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THE COST OF CONSUMER EXPECTATIONS

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When it comes to buying a car (or any goods for that matter), consumers have certain expectations. They expect that the car does what it says it can do, they expect it can be returned if the car does not operate as expected and they expect that if it breaks within a reasonable warranty period, the car manufacturer will fix the problem. But it is broader – amongst other aspects, they expect that:

- They can choose any car that they want (competition exists and they can access it);
- The salesperson tells them everything they need to know about the car, in a way that consumers can understand (transparency);
- It's understood how the salesperson is remunerated (conflicts of interest are clear); and
- the manufacturer will honour and treat them fairly with regard to any promises made, how they are charged and look after them through the process (fairness).

It's worth observing that consumers do sometimes expect that the service they receive will be poor or believe that the salesperson they are dealing with cannot be trusted. Consumers also expect a different experience depending on how much they are paying for the car.

Life insurance is really not that different in terms of these expectations. There are some subtle differences though such as consumers most likely won't 'drive' the insurance at all if all goes well or at least until many years later. The sale is also predicated on upfront detailed medical information from the consumer being provided to determine eligibility to 'own the car' and may be reviewed for accurate disclosure only at the time you get to drive it. But all the other expectations are broadly the same, save for the higher expected quality of the experience given the significance and importance of this financial product.

If boiled down to the most important expectation, consumers expect that if you are paying for a life insurance policy for a specific benefit, you will be able to claim. However, not all life insurance (in fact this is applicable to all insurance) claims are paid, with approximately 10% of claims being declined according to ASIC. One needs to consider that some of these are due to fraud and these claims should never be paid (also the reason why insurance will never be able to pay out 100% of the time). However, ignoring the drivers for these declinatures, it's almost completely contrary to the idea of consumer expectations that consumer 'pay' for the car but then 10% of them don't get to drive it down the road when they need it most. And therein lies the key misalignment of life insurance (or any insurance) for consumers who were told they were eligible for a policy, pay a premium on an ongoing basis and then one day can't claim.

'Community standards and expectations' has emerged as one of the game-changing phrases in the Australian financial services sector. Whilst not a legislated term and not clearly defined, the idea is that financial service companies (including insurers) need to align their business model with what consumers expect and not just the letter of the law. This simple phrase has far-reaching and material consequences on how insurance will be delivered into the future within Australia. And whilst it cuts across each and every function of a life insurer's business, this paper focuses specifically on the impact of this change on the pricing of life insurance which is the part of the chain that will need to cater for and pre-empt this emerging model and how this will impact the cost of life insurance for consumers.

THE 1 MINUTE STORY

- **'Community standards and expectations'** has emerged as one of the game-changing phrases in the Australian financial services sector.
- This means insurers and superfunds will need to align their business model going forward with **what consumers expect** and not just the letter of the law.
- '**Should we do it?**' will define the approach to all future functions of the business.
- Pricing pre-empts emerging model changes and so should begin to cater for any impact on the cost of life insurance.
- The paper estimates a one off aggregate illustrative impact on future industry claims cost of 1.9% for lump sum products and 4.7% for disability income products.
- 8 trends are identified that will also need to be catered for, with an aggregate illustrative impact on future industry claims cost of between 2%-3% p.a.

These trends are:

- Claims transparency trend - The impact on pricing due to the public pressure of increased **transparent reporting**.
- Performance normalising trend - The compression on **margins** by product and channel going forward.
- Reviewability trend – The extent to which **future reviewability** will be allowed to capture changes in experience and impacts on capital and management action.
- Non-disclosure trend – The degree of change in **non-disclosure**.
- Orr trend - The extent to which consumers and other stakeholders are able to exert **pressure** on insurance companies to pay claims for fear of reputational damage.
- Expense trend - The **additional expenses** due to new processes and resources required.
- Product shift trend – The **changing product** structures and unwinding of cross subsidies.
- Behaviour trend – The extent to which consumer and organisational **behaviour** may shift.

