Actuaries Summit

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Actuaries Institute

# Are we there yet?
# The Group Risk Market two years on…

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## 1 Executive Summary

The authors originally intended to compare the suggestions and proposed solutions from the background literature against what has actually been implemented in the market over the last twelve months. In effect answering the question from the title: “Are we there yet?”

However, it quickly became apparent that there was a large gap between the proposed solutions and actual practice in the market. There had been a lot of discussion about the issues and potential solutions but in most cases a very material increase in the price of cover to members has been the primary response. There are signs that the market is starting to move in the right direction but the pace of changes has been significantly slower than might have been expected at the start of the crises two years ago.

The purpose of the paper therefore changed to try to determine the reasons why the pace of change has been disappointing and to determine the barriers for implementation to the proposed solutions. In effect, answering the question: “What is stopping us getting there?”

The authors concluded that potentially the most significant barrier to change is the misalignment between the manufacturers (both insurers and reinsurers) and the consumers (ultimately the member but represented by the trustees). In addressing this issue the authors borrowed the concept of Policyholders Reasonable Expectations from another Actuarial discipline and introduced the analogous Members Reasonable Expectations instead. The paper looks again at the proposed solutions to the issues and compares the perspectives of manufacturers and the consumers.

The authors are proposing that by manufacturers adopting this framework of Members Reasonable Expectations (MRE) they will achieve greater alignment with the trustees. Initially this will result in implementation of the tactical solutions where alignment is the strongest. However, this framework will also facilitate cooperation with the trustees on more strategic solutions that require more trust between the respective parties. In the paper we have described this as moving from the “no brainer zone” to the “trust zone”.

The ultimate goal of this paper is therefore to suggest a roadmap which will give the best chances of implementing sustainable product design rather than primarily price increases as the preferred solution to the current issues.

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# 2 Member Reasonable Expectations

## 2.1 Member Reasonable Expectations

At the heart of Group Risk Insurance lies the member. In the last few years however, the industry has (justifiably) been very internally focused on a range of challenges which have been well documented and discussed. Regardless of how we arrived at the current point, it's worth considering whether Group Risk Insurance is generating outcomes in line with some reasonably high expectations that the members should have of our industry.

On the face of it, Group Risk insurance has delivered. Rice Warner estimates that Group Insurance is the cheapest mechanism for insurance cover in the market (e.g. Death and TPD covers are estimated at 44% of advisor sold products). The same report notes that as at June 2013 there were around 11.6m death cover member accounts (caveating duplication which exists) and around 11.6m employed people so the coverage is broad. As a distribution mechanism, the insurance penetration rates could arguably not be much higher which again suggests an efficient and enviable delivery vehicle for insurance benefits in Australia.

In the last two years however, the industry has gone through the equivalent of a General Insurance catastrophe. For reasons set out later, the industry took a profitability cold shower to such an extent that all profits back to 2010 were wiped out. More concerning, APRA statistics suggest that since 2008, insurers have cumulatively taken 2.5% of net premiums as profits after tax for group risk business (compared with insurers on the individual side who have collectively declared after tax profits of c12% of net premium over that same period). On the Group side in particular, it's also worth noting that reinsurers have borne a larger share of these expected losses (collectively reinsurers have increased reserves by over $1bn in the last two years). So, it has turned out that whilst members were winning (by enjoying higher benefits and cheaper rates), the manufacturers weren't enjoying the same benefits.

With the losses came subsequent price rises in the market along with all the fallout that inevitably follows a market that has lost money. Whilst products weren't fundamentally changed (the subject of this paper), price rises were seen as the key lever to pull to put the industry back into sustainability.

Inevitably the pendulum swung so far back that it's important to now

question whether members are still enjoying the fruits of this enviable distribution model.

The rough rule of thumb for trustees is that members should be contributing around 1% of their salaries towards insurance within Superannuation. Whilst average Group Insurance prices went up around 35%, some segments (e.g. light blue) were particularly harder hit. Five of the top eight largest Superannuation funds saw premium rises in excess of 80% for Death and TPD. So whilst compulsory contributions into Superannuation have risen from 9% to 9.5%, all of the increase (and more) has been swallowed up by the price rise put through for insurance.

Whilst one could argue that insurance within Superannuation was historically underpriced (and so members were receiving an artificially rich benefit), this change does imply a significant erosion of members' future retirement assets. This is the primary motive for compulsory Superannuation with sufficient assets built up over time as the primary expectation by members.

| Are members receiving value for money given the relative insurance price rises across the segment? |
|---|

The other concern now for members is that, along what might ultimately turn out to be a heavy handed reaction to pricing amendments, the product design and controls have been tightened significantly but the premium rates do not yet reflect the expected best estimate benefit of these changes. This raises the question of whether there is sufficient transparency to understand the impacts of these amendments (extending to the levels of price increases too).

Whilst the insurance industry has lost money, we should also ask ourselves the extent to which current members should be bearing the cost of this implicit recoupment of losses due to historic members' experience.

Fairness also extends to the impacts of the inherent cross subsidies in Group Risk (be it via rating factors such as age, spreading of profit shares or simply the healthy members paying the cost of the anti-selection and leakage through the entry and subsequent claims processes).

| Is the structure of the market for member still fair, equitable and transparent? |
|---|

We should also consider the conflicts inherent in the system. Whilst the insurer and reinsurer alignments are now closer together, the administrators are still typically remunerated on a fee for service basis and the Funds take no immediate share of the risk nor have built servicing models more focused on returning members to work rather than paying insurance claims. Plaintiff lawyers are still conflicted in that the longer a TPD claim goes on, the less likely the member is to return to work.

The misalignment between stakeholders is largely ignored when times are good but in the extreme events of the last two years, the divisions and conflicts have resulted in less than favorable outcomes.

| Are all stakeholders aligned to achieve the best outcome for members? |
|---|

Lastly, the action of implementing such significant price changes was also inconsistent with the Superfunds past actions and communication around how insurance premiums could rise and fall. Since the introduction of default cover into the Superannuation system, there has never been a sustained period across the market where Group Insurance prices have risen. This has created some expectations, to the extent that members are engaged with the insurance offering, around the stability of their Superannuation.

| Do members have an expectation that prices can rise and fall? |
|---|

In the wake of the Equitable Life failure, the UK market was tested in the With Profits space around Policyholder Reasonable Expectations (PRE). Indeed, this has become a standard component of actuarial training where actuaries need to consider the implications of their actions and assumptions in the context of whether a reasonable policyholder would expect the approach taken.

