



Super, Life and General meet at the Crossroads

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Abstract

Workers compensation claimants are increasingly turning to Income Protection (IP) and Total and Permanent Disability (TPD) benefits when their weekly payments cease. However, someone with the same injury, but injured outside of work, will only have access to Income Protection and/or TPD benefits (a.k.a. disability insurance products). This is an example of where insurance products are not well matched with an individual's needs following injury or illness. More recently, these group life insurance products, i.e. IP, Death and TPD offered through superannuation funds have sustained poor profitability.

In this paper, we aim to share some parallels between the issues facing group life insurance with similar general insurance related experiences, and from these suggest some possible avenues for further investigation. We consider the range of insurance products and government provided benefits available to an individual following illness or injury. If we can identify the overlaps and gaps in injury and illness insurance needs, we can start to design products that better fit with each other. In this way, the traditional silos between life insurance, general insurance, and superannuation should converge to better meet the claimant's needs.

For disability insurance to be sustainable and value adding in the long term, we suggest a re-think of the product. At the end of this paper, we also suggest some ideas that may form part of the solution.

Keywords: TPD; Income Protection; Salary Continuance; Workers Compensation; CTP; Medicare; NDIS; Health Insurance; Personal Insurance; Group Life Insurance; Superannuation;; Accident Compensation; illness; accident; injury

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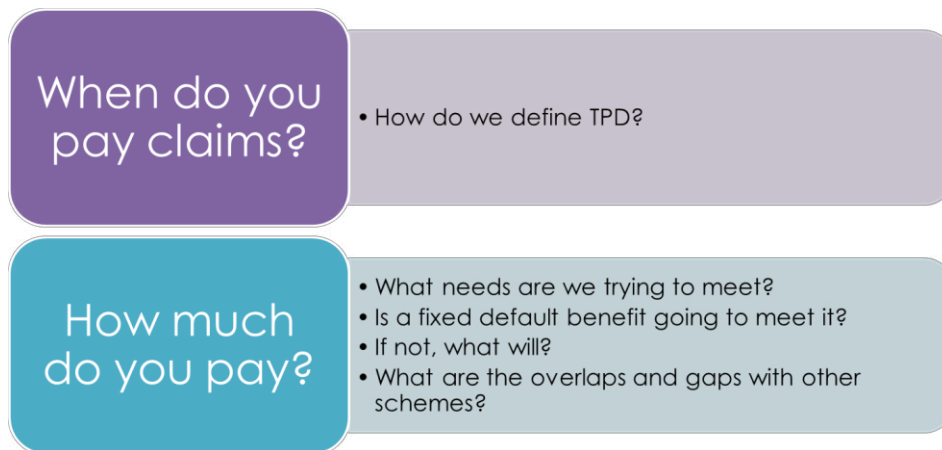
We would also like to thank Estelle Pearson for generously giving her time to peer review this paper.

1. Introduction

Over the past few years, group life insurers have reported large losses totalling around \$500 million. This has come from increases in reserves to recognise a greater number of disability insurance claims, more specifically, TPD claims. The greater number of claims has been blamed on increasing legal representation.

Insurers pay claims based on the terms and conditions of the policy which they have sold. Over the last three decades there has been a gradual shift in the legal environment such that challenges to insurer decisions are the norm rather than the exception. Rather than pointing the finger at lawyers for doing their job, a more appropriate response is to revise the terms and conditions of policies so they pay the types of claims that the insurer intended in the first place.

In our opinion, there are two main conversations that are required, as shown in the figure below.



We consider the parallels with general insurance issues that have been faced before, and how the learnings from these experiences may be applied to the group life insurance context.

There are similarities between the issues in TPD and the liability crisis of the early 2000s, both in terms of the slow recognition of poor claims experience (due to long delay from accident/event to report) and the subsequent initiatives to correct this experience, such as industry-wide data collection used for understanding trends and better reserving and pricing.

We also consider the changes in workers compensation schemes which can be adapted to group disability products:

- use of objective medical assessments for determining access to benefits, such as Whole Person Impairment assessments, and;
- use of early intervention and injury management to reduce the number and size of disability related claims.

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We put forward ideas that would be useful in re-thinking the disability insurance product of the future. Ultimately, the aim is to end up with a financially sustainable product that offers good value to policyholders. The “solution” should consider potential overlaps with other benefits, such as workers compensation, and will most likely require working with superannuation fund trustees to implement (which is also one of the reasons for the title of this paper).

2. Why Super, Life and General are at crossroads

Sharing expertise within the profession

The actuarial professional has diverged along these three lines, which broadly reflects our specialisation within these industries. Over time, our skills have evolved with the needs of our respective employers. This has evolved to a stage that we could be members of separate professions.

Life insurance actuaries specialised in long term products and the reserving and profit measurement relating to these products. General insurance actuaries specialised in working with claim reporting delays, allowing for IBNR, and recognising behavioural trends in experience. Due to the long delays in claim notification, the issue of determining IBNR is particularly important for TPD, and an area where general actuaries can contribute positively.

The recent discussion around measuring rising TPD losses has led to suggestions of accident compensation focused solutions, such as return to work initiatives. There are many comparisons that can be drawn to previous General Insurance experience, some more likely to be useful in the TPD context than others. We suggest that we can gain as a profession from sharing and incorporating our knowledge between our practice areas.

Convergence of insurance products

The separation of the three disciplines relates to a time when insurance products were simpler and more clearly separate. This has changed with the evolution of civil liability, compensation schemes, other insurance products (e.g. accident and health, health insurance, consumer credit), and government initiatives (e.g. the National Disability Insurance Scheme).

The convergence and overlap of insurance products mean that a solution to the disability insurance issues should consider the other products. A value adding product should avoid duplicating what is already offered (and often compulsory in the accident compensation space).

Superannuation fund are also important in this context. As the main mechanism for distributing disability products, they are inevitably part of the solution.

3. Outline

The remainder of this Paper is set out as follows.



4. Group life insurance has been unprofitable

Life insurance industry news has been dominated by large losses experienced by the major players of group life insurance. Below is a snapshot of losses experienced by the major players and the cited reasons.

Company	Reported Loss
Swiss Re	Swiss Re's Australian group disability business has experienced rising claims trends. This has led to a strengthening in claims reserves of USD\$369 million in 2013. The operating margin in its life reinsurance has declined from 10% of net premiums earned in 2011, to 8% in 2012, 5% in 2013 and 7% in 2014.
RGA	RGA strengthened Australia's group claims liabilities by A\$274 million in 2013; primarily due to group TPD reinsurance. RGA also suspended new quoting activity in the Australian group TPD market.
Hannover Re	Hannover Re's life and health portfolio net income fell by 26% in 2013, primarily due to the strengthening of Australian

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	disability reserves.
Munich Re	Munich Re's 2014 Annual report stated that the "unsatisfactory" result in life insurance was primarily due to the Australian disability business. The reserves were raised by €100 million in the fourth quarter of 2014.
CommInsure	CommInsure's after-tax net profit was down by 7% for 2014. There was also a \$61 million strengthening of reserves in the 2014 financial year for its Wholesale life income portfolio.
TAL	In 2013, TAL's premium income increased by 24%, but this was more than offset by a 38% rise in claims. TAL's life business result was down by 14% in 2014.

The common theme to the losses has been with group life, more specifically TPD and IP.

