# Individual Disability Income Insurance (IDII) in Australia

## Proposals by Disability Insurance Taskforce of the Actuaries Institute

## Response to Feedback, Finalised Recommendations & Supporting Documents

## Early Release of Document C – The Reference Product

In September 2020, the Disability Insurance Task Force (the Taskforce) set up by the Actuaries Institute in mid-2019 published various documents for consultation with interested parties. This was part of a comprehensive process to address fundamental weaknesses in the sustainability of individual disability income insurance (IDII).

The covering explanatory note for the September 2020 documents can be found here.

That note includes links to the following September 2020 documents:

Document A: Provisional Findings and Recommendations
Document B: The Sustainability Guide – Draft for Consultation
Document C: The Reference Product - Draft for Consultation

### Feedback Received During Consultation Period

The Taskforce received feedback during the consultation period and afterwards, through various channels:

- **Formal Submissions received from a variety of parties;**
- **A Survey** held towards the end of the consultation period - the Taskforce ran an online anonymous survey which gave respondents the opportunity to rate their level of agreement with the 45 recommendations and give some more general feedback;
- **Webinars held in October 2020, December 2020, February 2021 and March 2021 for any interested parties;**
- **Further discussions** with interested parties e.g.
    - some life company boards
    - a number of individual life company directors
    - various CROs
    - a group of Appointed Actuaries and various other actuaries
    - various product managers
    - ASIC
    - AFCA, consumer advocacy bodies, Australian Lawyers Alliance, Public Interest Advocacy Centre
    - Ratings Houses
    - FPA/AFA task force and management; and
- **Personal and anecdotal feedback** e.g. Taskforce Working Group meetings, regular industry interactions.

The Taskforce has now considered all feedback and finalised its views and recommendations and much of this has been communicated via the webinars above. It plans to release the following documents over the next month.

**Document A-2: Final Findings and Recommendations**

This document will give an overview of the provisional findings and recommendations of the Taskforce as presented in September 2020. It will then summarise the feedback, provide comments on that feedback and set the final findings and recommendations.

The document will be of interest to anyone involved in the IDII ecosystem – consumer bodies, insurer management and boards, technical and professional specialists, regulators, government and financial advisers.

**Document B-2: The Sustainability Guide**

This will be the finalised Sustainability Guide – Version 1.0

This is intended to be a guide to good practice in the management of IDII business for insurance company boards and management. It will be of most interest to them, technical specialists and regulators.

**Document C-2: The Reference Product**

This is the finalised Reference Product - Version 1.0

This is to provide a reference point to aid senior management, the Board and regulators in assessing risk and uncertainty for both customers and the insurance company. In other words, it is intended to assist insurers in the prudential management of their individual disability income insurance product line. It is not intended to prescribe the design of a retail product.

**Because of industry interest in the Reference Product, the Taskforce has prioritised the preparation of Document C-2, and version 1.0 was released on 30 April 2021 to selected groups**[1], ahead of Documents A-2 and B-2. The latter two documents are still being prepared for publication, and will be released in the next few weeks.

The early release copy of Document C-2 is enclosed with this note.

The reasons for changing or maintaining various aspects of the Reference Product are set out in detail in the Appendix to this note.

Questions can be directed to DITF@actuaries.asn.au

30 April 2021

[1] Including Appointed Actuaries and CROs

# APPENDIX – Reference Product Rationale

A key part of the package of proposals in September 2020 was the use of a Reference Product. It was made clear that the purpose of the RP

> *"… is not to dictate the design of a retail product. Rather, its purpose is to provide a reference point to aid senior management, the Board and regulators in assessing risk and uncertainty for both customers and insurance companies. In other words, it is intended to assist an insurer in the assessment of risks and uncertainty and in the prudential management of their individual disability income insurance product line.*
>
> *Any significant difference in an insurer's product from the RP is expected to be subject to rigorous assessment to meet minimum requirements for CROs, Appointed Actuaries, Product Managers, and CEOs."*

There was considerable interest in the details of the RP design. The feedback provided was very helpful and generated much debate amongst Taskforce and the Working Group members. In turn, this led to a number of changes in the final version of the RP.

