Product Sustainability Working Group

Retail Advised Lump Sum Product Sustainability

Final Report

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Acknowledgements:

The Working Group would like to thank the following people who contributed their perspectives: -

- Wayne Brazel
- Peter Corbett
- Esther Kahumburu
- John Oakley
- Ignatius Li

1. Executive Summary

The problems that exist with disability income insurance are well known and potential solutions are actively being discussed within the industry. However, there has been limited discussion on whether there are also issues with the companion retail lump sum products covering death (including terminal illness), TPD and trauma. The Life Subcommittee established this Working Group to consider this question.

The Working Group has identified a number of problems that it believes exist with Retail Advised Lump Sum products. In summary these are: -

- Product benefits/features potentially breaching the indemnity principle by paying out amounts in excess of the actual financial loss incurred;
- Difficulty in identifying, in some cases, whether an insurable event has actually occurred for products such as TPD and terminal illness;
- Complex product terms and disclosure documents that are extremely hard for customers to understand;
- Affordability of current offerings both now and at future renewals;
- Fairness of level premium contracts both in terms of their description and operation;
- Potential changes in the future insurance environment with no ability to adjust product benefits or features; and
- Sustainability of the current distribution model and interaction of the parties involved.

To improve the existing new business offerings a number of changes are suggested for consideration, including: -

1. Shortening policy terms to allow companies to adjust for changes in the insurance landscape;
2. Replacing the lump sum TPD benefit with TPD instalments or removing TPD entirely;
3. Introducing surrender values on level premium policies (and appropriately renaming these products);
4. Changing the basis of trauma insurance from the occurrence of a specific event to cover all events where a significant financial loss has occurred;
5. Linking the payment on trauma insurance (especially) to the actual financial loss incurred; and
6. Limiting payments where the occurrence of the event is uncertain.

Some of these changes are significant and to illustrate how they could be applied, the Working Group has outlined a potential new product that it believes would meet the life insurance needs of most customers and also be more sustainable.

It is recognised that, given some of the changes being recommended are substantial, they are likely to have a material impact on the retail insurance industry – particularly in introducing such a product. In this paper, the Working Group has also attempted to consider some of the potential consequences for the industry.

2. Introduction

This paper has resulted from the growing body of thought that the current set of products being issued within the Australian retail insurance market is not sustainable in the long-term.

That is not to say that the products have always been unsustainable but that there has been a gradual increase in the benefits that are offered and a change in the risk environment which has led to this outcome.

It is not intended that the paper produces a single 'answer'. The problems facing the industry are complex and will not be easy to resolve. Rather the Working Group hopes that it will: -

a) Stimulate and accelerate discussion of the current issues by succinctly summarising them;

b) Encourage market participants to think less incrementally and more radically; and

c) Demonstrate that meaningful action is entirely possible within the existing regulatory framework.

The tone of the paper is deliberately more 'conversational', rhetorical and, in some cases, controversial as the Working Group felt that this approach better fitted meeting its purpose: -

> *'Produce a piece of thought leadership that stimulates industry-wide consideration of issues with the sustainability of current retail advised lump sum insurance products, and changes that could be made to improve outcomes for all stakeholders. While the scope will address product design issues, it will not be constrained solely to that aspect.'*

Where possible, the paper uses a sound evidence base to put forward its points. However, the Working Group has found that there are several fundamental issues where: -

- Cause and effect has been difficult to establish;
- There appears to be no common consensus in the industry;
- There are no industry-wide statistics available; or
- Some beliefs, commonly held in the industry, have not been tested recently to see whether or not they still hold true.

In these instances, the Working Group has put forward its collective hypotheses and invites readers to challenge and improve our understanding of the industry.

3. Background

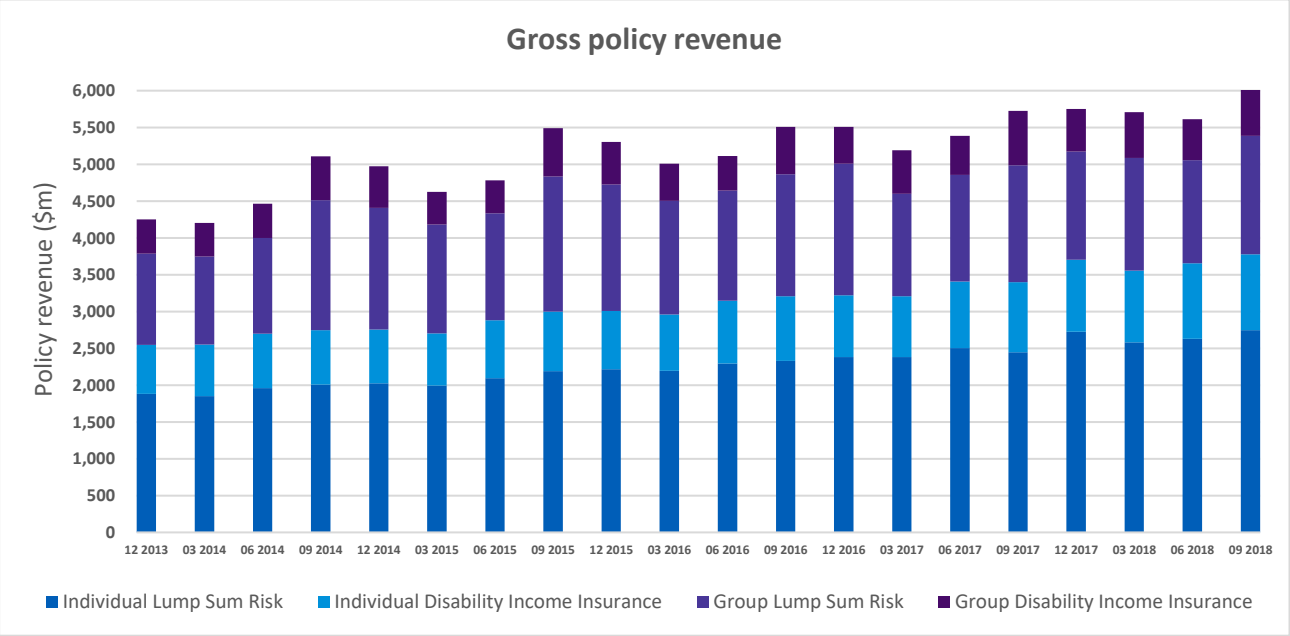
3.1 Market Experience

The main life insurance company products currently on sale in the Australian market are: -

- Death including terminal illness benefits;
- Total and Permanent Disability ('TPD') policies;
- Trauma policies (also referred to as Critical Illness); and
- Income Protection ('IP', also referred to as Disability Income Insurance, 'DII').

The above products are distributed through group arrangements such as Industry Funds, Master Trusts and Corporate arrangements, as well as individual arrangements. More tailored and complex individual policies are distributed through advisers and are subject to detailed underwriting, while simplified products are distributed directly to customers without advice and little or no underwriting.

This paper primarily focuses on individual lump sum products which broadly make up 45% of policy revenue but will also touch on other products where the aspects being considered may be applicable to them.



Source: APRA Quarterly life insurance performance statistics – June 2019

There are also a number of life insurance products which may remain inforce and are considered 'legacy' products. These products are no longer sold for a variety of reasons and are not considered in this paper which focuses on products currently available.

In recent years, the Australian retail advised life insurance market has become increasingly competitive in both pricing and the benefits offered. With access to more comprehensive

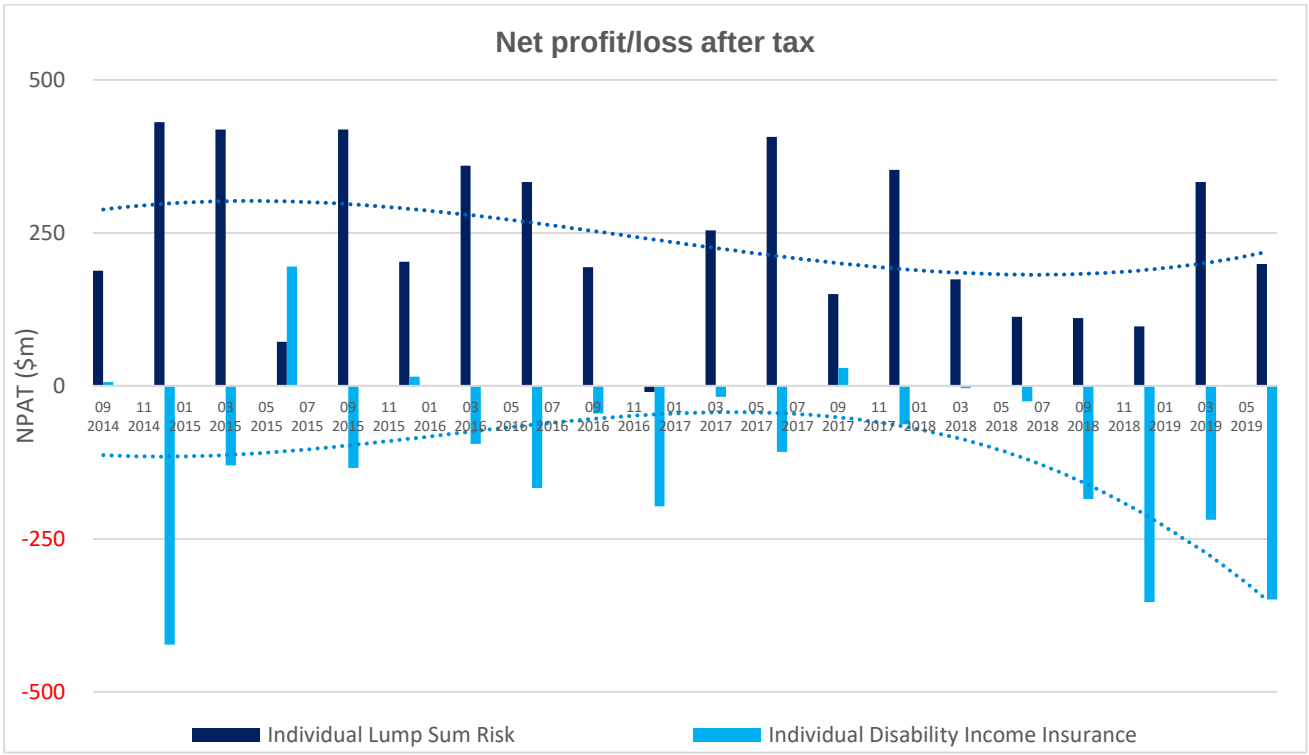
comparison and ratings tools, many ancillary benefits have been added to core benefits which have served to deliver better value for customers. However, this has also led to greater complexity for customers and reduced sustainability for insurers.

Despite the advice provided, customers remain largely disengaged with the product they purchase and do not always understand the terms and conditions of the increasingly complex products. This has left some policyholders dissatisfied with claim outcomes.

At the same time the industry has also faced several issues, including but not limited to the following: -

- Adverse claims experience trends;
- Heightened public scrutiny from media reports such as the Four Corners report in March 2016;
- Evolving community expectations which were highlighted in the findings of the Hayne Royal Commission in 2017/2018; and
- Increased regulatory oversight.

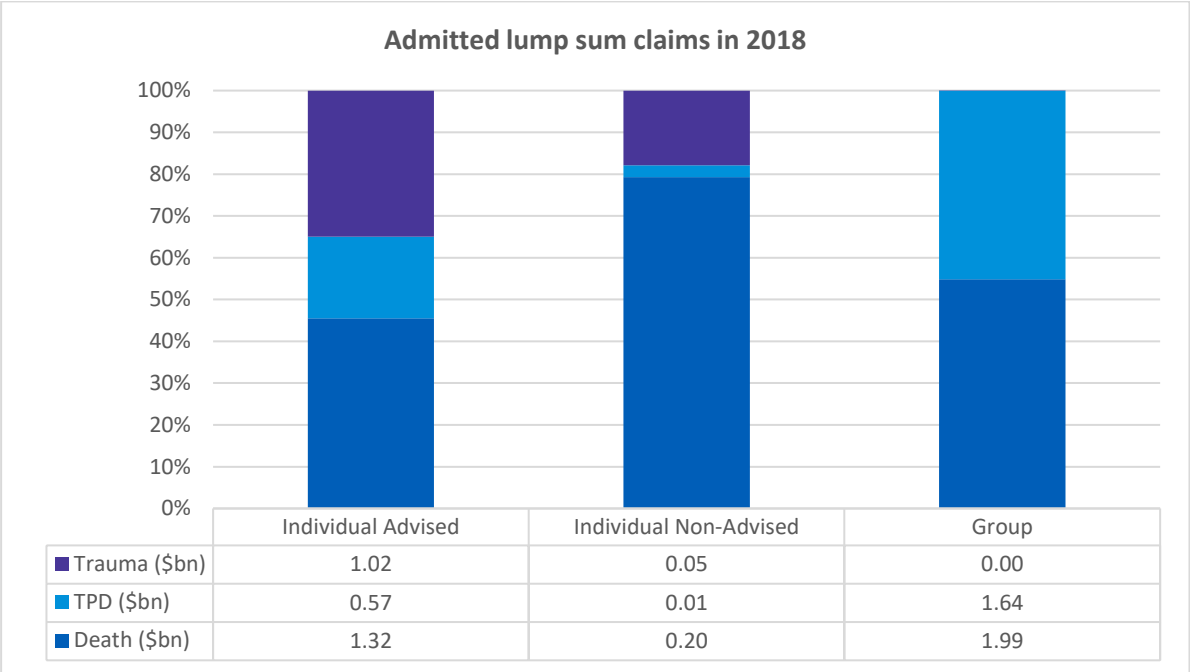
The impact of these issues has been acutely felt in retail advised insurance products. The following graph illustrates the net profit/loss after tax (net of reinsurance) of individual products (which include products sold directly to customers without advice) and raises concerns about the long-term financial viability of these products.



Source: APRA Quarterly life insurance performance statistics – June 2019

While individual lump sum products remain profitable overall, there are emerging concerns about the sustainability of living benefits, which make up a substantial proportion of lump sum benefit costs (please see the graph below). Some insurers are expressing concerns

about TPD profitability and there is industry-wide concern about poor financial results and/or the ongoing sustainability of trauma products. In addition to the existing issues, clarity around terminal illness claim events may reduce in the future. This is driven by the lengthening of the qualifying life expectancy for terminal illness benefits, increasing from likely to die within 12 months to within 24 months.



