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Dialogue Paper

Fairness in Insurance

A Challenge to Boards of Insurance Companies

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About the Author

Ian Laughlin

Ian Laughlin has extensive insurance experience in multiple countries - as an executive, managing director, a non-executive director and chair, a regulator and an actuary. He currently is a consultant to boards and management. He has a keen interest in risk management, governance and community expectations. The Actuaries Institute named him Actuary of the Year in 2018 and awarded him a gold medal in 2021.

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About this Paper

The Author would like to thank the various people who provided comments on draft versions of this paper and encouraged the Author to progress it to conclusion. The views expressed in this paper are the Author's own.

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Purpose of This Paper

The purpose of this paper is to help bring about a marked improvement across the insurance industry in the fair treatment of policyholders. It does this by challenging Boards of insurance companies to improve their oversight of fairness.

If the paper is of interest to Boards, inevitably, senior management will take note. It also should be helpful for insurance professionals such as actuaries, product managers, underwriters and claims managers. Regulators too may find it helpful in providing insights into industry management and governance of fairness.

The focus is on retail insurance – not commercial or other specialist insurance. This includes general insurance (home, motor, etc.), life insurance (including disability insurance) and private health insurance. Group life insurance is also considered, as it provides death and disablement cover to the individual members of large superannuation funds – and this means the paper may be of interest to superannuation trustees, given their responsibilities.

The paper does not directly address fair treatment of customers by intermediaries such as financial planners and brokers, but it does raise issues for consideration by insurance companies.

The Australian market only is considered, but many of the points made are applicable more generally.

In the paper, the insurance company is referred to as the “insurer”. In the interests of simplicity, the policy owner (or policyholder), a beneficiary or any other person with a financial interest is referred to as the “customer”.

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1. Introduction

1.1 A Little History and Context

The concept of insurance in one form or another has been around for hundreds, even thousands of years.[1]

Throughout that time, the general idea has been to spread the financial risks of one party amongst many other like parties. In long-past times, that may have been done by physically spreading risk,[2] but these days it is nearly always arranged through financial institutions – mainly insurers.

We can be sure that throughout that time, and however the insurance was implemented, the various parties set out to achieve what they perceived to be a fair deal for themselves.

The early life insurance and friendly societies in the UK were intended to help members of the community in need. As they evolved, there were ongoing efforts to improve fairness through improved methods of determining contributions.[3] Indeed, this was the very foundation of actuarial science.[4]

So, fairness is inherent in the idea of insurance, and it is a natural area of interest for actuaries.

1.2 Contemporary Insurance

In modern society, insurance plays a critical role:

- it helps enable a well-functioning and stable financial system and society; and
- it protects individual members of society from financial risks that might otherwise ruin them financially.

Our modern world has many wonderful attributes, but with that comes complexity. This has implications for insurance, which needs to respond to society's needs. At the same time, data, information, technology (including artificial intelligence), skills and techniques have developed apace, and so products and pricing have become more sophisticated and complex.

Moreover, the world is changing rapidly, which in many ways has implications for insurance – think of the potential impact of climate change, developments in medical treatment, and changing social attitudes and expectations.

All of this means there can be an element of subjectivity in the assessment of fairness.

At the same time, an insurance company is a business, supported by considerable capital (normally provided by shareholders), on which it is quite reasonably seeking a return.

And so insurance can be very complex, and challenging for customers to understand and assess, and for insurers to treat customers fairly and to be seen to do so.

1.3 Community Expectations

The Financial Services Royal Commission report of 2019 considered, amongst many other important matters, community expectations.

The Royal Commission was damning in its findings and laid down six principles to help financial services companies meet community expectations. These are:

- *obey the law;*
- *do not mislead or deceive;*
- ***act fairly;***
- *provide services that are fit for purpose;*
- *deliver services with reasonable care and skill; and*
- *when acting for another, act in the best interests of that other.*

The Royal Commission also promoted the notion of "should we" rather than "can we", which is very pertinent for fairness.

