Gen Re

Radical Steps Are Needed to Fix Individual Disability Income Insurance in Australia

TIME FOR ACTION

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By Andres Webersinke

Head of Life/Health Region Australia/New Zealand

As Managing Director of General Reinsurance Life Australia Ltd, Andres Webersinke is responsible for Gen Re's Life and Health business in Australasia. During the course of his more than 25 years with Gen Re he has held various technical, marketing and management positions in Germany, South Africa and AsiaPacific.

Tel. +61 2 8236 6200, webersin@genre.com

Individual Disability Income insurance (DII or Income Protection) is a key insurance product for consumers. It offers essential financial protection when income falls away due to sickness or injury but the expense outflow continues. It builds a bridge for the time needed to return to one's usual occupation or provides the time required to consider alternatives without financial hardship. Compared to other nations, Australia has one of the highest penetration rates for this product but many Australians are still not adequately covered against loss of income. Life insurers in Australia earned $2.8 billion in premium from individual DII products in the 12 months to March 2019, representing almost 30% of total risk business sold to individuals (retail consumers) and one-sixth of both individual and group business.[1]

With this background, it was even more alarming that in May 2019 the Australian Prudential Regulatory Authority (APRA) described in a letter to life insurers "factors that are impeding life companies' ability to improve the performance and sustainability of individual DII".[2] Following hard on the heels of this letter, industry statistics revealed that in the 12 months to June 2019 the Life insurance industry in Australia lost (net of reinsurance/retrocession) almost $1.1 billion (after tax) or $1.6 billion (before tax).[3] This 12-month period was the worst since the publication of this statistic in 2008. Accumulated losses since 2014 amount to $2.5 billion (or $3.4 billion before tax) – not including losses retroceded overseas. Based on local reinsurer's outward reinsurance premium volume, the total five-year accumulated loss since 2014 can be expected to be at least $0.7 billion higher. Some of the losses are driven by a reduction in discount rates but the by far most significant proportion relates to the recognition of persistent adverse claims experience.

Already in 2014/15 key market players commented on the under-performance of this product segment:

- APRA's then deputy chairman told the Actuaries Institute of poor market practices "that very likely contribute to poor performance over time".[4]
- The then biggest reinsurer of Individual DII in Australia urged "steps to be taken to develop and introduce more sustainable terms in DII products".[5]
- Another reinsurer promoted change of the product using the somewhat provocative title, "Lack of Interest – An Australian Disability?"[6]

In summary:

- "Significant changes are required if the products are to survive in the long term"; and
- "Disability insurance in Australia has reached a crisis point largely thanks to the underpricing of products carrying certain unsustainable features".[7]

A sense of déjà vu

These conclusions date back to the late 1990s. Not much has happened other than one notable change – the market ceased writing business with lifetime benefits. While this was an important change, no other significant changes happened over the past 20 years.

No doubt, (re)insurers embarked on many initiatives ranging from investing into new claims administration systems to integrating various new claims strategies. But most other initiatives, such as using collected data to produce a new experience table or a sequence of premium rate increases, have not addressed the fundamental problem with the Australian DI business.

Yet, industry experts, so it seems at least, identified the key reasons for the dilemma: Over-insurance, ancillary benefits and rating houses are often – at least anecdotally – associated with poor results. While the industry may agree on the taglines for the root causes of the problem, the required consequences appear less obvious or agreeable. This impasse does little to address the core problems. Attempts in changing the product end in smoke. Is the industry unable to self-help? And adding to this, demands to meet increasing consumer expectations, while understandable and important, may – at least in the short term – worsen the current situation.

A holistic view and a concerted effort are required. Government, regulators and the actuaries can all play a positive part in influencing the developments. But it is the product manufacturers who need to be bold and lead the change.

Over-insurance – Financially or otherwise

Over-insurance should be avoided – a simple insurance principle. Yet insurers designed feature-rich products – overloaded with additional benefits to cater for every possible claims scenario. A feature that pays a benefit during the waiting period for a disability – due to accident or offering short-term booster benefits – may help sell the product and is thought to be in the interest of the consumer, but is this true? It can be expected to lower the financial incentive to return to work at an earlier time. Key facets of concern, and by no means a complete list, are:

- Total disability doesn't mean the insured doesn't or can't work at all. It suffices for the claimant to be:
  - unable to work in his/her job for 10 hours or more;
  - unable to perform one important income-producing duty of his/her job; or
  - unable to generate 20% of pre-disability income in his/her job.
- Some benefits from other sources and even income earned from the ability to work up to 10 hours are not always offset, thus offering a financially better situation than pre-disability.
- There is no requirement for the claimant to be totally disabled during the waiting period other than perhaps a few days.
- Partial disability requirements are satisfied when the insured works normal working hours, say 40 hours per week (but formerly worked 60 hours per week) and has a commensurate loss of income.
- Guaranteed or endorsed agreed value cover limits financial underwriting to the application stage.

