FOR CONSULTATION

Document B

Individual Disability Income Insurance Sustainability Guide

IDII

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Disability Insurance Taskforce of the Actuaries Institute

Actuaries Institute

FOR CONSULTATION

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About the authors

Members of the Actuaries Institute Disability Insurance Taskforce are listed in the Appendix of Document A – Provisional Findings and Recommended Actions for Individual Disability Income Insurance.

Disclaimer

This paper is circulated by the Disability Insurance Taskforce for the purpose of providing information on the work to date and to facilitate further consultation. The Disability Insurance Taskforce is comprised of a range of participants and stakeholders in the Individual Disability Income Insurance ecosystem. The work of the Disability Insurance Taskforce has been to establish guidelines for a sustainable ecosystem including the development of a Reference Product for Individual Disability Income Insurance. The work has been undertaken to promote better, more sustainable outcomes for both consumers and the industry. The Taskforce participants have shared knowledge on the basis that the outcome was the public benefit of advancing the debate of more sustainable product design.

Actuaries Institute

About the Actuaries Institute

The Actuaries Institute is the sole professional body for Actuaries in Australia. The Institute provides expert commentary on public policy issues where there is uncertainty of future financial outcomes.

Actuaries have a reputation for a high level of technical financial expertise and integrity. They apply their risk management expertise to allocate capital efficiently, identify and mitigate emerging risks and to help maintain system integrity across multiple segments of the financial and other sectors.

This expertise enables the profession to provide important insights on a wide range of issues including life insurance, health insurance, general insurance, climate change, retirement income policy, enterprise risk and prudential regulation, finance and investment and health financing.

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Contents

1 Purpose

This guide has been developed by the Actuaries Institute Disability Insurance Taskforce (the Taskforce) to support actuaries and other insurance professionals create or enhance practices to promote sustainability in the retail Individual Disability Income Insurance (IDII) market. The guide is intended to help insurers consider critical aspects of product design, operational practices, pricing uncertainty, risk management and risk appetite. It will increase clarity about important practices that may lead to poor sustainability. Insurers should use this to continually improve their frameworks, policies and day to day practices to mitigate those risks. The updated frameworks and policies would be endorsed by the insurer's Board and used to demonstrate to APRA that any Pillar 2 capital charge can be reduced or is unnecessary.

2 Introduction

2.1 Background and context

Insurers face a number of conflicting commercial realities that over decades have resulted in poor outcomes for both customers and insurers in the IDII market. IDII products are complex and insurers have poorly understood the uncertainty[1] that has led to unexpected increases in claims cost. Consequently, the products have proven to be under-priced, benefited customers through cheap premiums and led to substantial industry losses. Conversely, consumer detriment has arisen from:

i. liberal benefits and poor risk management resulting in all customers paying higher premiums than necessary to benefit claimants who receive benefits in excess of their insurable interest[2] and/or avoid minimising the insured loss[3];

ii. the ongoing underestimation by insurers of the potential variability of experience and the resulting unexpected premium rate increases for customers; and

iii. selection effects by healthy customers responding to reducing affordability by ceasing cover and the consequent price increases for the remaining customers.

2.2 Response

This guide recommends that each insurer should have a documented approach to sustainability and proposes:

i. a framework to improve governance over decision making (including definition of a Target State);

ii. a Reference Product and benchmark operational practices to assist management and the Board understand and discuss aspects of their business that may reduce sustainability; and

iii. a framework to measure and monitor over time an insurer's sustainability by reference to the Reference Product and benchmark operations (including definition of an internal and self-assessed sustainability score).

2.3 Philosophy and content

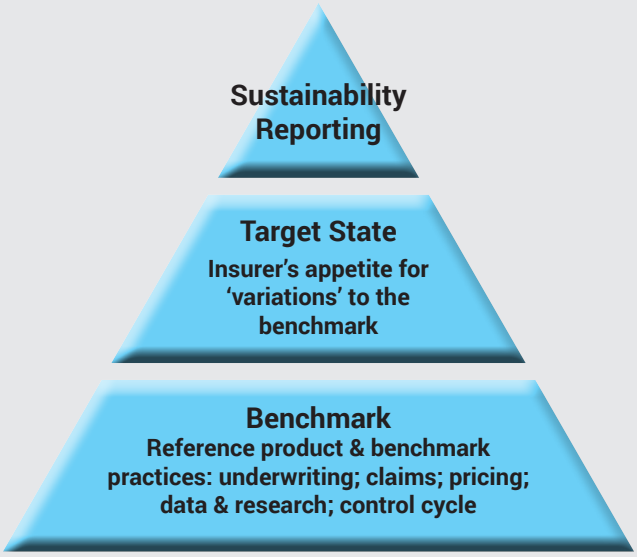
The guide outlines the most critical practices thought to promote sustainability of the industry. It complements and is no substitute for the insurer's team of insurance practitioners applying best practice. As such, it articulates the outcomes that need to be achieved to nurture sustainability and potential product and operating practices that could support those outcomes. It is envisaged that insurers will adopt their own practices within this framework.

The guide has been prepared in the context of sustainability for on sale (new business) retail advised products. The approach taken in the guide is intended to be usable for other distribution channels, product lines and the insurer's in-force portfolio. For example, in a direct distribution channel the insurer might choose to deviate from the Reference Product and benchmark practices with stricter product definitions and weaker underwriting practices.

