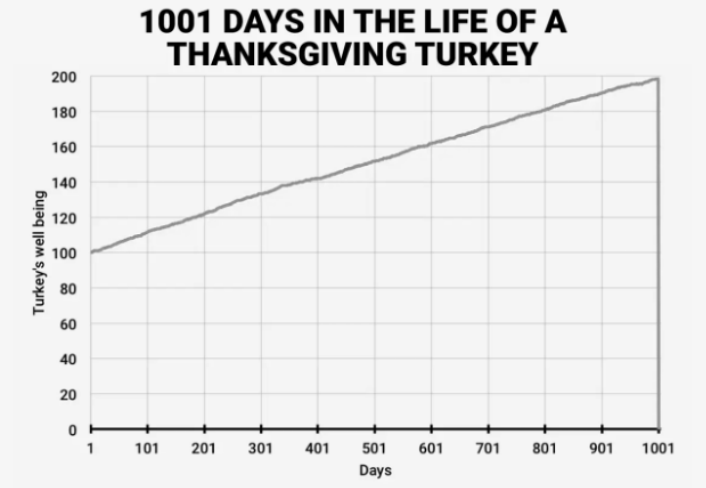
retender

THE THANKSGIVING TURKEY

In ‘Against the Gods’ by Peter L Bernstein, the author describes how no-one really had a need to consider probabilities in Ancient Greece or Roman times. Why? Well, if you rolled a two or a three on the dice, this was the will of the gods. Fast forward to the Reformation and the world instead started to question how various probabilistic outcomes could emerge to try and quantify the chances of a random event occurring or repeating.

The ‘Black Swan’ by Nassim Taleb took this a step further by calling out that despite all the data in the world, there are just some outcomes that no one can foresee – they don’t fall under some kind of probabilistic distribution and until you actually see it, you didn’t believe it was possible. His example of the Thanksgiving turkey illustrates his: "Consider a turkey that is fed every day," Taleb wrote. "Every single feeding will firm up the bird's belief that it is the general rule of life to be fed every day by friendly members of the human race 'looking out for its best interests,'….On the afternoon of the Wednesday before Thanksgiving, something unexpected will happen to the turkey. It will incur a revision of belief."



Source: Nassim Taleb, Black Swan

Black Swan’s aren’t an overnight outcome but could take years, maybe decades, to appear. And when these structural disconnects become apparent, the question is whether tinkering around the edges is the way forward or whether a wholesale change to the underlying principles needs to be considered? What if, like the Thanksgiving Turkey, we need to revise our beliefs about some of the products we’ve been selling for ‘1000 days’.

One of the revisions in particular has crept up on us as life insurance products expanded beyond pure mortality, and that is that for some of the newer benefit types inside life insurance, a number of policyholders buy a product that they ultimately don’t receive. They pay their premiums in advance but don’t receive the claim payment expected when they made that purchase at outset.

The underlying nature of insurance means that there will always be those customers who are ineligible to claim. There is no way to build a product that paid out 100% of the time. But what is an acceptable level? And in particular, what might you build differently if the starting point was solely to minimise any declined claims? This paper explores the nature of declined claims in the life insurance industry and puts forward a concept, as a thought experiment, about how life insurers and government might rethink the design of these products to achieve a different outcome.

THE 30 SECOND STORY

This story is about the life insurance product we might build if the sole measure of success was the lowest number of declined claims.

Approximately 1 in every 8 Trauma claims and 1 in every 9 TPD claims are declined. Only 35% of the time the original insurer decision is maintained when a claimant complains. Given the large claim amounts involved, a well-intentioned system where we are trying to provide cover for as many unexpected life events as possible may actually be creating worse outcomes for a significant number of consumers.

This paper proposes, as an alternative, a life insurance product built on two underlying principles – that a claim event must be able to be objectively measured and an actual financial loss must have occurred. Death and a different structure for Trauma emerge, and traditional Disability Income, TPD and even Terminal Illness would no longer be made available. And where subjectivity is required due to a societal need to maintain any form of coverage, such as for mental illness, the paper argues that government should be carrying the risk.

PART 1

An innocent person

We often hear in movies how the justice system is meant to be set up in a way so that not even one person who is innocent ends up in jail. The Innocence Project, a not-for-profit service set up in the US to prevent wrongful convictions, conservatively estimated that 1% of the US prison population are falsely convicted and The US National Registry of Exonerations put the number somewhere between 2% and 10%. There are meant to be checks and balances built into the system that would prevent this occurring and yet, despite all the lawyers, trials and appeals, innocent people are still convicted.

Drawing comparisons with insurance, are we comfortable with a handful of 'innocent' people not being paid as long as the majority are well looked after, or would we want to ensure that not even one 'innocent' person is declined if it meant that there was a cost impact on the majority? The answer unfortunately isn't as black and white as a John Grisham novel but sometimes it's about the re-examination of this question that matters, and seeking to understand when societal thresholds are being breached.