Other features, such as indexation of benefits to retirement age, are not reflecting reality or actual need. While more people will have to work longer periods, not everyone aims to work full-time along an upwards career trajectory until retirement age. Many of these features invite claimants to consider lifestyle choices rather than returning to the insured occupation, to opt for (partial) early retirement or simply taking time out.

Undoubtedly, each of these features was designed with good intentions and may have resulted from a shortcoming identified in a previous product generation when assessing one particular claim; however, the impact on an entire portfolio was not well researched.

Taxing benefits

Outside of Superannuation DI benefit payments are generally taxable. But are they taxed? Benefits could be taxed at source or, as in the UK and South Africa, paid tax-free with a commensurate lower income replacement ratio. The latter would reduce the overall premium level payable by the policyholder and would ensure the insured is not over-insured. Lower premiums as a result of a lower necessary replacement ratio should be preferred over higher premiums that are tax-deductible.

Lack of onus

Besides avoiding over-insurance, another insurance principle is loss minimisation. Starting with the insured, he or she should minimise the financial loss (i.e. the loss of income over a period of time), but such an effort should also apply to the employer. In particular in the initial phase, it is essential that the employer investigates the extent of the incapacity in view of offering alternative solutions to accommodate the employee. If the incapacity is long-term or permanent, the employer should determine the possibility of securing alternative employment or adapting the duties or work circumstances of the employee to accommodate the employee's disability – as is legislated in South Africa, for example.[8] The employee who is expected to be incapacitated for a long period, say six months or longer, should have a duty to re-skill if benefits are to be continued or, in the case of a self-employed individual, to restructure the business. This doesn't have to be arbitrary but if total disability simply continues because of the insured's inability to perform one important duty, or can work 10 hours, the insurer relies solely on the individual's self-motivation.

Rating/research houses

Rating houses are the only segment within the value chain that is not supervised or regulated. Rating houses quantify the generosity of a product without regard to its sustainability or impact on future premium changes.

"Using product scores as anything else other than a quick snapshot guide or starting point to obtain an opinion as to how generous a product is," as one such provider admits, is "detrimental to the recommendation process".[9] However, in practice, the scores are used to support and underline the advice provided to a consumer. What better way to use just one number to substantiate a recommendation than to explain the risk of unsustainability.

No doubt these scores – whether intended or not – result in a quasi-outsourcing of some aspects of the "best interest duty" process. The duty includes identification of the financial situation of the client and thus the affordability for the entire period.

Furthermore, the scoring methodology leads to a race of ever-increasing product generosity. At the same time, it leads to a convergence of policy terms and conditions. What may sound like an advantage to consumers is in actual fact stifling innovation, in this case for more sustainable products. If the rating houses can't be brought into the fold of insurance supervision, best advice must be redefined such that advisers need to incorporate a basic DII product, including pricing, and to let the consumer choose whether a more comprehensive cover is worth the extra premium and risk of rate increases.

Reinsurance and cross-subsidisation

Reinsurers offer the capacity to write DII business in the Australian market. More than 50% of the individual DII risk is reinsured and in some cases the manufacturer retains a very small share of the actual biometric risk. Poor results were tolerated for as long as there were sufficient profits from other risks (most notably mortality). This cross-subsidisation was never meant to exist but by now has led to the unfortunate situation that direct writers offer the reinsurance of lump sum risks only if the reinsurer also accepts the DI risk. It could be expected that reinsurance capacity for the current DII product would significantly decrease if reinsurers compete separately for different benefits and products and direct writers are required to split and evaluate reinsurance offerings for different benefits separately. Any risk appetite statement that depends on a degree of cross-subsidisation must address the risk of disruption and the risk of cross-subsidisation no longer functioning as expected. Furthermore, any insurer that factored in cross-subsidisation between benefit types does not treat customers fairly who do not purchase all benefits.

Product design – To cover what is intended to be covered

The current DII works well for short periods of debility and following a sudden or acute sickness or injury. It gives financial protection in a moment of crisis; it is meant to be a temporary benefit period for individuals who've had an emergency, who are being medically treated, and who are expected to return to the usual work duties – progressively or otherwise. If the circumstances change and a disability manifests, becomes long-term, or develops over a long time while still in employment – or is complicated due to unfavourable bio-psycho-social factors – the insurance product has to adapt. The current design tries to cater for all possible claims scenarios with one complex policy wording – and fails.