In the aftermath of a subsequent federal court case, there were arguments that the "act fairly" principle was so important that it was an umbrella for the other principles.[5]

It is thus clear that fairness is an extremely important aspect of meeting community expectations for insurers.

However, evidence such as complaint levels, adverse publicity and parliamentary inquiries suggests there is something of a groundswell of views in the community that insurance is often unfair.[6][7][8]

I hope this paper helps to markedly improve this position.

1 https://www.actuaries.org.uk/system/files/documents/pdf/seminar_2007_Lewin.pdf
2 For example, by distributing cargo across multiple boats
3 https://www.shepherdsfriendly.co.uk/resources/the-history-of-friendly-societies/
4 https://en.wikipedia.org/wiki/Actuarial_science
5 https://www.afr.com/companies/financial-services/hail-the-new-duty-of-fairness-for-financial-services-20191030-p535yh
6 https://www.insurancenews.com.au/daily/still-too-high-afca-insurance-complaints-climb-to-new-record
7 https://www.abc.net.au/news/2023-07-26/rising-home-insurance-premiums-raise-questions-of-fairness/102645526
8 https://www.swissre.com/institute/research/sonar/sonar2024/insurance-fairness.html

1.4 The Role of Boards

The role of Boards – especially those of financial services companies – has evolved significantly over the years. There are higher expectations placed on Boards than was once the case, and this includes taking a much broader perspective than their obligations to optimise shareholder profit.

The Board sets risk appetite, oversees culture, sets corporate values and determines the company's environmental, social, and governance (ESG)[9] stance and its strategy. It determines remuneration and incentives for management. Through legislation and regulation, the Board also carries considerable responsibility for the interests of customers.

It may also be able to sit above the fray, and so be more objective than management.

The Board thus sits in a unique and powerful position for ensuring fair treatment of customers.

1.5 This Paper

This paper draws together that critical role of the Board in overseeing fairness, and the need for improvement in fairness. Importantly, the paper does not propose that the Board encroach on management turf but rather seeks to strengthen Board governance.

In my experience, the great majority of directors of insurer Boards are diligent, capable, and intent on doing the right thing for customers. However, the role of an insurer Board is demanding and difficult, and inevitably there are ways to improve – in this case, oversight of fairness.

So, the paper is intended to help Boards of insurers to improve fairness for customers. It is not intended as a criticism of Boards for their past performance.

It does this by challenging Boards to consider how they carry out their duties to ensure fundamentally fair outcomes for their customers and how they might consider the insurer's impact on the community.

In this context, the sixth principle from the Royal Commission should resonate with directors:

When acting for another, act in the best interests of that other.

[9] https://en.wikipedia.org/wiki/Environmental,_social,_and_governance

2. The Challenge to Boards

The challenge to Boards is set out below in the form of questions. Boards should be able to satisfy themselves that the matters raised are being properly addressed by management or by the Board as appropriate.

Each subsection below addresses a particular matter for the Board to consider – see the box. In some cases, there is a supporting Appendix that contains background commentary to help understand the reasons for the questions.

2.1 Drivers of Community Views

What might be driving the groundswell of negative views, formal inquiries, etc (as mentioned earlier) about unfairness in insurance?

There are multiple examples of public criticism of insurers and their treatment of customers. **Appendix A provides some details.**

All of these matters are potential triggers for community unease. From the insurer's perspective, there may be a rational explanation for some; however, they have all contributed to consumer concerns. And, of course, even when there is a reasonable explanation for the insurer, the view of the customer may be quite different.

Questions for the Board

- Does the Board regularly and systematically consider the issue of fairness? For example, does it have a standing item on the Board agenda? Does it expect commentary on the impact of fairness in all relevant board papers?
- When considering matters of fairness, does the insurer consider all of the relevant contemporary areas of community concern, as set out in Appendix A (such as pricing for new customers relative to existing customers, or the appropriate use of customer data)?
- Does the Board have a stance on each of these areas of concern?
- Does the Board consider the harmony of the various matters addressed in this paper with each other and with community expectations?

2.2 Fairness – the Insurance System and Externalities

Appendix B provides supporting commentary.

There are two primary parties to an insurance contract – the insurer and the customer. Considerations of fairness start with those two parties.