Nonetheless, it remains important to emphasise the RP is intended to represent a sound benchmark product that has been specified with a wide cross-section of customers in mind.

Furthermore, in some cases, a diversion from the RP may not indicate a significant increase in risk – for example:

- For some sub-groups of consumers with certain characteristics or needs; and/or
- When subject to additional controls (e.g. underwriting) or limitations on other terms.

Equally, to maintain risk levels consistent with the Reference product, it may be quite appropriate to provide more limited terms than the RP for certain sub-groups of consumers.

# Feedback

All submissions were broadly supportive of the concept of a RP and of the draft RP directionally. Interestingly, some comments indicated that the RP could be more liberal while others suggested that it did not go far enough in mitigating some risks.

Comments on specific matters raised are set out below.

# Purpose of the IDII product

The nature of a number of comments made to the Taskforce suggest that there is not always a clear, common perspective on the role and objective of the core IDII product. This was apparent from the diverse views expressed on a number of elements of the RP, for example, why and when rehabilitation is required, the level of income replacement, and the length of the benefit period.

In order to help guide the Taskforce's analysis of the feedback and its refinement of the RP, the Taskforce has developed a statement of "Purpose" for IDII products which is now included at the start of the Reference Product document.

# APRA Requirements vs RP

Comments were made that the RP was not always consistent with the product limits that APRA promulgated, as set out in its letters of December 2019 and September 2020.

APRA is not a product regulator, and in its letters APRA made it clear that it was focused on prudential risk: "APRA is concerned with the current state of affairs and considers the detrimental impact on life companies and consumers to be a significant prudential risk. A step change is required to address the financial risks of IDII for life companies, as well as the longer-term affordability concerns for consumers."

APRA is necessarily using a fairly blunt instrument. Given it is not a product regulator; it is using its capital management tools to reduce prudential risk evident in the management of IDII.

APRA also said: "Over time, APRA will consider how best to reflect in its prudential framework the risks associated with features violating the principle of indemnity and the uncertainty of long time horizons."

The Taskforce is focused on long term sustainable outcomes and is not solely concerned with being aligned with APRA's requirements in all respects, although the Taskforce believes that the Reference product is consistent with the APRA prudential aim in principle.

Furthermore, the APRA product constraints are intended as effective product term "limits". As noted above, the RP is intended to reflect a sound benchmark product that has been specified with a wide cross-section of customers in mind. Terms more than or less liberal than the RP may be appropriate for certain consumer sub-groups, and /or with different controls or insurer risk appetite. It should therefore be expected that the RP reflect terms inside of the APRA "limits".

# Income Replacement Ratio (IRR)

The task force believes that high IRR has been a key driver of high claims experience.

Overall, there was strong support in feedback for tighter controls on replacement ratios. However, there were views expressed that the long-term 60% IRR (with scaling for higher income levels) was too low. It was argued that customers might not be able to live on 60% of pre-disability income, particularly those on lower income levels.

An important initial observation is that the IRR is applied to a customer's gross income (before tax). Allowing for the impact of income tax and Medicare levy, and making some allowance for reduced expenses related to work (e.g. travel costs, work clothing, etc), the actual effective IRR is typically much higher than the "headline" 60%. For example, for

someone earning a gross $150,000 per annum, and incurring work-related expenses of about 5% of their income, their effective IRR (net of tax, Medicare and work expenses) under the Reference Product maximum of 75% for 6 months and 60% thereafter, is closer to 85% and 70% respectively.

In proposing an IRR of 75% for the short term followed by 60% IRR after 6 months, the Taskforce had a number of considerations:

- In practice, product design, underwriting and claims management practices in Australia had allowed effective IRR levels well above 75%;
- The need for an incentive to return to work; IRRs which are excessively high, particularly at high income levels, give the customer a disincentive to return to work, which is fundamentally poor design;
- The customer may be able to reduce many expenses while disabled, but this adjustment requires time to put into place, hence the short-term allowance of a higher IRR;
- Overseas studies have consistently shown a clear relationship between high claims level and high IRR;
- Ultimately, a balance is required between affordability, effectiveness of the insurance and sustainability of the product; and
- Overseas markets where profitability is currently not a significant issue - for example the US and the UK - have offered IRR around 60% to 65%;

The Taskforce concluded that its original rationale was sound and that no changes should be made to the RP with respect to IRR.