	Individual Advised	Individual Non-Advised	Group
Trauma ($bn)	1.02	0.05	0.00
TPD ($bn)	0.57	0.01	1.64
Death ($bn)	1.32	0.20	1.99

Source: APRA Life insurance claims and disputes statistics – December 2018 – calculated as average sums insured x number of claims

Also, lump sum individual insurance policies are often linked to income protection policies which have seen poor profitability for many years.

A 2019 survey conducted by the Disability Income Working Group found that some insurers have responded to poor disability income profitability by introducing some level of cross-subsidy between lump sum and income protection products. Our experience is that this could take the form of: -

- Margin subsidies where profit margins on lump sum and income protection products are considered together to meet internal pricing hurdles; or
- Price subsidies where lower prices for lump sum products are offered to offset the cost of rising income protection product prices[1].

The latter of these could lead to lump sum products becoming unsustainable in their own right.

Historically, there have been very few step-changes in product development in the Australian life insurance market. Instead, insurers have traditionally taken an incremental approach. The Working Group's view is that developing products in this way has resulted

[1] Disability Income Working Group Survey Results presented at the Actuaries Institute on 30 July 2019 (https://actuaries.logicaldoc.cloud/download-ticket?ticketId=6509b84e-44da-459e-accd-15a427bb0e5e)

in a lack of an overall cohesive vision of how customer needs are met and have made it difficult for insurers to develop a customer needs driven product strategy.

3.2 Scope of Work

As highlighted in the previous section, there are a number of industry-wide challenges about the viability of individual products which have come together at the same time. This presents an opportunity to investigate some of the underlying issues and proposes ways to address them in the context of the current legislative framework which is built on the Life Insurance Act 1995.

The Working Group will therefore explore these challenges and deliver a thought leadership paper to: -

a) Discuss some of the main issues that face the Australian life insurance industry today;

b) Put forward some possible solutions to address the issues facing the Australian market;

c) Outline a product that incorporates many of the solutions we put forward; and

d) Consider potential benefits and drawbacks for the industry.

It was originally intended that the Working Group would look at overseas developments and any applicable learnings to Australia. However, the working group felt that overseas responses did not add any particular insights and so have summarised the responses received in Appendix D.

The Working Group originally released an interim report in October 2019 to the LIWMPC and Life Sub Committee to start discussions on how the retail advised lump sum market can be made more sustainable. The feedback collected at this meeting is contained in Appendix E.

Some of the learnings could apply to the retail advised disability income protection market (which we have not considered directly in this paper).

Appendix A shows the Working Group's Terms of Reference.

4. Issues within the Australian Retail Insurance Industry

Insurers are facing an increasing number of issues in respect of retail insurance business that collectively could mean that current products are not sustainable offerings in the short to medium term. In this section we outline some of the issues in respect of lump sum products and touch on related issues in disability income insurance.

4.1 Benefit paid does not always relate to the financial loss

Where an advice process is followed, the sum insured for a death benefit is often based on the likely needs of the policyholder's dependants in the event of the death of the policyholder. Hence, a broad relationship often exists between the death benefit of the policy and the likely loss on claim.

However, for other types of lump sum benefits the relationship to a financial loss is not so obvious.

4.1.1 Trauma insurance

For example, the Working Group believes that sums insured for trauma insurance are often based on affordability rather than an expected financial loss. Having a constant sum insured for all trauma events may be a simple approach, but we question whether all trauma events have the same expected financial loss? Even for a given trauma event, there is often no assessment of the relative impairment (apart from a small number of specialist products[2] that have not sold well) and so the same benefit may be paid irrespective of severity of the event or the success or otherwise of medical intervention. It is even possible that a full benefit is paid in circumstances where an insured event has occurred but there is no financial loss, for example, minor heart attacks where there is a full and rapid recovery.

With Disability Income Insurance, a parallel issue exists with guaranteed or agreed value benefits potentially providing benefits that are higher than the policyholder's actual income. APRA has recently issued an industry letter[3] where it highlighted its concern that such disability income benefits breach the indemnity principle of insurance and APRA's expectation is that insurers cease offering agreed value contracts by 31 March 2020. The same issue may exist within lump sum retail insurance products leading to a breach of the indemnity principle.

[2] Such as OnePath Essentials, Zurich Active and MetLife Protect

[3] APRA's letter 'Sustainability measures for individual disability income insurance' – 2 December 2019; see: https://www.apra.gov.au/sustainability-measures-for-individual-disability-income-insurance

4.1.2 Own Occupation definition in TPD

The 'Own Occupation' definition for TPD and disability income claims was introduced to enable someone who was permanently incapacitated to the extent that they could not perform their usual occupation, but not sufficiently incapacitated that they were unfit for all occupations (that they were suited to by their education, training or experience) still to make a claim.

The rationale for insuring this circumstance is that the 'usual' occupation would be more highly remunerated and so despite continuing to work the insured has suffered a real economic loss. However, no comparison of the earning differential between the usual occupation and the ones that the insured is capable of performing is made and so irrespective of the degree of incapacity (once it has reached the 'Own Occupation' definition) the same benefit is paid out. It is, therefore, quite possible that the benefit paid breaches the indemnity principle (with the value of the benefit paid plus the capitalised value of future earning potential being more than the capitalised value of previous earning potential).

4.2 Probabilistic definition of claims

For products with a probabilistic definition of claims, this creates difficulty in claim assessments and may also lead to inaccurate decisions. Examples of this issue are provided within this sub-section.

4.2.1 Total & Permanent Disablement

TPD claim definitions are the obvious example of claims that require a subjective assessment based on future likelihoods: -

> *'sickness or injury which has prevented the insured person from working in their own occupation for at least three consecutive months; and the three month period has ended before the review date on or following the insured person's 65th birthday; and the sickness or injury makes it unlikely that the insured person will ever again be able to work in any occupation for which they are reasonably qualified because of education, training or experience.'*[4]

Being probabilistic, there are always going to be cases where there are differences in opinion (especially) where what is being assessed is a customer's future capacity for work. This is because different stakeholders are likely to have very different views on whether a claimant is permanently disabled, thus making it difficult to objectively determine the occurrence of a claim.

This can not only lead to customer dissatisfaction but also to increased legal action and potentially provides a moral hazard to customers to overstate the extent of their conditions.

An analysis conducted by SunSuper in 2016 illustrated that, in Group business, this issue can be widespread. SunSuper investigated their superannuation based TPD payments and found that over one-third of those who had successfully claimed TPD had since found work

[4] Typical any occupation TPD definition

or were looking for work within five years after the TPD claim had been paid[5]. The incapacity definition that the SunSuper insurance used was 'any occupation'.

So it is apparent that TPD claims are being paid where the claimant is subsequently working after a successful claim has been made. This raises a question in relation to the difficulty involved in assessing the permanency of a TPD claim.

This issue has helped inform the redesign of the SunSuper TPD benefit. As a result SunSuper has implemented a TPD instalment structure where TPD payments are spread over six instalments (over five years) instead of being paid in one lump sum. Claimants are required to satisfy the TPD definition at each review date to be eligible for each subsequent payment.

Anecdotally, it is believed that the move to an instalment-based payment approach also reduces the motivation for lawyers to unnecessarily intervene in the claim process as there is less upfront monetary incentive – this may contribute to lower ultimate claims costs.

4.2.2 Terminal illness

A similar issue exists with assessing terminal illness claims. This was exacerbated when the period during which the likelihood of death was assessed increased from 12 to 24 months for death insurance in superannuation schemes:

> *'two registered medical practitioners have certified, jointly or separately, that the member suffers from an illness, or has incurred an injury, that is likely to result in the member's death within 24 months of the date of certification and at least one of the registered medical practitioners is a specialist practicing in an area related to the member's illness or injury'*[6]

In 2015, at the same time as this change was made, an Insights session[7] presented data from the UK on terminal illness survival rates. The UK assesses terminal illness based on the likelihood of death within 12 months, but despite this showed a reasonable likelihood of survival beyond the expected 12 month period as shown in the following table:

Duration after certification of likely death within 12 months:	1 year	2 years	3 years	4 years
Survival Rate:	30%	16%	12%	10%

Extending the assessment period to 24 months will introduce more uncertainty and it is more likely that survival rates beyond 24 months will increase over time rather than decrease. However, compared with the experience of SunSuper (discussed in section

[5] Sunsuper media release 26 April 2016, https://www.sunsuper.com.au/library/media/pdfs/media-releases/sunsuper-launches-industry-leading-tpd-insurance-product.pdf?la=en&hash=0670776F308AC86E5AED4C61B173A9D3

[6] ATO: https://www.ato.gov.au/Super/APRA-regulated-funds/In-detail/APRA-resources/Access-to-super-for-members-with-a-terminal-medical-condition/

[7] Actuaries Institute Insights Session: Pricing Terminal Illness – Is there no cost?: Nov 2015, https://www.actuaries.asn.au/Library/Events/Insights/2015/GerdingBurgessTerminalIllness.pdf

4.2.1), there does appear to be much less of an issue with terminal illness survival than there is with work capability after a TPD event.

4.3 Definition of events are extremely complex and not customer friendly

The definitions for TPD and trauma benefits in the terms and conditions of insurance policies are very complex. They are written with the intention to clearly, legally and medically, define what is covered under the policy and the degree of a condition that is required for a claim to be recognised.

The irony is that in attempting to attain clarity, insurers have created lengthy, dense and highly technical policy documents that deter customers from reading them. And, even if a customer does read the PDS, they would need to have reasonable degree of medical knowledge (and with TPD, legal knowledge) to actually understand the text.

To illustrate the complexity, please see Appendix C which contains the definitions for Severe Rheumatoid Arthritis and Benign Brain Tumour for products that are currently in the market.

4.4 Affordability of Retail Insurance

4.4.1 Affordability over time

In its 'Review of retail life advice'[8], ASIC notes that affordability over time may not be adequately assessed in the advice process and that the cost of life insurance was a major trigger for clients to seek such advice.

We considered a number of questions on the affordability of life insurance: -

- How affordable are life insurance products (both lump sum and disability income) when they are sold? When considered as a package, and depending on both the sums insured and the age of the customer, insurance premiums can be a material cost to a client – and more so when the insurance is purchased for a family (e.g. both husband and wife).
- Even if they are affordable at the date of sale, are they affordable if a customer's financial circumstances worsen? Or as the customer ages?
- Perhaps the level of cover that is sold is often too high? It is difficult to formulate an opinion on the 'right' level of cover and hence customers and advisers may default to a 'higher is better' view.

A key consideration for customers is a balance between the level and the cost of cover – and hence affordability. Current levels of cover may be driven by views on how advisers meet their best interest duties. However, what is better: to sell cover at the ideal level but with a real risk that it gradually (or in moments of financial stress) becomes unaffordable,

[8] ASIC Report 413, 'Review of retail life insurance advice', https://download.asic.gov.au/media/2012616/rep413-published-9-october-2014.pdf

or to sell at a reduced level (say 50% of the ideal coverage level) and be confident that it is affordable in the long term and provides a long-term safety net?

Customers' individual circumstances, time horizon for coverage, and needs over time could all be considered in the advice process to ensure affordable cover is maintained over time.

4.4.2 Built-in features create affordability issues for customers

Stepped premium business (which typically makes up 70% to 80% of total risk business sales) results in lower premiums initially, but the subsequent increases (with no changes in the sum insured) are often poorly understood leading to customer dissatisfaction and increasing lapses over time.

Annual increases below age 40 may be reasonably low (averaging approximately 2% to 3% p.a.) but these escalate substantially as the customer enters their 40s and beyond. Automatic indexation, especially at a fixed rate, exacerbates this effect resulting in annual premium increases of 11% to 17%[9] – six to nine times the current rate of inflation of circa 2%!

Level premiums may initially appear to be a more sensible alternative but they also have some inherent features that are not well understood – these are discussed in the next sub-section.

4.5 Fairness of level premium contracts

Level premiums generally assume that cover will be maintained at the same level throughout the policy term. However, often a customer's insurance needs will actually vary, typically increasing during their 30s and 40s (as they take on more financial responsibilities) before decreasing in their 50s. Therefore, although level premium contracts may provide greater certainty as to future premiums, they suffer from the drawback that the level premium effectively includes a pre-payment towards future cover that may not ultimately be required by the individual.

In itself, the Working Group does not see pre-payment as an issue, however current market practice is not to provide a refund if, ultimately, the "pre-paid" cover is not provided due to the policyholder reducing their sum insured or lapsing.

LPS 360 only requires surrender values for long term risk contracts where:

- The sum insured is greater than $15,000;
- The policy term is greater than 15 years;
- The policy term finishes at ages above 70; and
- A level premium is paid throughout the contract term.

Retail insurance products, although generally having sums insured greater than $15,000 and policy terms longer than 15 years that can finish up to age 75, only have level premiums for part of the contract term (normally up to age 65 at which point they

[9] 2% sum insured increase (CPI/fixed rate) and 9% at Age 41, 15% at age 64 average rate increase

convert to stepped premiums). Therefore, they are not classified as long-term risk contracts and so have no minimum surrender value.

This feature of level premium contracts has not received much discussion in the industry to date as there are many other issues to consider. However, with the hindsight of the Royal Commission, what may have been seen as a reasonable market practice should probably be reassessed as to whether it would meet 'community expectations' – which we acknowledge are largely undefined.

It may be wondered whether the surrender value of a level premium risk contract would be material. In fact, for a relatively modest sum insured of $500,000 Death/TPD and $200,000 trauma the difference between the level and stepped premium for a 35 year old (assumed to be a white collar male non-smoker with any occupation benefit) can be substantial: -

Average premiums paid[10]	**Lapse occurring after:**				
	2 years	**4 years**	**6 years**	**8 years**	**10 years**
Level premiums to 65	3,626	7,327	11,047	14,772	18,497
Stepped premiums	1,534	3,303	5,336	7,763	10,742
Excess level premium	*2,093*	*4,024*	*5,711*	*7,009*	*7,755*

Even if it was assumed that the customer had no intention of reducing their cover later in life, with a constant lapse rate of 8% per annum, only 43% of the original customers would be expected to be inforce after 10 years. So, over half will have ceased cover having paid substantially more premiums than under the stepped premium option. Indeed the total of the average premiums paid only becomes close after 18 years when it is expected that almost 78% of customers will have lapsed.

Finally, the term 'level' has a connotation that is not intended by most of these products – i.e. that the premium will remain unchanged ('level') during the term of the contract (irrespective of claims experience). It is more accurate to say it is a 'pre-payment' or 'smoothed' premium payment option. Perhaps the industry should think of removing the word 'level' and replacing it with 'smoothed' or some other term which does not imply constancy.

