The interface between medicine and the insurance industry

Doctors are frequently asked to provide reports and undertake medical examinations on patients who may wish to take out life or disability insurance. The insurance industry, on the other hand, depends on good-quality medical information and its accurate interpretation for risk selection or underwriting. A conference held at the Royal College of Physicians of London on Tuesday 19 March 1996 brought together underwriters and doctors in an effort to promote a clearer understanding of the aims and requirements of the insurance industry and the role of the doctor within this area, and to explore current and future problems.

Life and disability insurance

Mr Jerry Brown (Mercantile and General Insurance, London) set the scene by describing the various classes of life and disability insurance available. He outlined the need for an accurate underwriting process to optimise the claims costs and to provide consistency between mortality assumptions and experience. He introduced the concepts of anti-selection and equity which are essential to underwriting. The former is the situation in which individuals with high risk lives seek insurance, having a greater knowledge about the degree of risk than the insurer. Equity, on the other hand, is the principle by which an appropriate premium is allocated to each individual life according to the level of risk he or she brings to the fund. Thus, underwriting reduces the cost of cover to an acceptable level by applying the principle of equity and protecting the fund against anti-selection. Mr Brown outlined the stages of the underwriting process from class selection, where the actuary determines the mortality/morbidity assumptions for a company's policies, to the completion of a proposal form which is the main part of the individual risk-selection process. The quantification of the extra actuarial risk to be apportioned is derived from the private medical attendant (GP) report, a medical examination and HIV testing where necessary. He emphasised that the proportion of applicants receiving an extra rating on their premium or being declined was low.

The role of doctors

Mr Graham Spittles (Sun Alliance Life and Pensions, Bristol) spoke on the role of the doctor in the underwriting process. To reduce costs, underwriters only request medical evidence where the sum assured is high or where the applicant declares an adverse medical history. In addition, since 1987, HIV antibody tests have been requested, usually when the sum assured exceeds £150,000 for single men and £250,000 for married men and women. The life assurance industry is continuously looking for ways to improve the gathering of medical evidence, and there is a move towards health screening by qualified nurses. Another recent initiative is the supplementary health questionnaire (SHQ), whereby when an applicant discloses an adverse medical history, additional questions are asked in the hope that by obtaining additional information, requests for medical evidence can be avoided. Pilot studies suggest that non-disclosure with SHQs is minimal and has resulted in a speedier, more efficient and cost-effective processing of new business. Mr Spittles emphasised the important role of company chief medical officers (CMOs) in supplying guidance and advice with individual cases, the interpretation of ECGs and chest X-rays, and in areas such as medical confidentiality and new developments in medicine.

Sickness and invalidity

Dr Raymond Gill (Vice President, International Committee of Life, Disability and Health Assurance Medicine and Senior Honorary Clinical Fellow, Charing Cross Hospital, London) reviewed the reasons for individuals being unable to work. There has been an increase in the number of claims for sickness and invalidity from 500,000 in 1984 to 1,600,000 in 1995. In an effort to control the spiralling costs of claims, the government introduced a more objective assessment of incapacity in 1992 requiring an assessment by the family doctor of an individual's capability to work. In men and women the most common causes of incapacity are musculoskeletal problems which, in men, together with accidents and violence, make up nearly half the claims. Mental and respiratory disorders are also common. In the private sector, musculoskeletal causes were also common, closely followed by mental and circulatory causes, with manual workers making a larger number of claims. Early rehabilitation is important, and claims counselling services have the benefit of allowing claims to be checked and approved, and facilitate a return to work where possible. Benefits to the claimant include an explanation of the policy, practical advice and support in coping with the disability, advice on rehabilitation and referrals to government and voluntary organisations. Where appropriate, advice is given on the entitlement to state benefits.