Time off work, beyond a predictable period, should be accompanied by the insured's understanding that he or she will consider alternative occupations or job duties. The focus must be on acquiring new skills, rehabilitation, modification of duties and minimising the loss of income in the long run, i.e. extending and maximising the capabilities of the insured. Income replacement can't continue on the same basis as for a short-term off-work period.

DII must become a two-in-one product:

1. Cover of an acute phase of sudden sickness or injury. The benefit duration should be commensurate with an expected period for the diagnosed condition(s) or incapacity based on the insured's duties.
2. An add-on cover for extended periods of acute conditions, chronic conditions and disabilities of nonspecific nature, accompanied by clear expectations of the insured's involvement in rehabilitation or re-skilling efforts.

Over-insurance would be less concerning for any acute phase and indeed a 100% income replacement may be acceptable. However, for any extended benefit period the actual replacement ratio should be lower than the current maximum and consider a wide range of offsets including deemed income.

Underwriting

The underwriting of DII in Australia is both strict and generous. Certain market practices are unique to Australia (and perhaps New Zealand). This may be due to the underwriters' complacency or the desire to fit in with advisers' expectations. Seven to nine percent of DII policies have a premium loading due to the insured's medical history but a significantly higher share of policies have at least one exclusion.

Occupational categorisation

Australian insurers created occupation categories specific for certain professionals. "Medical professions" is one such category and includes all medical professions – whether general practitioner, dentist or surgeon – when in fact the experience within this group is very heterogenous. Effectively, all medical professions benefit from a relatively favourable premium level. In other countries, surgeons, dentists and nurses are classified more appropriately with other occupations doing manual work. Sufficient data is available to differentiate occupations more finely and appropriately.

Occupational re-classification

All too often self-employed applicants declare light duties at application stage but they then claim benefits for high levels of manual work, which delays the return to work – hence the term occupational drift phenomenon.[10] While self-employment should be a rate differentiator, it should also be a flag for insurers to prompt these insured lives to report changes in their occupation and duties. This could be implemented as part of the renewal notice. The continuous review of occupational classification of an individual must be the norm going forward also because "the concept of a job for life" won't exist in future and will morph into a "portfolio of jobs".[11] Alternatively, a claim should be assessed against typical duties of the insured's occupation at the outset.

Hazardous activities

Australian insurers are generous when it comes to the assessment of sports and pastimes. Private flying (helicopter or fixed wing aircraft) would be excluded by most DII writers in the UK[12] but is covered by most Australian insurers for as long as the number of hours flown does not exceed 100 per year.[13] This practice may not be relevant overall but it highlights the different approach to certain risks – one that is difficult to change as "it has always been done this way".

Bio-psycho-social factors

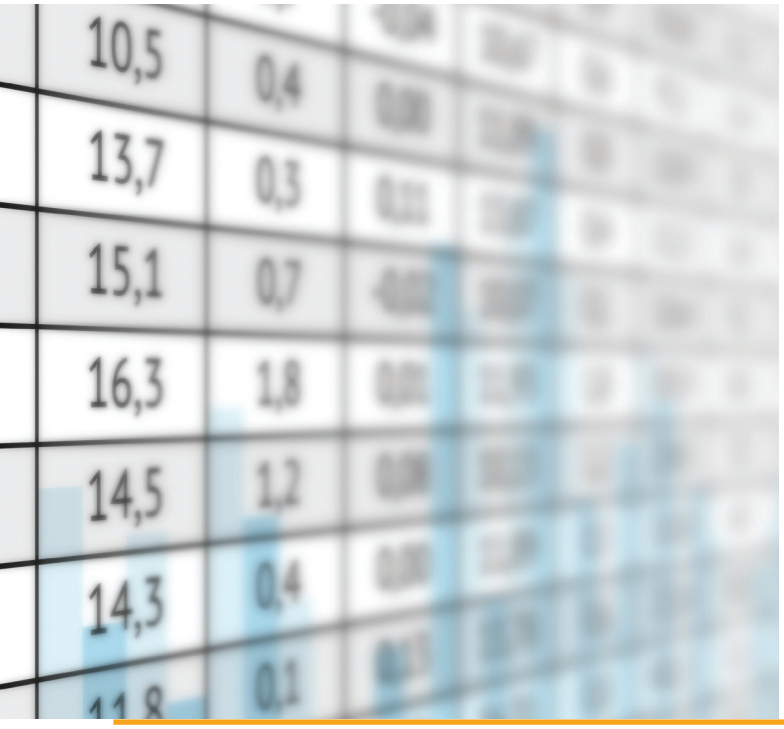
Individuals cope very differently with a setback than with an illness, and this significantly influences the duration of a claim. Insurers must consider new questioning techniques to elicit information that not only evaluates the incidence risk but puts a stronger focus on the termination risk. Insurers are limited when introducing new risk classifications due to the narrow exemption provided in anti-discrimination laws; for example, in Australia discrimination in insurance must be based upon actuarial or statistical data or, if not available, on other relevant factors.[14] This law aims to protect the consumer against arbitrary pricing but also adds hurdles for the insurance company when new approaches of underwriting are introduced, and data is scarce.