One of the key tenets of this paper that follows is whether Group Risk Actuaries should consider adapting this well-known actuarial concept, and develop a set of principles for ensuring we are meeting Members Reasonable Expectations (MRE) following the last few years of change. Trustee Boards' are operating with these principles in mind under the guidance of the SIS regulations but we should consider whether the actuarial profession should articulate these member principles for use when considering the insurance offering.

Based on above, these principles could be set out as follows:

Members Reasonable Expectations (MRE):

- Members expect to receive value for money for insurance within Superannuation and that their contributions will lead to a sufficient savings pool at retirements,
- Members expect that their insurance will be sourced and managed in a fair, equitable and transparent manner,
- Members expect that the parties acting on their behalf are as far as possible free from conflict in ensuring their return to work and
- Members expect that the Funds will be consistent with their past actions and communication.

Amongst other uses, these MRE's should form part of the both the design phase and subsequent tender stages where terms are provided to Superannuation funds. Any solutions proposed should be considered with the member hat on, particularly given the current status of the Group Risk Market, as this lends itself to a slightly different view for the manufactures to consider the answer to the question of whether we are there yet.

## 2.2 Purpose of this Paper

This paper discusses the last two years in the Group Insurance space, and considers some of the lessons learned, how the market has shifted and the remaining challenges in order of biggest impact and priority. We also consider analogies with other markets which have provided some lessons. We tend to focus on the Industry Funds segment given this represents the area which has generated the biggest impact. For the purposes of getting to the crux of the challenge, we have included this 'lessons learned' section as an Appendix but note that reading through is critical to understand the rationale and background for the changes that have been proposed.

In particular, the authors consider the challenges identified in the Appendix in the context of how to meet Members Reasonable Expectations (MRE) in the new world as the ultimate test of whether the members' best interests are being delivered.

The authors would like to highlight that many of the concepts are not necessarily new and we acknowledge the excellent body of work that has been completed by fellow industry participants over the last few years. Our aim is to approach the problem through the lens of the members (and

trustees acting on their behalf) which we believe suggests a different set of focus and priority.

# 3 Different Perspectives

## 3.1 Manufacturer (Insurers & Reinsurers)

Whilst this paper is advocating a member lens with which to view the Group Risk market, for the benefit of completeness it is worth considering the perspective of the manufacturers. In this case, we present these views combining insurers and reinsurers into one bucket although we note that the reinsurers have borne a slightly higher share of the historic losses. This has led to a different (perhaps stronger) response to the crisis by reinsurers but we do not cover these differences.

Manufacturers viewed the challenge primarily through the impact on shareholder returns. The increase in required reserves had a direct impact on the balance sheet and given the quantum (wiping out all profits in Group Risk since 2010 effectively), meant that shareholders (and management) demanded significant change to rectify the situation.

## 3.2 Customers (Members & Trustees)

In contrast, the trustees viewed the crisis through the impact on the members' experience. Since the insurance risk had been passed to the manufacturers, the balance sheet impact was relatively negligible but the impact of the proposed changes was operationally and from a reputational point of view their primary concern.

## 3.3 Member Reasonable Expectations

### 3.3.1 Policyholder Reasonable Expectations in With Profits

The concept of Policyholder Reasonable Expectations (PRE) appears to have been developed primarily to cater for life insurance actuaries in the With Profits segment. The basis behind this concept is that actuaries need to consider when setting their liabilities what policyholders expect based on past actions of the life company. So, to put into an overly simple example, if communication by the life office suggests that any bonuses declared (whether vested or reversionary) belong to the policyholders, shareholders

can’t rely on these bonuses to offset the amount of capital required by the office in setting their capital requirements.

APS L1: Duties and responsibilities of Life Assurance Actuaries by the Institute and Faculty of Actuaries (Sections 3.7-3.9) in particular sets out requirements for the UK actuarial function holders (akin to the Appointed Actuaries) to consider policyholders reasonable expectations (PRE) in the context of setting liabilities.

The first major test of the concept in case law was during the Equitable Life failure where PRE was really tested in the courts but there are other cases identified in a paper titled On policyholders reasonable expectations, 2005, Maini and Narayanan which summarizes some of the other judgments along with how some other markets consider PRE.

As with the UK, APRA sets out in LPS 360 (which covers Termination values) a reference to how termination values are to be considered with regard to PRE. In particular, reference is made in Section 9 which states that ‘the termination value of a policy, before adjustments, is the greater of:
(a) the amount that would be paid on the basis used in practice from time to time in the event of voluntary termination having regard for the amount the company is obliged to pay in accordance with the policy documentation and promotional material and the reasonable expectations of policy owners based on the company’s current practice…’

This concept is well entrenched for with profits products.

### 3.3.2 Australian trustee and actuarial guidance relating to member expectations

In Australia, whilst not an exhaustive list, the concept of considering the members best interests arises across a number of pieces of guidance.

The SIS Act discusses in a number of sections the duties of Trustees for each entity. As examples:

- Section 52, 7c refers to the requirement of trustees to ‘only offer or acquire insurance of a particular kind, or at a particular level, if the cost of the insurance does not inappropriately erode the retirement income of beneficiaries’.
- Section 52, 2c requires the trustee ‘to perform the trustee's duties and exercise the trustee's powers in the best interests of the beneficiaries’.

- Section 52, 2d references a number of areas around conflict whereby, amongst other aspects, highlights a requirement is there is a conflict '(e) to act fairly in dealing with classes of beneficiaries within the entity' and under (f), 'to act fairly in dealing with beneficiaries within a class'

In terms of the requirements for actuaries, APRA's prudential standard LPS 320 makes limited mention of the above concepts save under 24 (iv) where mention is made that 'if the life company is a friendly society, the proposed approved benefit fund rules or modification of the benefit fund rules, and whether the benefit fund rules will result in unfairness to any prospective or existing members of the benefit fund'. The concept of implications for members of friendly societies is therefore considered when making changes to the fund rules.

Prudential Standard SPS250 references in Section 23 and 29 (f) the requirement to consider the 'best interests' of beneficiaries in the context of changing insurers and SPG250 makes mention under Section 23 that APRA expects that strategic decisions relating to making insured benefits available to beneficiaries would be made with reference to the 'collective best interests of beneficiaries of the RSE as a whole'.

Lastly, in terms of professional requirements, Professional Standard 200 by the Institute of Actuaries of Australia has limited reference to policyholder (or member expectations) but does incorporate some considerations around 'equity'.

The authors acknowledge that a detailed review of legislation or guidance in Australia that considers the members of Superannuation funds has not been completed but the overall theme emerging from our research is that actuaries have a limited requirement to consider how our approach impacts members.