5. The perceived causes of poor profitability

The known causes are summarised below:

- Greater number of claims than expected, which has been attributed to more product awareness, increased legal representation, and the rise of mental health claims.
- The definition of TPD in the policies is open to challenge.
- An increase in TPD claims from white collar professions linked to mental health, sometimes with very generous benefits.
- Automatic acceptance, even for relatively high limits of cover has contributed to this. People can join a super fund and receive generous automatically accepted benefit levels even if they are ill/sick on joining.
- The insurer may have no knowledge of the claimant at early stages and limited access to the claimant when the claim is reported which means costs cannot be controlled with initiatives to encourage return to work
- Toughening Workers Compensation legislation with stricter controls around long duration benefits have led to the search for alternative sources of benefit
- Long reporting delay means that insurers were blindsided

6. Insurer response and its effectiveness

The primary response by insurers has been to put through large premium increases for group disability insurance products. For example, the Death and TPD insurance premiums for the largest industry super fund, Australian Super, increased by 35% in 2014, in addition to the 38% increase in the year before¹, with some other super funds

¹ Millan, Laura; "Australian Super insurance premiums to rise by 35%"; Financial Standard; 14 March 2014

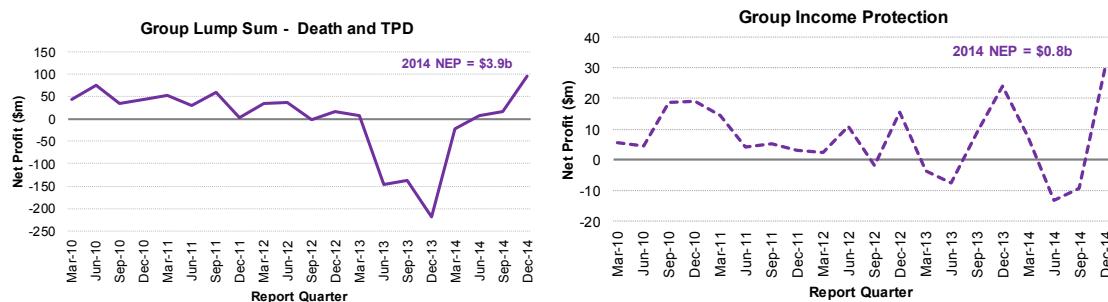
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following suit. Coinciding with the premium increases is a reduction of TPD benefits offered to members. Some insurers exited the group life insurance market altogether.

There were also other responses that will have a less immediate impact, such as the following:

- Working with super funds to improve data collected for premium rating.
- Fostering a more co-operative relationship with super funds with a focus on providing a sustainable solution rather than the cheapest solution.
- Changes to the definition of TPD and IP claims to require reasonable rehabilitation be undertaken and to incorporate stricter thresholds to qualify for the benefit.

How effective have these changes been? The following figures show the net profits reported to APRA up to 31 December 2014.



Source: APRA

The dip in profitability for group death and TPD products started in June 2013 and lasted for a year, which coincides with the reported strengthening of reserves by insurers. The reported losses totalled \$500 million, which more than wiped out reported profits of around \$400 million in the preceding 3 years.

The premium increases saw total industry premium grow from \$3.2 billion in 2013 to \$3.9 billion in 2014 (a 22% increase). As a result, profit has returned to its previous level, totalling \$120 million in the last three quarters. It appears that the increases in premium have returned group death and TPD products to a profit making position, provided the reserves are adequate.

Group income protection insurance has been moderately profitable over the last few years (notwithstanding quarterly ups and downs). As IP only represents 17% of the total group life insurance by premium volume, we focus our attention in this paper mostly on TPD.

Insurers have been able to pass on premium increases to superannuation fund members. Arguably, the steep premium increases appear to have been put through with not much general press coverage (especially when compared with home premium increases following the Brisbane floods in 2011). Presumably, this is because

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insurance premiums are paid from superannuation contributions, and the lower superannuation accumulation is not immediately “felt” by the insureds.

However, we believe that the premium increases are only a band aid solution due to the following reasons:

- **High premiums** are unlikely to be sustainable. In some instances, group life insurance is more expensive than retail products². This may lead to discussions around value for money and erosion of retirement incomes.
- **Benefits have been reduced** but is it still meeting the “consumer need” for TPD. This is discussed further in Section 9.
- Definitional changes have tightened the eligibility for a claim, but the **definition remains subjective and open to legal challenge**. This is discussed further in Section 7.
- There are some further issues which the changes to date do not address, such as limiting legal intervention (and therefore the costs associated with it). This is discussed further in Section 7.

7. Issues affecting disability insurance

Setting “appropriate” risk prices is obviously a requirement for insurance. However, this has not dealt with the structural issues facing group life insurers, especially as competitive forces will likely see some of the premium rate increases erode over time. A sustainable long term solution will involve developing appropriate responses to these issues.

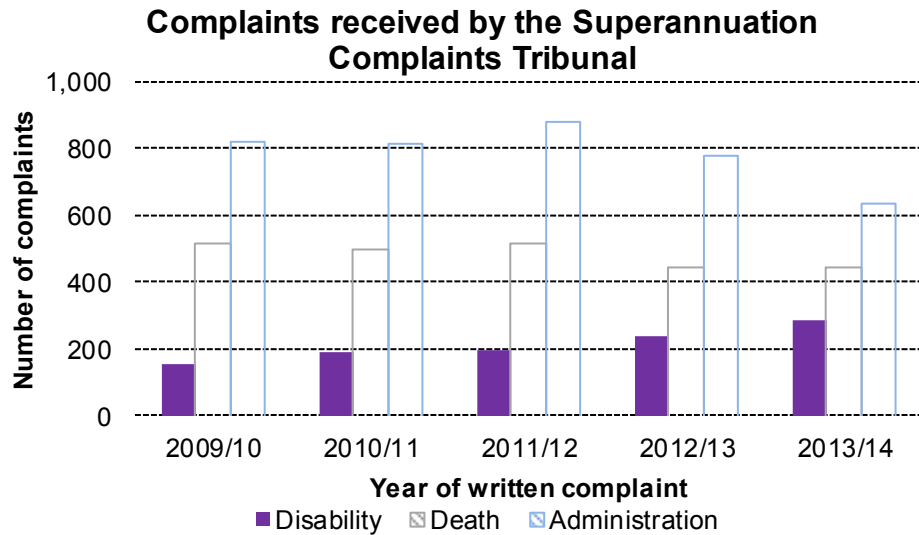
In this section we explore the following core issues in more detail:

- Subjective definition of TPD
- Increasing legal representation
- A search for other alternatives as Workers Compensation benefits tightens
- Growth in mental health claims

Defining a TPD claim

Determining whether a claimant satisfies the conditions for a TPD claim is subjective and therefore often a disputed matter. The figure below shows the number of written complaints received by the Superannuation Complaints Tribunal.

² LIWMPC; “Group Insurance – The industry response”; 8 April 2015



Source: Superannuation Claims Tribunal 2013/14 Annual Report

While the number of complaints has fallen over the last few years, the number of complaints received regarding disability has almost doubled since 2009/10. Industry funds make up the largest share of complaints regarding disability products (49.4%).

We have observed that disability insurance benefits have been subject to more legal activity over the last few years. Below is a short summary of judgements handed down by the courts over the last few years.

Case	Court	Year	Successful Party	Issues
MetLife Insurance Ltd v FSS Trustee Corporation / FSS Trustee Corporation v Maund	NSWCA	2014	Insurer	Appropriate date for calculating TPD benefit (should be date of event given rise to the claim)
Hannover Life Re of Australasia Ltd v Colella	NSWCA	2014	Claimant	Satisfying TPD definition; insurer acting reasonably
Banovic v United Super Pty Ltd	NSWSC	2014	Claimant	Satisfying TPD definition
Birdsall v Motor Trades Association of Australia Superannuation Fund Pty Ltd	NSWCA	2014	Insurer	Satisfying TPD definition
Preston v AIA Australia Ltd	NSWSC	2014	Insurer	Satisfying TPD definition
Lazarevic v United Super Pty Ltd	NSWSC	2014	Claimant	Satisfying TPD definition

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Folan v United Super Pty Ltd	NSWSC	2014	Claimant	Satisfying TPD definition
Ward v MetLife Insurance Limited	WASCA	2014	Claimant	Satisfying disability definition (income protection claim)
Erzurumlu v Kellogg Superannuation Pty Ltd	NSWSC	2013	Insurer	Satisfying TPD definition; insurer acting reasonably
Birdsall v Motor Trades Association of Australia Superannuation Fund Pty Ltd	NSWCA	2015	Insurer	Satisfying TPD definition

Source: Finitly analysis of Benchmark (published by A R Conolly and Company Lawyers)

The common theme with these cases has been deciding whether or not the claimant satisfied the disability definition. It is clear that defining a disability claim is not straightforward, with this being tested by court rulings. The large sums at stake make pursuing a claim attractive and engaging legal action financially viable.