Confidentiality

Mr Spencer Leigh (Chief Underwriter, Royal Insurance, Life and Pensions, Liverpool) and Dr Bryan Walker (Chief Consulting Medical Officer, Royal Insurance and Consultant Physician, Royal
Liverpool University Hospital) spoke on aspects of confidentiality. Every insurance company ought to have a document outlining the need for confidentiality by its staff and each office should have regulations written in plain English and clearly communicated to the staff. They should include clear guidelines on the storage and disposal of medical evidence. Problems with modern forms of communication include the possibility of personal health information being inadvertently sent by fax to the wrong number! The industry depends entirely on the medical evidence it receives, and it is the company CMO’s duty, with the help of the chief underwriter, to ensure total confidentiality. Dr Walker emphasised the medical profession’s moral and legal responsibilities with regard to the provision of medical information, and referred to the General Medical Council’s insistence that information should only be provided with the patient’s written consent.

Genetic diseases

Dr Richard Croxon (Secretary, Assurance Medical Society and Consultant Cardiologist, London) spoke on the major categories of genetic diseases and gave a brief review of molecular biological techniques, their role in diagnosis and risk stratification, and the importance of establishing their validity and reliability. Critical factors important in assessing individual risk predictions based on genetic testing include the nature of the disease, its inheritance pattern, its prevalence in the specific population to be tested, and whether or not suitable interventions would reduce risk. Specific conditions where advances in identifying the causative genes have been made include the BRCA 1 and BRCA 2 genes in breast cancer and hypertrophic cardiomyopathy. Dr Croxon ended by highlighting the legal and ethical aspects of genetic testing: in particular, the provision of such information for insurance purposes requires clarification and is under review by the Commons Select Committee on Science and Technology.

Hepatitis B and C

Dr Stuart Glover (Consultant Physician and Specialist in Infectious Diseases, Southmead Hospital, Bristol) reviewed the natural history of hepatitis B and C infection, and pointed out the increased risk of hepatocellular carcinoma and cirrhosis in chronic carriers. HBV carriers can be categorised as ‘healthy or low-risk carriers’, characterised by the lack of HBe antigen and the presence of anti-HBe antibody, and with normal liver function tests. Such carriers would normally be declined critical illness contracts but might be acceptable for life insurance and permanent health insurance (PHI) contracts at an extra mortality of between 50 to 150%. The high-risk carrier, on the other hand, characterised by HBe antigen but no anti-HBe and who usually has abnormal liver function tests, would generally be declined on all contracts. In hepatitis C virus infections, 80% of patients become chronically ill and approximately 20% progress to cirrhosis within ten years. The risk of contracting hepatocellular carcinoma increases with co-infection with HBV and HIV and alcohol. From an underwriting point of view, the risks are uncertain but those with abnormal liver function tests would generally be declined, while those with normal liver function tests might be accepted for PHI and life contracts with an extra mortality rate of 100%.

Into the future

Mr Tony O’Leary (Chief Underwriter, Employers Assurance International, London) looked into the future at how insurance and, particularly, medical underwriting, might alter. He felt there would be a change in demand for insurance, with investment products being replaced by products designed as protection vehicles, and fewer insurance providers available because of the significant financial burdens placed on offices by the Financial Services Act. Recent legislation and voluntary controls affecting the underwriters include the Access to Medical Reports Act 1988, the statement of Long Term Insurance Practice (issued by the Association of British Insurers and voluntarily adopted by the industry), the Financial Services Act 1986, the Data Protection Act 1984, and the more recent Disability Discrimination Act 1995. Overall, legislation restricts the underwriter’s ability to function and increases costs for the insurer which are eventually passed on to the public. Two of the more recent insurance products are long-term care policies that provide cover for nursing home care or home nursing and preferred life policies in which a normal standard rate acceptance category is further divided into preferred lives, who potentially have a lower mortality, and non-preferred lives. Factors considered in making this decision would include smoking habits, occupation, build, blood pressure, family history, blood lipids etc. This approach allows insurers to offer lower rates to the preferred life which, one could argue, was an extension of the principle of equity. Finally, Mr O’Leary reviewed the impact of a single European market on the UK underwriter.

Conclusion

The conference resulted in the medical personnel present receiving a well-balanced introduction to the complexities of medical underwriting, and demonstrated the service the insurance industry provides to society to protect individuals and their families. The underwriter has to make a commercial success of this to ensure the survival of the industry and for this he needs medical expertise. The close liaison between the insurance industry and the medical profession is therefore likely to continue well into the future.