### 3.3.3 Members Reasonable Expectations in Industry Funds

Whilst each stakeholder is governed by legislation aligned to where their focus should lie, the authors argue that actuaries should consider increased consideration of the expectations of members of Superannuation Funds.

Out of all the various pieces of legislation, the SIS Act requirement for trustees arguably comes closest to requiring consideration of the members. So, akin to

these requirements and to adapt the concept of With Profits PRE, the authors are proposing the following concept of Members Reasonable Expectations (MRE) for consideration by Group Risk actuaries:

- Members expect to receive **value for money** for insurance within Superannuation and that their contributions will lead to a sufficient savings pool at retirements,
- Members expect that their insurance will be sourced and managed in a **fair, equitable** and **transparent** manner,
- Members expect that the parties acting on their behalf are as far as possible **free from conflict** in ensuring their **return to work** and
- Members expect that the Funds will be **consistent** with their past actions and communication.

We note for the purposes of this paper that the trustees of Superannuation funds have the same broad alignment with their members.

In terms of use, this test of MRE should and could form an integral part of the both the product design phase and subsequent tender stages where terms are provided to Superannuation funds. Making MRE a key consideration lends itself to slightly different solutions and challenges actuaries to consider their proposals in the context of whether the outcome is in the best interests of members alongside the implications for shareholders.

# 4 Potential Solutions

## 4.1 MRE and Potential Solutions

In this section, the authors attempt to compare the different solutions being proposed in the market. As it's clear that not all changes should be prioritized or can practically be implemented, we identify our top 10 changes from the long list of potential solutions.

The broad theme is that whilst the manufacturers and trustees are broadly aligned, there are some areas where the member solutions through the MRE lens would suggest a slightly different approach. In the cases where there is alignment, we should also consider how the changes could be positioned to obtain maximum buy in and support from trustees. We also lastly consider some of the trustees residual concerns which we believe have presented barriers to implementation of some of the more obvious required changes.

The table below sets out the key solutions, through the lens of the manufacturers and MRE. This needs to be read in conjunction with the Appendix as the basis for these current solutions in the market. In particular, we highlight in red, areas where this is clear misalignment, green where there is clear alignment and orange for something in between.

| Challenge | Optimal Market Manufacturer solution | MRE lens | Trustee balancing act |
|---|---|---|---|
| Benefit Definitions | Reduce subjectivity by tightening definitions (e.g. for TPD, to reflect unable test, introduce retraining and rehab requirement and ability to allow for all information up to assessment date). | Ensure **fairness** for all members by removing subjective claims and increase **focus on returning members to work** through introducing retraining and rehab requirement and ability to allow for all information up to assessment date. | • Lack of understanding and evidence of definitions impact across pricing and operationally.<br>• Building end to end supporting functions for return to work programs.<br>• SIS conflicts. |
| Anti-selection (includes AAL's, prior claims and Opt Up's) | Reduce anti selection by dropping AAL's, restricting cover for prior claims and reducing opportunity to increase cover without underwriting (or PECs). | Ensure **fairness** for members by introducing underwriting (or PEC's) for members increasing cover. | • Ease of coverage for new members a key Superannuation differentiator.<br>• Operational impact of underwriting or PEC's. |
| Moral Hazard (includes Transfer of Cover, All or nothing TPD design, Replacement | Reduce claim size by limiting total cover available in aggregate, use objective definitions, shift from Lump Sum to composite | Ensure **fairness** for members by limiting total cover available in aggregate, reducing reliance on all or nothing | • Operational impact of monitoring aggregate cover and service concerns with |

| | | | |
|---|---|---|---|
| Ratio's) | Income design and capping IP replacement ratios or offsetting to increase terminations. | benefit by increasing **transparency** of claims definitions and helping members return to work through appropriate incentives such as capping RR's. | capping claims.<br>• Operational and member impact of shifting TPD to income. |
| Cross subsidies | Manufacturers can accept cross subsidy with a risk margin to cater for mix changes. | Ensure **fairness** for members by having members pay their own way along with improving **value for money** through removing risk margins. | • Operational impact of introducing additional rating factors. |
| Plaintiff Lawyer Involvement | Reduce subjectivity of definitions. Shift product from Lump Sum to composite Income. | Reduce subjectivity of definitions to ensure **fairness** but simplify and increase **transparency** of claims process to allow ease of claiming. Support advice through the Fund. | • Allowing an easier claims process could further erode **value for money.**<br>• Operational and member impact of shifting TPD to income. |
| Member Awareness | Maintain current levels of member awareness and introduce sunset clauses to limit backbook shock via trust deed | Increase communication to members to seek maximum engagement and awareness with members. | • Pricing in increased awareness could further erode **value for money**. |
| Insurance structures (includes rate guarantees | Reduce rate guarantee length to reduce capital requirements and | Longer term rate guarantee to ensure **consistency** and stability. 100% profit | |

| | | | |
|---|---|---|---|
| and profit shares) | allow speed of change for new data. No profit shares to allow equal share of upside as further downside. Funds share in risk and insurers and reinsurers incur losses at similar points to manage alignment of interests. | share to ensure that manufacturers can't over correct on price and retain upside. | |

As part of setting out some of the solutions proposed, we acknowledge the excellent body of work put forward by our peers in the industry around the various solutions available. Our aim is not to reinvent the wheel with any of the above proposed options available to manufacturers and trustees but rather highlight the different lenses through which each party views the problem and identifying some of the barriers towards implementation.

For example, from this table, we can delve into the balancing act that trustees have to play and some of their residual concerns around implementation. These fall broadly into 3 different buckets:

- Concerns around operational limitations,
- Concerns around change further eroding member value for money and
- Concerns around lack of understanding (and trust) in receiving a fair deal.

Whilst transition arrangements that provide sufficient and reasonable time to make changes are one tool to move towards change, the authors believe that appropriate incentives for the members/trustees will provide a far more valuable incentive. Asking trustees to make some of these changes, whichever lens one looks through, without sufficient benefit for members is one of the key reasons why limited change has occurred to date (see next section). Given the administrative complexities and costs involved, suggesting change is made without appropriate reward is a recipe for no movement.

