retender

THE SUSTAINABILITY FALLACY

If you've ever owned a fridge for long enough, you will have experienced the day where something breaks and you are faced with the question of repairing or replacing. Repairing is almost always cheaper but the dilemma is how to work out the number of future repairs needed as other components (perhaps even the same ones) break. Every so often, the repairer honestly calls out that you are going to be in for a lot more long-term to try keep the old fridge than go and buy a new one.

Added to our natural scepticism as consumers is the inherent conflict of interest for the repairer who does not make money if you choose to replace the fridge rather than repair it. At the same time, he wants to make the most money he can and must play a careful game judging at what point the quote will cause you to buy a new fridge instead. He also must factor in whether the fridge is repairable as it is costly if you come back with problems with the repair. What would happen if instead of a quote for that single repair, the repairer was obligated to provide and honour a quote for all future repairs?

The subject of this paper is whether the the life insurance model in Australia can be repaired or whether it needs to be replaced. In particular, what is the long-term impact of the market's recent losses and capital calls on future premiums and at what point, no matter how much of a vested interest consumers have in their fridge, is it time to start fresh and accept we've made a bad buy.

Part 1 of the paper explores the fallacies or heuristics that we take as certainties but may be wrong. Part 2 then explores some options on how to move forward to add to the market debate.

THE 30 SECOND STORY

This paper challenges the assumption of whether the current life insurance model can ever be sustainable. Losses are far worse than being reported and the industry may be locked into a deteriorating spiral.

One way of moving forward requires agreeing some clear principles of the future business model, potentially including:

- Stop talking about losses year after year – re-capitalising once;
- Hedge the insurance risk – reduce volatility;
- Separate new business and the backbook – move the backbook into run off;
- Go further than the minimum product requirements – reduce replacement ratios, reduce benefit term and remove stepped products;
- Develop a clearer picture of future trends – start again without an anchor;
- Better align behaviours with long term outcomes – ultra long-term remuneration and upside for life insurance executives; and
- Be honest about the uncertainty for customers – communicate they could be seeing 20% p.a. increases for the next 7-10 years.

New business faces fewer regulatory obstacles to finding a fix but the challenge remains on how to deal with the backbook. The silver bullet of government intervention is needed more than ever before but in the absence of a legislated solution, some extreme actions are needed to protect consumers.

The losses are worse than being reported

Recent APRA statistics to December 2019 paint a bleak picture of industry profitability:

Table 1 - Risk product net profit after tax for the life insurance industry in the year ended 31 December:

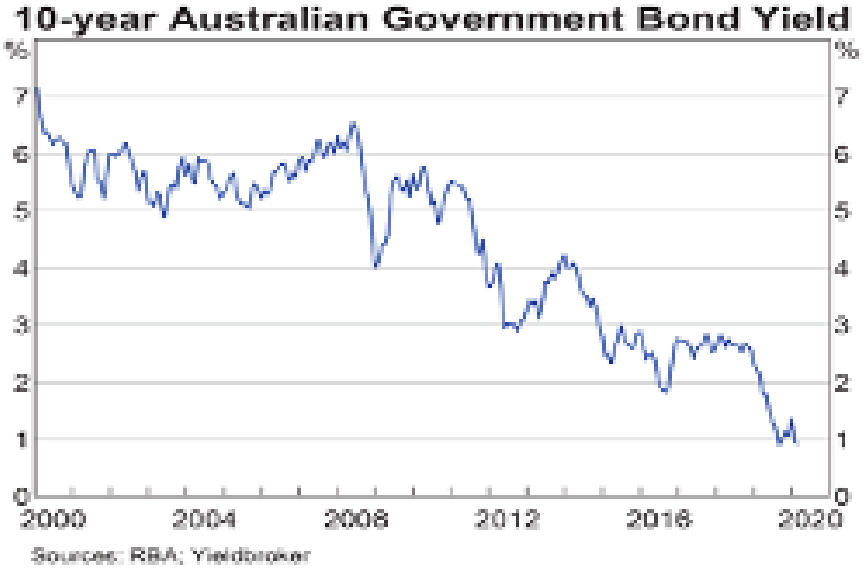
Risk product	Dec-18	Dec-19	December 2019 quarter only
Individual lump sum	495.2 million	648.3 million	-120.9 million
Individual disability income insurance	-567.1 million	-1,467.4 million	-701.2 million
Group lump sum	93.6 million	-206.5 million	-203.3 million
Group disability income insurance	12.4 million	-262.8 million	-125.3 million

Source: APRA Quarterly Life Insurance Performance Statistics

For the 12 months to December 2019, risk products reported a combined after-tax loss of $1.3 billion. However, these numbers are understating the true extent of the losses incurred by the industry. Reinsurers are able to retrocede risk (as much as 50%) to their global parents or other overseas reinsurance entities. Losses on retroceded business are not incorporated into the APRA statistics, meaning gross reinsurer losses could be double that reported. Further, the retrocession capacity does not have to be filled uniformly across business lines – for example, more can be allocated to disability income than mortality. Retender estimates a truer estimate of industry losses for 2019 might be closer to $1.7 billion, and potentially even higher as reinsurers hold a greater weighting to DI.

