sickness and as a result completely unable to work in their own or any other occupation which they are reasonably suited by way of education, experience and training and unable to do so again.

Any occupation definition – this definition requires the insured to be disabled through injury or sickness and as a result completely unable to work at any occupation ever again.

In all cases, the circumstances as outlined above must have existed for a period of (usually) 6 months.

Trauma Insurance/Crisis Cover/Critical Illness

Trauma insurance provides for the payment of a lump sum benefit if the insured person is diagnosed with one of a list of specified trauma conditions, such as heart attack, stroke, cancer or a chronic disease like kidney failure. Most insurers do not provide cover for the major critical illnesses if they occur within 3 months of commencement of the policy.

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Some Common Misunderstandings about Insurance

Myth: An insurance company can cancel your life insurance policy if you come down with a serious illness

The fact is that a life insurance policy is a contract between the company and the policyholder. It is a long-term contract and in recognition of this, the law stipulates that as long as the policyholder pays his or her premium, the company cannot cancel the policy.

Myth: Once I am denied insurance, I will never be able to get it.

The fact is that different insurance companies use different criteria when determining who to insure and what price to charge. Insurance is very competitive and consumers should always shop around. Also, if a company declines your application as a result of a current health problem that improves or goes away, the company may reconsider your application.

Myth: It would be fairer for us all to pay a little more to allow everyone, even sick people, to get insurance at the same price.

The fact is the additional cost to provide insurance to everyone could be as much as a 50% increase, probably well in excess of what most people are prepared to pay.