# Benefit Period

There were arguments that the benefit period ceasing at age 60 is too restrictive.

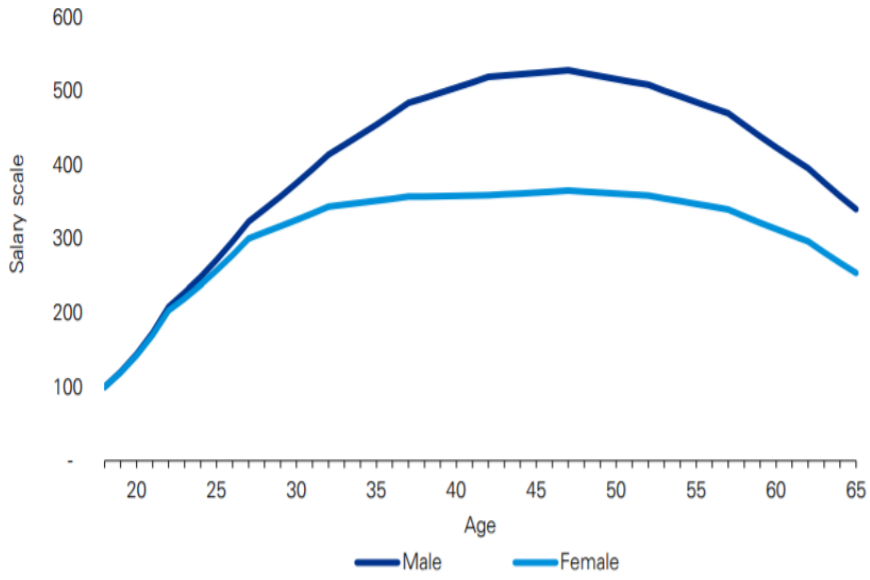
Insurance that provides benefits that extend beyond age 60 increases the likelihood of over-insurance for many customers. The limitation of benefit period to age 60 is to mitigate such over-insurance risks.

In its thinking about this issue the Taskforce had a number of considerations:

1. Incomes for many people naturally decline in the years leading up to retirement, for various reasons. This is borne out in large income samples in Australia and in the US.

   The graph below shows the average income level of Australian tax-payers by gender, based on a sample file of 240,000 taxpayers for the year 2014-2015. Overall, income typically peaks around age 50 for both men and woman and declines steadily thereafter, and more steeply beyond age 60. This shows that a benefit based on a claim commencing at age 55, say, as a % of their income at age 55, will typically become a significantly higher % relative to the income the person

can expect to earn by the time they reach age 60, and even higher (possibly over 100%) by the time they reach age 65.




Source : Review of default group insurance in superannuation,2019, a white paper produced for the ISA by KPMG (Hoa Bui, Platon Chris and Edward Tam.

Similar patterns of income by age can be observed in other western economies. The presentation by the Taskforce on 9th February showed an equivalent graph for the US, by level of income. It shows the same decline after about age 50 for all levels of income except the bottom 20% of taxpayers.

The implication of this graph is two-fold:

- Income needs to be updated regularly over time. It is clearly not appropriate from either the customer's or insurer's perspective to issue a disability income policy based on the income at the outset of the policy and never update this information again until a claim is made years later; and
- Significant insured benefits with benefit periods that extend close to normal retirement age (e.g. 65 or 70) involve significant over-insurance risk (i.e. the risk of exceeding insurable interest).

2. Claims experience for older customers has been deteriorating for some time, at a faster rate (51%) than for other age groups (24% to 29%). This is illustrated in the table below.

| Age group | 20-24 | 25-29 | 30-34 | 35-39 | 40-44 | 45-49 | 50-54 | 55-59 | 60-64 |
|---|---|---|---|---|---|---|---|---|---|
| Change in A/E since previous investigation | -2% | 24% | 29% | 20% | 27% | 24% | 29% | 21% | 51% |

Source : FSC – KPMG analysis of 2014-2018 increase in claims costs by age. December 2020

Similarly, claims experience of longer benefit periods (e.g. the common to-age-65 benefit period) has seen much greater deterioration than shorter benefit periods (e.g. 2 year benefit periods).

