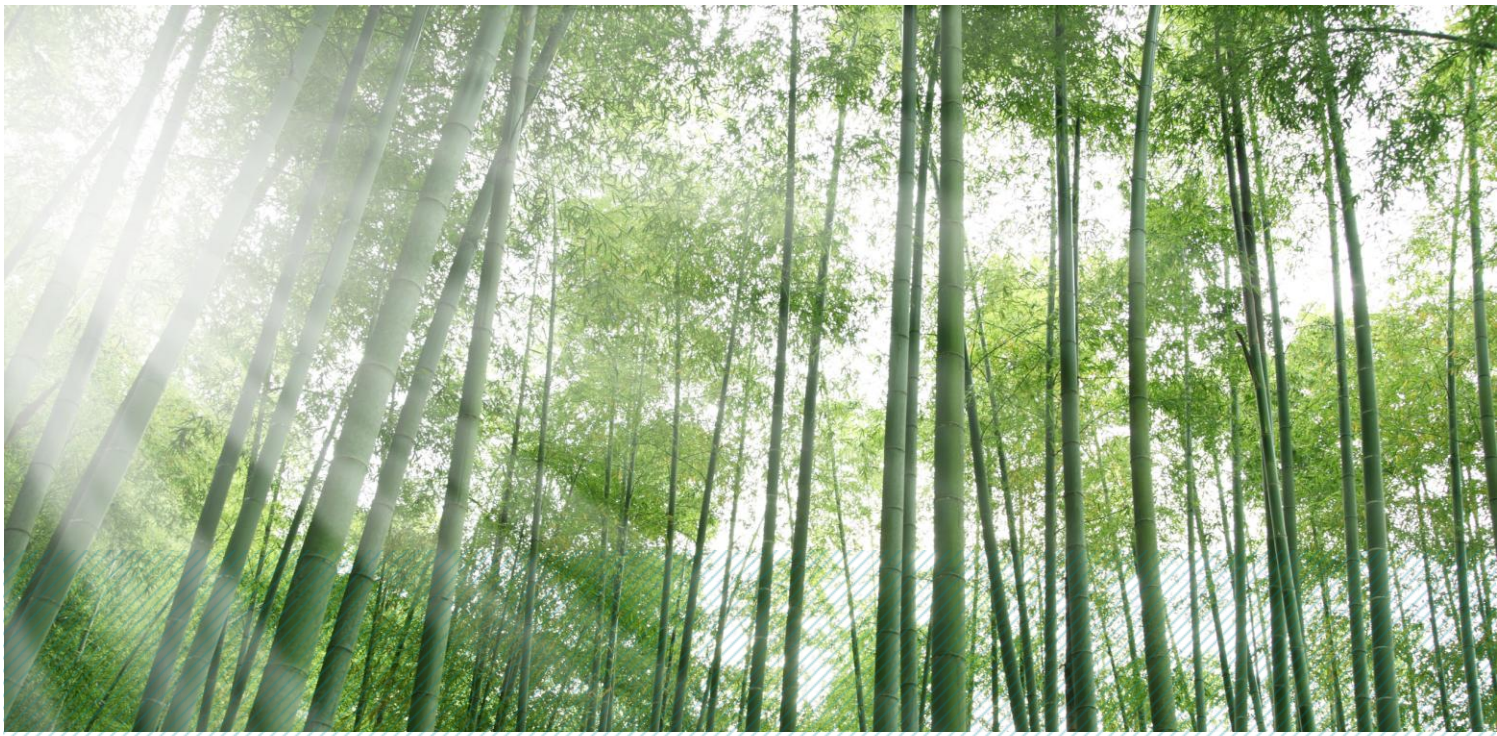

Income Protection – A time for review

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In this paper, titled ‘Income Protection – a time for review’, we take a high level look at the income protection market in Australia and explore the key areas where current IP products have failed, identifying common themes such as the introduction of new benefits, broadening of policy terms, communication failure and process inadequacies. We have then addressed these thematic failings and advocated a position change in order to promote a more sustainable IP market.

The issues raised in the series are broad and have highlighted that there is much work to be done in developing a profitable, customer focussed income protection solution. However it is clear that there are significant rewards to be had for the company that moves first, using an holistic approach

Author

Alex Threlfall

Alex Threlfall is the Senior Research Propositions Specialist in the Research and Development team at Munich Re with a particular focus on product strategy and disability. Alex has more than ten years experience in the life insurance industry with roles in product development, strategy and service delivery at a number of direct offices.

Alex is currently studying psychology and is passionate about the subtle motivators of wellbeing that can impact on individuals’ health and ability to recover and the interplay that can have with insurance.

Part 1 – An overview of the retail disability market

The IP Marketplace

Income Protection has been a huge marketing success in Australia over the last decade. In the retail broker channel, for example, where the majority of IP individual covers are sold it is commonly regarded as the core protection need and the 'lead' sale in the minds of advisers. As a result, the product has typically sold very well and in 2014, $480 million in new annual premium sold in Australia, equivalent to approximately 63 percent of life cover only sales and over 1.75 times trauma sales[1]. New business sales have almost doubled in the five years from 2010 to 2014 compared to the prior five year period from 2005 to 2009.

Such is the success of the IP sales story, Australia is often cited by many overseas insurance markets as a case study on how to sell income protection covers. This success has been well earned. By international standards, IP is regarded as notoriously more difficult to sell than 'simpler' covers such as life cover only and trauma.

Whilst sales have shown a consistent and upward trend, the same cannot be said of the sustainable development and profitability of such products. A brief look at the past thirty years shows a tendency toward a period of relatively good experience and profitability which prompts an investment of profit margin into improved policy terms with a view to increasing new business sales. The 'improved' policy terms lead to an increase in claims, triggering a contraction of terms in an attempt to halt the deteriorating experience. After a period of relatively stable profits, the cycle repeats itself.

The Australian cycles of product development and profitability have remained somewhat unnoticed by overseas markets where the sales success story and how to grow the IP market is receiving the greatest attention. However, there are lessons to be learnt from the Australian market distribution 'success' story and the current market conditions strongly indicate that there are further expensive and unintended surprises still to come, with the distinct possibility that the eventual claims experience over the medium to longer term will be worse.

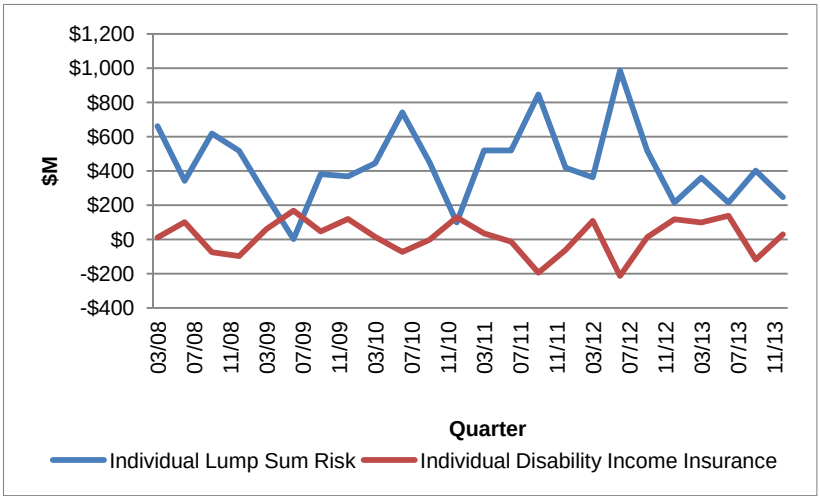
[1]Plan For Life. 2014.