4.6 Long policy terms expose the insurer to changes in the risk environment

Many retail products issued today have policy terms which expire at a particular age (often 65 or 70). For customers aged 35 to 45 at inception, the policy term could easily be 25 to 35 years.

[10] Average premiums paid (with no indexation) from the eight highest rated products on the IRESS software in August 2019

The provisions in the Life Insurance Act 1995 (LIA 1995) mean that benefits provided under continuous disability policies (TPD, trauma and disability income) cannot be altered except to improve them (LIA 1995 Paragraph 9A (4) – see Appendix B).

This provision and the very long policy terms means that insurers are guaranteeing to provide customers cover, with benefits at least as good as they are today, not just this year (in 2020) but in 2030, 2040 and perhaps even in the year 2050!

In a stable environment where change is slow and predictable the long-term nature of the current products would not be a major issue. However, we are living in a world of rapid and (perhaps even) accelerating change where it is difficult to predict even 5 or 10 years ahead. To guarantee coverage 30 years into the future on benefit definitions and terms that are applicable today could be considered brave!

There is an argument that an insurer can respond to increased risks that emerge in the future by increasing premiums. However this is not an effective mitigant as consistently increasing premiums can lead to adverse customer and adviser reactions, for example, increased lapses of business (with the associated write-off of deferred acquisition costs and the loss of future economic value) and also an increased risk of anti-selection (with unhealthy lives more likely to endure the premium increases).

4.7 Trauma product

The trauma product was initially developed in South Africa where there was, at the time, a significant gap in customer needs and the public health system. However, a product (which is substantially the same) is now sold in Australia where there is a comprehensive public health system supplemented by a mature private health care system. So the product might not be providing benefits that meet the needs for which it was designed.

The financial loss suffered varies considerably according to the claim condition but the trauma product benefits are based on a sum insured with limited adjustments for the severity of the condition.

A number of reasons are often put forward for having a non-indemnity trauma insurance benefit including: -

- Provides financial freedom to make choices (if a customer gets diagnosed with a trauma condition and no longer wishes to continue working then it gives another option);
- Help fund alternate remedies not on the Pharmaceutical Benefit Scheme;
- Cover medical costs not picked up by health insurance; and
- Allows fulfilment of things they always wanted to do (such as family holiday, etc.).

It can be argued that the first 3 of the above can be more effectively addressed by adjusting other forms of insurance while the last can be covered by a savings product.

Further, medical advances mean that some claim conditions lead to a much smaller financial loss at the time of claim compared to when the policy was first taken out.

However, the yearly renewable feature of almost all Australian individual life insurance products and paragraph 9 of the Life Insurance Act 1995 means that benefits cannot be reduced to fit the financial loss suffered after the policy has been taken out. Moreover, adding more and more conditions to the trauma product without adjusting the benefits to reflect the financial loss suffered leads to an ever-increasing claims cost and an unsustainable product.

4.8 Advances in medical science lead to outdated definitions over time

Medical science has advanced substantially over the last 20 years, and the rate does not appear to be slowing. This may already have started to have an impact on claims experience.

Improved diagnosis techniques lead to earlier recognition of condition which give rise to claims. This may result in: -

1. An earlier claim payment (i.e. an acceleration of a claim the insurer would always have paid);
2. Diagnosis of conditions which previously would not have been realised (perhaps due to their mildness) leading to unexpected claims that have not been priced for as yet; and/or
3. Unexpected contract risk, as definitions are reinterpreted as part of an insurer's social contract with an evolving society.

Treatment of medical conditions has also greatly advanced and what may have once been considered a serious traumatic event may be more treatable, often with the patient making a full (and swift) recovery (e.g. mild heart attacks) and suffering no or minimal financial loss as a result. However, as policy benefits can only be improved and not weakened (LIA 1995 Paragraph 9A – see Appendix B), it is generally not possible for the insurer to reflect the benefit of medical advances in existing policy terms. This can result in payments being made for events that are no longer 'traumatic' and so a potential offset to the increased claims costs from improved diagnosis, leading to improved health outcomes, is denied to the insurer.

It is also interesting to consider how it is possible to determine, with the expectation of continued future advancements in medical science, that a person is 'totally and permanently disabled' at the time a claim is made – and whether this can be suitably defined in policy terms at the outset?

Looking forward, cheap and accurate genetic testing may inform a potential customer the likelihood that they will develop certain identifiable conditions later in life. This may lead to anti-selective behaviour as customers are not compelled to disclose the results of genetic testing to insurers. This may fundamentally undermine insurance and exacerbate current adverse claims experience.

4.9 Changing societal attitudes towards mental health

In recent years there has been an increase in claims ascribed to mental health. This has worsened experience in two lines of business: lump sum TPD and income protection, with longer duration claims (generally above 2-3 years) starting to be driven by mental health as a secondary condition in many cases.

Although mental health has been recognised as a claim cause in the past, changing societal attitudes has meant that there is a reduced stigma around admitting to a mental health condition which has resulted in an openness and an increased willingness to claim. This in turn has led to an increase in claims out of line with historic experience.

It is fair to say, that experience is still developing and, in particular, claims management has yet to really successfully respond with appropriate strategies for managing customers with mental health conditions (even to the extent that existing strategies may be considered too onerous for vulnerable customers[11]). Thus it is unknown whether this is the start of a major emerging trend or, with hindsight, will end up being a small 'blip' of adverse experience (potentially if claims management practices are able to evolve to limit the impact).

However, it is fair to make a similar point to that made earlier, with our developing understanding of mental health and its treatment, is it possible to reasonably assess that a customer who claims a TPD benefit on mental health grounds is actually 'totally and permanently disabled'?

4.10 Impact of product ratings on the advice process

Advisers place heavy reliance on the recommendations of research houses as this is often seen as the simplest way to demonstrate that the advice they have given is in the best interests of the policyholder.

Current ratings approaches can suffer from a number of drawbacks. Firstly, most products provide the same core benefits and so differences in ratings tend to be driven by minor rather than fundamental features of the products[12].

Even where products try to be more sustainable by offering 'severity' based benefits, they are rated poorly relatively to fully featured products as the level of benefits provided is lower. In the recent industry letter[13], APRA questioned whether, in product development, research houses were engaged early enough and also stated that advisers need '*to balance the type, level and structure of coverage with affordability and sustainability considerations*' rather than rely solely on product ratings. The fact that the level of benefits

[11] ASIC report 498, 'Life insurance claims: An industry review', https://download.asic.gov.au/media/4042220/rep498-published-12-october-2016a.pdf

[12] Trauma product comparison on IRESS software in August 2019

[13] APRA's letter 'Thematic review of individual disability income insurance – Phase Two' – 2 May 2019; see: https://www.apra.gov.au/sites/default/files/thematic_review_of_individual_disability_income_insurance_-_phase_two_-_v1.pdf

at the current price may be more sustainable in the longer term than that of the fully featured products is not reflected in the rating.

4.11 Role of advisers can cause misalignment of interests

Advisers play a critical role in shaping insurers' product design, because of the 'personal advice' given to customers during the sales process. While this provides advisers with a direct customer relationship, it limits the engagement of the insurer with the customer.

This has resulted in insurers designing fully featured, complex products that advisers can then adapt to the individual needs of each client. This has meant that: -

- Product development often results in additional features and options to make a product more flexible for the adviser;
- Additional features often increase a product's ratings;
- Best Interest Duty obligations have often been interpreted as to offer the best featured products; and
- The working group's experience suggests general product design may focus on the requirements of the adviser over the end customer's needs due to limited direct engagement.

This helps contribute to the complexity of products which is not always in the interests of the customer.

The lack of direct engagement has also meant that insurers must balance communication strategies between both the adviser and the end customer, with the consequence that they are (arguably) not fully meeting the needs of either.

Although advisers play an important role in the market, the lack of direct engagement between the insurer and the customer, and the possible misalignments between adviser and customer interests have contributed to complex, unsustainable products which do not always address customer needs. In turn, this has resulted in an arms race on product features and benefit definitions driving extremely complicated product design.

4.12 Sustainability of current distribution channels

The retail insurance advice market is shrinking with NMG data[14] indicating that the IFA market has shrunk by 11% for the Apr-Jun 19 ($96.9m) quarter compared with Apr-Jun 18 ($109.1m). Overall, the market has shrunk by 24% since its peak in Q2 2013 ($128.2m).

There are also a number of headwinds for future sales of retail insurance products which could cause them to fall further: -

- New educational standards for advisers (that come into effect for existing advisers in 2022) could cause a reduction in active advisers;

[14] IFA Risk Distribution Monitor, Q2 2019, published by NMG Actuaries

- The impact of the commission cap of 60% (applicable from 1 January 2020) on advisers and new business introduced by LIF is yet to play out;
- The Royal Commission recommended that ASIC review in 2021 whether insurance commissions should be removed altogether:

> 'When ASIC conducts its review of conflicted remuneration relating to life risk insurance products and the operation of the ASIC Corporations (Life Insurance Commissions) Instrument 2017/510, ASIC should consider further reducing the cap on commissions in respect of life risk insurance products. Unless there is a clear justification for retaining those commissions, the cap should ultimately be reduced to zero.'[15]

- Increasing promotion and awareness of insurance in superannuation may give potential customers the belief that their full insurance needs are being met.

A continued reduction in the retail insurance market would raise questions as to whether there is sufficient new business to support the current number of market participants or advisers (which remains the dominant source of new business).

The ongoing role of trail commissions should also be considered, especially given the changes to commission structures and the increasing importance of it in the adviser remuneration structure. The Life Insurance Framework reforms increased maximum trail commission from 11% to 22% p.a. (incl. GST) as part of the reduction in upfront commission with the aim of reducing lapse rates and improving retention.

However what services does an adviser provide for this ongoing remuneration? Renewal commissions can be seen as: -

- Smoothing upfront payments into a more regular income that does not encourage early rewriting of the business ('churn') – which is the rationale put forward in the 'Review of Retail Life Insurance Advice'[16] (see page 29);
- Remuneration for ongoing services during the policy's lifetime; and
- Remuneration taken from all of the adviser's customers for services provided to the few customers who claim.

However, there is no generally accepted rationale for trail commission. Failure to clearly define the purpose of trail commission, and the service that advisers provide in return for this remuneration, may increase the likelihood of it being removed when ASIC reviews insurance commissions in 2021/22.

[15] Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry, 'Final Report', Recommendation 2.5, https://www.royalcommission.gov.au/sites/default/files/2019-02/fsrc-volume-1-final-report.pdf

[16] Trowbridge report, 'Review of Retail Life Insurance Advice' https://www.afa.asn.au/resources/trowbridge-report-final

5. Potential solutions to these problems

In this section we look at a number of options that are currently available to address some of the issues outlined in the previous section for new business. The options presented should be considered as individual ideas, rather than necessarily operating together. Indeed, some of the options are mutually exclusive.

The options discussed do not address the issues for in-force business. The working group believe it is important to establish a sustainable new business product initially and then consider options to transition the in-force book. Due to the restrictions of the Life Insurance Act 1995, it is not possible to change the terms and conditions of business already written, and so any transition can only be with the consent of the customer. Transition strategies (and the likely need for advice) is a substantial topic that could be the subject of a separate paper.

5.1 Shortening policy terms

Despite the long policy terms currently offered in the Australian life insurance industry, there is no requirement in the LIA 1995 that requires them to be this long. There are minimal restrictions on the death benefit, except that policy terms must be for over 1 year where cover is for accidental death or a specified sickness. However, continuous disability business (TPD, trauma and income protection) must be for policy terms normally more than 3 years. A far cry from the policy terms of 25-35 years currently offered.

With shorter policy terms, the insurer would still be bound by the terms of the LIA 1995 and cannot change benefits except to improve them; however, this would only be for the much shorter policy term. After the policy term has ended, the insurer can offer new terms for a new policy – and these terms can be less generous than the terms of the previous policy. This allows for a continual reassessment of the appropriateness of the benefits/definitions offered based on changes in the risk environment, societal attitudes and advances in medical science.

An additional benefit of this approach is that legacy business would not increase as policy terms are effectively updated to the latest terms every 5 (say) years.

However, it should be noted that one of the current features of life insurance that is seen as a benefit to customers is its guaranteed renewability - no matter a customer's state of health. Without additional options, shorter duration policies could inadvertently remove this, with an insurer being able to re-underwrite a customer when a replacement policy is taken out.

To avoid this, policies could have a guaranteed ability to take out a replacement policy for the same level of cover at the end of the policy term – similar to a continuation option in group schemes. Importantly, the benefits, definitions and overall terms of the replacement policy could be set to be the same as those offered on new policies.

5.2 Linking payment amount on trauma to loss suffered

Today most trauma lump sum benefits are expressed as a fixed monetary amount, even though this is not a requirement of the LIA 1995. There has been some development of scaled or partial benefits on lump sum policies (such as the previously mentioned severity based trauma products) but the majority of policies continue to pay the full sum insured.

Where fixed sum insureds exist, it is unlikely that the trauma benefit paid will be equal to the actual financial loss incurred. This difference could result in benefits being paid in excess of the actual financial loss suffered by the customer. While one may consider this as a 'windfall' financial benefit to the customer, it increases the claims cost to the insurer, who ultimately passes it on to other customers in the form of higher premiums.

In other insurance lines, it is common practice to pay an 'indemnity' benefit that has an upper limit of the sum insured. With a home and contents policy, the benefit paid on an occurrence of a break-in is not the sum insured, but the actual financial loss incurred for the goods stolen (possibly even reduced for underinsurance). Contrast this practice with trauma policies, where a fixed sum insured is generally paid on the occurrence of an event irrespective of the actual severity.

A change that could be made is to restrict the benefits paid to the actual financial loss incurred (to the extent that the losses are not considered to be covered under health insurance legislation) subject to a maximum of the sum insured.

Such a change would undoubtedly make the determination of the benefit paid at claim to be more difficult. Assessing the severity of loss will increase claims assessment costs and so similar approaches to those adopted by the general insurance industry (such as excesses) would need to be considered to avoid large claim handling costs on small claims. It could also result, in some cases, to disagreements on the actual amount paid, with the potential increase in risk of customers feeling aggrieved. This may expose insurers to more complaints and reputational issues.

In exceptional circumstances, if a customer really requires a fixed sum insured in the event of a claim, then it could still be offered, but the rationale should be discussed with the insurer at the time the policy is taken out, with appropriate pricing.

5.3 Replacing TPD benefit

TPD cover is offered both inside and outside of superannuation and is typically paid as a lump sum benefit. What role does a Total & Permanent Disablement benefit actually play today?

