UNDERSTANDING INCLUSIVE INSURANCE MARKETS: A BROADER PERSPECTIVE

BY **CHRISTOPHE HECK**

Discussions about fairness and inclusion in insurance underwriting have intensified in recent years as regulators, policymakers, consumer groups and insurers find themselves grappling with increasingly complex questions about the use of data, the role of underwriting and societal attitudes towards acceptable risk differentiation.

At the heart of these debates lies a healthy tension between two views of 'fairness': the evidence-based, rational underwriting processes, and evolving social norms with political, moral and often deeply personal views. When it comes to 'social fairness', the idea that individuals should not be excluded, penalised or treated differently on the basis of characteristics society considers unacceptable to use – even where those characteristics may be risk-relevant. For underwriting fairness, insurers are looking to offer protection that is commensurate with the risk they are taking on. This requires an evidence base of credible, relevant data to assess risk.

To be clear, this is not a conflict between good and bad, or between economics and ethics. Both forms of fairness are legitimate.

In order to understand how these fault lines can create tension, it is worth taking a step back and identifying the key issues. Let's apply two views of 'fairness' to a very simplified scenario of a certain population, with a standard distribution of risk. >

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FULL SOLIDARITY

At one end, 'fairness' means everyone should be included, with risk shared evenly by everyone paying the same premium.

In this case, the mechanism to build the insurance market is relatively simple: The insurer estimates the expected claims cost across the whole population, adds expenses, capital costs and an uncertainty margin, and charges a single premium to every participant. See figure 1.

At first sight, this appears fair and inclusive. Everyone is treated the same. No distinction is made by age, gender, health history, occupation or lifestyle. The cost of risk is simply redistributed across the population.

That redistribution may be socially acceptable. Indeed, many insurance systems contain deliberate elements of solidarity: national health insurance programmes, or countrywide natural catastrophe programmes might look something like this simplified model.

In such a system, adverse selection is a challenge if participation is voluntary. Lower-risk individuals may conclude that the premium is higher than their perceived risk and so decide not to buy. Higher-risk individuals have a stronger incentive to remain in the pool but are effectively subsidised by lower-risk members.

A second important problem emerges if there is a significant change in the system and no mechanism to adapt the rate over time. Ageing populations, health trends and scientific advances such as new medications might be typical reasons that such systems become stressed in a life or health context.

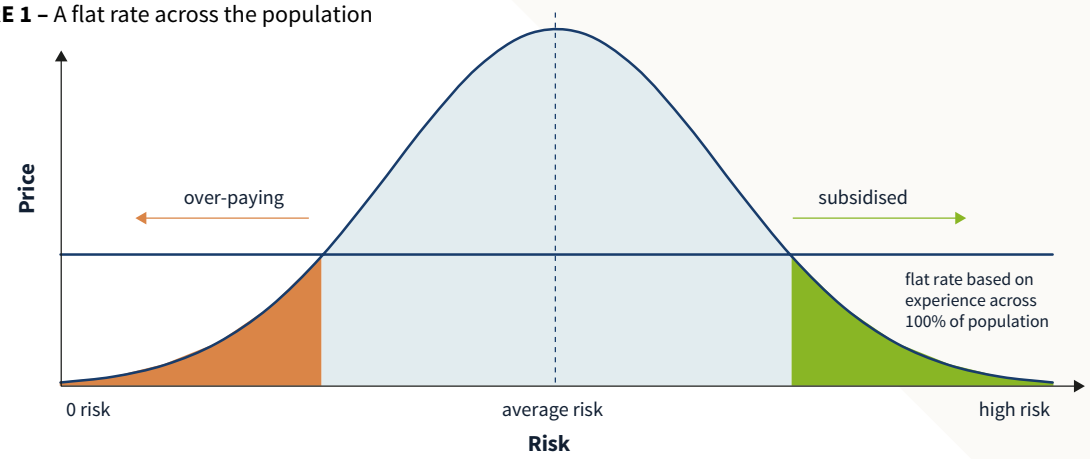
RISK-BASED FAIRNESS

At the other end of the spectrum, consider a theoretical fully risk-based mechanism to assess the cost of risk. In the idealised version, the insurer has access to the required information about each individual and freedom to use that data for risk assessment. Each person is therefore offered a premium that reflects their individual expected claims risk. Cross-subsidies are minimised. Lower-risk individuals pay less. Higher-risk individuals pay more. See figure 2.

This system is also 'fair' and inclusive. The difficulty, however, is that individuals with the greatest need for insurance may face the highest prices, exclusions or be declined cover. They may also be simply priced out of the system.

If this is applied to a property line, where those offered higher rates are wealthy individuals insuring luxury cars, there may be little social friction to this approach. However, in the case of products that supplement the welfare system, such as critical illness or disability covers, this approach may risk outpricing the most vulnerable members of the community. This system can therefore be technically fair but fail a broader social fairness test. >

FIGURE 1 – A flat rate across the population



THE HYBRID REALITY WORKS

The above examples are theoretical, and most real insurance programmes lie somewhere in the middle. If we look at healthcare, life insurance, and even beyond life to products such as motor insurance, we see there is some form of societal mechanism, whether policy-driven or driven by demand, that determines what 'fair' participation looks like. Insurers then work in a competitive environment to assess their risk appetite, define their risk assessment strategy and serve the market.