1 For the purpose of this guide 'uncertainty' is intended to include a range of factors outlined in section 4.4.
2 'A person or entity has an insurable interest in an item, event or action when the damage or loss of the object would cause a financial loss or other hardships.' In this case, the insured asset is future income. See https://www.investopedia.com/terms/i/insurable-interest.asp for more detail.
3 An important principle of insurance is that the insured must act to minimise the loss once the insured event occurs.

2.4 Executive summary: elements and processes in the guide

Framework elements



Steps for insurers:

1 Discuss IDII uncertainty in the context of the benchmark
2 Determine features to adopt in the insurer's Target State and their relationship to the benchmark
3 Board approval of high sustainability impact Target State variations to the benchmark
4 Identify and evaluate variations for their impact on claims cost arising from uncertainty
5 Ongoing monitor of variations and sustainability reporting
6 Continuous improvement of data collection, research and control cycle to reduce uncertainty

3 Governance and Target State

Governance structures and reporting should enable development and maintenance of sustainable practices over the long term. The following elements are recommended:

i. a clear Target State linked to risk appetite and delegations to management;

ii. senior management review of product performance, product changes and operational performance to drive sustainability; and

iii. Board approval and monitoring of sustainability including their organisation's sustainability scores.

3.1 Target State

The guide proposes a reference set of product features[4] and benchmark operational practices (including underwriting, pricing and claims) that when taken as a whole provide a robust foundation for sustainability (see section 4). The insurer should set its Target State by defining acceptable 'variations' to this reference/benchmark (see section 5). For each item in the register of these variations, the insurer should define whether its risk appetite is such that: (i) the variation is 'to be eliminated', (ii) the variation has a target impact rating of 'Low/Medium/High' or (iii) there is a target level of 'premium exposure %' to the risk.

It is envisaged that the Board would approve the Target State and in doing so it would consider:

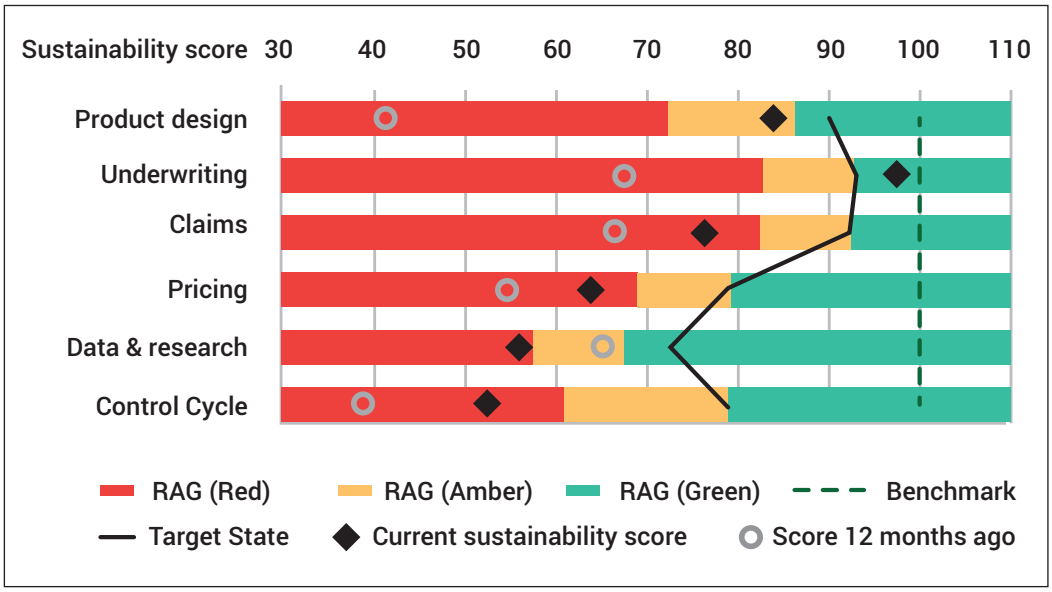
- the detail of all high impact variations to the reference/benchmark including mitigants (if any);
- the number of medium impact variations and the themes justifying those variations; and
- how the insurer's pricing philosophy supports sustainable and equitable outcomes (see section 4.4.2).

The insurer's risk appetite statement would be updated to reflect the Target State and delegations to management should ensure that future product and operational changes that are critical to sustainability are considered by the Board.

3.2 Monitoring by the Board / Sustainability Heatmap

The Board should monitor the insurer's sustainability scores (see section 5.4) including how these may change over several years to avoid unintended accumulation of uncertainty. For example, the dashboard for an insurer with a Target State sustainability score averaging 85 relative to the benchmark score of 100 could look like the following.

4 For absolute clarity, the Reference Product features are not set out for marketing purposes; they are an aid to sound prudential management of the product as a foundation for sustainable outcomes.



The metrics would be forward looking for on-sale products. Multiple dashboards could be presented separately for each major product series or a weighted average dashboard used (weighted by premiums for example). Although not the focus of this guide, the insurer may also have a separate dashboard to monitor sustainability of the in-force portfolio. The ongoing effectiveness of mitigants should be monitored and incorporated in the low/medium/high rating within the impact scores.

At least annually the Board should review a summary of management's sustainability analysis (see section 3.3).