An overview of the retail disability market

The need for change

It is acknowledged by the local industry regulator, APRA, that insurer profit margins are increasingly under considerable pressure (see Figure 1, below), particularly for individual income protection benefits from broader terms, weak risk management practices and to a lesser extent, external factors.

Figure 1: APRA Quarterly Life Insurance Performance Statistics: Net Profit (after tax) 2008-2013



As we move out of 2014, a year of heavy disability losses, increased stress within the pool of experienced claims assessors and ongoing industry discussions regarding the possible impact of high lapse rates on disability portfolios, there is potential for worsening future experience on the existing in-force business.

An overview of the retail disability market

Moreover, challenges with profitability appears to be repeating the scenario experienced in the 1990's, where intense market competition in disability business created similarly complex and over generous product features. Whilst some lessons were learnt from that period, such as the high cost of offering lifetime benefits and no-claims bonuses, it seems that competition has again led to more generous policy benefits and new, equally costly, features have been introduced for the first time, such as the '10 hour' total disability definition and generous partial disability claims triggers. Is history repeating itself?

A particular concern for the market is that the losses sustained in the 1990's, plus the poor returns since 2008, have generally not been compensated for by high profits during the intervening period as profit margins were quickly eroded by competition for market share and increasingly generous benefits.

This raises two primary concerns:

1. On the face of it, the IP market is showing the characteristics of a cyclical market whereby 'soft' market conditions are followed by a period of 'hard' market conditions which then 'soften' again with time and competition. This immediately increases the need for extra vigilance with risk management and controls.
2. More importantly though, is the fundamental concern of shareholders as to whether disability business can make sufficient profit over the longer term to warrant the effort involved in writing the business on a standalone basis or at best on a 'loss leading' basis such that profits must be made elsewhere, for instance by lump sum covers. This leaves IP vulnerable to capacity constraints as reinsurers seek minimum returns per business line.

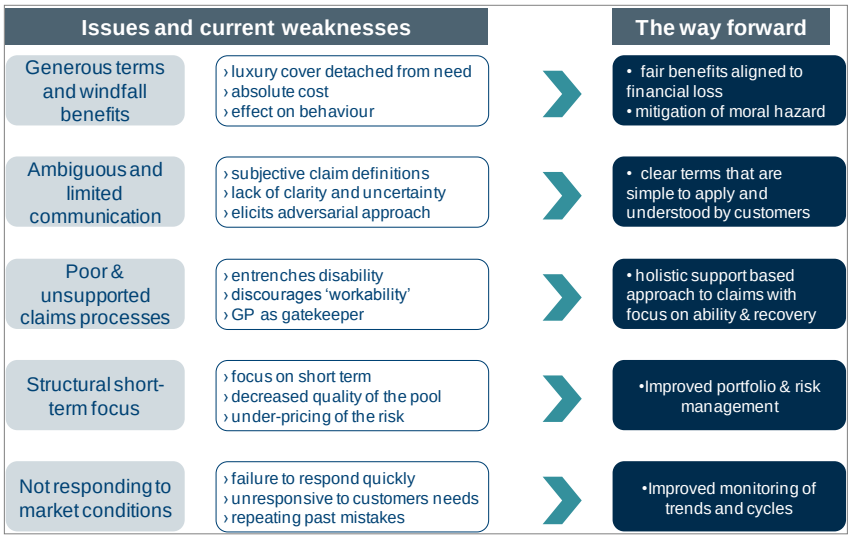
From this rudimentary analysis, this apparently cyclic experience seems to indicate that when times are good, policy terms and conditions should not be relaxed so readily, as the increased profit margins will be required to smooth out experience over a longer period. Shareholders will be wise to this and demand that IP is underwritten for sustainable profitability meeting minimum profit hurdles.

An overview of the retail disability market

The way forward – a new approach

The way forward requires a number of product dimensions to be addressed simultaneously with a transformational approach setting out the road map for a new way of doing business. The ideal way to achieve this is through measures that are win-win for all parties involved – that is, they improve the position for clients, advisers, insurers, reinsurers and shareholders.

Figure 2: The principles of sustainable DI



The principles of sustainable IP, as outlined in figure 2 above, are explored throughout this paper, covering the problems that exist within the current model for disability income and how they might be addressed to improve the overall experience.

An overview of the retail disability market

Summary

Such has been the enrichment of product features and relaxation of benefit definitions over recent times that premiums have not kept pace and worse still, significant unintended moral hazard risks have been introduced or heightened. This is compounded by the effects of annually reviewable premium structures and elevated policy lapses. This points to more pain ahead for customers, advisers and writers of IP business unless these design weaknesses are addressed.

This paper aims to review the current IP product against the key requirements of stakeholders, notably customers and shareholders. We then suggest a way forward which could be mutually beneficial for customers, advisers and disability writers and capacity providers alike.

Without question, IP has many strengths and the paper seeks to build on these, whilst recognising and addressing the potential weaknesses of the typical current product. Our overall objective is to establish the case for positive and constructive change in the Australian retail IP market that provides the majority of customers with protection for their core need at an affordable price.

Part 2 – The core need

In Part 2, we look in detail at the core need of customers in Income Protection and how the products have evolved to offer generous terms to the extent that the benefits have fallen out of line with needs. We explore the consequences, both the obvious and unexpected, of such product development and how they might be addressed.

The Product Features 'Arms Race'

Income Protection insurance is straight forward in principle - it provides monthly financial payments upon the occurrence of illness or injury that prevents a person's ability to work. IP is intended to provide a replacement of a proportion of pre-disablement earnings until the period of incapacity ceases or to the end of the policy term, typically retirement age, whichever happens first. Cover was originally intended to meet such basic needs as household bills and everyday living expenses, with strict underwriting criteria and clear benefit definitions.

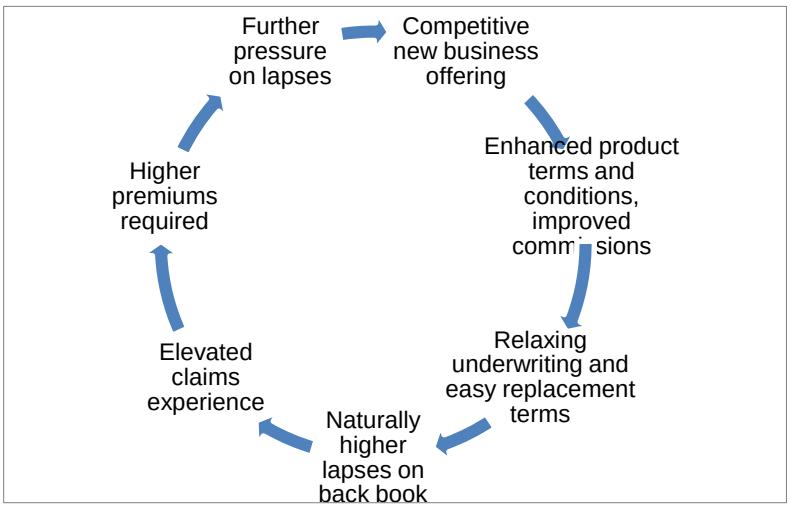
However, over the years, market competition has led to expanding benefit coverage that could be called a 'product arms race'. Most insurers, supported by their reinsurers, have embraced this 'game' because a primary point of competition is product feature comparability on the various comparison portals, supported to an extent by an over-reliance on a research score to justify the basis for a product recommendation in the context of a strong compliance regime.