However, there are others affected by insurance arrangements between the two primary parties. For example, society has an interest in properties being insured against natural catastrophes, since wider society often will be called on to help those impacted by a major catastrophe, and insurance will help maintain the economy to the benefit of all.

Also, a third party might suffer damage or loss (for example, in a car accident) with compensation dependent on the insurance held by the primary party.

As another example of an externality, the very existence of cover – for example, directors and officers, or cyber insurance – might encourage third parties to take legal action.

Thus, in various ways, other parties have an interest in fair treatment by the insurer.

Questions for the Board

- Does the insurer consider these various interests in the context of fairness?
- Does the insurer have a formal stance on how third-party interests should be considered by management? How does that stance sit with the insurer's corporate values and ESG stance?
- Does the insurer discuss these various interests in its communications with customers and society?

Matters for consideration

- Drivers of Community Views
- Fairness – the Insurance System and Externalities
- Obligations of Insurers and Customers
- Purpose and Principles of Insurance
- Financial Inclusion
- Cross-subsidies
- Product Philosophy
- Pricing Philosophy
- Claims Philosophy
- Individual Customer Disputes
- Quality of Customer Relationships
- Agency Risk, Incentives and Culture

2.3 Obligations of Insurers and Customers

There are multiple obligations placed on insurers to treat their customers fairly in insurance laws, other legislation, regulations, guidance from regulators and codes of conduct.

Appendix C provides a summary.

All of this suggests that there is no lack of formal direction given to insurers about fair treatment of customers.

At the same time, there are significant obligations in legislation placed on the customer. This starts with the principle of Utmost Good Faith, which is addressed in the Insurance Contracts Act 1984 and explained further in the next section. This Act also imposes a duty on the customer to take reasonable care not to make a misrepresentation to the insurer.

Social Licence and Trust

There is a legal requirement for an insurer to have a licence to operate, provided by APRA. However, there is also the concept of a 'social licence' – the idea that certain businesses are given a privileged position in society and in turn can be trusted by members of that society.

The rationale for this is particularly strong for financial services businesses – including insurers – as they effectively make money by helping their customers manage their financial affairs.

Note that even with the best of goodwill and intentions from both parties, there is asymmetry of information between the insurer and the customer. That is, the customer will nearly always know more about their particular circumstances, and the insurer will always know more about the product and its pricing. This underlines the importance of trust and mutual respect in the relationship.

Questions for the Board

- Does the insurer systematically consider each of the formal obligations in Appendix C in any changes to product or practices?
- Does the Board seek positive assurance from management (rather than limited or negative assurance) of compliance with fairness obligations from time to time?
- As a matter of course, does the insurer filter products and practices through the notions of unfairness set out in the Competition and Consumer Act?
- Does the insurer recognise its significantly superior knowledge and understanding of its products in its customer communications, handling of claims and training of staff?
- In its consideration of matters involving product design, pricing, claims management, etc., does the insurer give consideration to its position of trust in society and obligations under its social licence?

2.4 Purpose and Principles of Insurance

The purpose of insurance lays the foundation for what is fair or unfair.

That purpose basically is to protect the customer against financial loss from one or more specific contingencies – for example, the loss of property due to fire.

To help ensure the integrity of the process supporting that purpose, an insurer should have in place a set of *insurance principles* to guide them in their decision making. Principles to support fairness might address matters such as these:

- **Indemnity**

  Insurance cover is intended to indemnify the customer for loss. It is not intended to provide a windfall profit – for example, because the sum insured is much greater than the value of the loss.

  Note: This principle might also address particular issues such as the insurer's attitude to the cost of meeting new building codes and new-for-old car insurance.

- **Utmost Good Faith**

  Insurance policies are contracts requiring Utmost Good Faith on the part of both the insurer and the customer (as per the Insurance Contracts Act 1984). This means that all parties to an insurance contract must be open, honest and fair in their dealings with each other. The Insurance Council of Australia provides a fuller explanation.[10]

- **Objectivity**

  Ideally, each event that could be a claim should be objectively verifiable. So, a house fire would be readily verified. However, under various forms of modern insurance, there are claims that can be challenging to assess – for example, those that involve the ability to work (under general or life insurance). These types of claims can often lead to disputes because of this difficulty.