3.3 Product governance and sustainability monitoring

An insurer should update its framework(s) to cover sustainability of the product. As a minimum, the framework(s) should set out how the insurer:

i. receives and considers CPS320 specific advice to the company as well as specific advice from senior representatives from the product, underwriting and claims teams on sustainability and in respect of all significant product and operational changes;

ii. makes decisions about changes to products and processes when the above advice raises concerns in relation to long term sustainability;

iii. ensures that the Appointed Actuary and Chief Risk Officer are provided with the appropriate information, have the opportunity to challenge assessments prior to approval and escalate to the Board where necessary;

iv. monitors and understands sustainability issues detailed in the annual sustainability assessment (see section 4.6);

v. periodically reviews variations to the benchmark, mitigants, resourcing to support mitigants and the Target State itself;

vi. reports to the Board on management's sustainability analysis and effectiveness of the sustainability framework; and

vii. considers the ongoing appropriateness of historical product designs and transition of customers to on sale products.

4 Reference Product and associated benchmark operations

This section details the main elements of the Reference Product and benchmark operations. These elements are not intended to cover every possible aspect of an insurer's product and organisation. The focus is on the most material outcomes that are expected to lead to a relatively sustainable industry. In developing an insurer's own approach to sustainability, it is envisaged that the rationale for any variations to this benchmark are discussed, documented and agreed (see section 5).

The reference/benchmark aims to deliver on the principles of insurable interest and loss minimisation. It is not intended to achieve the 'ultimate' in sustainability; rather deliver more consistent outcomes for both the customer and insurer in a range of potential future social, regulatory and economic scenarios. It is recognised that many of the components interact and similarly sustainable outcomes may be achieved with a different combination of factors. The insurer's Target State and actual go-to-market product and service offerings may be more or less conservative than the benchmark.

The following sections complement rather than substitute for a team of insurance practitioners applying best practice in their fields.

4.1 Product design

The Reference Product has been designed to meet the following insurance principles.

1. The event giving rise to a claim must be objectively definable and measurable. The event should also occur by chance – that is, it should be beyond the control of the beneficiaries.
2. The customer's financial loss on the occurrence of the event must be measurable and definable.
3. The benefit payment should not exceed the financial loss suffered, after allowing for other sources of financial support.
4. Maximum benefits provided should be set at a level to provide a financial incentive for claimants to return to work. Benefits should not provide disincentives to return to work, either initially or over time. A customer should not be financially better off while on claim. This helps provide an incentive for customers to return to work and for the cover to focus on those in need.

The following sections detail the outcomes / themes that are central to sustainability and cross references the full discussion of the Reference Product in Appendix A.

4.1.1 Income definition and replacement ratio incentivise return to work / wellness

The combination of income definition (see A.4) and replacement ratio (see A.2 including offsets in A.5 and ancillary benefits in A.11) is intended to ensure that the product covers an insurable interest of the customer and incentivises return to work / wellness. The Reference Product provides benefits on an indemnity basis only.

4.1.2 Disability definitions are clear and support the customer when they are unable to work

The total disability definition in the Reference Product aims to be as clear as possible and provide support for the consumer (see A.1) where there is a significant incapacity to work. Partial disability benefits are structured to promote return to work and not encourage remaining on claim (see A.3).

4.1.3 The occupation definitions and replacement ratios encourage the customer to minimise the insured loss

The Reference Product design is intended to ensure that claimants are aligned with the insurer on the insurance principle of loss minimisation. The replacement ratio is higher in the first 6 months (see A.2) and the occupation definition moves from own occupation to an education, training or experience definition at 2 years (see A.1).

4.1.4 Product terms and conditions keep up with environmental changes

Under the Reference Product the insurer retains rights to alter all terms and conditions at least every 5 years to ensure that changes in environmental and other factors can be reflected in product design (see A.9). Factors may include social inflation (e.g. societal expectations, attitude to mental health, lawyer involvement), regulatory change, medical advances, change in the structure of the economy (e.g. casualisation of the workforce) and shifting economic conditions (e.g. high to low inflation environment).

Under the Reference Product, the insurer's intent is that the product would most likely not need to be changed. That is, the right to change product terms would not be used to experiment with unsustainable terms that are likely to be subsequently withdrawn.

4.1.5 Products communicated to promote alignment between insurer and customers

Under the Reference Product, the intention is that customer expectations of the product should be aligned with the insurer. This is intended to support the long term expectations and needs of the community. To achieve this, the benchmark practice is to:

- Describe the product using language that is easily and succinctly understood by the customer. Examples of poor use of language are: (i) calling the product 'income protection' when the insurer expects return to work to be a key focus, (ii) complex disability definitions that make it difficult for customers to understand what they can claim and (iii) use of the term 'level premiums' which to most customer implies that the dollar premiums will always remain unchanged.
- Clearly and regularly communicate about the uncertainty and profitability of the product so that customers are not surprised by premium rate increases. In support of this, under the benchmark practices the insurer would provide key elements of its pricing philosophy (see 4.4.2) to rating houses for inclusion in their product ratings.
- Support publication by the industry of claims statistics on components of benefits such as key types of disability definitions, claims causes and ancillary benefits.

4.2 Underwriting practices

The Reference Product requires supporting underwriting and claims practices to promote sustainable outcomes including return to work where appropriate. Underwriting and claims practices must combine with product design to:

- limit claims to the insurable interest of the customer; and
- operate to encourage the consumer to return to health and minimise loss of their income.

4.2.1 Financial underwriting ensures that benefits cover insurable interests and promote loss minimisation

Under the benchmark practices, the intention is that the combined value of the customer's passive income, lump sum living benefits and disability income benefits incentivise return to work. Benefit periods that are too long may encourage the use of an insurance claim as an early retirement strategy. The Reference Product has maximum entry ages, allowable waiting periods and maximum benefit period of 'to age 60'. (see A.6, A.7 & A.8)

4.2.2 Insured events updated to keep up with the customer's changing circumstances

Under the benchmark practices, financial underwriting is updated at least every 5 years to ensure that cover continues to deliver on the insurable interests of the customer (see A.9). This includes the customer's occupation and income level (see A.4). This helps ensure that the correct premium rates are charged and enables the insurer to effectively promote return to work should a claim occur.