3. There is a lower financial incentive to return to work for many older customers, who on average would have less commitments and more assets than younger customers.

The Taskforce concluded after considering the arguments that no change should be made to the RP with respect to maximum benefit period.

# Coverage for all Causes of Claims

Under the RP, cover is provided for loss of income due to physical or mental injury or illness, as long as the claimant meets the definition of disablement and other policy terms. No distinction is made for the degree of subjectivity in the assessment of any claim.

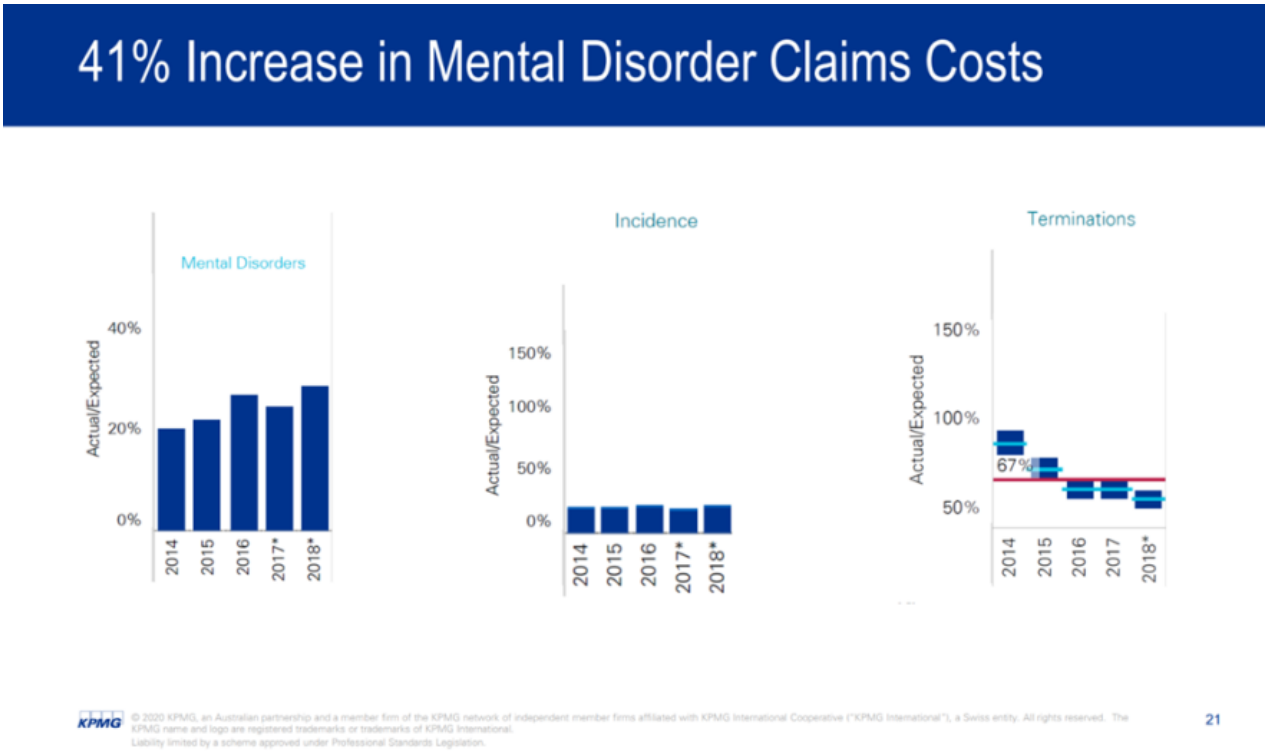
The taskforce received a number of suggestions that the RP benefit period should be restricted for some causes of claims where there are substantial elements of subjectivity in the assessment or diagnosis process. Some of the feedback suggested that certain causes of claims should not be covered at all or have a limited benefit period, such as 2 or 5 years. Mental health claims were cited as an example.