While there are differences in the definition of what constitute a TPD claim between insurers, it is broadly defined as follows (taken from Hannover Life Re of Australasia Ltd v Colella):

“are unable to do any work as a result of injury or illness for 6 consecutive months and at the end of the 6 months they continue to be so disabled that he or she is in our opinion unable to resume their previous occupation at any time in the future and will be unable at any time in the future to perform any Other Occupation”

Common disputes that arise with this definition is the assessment of whether the claimant will return to work in future (based on only information currently known), and what constitutes an occupation. Whether a claimant does ultimately return to the workforce, has no impact on the payout of the claim. These disputes lead to higher costs to the insurer through additional friction costs including legal fees and multiple medico-legal assessments.

This form of TPD definition has been entrenched for quite some time, ultimately leading to the definition being encapsulated in the Superannuation Industry (Supervision) Regulations 1994, Section 1.03C, which states:

“if a trustee of the fund is reasonably satisfied that the member’s ill health (whether physical or mental) makes it unlikely that the member will engage in gainful employment for which the member is reasonably qualified by education, training or experience”

This is now a barrier that needs to be overcome when considering changes to definition.

Takeout:

It would be fair to say that the definitions in policy wording have not achieved the expectations of life insurers. A few observers have suggested that one possible enhancement to the TPD product is a clearer definition for permanent incapacity, and for the assessment to be made by a medical practitioner. This is similar to approaches taken in the workers compensation space, and we explore this further in Section 8.

Corporatisation of law firms and increasing legal representation

The Australian Financial Review (AFR) reported on 30 March 2015 that the Association of Superannuation Funds of Australia (ASFA) had complained to the Law Society of NSW about lawyers launching legal action against super funds to force insurance claims “in the first instance”, rather than waiting for the normal assessment and dispute processes to be completed. Against the backdrop of a sharp rise in claims, ASFA has raised concerns about the increased administration costs involved in fighting legal cases and the high fees law firms receive should cases succeed. The AFR reported that super funds are “infuriated” by the trend for more law firms to target the life insurance arena since their involvement in workplace claims was severely curtailed.

A key challenge for the life industry has been the increased involvement of lawyers in the claims process. Lawyers are becoming increasingly proactive in assisting policyholders to understand their potential benefits. The problem is further compounded by insufficient collection of data which could raise early warning bells and properly guide decision making. Without better data, the nature and size of the issue, and therefore possible solutions, will be harder to determine.

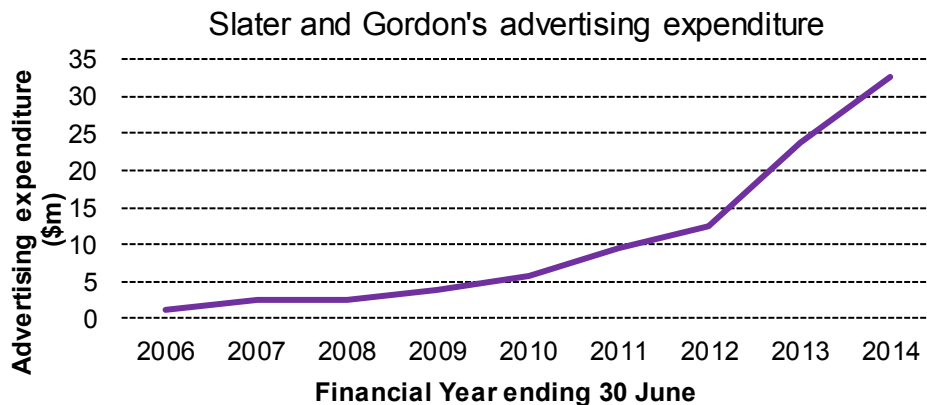
The increase in legal representation coincides with the corporatisation of law firms. Compensation cases are increasingly being handled by specialist law firms, such as Shine, Slater & Gordon and Maurice Blackburn, which provide assistance with all forms of compensation payments. Below is a screenshot of the Maurice Blackburn website illustrating the service offerings.

LEGAL SERVICES			
COMPENSATION LAW	GENERAL LAW	SUPERANNUATION AND INSURANCE	EMPLOYMENT LAW
Institutional abuse	Class actions	Superannuation claims	Employment law services
Medical law	Financial advice disputes	Insurance claims	
Military compensation	Social justice		
Motor vehicle compensation	Will disputes		
Negligence claims			
Workplace compensation			

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Personal injury and superannuation claims feature prominently on the websites of these firms. This contrast with the traditional “generalist” law firm, which may have been a last resort for a claimant if an issue with the insurer arose. Claimants are more aware of their legal options and increasingly approaching these law firms if they have a problem, often in advance of notifying the insurer and by-passing the Superannuation Complaints Tribunal altogether.

Despite provisions implemented by state law societies designed to limit advertising for personal injury and work injury services, there has been a notable increase in television, radio, billboards and online advertising. The figure below shows the annual marketing and advertising expenditure of Slater & Gordon as stated in their annual reports.



Shine and Slater & Gordon are both ASX listed and have expanded their operations through acquisitions³. These changes influence business strategies such as a focus on delivering returns to shareholders.

A related issue, whether perceived or real, is that the assessment of whether someone qualifies for TPD benefit rests with the insurer. This could be a frustration for the claimant, as it may appear that they have little control over the outcome of their claim, and drives the claimant to seek legal options. This reflects society's changing attitudes to litigation with Australia increasingly being seen as a litigation hotspot on a global scene.

Legal fees are not ordinarily paid as entitlements under a policy, so costs can very easily erode benefits payable. Lawyers seek to overcome this hurdle by litigating early in the process (so as to potentially recover costs and interest) which further add to claims cost and duration. In court proceedings you can also claim interest on the

³ In June 2014, Shine announced its acquisition of Western Australia's Stephen Browne Personal Injury Lawyers and North Queensland's Emanate Legal, a law firm that specialises in landowner compensation. In August 2014, Slater & Gordon announced its acquisition of Victorian personal injury law firm Nowicki Carbone Partners and Queensland consumer law firm Schultz Toomey O'Brien.

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benefits that you should have been paid, as well as a contribution towards your legal costs if you are successful. This is not the case in other forums such as the Superannuation Complaints Tribunal or when utilising the services of the relevant Ombudsman.

Why this is important to life insurers:

- *If this corporatisation of law firm trend continues, we imagine it would lead to further claim activity on superannuation claims.*
- *Involving lawyers increases the cost of managing and settling claims.*
- *Specialist compensation law firms have a database of past clients (from say workers compensation, CTP or common law cases). This can increase the awareness of superannuation insurance products and therefore the level of claims, especially late reported TPD claims.*
- *In addition, lawyers are being involved at earlier stages of the claims process, and often at the notification stage. The adversarial legal process may limit access to the claimant by the insurer, thereby making rehabilitation efforts less effective.*

A search for other alternatives as Workers Compensation benefits tighten

Workers' Compensation schemes have been undergoing reforms over several decades that aim to reduce claims cost and leakage, particularly around eligibility and quantum creep. The tightening of workers' compensation benefits and hard boundaries has shown a drop in claim numbers as well as duration.