The development approach of simply adding more and more features in the belief that this equates to a better product is misdirected. The result of competing purely on product features is that we have cover with generous terms that no longer aligns to the core need. It often provides benefits that exceed the financial loss, leading to a better financial position on claim than off for some claimants, as well as placing increasing pressure on the premiums that customers have to pay for such cover.

The core need

This short term focus leads to a vicious circle of the “product arms race”, whereby weak fundamentals contribute to and compound poor experience, with any response, whether it be premium increases or increasingly more competitive new business offers to attract greater sales, likely to further fuel deteriorating experience.

Figure 3: The Vicious Circle of the "Product Arms Race"



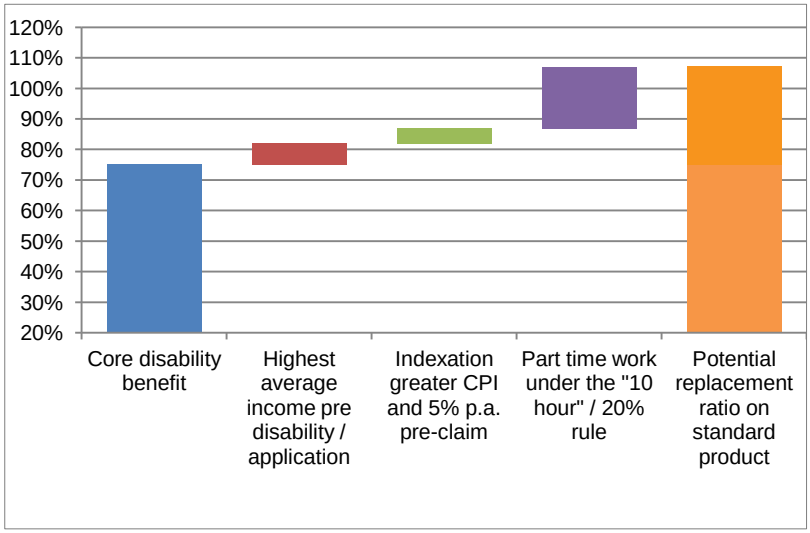
Generous terms

The simplistic graph in Figure 1 illustrates an example of the several layers of claim benefits that are available within current retail products measured as a proportion of typical pre-disablement income, particularly at the early stages of disability

The core need

Figure 4 illustrates the high potential replacement ratios that are available from current standard products excluding further optional benefits.

Figure 4: Replacement ratio 'inbuilt' into on Australian IP products (no options)



The core product typically offers a 75% replacement of pre-disablement income and this is then supplemented by:

- A definition of pre-disablement income that can result in especially generous replacement ratios for those whose income has been reducing prior to claim; where for agreed value it preserves income from application, with no limit to time or extent of reduction in income, and for indemnity it often allows the highest average income for any 12 month period in the three years prior to start of the waiting period
- Agreed value contracts with limited controls to adjust benefits should the income stated at application not be an accurate representation of their income at the time
- A generous allowance for indexation of policy benefits, typically the greater of CPI and 3 to 5%, which in a low inflation environment and low income growth can increase the potential replacement ratio as policy duration increases, and
- A generous definition of total disability, allowing claimants to generate up to 20% of their monthly income or work up to 10 hours per week with no reduction in the benefit payable regardless of what income was earned in those 10 hours.

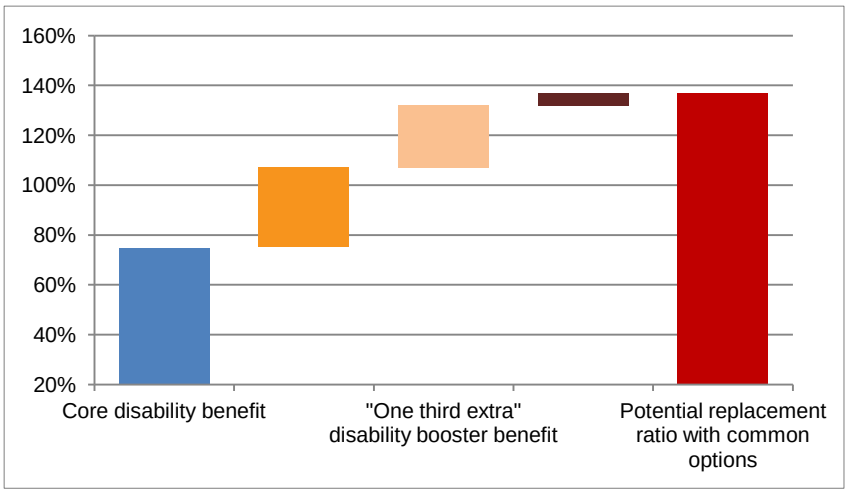
The core need

In addition to inbuilt coverage which has been extended, most insurers also offer a range of additional optional benefits. Figure 5 illustrates the extremely high potential replacement ratios that are available from current IP products when including some of the common optional benefits.

The core product with the extra implied benefits as described earlier can be supplemented by the following optional benefits:

- A disability 'booster' benefit paying an extra 1/3 of the monthly benefit for a pre-defined period at start of claim, and
- An additional 5% of a claimant's insurable income to cover superannuation contributions or, for some companies, mortgage payments during claim.

Figure 5: Replacement ratio on Australian IP products (with options)



These optional policy features extend the potential replacement ratio to well over 130% of pre-disabled income in the early stages of a claim and indicate that cover is no longer in line with actual loss of income, providing a much broader lifestyle coverage.

The core need

Further to increased coverage levels we also commonly see the following generous policy features and reductions in risk controls added into the mix:

- Day 1 accident benefits, effectively waiving the waiting period
- High maximum benefit limits (AUD$30,000 per month to age 65 as standard)
- Generous partial benefits available with the allowance of 100% replacement ratios, 'day 1 partial' benefits and provision for those applicants working excessive hours, such as medical professionals working 60/70 hour weeks
- Limited income offsets – as competition in product features has evolved, previously sound income offsets such as sick leave and ongoing business profits for the self-employed have been removed from standard policy wording
- 'Occupation drift' – in underwriting and claims data we are seeing a shift from desk bound duties orientation at underwriting stage to manual duties orientation at claim stage, even within the same occupation classification and industry.

These in-built and optional policy features plus reduced risk controls, extend benefit payments well beyond the intended replacement ratio of 75%, meaning that on a simple dollar value basis, we are paying out more for claims than we mean to under such policies. The incremental enrichment of product features not only affects the level of benefits paid, it also has unintended consequences on claimant behaviour and the overall claim rates and claim durations.

Experience has shown that as coverage goes up, claims go up and the rule of thumb often cited suggests a one-to-one correlation; when coverage goes up 1%, rates go up 1%.[2] If this were true, the inbuilt liberalisation of policy coverage above would count for potentially an extra 40% claims cost over base line cover

The cost of an ancillary benefit such as 'day 1 accident' is not just an additional cost to the base line IP coverage for the extra accident claim during the waiting period, they also have a second order impact on claims beyond the waiting period including claimant return to work outcomes. As we continue to enrich disability benefits we enable higher rates of claim, which are then entrenched through replacement ratios that match or even exceed pre-disablement income, making return to work a much less attractive option and resulting in a natural extension of claim durations.