This is a major aspect of the product design that the task force spent significant time debating, so it is no surprise that there is a range of views on this issue.

Firstly, the Taskforce acknowledges that mental ill-health[2] has been a rising cost for the community over the last two decades, and this is in turn reflected in IDII claims costs. The table below shows that the cost of mental disorder claims has increased rapidly (41%) over the last 5 years compared to an overall increase of 25% for claims costs from all causes.

The mental illness increase in claims cost is due to both an increase in the number of claims and increasing length of claims, whereas most of the increase in claims costs for other causes have been due to people staying on claim for longer.

[2] See Actuaries Institute Green Paper on Mental Health (2017) for a deep consideration of the key issues that mental health presents for insurance.




Source : FSC-KPMG Industry experience investigation 2014-2018, published 2020.

Secondly, the Taskforce agrees that limiting the benefit period could be an effective way to contain the cost of claims, because a significant proportion of claims cost come from long term claims (i.e. payment beyond 2 or 5 years).

In Australia, for every $75 of total claims cost incurred, $55 relates to claims beyond 2 years; while $40 relates to claims beyond 5 years. A closer examination of the table shows that these claims are spread across many causes of claims, with mental illness being only one of the causes of claims with significant costs beyond 2 years. Limiting the benefit period to 2 years for mental illness cause of claims is unlikely to achieve a major reduction of claims costs.

| For every $100 Gross Premium | | | | |
|---|---|---|---|---|
| Cause of Claim | Claim Year (from end of waiting period) | | | Total |
| | 1 to 2 | 3 to 5 | 6+ | |
| Cancer | 3 | 2 | 3 | **7** |
| Cardio-vascular | 1 | 1 | 2 | **4** |
| Mental Illness | 4 | 4 | 11 | **18** |
| Musculoskeletal | 4 | 3 | 9 | **16** |
| Nervous Disorder | 1 | 1 | 4 | **7** |
| Other Sickness | 3 | 2 | 5 | **9** |
| Accident | 4 | 2 | 6 | **13** |
| **Total** | **21** | **15** | **40** | **75** |

Proportions by cause of claim are estimated based on historical claims over 2014-2019.

Source : FSC – KPMG analysis based on historical claims over 2014-2019 . Early insights dated 18 December 2020

Beyond these facts, our reflections on this issue are set out below.

Determining the incidence, existence and impact of many illnesses and injuries on the ability to work can be dependent to a greater or lesser extent on symptoms and their consequences that are self-reported by the customer. Such assessments also depend on observations by professionals of the claimant's actions and/or behaviours, sometimes without these being corroborated by other separate and identifiable indicators (e.g. x-rays, ECGs, chemical analyses, etc).

Assessment of the ability to work when the claimant is suffering from conditions such as non-specific back pain, neck pain or chronic fatigue, or certain mental health conditions such as anxiety can be particularly difficult for all stakeholders involved (claimant, insurer, and supporting professionals).

Claims based on such conditions have been systematically increasing over recent years, and have been an increasing proportion of total claims. They have been a material contributor to the significant rises in IDII premiums over time. The rise in such claims would seem to reflect that:

- These conditions are now quite common and their prevalence in western societies has been increasing. This may well reflect, inter alia, changes in the nature of our work;
- Social attitudes to these conditions have changed significantly over the years, and the community generally recognises that people can suffer greatly from these conditions; and

- To the extent existing products have provided a high level of benefits (in some cases an effective IRR of well over 75%), they provide a means for some claimants to exploit assessment limitations and seek windfall gains (intentionally or otherwise).

This presents insurance companies with a number of dilemmas:

- While the underlying conditions may be genuine, the rising claims costs associated with these conditions are making existing IDII products increasingly expensive and unaffordable. This trend is expected to continue, given the population trends in mental illness;
- Uncertainty over the future trend in such claims and variability of aspects of such claims can be linked to economic conditions, which means the coverage of such claims involves significant risk over future financial outcomes for life insurers; and
- Insurance principles indicate a strong preference for insuring objectively identifiable and measurable events and impacts. The nature of these claims involving substantial judgement and subjectivity makes them the most difficult to assess and manage.