In 1997, a mining executive named Jim Cooney first used the term 'societal license to operate' as a metaphor to emphasise that the social acceptance of mining was as important as its legal licensing. Since then, the concept has been applied to many industries, including Financial Services. Importantly it isn't a once off question but rather something that requires constant re-examination over time as social attitudes and expectations change. We refer to it now as community expectations and this is where we could reconsider what the community wants when it comes to declinatures?

The 10,000 rule

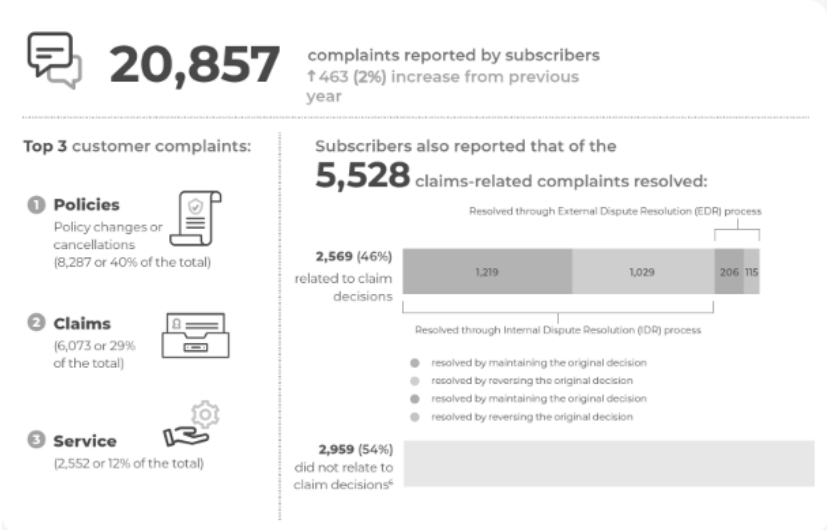
So how big is our problem? For the Individual Advised and Group Super segments, c6.5% of finalised life insurance claims were declined for the rolling 12 months up to December 2021. That's 1 in every 15 claimants and represents 4,000 declined claims.

On the face of it, this ratio might seem low but when you consider the breakdown by benefit type, the story that emerges for TPD and Trauma in particular is concerning. 1 in every 8 to 9 claimants for TPD or Trauma are declined.

Dec 2021 % finalised claims declined	Death	TPD	Trauma	DII
Individual Advised	2.9%	17.5%	13.2%	5.0%
Group Super	1.7%	10.6%	N/A	4.1%
1 in every X claims is declined	**47**	**9**	**8**	**22**

Source: Retender estimates based on APRA Life Insurance and Claims Statistics December 2021

If only this told the whole story. In that same period, 6,500 disputes were lodged with insurers and of these, c5,000 were resolved. This represents another cohort of policyholders receiving a difficult experience, albeit there is overlap in that some of these were also part of the 4,000 declined claimants.



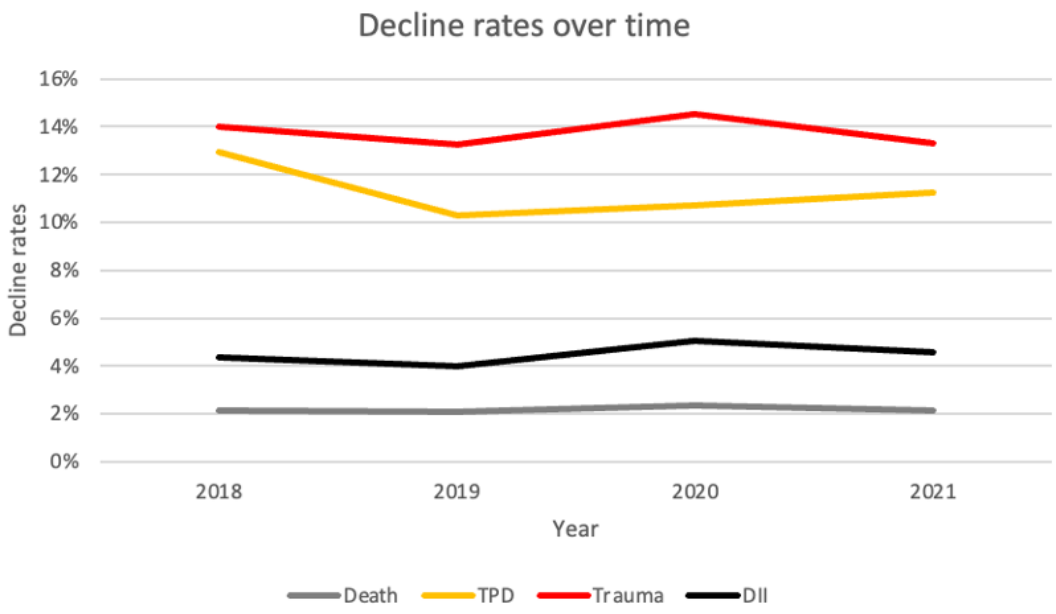
Source: Excerpt from LCCC Life Insurance Code of Practice Annual Industry Data and Compliance Report 2020–21

There's unfortunately more. Of those resolved disputes, and ignoring Death and withdrawn disputes which mask the true picture, the original decision was maintained in only 35% of the resolved disputes. It pays to complain.

