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Discussion Note

Work Capability Assessments in Individual Disability Income Insurance:

Introduction and Considerations for Actuaries

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Disability Insurance Taskforce
of the Actuaries Institute

About the Authors

This Paper has been prepared by the Disability Insurance Taskforce of the Actuaries Institute (the Taskforce).

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Acknowledgment of Country

The Actuaries Institute acknowledges the traditional custodians of the lands and waters where we live and work, travel and trade. We pay our respects to the members of those communities, Elders past and present, and recognise and celebrate their continuing custodianship and culture.

About this Discussion Note

Feedback on this Guide is encouraged and should be forwarded to the Working Group using the email address ditf@actuaries.asn.au.

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Contents

1 Introduction and Summary

This Paper seeks to support actuaries in their understanding of:

- good practice principles which insurers might use to improve the effectiveness and clarity of how disability and work capacity are defined in Individual Disability Income Insurance (IDII); and
- good practice principles and relevant case studies for consideration in the assessment of work capacity.

The Disability Insurance Taskforce (DITF) of the Actuaries Institute published in December 2022 the *Individual Disability Income Insurance Sustainability Guide* (*Sustainability Guide*). Its purpose is to enhance practices to promote sustainability in the retail Individual Disability Income Insurance (IDII) market by helping actuaries and other readers consider critical aspects of product design, operational practices, pricing uncertainty, risk management and risk appetite.

An example set of Insurability Principles is provided, and these example principles have informed the creation of this paper. The first example principle, which states in part,

> **"*the event giving rise to a claim is objectively identifiable, definable, and measurable*",**

has been particularly informative in creating this paper.

While insurers must determine their own insurability principles to inform sustainability, this example principle is particularly important, as at the time of claim much effort is undertaken by the customer to prove they are eligible for a benefit and by insurers to validate if the customer is eligible for the benefit. This is made difficult in some cases due to the complexity of what is being insured; that is, a disability resulting in work incapacity.

Section 4 of the *Sustainability Guide* elaborates on an example Product Target State and suggests insurers:

> **"*consider whether the total disability definition is clear and seeks to provide support for the customer where there is a significant incapacity to work*."**

In this Note, as in the *Sustainability Guide*, the words "sustainable" and "sustainability" should be read in the following context:

- Products that perform as expected by customers, with features that, compared with the past:

  a) better meet their needs without frills, and reflect their insurable interests – both on policy inception and subsequently, and at individual and community levels; and

  b) provide more certain outcomes and are more readily understood.
- Prices for customers that are more stable and predictable over time, better understood and more consistent with underlying risk, compared with the present situation.
- Product features and underwriting that:

  a) promote alignment between customer and insurer through appropriate consideration of each customer's insurable interests; and

  b) support loss minimisation at time of claim.
- Financial outcomes for insurers that ensure a sustained ability to pay claims and that are sufficient to ensure insurers will continue to compete and provide valuable products to the market.
- Community confidence as to the enduring value and fairness of life insurance.

1.1 Clear Definitions of Disability

The *Sustainability Guide* suggests that insurers have clear definitions of disability, with objective measures. Clear definitions of disability allow:

- the customer and their treaters to understand what is covered and what is not covered;
- the insurer and customer to reliably establish the presence of a medical condition(s)/injury causing impairment severe enough to result in a work incapacity, minimising delay or dispute; and
- the insurer to best support the customer via benefits and/or other means.

Clear definitions of disability with objective measures are challenging due to the complexity of what is being insured. Complexity arises from the subjectivity of some of the influencing factors, including the medical conditions and impairments themselves as well as the broad biological, psychological, and social factors. Not all medical conditions and their related impairments are objectively assessable (making validation challenging), and certain disabilities may only manifest in specific contexts. This results in more subjectivity in any claimed associated disability and work incapacity.

Insurers have updated their on-sale IDII product disability definitions to be more clearly and directly linked to work incapacity however, given the complexity of the risk, these definitions will need to be monitored for effectiveness versus intent as experience emerges.

1.2 The "Work Capacity/Capability" Clause in Contemporary IDII Products

As of 2024, a Work Capacity/Capability Assessment ("WCA") forms part of the definition of disability within most contemporary IDII products on sale in the Australian market.