For example, the NSW legislative amendments in 2012 significantly curtailed entitlements, such as having:

- Weekly payments cease at 5 years (or retirement age) for those with less than 30% whole person impairment
- Work capacity assessments every two years, with restricted review rights
- Lump sum payments for pain and suffering eliminated
- Each party would ordinarily have to bear its own legal costs as opposed to being covered by the scheme, which when combined with eliminating lump sum benefits, makes legal action less attractive for plaintiffs and their law firms
- Journey claims largely eliminated unless there is a substantial connection to employment
- Permanent impairment claims – threshold was lowered from 15% to 10% impairment for physical injury (15% maintained for psychological/psychiatric injury)

These changes contributed to the improved financial performance of the NSW workers compensation scheme. Most notably, the scheme moved from a \$4.1 billion deficit in December 2011 to a \$1.4 billion surplus in December 2013, partly reflecting early evidence of reduced active claims and lower payment levels⁴.

Most workers' compensation schemes use injury severity thresholds to determine impairment, common law gateways and weekly compensation caps and step downs. When claimants come off workers compensation benefits, they turn to their life insurer for TPD and income replacement benefits.

Growth in mental health claims

Mental health claims are now one of the top three causes of disablement claims in the life industry. Group insurers are reported to pay more than \$160 million per annum for IP and TPD claims where the primary cause of claim is mental health alone. This is perhaps unsurprising as it mirrors national health statistics placing mental health issues in third place in terms of the burden of disease. Alarming, stress related illnesses are predicted to be the leading cause of global disease by 2020.⁵

The rise in mental health claims can be attributed to changing societal attitudes with perhaps less stigma attached to mental health, as well as more liberal diagnostic practices. Recently, the publication of the latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) has arguably led to the lowering of diagnostic thresholds as a major depressive disorder can now be diagnosed even during the acute phase of 'normal' grief or bereavement. On one view, 10% of life policy holders who weren't previously eligible for claim now are.⁶

Pertinently for IP and TPD claims, studies have shown that psychological and cognitive barriers rank as the primary factors preventing return to work. Australian workers' compensation statistics also show that mental injury claims are costlier than physical injury claims.⁷

Mental Health – the Workers Compensation context

The increase in both claim frequency and severity pertaining to mental health is not unique to life insurance, with Workers' Compensation insurers also facing challenges in dealing with mental health claims. In the Workers' Compensation context, the injuries can be caused by sudden and traumatic events or ongoing and more subjective perceptions. Examples of the former are post-traumatic stress disorder (PTSD) as a

⁴ The Centre for International Economics, Statutory review of the Workers Compensation Legislation Amendment Act 2012, 30 June 2014

⁵ SuperFriend research cited in Strickland S, A critical equation: balancing Australian worker health and company wealth, AIA Australia, August 2013

⁶ Samuell D, Medical Director, Corporate Health Services, Australian Financial Review, 29 June 2013

⁷ Safe Work Australia, The Incidence of Accepted Workers' Compensation Claims for Mental Stress in Australia, 2013

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result of a robbery; the latter includes depression and/or anxiety developing due to bullying or poor relationships at work.

A multitude of factors influence whether an individual develops a mental injury in response to an underlying event, including underlying personality traits, workplace issues, personal circumstances and any pre-existing psychological conditions.

The role of the general practitioner (GP) as 'gatekeeper' for compensation is noteworthy for psychological/psychiatric claims. Research shows that GPs are more likely to certify mental health conditions as unfit for work and for longer periods. Further, the median mental stress claim has 10 times longer off work than the median across all claims. Overall, claims arising out of perception based injuries fare significantly worse than event based injuries.

The following table illustrates the stark difference between mental injuries and physical injuries in the Workers' Compensation context:

		Physical Injuries		Mental Injuries	
		Acute	Degenerative	Event Based	Perception Based
How Many?	% of all claims	60-70%	30-40%	1-2%	2-3%
Claim Acceptance	Avg Time to determine	< 1 week	<2 weeks	2-6 weeks	
	% accepted	>90%	80-90%	60-70%	
Claim Duration	% with >1wk lost time	40%	50%	60-80%	
	Median lost time	<0.5 weeks	0.5 to 1 week	3 weeks	9 weeks

Source: A. McInerney & D. Gregory, "Stress and mental injuries – how to compensate?" Actuaries Institute Injury Schemes Seminar, 2013.

Takeout:

Mental health claims are likely to rise for life insurers. The approach to handling these claims will need to be carefully considered. For example, strategies designed to facilitate return to work would be counterintuitive if the claimant suffered bullying at the workplace, but this doesn't mean they can't go back to work somewhere else.

8. Useful comparisons to issues faced by General Insurers

There were concerns that the recent premium increases would not be sufficient for the industry to return to profitability, as it was unclear when the increasing claim numbers would level out. There have been similar instances in general insurance where the market premium reacts to poor experience, often with steep increases to allow for uncertainty (e.g. liability premiums following the liability crisis).

Are there lessons which we can learn from these events?

Liability crisis – early 2000s

There are similarities between the current TPD environment and the liability crisis of the early 2000s. Public liability insurance costs rose during the 1990s, due to superimposed inflation and some increase in claim frequency. Market prices fell, however, and some companies (HIH and FAI) continued to provide cover in certain segments at prices that other insurers would consider unsustainable.

The following similarities with the current situation facing group life insurers can be drawn:

- The competitive landscape led to turnover of policies between insurers as they vied for new business growth. The implication was that data held by an insurer was not very useful for reserving or pricing. This contributed to inadequate monitoring of early trends – of course this is always easier to say in hindsight.
- Expanding coverage offered by insurers.
- Broadening duty of care, largely due to the legal process.
- Long delays from claim occurrence to settlement meant that there was a delay in identifying the problem.

The collapse of HIH and FAI led to an insurance crisis, brought about government reviews and ultimately reforms to civil liability laws throughout Australia around 2002. While there were differences in legislation between States, some common changes were:

- caps and thresholds introduced for pain and suffering damages
- caps on economic loss
- limits placed on defendant liability for obvious and inherent risks
- restrictions on claims for mental harm

Stricter legislated definitions of when a valid claim arises significantly reduced the claim frequency. This clarified what constituted a claim, and what was excluded. Before the reforms, there was undoubtedly an element of opportunistic “gambling”. The reforms arguably removed these claims as it was much less likely these claims would have been successful.

The legislative changes coincided with a shift in the tort environment. The judicial environment, which was seen as pro-plaintiff, was shifting. There was judicial concern over the “stretch[ing of] the law” that was occurring, and a recognition that pressure on premiums should be “a consideration of critical significance” for the judiciary⁸.

⁸ Spigelman, Hon. CJ J., 2002, Negligence, The Last Outpost of the Welfare State, The Judicial Conference of Australia: Colloquium 2002, Launceston, 27 April 2002

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As a result of these changes, the number of claims fell drastically. Liability insurers subsequently experienced an extended period of subdued claim activity which persists even today.

The issues in liability required legislative and environmental changes because they stemmed from problems with the common law system at that time. However, the conditions for a TPD or IP claim to be satisfied are governed by the policy itself, and can be directly influenced by the insurer. The courts are there to enforce the agreement between the insurer and the claimant.

National Claims and Policy Database

Another major development was the establishment of the **National Claims and Policy Database** (NCPD). The NCPD collected policy and claim information for public liability and professional indemnity classes of business from all APRA authorised insurers.

The NCPD was seen as a necessary measure to enhance the information available to insurers and other stakeholders. Complete and unbiased data with sufficient claims history is important for proper management of pricing and reserving risks, and at least in theory, moderate insurance cycle swings. It is not yet clear that the NCPD successfully addresses these issues, although it is fair to say that it has enabled a more informed discussion within insurers regarding superimposed inflation and industry profitability levels.