In a credit to the industry and government policy over the years though, as at December 2021, there is c$6.2 trillion worth of cover in force in the Australian life insurance market. That's an astounding number when you consider the peace of mind that society has purchased. But that size also means that the potential scale of the amount being declined per annum is nearing c$1bn after allowing for DII durations – that makes this a problem worth investing in to solve.

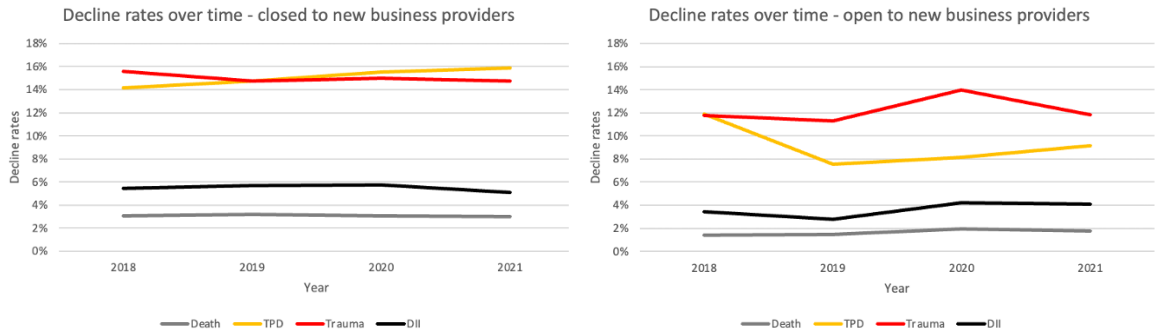
A tale of two providers

The expectation was that once APRA started to transparently publish these decline rates, there would be an increased pressure on life insurers to pay more claims to avoid being the 'outlier' against peers. Certainly this effect is visible in 2019.



Source: Retender estimates based on APRA Life Insurance and Claims Statistics June 2018 to December 2021. Individual Advised and Group Super only

The story becomes interesting when you consider though the differences between new providers and the licenses that have gone into run-off, where the run-off entities are displaying between a 23% (Trauma) and 64% (TPD) difference in the average declinature rates over time.



Source: Retender estimates based on APRA Life Insurance and Claims Statistics June 2018 to December 2021. Individual Advised and Group Super only

Some of this may be due to the different age profiles of the run-off books, selective lapsation (healthier people exiting over time from legacy books) and different legacy products but this does suggest a very different experience depending on whether your provider is currently open to new business or not. But even for Death, the difference that is not easily explainable when the criteria for claiming should be the most straightforward. More interesting may be to consider what pressure there is on run off providers to reduce their declinature rates and whether the impact on their reputation matters.

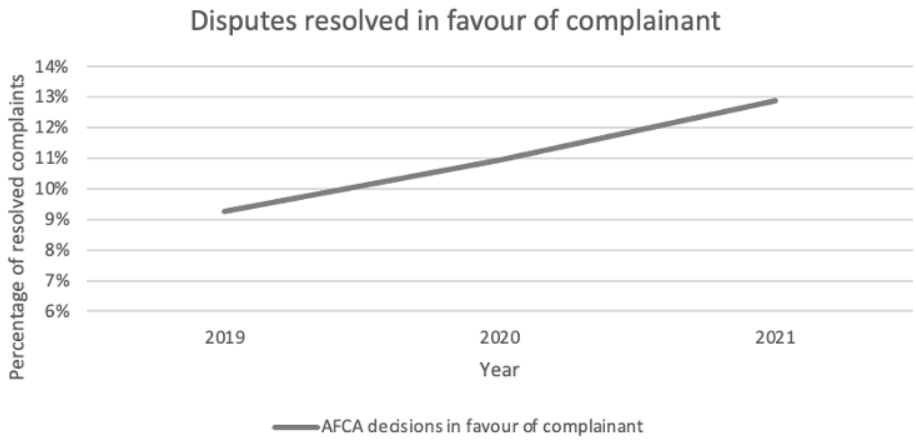
No reward for no

Understanding why this happens is the next thread. We start with the toughest challenge in that there is that implied structural conflict for insurers with accepting claims. The more they accept, the less money they make so a product is being sold where there is a conflict with delivery.

But putting any (unlikely) bad faith aside, why are disability declinature rates so high? Whilst establishing the permanency of lump sum disability under TPD could partly explain this benefit type, rationalising the same for Trauma claims is more difficult. Is it the lack of understanding of consumers (and advisors) of the definitions? Do the definitions not keep up with the latest available diagnostics?