From our experiences, the main reasons usually given for continuing to offer TPD products include: -

- The benefit potentially bridges the gap between the actual financial loss and the benefits offered by IP products;
- Some customers may prefer lump sums to ongoing payments;

- Claims administration, whilst onerous at the beginning, may be simpler relative to ongoing payments (for long-term IP) over a claims' lifetime; and
- There may be tax advantages in receiving TPD benefits because even though TPD premiums are not tax deductible, the TPD benefits are, however, not subject to tax. The converse is true of IP cover written outside of superannuation policies.

However, in a market which offers long-term IP benefits, the TPD benefit may provide considerable overlap in cover for some customers.

This could lead one to ask, do we offer the benefit today because we always have offered it? Also, if it didn't exist today, would the industry develop and offer this benefit? We do not believe that it would. Therefore, would removing TPD on new policies, except perhaps in limited cases (e.g. where customers have short-term IP cover or none at all), be the simplest response? This would imply that the basic insurance needs of a customer are essentially covered by death and long-term IP cover.

An alternative solution we have considered is to make the TPD benefit payable in instalments, which is one way of mitigating the uncertainty of making a one-off upfront assessment of disability. The payment of each instalment would be subject to an assessment of whether or not the customer is likely to be disabled for the duration of the period covered by the benefit payment. This would restrict the exposure to risks from probabilistic statements (as outlined in section 4.2) and the medical advances and changes in case law invalidating the initial view of permanent disability (as highlighted in section 4.8) to a much shorter time horizon. Two group life arrangements[17] have already introduced this with disability being assessed between 1 to 3 years before the next benefit instalment is paid.

Another potential solution that could improve the sustainability of the TPD benefit, is to remove the 'Own Occupation' definition. Section 4.1.2 outlined reasons why the 'Own Occupation' definition for TPD claims is regarded by many as an unsustainable feature of the TPD product and may provide a benefit which is more than the financial loss suffered by the policyholder.

An alternative solution to removing the 'Own Occupation' definition altogether, could be to link the TPD benefit to the value of the income lost due to disability (subject to a maximum of the sum insured). This may need to be achieved in a pragmatic and simple way to ensure that the benefit can be understood by customers at the time of buying the policy.

5.4 Removing stated conditions and definitions from Trauma policies

Listing particular medical conditions and the required degree to qualify for a benefit has resulted in very long and complicated product disclosure statements across the industry and requires the currency of definitions to be reviewed on a regular basis. It has also meant that, due to the restriction under the Life Act of only being able to improve benefits, it is

[17] Based on the review of SunSuper and Catholic Super product disclosure statements effective 1 July 2019

not possible to change definitions where medical advances make the occurrence of a condition less severe.

The rationale for a stated condition appears to be in Paragraph 9A of the LIA 1995 (that defines what is a continuous disability policy) which talks about *'a benefit is payable in the event of……the insured being found to have a stated condition or disease*'.

What about the long list of conditions that are not covered? Would it not be easier for customers and insurers to simply cover customers for all medical conditions? That is the potential solution we have considered. However, in order for the product to be affordable and sustainable, we believe the benefit payment would need to be linked with the actual financial loss incurred and not a fixed sum insured (as per section 5.2). It may be better to think of this solution as an insurance benefit covering the financial loss arising from any temporary incapacity.

Such a change would give greater certainty of coverage, be simpler to explain and result in (much) shorter and easier to understand PDSs. Importantly, it would also provide a more sustainable insurance product, as medical advances mitigating the impact of a condition would also reduce the financial consequences of the condition.

One may naturally question whether this potential solution would still meet the requirements of Paragraph 9A. That is, could the 'stated condition' be a condition of invalidity or severity of impairment such that a financial loss is incurred? In our interpretation, this is the reading that is applied in enabling TPD benefits to be paid for any condition that results in the required degree of impairment to qualify under the policy definition.

However, we note that this may be major change in approach to trauma/incapacity insurance, which also brings a number of problems and complexities. Some of these include: -

- Potentially insufficient credible information/experience to accurately price such a product;
- Increased effort at claim time to assess the actual financial loss (in the same way as 5.2);
- Moral hazard risk of the customer making choices that escalate that cost (this is faced and combatted by the general insurance industry by not necessarily accepting the most expensive quotation); and
- Interaction with health insurance in determining what costs fall under health vs. under life insurance.

5.5 Ratings should focus on core benefits and consider sustainability

Ratings for products should have a greater emphasis on the core benefits of the products delivered. If the core benefits are equal, then why use ancillary benefits to materially differentiate between products? Such a practice only encourages the proliferation of

ancillary benefits in an effort to improve a product's rating, which further complicates products generally.

A potential solution could require the 'core benefits' to be properly defined for each product, which could have additional applications and utility in the advice industry. For example, an argument is sometimes put forward that advisers tend to recommend the best rated or the product with the most benefits in an attempt to make certain that they satisfy the best interest duty. Defined 'core benefits' could form the basis of a 'safe harbour', whereby the adviser is deemed to satisfy the best interest duty if the product recommended has the defined core benefits.

In addition, ratings could also consider whether a particular benefit/price is actually sustainable. It is appreciated that this is not an easy function to fulfil but, at the same time, not to consider the ongoing sustainability of a benefit/price combination must be seen as a gap in an era of sustained price rises and low and falling industry profitability. Implementation of a sustainability measure may potentially help in bringing out the benefits of 'severity-based' products versus the full-featured versions.

5.6 Introduction of a surrender value on level premium contracts

Introducing a surrender value on level premium contracts would be an obvious way of recompensing customers who cease their cover in the early years for the excess premiums paid.

The introduction of a surrender value would not only provide a 'refund' of pre-paid premiums to existing customers, but would also allow the 'accumulated policy value' to be taken into account in calculating the future premium for existing customers. Incorporating this may be a useful retention mechanism, when there is a reduction in future cover (as typically occurs during the 50s), or when affordability is an issue and reducing sum insureds – a partial lapse.

We do, however, note that there may be downsides to this proposal that should be addressed. These include the increased complexity and burden of having to calculate surrender values on insurers, the issue of what to do with accumulated small surrender values when a customer is not contactable, the removal of a source of profit (in an already challenging market), and the possible anti-selective impact of healthy lives lapsing. Although surrender values will provide lapsing customers with protection against the loss of prepaid premiums and the flexibility to change insurance provider, the price for all customers is likely to increase – particularly for policies with longer contract terms.

5.7 Making terminal illness payments a proportion of sum insured

To partially mitigate the impact of an incorrect diagnosis of imminent mortality, an alternative approach could be to only pay a proportion of sum insured on initial diagnosis.

As an example, on initial diagnosis of likely death, payment could be limited to 25% of the sum insured. A further 25% could be paid if the medical professional diagnoses likely death within 6 months. This would not only provide a substantial sum, in most cases, prior to

death, but also reserve at least 50% of the sum insured for the estate and dependants of the life insured. It would also limit the impact of incorrect diagnoses of imminent death.

Obviously, where regulations require the full sum insured to be paid, this would need to be adhered to.

5.8 Increasing the focus on affordability over the policy term

We have considered a number of potential solutions that could help improve the affordability of insurance over the term of the policy and, in doing so, avoid potential surprises for the customer.

5.8.1 Advice process

Generally, the advice process looks at the financial needs of the customer or their dependants if an insurable event occurs. This may result, in some cases, in a level of ideal cover, which although prudent, may stretch current affordability.

Would customer interests be better served by seeking a lower level of insurance (for what is expected to be an infrequent event) and paying a commensurate lower level of premium (which is a constant and certain expense)? Perhaps the level of insurance sought should not start from what is required if an infrequent event occurred, but what can be afforded out of current excess income (with a suitable margin for the uncertainty of future increases), and then determine how much cover that would purchase?

Banks normally assess a customer's ability to service a mortgage should interest rates rise above the current low rates. Although there is debate about whether the current levels are too stringent, the concept appears sensible. A similar idea could be applied to life insurance products, whereby assumed price increases (over and beyond normal age rating increases) are included in the initial sales advice to allow for the likely affordability of the product over its term.

If one was to assess future affordability for customers (at point of sale or during a review) it may be sensible to look at the cost over the next 5 years (say) and allow for: -

- Increases in premium due to age rerating (if stepped premiums are chosen);
- Increases in premium due to benefit indexation (unless a customer opts out);
- Buffer for potential premium rate increases put forward by insurers. Although unknown whether there will be price changes, recent experience would indicate it would be optimistic to assume that prices will remain at their current level. As such, allowance for potential rate increases (based on historical experience) could be assumed in the illustrations provided to customers; and
- Additional buffer for other circumstances. Good practice may be to choose the cover at a level which could allow for some adverse changes in the customer's financial circumstances.

Whilst there is a trade-off between benefit levels and affordability, it may be appropriate for insurance cover to be set allowing for affordability (with a view to revising – up or down

– the level of cover over time). As such, advisers could structure the level of cover to allow for affordability at regular review periods in line with service levels and trail commission payments. This may strengthen the purpose of the trail commission (covered in section 4.12).

5.8.2 Product design

It is also important to consider what changes to product design could also improve future affordability.

For example, in a time of low inflation, should manufacturers reconsider offering fixed rate indexation and always have inflation linked indexation as an option? Perhaps more emphasis should be placed by advisers and manufacturers on opting out of automatic indexation?

However, given it is difficult to provide certainty of future affordability, it is important that manufacturers promote ways in which customers can keep some of their cover if future circumstances are more adverse than when the product was taken out. This could include opting out of benefit indexation, removing ancillary benefits or reducing the current level of basic cover.

6. What could a sustainable product look like?

Of necessity, driven by the confines of the paper, the product design and granularity of the description of the benefits presented in this paper is briefer than is normally the case but it is hoped that it will still be useful.

6.1 Customer needs

For the purposes of the design, it is assumed that the customer has the following insurance needs: -

- A benefit on death that is equal to a fixed amount (it is assumed that advice is being provided that quantifies this);
- Income replacement of a proportion of salary if unable to work due to illness or sickness;
- Coverage of one-off costs as a result of being temporarily or permanently disabled; and
- Coverage of hospital and rehabilitation benefits.

In essence the product is attempting to cover any financial loss that the customer (or their family) may experience due to their death or incapacity.

The customer's insurance needs could be validated via consumer testing or be explored in Phase 2 of the investigation into the sustainability of lump sum products.

6.2 Product design goals

In designing the sample product we have described below, we have sought to achieve the following goals: -

- Provide benefits which seek to indemnify the policyholder against clearly identified insurance needs in specific situations;
- Give certainty to stakeholders including both insurers and policyholders to the extent possible;
- Be flexible enough to adapt to the changing socioeconomic environment and can be tailored to suit the customers' needs;
- Remain affordable throughout the term of the product; and
- Be simple enough for customers to understand what benefits they will receive and for insurers to efficiently manage the product.

6.3 Outline of product features

The needs of the customer have been deliberately chosen to be similar to many of the needs of customers in the Australian market. Consequently, the proposed product shares many features with products in the market today but with some important differences to make it more sustainable.

In the sections that follow, we describe in more detail what benefits the product provides, the events in which the benefits will be paid and what insurance need the benefit is intended to cover.

Death Benefit

The full sum insured is paid on death and the amount is fixed as it is assumed that the sum insured was determined through an analysis by the adviser of the customer's liabilities and hence the required lump sum on death.

A percentage of the sum insured is advanced on diagnosis of a terminal illness where death is expected within 12/24 months. Here, we suggest paying an advance payment of 25% of the sum insured on the initial diagnosis of likely death, a further 25% where the diagnosed life expectancy is within 6 months. The remaining 50% of the sum insured would be paid on the customer's death.

We feel it is important to limit the percentage available in advance of the customer's death, partially to reflect the uncertainty of the diagnosis, and also to reflect the purpose of the death benefit which is to meet liabilities at death or provide a lump sum for dependants. Access to 100% of the sum insured prior to death may lead to the protection of dependants being eroded.

Income Replacement Benefit[18]

This benefit is the same as that provided by current income protection products. However, all income earned or benefits received from other products would be offset from the benefits paid.

The product would have the same waiting period and benefit period options as are currently available in the market.

It would be offered on an indemnity basis only (and not on a guaranteed or agreed value basis) with the benefit being based on earnings averaged over the last 2 years. At each renewal, the customer could be asked to indicate their earnings over the last 12 months and this would be used as the basis for the maximum benefit. To simplify the administration of this feature, the customer's tax return could be used (noting that there is likely to be a delay in getting this information).

[18] We have deliberately not explored this benefit in much detail in this section, given that it and the associated issues are being addressed separately by the Disability Income Working Group

Incapacity Benefit

This benefit would be paid on the occurrence of sickness, illness or other medical incapacity that is severe enough to cause a financial loss (except for those losses covered by other products).

The benefit is not provided as a fixed sum insured but recompenses the customer for the actual financial loss incurred. The product would provide a maximum sum insured chosen by the customer to limit the cost of the benefit. There would also be an excess to prevent small claims i.e. no benefit is paid where the financial loss is below a certain amount.

This benefit is intended to cover costs incurred as a result of the customer needing to customise their home, change their lifestyle, etc. because of the incapacity. It is not intended to be same as the current TPD benefit and should not overlap with the income replacement benefit.

The benefit would be described as 'insurance to cover any financial loss incurred by you arising from your incapacity up to the maximum of the sum insured'.

Hospital and Rehabilitation Benefit

These benefits cannot be provided by a life insurance company and so the product would theoretically need to also have a health insurance element provided in partnership with a health insurer. It should be noted however, that complying health insurance products are required to offer a minimum set of benefits. Therefore, some modifications in the life insurance legislation would be required to carve out those health insurance benefits that would be needed to compliment the benefits offered under the life insurance licence. Products that utilise two different insurance companies are common within the consumer credit insurance product range (as involuntary unemployment is legislated to be a general insurance benefit).

The benefit of offering a combined health and life insurance product is that rehabilitation benefits can be provided which may reduce the cost of other benefits such as the Income Replacement Benefit and help the customer to recover faster with an appropriate level of care being jointly designed and provided.

The benefit would be described as 'insurance to cover any hospital and/or rehabilitation costs incurred by you up to the product's benefit limit arising from your incapacity'.

Policy Term

The policy term of the product is proposed to be 5 years. As the product contains continuous disability features the minimum term of the product must exceed 3 years (as per the LIA 1995).

Benefits (including policy conditions and definitions) are guaranteed for the policy term.