Improving the availability of data is one of the key recommendations from the 2014 Financial Systems Inquiry:

“Enable the development of data-driven business models through holding a Productivity Commission Inquiry into the costs and benefits of increasing access to and improving the use of private and public sector data.” (page xix)

Workers Compensation reforms

As referred to in Section 7 above, workers compensation has a long history of reform aimed at balancing adequately compensating injured persons and scheme sustainability. Some of the key reforms which have led to reduced costs are shown in the table below.

Beneficial Workers Compensation Reform	Potential application for TPD and IP
Reducing or removing benefits paid.	Immediate benefit from lower claim costs, but does not address insurance needs and underinsurance issues.
Defined impairment thresholds for access to certain benefits. This previously focused on defining permanent disability. Most recently, thresholds are set based on Whole Person Impairment (WPI) from the American Medical Association	Defining permanent disability is difficult. The WPI introduces a more objective and replicable line in the sand to follow for claims payment and avoids definition issues.

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Impairment Guides 5 th edition.	
Work Capacity decisions reverse the focus from incapacity to the health benefits of work.	A definitional shift whereby the 'test' focuses on work capacity rather than a measure of disability or "inability to work".
Greater emphasis on outcome based agent remuneration.	Limited application under the current TPD/IP paradigm.
Experience rated premiums by employer.	Limited application under the current TPD/IP paradigm as premium is not paid by the employer.
Limited access to courts as a means of dispute resolution, with a focus on alternate processes of decision review.	Alternate Dispute Resolution (ADR) avenues, such as the Superannuation Complaints Tribunal (SCT) could be stipulated in policy wording as a "first resort" process. This may reduce expenditure on legal fees. Provisions to allow commercially "settled" claims for a reduced benefit amount.

There's a megatrend towards using WPI measures in accident compensation schemes. There are drawbacks to this, as WPI was not intended to be used for determining compensation. Nevertheless, the advantages of having a replicable and objective process generally outweigh the drawbacks.

Takeout:

A WPI measure could be used to replace the current definition for TPD claims. However, WPI measures the level of injury suffered, not whether someone can return to work.

Work Capacity assessments would be more relevant to the TPD/IP context. Perhaps without the legislated restrictions on appealing decisions, this will have similar pitfalls as the current TPD definition. Nevertheless, a transparent and well defined guideline for determining work capacity would be an improvement on the current situation (perhaps working in tandem with a WPI measure).

Early Intervention – why it won't work

Early notification and intervention has been touted as critical for IP and to some extent, TPD claims management in order to maximise return to work chances. Below we discuss early intervention in workers compensation and CTP schemes.

Early intervention in workers compensation schemes

A telling comparison can be made between many workers' compensation regimes and the life industry. If an employee has a workplace injury and make a workers' compensation claim, then in order to access weekly benefits and medical expenses, it is in the employee's interests to lodge a claim as soon as possible. Furthermore, most

workers' compensation legislation, treatment, rehabilitation and weekly benefit payments commence within days or weeks of claim notification. The workers' compensation claims manager will most likely devise an injury management plan and involve the claimant's treating doctor and employer in coordinating return to work efforts, if appropriate. In addition to the legislated obligations to report claims early, employers are incentivised to minimise claims costs through experience premiums.

On the other hand, under an income protection policy, the insurer is likely to be notified after the waiting period, which is typically in excess of 30 days. For TPD claims, a delay of six to twelve months is common – and with that time off work, any remaining connection with the employer and any residual capacity to return to work will be diminished.

One large insurer which operates in both the life insurance and workers' compensation markets reports that for a particular industrial services client with a large blue collar workforce, the average notification period for workers' compensation claims was four days; for income protection claims it was 48 days.⁹ The outlier notification period was 16 days for workers' compensation as opposed to 212 days for income protection.

Why is this difference in timing critical? Essentially because research studies paint a consistent and compelling case for early intervention to maximise return to work chances. One particular Australian study, in the case of physical injury and disability found that if a person is off work for:

- 20 days, the chance of ever getting back to work is 70 per cent.
- 45 days, the chance of ever getting back to work is 50 per cent
- 70 days, the chance of ever getting back to work is 35 per cent.¹⁰

For life insurers, managing claims towards better outcomes, such as facilitating earlier return to work and minimising income and disability payments is therefore very reliant upon early notification and intervention processes.

A basic problem with TPD is that the very nature of the cover means there may be no relationship between the claimant and employer for an extended period of time, and the insurer has no knowledge of the possible claim for at least this period. There is no relationship between the insurer and the employer, no statutory obligations on employer or claimant, and the employer does not have a financial incentive to mitigate costs (like it does for workers' compensation). Unless these issues are worked through, focusing on early intervention will be an uphill struggle for life insurers.

⁹ Suncorp Insurance, Johnson C, Annual Group Life Seminar 26 June 2014, Sydney, reproduced with permission.

¹⁰ Johnson D, Fry T. Factors Affecting Return to Work after Injury: A study for the Victorian Workcover Authority. Melbourne Institute of Applied Economic and Social Research; 2002

Early Intervention in CTP Schemes

Similar to Workers' Compensation, some other personal injury regimes in Australia have also attempted to introduce early treatment intervention provisions. For example, under the Accident Notification provisions of the *Motor Accidents Compensation Act 1999* (NSW), claimants can access capped treatment and past economic loss payments on a no-fault basis by lodging a form within 28 days of the motor vehicle accident. Similar provisions also apply to the TAC scheme in Victoria and several other jurisdictions.

Takeout:

In WC and CTP, the conventional wisdom is that early intervention and active psychosocial support can reduce claim numbers and their size. Evidence shows that the intervention needs to be in the first few days to be effective. Even twelve week delays, typical for life insurers, are too long.

For early intervention to be useful in the life insurance context, there must be an incentive or requirement for claimants to report early and a benefit or premium structure that encourages returning to work.

Independent medical assessments

Another claims feature that distinguishes some of the CTP schemes from the life sector is the availability of independent medical assessments, for example the Medical Assessment Service in NSW. This panel is convened by the Motor Accidents Authority (the CTP Regulator) and determines a claimant's whole person impairment, where there is a dispute regarding this issue. Such a determination is binding with respect to impairment (which acts as a gateway for any entitlement to non-economic or general damage losses).

Having an independent service that can act as the ultimate arbiter for (at least some) benefit entitlements can be a more efficient and cost effective way of resolving claims disputes.

Takeout:

There are obviously legislative hurdles to overcome in forming a legally binding medical assessment panel for life insurance purposes. If such a panel was established by cooperating life insurers, the question of independence may remain as the service will likely be funded by the insurers themselves. Nevertheless, if a credible independent service could be established, then we foresee potential savings in claims handling and legal fees.

9. What are disability insurance products insuring?

When considering the point of disability insurance, two main issues come to mind:

- (a) How does disability insurance interact with other compensation options?

(b) What are these products really aiming to insure?

(a) Working around other compensation schemes

There are a range of insurance products, compensation frameworks and government programs available to cover needs of people who suffer a disability/injury. The table below summarises the supports applicable for a range of circumstances leading to long term inability to work (leaving out the life insurance products to highlight the "gaps"). We have ignored shorter term supports, such as sick leave, sickness and accident coverage, for this purpose.

	Lost Income	Medical Costs	Support programs (e.g. domestic assistance)
Basic safety net level of support available to everyone	Disability Pension	Medicare/PBS	NDIS/NIIS
Workplace Injury/Illness	+WC	+WC	+WC
Motor Accident Injury (when you're not at fault)*	+CTP	+CTP	+CTP
Medical Malpractice (if negligence proved)	+Common law damages	+Common law damages	+Common law damages
Other Injury (as a result of someone else's negligence)	+Common law damages	+Common law damages	+Common law damages
Other Injury (your own fault or no negligent party found e.g. sporting injury, motor accident)	None	+Private Health	None
Other Illness	None	+Private Health	None

* Some jurisdictions have no-fault motor accident insurance schemes which will cover the at-fault party as well.