By its definition, community standards and expectations require the custodians of pricing to consider all factors impacting consumers in the future, not just the ones that can be kicked down the road until a historic pricing trend is crystal clear in hindsight.

Organisations who consider and respond as first movers, stand to significantly gain in the long run.

AUDIENCE

This paper is written for pricing actuaries and senior management concerned about the impact of the application of 'community expectations' into their pricing and product design. Pricing is a lead factor that will predate all other changes to an insurer's business practices. Business already written and after today will fall under a different operating model in the future and as such, any expected one-off changes or new trends should be considered.

Part 1 sets out a summary of the key issues and aggregate cost impacts while Part 2, only supplied through engagement by Retender, sets out a framework and example of granular cost estimates, based on industry data, to be applied by pricing teams to determine the impacts at an insurer or superannuation fund level. It also considers who are the winners and losers and how differences in approach might emerge as competitive advantage

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PART 1

What's changed?

Whilst we can look to changing politics or media, the reality is that too many consumers have had too poor an experience with their financial services companies. This has led to a groundswell of consumers rightly fighting back and the narrative of financial service companies making significant profits and paying high executive salaries at the expense of good consumer outcomes. In particular, the market has experienced over the last few years, in response, a number of very public and embarrassing interrogations of the insurers (through investigative journalism, regulator reviews, senate hearings, government reports and culminating in the recent Royal Commission).

Regulatory oversight has also responded with an increasing focus on consumer outcomes, conduct risk and community expectations. APRA's recent review of CBA highlighted repeatedly that insurers need to 'act in the spirit of the legislation and not just the letter'.

The report sets out in particular:
Compliance obligations are broader than strict legal requirements and incorporate standards of integrity and ethical behaviour. For that reason, compliance risk and conduct risk overlap. Conduct risk is 'the risk of inappropriate, unethical or unlawful behaviour on the part of an organisation's management or employees.'

At its simplest, conduct risk management goes beyond what is strictly allowed under law and regulation ('can we do it?') to consider whether an action is appropriate or ethical ('**should we do it?**'). This in itself is a fundamental game-changer for the industry as it proposes that the intent and not the terms and conditions should be the primary driver of decision making.

Coupled with this is the future reputational pressure felt by life insurance companies, which we might name the 'Orr factor', which will influence how life companies treat anything grey. This pressure will emanate not only from consumers but will also be supported by other industry stakeholders (including but not limited to the regulators, lawyers and the media). The biggest impact of this pressure is going to emerge internally, not only through Board reporting on customer outcomes or changes to KPI's, but also the way that individual claims assessors (or others involved in the claims process) will address claims in the future. In short, the public shaming experience of the royal commission will drive a fundamental shift in attitudes to paying claims, across retail and group insurance.

It's worth noting as a useful benchmark that the UK also saw the implementation of a regulatory requirement to treat customers fairly (TCF – Treating Customers Fairly), beginning in July 2004. This is similar in theme to community expectations and provides a useful benchmark and precedent for the broader areas of consideration underlying insurer and superfund business functions in Australia.

The FSA (UK regulator) sets out the expectations of firms under this regime as:

'Firms must be able to demonstrate that they are consistently delivering fair outcomes to consumers and that senior management are taking responsibility for ensuring that the firm and staff at all levels deliver the consumer outcomes relevant to their business through establishing an appropriate culture. We expect firms to:
• demonstrate that senior management have instilled a culture within the firm whereby they understand what the fair treatment of customers means; where they expect their staff to achieve this at all times; and where firms promptly identify (a relatively small number of) errors, put things right and learn from them;
• be appropriately and accurately measuring performance against all customer fairness issues materially relevant to their business, and be acting on the results;
• be demonstrating through those measures that they are delivering fair outcomes; and
• have no serious failings – whether seen through management information (MI) or known to us directly – including in areas of particular regulatory interest we have previously publicised.'