Annual renewals would occur within the policy term (when the customer can choose not to continue with the product). At the end of the product term, there is a continuation guarantee that the customer can take out a new policy (at the same benefit level) but on the terms and conditions applicable to new customers without underwriting. This gives the

customer the certainty of future insurability that the shorter policy term would otherwise remove.

The above also ensures each insurer is likely to require less than 5 different product series (per each product) which will limit the potential for creating new legacy product issues.

Careful consideration about the structure of commission is needed if the term of the product is to be shortened and this will be discussed in section 7.

Premium Payment and Automatic Indexation

Premium payment options could include both stepped and 'smoothed'.

Importantly, the existence of a surrender value discussed in the section below limits the loss to the customer where cover is stopped or reduced under a smoothed premium product.

In a low interest rate environment and with shorter policy terms the need for automatic indexation reduces. Automatic indexation would be replaced with an option to increase cover on the replacement policy by the impact of inflation over the previous policy term.

This could be an incentive to take out the replacement policy but also leaves the insurer open to selection risk. One possible mitigation is to only allow coverage increases on an indemnity basis.

Surrender Value and Alterations

With the reduced policy term, if the customer chose the smoothed premium option then there are two potential designs that could be incorporated into the product:

- Where smoothing aims to keep premiums unchanged over the current policy term (assumed to be 5 years) only; or
- Where smoothing aims to keep premiums unchanged over both the current and future replacement policy terms up to the expiry age (equivalent to the current level premium options in the market today).

For the first design, the difference between the stepped premium and smoothed premium will be small and the concerns around material pre-payment do not exist and so a surrender value is not necessary.

However, for the second design, there would still be a substantial degree of pre-payment and so, although the business would not be classified as long-term insurance, the policy would acquire a surrender value during its term. At the end of the policy term, if the customer decides not to take out a new policy then a surrender value is paid out to reflect any pre-payment for future periods. Where there is a benefit alteration at the request of the customer, then the surrender value is taken into account for any reduction in coverage when calculating the new premium after policy alteration – which may assist retention if affordability becomes an issue. However, the existence of a surrender value may also provide an incentive to the customer to lapse.

In line with current practice there would be no surrender value on the stepped premium option.

Pricing Guarantee

A pricing guarantee could also be offered for the term of the policy. Although not required this may give the customer certainty over the cost of insurance in the immediate future. This will place restrictions on the insurer, but importantly, this guarantee is only for the current policy term.

6.4 Sample product summary and assessment against issues identified

The table below summarises the above sample product design and compares it against the current standard product benefits, as well as providing an assessment against the issues identified in this paper (where relevant).

Item	**Current State**	**Proposed Core Benefit**	**Assessment Against the Issues Identified**
Product Benefit Design			
6.4.1 Death Benefit	Full sum insured	Fixed sum insured with 25% payable on terminal Illness diagnosis, additional 25% where life expectancy is less than 6 months and the balance payable on death	Addressing 4.2.2
6.4.2 Income Replacement Benefit	Max 100%+ replacement ratio (as a result of indexation based on CPI with floor and ancillary benefits), agreed value and to age 65	A product with more sustainable features such as: • lower than current replacement ratios e.g. 50% to 75%; • policies written on an indemnity basis only; • full offsets of income and benefits provided under the proposed lump sum benefits in 6.4.1, 6.4.3 and 6.4.4	NA – covered by the Disability Income Working Group
6.4.3 Incapacity Benefit	TPD paid on event including Own Occupation and not necessarily linked to actual financial loss, trauma paid on diagnosis and not necessarily on severity and actual financial loss Private health insurance not necessarily covering gaps on all hospital and rehabilitation costs in full	Benefit payable to cover actual financial loss up to pre-agreed fixed sum insured but not to overlap with income replacement benefit	Addressing 4.1.1, 4.1.2, 4.2.1, 4.3, 4.7 and 4.8
6.4.4 Hospital and Rehabilitation Benefit		Combined Life/Health insurance benefit to cover actual expenses incurred up to a maximum of a pre-agreed benefit limit	Addressing 4.1.1, 4.2.2, 4.3 and 4.7

General Product Features			
6.4.5 Term of Product	To age 99 (or ADL from age 65/70 for trauma and TPD)	Maximum 5 Years	Addressing 4.6
6.4.6 Premium Payment	Stepped is more common than level premium	Smoothed and stepped	Addressing 4.5
6.4.7 Surrender Value and Alterations	Generally not available	Yes (for smoothed premium up to the expiry age)	Addressing 4.5
6.4.8 Pricing Guarantee	Generally only for one or two years	Yes (and no option to reprice)	Addressing 4.4.1
6.4.9 Automatic Indexation	Generally default or opt-out only	No	Addressing 4.4.2

Other product features which are assumed to have a smaller impact on sustainability are not discussed here including policy structure (inside vs outside Super or linked benefits), exclusions and offset clauses, entry and occupation etc.

6.5 Further considerations on sample product

A tiered approach was also considered by the Working Group and is summarised in the table below to highlight that the example product in section 6.4 is not the only solution available. The tiered approach could improve flexibility to meet varying customer needs, highlight the likely need for financial advice and increase market competition and innovation.

Item	**Proposed Core Benefit**	**Proposed Optional Features**	**Rationale for providing option**
6.5.1 Death Benefit	Fixed sum insured with 25% payable on terminal illness diagnosis, an additional 25% where life expectancy is less than 6 months and the balance payable on death	Fixed sum insured with terminal illness benefits of up to: • 25% on where life expectancy is 12 to 24 months • 50% where life expectancy is 6 to 12 months • 75% where life expectancy is within 6 months The balance would be payable on death	Provides benefits which increases with certainty of diagnosis
6.5.2 Income Replacement Benefit	A product with more sustainable features such as: • Lower than current replacement ratios e.g. 50% to 75%; • Policies written on an indemnity basis only; • Full offsets of income and benefits provided under the proposed lump sum benefits	Additional ancillary benefits	More generous benefits payable to suit the insurance needs of some customers
6.5.3 Incapacity Benefit	Benefit payable to cover actual financial loss up to pre-agreed fixed sum insured but not to overlap with income replacement benefit	Additional pre agreed amount (maybe indirectly linked to a financial loss incurred but only a small amount e.g. up to $100,000)	Gives the certainty of a minimum benefit to customers

Item	Proposed Core Benefit	Proposed Optional Features	Rationale for providing option
6.5.4 Hospital and Rehabilitation Benefits	Combined Life/Health insurance benefit to cover actual expenses incurred up to a maximum of a pre-agreed fixed sum insured	Other ancillary benefits (e.g. no excess applies)	
6.5.5 Term of Product	Maximum 5 Years		No option is offered to limit exposure of product to changing socioeconomic environment
6.5.6 Premium Payment	Smoothed and stepped	Smoothed and/or stepped and/or hybrid (e.g. fixed premium with reducing sum insured)	Stepped or hybrid structure generally offers lower initial premiums for customers whose financial capacity increase over time (that can match the future premium increase due to age rerate)
6.5.7 Surrender Value and Alterations	Yes (for smoothed premium up to the expiry age)	Yes or No (for a cheaper premium)	Offers a cheaper premium for those who expect to retain cover during the product term and without any surrender value
6.5.8 Pricing Guarantee	Yes (and no option to reprice)	Yes or No (for a cheaper premium)	Offers a cheaper premium for those who are willing to share in the insurer's adverse experience
6.5.9 Automatic Indexation	No	No or Yes (to be priced accordingly)	Suitable for those whose insurance needs are expected to increase in line with inflation

6.6 Other considerations for product design

Other key factors that could, in practice, drive product design considerations and would be important in bringing a new product to market. These factors include: -

- Distribution channel: assumed to be similar to the current advice channel, or growth in the direct channel to support simplified products hence simpler (e.g. robo-advice) or only general advice is required;
- Target segments: assumed to be the general Australian working age population (preferably employed at the time of purchase);

- Implementation considerations: assumed to not impact product design; and
- Adviser fees: the fee structure will be considered in section 7.

The Working Group recognises that not all of the issues raised in section 4 have been addressed in the sample product. However, we believe that the sample product would go a long way towards making the retail advised lump sum product more sustainable.

7. Looking forward and consequences for the industry

A number of the potential solutions discussed in section 5 could have substantial implications for the industry. A separate section has been used to discuss these implications as the Working Group recognises that these are more speculative and that other outcomes are possible from the same potential solutions.

7.1 Shortening policy terms

One of the most far-reaching solutions suggested is to reduce the policy term to (say) 5 years but with a guaranteed renewability option that should ensure that coverage can continue to be obtained at policy expiration. Throughout this section, the term of 5 years is used, but it is accepted that other policy terms (greater than 3 years) are also possible.

The rationale given in section 5.1 for the adoption of shorter policy terms was primarily to allow the insurer to update the benefits provided under the policy at regular intervals taking into account changes in the risk environment, medical advances and societal attitudes. This allows the insurer to avoid being locked into providing benefits which no longer meet an insurable need. However, the shortened policy term could also change adviser behaviour, assist in legacy book management by the insurer and be ultimately of benefit to the customer.

With shorter policy terms, it is unlikely that the current maximum commission terms[19] under the Life Insurance Framework (66% initial commission, 22% renewal commission incl. GST) would be supportable and a reduction would have to occur (as otherwise the cost of distribution would become a disproportionate share of the customer's premium). Before considering movements in commission rates, it is worth looking at potential changes in adviser behaviour as a result of the shortened policy terms.

With a 5 year policy term, a natural review point is introduced where the adviser can reassess the customer's needs, taking into account changes in circumstance since the policy was established, and provide advice on any required changes on type or level of cover. Not only would this provide an up-to-date assessment of the client's circumstances and advice requirements, but it would also prevent the long-term over-insurance that currently can occur and encourage more frequent and regular contact between advisers and customers.

The end of policy term review would probably result in a substantial increase in lapse rates as the advice provided would also look at insurance provider as well as required coverage. However, it is arguable whether this would be partially offset by improved persistency

[19] It is assumed that advisers will continue to be remunerated via commissions. Should fees replace commissions then the points discussed in this section remain relevant

during the policy term with a reduction in adviser initiated lapses as the focus shifts to the policy end review.

Given the work of an adviser is more likely to be focussed around the start of the policy review, it makes more sense that any remuneration reflects this. So a remuneration scale (be it commission or fee-based) that maintains an upfront element seems sensible. Additionally, this upfront element could be related to anticipated length of the policy term (as an example 13% for each expected policy year, subject to current LIF maxima).

This is a substantial reduction from current remuneration rates and so it would be expected that it would be necessary to maintain renewal commissions. However, it should also be remembered that the upfront commission would be available for every new policy term and so renewal commission rates would reduce. A recurring initial commission every 5 years of 60% and a renewal commission of ~13% would give advisers a similar proportion of premium over 15 years.

From a product management perspective, the shorter policy terms would have a substantial impact. Firstly, it would remove the ever present risk of being unable to respond to a future chronic change in the risk environment for which it is arguable whether this risk has ever been properly priced for by the industry.

Secondly, it would limit the growth of new legacy blocks of business as, at the end of each 5 year policy term, renewal is offered on the latest new business terms. This would mean that, apart from existing legacy products, no product benefit is 'out of date' by more than 5 years - this has substantial implications for the insurer's approach to knowledge management (and, in particular, the difficulties that are often encountered within product management and claims departments). Looking at the same point from a slightly different angle, this means that there would also be a limited number of versions of a given product – and this could be reduced to a single version by not changing product terms for a number of years (with all renewing business adopting the current terms). This could simplify the complexity of registry systems and product series management (making the heroic assumption that companies do not find a rationale to needlessly introduce complications!).

A more proactive and frequent approach to updating benefit terms and conditions may eventuate as a result of them being applied to the new business offering (which has greater market focus) and also as less time is required to be spent on management of legacy benefit terms. Therefore, the simplification benefits mentioned previously will not extend to the claims area, with the prospect of claim managers having to manage an increasing plethora (as products are update more frequently) of terms and conditions on historic claims.

Retention initiatives within organisations would also likely change, with greater emphasis being placed on the policy expiration and the reason to renew with the current provider. Also the recent involvement of an adviser would reduce the number of orphan customers and increase the level of understanding customers have around the reasons for their insurance coverage: reducing one of the reasons for retention activities.

Profitability will need to be more tightly managed with there being less likelihood of excessive profitability in some products (or tranches) being available to cross-subsidise losses in other products. Although, overall, there is likely to be a reduction in profitability (as the legacy products move to the more competitive new business terms) there will also be a reduction in the risks the insurer undertakes.

From a customer perspective, there are also advantages of shorter policy terms. As mentioned previously, it is questionable whether the industry has properly priced for the guaranteed cover that it is providing irrespective of long-term changes in the risk environment. If it hasn't, and the environment continues to change then existing customers can expect premium increases to continue. Shorter policy terms allow the insurer to adjust the benefits for the risk environment potentially limiting future premium increases.

Also, the current differential that exists between the pricing of legacy products and new business would disappear and customers would take advantage of the competitive new business terms each time the policy expires.

With shorter policy terms companies may consider offering premium rate guarantees for the duration of the policy term. This could be on both level and stepped premiums (although with shorter policy durations the difference between level and stepped premium rates will be much smaller and it is possible that only level premiums are offered). This would provide certainty to customers of the cost of insurance for the policy term – although, obviously, beyond that there is no guarantee.

7.2 Linking payment amount to loss suffered

Removing the fixed sums insured from trauma policies and also introducing an indemnity payment would be a major change for the life insurance industry. Currently, the focus of an insurer and its claims department is on understanding whether an insurable event has occurred or not, whereas in future this would extend to understanding the severity of the event to the customer.

Such a change would likely: -

- Reduce overall claim payout costs, but
- Increase claim handling costs and change approaches.

Claims payout costs would reduce in a number of ways. Firstly, the move from a fixed sum insured to an indemnity basis (subject to a maximum of a nominated sum insured) would reduce the actual claims paid on a claim by claim basis. Secondly, there could also be a reduction in absolute claim numbers as a potential moral hazard is partially mitigated. This is more likely to occur in TPD coverages than trauma coverages which are normally for a specific identifiable event.

The overall reduction in claims costs, would initially improve insurer profitability but longer term would probably be passed onto customers through the effects of competition reducing premiums.

Claims handling and claims management practices would also change, with customers needing to be more aware of where an economic loss has occurred, and insurers needing to invest more time and incurring more expense in validating the claim amounts. However, excesses and other devices to limit the claims handling expense increase would likely be adopted. Similar to the general insurance industry (and the motor repairer networks run by insurers) this could lead to the development of specialist service providers at claims time that customers can access and that life insurers recommend.