One key driver in the case of Trauma is that when a consumer hears from the Doctor that they have had a heart attack, they don't check whether this meets the definition under the policy (much less meeting the FSC minimum standards or the current policy definitions available for new business). Another driver that is potentially hidden in the lack of granularity of the data is that even if the claim is not covered, claimants may be encouraged to put the claim in and 'cross fingers' that it will be accepted. The most efficient practice may be for the insurer to have some kind of pre-assessment claims discussion upfront with the potential claimant to guide them as to whether they actually have a claim. However, because a pre-assessment could be akin to putting pressure on the policyholder not to submit the claim for assessment, the lowest risk outcome for insurers (and maybe advisors too) is to encourage as much as possible for policyholders to submit the claim even if there is a low likelihood of acceptance. So, we end up declining them later after creating an expectation of a positive outcome.

In the 12 months to June 2021, the Australian Financial Complaints Authority (AFCA) received 1,623 life insurance complaints (32% of which were resolved at the registration and referral stage), and they closed 1,595 complaints. There is an anecdotal view that AFCA are ruling more and more in the consumer's favour. Although still a small sample size (1913 life insurance complaints closed since AFCA commenced with regard to Death, TPD, Trauma and DII), there is an increasing trend appearing with regard to consumers receiving a favourable outcome. Similarly, there appears to be an increasing trend for disputes raised with insurers directly where they are prepared to reverse the original decision.

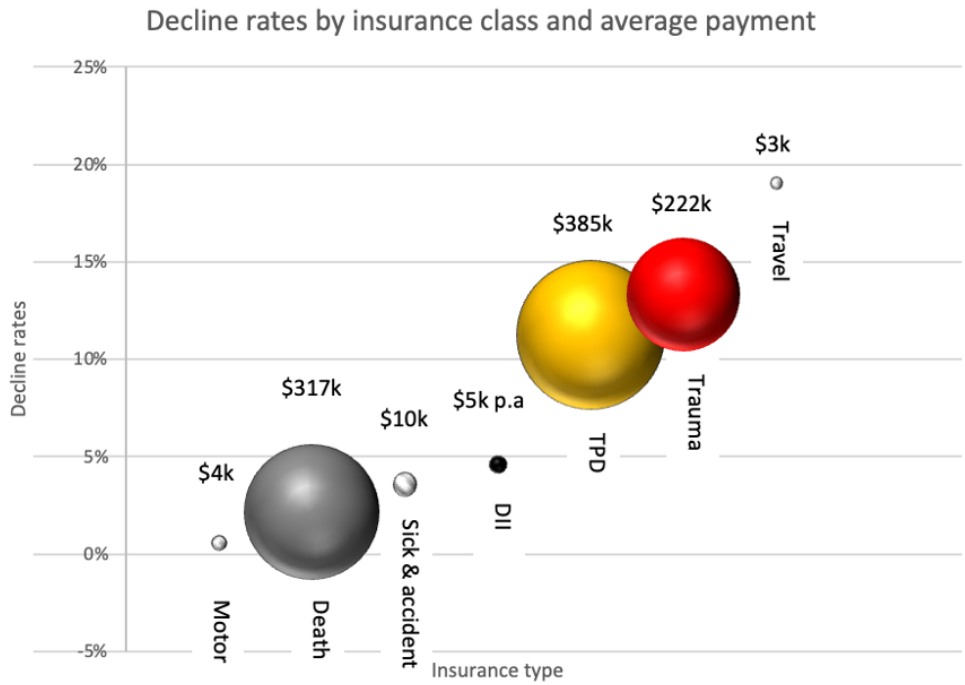


Source: Retender estimates based on AFCA Life Insurance complaints

The protections for consumers in the system, and implied threats, certainly appear stronger post the Royal Commission. And it's not just AFCA. A recent Federal Court ruling in May 2022 sent a fraudulent misrepresentation decision back to AFCA for re-determination where AFCA had previously ruled in the insurers favour. This particular case (Sharma v Hesta) was centred around a medical doctor who, when applying for additional cover, answered 'no' a question around previous heart trouble but more than 10 years earlier had a surgical procedure where 'three stents were placed into two different sections of his coronary arteries after he suffered a myocardial infarction'. The gap will likely be closed to manage this risk in the future but just highlights that there are additional risks on some of these legacy exposures that would have been near impossible to predict at the time these products were sold.

Robinson Crusoe

In terms of a comparison with other forms of insurance, particularly General insurance, generates some interesting questions. In 2021, Motor insurance showed the lowest decline rates (<1%) in contrast to Travel which showed the highest (19%, albeit this may have been Covid related – 2020 has this figure at 15%).



Source: Retender estimates based on General Insurance Code Governance Committee Annual Report 2020-2021 and APRA Life Insurance and Claims Statistics December 2021. Size represents Sum Insured levels.

Core to the issue is the average amount paid under the different insurance types. General insurance has a far lower average payment (<$10,000) compared to the various Life Insurance benefit types. Even DII, which has c$5,000 average claim amount, is paid on an annual basis meaning that the total amount that is ultimately paid is far higher.