A significant driver of industry losses on disability income business over the last 5 or more years has been falling interest rates. That alone is alarming as it points to a challenge in asset liability matching strategies, a topic worthy of further exploration in its own right. In the last quarter of 2019 however, interest rates rose meaning investment experience would have been positive over the quarter. The implication is that claims experience is worse than suggested by reported industry losses as they were partially masked by positive investment experience. And the RBA reducing interest rates this quarter suggests more bad news to come all else being equal.

Table 2 – 10 year government Bond Yield



We should also note that this was the first quarter in over 10 years of data where individual lump sum profitability was negative meaning that the common wisdom that 'the overall individual experience cross subsidy means on average we are ok' may not be relied upon going forward.

Added to these experience changes and write-off's are the recent APRA requirements for a Pillar 2 capital adjustment. APRA is requiring all life companies to hold additional capital. Retender estimates this could add an extra $1 billion in capital (at least) to be serviced by the industry, which is required to be in place by 31st March 2020.

These costs will need to be recouped. Shareholders are unlikely to have appetite for returning to profitability over the traditional long tail of insurance policies and the spreading of this cost may need to be accelerated over a shorter timeframe than the average term of the book.

APRA has suggested that the supervisory adjustment can be reviewed downward for each insurer where there is a 'demonstration of sound and timely progress in meeting APRA's expectations in respect of the key focus areas in the May 2019 letter; and sustained improvement in financial performance as a result of better practices in management and control.' However, given insurers can't implement rate changes of this magnitude in a short time period, it is possible the Pillar 2 adjustment could be sustained for a number of years.

The sum of the parts

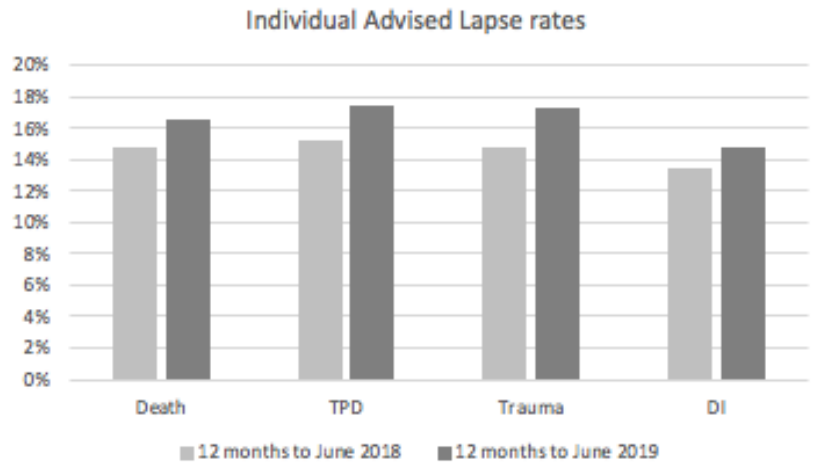
The operating environment has three other components where the interaction between them creates additional headwinds:

- **Expenses** for insurers have significantly increased due to increased business change requirements, increased data gathering, regulatory change, merger activity and additional risk controls. In themselves, these are positive developments for consumers but they need to be considered in the context of the current industry cycle. Further, the expense allocations of insurers will be seeing an increasing amount of costs being attributed to maintenance expenses rather than acquisition as new business drops. The allocation of expenses between acquisition and maintenance directly impacts the profit margins due to the way that policies are valued; this reset of expense mix in line with changes in business activity will further reduce margins (or losses will grow further) if insurers don't cut costs or increase the top line.

- Falling **revenues** across the segments, driven by falling sales in individual segments, reduction in direct (fallout from the Royal Commission) or falling premiums in group (legislation effects but also re-weighting spend towards retirement) all put pressure on expense margins and overheads.

- **Lapse rates** have increased as premium rate changes are being put through in the individual segment.

Table 3 – Lapse rates for individual advised products



Source: APRA Life Insurance Claims and Disputes statistics

The effect of these factors have (hopefully) been booked into the prior year but the combined pressure of falling revenue, customers exiting and higher expenses all point in one direction for consumer premium rate changes.

Fuel on the fire

Moving from the revenue line to the claims line, 2019 saw the introduction of two significant pieces of legislation in the group insurance space. Protecting Your Super (PYS) and Putting Members Interests First (PMIF) both have had the effect of requiring a significant increase in communication with members to explain the changes that would lead to some members automatically being defaulted out of cover unless they opt in.