4.3 Claims practices

4.3.1 Claims team has the capacity and skills to assess the claims definitions

Under the benchmark practices, the claims team has a sufficiently skilled and experienced team with sufficient capacity to assess claimants against the claims definitions (see A.12). Claims assessors must retain ownership of the decision regarding payment of a claim and (i) request only factual medical information from GPs and (ii) use assessments from occupational physicians, occupational therapists and other specialist practitioners in assessing function and capacity to work.

4.3.2 Claims team actively plans, encourages and implements return to work / wellness with claimants

Under the benchmark practices, during the first 18 months of each claim it is important that the claimant receives regular communication on return to wellness / work expectations at least every 6 weeks following acceptance of the claim. Communication should include the typical return to work plan for their condition, a customised plan for their recovery and future changes in benefits under the product terms and conditions (see A.10). Rehabilitation support should be provided.

4.4 Pricing for uncertainty

Uncertainty is particularly high in IDII products for a number of reasons including:

- in a rapidly changing environment, historic data may be inadequate to estimate the future claims cost;
- limited understanding of customer behaviour and social factors impacting on claims cost; and
- the high potential for social inflation / environmental changes / black swan events to increase costs (including social, medical, economic and regulatory factors).

Sustainability requires that insurers proactively seek to understand and reduce uncertainty through product terms, underwriting and claims practices. Only in this way will pricing become sustainable. The primary focus of this guide is to achieve that outcome.

Insurers should acknowledge uncertainty and not default to being optimistic about the cost of uncertainty. Pricing assumptions / margins should allow for that cost. If insurers are routinely optimistic about uncertainty, then competition results in the ongoing / iterative relaxation of product terms and insurers increasing premium rates in future. An argument can be mounted that no consumer detriment occurs because there is a free market and customers can move to a superior and/or cheaper product. This argument has limitations for IDII products because consumers face high frictional costs[5] that the insurer should consider in their pricing decisions. The customer also has a right to understand how the price of their product may change over time.

4.4.1 Pricing assumptions put a cost on uncertainty for at least 5 years

Under benchmark practice, careful consideration of uncertainty over at least the first 5 years from inception of policies is required. It is intended that it is more likely than not that allowing for uncertainty over this period: (i) the premium rate schedule will remain unchanged and (ii) the insurer will meet its minimum profit metrics[6]. This does not imply that that premium rates should be guaranteed.

Uncertainty should be allowed for in best estimate assumptions or profit margins. Under benchmark practice, the starting point for best estimate assumptions should be the industry table and a credibility approach used to overlay the insurer's own historic experience (and/or alternate rating factors).

A number of additional factors should be considered in respect of uncertainty of the best estimate assumptions. If there is reasonable empirical data or research to explain why the potential uncertainty will not emerge then under benchmark practice the cost of that uncertainty can be reduced or removed. Equally, evidence may indicate that a loading is required to best estimate assumptions instead. Section 4.5 details benchmark practices to reduce uncertainty over time. Under benchmark practice, the uncertainty factors to consider include:

i. Continuation of adverse historic trends in experience (unless credibly explained as one-off by factors such as changes in the insurer's operations, social inflation / community attitudes, regulatory expectations or industry and legal practices);

ii. Mis-estimation of the mean by assuming that the insurer's own favourable and credible experience compared with the industry will persist into the future. Any best estimate

5 Frictional costs for consumers include: (i) the significant cost to understand and transact, (ii) actual inability to transact because of changes in their health and the insurer's medical underwriting and (iii) fear of making a mistake because of the complexity of the product.

6 The insurer should determine the methodology and metric(s) that it wishes to use to assess profitability and profit margins (i.e. this guide neither defines a technical approach nor whether uncertainty should be included).

assumptions that are more favourable than the lesser of (i) the insurer's credibility weighted experience and (ii) the industry experience may not be sustainable;

iii. To the extent not reflected in the underlying experience, the average cost of cyclical effects such as the impact of the economic cycle should be costed. In particular unemployment and underemployment;

iv. The potential that duration based termination assumptions are optimistic because: (i) the insurer assumes that credible insurer experience at short durations implies credible experience at longer durations or (ii) the shape of the industry table has been altered without evidence that there is not an unaccounted for opposite effect at another duration; and

v. Any expectations that customers would reasonably have.

It is recognised that it may take insurers some time to better understand uncertainty and reduce the cost of uncertainty in pricing.

4.4.2 The pricing philosophy addresses key questions of equity

Under benchmark practice, the pricing philosophy articulates how the insurer proposes to address factors that impact on the product's cost over time. Factors include how the insurer:

i. addresses cross subsidies between the early policy years and later periods so that pricing allows for factors including the spread of acquisition costs and known policy duration effects on claims costs;

ii. allows for uncertainty in its pricing including the practices detailed in section 4.4.1 and how pricing of uncertainty differs between short and long duration benefits;

iii. exercises its repricing rights if uncertainty crystallises and in particular how it proposes to balance: (i) allowance for uncertainty in upfront pricing, (ii) frictional costs that customers may face if prices are increased and (iii) how it will manage its profit metrics; and

iv. ensures that pricing for each individual product line[7] is not loss making at least on a marginal cost basis.