**** Bolded items means the level of support is substantial and provides significant income replacement and a high level of care**

Workplace injury and motor accidents are reasonably well covered by legislated insurance arrangements/schemes. While there are differences in the level of workers compensation and CTP benefits (and also differences by jurisdiction), they both provide medical benefits for the injury suffered, as well as income replacement generally at some proportion of pre-injury levels. Similarly, there are provisions in common law to claim damages for injuries as a result of someone else's negligence.

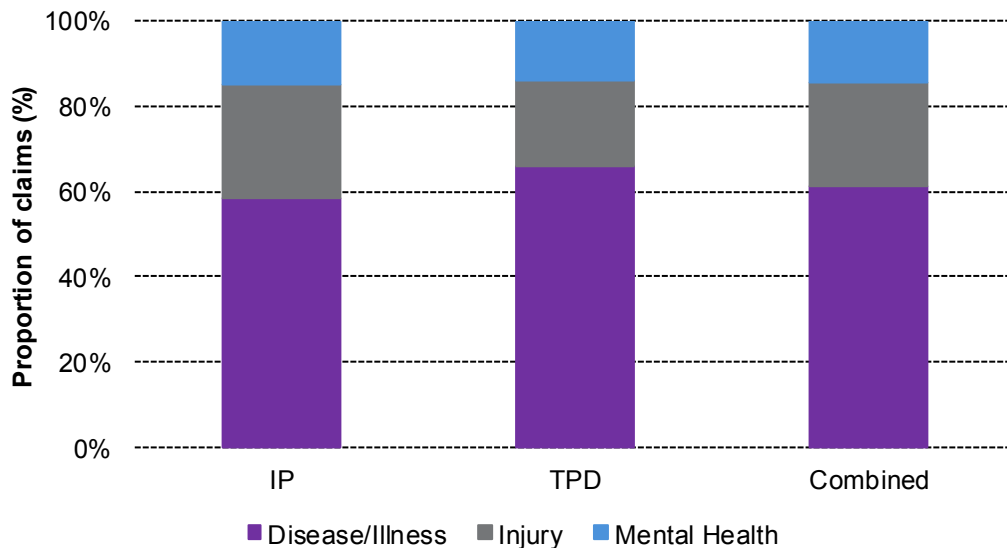
Simplistically, the obvious gap is when someone suffers injury and there is no one to sue or when someone suffers from an illness that prevents them from working. This is a gap that IP and TPD products fill. Arguably in the circumstances where other compensation is available, IP and TPD cover duplicates what is already provided.

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At this stage, we note that IP payments are usually offset by other income replacement benefits if they are available, and “top-up” income benefits to a pre-defined level (say 75% of income). However, to our understanding there is no similar offset applicable to TPD benefits in respect of other lump sum payments that may have been paid to the claimant.

What are the main causes of disability insurance claims?

The following figure shows the main causes of disability insurance claims.



Source: TAL accepted disability claims from 2007 to 2012.

Illness and disease make up around 60% of disability insurance claims. These are unlikely to have been caused by the workplace, and are therefore not covered by workers compensation.

Around 25% of claims arise from injury. Some of these will be due to workplace and motor vehicle accidents, though we haven't been able to identify these.

Around 15% of claims arise from mental health issues. A majority of mental health claims arise from depression, some of which are caused exogenously and some from the workplace (again, we have not been able to quantify the workplace component).

Takeout:

Up to around 40% of claims are caused by injury or mental health issues. A proportion of this 40% will relate to work place injury/harm or motor vehicle accident, and for that proportion there may be an overlap of coverage with workers compensation or CTP insurance.

(b) What does TPD insure?

This raises questions about what it is that TPD policies are insuring. Some reasons that are stated include the following (taken from Suncorp's webpage on TPD):

- Pay off the mortgage and other debts
- Make home modifications or pay for rehabilitation
- Pay for nursing or other medical care
- Meet ongoing household expenses
- Pay for your children's education

TPD usually has default benefits that are based on presumed stages of life. It is obvious that the need for TPD insurance depends heavily on very specific individual circumstances, and whether compensation has already been provided through another avenue. Logically, a default benefit amount will not appropriately allow for these specifics.

Perhaps the supposed "needs" of TPD are a little outdated, as many families now have dual incomes. More people are also living alone with no dependents, and people stay at home longer than they used to. As more people move away from these lifestyles and stages of life, then a one size fits all approach to default benefits will no longer be appropriate.

Further, we must recognise that TPD insures an existing lifestyle, i.e. to pay off the mortgage for the house you are living in, and to pay for your children to continue going to the same school. Basic "needs" are generally met through public systems and government safety nets (e.g. pensions, rental assistance, public schools and Medicare). While this basic level of support is obviously not an appropriate level to target, it is important to recognise that TPD insurance is about maintaining a lifestyle standard.

10. MySuper and the requirement to offer default insurance

MySuper is part of the Stronger Super reforms effective from 1 January 2014, whereby employers must only pay default superannuation contributions to an authorised MySuper product. Given that the majority of employees do not deviate from their employer's default fund, the majority of Australians would therefore be in a MySuper product once the transition is complete.

A MySuper product is one which complies to a regulated set of features, including:

- a single investment option
- a minimum level of insurance cover

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- an easily comparable fee structure, with a short prescribed list of allowable fee types
- restrictions on how advice is provided and paid for, and
- rules governing fund governance and transparency.

MySuper products are required to offer a standard, default level of life and TPD insurance. Members of MySuper products will be able to increase or decrease their insurance cover (if offered by the trustee) without having to leave the MySuper product.

It is up to the Super Fund's trustees to determine a suitable default benefit level of insurance for its members. Theoretically, the default benefit level could be minimal. However, it is unlikely that very small benefit levels would be approved by Fair Work Australia (FWA), which approves MySuper products as part of their review of awards.

All APRA-regulated funds will be required to offer death and TPD cover on an opt-out basis. Trustees must, at a minimum, allow members to opt-out of life and TPD insurance within 90 days of the member joining a fund, or on each anniversary of the member joining the fund. It is left to the trustee's discretion whether to offer income protection insurance, on an opt-in or opt-out basis or at all.

We mention MySuper due to its importance as a distribution mechanism for disability products. Distributing disability insurance this way is efficient and aligns well with the goals of superannuation. Notwithstanding this, MySuper legislation will also dictate what can and cannot be done to the design of disability insurance.

11. Dealing with underinsurance

Default TPD benefits have bridged the underinsurance gap, but obviously have contributed to the unintended consequences of large industry losses. Notwithstanding this, it is suggested that the median level of life insurance cover across the working age population is 64% of basic life insurance needs, and only 42% of the amount needed to maintain standard of living¹¹.

Increasing the level of default benefits, and therefore the cost of the insurance, is not a sustainable option to address the underinsurance issue. This assumes too much about the individual's needs and ends up not suiting most people. Moral hazard and anti-selection effects will only be exacerbated.

Takeout:

Underinsurance remains an issue to be addressed. A suggestion is to design the product in a way that directly meets needs, as opposed to a fixed lump sum. The other component is educating policyholders about their insurance needs given their

¹¹ "Underinsurance Research Report", Rice Warner, December 2013

individual circumstances. In an area where apathy dominates and the majority of superfund members receive the default insurance benefit, this is not an easy task.

One positive step would be to simplify the insurance information presented to policyholders, and send this out with annual superannuation statements. This should set out what the TPD benefit means in terms of quality of life and income replacement level. Perhaps this advice would also allow the member to customise their default benefit based on a fixed sum per dependent (and their age), balance of their mortgage etc.