These systems are volatile but adaptable. They will go through pricing and competitive cycles. Regulatory adjustments, economic trends, consumer demand, and innovation will drive changes which the industry can adapt to. There will be peak losses. There will also be mechanisms in place, such as reinsurance, to absorb those peaks.

THE TRUE FAULT LINE IS INFORMATION

No insurance system can function without being able to assess risk. And to do that, we must have the risk knowledge to set our assumptions. That becomes difficult when information is both socially sensitive and actuarially relevant.

The Right to be Forgotten (RTBF) is a poignant example of this. The RTBF for cancer survivors means that, after a defined post-treatment period, insureds are no longer required to disclose a previous cancer diagnosis. As such, this information will not be available to the insurer when assessing risk.

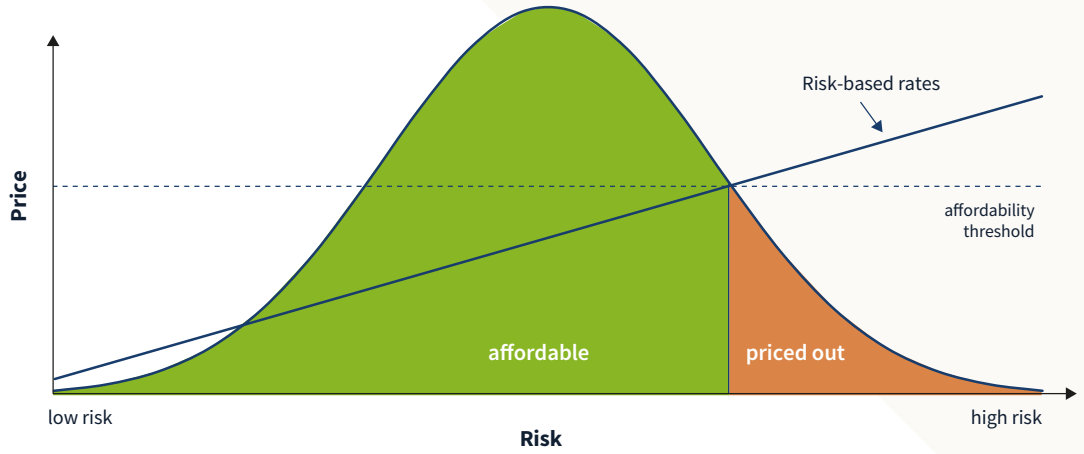
This was developed in response to a real social concern: cancer survivors may face financial exclusion or discrimination years after treatment has ended. 14 EU countries have implemented national Right to be Forgotten frameworks for cancer survivors. The first was introduced in France in 2016, and national approaches differ in both timeframe and product scope, with periods ranging from 5 to 15 years.

This is social fairness in action. It recognises that a person who has survived cancer should not necessarily carry that history indefinitely into every financial decision. It also reflects legitimate public discomfort with the idea that someone may remain penalised long after treatment has ended.

The question for insurers, however, is whether cancer survivorship is risk-relevant for future cover.

There are studies which have shown increased risk. The Surveillance, Epidemiology, and End Results (SEER) Program of the National Cancer Institute (NCI) found that cancer survivors in >

FIGURE 2 – Riskbased rates, affordable for more people



the general population have a 16% higher risk of developing subsequent cancers.[1] NIH has shown that nearly one in five cancers diagnosed today occurs in an individual with a previous diagnosis of cancer, and these 'second cancers' are a leading cause of morbidity and mortality.[2] There are many more studies and estimates of recurrence.

Secondary cancers vary depending on the population studied, age, sex, and other factors. However, from an insurers perspective it seems fair to say that cancer survivors generally carry a slightly higher risk of developing cancer again, compared to the general population.

Being able to assess that risk is important for products where cancer risk is central to the proposition. Critical illness is an obvious example. Cancer is often a major driver of claims experience, and products with cancer-heavy definitions will therefore be sensitive to changes in incidence, diagnosis patterns, screening practices, benefit wording and underwriting rules.

We have seen how this can cause issues in a market. Romania is one example, where RTBF allows for a statutory period of 7 years from completion of the oncology protocol, or 5 years if cancer was diagnosed before age 18. The definition of 'cancer survivor' is broad and includes controlled chronic cancer situations, although the non-disclosure right still depends on the waiting period after completion of the oncology protocol.

This has created a genuine anti-selection concern whereby an applicant eligible for RTBF may not disclose prior cancer history when buying a product where the insured event is cancer itself. This created enough uncertainty for some to reduce or withdraw capacity until the market has been more thoroughly tested and more evidence is gathered.

NO PROGRESS WITHOUT INFORMATION

The information gap in RTBF is a challenge for medical underwriting today. But it also raises questions for future product innovation. Where society decides that certain information should not be used, product design must acknowledge the resulting uncertainty rather than pretend the risk has disappeared. This adds complexity and uncertainty. It introduces the risk of developing unsustainable product lines based on inaccurate assumptions.

The conclusion is not that social fairness should give way to underwriting fairness. Nor is it that underwriting fairness should be abandoned in pursuit of inclusion. Insurance is a vital part of the financial safety net and thus needs to operate sustainably with an understanding of its social context.

Inclusion fails when people are unfairly excluded. But it also fails when products become so expensive, narrow or unstable that they disappear. The future challenge is therefore to develop protection that is socially acceptable and based on sound risk economics.

Disclaimer

[1] Do cancer survivors have an increased risk of developing subsequent cancer? A population-based study - PMC

[2] Second Primary Cancers Among Cancer Survivors - NCI