[2]Meilander, B. & Simbro, D. (1993). The Impact of Replacement Ratios, *Disability Newsletter.*

The core need

Equity in benefits

As a first measure, we need to rediscover what people really need and want from an IP policy. Product features are only one part of the solution in developing a comprehensive insurance cover and as we have discussed, more doesn't necessarily mean better.

Most people expect the cover they purchase to be equitable amongst all policyholders and not unduly favour one person (or types of people) over another. Many policyholders would be surprised to learn they were paying a substantially higher premium for generous benefits to be paid to other members of the insurance pool that are not in line with the underlying financial loss.

A product that reintroduces a greater balance in the premium and benefits covered would be much closer to meeting client needs and expectations than the current product that has evolved. Such a product would also provide greater protection from the increasing pressure on premium rates due to claims costs attributable to generous terms that impact both incidence and duration.

Currently, the typical product offer includes a standard and a plus option, with the standard option generally containing the same definitions as found in the plus product and the main differences being the inclusion or exclusion of ancillary benefits. The great irony is that the generous terms that make it easier to start a claim are provided as inbuilt benefits across all levels of cover while it is the ancillary benefits typically associated with increased support for recovery and shorter claim durations that are extra cost options. This imbalance in cover needs to be reversed and a simpler, foundation product that is aligned with core needs andpromotes recovery should be made available, with the following characteristics:

Cover that meets core need	Terms that are less susceptible to indirect drivers of claims and selection behaviours. Limit benefits to a percentage of actual financial loss
Simpler definitions	Terms that can be applied with greater clarity and certainty and thus produce a more predictable experience
Limited ancillary benefits	Inclusion of features that only support recovery, return to work and replacement of actual loss.
Lower premium with more stability over time	Stronger price differential between a foundation level of cover and one providing more generous terms. Greater stability over time due to the more predictable experience

The core need

Providing a much clearer distinction between the levels of cover, means that customers will have true choice in the cover they take up. A 'top end' level of cover will still be available to customers who want broader cover with the more generous terms, such as higher replacement ratios and a greater range of ancillary features that may pay benefits not always directly aligned to financial loss. However, customers must also be willing to pay a substantially higher premium that reflects the greater claims cost of such a product and which may also be more susceptible to volatility and indirect drivers of experience than simpler and more objective definitions.

The policyholder / insurer relationship

Once a policy has been bought, there are two main touch points as part of the ongoing service arrangement: policy renewal and claim. The claim, which is the core service being bought, has a high degree of uncertainty about if and when it will ever occur. Therefore, policy renewal will generally be the primary indicator that customers have to assess whether the insurer is delivering on the promise.

With most IP policies bought on the stepped premium model, policy renewal is marked by year on year increases, providing a very poor representation as to the level of service to be expected of the insurer. Each increase in the premium may incrementally reduce absolute affordability. However absolute affordability may not be the issue so much as relative affordability, which is arguably reducing at a faster rate. If a client does not believe that their health has deteriorated and increased their likely need for the insurance at the same rate that the premium increased, the perceived relative utility of each dollar spent on insurance will have reduced.

The complex web of issues that policy renewal invokes through the perceived inequity of premium increases, the reduced relative affordability and how the policy renewal may be perceived as a representation of future service may provide sufficient reasons for a customer to choose not to continue their policy. Products with generous terms have a negative impact on claims experience and ultimately the profitability of the book and make base rate increases on top of age and cpi increases even more likely, compounding the issues already discussed. Further, there is already a high degree of mistrust y customers about how fairly an insurer will act in the event of a claim.[3]

[3]AFA. (2013). White Paper: The Value of Protection. Sydney, Australia. Author

The core need

From a customer perspective, there is very little information provided about the process for submission and assessment of a claim and what to do if the outcome does not meet the customer's expectations. There is a huge opportunity to elevate core insurance functions into high value service offers that differentiate the customer experience.

Equity in service

One of the core needs for customers in the provision of service is that there is equity and they are treated fairly. Insurers can provide much greater transparency and guidance as to what the policy renewal and claims process will entail, so that customers' expectations are set up-front, helping to reduce the anxiety about a very unfamiliar service experience for the client.

Providing clear communication about policy renewal and what a client can expect is important in demystifying the process, as well as providing some basic education as to why premiums increase each year and the options customers have to manage the increasing cost. Also, it is an opportunity to introduce and promote existing components of the cover, such as features to increase cover without underwriting, or reduce it if their needs have changed, giving the customer a sense of choice and control at policy renewal.

Similarly, having clear and shared procedures about the claims process and particularly the avenues of appeal should a claim outcome not meet client expectation, can help reduce the perception that the claims process will be adversarial. In Workers Compensation, a client may request an 'internal review[4], which is a formal escalation process that precedes lodgement of a formal complaint with an independent body.

Most life insurers already have an internal claims committee to which disputed or complex claims are escalated, however the level of due diligence that is often applied for disputed claims is not made known to customers. By simply sharing the internal procedures and implementing an open process, giving customers the right to initiate a request that their case be referred to the claims committee, can deliver a strong message about customer rights and equity in the claims process. Instilling a greater sense of control over the claims process for customers is particularly important as a feeling of loss of control by claimants has been shown to have negative impacts on recovery and claim outcomes[5].

[4]WorkCover. (2013). Work capacity – application for internal review by insurer. Sydney, Australia. NSW Government

[5]Aurbach, R. (2013). Breaking the Web of Needless Disability. *Work: Journal of Prevention, Assessment and Rehabilitation.*

The core need

Summary

For customers, it is important that we get the basics right through product design, pricing and service and there can be no doubt a simpler product that produces fairer and more equitable results for policyholders is needed. This will help to bring income protection products back to being in line with principles of insurance, that is that it covers financial loss and no more. Such a product will be more affordable and less volatile, providing greater stability and confidence for customers in the product they have purchased.

The benefit for insurers is that it will also address many of the fundamental risk aspects that are currently problematic for Australian insurers such as claims trends and costs, as well as lapse rates and customer satisfaction.

Part 3 – Communication

In Part 3, we explore the role of communication in the life insurance context, from ambiguity in definitions through to how we share information with our customers. We consider opportunities to drive a better customer experience and improve margins by focusing on communication as a critical part of insurance design.

Customers want change

IP has evolved into providing more than a disability safety net, sometimes providing benefits in excess of financial loss and at its extreme worst, potentially driver behaviour so that those who could reasonably keep working make a claim, while rewarding existing claimants to remain on claim.

We are seeing retail premiums beginning to increase in the IP market and further substantial increases are expected. This will be a less than ideal outcome for the majority of customers who fundamentally wanted to protect their income and achieve simple peace of mind. These customers may otherwise object to funding perceived 'luxury' elements such as high benefits and generous claims definitions for others.

We should consider asking whether customers properly understand their cover, are satisfied that it meets their core requirements and gauge their level of comfort about paying for the cost of 'luxury' features. We think it is our duty as an industry and in the best interests of the majority of policyholders to keep cover in line with real needs and keep premiums affordable and sustainable. Whilst additional product features may appear attractive and on the face of it have immaterial cost, much in life tells us that this cannot be true.

Research conducted by the Association of Financial Advisers in 2013[6] suggests that there is consistent feedback regarding lack of trust that consumers have of the life insurance industry and its commitment to consistently pay valid claims. Complex and legalistic language and 100 plus page policy documents clearly do not help, with the adviser often required to act as the interpreter of benefit coverage and the middleman in the handling of claims. One must ask "does the customer really need or even want such a level of complexity?".