Given the issues above, one strategic response could be to avoid the difficulties and not cover such claims or significantly restrict coverage for such claims.

On the other hand:

- From society's and a consumer's individual perspective, there is a real need for comprehensive coverage;
- The actuarial evidence available as to the net impact of these claims on the industry's current sustainability issues is inconclusive. No single cause of claim can fully explain the rise in claims costs; and
- The focus of the RP on ensuring that benefits are within the range of insurable interest (i.e. not providing excessive or wind-fall benefits) is expected to greatly reduce the industry's exposure to excessive claims behaviours.

Taskforce discussions suggest there may be merit in insurers working with the medical profession and other stakeholders to introduce more objectivity into the claims process, better understand the issues at play and collect relevant data and evidence at a more granular level.

Even with coverage for all causes of claims, the RP represents a significantly more sustainable product than those offered in the market today.

On balance, the Taskforce concluded that the RP should cover all causes of claims, without restricting benefits for particular claim events:

Notwithstanding the Taskforce conclusion, (subject to meeting relevant laws) insurers have available multiple alternative avenues for limiting or mitigating the risk associated with coverage of the conditions mentioned above. These include:

- Issuing products that exclude or restrict the amount of cover or benefit period for certain conditions, in general or for certain customer sub-groups;

- Offering cover for (a restricted list) of nominated conditions as an option and letting the customer choose whether to pay additional premiums for all conditions (noting that this may require pricing and/or other allowance for potential customer selection biases);
- Improving transparency at a macro level by publishing the amount paid in respect of certain nominated conditions relative to other conditions and the trend in those payments. This will make the issue more apparent to the community over time, and will promote discussion about how it is best addressed; and
- Improving transparency at customer level by publishing the premium as two components – one for coverage in respect of claims of the type discussed above and one for the balance of claims. Commentary on the first component would indicate likely premium volatility as a consequence, for example, of changes in attitudes in society or medical advances.

At an industry level, actions that can be considered to help address this issue include:

- Industry-wide mechanisms such as risk pooling for certain systemic risks which are too large or uncertain for individual insurers to retain. The Australian Reinsurance Pool Corporation for terrorism risks and potentially climate change risk for vulnerable locations, for example in northern Queensland, are examples of this sort of mechanism;
- Joining forces with government and other interest groups to help mitigate conditions that are driving rising costs, through education, early detection or other mechanisms such as investing in supporting the community being impacted; and
- Working with medical practitioners and other professionals to identify and development more objective diagnosis and assessment techniques as the basis of claim determination.

Each of these options has advantages and disadvantages. Some may not bear fruit for some time. Others may be deemed discriminatory, or not meeting community expectations or be inconsistent with the law.

For avoidance of doubt, the absence of these considerations within the RP should not discourage insurers from adopting one or more of the options above and managing risks below the benchmark reflected in the RP.

> The Taskforce concluded that no changes should be made to the RP with respect to coverage - that is, all sources of claims are covered under the RP.

# Group super benefits vs RP

There were observations that benefits available under certain disability income benefits provided through superannuation funds would be more comprehensive and liberal than the RP for at least some members, therefore restricting the market for IDII.

The group insurance salary continuance market is different to IDII in many ways – particularly in the detail of benefits, underwriting and the ability of benefit terms to be varied at relatively short notice. It is to be expected that some potential customers for IDII will be able to access benefits and premiums that suit their needs. However, many others will want to use IDII, particularly the self-employed customers.

More importantly, the Taskforce considers that much of the thinking that has been applied in the RP and the recommendations for IDII should be assessed for application to the group insurance market. The Taskforce will consider this in due course.

# Claims indexation

There were concerns expressed that limiting claims indexation in course of payment to CPI-2% beyond age 55 was unnecessary and potentially too conservative.

The original thinking by the Taskforce was that providing less than CPI indexation for claims beyond age 55 was linked to the discussion above around customer income patterns and expectations beyond age 55 (where average incomes reduced materially p.a. beyond age 55). Over-indexing may provide a disincentive to return to work.