As a direct result of PYS for example, implemented in July 2019, the industry saw a spike in claims notifications in the middle of the year. One of the core challenges for actuaries is determining whether such spikes are one off events (a one off acceleration of claims and therefore unlikely to happen again) or part of a sustained increase in claims that requires a trend cost to be incorporated (as a result of an increase in awareness of benefit entitlements by members).

2013 and 2014 provides a lesson on the impact of step changes in an industry. Around this period there was a significant increase in late notified claims that rightly frightened the industry into expecting the tail risk for TPD was far longer than anticipated. Claims were being notified as long as 15 years after the event. Australian Life Insurance has no sunset clause on eligibility to claim, made even more complex by claims assessors having to assess those claims as at the date of event (15 years earlier, for example). Increased awareness, supported by fund communication and plaintiff law firms, helped members who hadn't claimed realise that they may have been eligible. Although many industry pricing actuaries were confident that there was an element of a one-off spike, it would take a very brave actuary to make this call at the time without the data to show the spike was temporary.

Fast forward 7 years and the industry is observing a similar tick up in group claims on the back of increased awareness. With the experience, data and lessons from the last spike available to us, despite the contagion effect of losses in some of the segments, actuaries should factor in treatment of this spike in a way that recognises that this may not be a step change.

Unintended consequences of the Royal Commission

In 2018, Retender predicted in a report titled 'The cost of consumer expectations' that life insurers and superfunds faced eight new trends as a result of the Royal Commission that could cost the industry $1bn. Unfortunately we were wrong - the impact was even worse than predicted.

With claims declinature data now available, one year on, we can observe how one of those trends for example (pressure on life companies to pay "grey" claims, called the 'Orr factor') have started to play out in practice.

Table 4 – change in declinature rates from June 2018 to June 2019 – Retail advised

Period	TPD	Trauma	DI
Aggregate declinatures - June 2018	15%	15%	6%
Aggregate declinatures - June 2019	15%	13%	5%
Aggregate estimated additional cost ($000)	516	-25,727	-26,531
Insurer - largest change in segment ($000)	-69,350	-10,201	-10,520

Source: APRA Life Insurance Claims and Disputes statistics

At an aggregate level, declinature rates have reduced for Trauma and DI policies, costing the industry a further $50m in one year alone. However once we dig into the individual entities, we observe that the variance tells a different story. For example, in some cases there have been double digit (absolute) changes in the reduction in declinature rates assuming the data was accurate when reporting to APRA. One insurer for example has reduced their declinature rates to such an extent on TPD that this alone may have increased their claims cost by $70m. Product change might be driving some of this change but no doubt some insurers are feeling the pressure more than others to admit claims.

This trend is unlikely to reverse any time soon. Claims managers will remain under pressure (including from AFCA and the broader system) to accept more claims as the industry continues to grapple with the recent reputational damage emerging through the Royal Commission.

Winners and losers

From a shareholder's perspective this is bad news. A number of acquisitions have taken place which in hindsight are potentially far more costly than expected and – more worrying from a prudential and product sustainability standpoint – it is conceivable a point will come when shareholders (many of whom are overseas) will refuse to continue injecting capital when the long-term outlook for those products fails to satisfy return on investment requirements.

From a policyholder perspective, the situation is the opposite. Every time the industry announces a record loss, the beneficiaries of this in the short term are the policyholders. ASIC is currently reviewing the value of insurance within superannuation, but even before their report comes out consumers can easily be shown to have been the primary beneficiary of life insurance losses over the last 5 years. This is even clearer in individual business where disability income insurance has been unprofitable for most of the last decade. Whilst this highlights the value delivered to policyholders, these losses will impact the viability of the remaining risk pool who will ultimately need to absorb the cost as premiums increase.

Distribution is one stakeholder that may benefit. With significant increases coming, financial advisors will need to relook at their clients' portfolios with a view to radically changing cost. They may also target disgruntled other clients who are frustrated with rate rises. The challenge is, based on anecdotal input, whether the value equation gets tipped over when consumers are considering whether to reduce coverage or stop life insurance altogether in response to a rate rise. Superfunds in contrast went through a period of little competition while their rates have been reviewed for PYS and then PMIF, as the entire market was having to reprice in less than a year and there was no scope to run tenders. This led to funds being price-takers due to limited resource bandwidth, though some are running tenders presently and testing the market. The governance requirements and focus on member best interests drives regular benchmarking of rates, and it will be interesting to see how the recent limited competition under PYS and PMIF versus the deteriorating industry claims experience plays out in the next round of rate reviews.

What are we in for?