A determination of work capacity is an assessment made about the insured's capacity to work in their assessed occupation. It may be used for assessments of total and/or partial disability claims. In simple terms, inclusion of WCA is intended to help align the payment of disability claims more clearly and directly with an insured's loss of income producing capacity/capability (solely due to a disabling event), thereby creating a fairer and more reliable balance between all premium payers and claimants.

Examples of how this is incorporated into PDS wording include[1]:

TAL Accelerated Protection: "*unable* to perform all the duties necessary to generate income in the Life Insured's Own Occupation…"

AIA Income Protection Core: "*Not capable* of performing the Material and Substantial Duties of your Own Occupation… If you *are capable of performing… in a reduced capacity*, you won't be Totally Disabled but you may be Partially Disabled…" and "If you are Partially Disabled … and you are either not working in, or not working to the extent of your capability in … and this situation continues for at least two months, then your benefit will be calculated based on what you could reasonably be expected to earn … if you were working in that occupation to the extent of your capability."

The clauses typically allow adjustments to the benefit to be made where an individual is either:

- not working but capable of working;
- working, but not to their full capability; or

[1] PDS versions as at 30 June 2023

- earnings are not representative of the work being performed.

It is important to note that the presence of a WCA clause such as above will not in and of itself be enough to achieve this end; it must work holistically with the overall PDS wording.

Establishing the presence of work incapacity commences as soon as a claim is lodged and is ongoing. Depending on insurer practices and the context of the claim, the assessment itself can be either a simpler assessment performed by claims assessors or more in-depth assessments by work capacity experts. Different levels and types of assessment may be more appropriate at different stages of a claim.

Insurers' process for WCAs could align with the good-practice principles of being:

- valid
- reliable
- transparent
- fair
- proportionate

including being carried out by suitably accredited assessors.

The assessment of disability and work capacity is a broader concern in society than just life insurance, and that the assessment is a key part of other disability insurance schemes in Australia and around the world (e.g., within workers compensation schemes, CTP schemes, and other social insurance schemes and benefits).

1.3 Key Considerations Outline

Below is a summary of the key considerations in the Note, for the purpose of informing actuaries.

1) Insurers might consider, for disability definitions already in place, need for them to be monitored for effectiveness versus intent with an effective control cycle, as experience emerges.
2) Insurers might engage with relevant stakeholders and experts on offering clear definitions of disability (work incapacity arising from a medical illness or injury), definitions which are clear about the eligibility thresholds and that are consistent with the reality that disability has a spectrum in terms of severity and associated impairment.

   Stakeholders could include: Royal Australasian College of Physicians ("RACP"), Royal Australian and New Zealand College of Psychiatrists ("RANZCP"), Royal Australian College of General Practitioners ("RACGP"), and other relevant bodies.

3) Insurers might set out clear processes for how and when work capacity assessments should be performed (involving, where appropriate, recovery activities, rehabilitation and retraining).
4) Insurers might work with relevant stakeholders and experts to develop a formal work capacity assessment and framework that is valid, reliable, transparent, fair and proportionate.

   Stakeholders could include: the Collaborative Partnership, RACP, RANZCP, RACGP.

5) Insurers might ensure that any work capacity assessor is suitably trained, and accredited to perform them, with a regular assessment of performance including quality.

2 Defining Disability and Work Incapacity

Disability has a spectrum of definitions and understandings in society. The United Nations Convention on the Rights of Persons with Disabilities defines disability as “having a long-term physical, mental, intellectual or sensory impairment that – in interaction with the environment – hinders one’s participation in society on an equal basis with others”. The WHO International Classification of Functioning, Disability and Health has a complex definition of disability that considers it a “dynamic interaction between health conditions and environmental and personal factors”. Various government agencies will have different definitions and individuals themselves may have their own unique understandings of the term.

Life insurance products generally have a more specific definition of disability, with more focus on disability relating to what is being insured, which is usually the ability to earn an income through work (insuring the onset of work incapacity). These insurance products generally define disability, considering it present when a medical illness or injury causes an impairment or impairments (physical, mental, intellectual or sensory) that result in work incapacity. The focus of life insurers' definitions of disability versus that broader spectrum of understandings can be a source of some confusion, delays and even dispute.