Actuaries are also familiar with the concept of policyholder reasonable expectations, and the UK again provides a benchmark where historically this concept has developed in the context of with-profits business and termination values. Australia has very limited references to this concept, although the SIS Act (section 52), a number of prudential standards (SPS250, LPS360, and LPS320 for friendly societies) and actuarial professional standard (PS200), as referenced in a 2015 paper on members reasonable expectations, do refer to various best interests or equity tests for consumers. This is a long way from a more direct requirement to meet policyholder expectations and perhaps an opportunity for enhancement.

Whilst the remainder of this paper will focus on pricing implications, the ramifications will touch every part of the value chain and operating model.

Scale of potential impact

In theory though, there is going to be a cost to this different treatment of customers, due to the fact that historic data used for pricing may not have fully incorporated the community expectations overlay of 'should we pay it'.

Estimating the mechanical impact can be done as follows, by considering:
• How many additional disputes will be overturned going forward?
• What proportion of previously declined or withdrawn claims will no longer be declined?

Linked to mechanical impacts, we should also consider the retrospective impact (a surge of reopened claims from historical declined/withdrawn cases, changes to IBNR levels and patterns etc). How far back could this go?

Part 2 sets out the data and detailed methodology for determining the potential increase in claims cost as a result of a one off expected increase in claims emerging. This suggests an aggregate illustrative impact on industry claims cost of c1.9% for lump sum products and 4.7% for disability income products. A key overlay behind these mechanical estimates relies on assumptions being made about the proportion of previously disputed, declined and withdrawn claims that are expected to materialise going forward into claims.

However, alongside this, one also needs to consider the trend impact on costs by also understanding:
• Claims transparency trend - The impact on pricing due to the public pressure of **increased transparent reporting**.
• Performance normalising trend - The impact on **margins** by product and channel going forward.
• Reviewability trend – The extent to which **future reviewability** can capture changes in experience and impacts on capital and management action.
• Non-disclosure trend – The degree of **change in non-disclosure**.
• Pressure trend - The extent to which consumers and other stakeholders are able to exert **pressure** on insurance companies to pay claims for fear of reputational damage.
• Expense trend - The **additional expenses** due to new processes and resources required.
• Product shift trend – The **changing product structures** and unwinding of cross subsidies.
• Behaviour trend – The extent to which **consumer and organisational behaviour** may shift.

Some factors will provide downward pressure on price, others upward pressure. The timing and emergence of this cost is important and there is also an interrelationship between these factors that needs to be incorporated. This may be a source of competitive advantage for some life companies, depending on their starting position. It is also worth noting that some insurers and funds could be applying these concepts already and so their relative impact might be much smaller. As an example, one plaintiff law firm has anecdotally shared that around half of their cases related to one insurer – the jump in pricing if this was unwound for that insurer would likely be significant (and equally could explain historic aggressive pricing) but for those insurers on the other end of that spectrum, there is less distance to fall. Like all situations that suggest price needs to increase, the game is to understand this risk, the drivers and the potential impacts of a slow bleed into performance if no mitigating action is taken.

Pricing for trend risk is fraught with conflict. As discussed in the recent Retender paper on anti-selection, there is a belief that the reviewable nature of life insurance policies in Australia allows repricing if claims experience emerges as worse than expected. However, one has to apply an updated community expectations test here which suggests that consumers paying for cover today do not expect that their future cost will increase by more than the age-based increases and allowance for CPI increases. The historic approach of being aggressive on assumptions in order to generate a cheaper price today, that can subsequently be corrected if experience emerges differently, is no longer valid. The conflict created under that model where the “can is kicked down the road” for another decision maker to address taking into account different generations of policyholders, can no longer be applied. Potentially, one could even question whether age-rated or reviewable policies are in line with community expectations but this presents a different consideration (particularly reviewability which effectively passes the trend risk onto the consumer without their explicit knowledge) that is not the subject of this paper.