There is a limit to how much a life insurer can increase rates in one go. Insurers need to carefully balance the trade-off between what can be charged to policyholders and at what point, like the choice of buying a new fridge, those policyholders will lapse their policy and walk away. The issue is compounded because the greater the increase, the more likely the healthier policyholders leave and unhealthier (or higher risk) policyholders remain. This is known as selective lapsation, where the insurer is exposed to the pool deteriorating if they play the increases poorly. In addition, reinsurer rate increases for DI are not always aligned with the increases that are directly passed onto policyholders which may for some insurers mean 'stored up' reinsurer rate increases have not yet been put through for consumers.

Under the current stepped policy structure, each year those policyholders are going to have to be charged an increase for their older age (premiums increase with age) as well as, for many policies, an increase in cover for CPI. This may well be of the order of 10% per annum that an individual policyholder is already in for at the start of a stepped policy.

Assuming that there is a natural cap on how much can be passed onto policyholders each year (20% say), and a time limit on patience by owners for restored proftiability, we estimate that DI policyholders might be expected to have a **20% increase in premiums coming through for at least each of the next 7-10 years** (or successive years of different increases such as 10% and 30%).

Imagine if your phone provider, home loan provider or fridge repairman increased costs 20% or more every year. And they and you knew this was coming. Clearly there would be severe consequences with customer attrition and complaints. How life insurers respond to this scenario therefore requires new thinking before policyholders exit on mass, which will impact the insurance brand far more broadly than just on DI products.

This also assumes healthier lives continue to hold their policies. The greater the rate increases, the greater the risk of selective lapsation – and unhealthy lives are likely to remain no matter the cost, sending rate increases into a continuous spiral through to the time the last policy exits.

In the US we can look to a case study where insurers (and reinsurers) were faced with a similar challenge on mortality products due to the product design and recognised this spiral risk. Insurers balanced (optimised) the level of increase required against the potential worsening impact on mortality experience which dramatically led in some cases to writing off a portion of the theoretically required increase in a bid to retain more healthy lives in the pool.

The irony is the belief that reviewable policies would be less risky for insurers has proven to be just the opposite – a fallacy.

The race to get in before the gates close

In the lead up to the industry stopping agreed value DI policies, there may be a surge of sales of these products before the gates close. Whilst appearing in the policyholder's best interests, one has to question whether this risk pool will have an even more disproportionate level of increases being required over time. Equally, it may be better for insurers to stop selling these policies immediately to avoid adding to the pool, a bit like a tax change commencing immediately to avoid gaming of the system.

What are the implications of shutting products to new business? We can look to overseas markets for examples where products have been exited. One such case study is from the UK in the early 2000's where reinsurers (and then insurers) exited guaranteed trauma products due to sustainability questions arising from pricing failing to adequately factor in the risk of long term medical advances. Some insurers left it too late and were faced with the headache of whether to honour their applications or go back to advisors that these couldn't be processed. In one case, an insurer chose the latter, burning their advisor relationships for a number of years thereafter - a very real example of reputational damage. It's worth noting the difference with the UK in that once written, the premiums were guaranteed so advisors were correct to try and lock in prices and the products before the world changed. In Australia in contrast, locking in the product might be locking in that policyholder to years of rate increases.

Another dimension to this change event relates to whether product terms are being strengthened or weakened. There are examples from the group market where tightening has had the perverse effect of shifting claims into prior periods where the terms were more generous (witness shifting of lump sum into income streams or changes to benefit levels or definitions). Although APRA has helped the industry overcome the first mover disadvantage, the execution of these changes is critical. It's likely that industry will see a flurry of claims activity in prior periods which on the face of the data will appear as yet another uptick that will flow through into policyholder future claim expectations.

Capital is not free

In the midst of volatile market conditions due to the Covid-19 virus whereby pressure is now on the asset side of balance sheets too, it's not as simple to believe that insurers can be recapitalised. If you've recently purchased an insurer for example and then find that you effectively have to put in even more, there may be a natural reticence to commit further capital until you are clear that the balance sheet has stabilised. That or be prepared to dilute ownership.

Added to this, any capital raising is inefficient in that insurers will be buying at the top of the cycle. Arguably this becomes a buyer's market but balancing this, insurers will need to consider carefully whether they are giving away their assets too cheaply owing to the cycle.

The contagion effect

Experience losses and raising of capital are leading towards a significantly hardened market in some segments. Within this environment, along with price changes, risk appetites shift. The implications for the clients of insurers and reinsurers (advisors and superfunds) needs to be considered and well managed by these stakeholders as well as raised in risk levels within the respective distribution outlets.

With the balance of appetite shifting, superfunds in particular need to ensure that competitive tension is being maintained for their members, whether through tenders or having alternative operating options to manage through the cycle. Limited capital will lead to more selective opportunities but the good news for buyers is that insurers do want to grow, particularly in light of recent reductions in revenue due to the legislative changes. Balancing competition with risk appetite should be a core focus going forward.

Part 2 - looking forward

The starting point to move forward effectively is to consider the lessons learned and understand why this occurred, to avoid a repeat. The root of the challenge lies, in the author's opinion, in two core aspects.