More data is better, but...

In May 2015 the ADI 2007–2011 Disability Income table was released – 20 years after the previous industry table. Anyone who expected that publishing a new table would change everything for the better was disappointed. Surely, the past poor performance was already well understood and older tables were accordingly adjusted. The benefit of the new table was the confirmation of rating factors not captured in previous industry tables.

Insurers with a small portfolio may use the table, making too few adjustments and relying on its supposedly up-to-dateness. However, it was already several years out-of-date the moment it was published and missed trends that started to materialise in 2014. Some writers did not adopt the new rating factors as they were considered an issue of the past or not applicable to their portfolio. Furthermore, any such table must be read with much care as the data used is everything but "clean", due to the underlying complexity of the product (ancillary benefits, re-opens, different and changing occupational classification, accident vs. sickness classification, settlements, etc.).

APRA's quest for more data should be supported. However, data and up-dated tables alone do little if its use, judgement and interpretation are poor. More guidelines are required for the valuation of a DI block of business, and deviations thereof need to be challenged more robustly. Calling for more data is one thing; interpreting the data is another one.



Pricing

Individual DII is difficult to price. Premium rates depend on incidence and termination rates but also pay-out ratios and interest rates. Each assumption is based on further assumptions, such as the effects of anti-selective lapsation or policy year. Actuaries have been unable to predict the future risk of individual DII sufficiently well enough. Over a few years, basic premium rates increased by 30% or more (for existing customers).[15]

Given the losses made and the fact that premium levels trailing actual experience, it is questionable why the market continues offering generous premium discounts – most often aimed at new business customers – whether a first-year discount of 10% for using a digital application or a discount of up to 30% for bundling DII with other benefits. The market also offers premium rate guarantees for a limited period (two years) and at least one insurer promises not to increase premium rates by a specific relative amount for a further two years.[16]

The questions to be asked are

a) Do these discounts appropriately reflect the savings in operational and risk costs? and b) Why is the premium rate guarantee, if any, extremely limited? What makes the pricing of the product so unpredictable? If the answer is under-pricing of the product in the first place, the customer would not be treated fairly. Consumer expectations would certainly extend to the sustainability of premiums and, when premium rates are reviewed, they should reflect whether the reasons for changes in premiums have been suitably communicated upfront in the policy conditions and at the time of the actual premium adjustment. If the answer is that a product is poorly designed and thus does not lend itself to greater certainty in pricing, the conclusion must be to re-design the product.

It appears appropriate to allow premium reviews only for clearly defined reasons that consumers are made aware of when purchasing the product. Changes in rates – because of weakening cross-subsidisation between benefit types, subjective premium discounts for some policyholders and known but ignored trends – would unlikely be reasons considered acceptable.

The UK Unfair Terms in Consumer Contracts Regulations 1999 (replaced by the Consumer Rights Act 2015) implemented a EU Directive and led to greater clarity in product literature and better documentation as to when premiums can be reviewed. An initial

pricing decision that was not based on a carefully considered estimate of the cost variables – such as the cost of providing benefits under the contract over the long term – is almost certainly not a valid reason for a premium review, according to the predecessor of the Financial Conduct Authority.[17] In February 2019 the Australian Government announced it would extend the Unfair Contract Terms regime to insurance in response to the Financial Services Royal Commission. It can be expected that the UK (or European) approach will be considered as a blueprint for Australia. And it may well result in forcing insurers to provide greater certainty about future DII premium rates.

Claims Philosophy

Many issues must be taken into consideration when evaluating a claim:

- How much time should be spent on a claim?
- How much time is available?
- What does it mean to be customer-centric?
- What are the consumers' expectations?
- What is the fiduciary duty to all policyholders (including those not claiming)?
- How to handle a claimant that was expected to return to work three months after the incidence but is still claiming benefits three years later?
- When and how much empathy is appropriate?
- Should benefit payments stop when information is not forthcoming?
- What does senior management want?