12. Re-thinking the group TPD insurance offering of the future

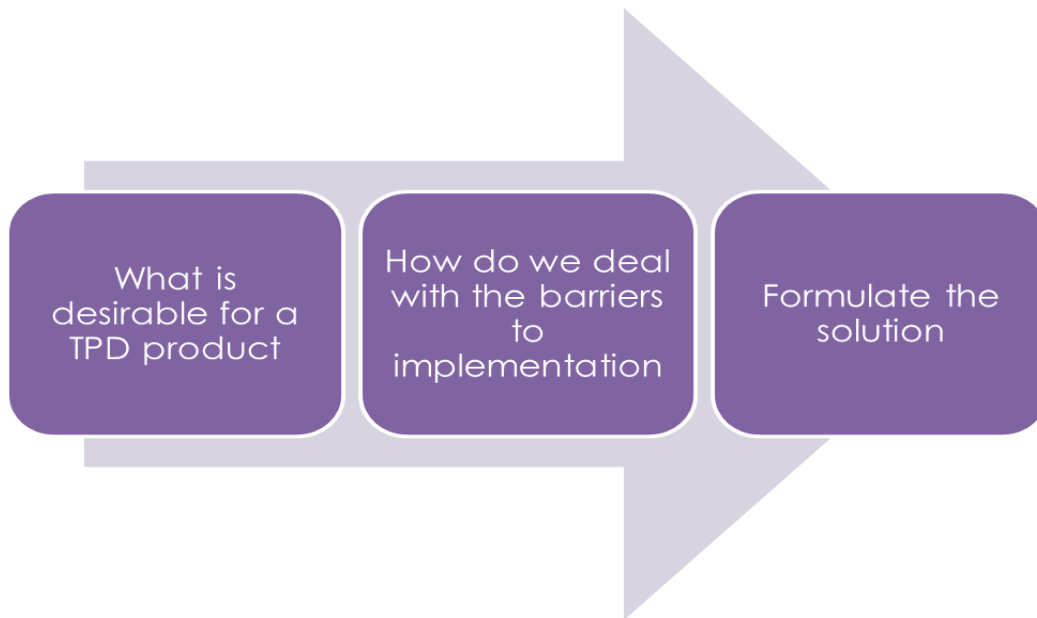
In this paper so far, we have highlighted some of the issues facing group life insurance offered through superannuation and some emerging ones. We also drew comparisons with past general insurance issues to see what could be learned and looked briefly at how TPD/IP insurance may fit into the existing support framework.

As much of the recent issues have been due to TPD insurance, we focus on this. We now discuss what we would consider if we were to re-think the “default” TPD product, split into the following categories:

- (a) Product design
- (b) Approach to pricing
- (c) Claims management process

The topics of insurance and health financing are highly regulated, which might limit what can and cannot be done. We have chosen to not worry about the detail of these constraints too much, but rather consider ideas at a high level. Once we decide on what the TPD product should look like, we can then plan how to get there – as set out in the figure below.

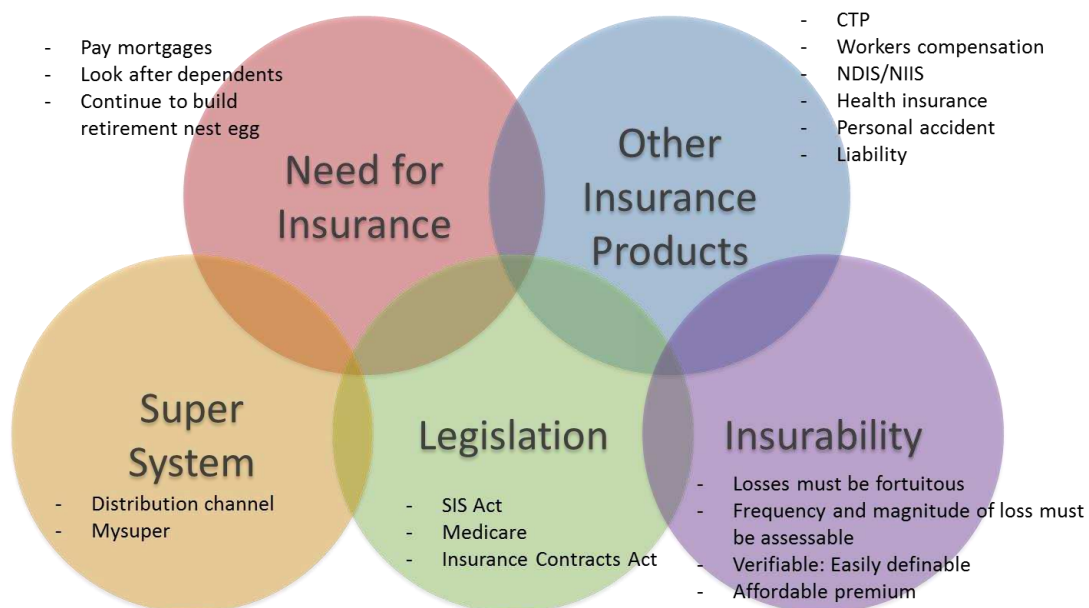
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The ideas presented in this section are intended to progress the conversation about what may be desirable for the TPD product, which is the first step in the process.

(a) Product design

There are product design issues that need to be worked through to make TPD a valuable and sustainable insurance offering. The benefits being paid should be matched with the need for insurance, claim definitions should provide insurers/insureds with more certainty/predictability about what constitutes a claim, and ultimately the product will need to work within the legislative framework. Some of the key considerations for TPD product design are summarised in the figure below.



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Below are some other ideas that could be considered:

- Whether TPD could be offered on a **claims made** basis. This could work similarly to Professional Indemnity policies where policyholders notify the insurer when a claim is likely. While this will not reduce the number of people claiming, it will reduce the reporting delay lag and allow insurers to react more quickly to emerging trends.
- **Defining what is being insured** rather than an arbitrary lump sum benefit. For example, the policy may be structured to pay benefits proportionately to the balance of the home loan, or to directly meet school fees?
- The policy could **pay for reasonable retraining**. The benefits of work for the individual are immense, and should be encouraged.
- **Offset against lump sum benefits** provided from other sources (WC, CTP, common law) designed to meet similar expenditure needs.
- **Objective threshold for “permanent disability”** criteria to be met. A WPI or similar measure as used in CTP and Workers Compensation could be adopted. The policy could specify an independent body to make this determination. Ultimately, the WPI should be integrated within a **work capacity assessment framework** that is transparent, with a pre-defined process that is set out in the PDS (and thereby reducing disputes).
- Provide **incentives for early claim reporting**. Paying money is usually a great incentive. Perhaps a **linked life insurance and health insurance product** could be designed such that the life insurer can supplement payment of health costs with return to work initiatives.
- Some product ideas have already been suggested by the industry – a hybrid TPD/IP policy that pays a reduced lump sum benefit upfront within a certain timeframe incentivises early reporting. Such a product would reduce the reporting lag that made it difficult to identify the deteriorating experience and also may assist the insurer to intervene and encourage return to work.

Takeout:

There are many considerations that must be balanced. The goal is to end up with a value adding product that can be sustainably offered by the life insurance industry.

(b) Pricing approach

Better quality data

Group life programs are competitively tendered between life insurers, often based on snapshots of information provided by the superfund. Pricing is often portfolio and experience based, and is guaranteed not to change for a period of time.

APRA's Prudential Practice Guide LPG 270 acknowledges the importance of having cleaner and longer history of data, including adequate historical membership data.

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The benefit of having detailed data is that it provides better visibility of why the portfolio might be behaving better or worse than expected. Having more details about the members and claims allows for more complex analytical techniques which can inform risk pricing. Ultimately, this information should be used to make informed judgements about future trends and to set premiums accordingly.