Why does this matter? Well, if you pay for Travel insurance and your $3,000 claim amount is declined, you move on. If in contrast you pay for TPD insurance and your $385,000 average claim amount is not paid, you may have no choice but to explore every possible route to secure that payment.

Effect and Cause

The last thread is to try understand the impact on those claimants who have clearly had some form of difficult event but are declined. There are many consequences for them but one that stands out is that of compensation neurosis, described as the exaggeration of symptoms as a result of the stress of seeking compensation. A 1946 quote from Foster Kennedy summarises "compensation neurosis [as] a state of mind, born out of fear, kept alive by avarice, stimulated by lawyers, and cured by a verdict".

Extract from Compensation Neurosis: A too quickly forgotten concept?

'Unique to individuals seeking compensation is that they have to make and sustain a claim of injury and impairment in an adversarial system. Individuals in the compensation system, be it civil litigation or disability certification, may be interviewed and medically challenged many times, often over a period of years. They often experience, especially with disability claims, an initial rejection of their claim followed by a lengthy appeals process that leads to further anger, frustration, or need for validation and retribution and a sense of prolonged uncertainty and helplessness. In addition, even after being awarded disability, individuals may be concerned about losing their benefits because of future reviews, which becomes a sword of Damocles hanging over their heads. These factors result in conscious and unconscious pressure not to get better or progress in treatment, because improvement could diminish or eliminate compensation, create the impression that the claimant was not initially injured, raise questions about integrity, or disappoint people in the claimant's life, such as family members and lawyers, who are also highly invested in the disability claim'.

Source: Ryan Hall and Richard Hall, 2012, Journal of the American Academy of Psychiatry and the Law

How does the claim's process, along with these particularly high life insurance claim amounts available, create this effect for declined claimants? Even for DII claims where the average payment is lower, eventually many of them will be 'declined' for future claims payments at the point where they are able to return to work or end the term of the policy.

What if the well-intentioned system we have put in place to support disability may also contribute to its cause?

Sometimes is not good enough

The principles of a sound product design in insurance are straightforward and generally there is plenty of agreement. The Disability Taskforce at the Actuaries Institute for example recently set out what they defined as 'Sound Product Design/Insurability Principles' as part of the review of DII products. They were defined as follows:

- 'The event giving rise to a claim should be objectively identifiable, definable and measurable. The event should also occur by chance - that is, it should be beyond the control of the beneficiaries.
- The customer's net financial loss on the occurrence of the event should be measurable and definable.
- The insured benefit payment should not exceed the net financial loss suffered, after allowing for other sources of financial compensation and/or support.
- 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 support those in need.'

Extending these, we can apply these principles to the other benefits available in the market to test how they measure up. Whilst Death cover almost always meets these criteria, where relevant, TPD as currently designed is on the other end of the spectrum where only sometimes does it meet the principles.

5-year scorecard

ASIC's Report 498 titled 'Life Insurance Claims: An industry review' was released in October 2016 and found that 10% of claims were declined.

But dig a little deeper and when you exclude non advised channels, the comparable decline rates with this Retender report was between 7%-8% for the Individual Advised and Group channels. Contrast to the aggregate figure today just over 5 years later of c6.5% and the change isn't that significant. This is good news as it suggests that prior to the ASIC Report (and subsequent Royal Commission), insurers were paying out the right claims and a strengthening system has not resulted in what would have been a disturbing step change in additional consumers being paid.

This same report also made a number of recommendations that have subsequently been put in place, not limited to better and more transparent data, changes to the regulatory and legal frameworks for claims handling, improving industry standards and a change to the external dispute resolution process with the introduction of AFCA.

Source: REP 498 Life Insurance Claims: An industry review, October 2016

Back to the 'Innocent Person', the strengthening of the system has been a positive and there is no doubt that the industry is on an upwards trend journey to protect that one person who should reasonably be paid out their claim. But the starting point has been a system that, if you could start again, you might not have been created with a blank page. In this next section, we explore a thought experiment whereby the journey wasn't one of tinkering but rather starting from scratch with a different KPI.

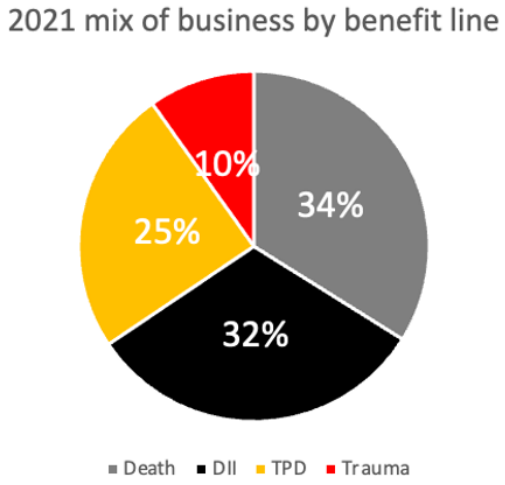
Part 2

Throwing the subjective baby out

The nature of all insurance claims is that there will always be some claims declined. But what if the overarching criteria or principle for design became minimising that decline rate.