Managing DI claims is complex. Medical, rehabilitation, financial and occupational knowledge must be applied against complex policy wordings that changed over time. Add to this the right level of empathy and results-orientation. Furthermore, advisers and medical doctors are only too keen to help make the decision for the claims manager.

There is nothing more frustrating than seeing a claimant with working capabilities who exhibits no willingness or motivation to return to work. Current policy wording makes it near impossible for assessors to "manage" these claims.

And while not every claimant should be under general suspicion, the claims manager must balance the need for sufficient evidence of a valid claim with a smooth process at a time when customers' expectations are high. It is absolutely critical that product developers, underwriters and pricing actuaries spend time with claims assessors and review some claims. Getting hands-on experience will facilitate a better understanding of the circumstances in which decisions are being made. While more data can provide valuable insights, getting into the depths of actual cases best demonstrates the shortcomings of the policy wording and completes the control cycle.

Senior management in particular must know their products better. In 2016 Australian media touted and insurers reacted to the impression that an insurance definition for heart attack, with a minimum cardiac troponin requirement above typical clinical limits, is not up-to-date. The question to be asked should have been whether such a definition can be easily and objectively applied at claims stage to avoid unintended consequence for either the insurer or the insured. Similarly, how straightforward can the complex DII policy conditions be applied in actual claims scenarios?

Most claims philosophies are designed around valid claims and how to approach them. However, not all claims are valid or equally valid. While claims philosophies underline that insurance is about paying claims, an equal emphasis is required to identify non-disclosure, invalid claims at inception or, most importantly, continuous validity. Unfavourable media reports and findings at the Royal Commission set "community expectations" as the new norm for insurers. This is a moving target that seems to know no grey and could easily mutate into an entitlement mentality. No mandatory (social) and certainly no voluntary system can survive an entitlement mentality.

Claimants must have ways to submit claims easily and technology should help. Empathy starts with making it easy to lodge a claim. At the same time, insurers need to set clear customer expectations early-on – not only at claims stage or in drips and drops. It is a good way to build trust and retain customers in the long term. A claim that is submitted early and with full documentation across medical, financial and occupational aspects can be assessed faster than a claim for which parts of the information is not forthcoming. Customers should know this well before there is a claim.

In conclusion

The current product design of DII works well when assessing a case of acute sickness or injury. It doesn't work well for prolonged periods of disability or chronic conditions. More importantly, there is no financial incentive to minimise the loss of income.

Past losses are not – per se – caused solely by:

- The fact that DII is being sold via independent advisers or even how they are remunerated;
- Economic factors, such as lower interest rates or low wage increases; or
- Mental health claims for which claims costs have grown in tandem with all other claims.

Key contributors to the DII misery are:

- The generosity of the products stifling self-motivation for an early return to work;
- A claims handling approach that shows scars following increased media scrutiny and is based on misunderstood customer-centricity; and
- The eternal hope that a worsening trend will ultimately plateau and rate increases will restore profitability.

DII requires a concerted effort by multiple parties, such as:

- The Actuaries Institute providing more robust advice on valuating DII business;
- The ATO in reviewing taxation of DII premiums and benefits;
- ASIC and APRA supervision of rating houses or how their ratings and scores are used by independent advisers with a particular view of the client's financial situation when premium rates rise;
- The insurers' radical re-design of the products, placing the onus on claimants to minimise the insured's loss;
- A claims handling process that sets clear expectations even before a claim is submitted;
- A claims team that is continually trained on medical, financial, occupational and rehabilitation matters;
- A government that promotes rehabilitation and gives life insurers the opportunity to reimburse costs associated with rehabilitation;
- A government that promotes the inclusion of employees with disabilities in the workforce;
- The reinsurers to offer capacity for DII without the need for cross-subsidisation; and
- A media that focusses on premium sustainability and processes instead of hand-outs.

But most of all, it requires the insurers to fundamentally re-design the current DII product, to align the claims management capabilities with the new product and to fine-tune the underwriting. It can be more generous in parts but overall must adhere to simple insurance principles. And finally, actuaries must adopt a long-term view.

With few large players in the market, the myth of first-mover disadvantage disappears. It is time to lead the change and benefit from it.

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genre.com | genre.com/perspective | Twitter: @Gen_Re

General Reinsurance Life Australia Ltd.
Level 20
1 O'Connell Street
Sydney NSW 2000
Tel. +61 2 8236 6100