Generally, establishing work capacity/incapacity requires consideration of a person’s impairments, contextual factors (including usual occupation along with education, training, experience) and environmental factors. The assessment of all of these can be challenging, and this complexity contributes to confusion in some cases. For a work capacity assessment to be deployed successfully, the definition of disability/incapacity should be set out as objectively, transparently, and fairly as possible. If the insurer is not clear with its definition of disability, and clear about when someone meets the eligibility criteria for benefits, the assessment is more difficult and this could contribute to both consumer confusion and sustainability issues. A poorly defined product is more difficult to underwrite, assess at claim time and reliably price.

In designing the definition the insurer may consider:

- recognising that disability exists on a spectrum of severity. How it manifests can depend on the nature of the disability and the context and environment the person with disability is within;
- including consideration of recovery, rehabilitation and return to work capacity potential; and
- being clear about how work capacity is assessed.

The *Sustainability Guide* encourages insurers to have clear definitions of disability (work incapacity) and suggests the presence of the claimed event should be objectively assessable. A perfect definition of disability may not be easily done or feasible given how complex the spectrum of disabilities is, however insurers can still strive for continual improvement.

As of 2024, many life insurers have updated their on-sale IDII product disability definitions with the intent to be more clearly and directly linked to work incapacity. These definitions should be monitored for effectiveness versus intent with an effective control cycle as experience emerges. Both claims experience relative to expected as well as claims team operational effectiveness should be considered. Definitions can be refined for new policies and claims team operational practices can be improved for all new and open claims.

Consideration 1: Insurers may consider, for disability definitions already in place, the need for them to be monitored for effectiveness versus intent with an effective control cycle, as experience emerges.

In addition to reviewing their own experience, insurers could consider engaging with stakeholders and suitable experts in the broader medical field to reach an agreement around reasonable frameworks to support insurance disability definitions. Engagement could include working with the RACP, RACGP and/or RANZCP, who have expertise in assessing medical and psychiatric conditions and related functional impairments along with the contextual factors that can impact on work incapacity.

Consideration 2: Insurers may consider engaging with relevant stakeholders and experts on offering clear definitions of disability (work incapacity arising from a medical illness or injury), including the eligibility thresholds and that are consistent with the reality that disability has a spectrum in terms of severity and associated impairment. Stakeholders could include: RACP, RANZCP, RACGP and other relevant bodies.

3 Work Capacity Assessments

Establishing the presence of a work incapacity commences as soon as a claim is lodged and is possible in a majority of claims by collecting information from the customer, their treating health providers, their employer, their advisor, and other sources. The information is analysed by claims assessors with input from other technical staff and internal subject matter experts where needed.

For more complex claims or where there is uncertainty about eligibility, a more formal WCA may be required. This is a specialised assessment performed by a suitably trained expert, of someone's capacity to perform the meaningful income producing functions within a defined role or job safely.

They can generally consider:

- personal factors (including attitudes and beliefs);
- medical factors (including impairments and medical risks);
- contextual factors (education, training and experience);
- work factors (the functional demands of the role, including physical, cognitive, and psychological demands, how the work is to be performed, modifying factors available); and
- environmental factors (where and when the work is to be performed).

These assessments are complex, involve the assessment of many factors, require expertise and can be a mixture of objective and subjective factors and testing.

In operationalising WCAs, insurers will need to decide what level of assessment is appropriate for each claim and (if relevant) at which stage it should be used during the claim. Considerations could include:

- how objective the injury/illness is: cases without objective medical confirmation may require a more in-depth WCA;
- how long the customer has been disabled for: given (typically) higher rates of recovery in initial months on claim, it may generally be less efficient to perform in-depth WCAs immediately. However, this should also be balanced against the risk of waiting too long and missing opportunities for early rehabilitation;
- how the customer has engaged in rehabilitation and retraining opportunities: if the customer has been supported through rehabilitation and retraining it might be expected that their work capacity will have improved.

Consideration 3: Insurers may consider setting out clear processes for how and when work capacity assessments should be performed (involving, where appropriate, recovery activities, rehabilitation and retraining).

3.1 Example Principles for Work Capacity Assessments

In developing process for WCAs, insurers could consider aligning with the below principles, for it to be:

- valid
- reliable
- transparent
- fair
- proportionate

including being carried out by suitably accredited assessors.

These are adapted from principles outlined in *World Report on Disability* (WHO & World Bank, 2011) and *Assessing Disability in Working Age Population* (Bickenbach et al, 2015).