As such, the authors have attempted to prioritize the above table in terms of where the change offers the biggest 'bang for buck'. Whilst high level pricing ranges have been provided (as a rule of thumb), we note that more analysis would be needed to firm up any of the ranges suggested.

| Challenge | MRE lens | Potential benefit | Impact |
|---|---|---|---|
| Benefit Definitions | Ensure **fairness** for all members by removing subjective claims and increase **focus on returning members to work** through Introducing retraining and rehab requirement and ability to allow for all information up to assessment date. | For long tail claims, impacts claims cost by 10%-30%. Changes tail in pricing. | High |
| Anti-selection (includes AAL's, prior claims and Opt Up's) | Ensure **fairness** for members by introducing underwriting (or PEC's) for members increasing cover. | Potential impact of c10%-15% for new members only. | Low |
| Moral Hazard (includes Transfer of Cover, All or nothing TPD design, Replacement Ratio's) | Ensure **fairness** for members by limiting total cover available in aggregate, reducing reliance on all or nothing benefit by increasing **transparency** of claims definitions and helping members return to work through appropriate incentives such as capping RR's. | Income design shift on different basis but capping RR or offsets has potential impact of 1% change in claims cost for every 1% change in RR. | High |

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| | | | |
|---|---|---|---|
| Cross subsidies | Ensure **fairness** for members by having members pay their own way along with improving **value for money** through removing risk margins. | As an example, potential impact of 10%-20% on premiums for changing benefit for 5%-10% of members. | High |
| Plaintiff Lawyer Involvement | Reduce subjectivity of definitions to ensure **fairness** but simplify and increase **transparency** of claims process to allow ease of claiming. | No discount but increased value for members in terms of net payout. | None |
| Member Awareness | Increase communication to members to seek maximum engagement and awareness with members. | Fund approach could increase cost by 0%-30%. | High but in reverse |
| Insurance structures (includes rate guarantees and profit shares) | Longer term rate guarantee to ensure **consistency** and stability. 100% profit share to ensure that manufacturers can't over correct on price and retain upside. | Increase of 3-10% to allow for differences in cost of capital and upside but offset against aligned structures. | Depends |

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# 5 Review of What's Been Implemented ("Are We There Yet?")

## 5.1 Looking Back at the Last 12 Months

It's worth considering some of the major Superannuation Funds that have made changes in the last 12 months. This review focuses on a subset of 10 large funds (all public information) that have made some changes since July 2014 but the broad summary of the changes is that mainly the price lever has been pulled:

| Fund | Major changes* | Approximate price increase (rounded) | Comments |
|---|---|---|---|
| AustralianSuper | • 'Agreement to align the interests of members, the insurer and the reinsurer through a new, long term partnership'<br>• Reduction in TPD units from 3 to 1 unit for new members.<br>• AAL's reduced from $1.5m to $600k ($20k to $10k for IP)<br>• Dial up's subject to short form underwriting and time limit<br>• Definition change for TPD to introduce capability, allow all evidence up to time of assessment to be considered and member not considered TPD if refuse to engage in rehab.<br>• Definition change for IP from 1 income producing duty to all duties. | c65% DTPD<br>c75% IP<br><br>This includes a c10% reduction for DTPD and 20% reduction for IP scheduled from 30 May 2015. | Some extremely difficult changes. Shifting the focus onto claims and rehab services (aligned with definitions). |
| MTAA | • Reduced AAL's<br>• Tightened Active | c100% for DTPD | First scheme to introduce |

| | | | |
|---|---|---|---|
| | Employment Definition<br>• Split TPD benefit into traditional ETE occupation definition (80% of benefit) and Activities of Daily Working (ADW) (20% of benefit)<br>• Tightened TPD definition (unlikely to unable) | | severity based TPD with ADW definition. Sensible changes to AAL's and Active Employment. |
| Sunsuper | • Remove eligibility for standard cover for new members if a prior claim<br>• Definition change for TPD to introduce 'unable', consider all evidence reasonably available and under care of medical practitioner | c90% DTPD<br>c30% IP | Mainly a price correction but earliest adopter of amending TPD definition. |
| Hostplus | • No significant product changes | c90% DTPD<br>c-10% IP | Purely a price correction. |
| Hesta | • No exercising of Life Events cover without underwriting | c35% DTPD<br>c70% IP | Mainly a price correction. |
| CBUS | • No significant product changes | c85% DTPD | Purely a price correction. |
| First State Super | • No significant product changes | c60% DTPD<br>c20% IP | Purely a price correction. |
| REST | • Increased cover levels for Death and IP for members over 25.<br>• Change to TPD definition to allow for inclusion of rehab into assessment | c40% DTPD<br>c5% IP | Product changes were made in July 2013 so is dated and scheme design very different. |
| GESB | • No significant product changes | c40% DTPD<br>c5% IP | Purely a price |

| | | | |
|---|---|---|---|
| | | | correction. |
| CareSuper | • No significant product changes | c25% DTPD<br>c15% IP | July 2013 so dated. |

*Ignores tweaks to waiting periods, SIS required changes, life events cover, active work etc.

It is important to note that these funds are generally very different and may already incorporate various design features or risk controls that have been identified as potential solutions to the markets challenges. Again, a one size fits all approach is not appropriate.

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# 6 Next Steps / Future Actions / Conclusion

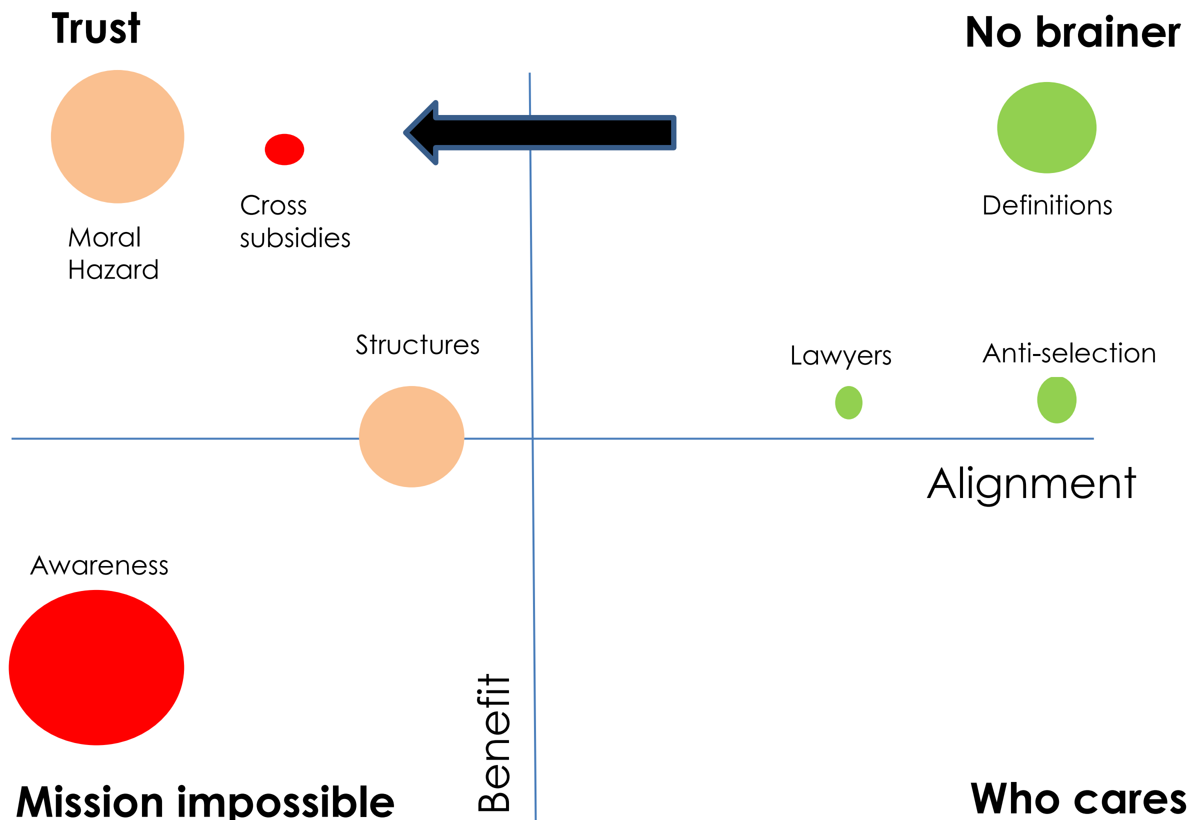
## 6.1 "How to finally get there!"