Overall, one would expect that the reduction in overall claim payments would more than offset the increase in claims handling expenses.

From a customer's perspective, such changes would undoubtedly increase the uncertainty at claim time (not just whether an event has occurred, but also what was the financial loss they had experienced). However, they would likely be the beneficiary of lower premiums (reflecting the overall lower claims costs) and also possibly benefit from a less binary approach to claims management.

7.3 Instalment payments

Section 5 proposes the increased use of instalment payments for certain types of insurance: terminal illness and TPD. Instalment payments are a response to counter potential non-indemnity benefits that are currently offered (such as payment of a fixed TPD sum insured where the claimant returns to work following payment or elects to have life-saving surgery following the payment of a terminal illness benefit[20]). So, if full indemnity benefits were introduced, instalment payments may not be required. However, the development of indemnity benefits will be gradual and existing insurances with fixed sums insured may only gradually be phased out, so instalment payments may be a transitional step.

Obviously, an instalment payment would require a regular reassessment of the condition which inevitably would increase the associated claims handling costs. However, there may be substantial offsets to this besides the potential for lower claims payments where the progression of the condition would not result in a permanent disability condition or death.

Firstly, an instalment system would engender a less binary outcome to claims assessment (a successful claim with full payment versus a claim denial with zero payment). This could not only lead to a better experience for customers, in that where there is reasonable doubt about the long-term prognosis, they are paid the first instalment whilst further understanding of the severity of the condition (which often requires its ensuing development) is gathered. It could also lead to quicker and less involved assessments as the amount being paid is not the full sum insured. It may be argued that such an approach would increase claims costs (through the payment of the first instalment), but in the experience of the Working Group, where there is doubt today, claims are generally paid

[20] Although rare, the Working Group is aware of some cases where (unbelievably) customers have delayed surgery until a terminal illness benefit has been paid

rather than denied, so this approach would actually result in a lower (i.e. rather than the full sum insured) and swifter payment.

Secondly, the regular assessment would allow insurers to work with claimants on potential recovery options, especially for TPD insurance. This is not just a case of trying to limit claims costs but is actually the better outcome for claimants: the goal of a claimant should not be to obtain an insurance benefit but not to require one. So rehabilitation activities that exist in disability income insurance may increasingly be used in TPD insurance.

There may be cases where support is required whilst a customer is recovering and instalment payments can go some way to meeting this. Where there has been specific financial detriment over and above the instalments paid, evolution of the product may see these being explicitly covered but only on an indemnity basis and subject to the overall sum insured.

Finally, an instalment approach creates a longer term relationship between the insurer and the claimant, allowing for greater support (both tangible and emotional) to be provided. This would also lead to a similar evolution of claims management (and claims managers) that has been seen in disability income insurance.

7.4 Removing specific conditions

Removing specific conditions would obviously help with customers' understanding of what they are covered for and remove the complex definitions that are currently included with trauma PDS's. However, the removal of insurance for specific conditions could also lead to the emergence of a new form of insurance that effectively combines the comprehensive nature of TPD insurance (comprehensive in that it provides cover irrespective of the cause of disability) with the shorter term nature of trauma insurance (shorter term in the sense that payment is made irrespective of the long-term prognosis). In previous sections this has been described as an incapacity benefit and is worth exploring further.

It is important to emphasise that any such incapacity benefit would adopt the indemnity principles previously discussed and so payment would only be made where disability has led to a proven financial detriment.

In some ways an incapacity benefit only really makes sense when sold in conjunction with disability income insurance as the biggest financial detriment from a disability is normally the loss of income. To be clear, the incapacity benefit envisaged is not meant to cover this – rather, it is there to cover other incidental expenses that have been incurred as a result of the disability. So it could be seen to cover gaps in the Pharmaceutical Benefits Scheme, residual expenses after allowing for health insurance coverage, and acknowledged additional costs that a customer has to incur as a result of their disability (such as required modifications to the home which are not met by benefit payments made by government agencies e.g. NDIS).

So it should really be seen more as 'wrap around' of existing insurances to provide indemnity based-coverage where existing insurances stop. Inevitably, barriers from existing regulation notwithstanding, this would lead to closer co-operation between the

health and life insurance industries and the likely development of single products where the various benefits (invisible to the customer except for required disclosures within PDS's) are underwritten with life or health insurance entities. An example today would be the current set of consumer credit insurance products where the death insurance is provided by a life insurer and the involuntary unemployment and short-term disability insurance is often provided by a related general insurance provider.

Close co-operation could also lead to common ownership.

With such a product and industry structure some of the problems that life insurers face with respect to providing rehabilitation benefits to assist claimants to return to work can be avoided. Insurers that own both health and life insurers (or separate entities that form a joint product co-operation) would be able to provide comprehensive rehabilitation benefits (not limited by strict legal definition of life insurance) to claimants that would provide a superior customer experience and also improve disability income insurance claims termination experience and ultimate claims cost.

Even on the preventative side both industries have been exploring how to improve the health of customers before a claim has occurred and there are obvious synergies between the 'wellness' programmes of both life and health insurers.

In the end, should customers be talking about life insurance or health insurance? These are legal and regulatory terms that we have let filter into client communication. What really matters is that customers are securely covered if they fall sick, assisted back to wellness or supported if that is not possible, and compensated for any material financial detriment incurred. They should not need to worry whether they should 'claim this on their health insurance and this on the life insurance'; they just should be concerned about whether they have decided to have insurance coverage.

Appendix A: LIWMPC/LSC 'Product Sustainability' Working Group - Terms of Reference

Item	Description
Purpose	The purpose of the Product Sustainability Working Group ('PSWG') of the Life Sub-Committee ('LSC') of the LIWMPC is to: Produce a piece of thought leadership that stimulates industry-wide consideration of issues with the sustainability of *current retail advised lump sum** insurance products, and changes that could be made to improve outcomes for all stakeholders. While the scope will address product *design* issues, it will not be constrained solely to that aspect. *We deliberately included in the scope all retail lump sum (i.e. not just trauma) as we felt also needed to consider issues with TPD and the terminal illness benefits under Term Life cover. Only current, on-sale products will be considered (i.e. we will not be considering legacy products). We have also deliberately constrained the scope to retail advised products, although the applicability of the issues identified will be briefly considered in relation to Income Protection, Direct, Online and Group business.
Approach and Scope of Work	To achieve the stated purpose above, the PSWG will break the work in two phases: - **Phase 1:** • Discuss some of the main issues that face the industry today including examples and/or case studies to support the evaluation of the issues identified • Suggest potential amendments and/or modifications to current products/practices taking into account the underlying customer need that could be used to promote better outcomes for ALL stakeholders • Outline how a product could be developed that incorporates these changes • Consider potential barriers to implementation, potential consequences for the industry and overall pros and cons • Briefly consider the applicability of the findings to Income Protection, Direct, Online and Group insurance lines • Review overseas developments at a high level and incorporate any learnings/findings • Socialise the findings and suggestions for feedback from stakeholders (see below), and refine • Write a paper (format tbc) outlining the findings and recommendations for wider consideration 'Stakeholders' we will engage with for the 'socialisation and feedback' referred to above will be decided closer to engagement but could include the following: • the Actuaries Institute – represented by the Life Sub-Committee of the LIWMPC • product manufacturers – represented by the Financial Services Council (and product managers within the industry) • industry regulators – represented by ASIC and APRA • financial advisers – represented by AFA and/or some actual financial planners • claims and underwriting professionals – represented by ALUCA (and/or practitioners within the industry) • the legal profession – i.e. lawyers who work in this space • ratings agencies – e.g. Rice Warner, IRESS (X-Plan software) The PSWG will have regular meetings to work through the above, allocate responsibilities, and track progress against deliverables. Due to the technical nature of the issues, stakeholder feedback will be obtained from market participants (excluding end customers) only. Future working groups could 'road-

<table>
<tr><td></td><td>test' some of the proposed solutions with end customers after their feasibility has been explored. This is outside the scope of this working group.
The PSWG will run an Insights session with a draft paper included to share and seek feedback on the findings of the paper.

Phase 2:
Following Phase 1, it will be considered by the Sponsor whether Phase 2 is required. If this goes ahead then it will be run as a separate working group with a scope to be defined at that stage.</td></tr>
<tr><td>Membership</td><td>The members of the PSWG are:

• Catherine Robertson-Hodder (LIWMPC Sponsor)

Phase 1:

• Jaimie Sach (Chair)
• Luke Liu (Secretary)
• Pallav Bajracharya
• Raymond Bennett
• Hean-Peng Thniah
• Giri Varatharajan

Phase 2 - TBD</td></tr>
<tr><td>Output</td><td>The PSWG will produce a paper outlining its finding and recommendations (format to be decided closer to the time). A skeleton outline of the paper is attached as Appendix A.</td></tr>
<tr><td>Timetable</td><td>Our timetable to meet the terms of reference is as follows:
<table><tr><th>Deliverable</th><th>Delivery Target (Date)</th></tr><tr><td>Agree restructure of PSWG & Phase 1 ToRs</td><td>Mid-May 2019</td></tr><tr><td>Determine key issues to highlight</td><td>May - June 2019</td></tr><tr><td>Develop suggested solutions</td><td>July - Aug 2019</td></tr><tr><td>Consultation via LSC</td><td>Sept – Oct 2019</td></tr><tr><td>Socialisation and feedback with Stakeholders</td><td>Oct – Nov</td></tr><tr><td>Phase 1 report (draft for peer review)</td><td>Dec 2019</td></tr></table></td></tr>
<tr><td>Peer Review</td><td>To be determined by LIWMPC</td></tr>
<tr><td>Approvals</td><td>The LIWMPC will approve the final paper.
Final sign-off from the Institute's Public Policy Committee.</td></tr>
</table>

APPENDIX A: Skeleton Outline of Report

1) Executive Summary
2) Acknowledgements
3) Introduction & background (i.e. why are we here)
    a. Why we are here? (Problems in the industry)
    b. Scope of review (What we hope to achieve)
4) Issues within the Australian Industry
5) Insights from Overseas Markets
6) Potential Solutions to these problems
7) What could a sustainable product look like
8) Looking forward and potential consequences for the industry
9) Recommendations
10) Appendices

Appendix B: Extract of the Life Insurance Act 1995

A.1 Extract of Life Insurance Act 1995

Paragraph 9: Life policy

(1) Subject to subsection (2), each of the following constitutes a life policy for the purposes of this Act:

(a) a contract of insurance that provides for the payment of money on the death of a person or on the happening of a contingency dependent on the termination or continuance of human life;

(b) a contract of insurance that is subject to payment of premiums for a term dependent on the termination or continuance of human life;

(c) a contract of insurance that provides for the payment of an annuity for a term dependent on the continuance of human life;

(d) a contract that provides for the payment of an annuity for a term not dependent on the continuance of human life but exceeding the term prescribed by the regulations for the purposes of this paragraph;

(e) a continuous disability policy;

(f) a contract (whether or not it is a contract of insurance) that constitutes an investment account contract;

(g) a contract (whether or not it is a contract of insurance) that constitutes an investment-linked contract.

(2) A contract that provides for the payment of money on the death of a person is not a life policy if:

(a) by the terms of the contract, the duration of the contract is to be not more than one year; and

(b) payment is only to be made in the event of:

i) death by accident; or

ii) death resulting from a specified sickness.

Paragraph 9A: Continuous disability policy

(1) Subject to this section, a continuous disability policy is a contract of insurance:

(a) that is, by its terms, to be of more than 3 years' duration; and

(b) under which a benefit is payable in the event of:

i) the death, by accident or by some other cause stated in the contract, of the person whose life is insured (the insured); or

ii) injury to, or disability of, the insured as a result of accident or sickness; or

iii) the insured being found to have a stated condition or disease.

(2) A contract of insurance that is, by its terms, to be of a duration of not more than 3 years is taken to comply with paragraph (1)(a) if:

(a) contracts of insurance of the same kind as the contract are usually of more than 3 years' duration; and

(b) the contract is of a lesser duration only because of the age of the owner of the policy at the time when it was entered into.

(3) A contract of insurance is not a continuous disability policy if the terms of the contract permit alteration, at the instance of the life company concerned, of the benefits provided for by the contract or the premiums payable under the contract.

(4) A contract of insurance the terms of which permit alteration, at the instance of the life company concerned, of the benefits provided for by the contract is not thereby excluded by subsection (3) from being a continuous disability policy if, by those terms, the only alterations that are permitted to be made are alterations that improve the benefits and are made following an offer made by the life company and accepted by the owner of the policy.

(5) A contract of insurance the terms of which permit alteration, at the instance of the life company concerned, of the premiums payable under the contract is not thereby excluded by subsection (3) from being a continuous disability policy if the terms of all contracts of the same kind as the contract only permit such alterations if they are made on a simultaneous and consistent basis.

(6) A contract of consumer credit insurance within the meaning of the Insurance Contracts Act 1984 is not a continuous disability policy.

(7) A contract of insurance entered into in the course of carrying on health insurance business is not a continuous disability policy.

Appendix C: Example of complex event definition

One of the issues noted in this paper is that the definition of claim events for TPD and trauma benefits are very complex (see section 4.3). This appendix shows two such examples based on extracted definitions from the policy documents of several different life insurance companies.