3.1.1 Valid

The WCA should be a valid assessment, with the result reflecting the true state of disability. This is achieved by having effective sensitivity and specificity, meaning once applied it should be able to determine with confidence the presence or absence of the claimed state of disability (minimising false positives and negatives). The performance of any WCA or test should be formally assessed over time in terms of validity, including measures of sensitivity and specificity.

3.1.2 Reliable

Any WCA developed should have both internal and external reliability. Internal reliability means that if the same assessor conducts the same assessment twice within a short time frame the result is similar. External reliability is when two different assessors assess the same individual within a short time frame, they also get a similar result. To improve reliability (and credibility), the use of suitably trained experts in these fields should be accredited to perform the assessments with a quality review process in place to support their use.

3.1.3 Transparent

Conduct of the assessment should be transparent, meaning that any interested party, including the customer, can review the assessment and the result and understand how the assessor concluded what they did.

3.1.4 Fair

The assessment should be considered fair by all parties involved. Fairness can be improved by having clear definitions of disability (written in plain language), clear processes and procedures around underwriting and claims management, a clear assessment of work capacity and clear communication. Given the complexity of disability and the assessment of work incapacity, there will likely be disputes that arise from time to time. Utilisation of a WCA should be accompanied by a dispute resolution mechanism to support fair outcomes and support external reliability. Ensuring validity, reliability and transparency will also improve a sense of fairness.

3.1.5 Proportionate

WCAs come with cost and can be onerous for customers, so the assessment process used should be proportionate to the context of the claim in order to optimise sustainability and fair outcomes. Generally, more subjective and higher value claims might be better suited to more in-depth WCAs (and vice versa).

Consideration 4: Insurers may consider working with relevant stakeholders and experts to develop a formal work capacity assessment and framework that is valid, reliable, transparent, fair and proportionate. Stakeholders could include: the Collaborative Partnership, RACP, RANZCP and RACGP.

Consideration 5: Insurers may consider ensuring that any work capacity assessor is suitably trained, and accredited to perform them, with a regular assessment of performance including quality.

3.2 Example Case Studies of Work Capacity Assessments

Examples below set out how the capability/capacity clause may play a part in a series of example claims. Note that actual outcomes will depend on a wide range of factors, including the particular wording of each product's Product Disclosure Statement (PDS).

1. **Resigned from role and not working, but capable of working**
   - Shop Assistant (employee)
   - 40hrs per week
   - $60,000 income ($5,000 per month) in the 12 months prior to claim
   - Insured Monthly Benefit of $3,500 per month

   Diagnosed with depression, following workplace bullying by their supervisor. Shortly after ceasing work the customer resigned.

   After being unable to work in any capacity for a short period, the GP completed a progress medical report stating the customer is fit to return to part-time work, 20 hours per week in the same occupation but with a different employer.

   As the customer is unemployed, they have not been able to return to work.

   <u>Application of Capability Clause</u>
   The Claims Assessor identifies that the customer can work 20 hours per week however is not working for a reason unrelated to sickness or injury. The Claims Assessor therefore makes an adjustment to the customer's earnings to reflect their capacity to work.

   As the GP has confirmed the customer can work in the same occupation for 50% of their pre-disability hours, the Claims Assessor determines the customer is capable of earning 50% of their pre-disability income ("PDI").

   <u>Calculation of Benefit:</u>
   PDI = $5,000 per month
   Earnings potential = $2,500 per month

   Partial Disability Benefit (Monthly Benefit = 75% of earnings potential)
   $3,500 - $1,875 (75% of $2,500) = $1,625

2. **Reduced work temporarily to relocate, but capable of some work**
   - Self-employed Dentist
   - 40 hours per week
   - $180,000 income in the 12 months prior to claim ($15,000 per month)
   - Insured Monthly Benefit of $10,500

   Diagnosed with tenosynovitis of the dominant right wrist. After a period of treatment which included splinting, anti-inflammatories and steroid injections, the customer returned to part-time work. Over time their level of function increased and they were working 30 hours per week in accordance with the certification of the GP and an agreed return-to-work plan.

   Whilst on claim the customer sold their practice and relocated interstate to be closer to their extended family. Their intention was to set up a new practice however delays were experienced, meaning that they were temporarily no longer consulting patients or generating income.