This measure, coupled with the rehabilitation and retraining assistance, would be a complete package to help customers with the motivation to return to work.

However, the Taskforce has been persuaded that other measures, such as a long-term IRR of 60% and a benefit period of no more than to 60 years of age as included in the RP are sufficient to address this issue without adding the extra CPI-2% complication beyond age 55.

> The Taskforce concluded that having claims indexation at CPI for all claims was appropriate. The RP has been changed so that claims may be indexed at up to CPI (i.e. no deduction from CPI from age 55).

# Practical issues with 5 year contract term

A number of submissions and comments indicated significant practical issues with a 5 year contract term for a life insurance policy in Australia.

Submissions suggested, in broad terms, that:

- An “opt-out” model would be the preferred approach (where policy terms automatically roll-over to new terms at the five year mark, with the policyholder asked to update financial disclosures at that time). However, the submissions suggested that there were a number of legal impediments and limitations to this approach under current law that makes it problematic; and
- An “opt-in” model would likely be required (with the policyholder having to actively opt-in to continuing cover). However, submissions suggested the likely lapse rates,

anti-selective behaviour and costs of customer "re-acquisition" would materially increase premium costs for consumers.

The Taskforce believes this issue is central to the sustainability of the product.

It has 2 dimensions:

- The ability to have regular update of key financial rating factors such as salary, occupation and pastimes.

  Currently, this update does not occur at all after the initial underwriting is completed; at claims time, the insurer "discovers" the actual occupation, salary and pastimes of the customer, in some cases after many years. This is an undesirable situation, particularly in today's fast-changing environment where people can hold multiple jobs at the same time, and most people now change occupations more than once during their work lifetime. From a customer's perspective, there is no active engagement with the insurer until the moment of truth, at claims time, where surprises can occur as so much time has passed since the initial underwriting; and

- The ability of insurers to update key product terms and conditions to keep products modern and up-to-date.

  In today's rapidly evolving world, it is unlikely that a contract can endure and continue to be appropriate for decades.

The Taskforce concluded, taking into account these dimensions, that the RP should be adjusted as follows:

- The RP should be a comprehensive indemnity contract, which means the benefits are based on the salary, pastimes and occupation at the time of claim. In this context, it makes sense for the insurer to require, and for the customer to update this information regularly, preferably at every policy renewal. This will allow the premium to be calculated using the correct information, while at the same time avoiding the situation where the customer is significantly under-insured or, conversely over-insured and paying for cover which they cannot claim on; and
- In terms of its purpose as a product benchmark, the RP should continue to specify an ability to update product terms at regular intervals (i.e. 5 years). The Taskforce acknowledges that there are challenges implementing this aspect under current legislative settings, but sees this as a material risk management feature that Boards and insurer management need to consider in assessing their product's risk profile and sustainability. We note that a review of the Life Insurance Act 1995 is a recommendation from the Taskforce.

# Whole Person Permanent Impairment Test (WPPI)

There was broad support for a more objective measurement of impairment / disability. However, a number of submissions noted that the life insurance industry needs to better understand the WPPI test before it can be applied correctly to disability insurance, given that it is a test used to assess permanent disability for lump sum pay out in some workers compensation schemes. Implementation may require significantly more expertise than currently exists in the industry. In some circumstances, the test may not be fully applicable to life insurance.

The Taskforce discussed this feedback at length, noting that workers compensation schemes where the WPPI test has been used also have infrastructure and supporting legislation to enable the successful implementation of the test - for example the requirement for a medical practitioner to be accredited before performing the test. We also noted that the implementation of a WPPI test at 5 years in one Workers Compensation scheme has been effective in reducing the length of long-term claims.

In principle, the Taskforce remains convinced of the value of a severity assessment of impairment and its value in assessing work capacity. However, the Taskforce accepts the feedback and has concluded that from a practical perspective, the IDII ecosystem would benefit from more research and dialogue before adopting such a test.

> Consequently, the Taskforce decided to remove the WPPI test from the RP for now but will maintain a focus on developing more objective ways to assess impairment to promote longer term IDII product sustainability.