4.5 Data, experience investigations and research

IDII products are inherently complex. To reduce uncertainty and understand risk it is necessary for each insurer to collect data, analyse that data and collaborate on industry research.

4.5.1 Data is collected to cost all benefits, options and key drivers of claims cost

Under benchmark practice, data is collected so that a granular understanding of the product's cost is available. This includes:

- Demographic information that is relevant to pricing;
- All the choices made by the customer when purchasing a policy, including features that don't attract a separate premium. This includes changes made by the customer after purchase or exercising options (such as buy backs);
- The version of the product, underwriting practices and claims practices relevant to the

7 Product lines includes the separation of income protection and lump sum benefits

experience on individual policies and claims associated with that version should be tracked; and

- Factors relevant to customer behaviour at and during claim should also be recorded including the replacement ratio and any secondary claim cause.

Under benchmark practice, the data is analysed to provide empirical evidence for product features and processes that positively or negatively affect sustainability. Benchmark practice is to collect data in accordance with a benchmark data specification that the Actuaries Institute will, in consultation with the FSC, publish from time to time.

4.5.2 Data is shared to facilitate industry research topics nominated by the Actuaries Institute

Good quality published research is required to promote sustainability of the IDII product. Insurers with inadequate data and/or insights may make poor decisions that in a competitive market can impact on all participants. Subject to appropriate data privacy measures that protect customer and insurer anonymity, insurers should contribute data for publication and research by credible third parties. In particular, data should be collected and provided to support research into topics selected by the Actuaries Institute as high priority (having consulted with the FSC and APRA).

4.6 Annual Sustainability Assessment / actuarial control cycle

Under benchmark practice, there is a process to at least annually bring together the pricing, reserving, experience & analytics, claims, underwriting and product teams to analyse, explain and agree actions to improve sustainability.

Under benchmark practice, the sustainability assessment addresses the following items at a minimum:

i. analysis of granular experience study results compared with the latest industry study results and pricing assumptions;

ii. experience variations in the insurer's profit & loss including detailed movement analysis of the disabled lives reserve compared with assumptions;

iii. analysis of experience against items in the variations register (see section 5.3) including linking any changes to the premium rate schedule to root cause issues in the insurer's Target State;

iv. review of assumptions and uncertainty detailed in CPS320 advices for at least the previous 5 years against emerging experience on the portfolio;

v. the outcome of claims case file reviews targeted at assessing the sustainability of product design, underwriting and claims practices; and

vi. actions to improve IDII sustainability.

5 Measurement of variations to the Reference Product and benchmark operations

The insurer's actual product design and operating model at any time may be different to the Reference Product and benchmark operations; i.e. there will be 'variations'. Some variations will reduce sustainability and other mitigants will improve sustainability. Under benchmark practice these variations are evaluated for sustainability under potential future scenarios (i.e. neither best estimates nor weighted by likelihood). The cumulative effect of variations are tracked over time.

5.1 Identification of variations

Variations may be a difference to core features of the Reference Product and benchmark practices or an 'add on' that may alter the claims cost of the product. Whether variations should be split or aggregated may be subjective. Under benchmark practices:

- A single variation would typically be associated with something that would be defined or described separately in the PDS to other product features; for example, the total disability definition may have a number of individual elements that differ from the Reference Product but it would be a single variation;
- Some variations may interact with each other and should be treated as separate variations; for example, the earnings definition and the maximum replacement ratio; and
- Some variations or a group of variations may have a partial mitigant to the likelihood or consequence of adverse claims experience. The mitigant should be recorded separately (and its link to the risks explained); for example, reducing the replacement ratio in calculation of sums insured exceeding $X maximum.

The benchmark approach to repricing rights are addressed under section 4.4.1 (pricing for uncertainty).

5.2 Impact rating of variations

Under benchmark practices, variations are assessed to determine whether each variation has low, medium or high impact on claims cost, assuming that uncertainty is realised. The aim is to assess the approximate relative (rather than absolute) importance of each variation to the benchmark and Target State. In addition:

i. The approach to assessing the impact of adverse variations and favourable variations / mitigants is the same;

ii. The benchmark or Target State may have mitigants that in the insurer's business are absent or ineffective and those mitigants are treated as variations that reduce sustainability; and

iii. there are metrics to monitor the ongoing effectiveness of all medium and high impact mitigants.

Under benchmark practices, each variation is evaluated assuming that an uncertainty scenario emerges[8] over 5 years (and stabilises thereafter) from inception of new policies and its impact determined by:

- using the examples in Appendix B as guidance;
- ignoring the likelihood of the change;
- representing a reasonable magnitude of claims cost from the uncertainty being realised relative to the benchmark. This would include consideration of one-off effects and changes in trends in respect of claims incidence and termination rates (including a dislocation between short and long duration rates);
- using professional judgement (rather than actuarial calculation) on the magnitude of impact; and
- not requiring historic statistical information to support the assessment.

This approach is intended to be relatively easy to implement and to facilitate discussion within the insurer on the most important sustainability issues.

5.3 Variations register

Under benchmark practice, each variation to the benchmark is documented in a 'variations register'. The table below provides an example of what may appear in the variations register.

Variation	Name of the variation
Description	Brief description of the variation and what sustainability risk it could introduce / mitigate
Type	Risk / Mitigant
Category	Product / Underwriting / Claims / Pricing / Data & research / Control cycle
Rating (L/M/H)	Low / Medium / High
Premium exposed to variation	Approximate proportion of the portfolio exposed to this variation
Target State rating	At target / To eliminate / Target level (L/M/H) / Premium exposure %

Under benchmark practice, the variations register is summarised in a table that is used to track variations to the Target State, as illustrated in the table below[9].