The first is mispricing – the industry failed to consider all the emerging trends when developing the insurance proposition. In its defence, no one has a crystal ball but we charged too little and failed to appreciate emerging changes that necessitated changes to risk appetite and the costs of continuing to offer more generous product terms.

The second core driver has its roots in behavioural finance: overconfidence, bias, cognitive dissonance, herd behaviour and anchoring. Whilst not the topic of the paper and frankly there is little appetite for participants to explore all the reasons for what went wrong while the situation is raw, the market did not behave rationally as expected. Insurers and reinsurers kept writing loss making business year after year, aware of the cross subsidies yet ignoring them in a bid to maintain revenue and/or market share.

Stories about 'glide paths' and 'avoiding first mover disadvantage' could become business school studies. As could the study of conflicts of interests – for example, how might insurers with long tail business capitalise significant losses whilst still retaining the confidence of shareholders? The retail market might look back at how group insurance was able to take its medicine back in 2013 in contrast to their slow bleed of not being able to raise prices by enough or change terms and conditions.

One piece of clarity is that everyone got morbidity benefits wrong and far from assigning any blame, the story of how the industry works together to replace the fridge needs to be the case study we are all ultimately left with when the dust settles.

We also need to factor in the lens of time and perspective. In the same way that life insurance is a long-term contract, we might consider viewing the life insurance system outcomes with the same longer-term lens. Zooming out from the last few years of losses, we can observe for example that premiums for mortality products have fallen over the last 50 years as the population is living longer, and cover levels have significantly increased. Australia is now ranked 6th in life expectancy at birth in the world, the working population all have some form of life insurance through Super and no life company has ultimately failed in Australia. The potential for the Covid-19 pandemic should provide consumers with a real reminder (and marketing opportunity) of the value of having life insurance. On a long term measure, the industry has done well.

Table 5 – Without Profit Assurances – 1970 study

Rates of annual premium (excluding policy fee) for $1,000 sum assured.

Age next birthday at entry	Endowment assurances maturing at age 60	Whole of life assurances
(1)	(2)	(3)
	$	$
20	15.1	9.7
30	23.1	13.2
40	39.8	19.3
50	91.4	29.6
60	-	47.7

Source: John Kent, Individual Life Insurance Policies - their profit to shareholders. Note includes a surrender value.

So, how can we move forward? If it was that simple this would have been done. But perhaps highlighting some principles to consider would offer insights into how one might approach the challenge differently. We also explore some examples of how this could be achieved in practice. Note that Retender doesn't presume to know the answers but rather seeks to offer some input into the very raw debate on the industry's next steps.

Re-capitalise once

Principle: Stop talking about losses year after year

The slow bleed each year of sourcing new capital or having to capitalise losses needs to stop. Appointed Actuaries and CFO's should be encouraged to take a once off hit to profitability by considering the worst-case scenario for these legacy blocks in particular but for any other transactions won on ultra-competitive margins. To be fair, it's possible that many Boards have applied this thinking already and thought they had allowed for the worst-case scenario, until an even worse-case scenario emerged.

Reinsurers, with little brand risk, are more inclined to take this kind of aggressive approach to managing their portfolio's and perhaps there are some lessons here. APRA's supervisory adjustment is one step towards recapitalising the industry but arguably insurers will need to source capital far in excess of the traditional prudent approach.

Another case study is to consider US insurers and reinsurers experience with post level term products. The assumption about the level of renewals at the end of the initial term as well as the resultant mortality (the selection effect) emerged to be wrong. And as a result of them reporting on a GAAP basis (where effectively capitalising long term losses was impossible) they suffered a continued drain on earnings each year as experience emerged out of line with what was priced. It may be better for the industry to all take the maximum one-off hit to the balance sheet to ensure that we do not discuss losses each year going forward.

Reduce volatility

Principle: Hedge the insurance risk

One route that will likely emerge over the next few years will be the extent to which reinsurance can be utilised to support the raising of additional capital. As opposed to a public capital raising, this can be done both quickly and privately to shore up capital required.

Reinsurers also provide an example of the mechanics of solvency risk being managed whereby in 2013 and 2014, a number of local reinsurers effectively would have breached their solvency were it not for a phone call to their parents requesting transfers of capital overnight. The market was shown to be well functioning through this period where despite the losses, there was no market failure.

The other key area of reinsurance support will emerge in how much risk is ceded. In the UK market, some treaties pass on close to 100% of the risk to the reinsurance market. This is driven by competitive pricing but due to the guaranteed nature of products sold, it actually offers insurers a way to lock in their profits on the policies on day 1 at the same time as reducing (or removing) insurance risk. This frees them up to manage the services and lapse risk but context again is critical when comparing other markets in that most premiums are level and hence lapse risk reduces over time as contrasts with the stepped structure in Australia.