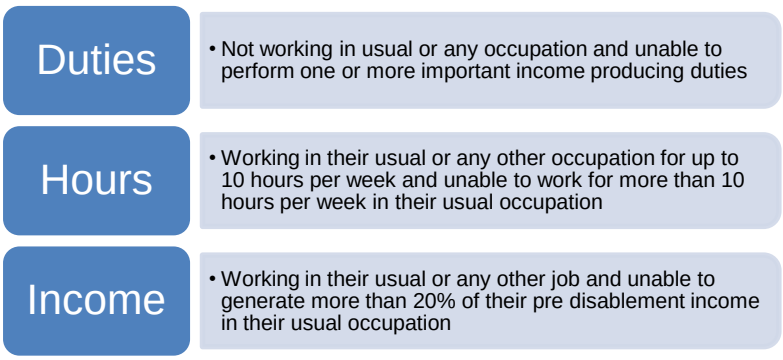
We think customers do want change, including plainer language, clear and objective benefit features and claims definitions that provide reduced subjectivity at claims stage to make claims more certain, as well as achieve greater stability in long term premium expectations.

[6]AFA. (2013). White Paper: The Value of Protection. Sydney, Australia. Author.

Communication

Subjective Definitions

The majority of Australian IP contracts offer a three tier total disability definition which entitles claimants to a full benefit on the most beneficial of the three.



Putting the generosity of this tiered approach aside for a moment, there are clearly high levels of judgement required to assess whether a definition has been met or not.

Take the first one, which hinges on the meaning of “one important duty”. Which duty will be determined to be sufficiently important to entitle an individual to a full payout, especially when insurers are not always clear about an individual’s key duties for ‘generic’ occupations (e.g. “manager”) across different industries and trades? This points to the insurance industry needing to improve its underwriting of ‘important’ job duties and potentially deciding the degree to which it wants to monitor material changes to job duties since the policy was taken out (in order to maintain this definition with more certainty).

Then, there is the problematic and arguably flawed “10 hours” definition. Whilst encouraging claimants to maintain some level of employment after injury or sickness is well intended, the industry has created problems for itself by needing to find ways to objectively ascertain that no more than 10 hours have been worked by an individual. 10 hours becomes a financially important tipping point as to what benefit amount will be paid. More importantly though, with changing modern working lives, many individuals, especially business owners, can earn a substantial portion of their pre-disablement income by changing their working patterns and organising their week accordingly and income earning capability is no longer necessarily proportional to hours worked.

Communication

For partial disability, the claims definition has a similarly tiered structure and thus a similar problem as described above.

These are examples that cause issues for customers and insurers alike. For customers, at the time of submitting a claim, it is not clear what evidence is required to meet the definition of disability and whether or not their adviser (or a lawyer) will be required to assist the claims admission process. For insurers, there is a need to actively and consistently manage much more evidence: usual job duties, working hours and income.

Almost by definition, we have established muddy waters resulting in an increasingly adversarial environment between customers and insurers with reduced clarity, more lawyer involvement and the distrust of insurers.

More objective terms

This lack of clarity flows through to the definitions within the products. Even in trauma where we have historically considered the definitions to be objective, we are beginning to see a drift in how some definitions are interpreted. Within IP, the lack of clarity is even more pronounced. Sufficient detail is lacking in fundamental definitions of the product to be able to apply them as intended. As a consequence, over time we have seen the boundaries pushed further away from the starting point.

A loss of a sense of control is a factor that can significantly contribute to poorer claims outcomes[7] and poorly-worded definitions that provide no clarity regarding how claims definitions will be applied or interpreted can add to the lack of control experienced by a claimant. Reintroducing objective and clear definitions for income protection will improve overall application of definitions at time of claim in a number of ways:

- improve the capability with which claims assessors can interpret policy definitions
- provide greater confidence for claimants in the process and reduce adversarial outcomes
- reduce the need to involve lawyers in determining how to assess a particular claim
- ensure that definitions are applied in a way that is consistent with how actuaries have interpreted the definitions for setting of assumptions
- reduce future uncertainty regarding the potential for interpretation-creep by the courts and, over time, by the market.

[7] Aurbach, R. (2013). Breaking the Web of Needless Disability. *Work: Journal of Prevention, Assessment and Rehabilitation.*

Communication

Information sharing

Customers want information and insights from experts. Life insurers, by nature of the business we are in, receive a breadth of detailed information about how people recover from different illnesses and injuries. It makes sense that customers would look to us as experts and expect us to share any valuable information that may help them in their own recovery.

While for an individual a health condition is typically new and daunting, claims departments have seen most common conditions many times before and have a unique perspective to observe the impact of customer behaviour, the level of engagement with GPs, specialists and other health care professionals, plus the effectiveness of a range of treatment regimes on the duration and overall degree of recovery. This value of experience can be shared explicitly to improve customer views about the service and support provided. It may also help to remove perceptions about any imbalance of information power, particularly if we use that information to say to customers that 'with x condition we would have expected you to have returned to work by now' but have never previously shared that expectation or knowledge with them.

Information sharing can also be used in more subtle ways to help focus behaviours in a certain direction. Setting expectations with customers upfront about typical claim duration for conditions can help remove uncertainty as to how the claim will progress, while easing the sense of need for the claimant to prove their condition each month. People also unknowingly tend to conform their behaviours to what others are doing[8] and, by sharing how long others with a similar condition would typically be off work, insurers can subtly shift durations toward a certain outcome while at the same time improving claims experience and customer satisfaction.

[8] Thaler, Richard H.; Sunstein, Cass R. (2008). *Nudge: Improving Decisions about Health, Wealth, and Happiness.* Yale University Press. ISBN 978-0-14-311526-7.

Communication

Documentation

The length of a typical PDS is known to be an issue in the industry, as is the complexity of the cover provided within an IP product. At last count there were at least 50 benefits and features across the market, with many using vastly different terminology and one benefit having six distinctly different names between providers to cover the same benefit. Regulatory compliance requirements mean the length of PDS will be unlikely to change in the near future. However an alternative solution must be developed so that customers can easily digest the information and make simple comparisons between products. Perhaps the industry should self-regulate in this regard and develop a standard for summarising the structure and benefits under each product which will not only help customers, but advisers as well. A simple document that is consistent between all insurers to be used in the sales process would go a long way in improving the ease with which people can begin to understand our products.

If we do not improve how we communicate with customers, we may find that it is imposed upon us. Other markets have already discovered what it means to have a customer focus incorporated into regulation, with the Treat Customer Fairly regulations having been introduced in both South Africa and UK9[4]. Participants in the UK market consistently state that the government-imposed regulation in regard to fair treatment of customers is onerous and further adds to already complex compliance obligations. It is clear that being proactive in self-regulating customers' interests in product and communication design is by far the preferred outcome.

[9] FSA. (2007). Treating customers fairly – guide to management information. London, UK. Author.

Communication

Summary

The life insurance industry has much ground to make up for customers in establishing trust and confidence in the services we provide. Improving how we communicate with customers through the language we use in PDS, how information is presented and the certainty with which terms are drafted is a crucial first step. The whole basis on which we interact with claimants needs to change so that the focus is on positive, mutually beneficial outcomes where we share information that helps our customers, rather than be perceived as trying to get customers ‘off claim’.