The theme remains in that funds have done relatively little over the last 2 years to amend product design. The authors, as with many market participants, strongly believe that the next 2 years will likely focus on how to advance the design within the insurance segment of Superannuation.

However, again through the lens of the members, the insurers and funds may have very different views on what should be amended so the focus should steer away from product design changes and rather focus on member design changes.

**So where do you start and what's important?**

One possible approach is to consider the above proposed changes as follows:



The key theme of this table is as follows:

- No brainers – where there is strong alignment between the manufacturers and members **along with** a high benefit in terms of making changes, this should represent a no brainer area for funds and insurers to continue to focus. Indeed, this area has been reflected in the few funds that have so far made some changes to their design.
- Trust – here, there is a high benefit typically to making change but the members and manufacturers are not as closely aligned. We have called this section 'trust' because this we believe will be key to making changes over the coming years where the funds and manufacturers (and by implication, other stakeholders) are able to work together despite this misalignment. An example here would be the development of a new form of TPD design which would revolutionize the current models and solve a number of the existing challenges
- Mission impossible – here there is a reverse benefit along with low alignment. The awareness challenge has been included here (where funds want to communicate more with members but this could impact existing claims costs)
- Who cares – there isn't anything at the moment in here (debatably) but represents an area that isn't worth focusing on from either the trustees or manufacturers.

This graphic representation therefore offers a potential path forward (call to action) which might be simply expressed as follows:

- Focus on the no brainer areas as a start. All funds should be considering their definitions along with opportunities to reduce anti-selection
- Move towards the trust areas over the coming years. This includes addressing moral hazard challenges (bravely) along with cross subsidies and insurance structures.

We should also acknowledge lastly the amount of effort and collaboration that has already gone into changing the group risk market, across all stakeholders. It hasn't been an easy journey but 12 months on, whilst there is still plenty to address, we should acknowledge how many steps have been taken to get us all to a much healthier point than 2013.

# 7 Appendix - Recap of the Issues

## 7.1 Overview

There have been many excellent papers and presentations that have addressed the issues and challenges the group risk market has faced over the last two years. These papers are acknowledged and referenced at the end of the paper.

It is not the intention of the authors to question or challenge the existing analysis but instead to provide a commentary as to the extent the market has responded to these issues. The purpose of this section of the paper is therefore to provide a background to the rest of the paper by way of a synopsis of previous material.

The authors have, however, categorized the current issue facing the market into the following sections:

- Product
- Environmental
- Pricing
- Claims Management
- Other

In each section, we attempt to highlight (very briefly) the key issues and in some occasions, highlight how the market has shifted in more recent years.

## 7.2 Product

### 7.2.1 Benefit Definitions (TPD)

Looking back to 2013 a typical TPD definition was of the form:

"In the opinion of the insurer, after considering medical and other evidence, you are unlikely ever to be able to engage in any occupation for which you are reasonably suited by education, training or experience."

There are a number of issues with this typical TPD definition including:

- The word "unlikely" indicates some form of probabilistic statement so it could be argued that you are unlikely ever to be able to engage in any occupation if you are less than 50% likely.

- The wording also leaves open the interpretation that you are "unlikely" to be able to return to work if your job is no longer available in your local area. For example, you are unlikely ever to be able to engage in your occupation if the main employer in the area has shut down the factory or an industry or trade is in decline.
- It is often difficult for medical practitioners to provide a definitive opinion of permanency especially for some early duration claims.
- The term "reasonably suited" is somewhat vague and open to interpretation.

In summary the benefit definitions (especially TPD definitions) are subjective and open to interpretation. This is an issue as there are a number of people making an interpretation on these subjective definitions including claims assessors, managers, lawyer, tribunals, actuaries and members and their interpretation may vary materially from what has been allowed for in the historic pricing of the benefits. There are also some limitations with the typical IP definitions but for the purposes of this paper, we tend to focus predominantly on lump sum benefits.

#### 7.2.2 Eligibility (including AAL's)

Historically, Automatic Acceptance Limits (AAL's) for industry funds were set at the same level as the default cover, which was significantly lower than that available for corporate schemes.

With less than 5% of group risk cover going through full underwriting, eligibility is seen as the primary approach to managing the underwriting process. Given the number of member applications passing through the system, actuaries were comfortable supporting the idea that the scale minimised any anti-selection risk.

Six years ago though, the market moved to offering higher levels of automatic cover than the default cover level partly as an attempt to address the under-insurance issue.

These benefit changes were introduced at the height of the group insurance cycle and there have been many arguments as to how it has allowed some members to anti-select higher levels of cover with greater awareness of their below average level of health. Advisors could recommend returning to work for a short period or taking out a part time job which afforded access to these high levels of non-underwritten cover. The disproportionate link in

particular with hours worked and size of benefits was not always controlled leading to cover well in excess of the level of cover that would be supported by the member's income. The nature of this weakened (or non-existent) underwriting can take several years to become apparent in the claims experience and therefore there is concern that there is still some residual impact of this effect still to come through.

Over the last couple of years there has been a trend to wind back some of the generous automatic acceptance limits to make them more balanced. This also extended to introducing some restrictions on opt-in levels of cover such as some basic underwriting questions, whether they are simple medical questions or simple financial questions such as multiples of salary limits as well as pre-existing exclusions.