C.1 Benign Brain Tumour

Insurer	Definition of "Benign Brain Tumour" (from Insurer's policy document)
AIA	BENIGN BRAIN TUMOUR' means a non-cancerous tumour of the brain or spinal cord. 100% of the Sum Insured will be paid if the Benign Brain Tumour gives rise to symptoms of permanent neurological deficit and results in the life insured either; (a) being totally and permanently unable to perform any one of the Activities of Daily Living (see page 92 for definition); or (b) suffering at least a 25% impairment of whole person function, attributable to the above condition, as defined in Guides to the Evaluation of Permanent Impairment (Guides) 5th edition, American Medical Association. The requirements above will be waived if the Benign Brain Tumour is surgically removed on the advice of a consultant neurologist/neurosurgeon. Where the above is not met, 25% of the Sum Insured (up to a maximum of $50,000) will be paid for a diagnosis of a non-cancerous tumour on the brain or spinal cord giving rise to symptoms of neurological deficit. The presence of the underlying tumour must be confirmed by a consultant neurologist/neurosurgeon based on imaging studies such as CT scan or MRI (Magnetic Resonance Imaging). Cysts, granulomas, cholesteatomas, malfunctions in or of the arteries or veins of the brain, haematomas and tumours in the pituitary gland are not covered.
AMP	Benign brain tumour A non-cancerous tumour in the brain that gives rise to characteristic symptoms of increased intracranial pressure such as papilledema, mental symptoms, seizures and sensory impairment. The tumour must result in neurological deficit, where: * there is at least 25 per cent permanent impairment of whole body function, or * cranial surgery is required for its treatment. The presence of the underlying tumour must be confirmed by imaging studies such as CT scan or MRI (Magnetic Resonance Imaging). The following are excluded: * cysts * granulomas * malformations in or of the arteries or veins of the brain * haematomas, and * tumours in the pituitary gland or spine.
BT	Brain or spinal cord tumour (benign) - resulting in significant permanent impairment or requiring radical treatment Noncancerous tumour in the brain or spinal cord which produces neurological deficit resulting in: a. significant functional impairment; or b. radical treatment which includes radiotherapy (eg gamma knife stereotactic radiosurgery), laser therapy, ultrasonic aspiration, or any other major invasive neurosurgical techniques necessary for the therapeutic management of the tumour. The presence of the underlying tumour must be confirmed by a registered medical practitioner specialising in the field relevant to the condition and by

Insurer	Definition of "Benign Brain Tumour" (from Insurer's policy document)
	imaging studies such as a CT or MRI scan. The following are excluded: (a) cysts, granulomas and cerebral abscesses; (b) malformations in, or of, the arteries or veins of the brain; (c) haematomas; (d) tumours in the pituitary gland; and (e) acoustic neuroma and other cranial nerve tumours. - - - - Significant functional impairment means a permanent impairment of at least 25% of whole person function as defined in the most current edition of the American Medical Association publication 'Guides to the Evaluation of Permanent Impairment', or an equivalent guide to impairment approved by us.
Clearview	Benign Brain Tumour or Spinal Cord Tumour - Severe A non-cancerous tumour in the brain, cranial nerve, meninges or spinal cord which is histologically described and which produces neurological damage and functional impairment which a consultant neurologist considers to be permanent: * at least 25% permanent whole person impairment as defined in the American Medical Association publication Guides to the Evaluation of Permanent Impairment 6th edition, or an equivalent guide to impairment approved by us, or * requires cranial surgery for its removal. The presence of the underlying tumour must be confirmed by imaging studies such as CT Scan or MRI. Cysts, granulomas, malformations in or of the arteries or veins of the brain, haematomas and tumours in the pituitary gland are excluded.
CommInsure	Benign brain tumour Diagnosis of: - a non-malignant tumour arising in the brain, - an acoustic neuroma or - a meningioma giving rise to increased intracranial pressure which results in neurological deficit. The condition must require: - chemotherapy - radiotherapy or - cranial surgery for its treatment or removal within 12 months. The diagnosis must be confirmed by a relevant medical specialist. The presence of the condition and intracranial pressure must be confirmed by imaging studies such as CT scan or MRI. The definition excludes diagnosis of cysts, granulomas, cerebral abscesses, malformations in or of the arteries or veins of the brain, haematomas and tumours in the pituitary gland or spine. Benign brain tumour of limited extent (partial benefit) Diagnosis of: - a non-malignant tumour arising in the brain or - an acoustic neuroma. The diagnosis must be confirmed by a relevant medical specialist. The presence of the condition must be confirmed by imaging studies such as CT scan or MRI. The definition excludes diagnosis of cysts, granulomas, cerebral abscesses, malformations in or of the arteries or veins of the brain, haematomas, meningiomas and tumours in the pituitary gland or spine. [Research Note: The following definition applies to policies issued prior to 13 November 2016]. benign brain tumour A non-cancerous tumour in the brain giving rise to characteristic symptoms of increased intracranial pressure such as papilloedema, mental symptoms,

Insurer	Definition of "Benign Brain Tumour" (from Insurer's policy document)
	seizures and sensory impairment as confirmed by a medical practitioner who is a consultant neurologist. The tumour must result in permanent neurological deficit: - causing at least a permanent 25% impairment of whole person function; or - requiring cranial surgery for its removal. The presence of the underlying tumours must be confirmed by imaging studies such as CT Scan or MRI. Cysts, granulomas, malformations in or of the arteries or veins of the brain, haematomas, and tumours in the pituitary gland or spine are excluded.
Integrity	Severe Benign Brain Tumour or Spinal Cord Tumour A non-cancerous tumour in the brain, cranial nerve, meninges or spinal cord which is histologically described and which produces neurological damage and functional impairment which a consultant neurologist considers to be permanent: - Causing at least 25% permanent whole person impairment as defined in the American Medical Association publication 'Guides to the Evaluation of Permanent Impairment' 6th edition, or an equivalent guide to impairment approved by us. - Requires cranial surgery for its removal. Cysts, granulomas, malformations in or of the arteries or veins of the brain, haematomas and tumours in the pituitary gland are excluded
MLC	Benign Brain Tumour - of specified severity The presence of a non-cancerous tumour of the brain or spinal cord which is histologically confirmed and results in: - at least 25% permanent impairment of the Whole Person Function; or - the undergoing of neuro-surgical intervention for its removal. The following are excluded: - intracranial cysts, granulomas and haematomas; - intracranial malformation in or of the arteries and veins; and - tumours of the pituitary gland. Early Stage Benign Brain Tumour - of specified type definition The presence of a non-cancerous tumour of the brain or spinal cord, giving rise to symptoms of increased intracranial pressure such as papilledema, mental symptoms, seizures, or sensory/motor skills impairment. The diagnosis must be confirmed by a consultant neurologist and the presence of the condition must be confirmed by imaging studies such as CT scan or MRI. The following are excluded: * intracranial cysts, granulomas and haematomas * intracranial malformation in or of the arteries and veins, and * tumours of the pituitary gland.
NEOS	Benign brain tumour (resulting in irreversible neurological deficit) A non-cancerous tumour in the brain, resulting in an irreversible neurological deficit which has caused: * a permanent impairment of at least 25% of the whole person function; or * you're totally and permanently unable to perform any one of the activities of daily living. The presence of the underlying tumour must be confirmed by CT scan, MRI or other imaging studies.
OnePath	Benign brain tumour (permanent impairment or requiring surgical intervention) means the diagnosis of a benign (non-malignant) tumour in the brain which results in the life insured or the insured child*: * suffering at least 25% permanent impairment as defined in the American Medical Association Guides to the Evaluation of Permanent Impairment, 5th edition, or an equivalent guide to impairment approved by us; or * being permanently unable to perform at least one of the activities of daily living without the physical assistance of another adult person; or * undergoing a craniotomy to remove the tumour. Cysts, granulomas, malformations in or of the arteries or veins of the brain, haematomas and tumours in the pituitary gland or spine are not covered. * In the event a claim is for an infant, impairment will be based on the Functional Independence Measure for Children (WeeFIM) and /or the Paediatric Evaluation of Disability Inventory (PEDI).

Insurer	Definition of "Benign Brain Tumour" (from Insurer's policy document)
TAL	Benign Brain Tumour (resulting in irreversible neurological deficit) means a non-cancerous tumour in the brain, pituitary gland or spinal cord, resulting in an irreversible neurological deficit which has caused: - a permanent impairment of at least 25% of the Whole Person Function; or - the Life Insured to be totally and permanently unable to perform any one of the Activities of Daily Living. The presence of the underlying tumour must be confirmed by CT Scan, MRI or other imaging studies. Cysts, granulomas, vascular aneurysms or haematomas are not covered. Advancement Benefit If the Life Insured suffers an Advancement Benefit Event, the Advancement Benefit will be payable. The amount payable is shown in the following table. The Advancement Benefit is payable only once for each of these Events. The total Benefit Amount will be reduced by the amount paid for each of these Events. The Advancement Benefit will only be paid if the condition or the circumstances leading to the claim first occurs after the Plan start date. Advancement Benefit Event: Diagnosed Benign Brain Tumour Maximum Payment: 25% of the Benefit Amount to a maximum of $100,000 Diagnosed Benign Brain Tumour means a non-cancerous tumour in the brain, giving rise to symptoms of increased intracranial pressure such as papilloedoma, mental symptoms, seizures, sensory impairment and motor impairment. The presence of the underlying tumour must be confirmed by CT Scan, MRI or other imaging studies. Cysts, granulomas, vascular aneurysms or haematomas are not covered.
Zurich	Benign tumour in the brain or spinal cord (with neurological deficit) means a non-malignant tumour in the brain or spinal cord which is histologically described and which produces neurological deficit, resulting in: * a permanent and irreversible inability to perform at least one of the activities of daily living or * the undergoing of surgery to remove the tumour. The impairment must be certified by an appropriate medical specialist. The presence of the tumour must be confirmed by imaging studies such as CT scan or MRI. We do not cover any of the following: * cysts, granulomas and cerebral abscesses * malformations in, or of, the arteries or veins of the brain * haematomas or * tumours in the pituitary gland. Tumours in the pituitary gland are covered only if the life insured undergoes total surgical removal by open craniotomy.

C.2 Severe Rheumatoid Arthritis

Insurer	Definition of "Severe Rheumatoid Arthritis" (from Insurer's policy document)
AIA	SEVERE RHEUMATOID ARTHRITIS' means the unequivocal diagnosis of severe rheumatoid arthritis by a consultant rheumatologist. The diagnosis must be supported by, and evidence, all of the following criteria: * at least a six week history of severe Rheumatoid Arthritis, which involves three or more of the following joint areas: - proximal interphalangeal joints in the hands; - metacarpophalangeal joints in the hands; and - metatarsophalangeal joints in the foot, wrist, elbow, knee, or ankle; * simultaneous bilateral and symmetrical joint soft tissue swelling or fluid (not bony overgrowth alone); * typical rheumatoid joint deformity; and * at least two of the following criteria: - morning stiffness; - rheumatoid nodules; - erosions seen on x-ray imaging; - the presence of either a positive rheumatoid factor or the serological markers consistent with the diagnosis of Severe Rheumatoid Arthritis. Degenerative osteoarthritis and all other arthridities are excluded.
AMP	Severe rheumatoid arthritis means the unequivocal diagnosis of severe rheumatoid arthritis by a rheumatologist. To fulfil the criteria for severe rheumatoid arthritis there must be: * diagnosis of Rheumatoid Arthritis as specified by the 2010 Rheumatoid Arthritis Classification Criteria(i), and * unresponsive to treatment for at least 9 months with disease-modifying antirheumatic drugs and biologic agents, and * symptoms and signs of persistent inflammation (swelling and tenderness) of multiple joints, and * due to rheumatoid arthritis, the insured must permanently satisfy two of the following criteria: - Dexterity - The inability to use hands and fingers to pick up and manipulate small objects such as cutlery, including being unable to write using a pen or pencil. - Lifting - The inability to lift, carry or otherwise move everyday objects by hand. Everyday objects include a kettle of water, a bag of shopping, an overnight bag or briefcase. - Bending - The inability to bend or kneel to pick up something from the floor and stand up again and the inability to get into and out of a standard car. - Mobility - The inability to walk a distance of 200 metres on flat ground, with or without the aid of a walking stick and without having to rest or experiencing severe discomfort. [Research Note: The following definition applied prior to 19 November 2016] Severe rheumatoid arthritis means the unequivocal diagnosis of severe rheumatoid arthritis confirmed by a Rheumatologist. The diagnosis must be supported by, and evidence, all of the following criteria: * at least a six week history of severe rheumatoid arthritis which involves three or more of the following joint areas: - proximal interphalangeal joints in the hands, - metacarpophalangeal joints in the hands, - metatarsophalangeal joints in the foot, wrist, elbow, knee, or ankle, * simultaneous bilateral and symmetrical joint soft tissue swelling or fluid (not bony overgrowth alone), * typical rheumatoid joint deformity, and * at least two of the following criteria, - morning stiffness, - rheumatoid nodules, - erosions seen on x-ray imaging, - the presence of either a positive rheumatoid factor or the serological markers consistent with the diagnosis of severe rheumatoid arthritis.

Insurer	Definition of "Severe Rheumatoid Arthritis" (from Insurer's policy document)
BT	Rheumatoid arthritis (severe) - of specified severity The diagnosis of severe rheumatoid arthritis by a rheumatologist, as evidenced by either of the following criteria. - The diagnosis must be supported and evidenced by all of the following criteria: a. at least a 6 week history of severe rheumatoid arthritis which involves 3 or more of the following joint areas: i. proximal interphalangeal joints in the hands; ii. metacarpophalangeal joints in the hands; iii. metatarsophalangeal joints in the foot, or any joint of the wrist, elbow, knee or ankle; and b. simultaneous bilateral and symmetrical joint soft tissue swelling or fluid (not bony overgrowth alone); and c. typical rheumatoid joint deformity; and d. at least 2 of the following criteria: i. morning stiffness; ii. rheumatoid nodules; iii. erosions seen on x-ray imaging; iv. the presence of either a positive rheumatoid factor or the serological markers consistent with the diagnosis of severe rheumatoid arthritis. OR - The diagnosis must be supported and evidenced by all of the following criteria: a. diagnosis of Rheumatoid Arthritis as specified by the American College of Rheumatology and European League Against Rheumatism: 2010 Rheumatoid Arthritis Classification Criteria; and b. symptoms and signs of persistent inflammation (arthralgia, swelling, tenderness) in at least 20 joints or 4 large joints (ankles, knees, hips, elbows, shoulders); and c. the Insured Person has failed at least 6 months of intensive treatment with two conventional disease modifying antirheumatic drugs (DMARDs). This excludes corticosteroids and non-steroidal anti-inflammatories; and d. the disease must be progressive and non-responsive to all conventional therapy. Conventional therapy includes those medications available through the Australian Pharmaceutical Benefits Scheme excluding those on the 'specialised drugs' list for Rheumatoid Arthritis. Degenerative osteoarthritis and all other arthridities are excluded.
Clearview	Rheumatoid Arthritis - Severe Means the unequivocal diagnosis of severe rheumatoid arthritis which has not responded to at least 6 months' intensive treatment with all conventional therapy (including non-biologic DMARDs). This must be supported by evidence of all of the following: * symptoms and signs of persistent inflammation (arthralgia, swelling, tenderness) in at least 20 joints or four of the following large joints (ankles, knees, hips, elbows, shoulders), and * evidence of joint deformity/destruction and limitation of joint movement. Degenerative osteoarthritis and all other arthritides are excluded.
CommInsure	Severe Rheumatoid Arthritis The person meets one of the following: - Diagnosis of severe rheumatoid arthritis by a relevant medical specialist where all of the following applies: * the diagnosis has been confirmed by appropriate radiology and blood tests * the person has undergone all reasonable treatment regimens, including but not limited to immunosuppressive and biological agents, as recommended by the person's medical specialist for the rheumatoid arthritis * despite undergoing all reasonable treatment regimens as recommended by the specialist, the rheumatoid arthritis has caused the person permanent whole person impairment of at least 25% (as defined in the 6th edition of the American Medical Association's publication 'Guides to the Evaluation of Permanent Impairment'). OR - The unequivocal diagnosis of severe rheumatoid arthritis by a rheumatologist. The diagnosis must be supported by, and evidence, all of the following