# Legal impediment to restrictions

Feedback was received that there are legal impediments to some of the features of the reference product, for example the insurer's inability to:

- offset social security benefits;
- pay certain rehabilitation benefits;
- pay medical expenses; and
- deduct tax before paying benefits.

The Taskforce acknowledges that the Australian legislative environment does not currently allow the above features of the Reference product to be implemented. However, in other jurisdictions, such as the US or the UK, where the product is sustainable, the insurers have the ability to pay rehabilitation benefits, medical expenses and deduct tax from the benefit payment.

The Taskforce has concluded that the RP should continue to include these features, albeit acknowledging the legal constraints where relevant. The Taskforce makes recommendations elsewhere in the upcoming Document A regarding the need to review some of these

legislative constraints. In addition, the Taskforce has commenced dialogue with the ATO on this topic.

# Underwriting and claims management

A number of recommendations by the Taskforce relate directly to claims and underwriting, including the need for greater focus on financial underwriting, and on the ongoing training of underwriters and claims managers.

Appendix A in the upcoming Document A sets out matters that the Taskforce (with input from underwriters and claims managers) believes underwriters and claims managers should be attuned to in respect of the RP, ahead of any subsequent actions taken by the underwriting and claims communities to address the broader Taskforce recommendations.

# Definition of income

A number of submissions were received on the definition of income and income offsets. In particular, some suggested that it would be operationally simpler to separate passive income into two components, and treat business income separately from other passive income such as investment income (e.g. dividend and rent).

There were also a number of requests to expand the approach to the "the strict requirement to count the most recent 12 months period of income", to further cater for the customer whose income is subject to fluctuation over time.

Following the feedback, the definitions in the final RP have been clarified and revised as follows:

1. To allow more flexibility in the period for determining income, including the averaging of income if it has been historically volatile, but still not allowing asymmetry in the averaging;
2. To separate passive income into two types: "unaffected business income" that continues to be received when the customer is disabled, and other "passive income" (e.g. investment income, annuities, etc) which is not produced by personal exertion and would continue while disabled; and
3. To separate the discussion of the treatment of income in the RP document into:
    a. The Concept and Design section, where insurable income is defined and discussed in terms of income due to personal exertion or otherwise, including examples for employee and self-employed customers; and
    b. The Technical Matters section, where the components of income are defined in more technical and objective terms.

While there have been a number of significant changes to the formulae and detail related to the definitions of income, the IRR scale application, and treatment of unaffected business income and passive income, the underlying mathematical outcome is intended to be the same as set out in the consultation paper.

# Return to work focus

A number of comments questioned the need for a return-to-work focus or the requirement to participate in the return-to-work programme.

A recovery management plan, along with rehabilitation and retraining, are central to the RP. This focus is based on a shared interest in a customer's recovery (where possible) from the injury or illness causing impairment and consequent reduced work capacity, and supporting the maintenance and/or restoration of work capacity where possible.

The Taskforce has maintained the focus on return to work.

# Partial Disability & Rehabilitation Clarifications

A number of submissions requested clarifications on Partial Disability:

- Can partial benefits be paid before the customer is considered totally disabled?
- Can partial benefits be paid within the waiting period?

The Taskforce has clarified these points:

- Partial benefits can be paid without the customer having to prove that they are totally disabled in the first instance;
- The waiting period is to be served in full, with days of partial disability only counting for a corresponding part day of waiting period;
- In addition, so that we do not discourage customers from attempting to return to work to the extent possible (even during the waiting period) if the customer wishes to return to work during the WP, then they can do so without having to start their waiting period again should the attempt fail; and
- As an overall control, we have imposed a limit on the total time over which the waiting period can be extended before it starts again.

Another question was about who decides what rehabilitation is to be undertaken: the insurer or the customer on claim.

The insurer shall not require a rehabilitation programme unless it is consistent with medical advice and appropriate for the customer. However, the RP puts a requirement on the customer to participate in a recovery management plan, consistent with the purpose of the product, which is to help people financially until they can return to work (where this is possible).

Waiting periods of greater than 180 days are considered to be inconsistent with an RTW focus.