8 See section 4.4 for examples of uncertainty scenarios.
9 Variations rated 'at target' in their Target State rating would be excluded from the summary of number of variations and included in the sustainability scores.

Category	RAG status	Target State Sustainability score	Current State Sustainability score	Net number of adverse variations to Target State (numbers in brackets are from 12 months earlier)		
				#Low	#Medium	#High
Product design	A	90.5	84.0	13 (9)	0 (3)	0 (3)
Underwriting	G	93	97.5	1 (1)	1 (1)	–1 (2)
Claims	R	92.5	76.5	2 (2)	1 (1)	1 (2)
Pricing	R	79	64.0	0 (–1)	1 (1)	1 (2)
Data and research	R	72.5	56.0	3 (5)	1 (-1)	1 (1)
Control cycle	R	79	52.5	3 (1)	3 (4)	1 (2)

5.4 Sustainability scores

Under benchmark practice, the summary table above also contains a 'sustainability score' and 'RAG status' (red/amber/green rating) for each category. The current state sustainability score[10] is calculated using the net number of adverse variations compared with the benchmark as: 100 - (0.5 x #Low + 5.0 x #Medium + 10.0 x #High)[11]. The Target State sustainability score is calculated using the same method based only on variations for the Target State. The RAG rating is based on the value of the current state sustainability score (in accordance with a scale determined by the insurer and likely linked to the Target State sustainability score for each category).

Overall sustainability scores are calculated as the weighted average of the category sustainability scores using the weights: 25% / 15% / 15% / 15% / 15% / 15% for each category respectively.

10 Adverse variations have a negative effect on the sustainability score and effective favourable variations / mitigants positive.
11 Initial calibration work has been completed but further refinement of the weights may be required.

Appendix A: Summary of the Reference Product

The Reference Product has been designed to:

- meet the fundamental needs of a customer who wants financial protection against loss of income as a result of disability, pending return to work;
- be reasonably easy to understand, notwithstanding the inherent complexity of the issue of disability;
- have premium rates that are reasonably affordable and stable over the course of the policy; and
- follow sound insurance principles.

It is expected that the Reference Product, were it to be offered as a retail product, would be seen by consumers as a reasonable product at a reasonable price.

However, the purpose of the Reference Product is not to dictate the design of a retail product. Rather, its purpose is to provide a reference point to aid senior management, the Board and regulators in assessing risk and uncertainty for both customers and insurance companies. In other words, it is intended to assist an insurer in the prudential management of their individual disability income insurance product line.

A.1 Overarching philosophies

- The Reference Product is an indemnity contract, designed using sound insurance principles, both at inception and over the duration of the policy.
- The purpose of the Reference Product is to support the customer to Return to Work (RTW) to help shift the focus from how disabled the customer is.
- In addition to 'income support', actual expenses incurred can be reimbursed where consistent with the RTW purpose. Other than this, there are minimal ancillary benefits.
- Terms and conditions should be updated over time to remain contemporary and respond to evolving society needs, for the benefit of consumers.
- The Reference Product is intended to support longer term product affordability.

A.2 Key Product Elements

A.2.1 Total Disability Definition

First 2 Years:	Unable to perform the customer's 'Own Occupation'
Beyond 2 Years:	Unable to perform work in any occupation for which the customer is reasonably suited by education, training or experience (i.e. an 'ETE' occupation definition).
All Periods:	The customer is required to comply with the insurer's and health professionals' reasonable requests to participate in rehabilitation and/or retraining. Reasonable job modification is expected if it will allow return to work.
Excluded:	The above definition is different from the current common '3-tiered' definition and does not include hours-based and income-based definitions. The definitional focus on inability to perform work means benefits are not paid simply because appropriate work is not available in a particular location. Retraining is specifically designed to facilitate appropriate return to work.
Whole Person Permanent Impairment (WPPI) test:	a Whole Person Permanent Impairment Test may be used as a tool by the insurer to help assess long term disability after the disability conditions have stabilized (that is no further improvements are expected, usually after about 2 years).

A.2.2 Basic Sum Insured – Income Replacement Ratio (IRR)

Long Term:	The long-term maximum IRR is calculated as follows (in 2020 dollars): • 60% up to $240,000 p.a.; • 40% of the next $240,000 p.a., and • 20% of the next $480,000 p.a. (nil thereafter).
Super:	Super Guarantee contributions can be insured in addition to the long-term IRR but claim payments are paid directly into a complying superannuation fund (not paid in cash to the policyholder).
6 Month Top Up:	An additional 25% percent of the long-term IRR scale (e.g. 60%x1.25=75% up to $240,000 p.a. income) can be payable for a maximum period of 6 months. This supplement is to be payable only if the customer is meeting RTW objectives, reports claims within 12 months of the date the disability was incurred and collaborates with the insurer in seeking ways to return to work.