One interesting analysis of value decision making would be to compare the volatility of results of insurers who are significant buyers of reinsurance against ones who prefer to retain risk. Arguably Boards should have a level of tolerance set for the volatility of their underwriting results and reinsurance provides the cleanest mechanism to manage against this tolerance. The treaty structure, commerciality of the arrangements and how this links with the Risk Appetite Statements of insurers need to be rethought to ensure alignment with shareholder and policyholder expectations.

Move legacy into run off

Principle: Separate new business and the backbook

Recognising that the underlying business model is flawed is a core heuristic (belief) that is required as a starting point. If we move into a mode of replacement, we accept that we've built an unfixable structure and instead focus on the rebuilding.

One option is to put legacy businesses into run off (one reinsurer has moved in this direction) and instead behaviourally invest in rebuilding a brand-new business proposition. Or alternatively split the legacy and new businesses up completely where the one can't interfere with the other.

What this might mean in practice is that decisions about the backbook would be completely divorced from thinking about the frontbook else the legacy remains and propositions cannot move forward. Imagine if the backbook were to be sold to a third party and how might this business be managed without this dragging the new business proposition. The suggestion is not as important as the principle but unless they are separated, the juggling act of an unsustainable legacy business could continue to cloud all new business structuring. And within such an environment, any new life insurer can enter and pick off the legacy providers with ease.

Going further than enough

Principle: Go further than the minimum product requirements

APRA has proposed a number of product changes as part of its letter to industry.

With effect from 31 March 2020, APRA expects that:

- *life companies discontinue writing DII contracts where insurance benefits are not based on income at time of claim, including agreed value (and endorsed agreed value) contracts.*

With effect from 1 July 2021, APRA expects that:

- *Income at risk for all new IDII contracts be based on annual earnings at the time of claim, not older than 12 months.*
- *Insurance benefits do not exceed 100 per cent of earnings at time of claim for the first six months of the claim, taking account of all benefits paid under the IDII product as well as other sources of earned income; and after the initial six months, insurance benefits are limited to 75 per cent of earnings at time of claim (subject to a dollar maximum of $30,000 per month).*
- *The initial contract is for a term not exceeding 5 years; and there is a right for the policy owner to elect to renew the contract for further periods (not exceeding 5 years) without a medical review on the terms and conditions applicable to new contracts that are then on offer by the life company. Changes to occupation and financial circumstances should be considered on renewal.*
- *Insurers have effective controls in place to manage the risks associated with long benefit periods (e.g. having a stricter disability definition for long benefit periods); and set internal benchmarks for new IDII products with long benefit periods which reflect the risk appetite and the effectiveness of the controls.*

One challenge is whether this goes far enough. Aside from the challenge of how to balance the regulators role in 'designing products' and then enforcing themselves as a 4th line of defence for risk management (a position no doubt they have had no choice to play), industry might consider taking this even further and building future products that accept the failure of the historic structures.

Three examples, each more extreme than the other, could be considered:

- For retail DI, require insurers to only be able to offer for example a 50% replacement ratio after 6 months with significant capital charges if insurers wish to go beyond this threshold. It's worth noting that the cost of a true 50% replacement ratio product is not 2/3rds (50%/75%) of the 75% product as behavioural changes on claim significantly lower the cost disproportionately.

- For retail DI, consider stopping selling of age 65 benefit periods and shift products to a shorter benefit term (5 to 10 years). This offers an integrated benefit for those with TPD in Super (TPD provides a backstop after the IP benefit period expires).

- Stop stepped premium structures for new business – a business model where between 15%-20% of policies lapse each year suggests that around 50% of policies sold will have exited after 4 years. There aren't many businesses that would be happy losing 50% of their customers after 4 years, particularly one that is meant to be long term. Whilst one year stepped reviewable products are theoretically the cheapest for consumers, the evidence suggests that these are not fit for purpose.