Some examples of where better data might be useful include:

- Occupation of the members, so the insurer can measure whether there have been any shifts in portfolio mix and quantify the future impact of this.
- Demographic information, as these factors can strongly influence claims
- Location of risks, which may provide insight into the socio-economic background of insureds or point to areas of claim “hotspots”.
- On the claim side, data on cause of claim (e.g. whether the claim arose from work place injury, etc.), legal representation, and the legal firm can often be very useful.

Industry data

Another idea is the establishment of an industry wide data collection, similar to APRA's NCPD for liability claims. This would allow insurers to identify market wide trends and to set prices accordingly, hopefully smoothing the hard/soft effects of the insurance cycle. Similar arrangements exist for domestic and commercial property insurers through Insurance Statistics Australia (ISA).

External information

In the Big Data age, external data is easily accessible. Simple information such as the postcode can tell us about the socio-economic situation of the insured. This can supplement internally collected information for risk pricing. It is especially useful when the member composition is changing over time, as the experience can be re-weighted accordingly.

Cloud based computer processing has made storage and processing of these datasets very accessible to insurers. Statistical techniques such as machine learning have also evolved so that trends and abnormalities can be quickly identified and acted on.

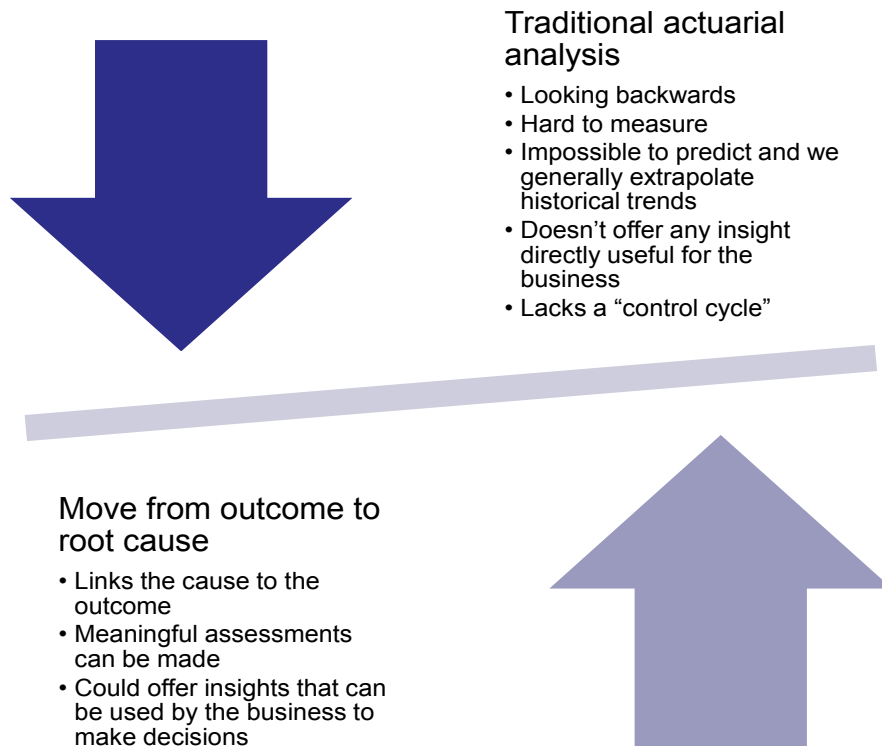
Looking at the root cause and not at the effect

The recent TPD experience has shown that environmental changes (such as claimant attitudes, the courts, legal intervention) are behind the poor performance of this class. The reporting lags mean that this is difficult to pick up until long after the fact if we rely on analysis of historical information alone.

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As the deficiencies of traditional numerical analysis are evident, we suggest that efforts should turn to understanding the “**Root Cause**” drivers of claims cost. This could include understanding whether more cases are going to court or whether there have been changes in the behaviour of claimants. In doing so, we can postulate on whether these trends will continue and the likely impact for an insurer.

The figure below highlights some of the benefits of understanding Root Causes.



Source: “Gauging the Tort Temperature and the Tort Temperature Scorecard”; General Insurance Seminar 2012

An immediate benefit of this approach is transparency. We move to measures that are more easily understandable and observable, and away from only looking at outcomes. The ease of communication of observed experience will help to foster constructive discussion within an organisation.

Similarly, it is easier to look back in a year's time to see how the experience has compared with what was expected. The reasons for deviation can be explored, learned from, and incorporated into the following year's analysis.

Importantly, this is not a process that is completed by the pricing actuary alone. It will incorporate expertise across the insurer – claims management, underwriting, legal advisors, etc. The process combines qualitative information with quantitative analysis, hopefully resulting in a reasoned view of what has happened and what is likely to happen.

(c) Claims management process

Earlier, we discussed the difference between workers' compensation and income protection/TPD portfolios with reference to claims notification, and in particular why early intervention can be such a challenge for the life insurance sector. We have also discussed some product design ideas which might reduce the notification delay.

We further discussed some other key differences in TPD product design which also makes it difficult to appropriately assess claim entitlements insofar as the definition of TPD is subjective rather than an objective whole person impairment type measurement common to many accident compensation schemes. The very notion of TPD is premised upon the subjective 'disability' rather than 'impairment'. Impairment is an injury, illness or congenital condition that causes or is likely to cause a loss or difference of physiological or psychological function. Disability, on the other hand, is the loss or limitation of opportunities to take part in society on an equal level with others due to social and environmental barriers.¹²

Life insurers are increasingly triaging and segmenting claims based on risk, particular by reference to bio-psycho-social (BPS) factors, something that general insurers have also adopted to varying degrees. Validated BPS tools can identify psychosocial risk factors associated with prolonged disability and incapacity.

For those claims with additional risk factors, it is critical that the employer also be engaged early. In such cases (as well as for high risk self-employed insureds), it is also important to provide timely access to appropriate rehabilitation and vocational assistance. Critically as mentioned earlier in this paper, such intervention is arguably a lot more difficult to implement than in say, a workers' compensation setting. Workers' compensation schemes benefit from fast direct access to employers as well as legislatively imposed return to work obligations. This "first line of defence" in managing workers' compensation claims, is not readily available to life insurers. What also places life insurers at a relative disadvantage is the inability to use legislatively mandated tools such as work capacity assessments ("second line of defence"), prescribed step downs and legal fee restrictions.

A fundamental principle in the assessment of compensation and/or damages at common law is the duty to mitigate one's losses. Accordingly, from a claims management perspective, life insurers can and should be invoking this principle by ensuring that interventions are appropriate and suitably timed. Such interventions could include functional and work capacity evaluations, forensic neuropsychological examinations as well as judicious use of surveillance and other factual investigations.

13. Conclusions

We, the authors of this paper, are employed at an actuarial consultancy that specialises in general insurance matters. Our interest in disability insurance started at

¹² See World Health Organisation on the topic of disabilities, (WHO 2015)

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the time life insurers reported large losses and the causes were being discussed within the industry.

The discussion quickly turned to possible solutions, with injury management similar to that implemented in workers compensation schemes suggested as a framework to learn from. Early intervention and a focus on return to work are to be encouraged. This clearly has social benefits on top of the purely financial ones. The challenge is how group life insurers, without a direct relationship with the policyholder, can intervene at an early enough stage.

Early intervention will not be a silver bullet solution. It must be a component of the rethink of disability insurance, and specifically TPD. For early intervention to have a meaningful impact there needs to be an incentive to report claims earlier to the insurer. Finding the solution should start from designing a product that helps people in need while minimising unintended claim outcomes.

We hope that this paper constructively adds to the conversation around the TPD product. We aim to have shared some parallels between the issues facing disability insurance with similar general insurance related experiences, and from these suggest some possible avenues for further investigation.

We know that some of the ideas may be a little controversial, such as moving disability insurance to a claims-made basis. More consideration is needed before we can say whether these ideas should be implemented. Nevertheless, it is important for insurers to debate solutions for making disability insurance a long term financially sustainable product that is valuable to policyholders.

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