Part 2 sets out the data and detailed methodology required to determine the potential increase in claims cost as a result of these emerging “community trends”, along with potential sources of competitive advantage. This suggests an aggregate illustrative impact on industry claims cost of between 2% and 3% p.a. that needs to be factored into pricing, excluding additional capital requirements.

Each of the trends are discussed in turn below.

Trends

Claims transparency

In the early 2000's, the UK began public reporting of claims outcomes by their insurance companies. For Trauma insurance as one example, the percentage of claims paid was 93.1% in 2015 (92% the previous year). This had increased since 2005 when it was 80%. There are other drivers for this convergence over time, particularly the introduction of a Code of Practice in 2008 to handle non-disclosure which provides useful insights into how Australia might apply these principles to reduce declinatures over time.

Assuming that Australia (currently declining an average of 14% of trauma claims) moved eventually to a level of trauma declinatures similar to the UK, this suggests that over the long run, one could project a deteriorating trend towards the steady-state UK average declinature rates. The impact on broader business (sales, lapses rates etc) also needs to be considered for those with a delayed shift.

Normalising Performance

Life Insurers' clients (advisor groups and superannuation funds) will increasingly demand greater transparency of the claims experience of the end consumer, generated through genuine, independent, transparent competition.

The effect of transparency around loss ratios will likely put upward pressure on insurers on the low loss ratio end of the spectrum, which will have no choice but to reduce consumer prices to ensure they are meeting the lower profit expectation demanded by their distribution partners. The more profitable the portfolio, based on lower claims experience, the more likely that the insurer will need to reduce premiums over the longer term. This same issue can be considered in two other ways - greater profitability might allow insurers to make more payouts when in a 'grey' situation or margins will be compressed over time as levels of any super profits (at a benefit level) are unsustainable.

Assessing this impact will need to be considered at an individual scheme/block level and based on the current loss ratios and margins against a community expected basis.

In the first instance, any assumption that current loss ratio levels will simply continue should be reconsidered. The degree of change depends on the ease and transparency with which the distributor may view the performance of their channel/scheme and the likely emergence of claims experience over time (e.g. large group schemes would behave differently to small advised blocks). It is also reasonable to assume that the insurers' or reinsurers' loss ratio estimates provided as part of their reporting (and incorporating their reserving assumptions which may be padded with contingency margins) will no longer hold water i.e. one needs to assume the loss ratios are those that would be generated in a competitive pricing situation rather than simply under reporting.

Transparency generally works both ways in that whilst underperforming schemes/blocks require rate increases , upwards movements are asymmetric in that the distributors can take a group scheme to market where rate increases are required but are less likely to take the scheme to market when rates are being reduced. Similarly, healthier lives can shift their individual risk policy to another insurer more easily as outlined in Retender's recent anti-selection paper.

Linked to a shift in reporting, we may also see a shift in rating houses increasing the weighting on claims payment rates rather than bells and whistles to critically assess the value within different insurer product offerings. Proper assessment of claims philosophies, going beyond standard wording, might offer real opportunities for distributors to understand their exposure and expected outcome for consumers.

The Fairness of Reviewability

In response to concerns raised by the UK Ombudsman in 2003 around whether reviewable-rate policies complied with the Unfair Terms in Consumer Regulation Act 1999, the FSA and ABI undertook a review of how reviewability was being applied. The traditional wording in most policyholder contracts was fairly light on detail around the circumstances under which a review could take place e.g. 'We may review the pricing based on actual experience emerging'. This is similar to the current Australian practice, whereby although we may set out how the premium is determined at outset, the circumstances in which future reviews can be made may be glossed over, as in one example:

'We don't guarantee premium rates in later years will be the same as current rates. We, as insurer, can change the rates for all policies in a group regardless of which premium rate option you select, but we won't change the rates for a policy by itself. We will give you at least 30 days' notice before any increase in premium rates.'