Insurer	Definition of "Severe Rheumatoid Arthritis" (from Insurer's policy document)
	criteria: * at least a six week history of severe rheumatoid arthritis which involves three or more of the following joint areas: - proximal interphalangeal joints in the hands - metacarpophalangeal joints in the hands - metatarsophalangeal joints in the foot, wrist, elbow, knee or ankle * simultaneous bilateral and symmetrical joint soft tissue swelling or fluid (not bony overgrowth alone) * typical rheumatoid joint deformity and at least two of the following criteria: - morning stiffness - rheumatoid nodules - erosions seen on x-ray imaging - the presence of either a positive rheumatoid factor or the serological markers consistent with the diagnosis of severe rheumatoid arthritis. Degenerative osteoarthritis and all other arthritides are excluded.
Integrity	Severe Rheumatoid Arthritis The diagnosis of severe rheumatoid arthritis which has not responded to at least six months' intensive treatment with all conventional therapy (including nonbiologic DMARDs). This must be supported by evidence of all the following: - Symptoms and signs of persistent inflammation (arthralgia, swelling, tenderness) in at least 20 joints or four of the following large joints (ankles, knees, hips, elbows, shoulders); and - Evidence of joint deformity/destruction and limitation of joint movement. Degenerative osteoarthritis and all other arthritis are excluded.
MLC	Severe Rheumatoid Arthritis - of specified severity The unequivocal diagnosis of severe rheumatoid arthritis by a Rheumatologist. The diagnosis must be supported by, and evidence, all of the following criteria: * At least a 6 week history of severe rheumatoid arthritis which involves 3 or more of the following joint areas: - proximal interphalangeal joints in the hands - metacarpophalangeal joints in the hands - metatarsophalangeal joints in the foot - wrist, elbow, knee, or ankle * simultaneous bilateral and symmetrical joint soft tissue swelling or fluid (not bony overgrowth alone); * typical rheumatoid joint deformity; and * at least 2 of the following criteria: - morning stiffness - rheumatoid nodules - erosions seen on x-ray imaging - the presence of either a positive rheumatoid factor or the serological markers consistent with the diagnosis of severe rheumatoid arthritis. Or, if the above criteria is not met we will also consider under the following definition: The diagnosis must be supported and evidenced by all of the following criteria: a. diagnosis of Rheumatoid Arthritis as specified by the American College of Rheumatology and European League Against Rheumatism: 2010 Rheumatoid Arthritis Classification Criteria; and b. symptoms and signs of persistent inflammation (arthralgia, swelling, tenderness) in at least 20 joints or 4 large joints (ankles, knees, hips, elbows, shoulders); and c. the Insured person has failed at least 6 months of intensive treatment with two conventional disease modifying antirheumatic drugs (DMARDS). This excludes corticosteroids and non steroidal anti-inflammatories; and d. the disease must be progressive and non-responsive to all conventional therapy. Conventional therapy includes those medications available through the Australian Pharmaceutical Benefits Scheme excluding those on the "specialized drugs" list for Rheumatoid Arthritis. Degenerative osteoarthritis and all other arthridities are excluded.

Insurer	Definition of "Severe Rheumatoid Arthritis" (from Insurer's policy document)
NEOS	Severe rheumatoid arthritis (with significant impairment) Diagnosis of rheumatoid arthritis, confirmed by appropriate radiology and blood tests, that has failed to respond to all treatment regimens including, but not limited to: * immunosuppressive and biological agents, causing permanent reduction of at least 25% to whole person function; or * the unequivocal diagnosis of severe rheumatoid arthritis by a Rheumatologist, supported and evidenced by all of the following criteria: - at least a six-week history of severe rheumatoid arthritis, which involves three or more of the following joint areas: > proximal interphalangeal joints in the hands > metacarpophalangeal joints in the hands; and > metatarsophalangeal joints in the foot, wrist, elbow, knee, or ankle, - simultaneous bilateral and symmetrical joint soft tissue swelling or fluid (not bony overgrowth alone): > typical rheumatoid joint deformity; and > at least two of the following criteria: >> morning stiffness >> rheumatoid nodules >> erosions seen on >> x-ray imaging; or >> the presence of either a positive rheumatoid factor or the serological markers consistent with the diagnosis of Severe Rheumatoid Arthritis. Degenerative osteoarthritis and all other arthritides are excluded.
OnePath	Rheumatoid arthritis (severe) means the unequivocal diagnosis of severe rheumatoid arthritis by a rheumatologist. To fulfil the criteria for severe rheumatoid arthritis there must be all of the following: - diagnosis of Rheumatoid Arthritis as specified by the '2010 Rheumatoid Arthritis Classification Criteria'* - symptoms and signs of persistent inflammation (arthralgia, swelling, tenderness) in at least 20 joints or four large joints (ankles, knees, hips, elbows, shoulders) - have failed at least six months of intensive treatment with two conventional disease-modifying antirheumatic drugs (DMARDs). This excludes corticosteroids and non-steroidal anti-inflammatories - the disease must be progressive and non-responsive to all conventional therapy^. * American College of Rheumatology and European League Against Rheumatism. ^ Conventional therapy includes those medications available through the Australian Pharmaceutical Benefits Scheme excluding those on the 'specialised drugs' list for Rheumatoid Arthritis.
TAL	Severe Rheumatoid Arthritis (with significant impairment) means diagnosis of rheumatoid arthritis, confirmed by appropriate radiology and blood tests, that has failed to respond to all treatment regimens including, but not limited to immunosuppressive and biological agents, causing permanent reduction to Whole Person Function of at least 25%; or; The unequivocal diagnosis of severe rheumatoid arthritis by a Rheumatologist, supported and evidenced by all of the following criteria: * at least a six week history of Severe Rheumatoid Arthritis, which involves three or more of the following joint areas: - proximal interphalangeal joints in the hands; - metacarpophalangeal joints in the hands; and - metatarsophalangeal joints in the foot, wrist, elbow, knee, or ankle; * simultaneous bilateral and symmetrical joint soft tissue swelling or fluid (not bony overgrowth alone); * typical rheumatoid joint deformity; and * at least two of the following criteria: - morning stiffness; - rheumatoid nodules; - erosions seen on x-ray imaging; - the presence of either a positive rheumatoid factor or the serological markers consistent with the diagnosis of Severe Rheumatoid Arthritis. Degenerative osteoarthritis and all other arthridities are excluded.

Insurer	Definition of "Severe Rheumatoid Arthritis" (from Insurer's policy document)
Zurich	severe rheumatoid arthritis (that fails to respond to treatment) means unequivocal diagnosis of rheumatoid arthritis confirmed by a rheumatologist or clinical immunologist, that has failed to respond to at least two disease-modifying anti-rheumatic drugs (DMARDs), excluding corticosteroids and non-steroidal anti-inflammatories, administered consistently for a period of at least nine months. severe rheumatoid arthritis (with permanent daily life impact) means unequivocal diagnosis of rheumatoid arthritis confirmed by a rheumatologist or clinical immunologist, that has: * failed to respond to at least two disease-modifying antirheumatic drugs (DMARDs), excluding corticosteroids and non-steroidal anti-inflammatories, administered consistently for a period of at least nine months, and * resulted in a permanent and irreversible inability to perform at least one of the activities of daily living. Degenerative osteoarthritis and all other arthritides are excluded.

Appendix D: Overseas experience

The Working Group reached out to stakeholders in several other countries to draw on their experience in respect of similar products and issues, and particularly to try to find out how these issues were resolved.

Comments were supplied by contacts in New Zealand, the United Kingdom, the Netherlands, Germany and Hong Kong in response to our request for information. The Working Party thanks all respondents for their time and contribution to this paper.

A summary of the comments and examples received are detailed in each of the sub-sections below. Where relevant, this paper reflects the Working Parties views in adapting these examples to apply them to the issues noted in section 4.

Key products

The key life insurance products sold across the countries varied markedly:

- The main life insurance products sold in the **UK** are term life, acute critical illness (ACI), stand-alone critical illness, income protection (IP), whole of life and guaranteed issue whole of life, long term care (LTC).
- Death and disability income are the key products within the **New Zealand** market.
- Traditional participating business were previously very dominant within the **German** market. Recently however, there has been a shift towards more risk/biometric and unit-linked products (which are less capital intensive). Disability fixed term insurance is also an important product within the German market.
- For **Hong Kong**, life insurance (protection benefits) is predominantly sold with participating savings policies as riders.
- Life insurance is a shrinking market in the **Netherlands**, with the key products being annuities, term life, and whole of life insurance. We also understand that disability products are considered non-life insurance products within Netherlands.

Key industry issues

The range of industry issues across the countries reflected the types of products typically sold, consumer preferences, and the economic condition of the country:

- Respondents in several countries commented on the impact of low interest rates on life insurance: -
    - In Germany, low interest rates made guarantees difficult to meet. This was addressed by increasing the level of participation (and consequently, complexity) in life insurance products. German insurers have also focussed on products that require less capital as a result of low interest rates.
    - However, in New Zealand, low interest rates have driven less participating and investment linked business due to expense commissions reducing competitiveness relative to similar products in other industries.
- Like current developments in Australia, issues relating to life insurers' conduct and culture have also been prevalent in the UK and New Zealand. For example, the Payment Protection Insurance (PPI) scandal in the UK have similarities to the issues with Consumer Credit Insurance in Australia.

Key regulatory developments

The key regulatory developments relating to product and distribution typically reflect the respective industry issues and the products sold:

- The Retail Distribution Review (2012-13) in the UK has resulted in protection being only advised as a commission-based product sale.
- In January 2018, the German government introduced an act to help increase consumer trust in defined contribution schemes. This was done to assist in meeting an objective to move away from defined benefit schemes which have become subject to additional reserves in recent times to meet guarantees.
- Despite regulators typically not being involved in product development, some regulatory actions have been used to address issues. In the Netherlands, regulatory guidance has been issues in respect of:
    - The impact of the declining insurance market on expense assumptions. Previously, insurers applied traditional actuarial approaches to determining expense assumptions; guidance was produced to help insurers to allow for continued declines in future volumes of business.
    - The use of artificial intelligence and machine learning in underwriting.

Key innovations

There are some similarities in the types of innovations across the countries, with many examples of digital innovation and health well-being propositions. Some examples include:

- In Germany, digital and online distribution (e.g. online startups) are being developed to provide simple policies (e.g. cover for 5 or 6 key diseases).
- In New Zealand, life insurers are innovating by incorporating health management add-ons into life insurance products. We understand that these add-ons relate to wellness benefits and reward programs which have also been introduced in other markets (e.g. the Netherlands).

Other notable observations

- In the United Kingdom, the life insurance industry has responded to **medical advances** by several actions – for example:
    - Critical illness conditions now allow for better survival rates and medical screening advances;
    - Income protection and private medical insurance now include allowance for mental health impairments;
    - Critical illness products have updated terms and conditions; and
    - In response to marketing requesting additional illnesses to make product seem more competitive, there was an industry initiative to have a generic list of terms and conditions introduced by the Association of British Insurers in the late 1990's.

Appendix E: LSC feedback on interim report

The Working Group originally released an interim report in October 2019 to the LIWMPC and Life Sub Committee to start discussions on how the retail advised lump sum market can be made more sustainable. A meeting was organised in November 2019 and was aimed at collating feedback from the Life Sub Committee on any key issues and potential solutions that the Working Group may have overlooked.

While we noted some variances in opinion, the Working Group is of the view that the key issues and potential solutions raised in this report are, in general, consistent with the broader Life Sub Committee. A list of the key issues and potential solutions are summarised below.

Key issues: -

- **Over-insurance** was an issue that was raised by many participants.
    - Many factors were raised as contributing to this including the lack of financial underwriting in the industry, and the "all or nothing" nature of the current products in the industry.
    - Some participants were also of the view that issues with consumer affordability was rather due to over-insurance and lack of value for money.
- A number of participants queried whether the current suite of products was **meeting consumer needs**. Anecdotal examples raised included:
    - Language and definitions of some products in the industry appear to be out-dated in the current environment. In particular, some participants questioned whether TPD was still relevant or if it should be more of a "life-change" type of product.
    - Products are currently bundled and sold to consumers without an appropriately holistic consideration of the needs of customers and other forms of support (e.g. IP, workers compensation).
    - Many products in the market currently lack options for policy modifications beyond sum insured changes (e.g. if there are occupation or income changes).
- **Role of advisers** was also raised as an issue.
    - Some participants were of the view that there was currently a lack of industry clarity around "best interest duty". There were views that the industry is not currently doing enough to provide guidance to advisers around this.
    - Reducing number of specialist advisers and the lack of a "value of money" measure were mentioned as possible drivers (or at least perpetuators).

- Many participants raised concerns around the **current competitive landscape** and **low industry sales volume**.
    - Some participants raised issues with discounting (particularly first year's discounts) and the vicious cycle of competition. A shrinking market was considered to be a key contributor to this.
    - Some participants highlighted risks with implementing features that dialled down benefits (to be more sustainable) in a shrinking market. An example included the likelihood of material sales volume of severity-based trauma products in the current market.

Potential solutions: -

- Many participants were of the view that **issues with distribution may need to be resolved first** before new products can be brought to market. Some suggested examples included:
    - Industry could potentially better meet customer needs by developing tools to model future needs, similar to investment advice and retirement.
    - Industry could provide guidance to advisers (e.g. an industry standard on insurability principle) on how to set sum insured amounts for customers.
- Many participants also suggested that having **industry standardised definitions** (at least for the core benefits) could be a potential solution. A potential argument for this is that product changes may be considered to be not worsening benefits, if the definitions are in reference to minimum industry definitions.
- Some participants considered that **improvements in pricing capabilities** may also improve sustainability. For example,
    - Some were of the view that as the level of granularity that insurers are able to price on improves, some of the issues relating to sustainability may also improve due to market forces.
    - Others were of the view that elements of the current premium rating structure may no longer be as relevant. That is, the industry should look to better understand occupational ratings.