The contrast between Motor and Death lines with Travel and TPD say perhaps provide a clue on where to start. At the root of their differences lie subjectivity. The more subjective the claims criteria, the higher the decline rates. Dying is about as objective as it gets. Determining long term permanence of disability, for mental or musculoskeletal conditions particularly, is arguably at the other end of the spectrum.

Subjectivity is also, no surprises, directly linked to the potential for mispricing. In the Australian market, the majority of benefits sold in the two segments we are considering (Individual Advised and Group Super) are in the subjective category. Trying to predict trends, behavioural changes or even outside pressures such as community expectations all increase the probability of getting a future stable price pattern completely wrong. And it's no surprise therefore that TPD and DII have proven the areas where the greatest losses have occurred.



Source: APRA Life Insurance and Claims Statistics December 2021. Individual Advised and Group Super only

So, what if, as a thought experiment, we defined our most important criteria for life insurance being the lowest level of decline rates? Zero is impossible given fraud but let's say we were prepared to live with only insurance products with a less than 2% decline rate. How might one build this world with a blank page? The first part of the answer may lie in increasing objectivity.

Our good news starting point is that there wouldn't be much more to do with regard to Death cover. Death is an objective fact, other than perhaps where there is fraud or a suicide exclusion. So, this benefit line can remain completely untouched, and we can begin the product renovation with 34% of Death premiums intact.

The one ring that rules them all

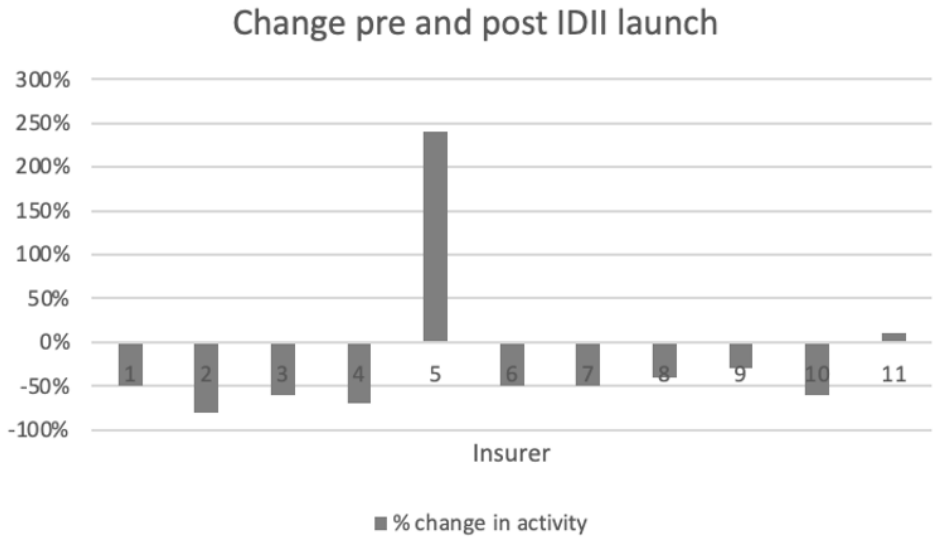
Tackling disability benefits is more complex though and it's here we might look to health insurance and Trauma severity-based products for our clues, that is, linking the claim to actual financial loss.

Health insurance pays out where an objectively defined medical cost is incurred. Days in hospital, the cost of a medical procedure or medicines can all be objectively quantified as there is a particular spend by consumers. The risk selection game is the opposite of life insurance as all pricing is community rated, meaning that there is one price within the same policy (risk pool) regardless of age, sex or health status. This equalisation mechanism transfers premiums from insurers with lower-than-average claims costs to those insurers with higher-than-average claims costs (over 40% of hospital and medical claims are shared in this way1). But the theme behind these products is that it isn't a binary outcome as to whether you are paid or not but rather how much are you out of pocket after payments by Medicare and your private health insurer.

Similarly, at the heart of Trauma based severity products lies the idea that some severe illnesses such as a major heart attack need a full payout (e.g. 100% of the Sum Insured) due to the potential financial implications but other illnesses such a minor heart attack might only require a smaller payout (e.g. 50% of the Sum Insured) due to the lesser financial impacts.

First pioneered in South Africa by Discovery Life, it wasn't the product that made it successful, in this authors opinion, but rather a first mover advantage at the time of switching to pure life (rather than investment linked/universal life) products, a game changing wellness program (Vitality) and a very different distribution model. Later this concept was tried unsuccessfully in both the UK and Australia although the UK false start was turned around at the second attempt. The main drawback in how these products have developed over time has been creating an overly complex system where you may get 10% or 25% or 50% or 75% or 100% of the Sum Insured depending on 'how bad it is.' Added to this, more and more conditions (well beyond traditional products) were added over time which were funded by those partial payments that would have usually attracted 100%. At similar price points, this clearly creates a challenge for advisors in comparing these products to traditional providers.