As a result of the UK exercise around unfair terms, clear wording as to the reasons why premiums may change is now required by insurers in their contracts with policyholders. In some cases, retrospective increases that insurers had put through had to be unwound (costing the industry millions along with embarrassing communication to affected policyholders), providing an actual case study where past Management actions were overturned. In particular, the new wording also set out the circumstances in which premiums could NOT be reviewed, with recoupment of past losses or changing expenses as two examples of unjustifiable grounds. Similarly, changes to rates as a result of changing reinsurer terms, were no longer acceptable as the reinsurers were required to be aligned with the insurers

It's reasonable to assume, therefore, that the ability of Australian insurers to recoup losses or change expense assumptions within pricing will no longer be allowed in the future. At an unlikely but extreme scenario, community expectations may not support reviewability under any circumstances. All of this would require additional capital, particularly if pricing assumptions (which would be documented and available) were set in a low interest rate or aggressive growth environment, for example..

Non-disclosure

ASIC report 498 highlighted a relatively small percentage of claims being disputed as a result of non-disclosure (c5%). However, for certain types of health conditions, this number is higher - for example, there were more non-disclosure disputes for mental health claims compared to the average (15% of all disputed cases).

The royal commission case studies and policy questions highlighted the challenge for consumers being expected to remember historic medical records (including the ability of insurers to seek retrospective information for all sources of linked non-disclosure). Similarly, the senate inquiry report also highlighted that future medical information sought must be entirely relevant to the risks being underwritten. Both of these shifts suggest that consumers might not provide, nor can be expected to provide, similar levels of historic information in future.

Insurers too will likely be limited in ability to decline claims for non-disclosure that is not directly related to the claim or for lengthy past periods. Non-disclosure application will likely be reconsidered (perhaps similar to the UK code introduction or as referenced in the policy questions of the royal commission, a duty to take reasonable care not to make a misrepresentation to an insurer, as has been introduced in the United Kingdom by section 2 of the Consumer Insurance (Disclosure and Representations) Act 2012 (UK) although repudiation for fraud should continue. Use of pre-existing condition exclusions, as referenced in the Retender report on anti-selection and also mentioned in the Royal Commission policy report, might no longer be aligned with community expectations, nor will retrospective business rules being applied at claims stage to decline a claim that may have attracted a significantly higher loading.

Pressure trend

Perhaps the biggest area of concern, what might be titled an Orr trend, relates to the impact of public reputational pressure on decision making within insurers – the fear of being made to stand up in the court of public opinion and justify why a claim may have been declined. This pressure is likely to be a shift of power towards distributors (funds and advisors) and plaintiff lawyers who will be able to exert a new level of pressure (and rightly so given their interests are aligned with the consumers they represent) on decision making.

Financial service companies are also more likely going forward to be called out in front of the press for misconduct (perceived or otherwise) and the royal commission findings about potential fines and regulator scrutiny will play into consumers hands. Also of importance for life insurance, claims assessors could have a paradigm shift in thinking after watching events unfold that will change the way they consider future decisions.

Historic experience doesn't fully cater, within declined or disputed claims, for the additional types of potential claims that could emerge. The conflict is magnified because in order for the industry to build trust again, the only way to change the current position is by paying more claims. So each repudiation has a much more profound impact on building trust again and delivering on insurer promises.

We should also consider the link between insurers and reinsurer in that insurers may be more exposed than in the reinsurers if a one-off public shaming event occurs. Reinsurers typically cover the surplus and so may not be in a position (or aren't exposed brand wise) to support large claims that fall under any insurer reconsideration – this could expose insurers to the cost of the surplus, ultimately returning the very volatility they reinsured away.

From a cost point of view, the effect itself is likely to be larger in the next few years and then decrease as the public pressure reduces and processes stabilise. The increased cost (or risk) of greater fines would also need to be considered.