As well as AAL's there have been other detrimental changes to eligibility criteria that have had pricing implications. For example, many funds reduced the hours worked per week for a member to be eligible for automatic acceptance and in some cases included previously uninsurable occupations or even unemployed members as eligible for insurance.

#### 7.2.3 Opt-ups

Opt-ups are very similar to increased AAL's in that they allow members to access higher cover levels voluntarily with limited or no underwriting. Technically it could be argued that opt-ups are just a different form of AAL but this product feature typically had different forms and history so in the author's opinion warrant a different section.

Firstly, the history of opt-ups goes back a long way and many industry funds have had this feature for ten or twenty years in some cases. Secondly there are a number of historic features that have made opt-ups less anti-selective than their AAL cousins, namely:

- Typically only available upon first joining the fund. The most common term is 120 days to coincide with the first superannuation contribution from the employer.
- Increases may be limited as a multiple of the default number of units. For example, you may have default level of cover of three units and only be able to opt-up another two units. This keeps the overall cost of any potential anti-selection to a reasonable level.
- If the benefit design in respect of opt-ups has been stable for many years and good data is available in respect of the costs of the level of

anti-selection then it is possible to incorporate some allowance for this feature correctly into the pricing as well as inform the trustee as to the appropriate level of cross-subsidy between different members.

It is therefore fair to say that the estimated pricing impact of opt-up arrangements is less significant than the automatic acceptance limits above. Nevertheless, where opt-up arrangements have gone from modest permitted increases of only a small proportion of the default cover to situations where members can now take up very high multiples of the default cover then the authors would expect the issue to be similar to a high AAL.

### 7.2.4 Transfer of Cover

Transfer of cover became quite common around the time of the Choice of Fund legislation. This feature was introduced to ensure that insurance was not a barrier for a member wanting to changing insurance funds.

Reasonably sensible controls were introduced so that the previous cover needed to be cancelled and often the whole account balance moved to the new insurer.

Whilst there are some potential issues around members moving to more generous definitions there are relatively minor and the transfer of cover terms are not seen as one of the principle issues affecting the industry by the authors. They are seen by the trustees quite reasonably as being required in some form to enable members to move their cover without being materially disadvantaged.

### 7.2.5 All or nothing TPD design – moral hazard

A key issue with TPD is the binary outcome of the claims decision. This leads to issues when the claims decision is not a clear cut decision.

A borderline claimant can be significantly financially incentivized to remain off work in order to qualify for the lump sum benefit. This moral hazard often has an age component and can be significant closer to retirement where the remaining years of employment are less. The moral hazard aspect means that doubling the benefit level will often more than double the claims cost as more members have a stronger incentive to make a claim.

A weakness of the lump sum TPD design is that it incentivizes members not to return to work or participate in rehabilitation which may be in the long term best interests of all parties involved.

#### 7.2.6 Replacement Ratios

Default income protection arrangements are becoming common in the Australian market. Whilst most of these arrangements are short term, there are some large schemes that offer long term disability as well. Trustees do not typically receive detailed salary information at the member level for default insurance arrangements and therefore have to choose appropriate levels of cover for all members. They need to balance the requirement to give adequate benefit for the members with higher than average salaries but also to ensure that only a minimal number of members receive pre-super contribution benefit levels greater than 75% (typically) of their salary which will result in their benefit being capped.

These default income protection benefit levels have been increasing as general trend. This has pricing implications as the average net replacement ratio will lead to higher incidence and lower termination rates due to incentives to return to work being lower for higher net replacement ratios. Also it has implications for member equity and fairness if the proportion of capped benefits increases too high and a material number of members are paying for a benefit they only partially use despite paying the full default premium.

### 7.3 Environmental

#### 7.3.1 Plaintiff Lawyer Involvement

There have been a number of excellent papers and presentations that have addressed the issue of plaintiff lawyer involvement. In this paper we will only give a brief synopsis but it is worth breaking down the impact of plaintiff lawyers into three components:

- Impact of legal involvement on decline rates for contested claims
- Impact of legal involvement on claimant behavior especially rehabilitation
- Impact of marketing on member awareness

The relative impact of the components of plaintiff lawyer involvement will vary by scheme but in our opinion the impact on member awareness is likely

to be the greatest.

Three years ago the proportion of disability claimants that used the services of a lawyer was anecdotally less than 5%. Now most schemes would have legal involvement in at least 30% of their disability claims with some schemes having over 50% of claims with legal involvement.

Given that decline rates prior to this period were only 10-20% for TPD claims, this clearly implies that the first component is not the primary driver for increased claim costs. In fact decline rates have risen for many schemes as legal involvement has increased.

Instead the pattern has been that notified claims have sharply increased in the last three calendar years. This has in part been driven by lawyers increasing their advertising to consumers and spending time working through workers compensation claim lists to assess whether claimants had some form of cover inside superannuation also. They provide a service that the industry shouldn't need if our claims processes and communication levels are sufficient but arguably, members are not in a position to navigate the complexity of some form of claims without support. Although some practices by the plaintiff lawyers may impact the outcome of a claim (for example, ensuring that the workers compensation claim is paid first or not engaging the Superannuation insurers rehabilitation services thereby making a disability claim in Superannuation hard to refute), it is rather the increase in awareness that the authors believe has had the most significant impact on driving up experience as the discount in the pricing for lack of awareness has been unwound.

The fundamental issue for pricing is whether or not the increase in notified claims represents an advancement of claims that would have been reported eventually or they represent additional claims that would not have been reported without the marketing and advertising of the plaintiff lawyers.

#### 7.3.2 Economic Conditions / Correlations

There has always been the assumption that disability incidence and terminations are statistically linked to economic conditions. There have been a number of papers internationally trying to quantify the extent of this presumed correlation. The most commonly reference paper in the Australian market is the James Collier and Rod Berry paper published for the Institute of Actuaries of Australia in 2008.

Nevertheless, the authors believe that it is still a matter of judgment as to the exact extent of the economic correlation with TPD and income protection benefits claims costs and unemployment and in particular the potential time lag between changes in unemployment and increases in claims cost.

Allowing for these potential one to two year delays (as suggested by the relevant Actuarial papers) makes splitting out the effects of experience into that caused by changes in product design and other environmental factors difficult and by necessity a matter of judgment.

It is also worth noting that different industry funds concentrate on different industries. Therefore the relevant economic metrics that apply to the mining industry over the last few years will be materially different to the economic metrics that might apply to the hospitality or retail sectors.

### 7.3.3 Mental health / greater social awareness

The final environmental factor we consider in this paper is mental health and in particular the changing social awareness and acceptance of this medical condition.