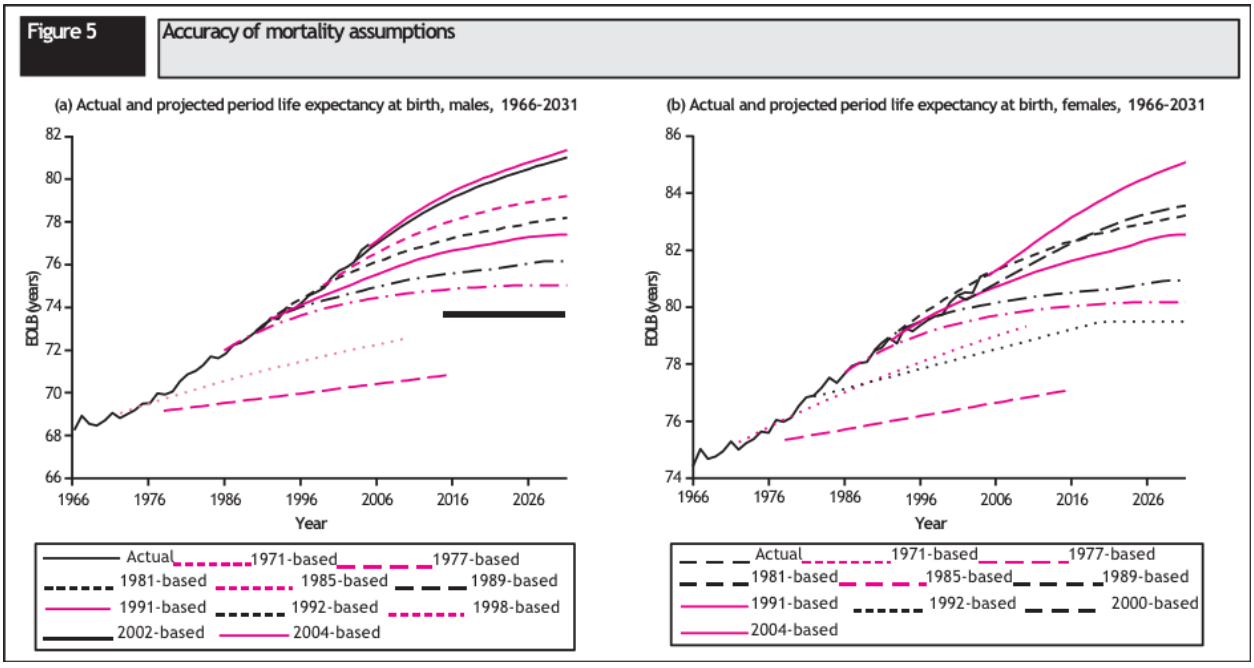
The combination of moving to level premiums and reducing cost due to more appropriate benefit design could create an opportunity, as witnessed in group insurance where some providers used to offer long term IP, to encourage existing policyholders into a design that is cheaper and more sustainable. However, we note that product change is a micro issue when the system itself is broken so we should be careful not to look for the answer in the design only.

Trend by trend

Principle: Develop a clearer picture of future trends

The one area that has caught the industry out relates to predicting future trends. Usually we start with the past but effectively this anchors our thinking about the future variation of outcomes. We are also anchored by how we have priced these trends historically if you were the one involved in that pricing (conflicted even). This story has led to extreme divergences of actual experience against expected experience in areas such as mental health, obesity, cardiovascular or even cancer related conditions. There is a graph of how annuitant mortality in the UK was consistently over estimated period by period, which led to some significant losses where annuity rates were guaranteed. And this is mortality which should theoretically be far easier to predict compared to the complexity of morbidity benefits.

Table 6 – Accuracy of projecting mortality



Source: Fifty years of United Kingdom national population projections: how accurate have they been? Chris Shaw 2007

One possible solution is to seek opinion (without being anchored by current pricing views) of the possible trends that may emerge. This could be done at a Board level or within pricing (but either independently or sourcing the analysis from a completely separate team).

Taking this further, each individual trend could be explored with the overall picture then aggregated, after allowing for correlations, so that each product has its own future pricing trend component. At the core of pricing, whilst developing a baseline view of past experience is critical, getting the future trends 'more right' than anyone else is the key to profitable outcomes as well as stability for policyholders.

Importantly, how the range of outcomes are communicated matters too. Best estimate might be the most spurious of all concepts. Actuaries being asked to deliver a single number answer is a fallacy when the future is so uncertain. Boards perhaps need to be spend more time understanding the range of outcomes as opposed to narrowing down the terms to a fixed answer.

Taking this one step further for debate, perhaps reporting and valuation bases should rather show the range of possible outcomes rather than point estimates. Should investors be aware of the range of risk and be able to assign a risk premium to life insurers based on the range? Would increased transparency here highlight the true long-term nature of this business line and avoid surprises when experience turns out to be out of line, as should be expected, with the point estimates.

Ultra-long-term remuneration

Principle: Better align behaviours with long term outcomes

The Treasury consultation on the Financial Accountability Regime (FAR), which extends the BEAR to life insurers, recently closed in February, with a view towards government implementing these changes in theory by the end of 2020.

In it, Appendix B specifies an indicative list of accountable persons that may fall in scope of the FAR which amongst other responsibilities would mean that 40% of those individuals variable remuneration would need to be deferred to up to 4 years where this exceeds $50,000. In particular, it references the 'senior executive responsibility for the management of the insurer's or RSE licensee's actuarial function' as one such accountable person.

Life insurance is far longer term than banking, most general insurance or health insurance lines, with a full understanding of profits or losses unlikely to be clear after 4 years. This consultation also doesn't include any reference to the pricing actuaries whom the Appointed Actuaries rely on to perform the initial recommendations and base level analysis. Lastly, this also fails to consider how many insurers and reinsurers utilise external consulting to support their pricing analysis, where it can be shown that their involvement does lead on average to more successful outcomes in terms of winning mandates.