Expenses

Whilst claims experience varies from block to block, we also need to consider the performance normalising around expenses. Pricing generally allows for a different expense assumption to the actual incurred expenses of the life insurer, with the expectation that over the long term the organisation will deliver on those pricing expense assumptions. However, the greater the organisation's actual expenses, the more likely that future rate changes in a reviewable setting will have upwards pressure on their pricing.

In addition, expenses are likely to increase as a result of:

- Additional legal and compliance costs
- Increased cost of regulatory oversight
- Increased fines and remediation
- Additional reporting costs
- Increased frequency of reviews
- Increased communication costs
- Potential retrospective review costs
- Increased claims volumes and process costs
- Increase staff training costs
- Increased general resource costs to align with new industry standards (Codes)

In a setting where industry premiums are likely to significantly reduce (e.g. group insurance post budget, direct insurance post limitations on outbound activity, retail insurance post FoFA), the level of current expense assumptions will need to be reconsidered. These additional expenses may not be able to be recouped under the reviewability clauses in the future, and if so then additional buffer margins will be required. We also should consider the idea of 'one-off recurring' costs, in that every number of years an extreme expense event may occur and hence allowance should be incorporated and spread.

Product shift

Community expectations will challenge the types of products delivered. Can we be sure as an industry that all consumers will understand that rates for some products go up each year (and that these increases are greater at older ages when you need the cover most)? Can we be sure that permanent incapacity or certain product definitions will not lead to disappointment at claims stage? Can we be sure that healthier lives or lower risk categories will not shop around to find the most competitive cost? Do consumers expect to pay more for profit shares being in place that may be returned to a different generation of policyholders?

As a result, we might find a product design shift over time. As examples, reviewable products may shift towards level premium products, TPD may shift towards inclusion of a temporary income replacement benefit or profit shares may need to be unwound to ensure delivery of lowest price to consumers today. Whilst these have always been discussed historically, the pressure to make these changes has suddenly shifted and will require a wholesale rethink of product approach.

Given the significant cross subsidies involved in insurance (across lump sum and income products, between rating factors inside some channels, across manufacturing and distribution etc), we will likely see this being slowly unwound. And in a market where the reviewable nature of premiums allows movement for healthy lives, first movers will take the largest benefit. To this end, in the retail setting in particular, lapse experience will be intrinsically linked with product strategy.

Alongside the product design shift, the new processes will change costs. As an example, will risk controls develop any new deficiencies in screening out anti-selection? How will the onboarding process for capturing information that would have otherwise identified co-morbidity adapt? The pricing impacts of this shift need to be factored in as a trend adjustment over time.

Behaviour change

The last trend discussed relates to whether consumers will change behaviours. A number of potential sources could emerge:

• Claimants being in a position to push for extensions to their income protection claim payments
• Healthier lives opting out of the system or increased activity to find cheaper pricing
• Increased awareness by advisors and consumers of life offices under pressure to pay claims (would you rather place your business with an insurer that has been in front of the royal commission or one that hasn't?)
• Further changes in consumer attitudes towards mental health and comfort to claim – incidentally, one of the significant trends that wasn't historically picked up in pricing and a cause of some of the continued losses in retail income protection insurance.

We should also consider staff behaviours here, particularly claims assessors and the support from risk managers. Similarly, underwriting behaviours will likely change, heading towards increased consistency of approach. Finally, the behaviours of distributors will place them in a position to extract value for their clients which might lead to a significant shift in the types of applications and the types of claims being processed.

Lastly, behaviours that choose to ignore potential cost impacts, similar to an ‘ostrich’s head in the sand’, are no longer reasonable or appropriate. Community standards and expectations require the custodians of this pricing to consider all factors impacting consumers, not just the ones that can be kicked down the road until a trend historic impact is crystal clear. We have some useful benchmarking from other markets to consider, including the extent to which we may or may not follow. As a topic, the issue of changing community standards and expectations is a fairly unique and new conflict for pricing actuaries, management and Boards' and will change the way that pricing is done but equally the organisation’s who consider and respond as first movers, stand to significantly gain in the long run.

End of Part 1