This greater social acceptance of mental health issues has led in some schemes to an increase in mental health claims. Discussions with claims teams indicate that mental illness can have more significance as a secondary cause of claim and that it is now common for many claims to have an additional mental health overlay as part of the claims assessment.

Data quality around cause of claim means this impact is difficult to quantify and in particular accurate analysis of secondary causes of claim are rare. Nevertheless, this can be a material environmental factor in the opinion of the authors although we note that the extent of the impact of this factor can vary by different funds depending on the occupational profile of the fund, the practicality of rehabilitation and the exact wording of the benefit definitions.

## 7.4 Pricing

### 7.4.1 Member Awareness

Pricing Actuaries have been aware of the material impact of the lack of member awareness on pricing for a long time. Claim incidence rates for group risk business and industry funds in particular have traditionally reflected a large degree of lack of awareness by the member of the benefits that they have within superannuation. There was an implicit assumption that not every member was aware of their cover given that Superannuation is compulsory, and for many members, the retirement savings component was the main driver of their choice of provider and focus.

This lack of awareness meant that historically claim incidence was lower for members who have group insurance through eligibility and automatic acceptance provisions than policyholders with individual cover who have gone through medical underwriting. This is despite expecting the medically underwritten lives to be in better health than those members that merely need to be at work in order to be eligible.

This implicit discount in the pricing has been a factor in group risk pricing for at least a couple of decades now and was effectively "built into the pricing" through the historic experience.

It is worth noting that the discount varied by fund to fund. Member communication, benefit design, the average level of cover, occupational profile and also the extent of union involvement in the fund could all affect the average level of awareness and unawareness of a particular fund.

The implicit pricing discount for awareness also differs materially by benefit type for most funds. This is because there are natural triggers for the payment of a death benefit within superannuation as the funds are paid out to the estate and whether or not there are death benefits is a question almost universally asked by the lawyer handling probate.

The natural triggers for TPD benefits are weaker than for death benefits but nevertheless if a member requests for early release of their superannuation account on the grounds of being disabled under the SIS Act, then the trustees will normally inform the member at this point of any default TPD benefits they may have.

The natural triggers for income protection are the weakest of the three benefits and therefore it has often been assumed that the implicit lack of awareness discount is greatest for income protection benefits. As an example, when some funds introduced income protection as a default cover they found that the incidence rate for this temporary disability cover was less than for TPD despite the income protection claims definition including temporary as a well as permanent disability and having a shorter waiting period.

From a pricing perspective lack of awareness is not an issue providing that it is stable and historical levels of awareness and the associated pricing discount are expected to continue into the future.

Allowance for changes in member awareness is not a new issue. Pricing Actuaries have been reflecting changes to member communication, the increased use of technology, trends in reporting delays and the seasonality of claims based on member communication into their pricing for many years. However, the recent calendar years have shown a rapid and dramatic change in the level of awareness in industry funds particularly due to the advertising and marketing of plaintiff lawyers.

Two years on we are still grappling with two fundamental questions:

- To what extent does the increased level of notified claims represent an advancement of claims that would have been reported eventually anyway and
- Greater awareness has led to greater claims recently but how far has this trend gone and what increases are still left to happen as members become increasingly aware of their benefits.

Until these two questions can be answered with a reasonable degree of certainty, there will continue to be capacity constraints and high capital allocations (and high profit margins) associated with industry fund pricing in the market.

### 7.4.2 Anti-selection

Another challenge for those pricing industry funds currently relates to anti-selection. The changes in product design outlined above have clearly materially increased the potential for anti-selection by members in terms of

the amount of benefits they could access without medical underwriting. It is a truism that Actuaries can price for most things but it is almost impossible to price accurately for anti-selection.

The potential for anti-selection raises significant pricing challenges:

- To what extent has anti-selection yet to arise in historic experience given the lag times between members in worse than average health and a potential claim?
- Are more members likely to anti-select in the future as awareness of these options increases?
- To what extend will recent tightening of product designs reduce this issue?

There is often insufficient data to answer these questions accurately and this therefore leads to increasing use of judgment and subjectivity in the pricing process. It also leads to potential conservatism in pricing as benefit changes are introduces with potentially lower associated discounts because there is insufficient data to justify the assumption.

#### 7.4.3 Model Problems – weakness in chain ladder methods

There has been a considerable amount of discussion within the industry and a number of presentations and papers about the inherent weakness of the chain ladder method. In particular, the authors would like to recommend to the reader the recent Institute Discussion Note on IBNR's which sets out many of the issues and considerations in more detail than we intend to go into in this paper.

Whilst acknowledging the considerable body of work done by the profession in this area we nevertheless feel it would be useful to make the following points by way of a summary:

- The chain ladder method has been used by practitioners for industry fund pricing for at least two decades and was the most commonly used pricing method.
- It is now acknowledged to have a number of weaknesses and in particular poorly handles the situation where there are changes to the reporting patters over time especially due to calendar year shocks. In these situations it can potentially materially overestimate IBNR's and hence lead to implicit conservatism.

- Despite its flaws many practitioners are still using a variation of the chain ladder method albeit with more allowance and judgment around the more clearly understood issues.
- There is still a consensus that models we are using and also the data we have available are poor tools to enable us to accurately predict future experience with some degree of certainty.

### 7.4.4 Data Quality

Data quality has long been an issue for pricing practitioners in group risk. The Regulator's views on the subject together with increased supervisory guidance in this area in SPS250, SPG250 and LPG270 are well documented in the associated literature.

However, the authors would like to make the following summary points:

- Data quality in group risk has historically been extremely poor and has contributed to the issues the industry is facing at the moment through both the inability to accurately price but also through ability to monitor the experience.
- Whilst significant progress has been made in this area there is still a long way to go. This is particularly the case with historic data which is simply not available in the required format
- There has traditionally been a lack of granulized exposure data and a reliance on historical premium measures to derive aggregate loss ratios. This lack of rich data makes it almost impossible for pricing Actuaries to perform detailed analysis of the past experience broken down into the level of detail that could assist with real insight to the underlying trends in the experience.
- It is difficult to get data on the impact of various changes to product design and some of the claims back testing exercises can be subjective and labor intensive.

### 7.4.5 Cross subsidies

Historically, there have always been significant levels of cross subsidies between members in industry funds although the magnitude of these cross subsidies does vary considerably from fund to fund.

The importance of analyzing, understanding and clearly communicating the level of cross subsidy has increased in recent years for a number of reasons.