Government could consider any of the following:

- Extend the FAR requirements to the Heads of Pricing or any senior pricing consultants performing the pricing for the insurer or reinsurer;
- Extend the term of the deferral to 7 years for life insurers; and
- Remove the cap of $50,000 to minimise the risk that remuneration is restructured to have no variable components or variable components fall underneath the limit

Offsetting these proposals which in isolation might be looked upon initially unfavourably by our actuarial friends, pricing actuaries (internal or external) need to have significant upside in their pricing exercises, **regardless of where employed** at a future date. If a pricing actuary has delivered a profitable piece of business, apparent after for example 7 years, then insurers should be rewarding them wherever they are working with significant upside. Although professional standards and other regulation already incorporate very strict and detailed requirements for prudent assessment of the risks, they don't specify remuneration so this would further encourage a sound valuation and assessment at outset. If FAR is just extended to these individuals without this upside, the risk is compounded that an unintended consequence might lead to some of the best actuaries exiting any roles that limit remuneration or creates additional risk without the commensurate reward.

If government didn't consider this change, there is nothing stopping companies from setting up their own ultra-longer-term incentive schemes for certain employees.

Transparency

Principle: Be honest about the uncertainty for customers

Part of accepting the medicine is recognising that consumers need to be made aware of their risk exposure. The lessons of the Royal Commission should encourage insurers and distribution to consider communicating to their policyholders the facts and the likely risks to their future premiums. The inherent conflict with any form of disrupting of the book (the more that leave today the greater the cost to the insurer) needs to be balanced against the position the industry is in.

Transparency also needs to work backwards. It appears that there is no readily available way for financial advisors (or industry) to view historic premiums charged to policyholders. ASIC is spending time looking at the value of insurance in super but arguably this could be extended to advised business too. Loss ratios should prove that consumers are the real winners in both group and retail but this doesn't help consumers understand relative value between insurers. To do this, consumers need to be able to track their starting point on price along with all future price changes in the reviewable structure and compare that against how other insurers would have charged for the journey.

This data should be made available going forward as a commitment by the industry to be measured by not only the day 1 pricing strategy but also the long-term outcome when all premiums are added up. This is consistent with the way investment performance is analysed.

Industry should also consider communicating, once the strategy has been finalised around the go forward position, the likely stream of costs that could emerge for consumers and let them make up their mind. In an era of more transparency, there are many more options beyond outright lapsation (cover levels can be reduced for example or shifting onto a shorter duration benefit period). Ideally this provides an enormous opportunity to communicate with the key asset in our industry (our customers) and potentially, an opportunity to find new customers at the same time.

The silver bullet that won't be fired

Government may not realise the extent of this market failure and after recent years, there is unlikely to be much support for anything that could reduce the rights of consumers. However, the industry is currently in a spiral that requires immediate government intervention and support (not dissimilar to health insurance, although the government has a different role to play within that system). The fallacy would be to think that this is all about the insurers bottom line when price rises are going to directly impact consumers.

Of all the suggestions in this paper, perhaps the most effective of all would be for a piece of legislation that allows Retail policies to be aligned with how Group policies can be treated. This has been called for years by the industry. Group Insurance effectively allows the Trustees of funds to overnight change not only the price but also the terms of the product, if this would be in the best interests of members. Retail insurance does not have this structure and changes can only be made effectively to the product, if they are the same or better than what the policyholder has in place. This has limited insurers ability to change any terms and conditions to move consumers onto more sustainable products.

APRA is recognising that the term of DI policies should be shorter (5 years) and at that point the product can be amended. Capital is ironically being increased for insurers by APRA on the backbook in order to incentive decisions on the front book. But all of this only solves the new business problem. Without legislation to recognise this can be applied to historic policyholders (the legacy blocks), insurers cannot arrest the spiral. Note that the consumer message in this scenario wouldn't just be that 'your terms are weaker than before' but it would also highlight that 'your new price is significantly cheaper than before'. In helping the industry, government would actually be significantly altering the financial equation and cost for consumers.

This suggestion is not new but rather one that is far more relevant and prominent in the context of the market (or some insurers) potentially failing.

So what?

Acceptance of the desperation of the situation is the starting point towards taking action. The losses are far worse than reported and will likely continue to drag on insurers results and consumer premiums for years to come. Some hard choices are needed along with the stomach for that extreme action. There is a fear that things could be made worse but we may be past that point.

Industry and consumers may be far better off replacing the fridge completely than trying to repair it for the next 5 or more years.

Thank you for reading. We'd welcome any views or thoughts to help support and further the industry debate. If you would like to discuss, please get in touch.

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