   On learning that the customer was no longer consulting patients, the Claims Assessor contacts the customer, who confirms they were experiencing some increased pain and inflammation towards the end of the week, however, were managing 30 hours per week at the time. Once they had secured a premises to set up their new practice, they intended to resume part-time work.

   Application of Capability Clause
   The Claims Assessor concludes from the evidence that there has been no exacerbation of symptoms or deterioration in function, therefore the customer retains the capacity to work 30 hours per week.

   As the customer was working 30 hours per week (or 75% of their pre-disability hours), the Claims Assessor determines that they are capable of earning 75% of their pre-disability income.

   Calculation of Benefits:
   PDI = $15,000 per month
   Earnings potential = $11,250

   Partial Disability Benefit (Monthly Benefit = 75% of earnings potential)
   $10,500 - $8,427.50 (75% of $11,250) = $2,062.50

3. **Not working, independent assessment obtained**
   - Self-employed Electrician
   - 40 hours per week
   - $156,000 income in the 12 months prior to claim ($13,000 per month)
   - Insured Monthly Benefit of $9,000

   The customer initially ceased work due to contracting COVID-19. In the months following diagnosis, they continued to experience symptoms consistent with Long-COVID and were certified unable to work in any capacity by their GP due to fatigue, chest pain and shortness of breath. Due to their chest pains and shortness of breath the customer was referred to a Cardiologist and Respiratory Physician to determine if symptoms could be explained by alternate diagnoses. On further investigation both specialists conclude there is no other cardiac or respiratory diagnosis.

   An Initial Needs Assessment was completed by a Rehabilitation Consultant to understand the barriers impacting a return to work. An exercise program was recommended and endorsed by the GP.

   On completion of the exercise program there were demonstrated improvements in exercise tolerance and overall energy levels. Despite these improvements in function, the GP continued to certify the customer unable to work in any capacity.

   The Insurer arranged an Independent Medical Examination (IME) with an Occupational Physician. On examination of the customer and review of the available evidence, the Occupational Physician

determined the customer was capable of returning to work in their occupation on a part-time basis with immediate effect, commencing at 16 hours per week.

The Claims Assessor requested a report from the GP to comment on the findings of the IME report. The GP acknowledged the IME report however maintained that the customer was unable to work in any capacity due to the customer's report of fatigue, chest pains and shortness of breath.

Application of Capability Clause
The Claims Assessor considers all available evidence and concludes that the customer is capable of working 16 hours per week in their occupation as outlined by the Occupational Physician (IME). As 16 hours per week equates to 40% of the customer's pre-disability hours, the Claims Assessor determines they are capable of earning 40% of their pre-disability income.

Calculation of Benefits
PDI = $13,000 per month

Potential earnings = $5,200

Partial Disability Benefit (Monthly Benefit = 75% of earnings potential)
$9,000 - $3,900 (75% of $5,200) = $5,100

4. Working, reduced earnings for reasons unrelated to disability

- Self-employed Restaurant Owner
- 40 hours per week
- $120,000 income in the 12 months prior to claim ($10,000 per month)
- Potential earnings = $7,500

Diagnosed with osteoarthritis of the hip. The customer continued to work in a reduced capacity up until the date they were admitted to hospital to undergo hip replacement surgery. After a period of post-operative rehabilitation, the customer was cleared to return to part-time work by their GP and Orthopaedic Surgeon. Over the following months, with treatment, their level of function increased and they were working 30 hours per week as certified by the GP.

Despite working 30 hours per week, the business continued to incur losses month-on-month. On discussion with the customer, it was revealed that turnover has been impacted by the commencement of a redevelopment project in the precinct.

Application of Capability Clause
The Claims Assessor identifies that the customer's earnings were not reflective of the duties they were performing or the hours worked. Prior to claim, the customer was working 40 hours per week and their average net profit in the 12 months prior to claim was $13,000 per month.

As the customer is capable of working 30 hours per week or 75% of their pre-disability hours, the customer's potential earnings are calculated to be $7,500 per month.

Calculation of Benefits
PDI: $10,000 per month
Insured Monthly Benefit of $7,000

Partial Disability Benefit (Monthly Benefit = 75% of earnings potential)
$7,000 - $5,625 (75% of $7,500) = $1,375

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