A.3 Partial Disability

Definition:	The customer has reduced work capacity due to injury or sickness.
Eligible:	When the customer earns a 20% reduction in their 'insurable income' due to reduced capacity to work.
Benefit Ceases:	When the customer has 80% or more capacity to work OR if the customer is capable of working 32 hours of work per week.
Waiting Period:	Must be served in full.
$ Payment:	Total Disability Benefit (pre offsets) – 75% x current earned income while partially disabled – 100% x offsets

A.4 Income Definition

Basic Insurable Income:	income from personal exertion from the customer's main occupation.
Passive Income:	Is not insured.
Self Employed Adjustments:	Income is after business expenses have been incurred and before tax. Benefit relates only to the true personal exertion component of the customer's income (and not any 'profit' element). For example, for customers who can replace themselves with a contractor while they are ill, and retain the business profit flow, the contractor's cost reflects the insurable income amount.
Income Period:	Income over the previous 12 months. In the first twelve months of a policy (after issue), insurable interest is limited to the actual average monthly income of the customer from the date of policy issue. In exceptional circumstances, a different period for averaging may be considered, but it must be 'unbiased' (e.g. it will not be higher of averages over two different periods). Reflects a maximum of 40 hours of work per week (consistent with claim payments).
Atypical Income:	Infrequent or atypical amounts are excluded. For example, variable annual bonuses should only be counted where there is a genuine history of their payment but not exceeding a reasonable, modest limit (e.g. 20% of regular income).

A.5 Benefit Offsets & Income Tax

Tax: The insurer deducts the expected tax from the benefit before payment to the customer[12].

Where benefit payments are not expected to be subject to income tax, the basic sum insured (and related IRR) is reduced to ensure a relationship consistent with the intentions of the basic cover.

Offsets: Any benefit payable will be comprehensively reduced for the effect of other 'disability income support' payments received by the customer, such as sick leave; workers compensation; other similar income replacement insurance payments; disability support pension or other social security payments.

A.6 Indexation

Benefit Indexation: No automatic indexing of cover. Increase of cover is an option, provided evidence for the insurability for the increased cover is provided by the customer.

Claims Indexation: No automatic indexing of claim payments. An option for indexation of claims payments may be purchased, with the indexation limited to CPI until age 55 and CPI less 2% after age 55.

A.7 Parental Leave & Sabbatical Adjustments

Definition: Eligibility for the 'own occupation' provisions of the total disability and partial disability definitions only apply for the first 3 months of claims payments (i.e. any ETE applies from 3 months);

Cover Suspension: Benefits are suspended from 12 months until the customer returns to regular employment.

A.8 Benefit Periods & Waiting Periods

Max Ben Period: To age 60 [Seven years before 67, the current full age pension entitlement][13]

Waiting Periods: Between 30 and 180 days.

Waiting periods of greater than 180 days are considered to be inconsistent with a Return to Work purpose

12 This may require legislation change to enable
13 Very long benefit periods such as 30 years are considered incompatible with a Return to Work purpose.

A.9 Updating Contract Terms at regular intervals

Financial Underwriting: The customer is required to update income, occupation and pastime every five years, but not health evidence. This updated information may be used to adjust premium rates.

Product Terms: the policy terms and condition can be updated every five years, subject to the customer being treated fairly at the five year roll-over.

A.10 Recovery management plan, rehabilitation, retraining

A recovery management plan is central to the Reference Product, being a Return to Work product, and may include rehabilitation and retraining program.

The customer is expected to actively participate in the recovery management plan including rehabilitation and training, in order to receive benefits.

A.11 Ancillary Benefits

The Reference Product has limited ancillary benefits in order to maintain simplicity and insurable interest. Where ancillary benefits are offered, they relate to an expense incurred or a need. For example:

Premium waiver: Yes.

Reimbursement of Costs: Unexpected costs incurred as a result of the cause of disability (e.g. medical and rehabilitation costs) will be met[14].

Other: None.

A.12 Coverage for all causes of claims

Access to benefits is not restricted for any cause of claim.

The decision to pay a claim rests with the insurer, but using the medical assessments made by a suitably qualified medical practitioner – for example an occupational specialist can determine work capacity, as opposed to a general practitioner. Medical conditions will be diagnosed by an appropriate accredited specialist (e.g. certain mental health claims to be diagnosed by a Psychiatrist or other appropriate accredited specialist).

14 Under existing law, payment of medical costs are not currently allowed to be paid by a life insurer.

Appendix B: Example impact rating for variations

This appendix details the likely impact rating for various medium and high variations. It is neither an exhaustive list nor are the ratings absolute. It is important that rating of the impact of the variations is consistent between variations. As such, the lists below are also intended to aid the insurer assessing the impact of variations not listed below.

B.4.1 Product design

Variation	Description	Rating
Replacement ratios greater than Reference Product	Above Reference Product replacement ratio reduces incentive to return to work.	High
Benefit periods greater than to age 60	Longer benefit periods increase the incentive to early retire rather than return to work	High
Broad total disability definition	Each additional tier of total disability definition counts as an additional variation.	High
Product terms are not updated every 5 years	Terms and conditions are not kept contemporary and consistent with community expectations.	High
Guaranteed premium rates	Unable to alter pricing to reflect any unexpected changes.	High
No step down at 2 years	Absence of switch to ETE at 2 years reduces the financial incentive to strive to return to work.	Medium
Superannuation benefit paid as cash	Above Reference Product replacement ratio arising from payment of superannuation benefit as cash.	Medium
Partial benefits disincentivise return to work	Partial benefits do not cease at 80% capacity or 32 hours per week and disincentivise return to work.	Medium
Partial benefits without total disability	Partial benefits are payable prior to the end of the waiting period and total disability.	Medium
Income definition greater than 12 months	Income definition is 'biased', is not based on the previous 12 months at time of claim or reflects more than 40 hours per week of work.	Medium
Generous treatment of other income	Income definition includes significant 'atypical income' or benefits are not reduced to offset other benefits (such as sick leave).	Medium