- Firstly, clear communication of existing cross subsidies to trustees is important to ensure equity between members.
- Secondly, trends in anti-selection and the awareness impacts interact with cross subsidy affects. For example, the financial incentive for plaintiff lawyers often varies by age and therefore it is important to understand not only how changes in awareness affect the aggregate level of claims but also the more detailed impacts on age cross subsidies.

## 7.5 Claims Management

### 7.5.1 Early intervention and rehabilitation

One of the positive claims trends over the last few years has been the increasing use of early intervention and rehabilitation in claims management.

The authors strongly agree with view that it is almost universally the optimal outcome for all parties (insurer, trustee and member) that the claimant returns to work. Obviously from an insurer perspective the claim cost is lower but the most important consideration is that overall wellbeing of the member who ultimately benefits from a social, financial and mental health perspective by return to gainful employment. This also links through to communicating to a member that they are 'permanently disabled' which is not in their long term interests.

### 7.5.2 Difficulties with late reported claims

Late reported claims cause issue from a claims management perspective.

One of the features of the late reported claims is that it severely limits the ability of the claims management process to implement potential rehabilitation strategies. When a claim is reported several years after the incidence date there is in practice very little that the claim manager can do other than accept or decline. This is especially the case with income protection where in extreme cases the member may be claiming for years of backdated payments with very little prospect of returning to work now.

For pricing practitioners this can often be a material impact on IBNR assumptions as termination rates can be significantly lower for claims with a long reporting delay.

The practical issues of managing late reported claims interact with the changes in reporting patterns arising from changes in member awareness.

## 7.6 Other

### 7.6.1 Rate Guarantees

As a result of the historic losses in the market and the increased uncertainty in pricing, the market has responded by moving away from three year rate guarantees. For industry funds, either a one year or two year rate guarantee are now the most typical outcomes of a scheme renewal.

The authors agree that this move towards shorter rate guarantees is rationale on the part of the manufactures and is a response to the lack of stability in reporting delay patterns that have made pricing so uncertain and also in response to the associated increases in capital. However, just because it is economically rationale doesn't mean that it is also optimal for all stakeholders. The move to shorter rate guarantees has had the following indirect effects:

- Less stability of insurance cost for members
- More frequent changes to insurance design and pricing, consuming more time and resources for both manufacturers and trustees
- Reduced incentives for investment in technology, people and processes if the expected tenure of the group insurance relationship is reduced

The authors have concluded that, whilst the move to shorter rate guarantees was indeed rational, it is unlikely to be in the long term interest of all of the stakeholders. However, a return to three year rate guarantees will only come about when pricing risk and associated capital charges are reduced which in turn will depend on stability of claims experience in the future.

### 7.6.2 Profit Shares

One of the consequences of the recent disruptions in the market has been an increase in the use of profit shares. This increased use of profit shares has reversed the previous trends where consideration of intergenerational member equity and the option cost were often perceived as a reason not to incorporate such profit sharing arrangements.

However, the reasons for this trend of greater use of profit shares may not be all positive. As uncertainty around reporting delay patterns has increased and risk appetite and competition has decreased, there has been an

increasing gap between the reasonable pricing expectations of trustees and manufacturers (insurers and reinsurers).

To put it bluntly, trustees are suspicious that the IBNR assumptions and associated trend analysis underlying some of the recent market tenders are overstated and that manufacturers are using the reduced competition in order to recoup past losses as well as reflect future experience.

It is not the authors' intention to opine on this debate but rather to note that profit share mechanisms are increasingly being used to bridge the gap between these different expectations. Again, alternative models that achieve the broad outcome of aligning the trustees with the manufacturers are also being explored.

#### 7.6.3 Trustee issues / SIS definitions

The current market conditions have created some issue for Trustees:

- In setting default insurance arrangements, trustees need to appropriately balance members' insurance needs against the insurance cost potentially eroding retirement benefits. The significant premium increases in the last couple of years need to be considered in the context of section 52(7)(c) of the SIS Act which states that: "not to inappropriately erode the retirement income of beneficiaries."
- Another significant issue of the trustees is the difference between the insurance policy and the SIS permanent incapacity definition (section 1.03C) which is "unlikely that the member will engage in gainful employment for which the member is reasonably qualified by education, training and experience." Given the current tightening of TPD benefit definitions, there is now the situation where a member may meet the SIS definition which enables release of superannuation monies but they do not meet the insurance definition. This can lead to complaints from the member to the trustees.
- Trustees now need to demonstrate that they are meeting the requirements of SPS 250. In particular, they need to have an insurance selection process which is at arm's length and acts in the members best interests. These requirements can prove to be difficult in practice in current market conditions where capacity is constrained and the traditional market tender may not necessarily be in the best interests of members.

# 8 Analogies with other industries

It's worth reflecting on whether there are any lessons to be taken from other adjacent industries or countries. Whilst not an exhaustive list, the authors would like to highlight two examples which may be appropriate given the current environment.

## 8.1 Managing the cycle

Poor management of a cycle inevitably raises its head as the cause of any correction. We've seen in recent years, for example, the US subprime mortgage market and associated financial instruments developed which contributed to the GFC as an excellent case study of poor cycle management.

In Life reinsurance markets, the US also offered an example where through the 2000's, reinsurance cession rates climbed, prices kept falling and terms and conditions were relaxed. Many years later, the US market is still being weighed down by GAAP earning losses due to business written through that cycle.

Closer to home, it's often quoted that we've gone through a disability cycle of losses many times before and yet here actuaries are again - are we doomed to repeat these cycles continually? What should we as an industry change to stop repeating the past?

## 8.2 Inertia

We've seen evidence in other markets where inclusion of inertia benefits in pricing has led to disastrous consequences. As an example, PPI (Payment Protection Insurance) offered historically in the UK, sold policies with loss ratios sometimes below 10%. Policyholders in many cases weren't aware they even had this cover attached to their mortgage and alongside poor sales practices, has led to restitution over the last years being set aside by these providers believed to be now well over £10bn in reserves.

Linked to this (or contributing to it), the legal professions' involvement in the UK around attempting to find members who weren't aware of their cover has also skyrocketed, creating an industry to support UK policyholders seek restitution.

Legal representation is important and valuable but one of the key issues to consider is whether the law firms acting on the members' behalf should be receiving a significant proportion of the members benefit. This is typically phrased as a no win no fee arrangement with the fee (based on anecdotal evidence) in some cases anywhere upwards of 30% of the benefit levels. In Britain for example, Wikipedia suggests that 85p is spent on litigation for every 1 pound of compensation and the US Tort system has arguably resulted a significant cost and drain on the economy. In our market, we should consider whether this leakage is reasonable and commensurate with the law firms' involvement? Who is best placed to implement change to ensure that members get a fair deal?

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