For insurers, the benefits include greater predictive accuracy in expected claims and pricing, as well as reduced reliance on claims and legal resources to defend the interpretation of definitions.

Part 4 – Claims processes

Here, we look in detail at the how product and claims processes interact and where the opportunities lie to improve the product and claims connection.

Lack of historical investment in claims processes

The design of IP products to date has made claims management increasingly difficult. The drafting of policy terms and focus on dollar benefits have resulted in a transactional service, whereby claims managers act as administrators of the policy provisions and the value which claims managers add has to date, largely been underutilised as a key differentiating service.

Further, claims departments have borne the brunt of the relaxation of policy terms, with claim volumes far outpacing growth in the number of experienced and qualified claims managers. Whilst policy definitions have broadened, reducing hurdles to commence claim and remain on claim, such as the day 1 accident and 10 hours definitions, plus the pressures on claim duration through increasing replacement ratios, there has not been an equivalent level of investment in claims management control mechanisms and technology to improve efficiencies within claim departments.

The result has been stretched claims resources, distracted by increasing claim volumes withlimited capacity to focus on long term strategic planning regarding claims management. The lack of growth in claims managers within the industry and the poaching of claims staff from one insurer to another has further exacerbated the problem, directing attention away from the underlying problem to deal with superficial recruitment issues.

The product factors that have heavily impacted claims departments are not the only issues that claims managers have had to handle. Inherent aspects of the medical landscape and its approach to occupational disability have also played a part in the complexity of managing disability claims.

Claims processes

The role of GPs

A claimant's regular doctor plays an important role in Australian IP. The GP provides the initial diagnosis to confirm claimant disability and it is this diagnosis that sets the date of disability and triggers the start of the waiting period. This claimant / GP relationship is built-in to policy contracts and whilst the insurer has the opportunity to challenge the opinion of a GP and ultimately decide the outcome of claims, the burden of proof is generally with the insurer.

The time-constrained primary care model can give rise to a number of limitations in medical care[10], particularly for patients with chronic illness, including:

1. Care not necessarily aligned with evidence-based guidelines
2. Limited engagement in proactively educating patients in self-care practices
3. Limited multidisciplinary approach within general practice

It also recognized that the co-ordination of care between different health care providers and the patient are often insufficient to produce effective primary health care outcomes[11]. In many cases, a GP may not have the necessary training to undertake occupational assessment, however referral strategies are often not readily employed.

[10]Harris, M.F. & Zwar, N.A. (2007), Care of patients with chronic disease: The challenge for general practice.. *Medical Journal of Australia*, 187 (*2).*

[11]Jordon, J. E., Briggs, A.M., Brand, C.A. & Osborne, R.H. (2008). Enhancing patient engagement in chronic disease self-management support initiatives in Australia: the need for an integrated approach. *Medical Journal of Australia, 189* (10).

Claims processes

A quote by Dr Harry Pert of the Royal New Zealand College of General Practitioners in response to the Realising the Health Benefits of Work (HBOW) position paper, sums the GP paradox:

"I prescribe medication every day. I order investigations every day - laboratory investigations, radiology investigations. My ability to do that safely is based on many years of preparation - chemistry and pharmacology and a lot of decision-support throughout my career.

I haven't had that training and support in my prescribing of work and absence from work; it is a big gap in our knowledge. I think we have to do some work, in order to fix that"

Insurers currently struggle to co-ordinate the resources needed to consistently assess claims holistically across bio-psycho-social criteria. This creates a more GP-dependent model which is typically overly medicalised, increasing the focus on medical impairment at the expense of more hoslitic psycho-social factors. Such an approach may further entrench disabilityand in doing so, overlook the more useful approach of 'work-ability'.

Greater focus on holistic support

The design of IP products has been so focussed on competing on product features that the fundamental question of whether continually adding more product features actually meets customer expectations in regard to their needs and wants has been overlooked. As discussed, this focus on product features has placed pressure on claims departments, distracting them from key services that could beprovided to improve claimant outcomes and the overall customer experience.

Through our IP products, we already offer a range of support and services to customers through the claims process by way of rehabilitation, carer payments, household support, business coaching etc. However we thoroughly undersell the benefits of these services, describing them in a dry and technical manner and relegating them to the position of 'ancillary' benefits or packaged as part of an extra cost option (if they make it into the policy terms at all). Perhaps it is time that claims services become the 'sizzle' in the product and the value that these services provide are brought to the forefront.

Claims processes

In a recent paper, The Value of Protection[12] , surveying customer and claimant perceptions about service, 'holistic support with recovery' was nominated as one of the key ways in which customers would like the claims process to be managed. We believe that the focus of DII policies should be changed so that the 'wants', by way of holistic support services, become the primary benefits under the policy and these are 'supplemented' by the 'need' in the form of income replacement benefits, which will continue to form part of the base cover.

This approach will contribute to better customer engagement both at purchase as well as at claims, where the claims experience is provided in the context of a positive focus on support, recovery and wellness, rather than on the benefit dollars being received. A product and claims experience framed in terms of benefit dollars only can subtly result in loss aversion behaviours[13] where the claimant may be attuned to the dollars he or she will no longer receive rather than the services provided i.e. support to recover his or her health and the ability to participate in occupational and social pursuits.

In addition, the range of support services could be expanded:

- psychosocial support such as greater home services, where the customer is responsible for the care of dependents (whether children, adult children with disabilities or elderly parents),
- psychological services
- financial or business management services for self employed customers whose poorly performing business are contributing to their condition
- vocational assessments and retraining.

Further, we are becoming increasingly aware of the value of intervention strategies in improving the termination rates on claims, with various studies citing returns for each $1 invested in rehabilitation ranging from $7[14] to $24-$39[15]. By bringing the holistic support benefits to the fore, we can improve both the customer experience and our own claims experience simultaneously

[12]AFA. (2013). White Paper: The Value of Protection. Sydney, Australia. Author.
[13]Kahneman, D. (2011). Thinking, Fast and Slow.
[14]Arnetz, Sjogren, Rydehn & Meisel. (2003). Early workplace intervention for employees with musculoskeletal-related absenteeism: a prospective controlled intervention study.
Journal of Occupational & Environmental Medicine, 45 (5), 499-506.
[15]SwissRe. (2014). Rehabilitation Watch 2014 – Australia. Sydney, Australia. Author.

Claims processes

Focus on ability not disability

Traditionally we have talked in terms of disability and what the person cannot do, requiring a customer to demonstrate to us that they are 'disabled'. Whilst the term disabled is an insurance definition which most of us will readily associate with a contractual construct to help apply policy provisions at claim time, the same word to the person on the street has a very different meaning. This focus on disability and what a customer cannot do can entrench a mindset of long-term work incapacity for individuals, particularly if the customer has felt the need to defend the legitimacy of his or her injury or illness to the insurer in order to prove 'totally disability'.

Once disability has been established, too often attempts to engage a customer in return to work activity may be perceived as the insurer trying to 'get out of paying a claim'[16]. However, the health benefits of work and its role in recovery have been well documented. In 2012, the Australasian Faculty of Occupational and Environmental Medicine (AFOEM), part of the Royal Australasian College of Physicians, published a paper on this topic called the Australian and New Zealand Consensus Statement on the Health Benefits of Work (HBOW)[17]. The primary purpose of HBOW was to raise awareness regarding the health benefits of work and negative consequences that can arise from long term absenteeism.