Indeed, the recent launches in October 2021 of a new advised DII product has highlighted this dilemma. The background is that in 2019, APRA mandated changes to DII to stem the unsustainability bleed of this benefit line under current design. Some work followed at the Actuaries Institute to help the industry take this a step further and then last year all insurers launched their new DII product. In the run up to the change, sales flew as advisors rushed to sell the old product before the doors shut. And then, post the market launch, anecdotally quotes of this product have fallen by more than 40%.



Source: Retender estimates based on activity in the 6 months prior and after IDII launch

The one provider showing significant growth offered a slightly different ('richer') design to the others showing which is competition rightly in action. As for the drivers behind the others, one story goes that insurers have long advocated that advisors sell the 'most rich' benefits, even if the price is higher (no self-interest at all if that insurers product was more expensive), and now they all find themselves in a position where one provider has the richest features and advisors can't do anything but sell that product. The other story is just simply that advisors are just confused on how to now compare these new untested products which are all so closely related yet have a handful of tweaks between them. Either way, and sadly, in trying to control the design, we're selling less of DII which means more selective risk pool, lower societal coverage and long-term less scale for insurers to manage these products efficiently.

Show me the receipt

Coming back to the principle of financial loss, this is the reason for buying insurance (as opposed to receiving a windfall benefit). So, consider if life insurance disability products leaned more into the health insurance and trauma severity-based space and only paid benefits linked to a clear financial loss. Loss of actual income is perhaps that measurable criteria which becomes the second part of our answer to now join the requirement for objectivity only.

So, rather than a windfall lump sum benefit, what if our Trauma products could instead link to the actual expenses actually incurred due to the condition in question? As an example, if a claimant needs money in excess of that available from health insurance for better treatment or to make changes to their home to accommodate a different lifestyle, these would all be covered as the actual expenses are incurred.

Taking this further, because the Trauma definitions meet our first principle of objectivity, loss of income due to that condition also falls under this umbrella, meaning that claimants can draw down on their lump sum to fund any loss of actual earnings. If you have a heart attack for example (objective event) and can't work (financial loss), you are eligible to claim.

In this model, there would be no severity-based definition nor limits on the replacement ratios but rather, if the claimant has had a condition on the list, they have purchased insurance to recover their actual costs (all the way up to their Sum Insured). As a result, consumers might be expected to buy up significantly higher levels of Trauma under this model because those lump sums may be needed to potentially fund years of lost income. Having a lump sum 'pool' of cover may have some appeal to consumers – it may be akin to your superannuation balance which one day you might expect to draw it down in the de-accumulation phase. It's also more similar to health insurance (or other forms of general insurance for that matter) where you have a list of what is covered that is both objective and linked to the actual costs incurred. Finally, we move away from the discussion of 'what type of heart attack' but rather whether or not a heart attack has happened that has resulted in financial loss. That is, rather than use the current definitions to control the risk, which leads to the disconnect between what your doctor says ('you've had a heart attack') and your policy says ('you need to have this type of heart attack we can only measure post the event using perhaps tests your doctor hasn't done yet') which opens the door to a broader definition of heart attack being available.

The tricky part that follows is what to do with mental and musculoskeletal conditions? If we stay true to our two principles and the new rule, any components of these claim causes that can be measured objectively and lead to financial loss will be covered. An injury for example that either leads to additional costs over and above Medicare and/or health insurance is clearly covered, so too if that claimant cannot work anymore for a period of time.

What falls out therefore is that the subjective mental and musculoskeletal conditions will not be covered. This messes with our minds a bit, that is to not offer this cover, because we come from an anchored position of what the market currently offers and a social position of recognising how mental illness in particular is becoming more and more prevalent as an arena. But subjectivity cannot be priced.

Lastly, because of the inclusion of income payments in this Trauma design, and inability to offer subjective coverage, we don't need traditional DII anymore and certainly don't need to offer Terminal Illness or TPD. An extension of the Death cover might also allow us to even consider linking death payments to the actual loss of income under this model rather than as a lump sum which is indirectly linked to loss of income.

There are a number of key questions we explored further, but for another paper, such as whether this has been tried before in other markets, how could this be administered, can this be done in Group insurance, what is still being covered by cause of claim after the shake-up and of course the financials? As always, the devil is in that detail, but the principles are the starting point. One important hurdle that particularly needs to be addressed is the question of whether 'best' advice is offering the most coverage or whether 'best' advice is offering the highest likelihood of being paid a claim? The Quality of Advice review later this year should be considering this question.

It's not an elephant

Peter L Bernstein also shares a story about a distinguished Professor of Statistics in Moscow who, in World War 2 during one of the air raids by the Germans, showed up at his local bomb shelter having never appeared there before. "There are seven million people in Moscow," he used to say. "Why should I expect them to hit me?" His friends were astonished to see him and asked what had happened to change his mind. "Look," he explained, "there are seven million people in Moscow and one elephant. Last night they got the elephant."