B.4.1 Product design continued >

Variation	Description	Rating
B.4.1 Product design continued		
Indexation results in over insurance	Sum insured indexation prior to claim results in higher replacement ratios or claims in payment indexation create a disincentive to return to work.	Medium
Over-insurance when not working	Benefits are not reduced when the life insured is not employed for a period of time (see A.7).	Medium
No consumer testing on PDS	Poor understanding by the consumer of the product's terms and conditions because the PDS has not been consumer tested and written to promote understanding.	Medium
Poor promotion of transparency on the product	Limited information published to help consumers understand the operation and value of the product and its various features.	Medium

B.4.2 Underwriting practices

Variation	Description	Rating
Inadequate underwriting resources	The underwriting team has inadequate capacity or breadth of experience and/or specialist skills to effectively underwriting in accordance with benchmark underwriting practices.	High
Inadequate financial underwriting	Financial underwriting doesn't meet benchmark practice; allowing combinations of lump sum insurance (TPD, trauma), IDII sum insured and benefit period that result in aggregate cover above insurable interest. Failing to consider other living benefits at underwriting.	High
Passive income is allowable	Financial underwriting does not seek comprehensive information on and/or comprehensively allow for the effect of passive income or 'profit' elements of a business in assessing insurable interests and needs.	High
Financial underwriting not updated regularly	Financial underwriting is not repeated to update occupation, income and passive income impacts at least every 5 years.	Medium
Lack of established income history	Allowing sums insured based on income amount with limited history, and/or not considering employment history (and changes in employment, income, etc)	Medium
Narrow occupation definitions	Narrowly defined occupation definitions that enable claimants to opt to 'early retire' rather than change to a similar occupation	Medium

B.4.3 Claims practices

Variation	Description	Rating
Claims practices and resources subject to regular change	Frequent significant changes in claims practices and/or claims staff responsibilities.	High
Inadequate claims resources	There is insufficient claims resource to reliably service customers and meet benchmark practice.	High
Insufficiently skilled staff	Claims staff has inadequate skills to assess the claims and instead rely on GPs or other factors in their assessments.	High
Insurer 'delegates' claims decisions	The claims process relies on 3rd parties to determine the eligibility of the life insured to claim.	High
Failure to set return to work or recovery plan	Claims managers do not set return to work expectations in accordance with benchmark practice	High
Limited rehabilitation support	The insurer provides rehabilitation support on a limited basis to assist the claimant back to work.	Medium
Overly simplistic claims practices	Claims practices do not adequately incorporate Bio-Psycho-Social factors when triaging and managing claims	Medium

B.4.4 Pricing for uncertainty

Variation	Description	Rating
No philosophy on optimistic pricing	The insurer doesn't have a documented approach to pricing for uncertainty or it doesn't require that optimism is removed for 5 years.	High
Not using the latest industry tables	The insurer is not using the latest industry table (unless there is a strong empirical reason not to do so).	High
Not applying credibility theory to assumption setting	Absence of a documented approach to credibility in assumption setting.	High
Optimism in historic trends	Approach to allowing for a repeat of historic trends into the future is optimistic / without empirical rationale.	High
Optimism in best estimate assumptions	The best estimate assumptions rely on experience relative to the industry without a credible and sustainable rationale.	High
Inadequate shape in termination assumptions	The shape of duration based terminations assumptions is not empirically justified against the industry table.	High

B.4.4 Pricing for uncertainty >

Variation	Description	Rating
B.4.4 Pricing for uncertainty continued		
No Board approved pricing philosophy	The insurer doesn't have a Board approved pricing philosophy that covers the issues in section 4.4.2.	High
Customer factors in repricing not articulated	The pricing philosophy does not clearly articulate how the insurer intends to exercise its repricing rights and balance that with pricing for uncertainty (see section 4.4.2).	High
Profitability is short of target minimum requirements	Profit (on a fully allocated basis) does not meet the insurer's target minimum requirements	High
Cyclical effects inadequately priced	Cyclical effects are not fully allowed for in best estimate assumptions	Medium

B.4.5 Data, experience investigations and research

Variation	Description	Rating
Inadequate data collection	Claims and policy data meeting the Actuaries Institute standard is not collected on a timely basis or not subject to effective data quality and governance standards.	High
Data is not collected on claims processes	Data is not collected on the main claims practices applied to each claim and thus it is not possible to measure effectiveness and improve processes in future.	High
Data at time of claim is not collected	Data related to salary, self employed vs employed status, biometric and secondary claim cause features is not captured.	High
Infrequent experience investigations	Detailed experience investigations against the latest industry table are not conducted at least annually	High
Data not shared annually	Claims data is not shared with the FSC experience studies program within the published timeframes of the FSC.	High
Published research is not promoted	The published research priorities of the AI are not actively supported by the insurer.	Medium

B.4.6 Annual sustainability assessment / actuarial control cycle

Variation	Description	Rating
No formal cross functional team forum	A cross functional team does not meet at least annually to formally consider emerging experience and agree actions to improve sustainability.	High
No sustainability reporting	The cross functional team doesn't produce an annual sustainability assessment detailing its analysis of the product's performance.	High
Limited actuarial control cycle	There is an incomplete actuarial control cycle linking experience investigations, assumption setting and financial results.	High
No claims case file reviews	There is not a regular and 'right sized' claims case file review process to identify product and process improvements designed to improve sustainability.	High
Inadequate governance practices and feedback	Insurance frameworks and policies (product, pricing, claims, underwriting, data) are not in place, not updated regularly or not subject to regular feedback loops based on experience.	High

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