Shifting the focus away from disability to what the person can do provides a platform from which to integrate work or aspects of work into the recovery process. Coupled with the holistic support services proposed earlier, it can be a powerful method in improving return to work outcomes with lower levels ofcustomer conflict.

[16]AFA. (2013). White Paper: The Value of Protection. Sydney, Australia. Author.

[17]Australasian Faculty of Occupation and Environmental Medicine. (2011). Australian and New Zealand Consensus Statement on the Health Benefits of Work. Sydney, Australia. Authors.customer conflict

Claims processes

This shift in focus also directly highlights the deficient premise of providing IP on an own occupation definition on a long term basis for most customers. The evidence from HBOW demonstrates the value of work in health and wellness and that long term absence not only has direct financial consequences but also has broader negative impacts on health and social aspects of an individual's life. Providing long term benefits for being unable to perform one's own occupation, disincentivises an individual to find other ways of re-integrating into the workforce if their usual occupation is no longer appropriate. We therefore strongly support that products be designed to encourage and reward people who return to work in any capacity, by incorporating allowances for assistance in retraining into other related fields and jobs that build on the individual's existing skills and experience. Such an approach also has obvious potential benefits regarding the underlying experience and cost for IP over the long term and may indirectly help to improve sustainability and affordability.

Summary

Bringing greater integration between claims services and support into the product and policy terms provides an opportunity to take DI products beyond only product features and dollars paid. It introduces a more positive platform from which the core service, being the claim, can be delivered. This approach helps to highlight the value of services currently offered by our claim departments but which we do not market or portray as core benefits, when in reality, it's these holistic services that customers want. Such services also allow the industry to move away from product competition and truly differentiate through the services provided.

Part 5 – Risk Management

Finally, we explore risk management and the impact a focus on short term metrics such as market share acquisition can have over the long term performance of a book of business.

Short term focus

Insurers in the Australian IP market compete heavily on price, underwriting requirements, replacement transfer terms and most importantly, product features. It is a dynamic marketplace where there is pressure to maintain a market leading new business proposition not just to maximise new business profitability but also to manage in-force business. This approach places greater focus on short term wins and less on longer term fundamentals, such as the quality of the overall pool of insured lives, sustainability of current assumptions and pricing and potential impacts on lapse rates.

As part of the price competition, stepped premiums dominate the market (over level premiums). As premiums follow the natural ageing process, there is no incentive for a policyholder to keep their existing policy if another insurer offers a better product with more features at a similar or lower price. Taken in combination with easy replacement transfer terms (where customers can provide limited health information at underwriting stage for the new (target) policy) and general increases in disability premiums due to poor claims experience, the industry is seeing sharply increasing lapse rates.

These lapses are highly likely to be concentrated towards the more healthy lives and thus insurers' in-force books are deteriorating in quality year-on-year as the less healthy are naturally more inclined to claim. This is well and good if the deterioration was priced into retail rates in the first place, but this is generally not the case.

As discussed in **Part 2 – the Core Need**, this short term focus can lead to a vicious circle of the 'product arms race', whereby weak fundamentals contribute to and compound poor experience, with any response, whether it be premium increases or increasingly more competitive new business offers to attract greater sales, likely to further fuel deteriorating experience.

The outcome is more IP pricing pain going forward. Not only are we seeing increasing premium rates due to past poor claims experience but also likely increases due to the anticipation of even worse future claims experience ahead. As a consequence, we predict further affordability issues for customers and pressure on lapses

Risk Management

Structurally, the retail market has become almost perfect in its competition, whereby the majority of the insurers position their propositions for adviser attention and product ratings by competing on the same limited short term factors that drive new business acquisition: stepped premiums, competitive price, low underwriting requirements, easy transfer terms and generous product features. Given the high number of market participants, it is inevitable that profit margins will generally be under pressure unless a circuit breaker is found such as the development of a more dominant level premium market or true features that differentiate on factors, such as service-oriented, preferred lives, lifestyle or wellness propositions.

Risk management at new businesses

Besides the aspects already discussed, other ways in which to influence the long term value of IP for all stakeholders include looking at management at a portfolio level. Too often the focus has been on the short terms gains of selling another policy, overlooking the longer term implications. When assessing new business applications, the ultimate goal should be 'underwriting for profit'. As Robert Kiyosaki[18] says when talking about making money in business (in his case through property transactions), 'profit is made when you buy, not when you sell'. It is equally applicable to life insurance, in that if you don't get the fundamentals right when you underwrite the business, you will struggle to ever catch up and make a profit on that book of business, no matter how good your in-force and claims management practices may be. It is a sentiment that has been endorsed before as a basis for making a profit in IP[19] and so it should be no surprise that it is strongly recommended that poor practices that undermine the quality of the pool at the outset, such as wholesale waiving of underwriting loadings for particular risk writers, not continue.

Ensuring that, at commencement, the risk accepted is consistent with the assumptions developed when pricing the product is the critical first step. With the mandatory non-medical limits having increased substantially over the last five to ten years, we need to revisit how health underwriting is applied and improve our accuracy of predicting the health prospects of an applicant. One such way is multi-factorial risk ratings where, rather than assessing an individuals' risk based on his or her BMI and blood pressure as separate risks that are added together, the combined risk of these two factors is calculated.

[18]Kiyosaki, R. & Lechter, S. (2000). Rich Dad Poor Dad. New York, US. Warner Business Books.

[19]Libbey, D., Palmer III, H. & Simbro, D. (1994). How do you make a profit in individual disability income (DI) *Record of Society of Actuaries.* Volume 20, No.3A.

Risk Management

For example, someone who has a BMI of 37 with a systolic blood pressure reading of 90 might be considered a standard risk, whereas the same BMI coupled with a systolic blood pressure reading of 100 pushes them into a medium risk category[20].

The multi-factorial risk assessment can add significantly more precision to the underwriting process but it can be extended even further, with a similar approach to the emerging use of profiling within claims also applied at underwriting. Traditional factors such as industry / occupation, age and medical history can be coupled with holistic factors such as health habits, resilience, workplace satisfaction, as well as home demands which are correlated with claims duration to build a broader profile as to the potential risk an individual might represent in respect of both incidence and duration. Understanding the interplay of multiple factors, not just medical but also psycho-social factors, disclosed in an application will allow us to build a profile to improve predictive capabilities for claims at a more granular level.

A broader set of questions, as well as the manner in which questions are asked can directly input into a more comprehensive risk profile of an applicant. Further, ceasing obviously poor practices such as waiving medical loadings, when the underwriting process has clearly identified a need for that individual to be loaded, should occur. These practices dilute the quality of the overall pool and ultimately mean that the healthy individuals are subsidising the non-healthy individuals based on some arbitrary factor.

[20]Armuss, A. (2014). The Multivariate Risk Calculator (or how to take weight off one's shoulders). Munich Re

Risk Management

Ongoing risk management

Once a portfolio has been established and the mix is consistent with pricing assumptions, the next challenge is to maintain the quality of that pool. As already discussed, once the quality of a pool begins to deteriorate, it can rapidly lead to a steep and irreversible decline. A more recent and alternate way for managing the quality of a pool is to focus on health maintenance.

Wellness programmes can help to reduce the burden of disease within a portfolio, coupled with predictive and early intervention activities to return those within the pool to health as quickly as possible, contributing to an improved portfolio over the longer term. The level of a wellness programme can range from the promotion of free, self-serve solutions, such as weight loss, health checks and fitness services that are not provided by the insurer and where no information or data is provided to the insurer, to the other end of the spectrum where full end-to-end solutions that tracks everyday activity and rewards positive behaviour are provided to customers.