Mental illness is no longer an elephant in the room problem and although we are putting forward the concept of objectivity only as a key principle, it's worth considering if we can or need to deal with mental illness in a different way. Retender's paper titled 'When the music is playing, you have to keep dancing', explored the role of the invisible hand of government and how in some situations the market cannot be relied on (or able to) solve certain challenges. Medicare or CPI linked age pensions were mentioned as example but so too were privately run solutions such as health insurance where without government mandating or tax incentives, insurers wouldn't offer coverage to unhealthy consumers.

Insurance for mental illness might be one such challenge that fits into the bucket of requiring government intervention to sustain a market. The incidence of mental illness conditions has been on a clear upward trend but for pricing actuaries to 'pick' the right sustainable expected level may be akin to throwing a dart at a board. Perhaps some might view mental illness as not even priceable until this trend stabilises and is clearer.

A survey of c300 Actuaries by Lessing and Cohen in 2013 concluded that 'members of the actuarial profession have a wide range of conflicting views which vary according to their level of experience with mental illness. Many agree that "society needs the coverage" of insurance for people with mental illness, and the insurance industry has a role, alongside the government, community and workplaces, to provide assistance.' In addition, although 73% of respondents believed that people with a history of mental illness should be covered by insurance there was also recognition that at least to some extent they might attract an exclusion for mental illness related claims or attract a "risk rating".

The challenge of not covering mental illness maybe goes against community expectations but it's possible that insurers are not best placed to offer it. So, there is an argument that government should, at least temporarily, take mental illness risk onto its balance sheet and ensure that all members of society are covered. The most efficient mechanism needs careful consideration, but some options might include either of:

- Mandated (or tax incentivised) mental illness specific coverage with a risk equalisation mechanism, co-ordinated by APRA, akin to health insurance; or
- A government reinsurance 'risk carrier' for mental illness conditions exceeding some threshold, akin to the reinsurance terrorism risk pools on the general insurance side.

Moving this into the government space however may introduce a new complexity whereby if one knows that someone else is paying the bill, what incentive would there be to help consumers manage those mental illness risks better (or similarly, why invest in better outcomes if there was no opportunity to profit)? But the theme of insuring this societal risk outweighs the frictional and second order costs.

If a review of the mandating of TPD ever comes up, this concept, along with allowing Trauma in group insurance could be explored as an alternative to the traditional TPD product. The interaction between the different types of insurance that cover these conditions (e.g. workers compensation, health insurance and life insurance) along with the interactions of primary and secondary conditions (e.g. a musculoskeletal issue causes a mental illness condition) should also be reviewed as tugging the strings in isolation in one part of the system may inadvertently unravel another.

Insurance is about taking risk but at the point where certain risks aren't priceable or are just outside the realms of acceptable uncertainty, the risk pools decrease in size as healthier people opt out and a spiral begins where cost keeps going up and up. Shifting back the principles of insurance to objectivity and financial loss are two first steps that along with government intervention in mental illness, might rebalance the pools into a more sustainable long-term outcome.

A Financial Advisor, Accountant and Lawyer walk into a bar

At a recent AFA discussion about ethics, a case study was put up around who would be represented where a couple was divorcing. The Advisor commented that they might have to pick (or the client would have to pick) one of the parties, an Accountant commented that this might all be managed as long as the conflict was disclosed, and a Lawyer spoken with afterwards commented that neither should be represented as he knew too much about both parties. Most interesting, each mentioned a reference to their code of conduct as the basis for their respective views.

Numerous examples of structural conflicts exist in our industry and other industries, and many times big decisions have been made to break them. The 2010 'Volcker rule' in the US broke the link between banks investing customer assets and trading on their proprietary capital. In the UK, the Competition and Markets Authority (CMA) investigated in 2018 the conflict between the same firms providing investment consultancy and fiduciary management services. This last month, EY, one of the big four, announced it was considering separating its audit and consulting business (the fact that this was raised matters more than whether this actually happens in the end). The key question is whether conflicts can be managed or whether you just need to get rid of them? It may be obvious but if a party is benefiting financially from the answer to the question of whether a conflict exists in something they are doing, that party cannot make that determination.

Which comes back to the structure of life insurance claims. Life insurance certainly didn't foresee when the first mortality tables were constructed in the late 1600's that we would one day be covering subjective conditions or ones where there wasn't financial loss. But it's the former in particular that may represent a structural conflict that we can't manage but rather need to get rid of – that is, that an insurer is making a subjective decision on whether to pay a claim but if they don't pay, they benefit financially. And despite all the controls put in place and well-intentioned processes to 'manage' this conflict, it's inevitable that the trust relationship with customers will be broken. Trust is keeping a promise which means that every person purchasing insurance needs to have full confidence in the outcome, not relying on fate, nor probability, nor an outcome that they could never imagine nor having to revise beliefs like the Thanksgiving Turkey.

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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