Linking lump sum claim flags to prospective disability income claims is another preventative method, particularly for degenerative conditions. This approach would not typically achieve gains by reducing duration due to the nature of the condition but could result in deferring the commencement of the IP claim. An example would be multiple sclerosis, where on notification of diagnosis in relation to a Trauma benefit, exercise therapy might be provided as a service under the IP policy, resulting in functional impairment being deferred for a matter of months or years, positively impacting the commencement of an IP claim, and contributing to the claimant's quality of life in a measurable way.

Risk Management

Responding to market conditions

It is our view that much of the competition seen in the disability market has evolved to ensure research ratings are maintained so that products will be recommended through the advice process and ultimately achieve new business sales, rather than competition having developed in response to changing market conditions or evolving customer wants and needs. We discussed in **Part 2 – The Core Need** of the series, the 'product features arms race' and the importance of developing products that align with how customers want to use income protection products. Of equal importance is recognising a changing market landscape and responding appropriately.

The significant tightening of various state government Workers Compensation schemes in recent times such as more stringent work capacity assessments, limitations to travel to/from work ("journey") claims and a requirement for the claimant to "make a reasonable effort" to return to work has generally not elicited any kind of response in the disability income insurance market. Also notable for its absence has been the lack of any particular tightening of terms and conditions in the market during the post 2008 global financial crisis at a time when experience is now acknowledged to have deteriorated.

Our industry's response to increasing trends in clearly important categories of work absence such as stress, depression and anxiety have also been minimal. Identification of real behavioural risk drivers and early warnings of mental health issues have not evolved much further than 'blanket' exclusions or outright declinature based on 'symptomatic' mental health history at application stage. These practices are coupled with poor management of mental health associated claims later down the track. The building of claims skill sets needed to intervene early and actively support return to work is generally not in place and we are still directing claimants from doctor to doctor in the hope that a more refined medical diagnosis of impairment is going to help. Insurers need and customers deserve something more practical and useful.

Risk Management

Trends versus cycles

As we attempt to be better users of data and monitor our experience with greater frequency, we need to be more adept at distinguishing between volatility, a trend and a cycle. Volatility and trends are expected and evidence is emerging that indicates life insurance is also subject to a cycle, albeit a long one. The historic experience has proven to be that periods of strong profitability lead to a general relaxation of terms and underwriting as a means of attracting greater new business. As the experience of these more generous terms play out, experience deteriorates, driving down profitability. In response to these periods of poor profitability and losses, the market moves to correct it by restricting terms and practices. The cycle then commences again. A search through the US Society of Actuaries archive produces many papers on the same topic, dating from the 90's, the 70's and even the 60's. Similarly in the Australian market, we have experienced this deterioration at least twice now, once in the mid 90's and again now.

Once we address these problems in the current market, how do we ensure that 20 years from now, our successors are not again facing the same problem? Being able to differentiate between volatility, trends and cycles, as well as identification of the indicators of the different phases of a cycle, we can institute a long term management model, where we do not relax terms and pricing in the good times to the extent that we cannot recoup our costs in the bad times.

Further, we need to acknowledge that new trends will always emerge which we did not anticipate when setting pricing assumptions that must last 20 to 40 years into the future. When setting the pricing only five to ten years ago, we did not predict the increased lawyer involvement in claims, the reduced stigma to making a claim, that mental health would be the second highest cause of long term claims, increasing work hours and the later age at which retirement now occurs. Ideally we would improve our skills in anticipating future trends, but at the very least, we need to include pricing assumptions that reflect there will be trends that impact on future experience that we do not yet foresee.

Risk Management

Summary

IP experience has significantly deteriorated in the last 5 years and the analysis provided in the five issues of this series has illustrated some of the contributing factors. The most worrying feature for insurers and customers is that, for current style policies, the future is likely to see elevated claims and potentially a continued upward trend due primarily to generous terms, anti-selective lapses and further resource stress upon claims management teams.

With the current 'product arms race' including liberal underwriting and easy replacement terms there appears little scope for insurers to manoeuvre other than to increase prices, reign in further product enhancements and invest in claims management improvements in order to make a reasonable risk rated return on capital. One solution appears to be to go back to basics and to look at what customers really need from an IP policy.

Whilst the issues that have led to the deteriorating experience in the Australian disability market are numerous, it means that the opportunity to respond and develop a new disability proposition that taps into customer motivators is significant. The insurer that moves first will be able to develop a unique competitive position that both attracts and retains the best type of customers and the type of business which will deliver superior characteristics of profitability.

The solution needs to address a number of aspects that have resulted in poor performance of income protection business and it is not simply a matter of turning off some benefits. It requires wholesale changes to the product incorporating a new approach to product design and customer value:

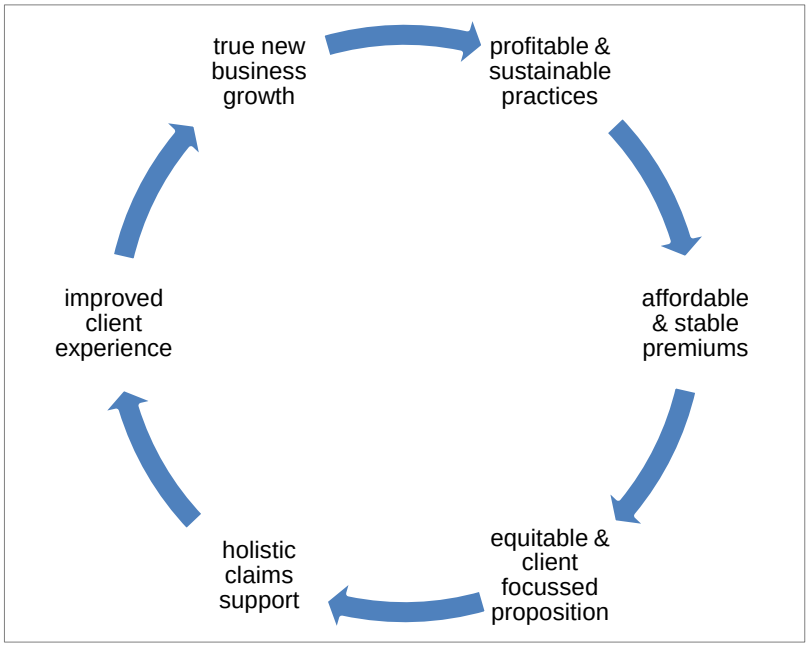
Fair benefits aligned to financial loss
Clear terms that are simple to apply and understood by customers
Holistic support based approach to claims with focus on ability and recovery
Improved portfolio and risk management
Improved monitoring of trends and cycles

Risk Management

Each of these changes could be made in isolation but the combined effect will be greater than the sum of the parts, flowing through to the underlying profitability in a number of different ways.

The ideal outcome is to create the opposite of the vicious circle, that is a virtuous circle that is self-sustaining through strong principles and risk management activity that contribute to positive customer experience, motivating beneficial behaviours. The ultimate position is where customers become advocates of their experience and through word of mouth, the industry grows. This is a long term vision but it must start somewhere.

Figure 6: Virtuous circle of income protection



By working through the issues and improving the whole process, the Australian success story about income protection can be restored so that it is not only a success story about sales but also about a profitable business model with customers at the centre.