Questions for the Board

- Does the insurer have a set of clearly articulated and diligently followed insurance principles to guide management in decision making?
- Does the Board pay attention to the application of Utmost Good Faith by the insurer?
- Is Utmost Good Faith captured in the insurer's Corporate Values?

[10] https://insurancecouncil.com.au/resource/q-what-does-acting-in-good-faith-mean/

2.5 Financial Inclusion

Financial inclusion "*refers to efforts to make financial products and services accessible and affordable to all individuals and businesses, regardless of their personal net worth*".[11]

It is given significant attention by the International Association of Insurance Supervisors[12] and its related Access to Insurance Initiative (a2ii).[13]

While financial inclusion is normally considered to be an issue for developing economies, the principles are quite relevant for poorer or disadvantaged members of wealthy countries like Australia – for example, those on basic incomes, parts of the indigenous community or new immigrants.

The Poverty Premium in Insurance

There is a concept known as the "poverty premium", which is the phenomenon of poorer members of the community paying higher prices or carrying greater risk than others because of their disadvantaged position.

This conundrum is well explained by AngliCare.[14] Anglicare refers to a report by the Brotherhood of St Lawrence,[15] which explains the particular poverty premium issues that they see in insurance.

For example, poorer members of the community can often pay more for insurance and/or retain greater risk than wealthier people. There are multiple possible causes of this with insurance[16] – for example, a lack of basic, low-cost contents insurance for poorer people living in higher-risk areas. They may find that a product is pitched at more wealthy people through its minimum levels of cover. A simple product, with basic cover might help meet their needs. Other examples of solutions include *incidental* insurance (cover as needed) and *embedded* insurance (cover built into products),[17] which could be facilitated by Insurtech.

The Brotherhood of St Lawrence proposes actions by various members of society, including insurers.

One estimate of this poverty premium effect in the UK[18] is 300 pounds a year for motor insurance alone.

Questions for the Board

- Does the insurer systematically consider how suitable their products may be for poorer or disadvantaged members of the community?
- Does the insurer have a corporate policy on this? How does this fit with the insurer's corporate values and ESG stance?
- Does the insurer analyse their products and pricing models to understand how they may be inadvertently excluding poorer members of the community, and adjust their models accordingly?

11 https://a2ii.org/en/home
12 https://www.iaisweb.org/activities-topics/financial-inclusion/
13 https://a2ii.org/en/home
14 https://www.anglicare.asn.au/wp-content/uploads/2023/09/Australia-Fair-The-Poverty-Premium.pdf – see page 23.
15 https://library.bsl.org.au/bsljspui/bitstream/1/6063/1/Collins_Reducing_the_risks_insurance_summary_2011.pdf
16 https://library.bsl.org.au/bsljspui/bitstream/1/6063/1/Collins_Reducing_the_risks_insurance_summary_2011.pdf
17 See page 14: https://actuaries.asn.au/Library/Opinion/DataScienceAI/2022/ABSDataPaper.pdf
18 https://actuaries.org.uk/general-insurance-spring-conference-2024-future-pricing/

2.6 Cross-subsidies

Cross-subsidies are something of a vexed, but very important issue when fairness is considered.

Appendix D provides detailed comments on cross-subsidies.

In a sophisticated system of risk pooling, each participant would pay according to the risk being insured – that is, participants would contribute to the pool according to their particular detailed circumstances. However, in practice, cross-subsidies emerge in various ways: in pricing, product terms and conditions, underwriting, and claims management.

Some are by design; some are a compromise; some are accidental.

Some are even legislated – for example, health insurance has heavy cross-subsidies mandated (with some offsetting tax incentives), as does compulsory third party (CTP) insurance.

Not everyone would like what is done in all cases.

Questions for the Board

- Does the insurer have a clear policy on cross-subsidies, which considers matters such as strategy, competition, risk management, corporate values, laws and regulations and community expectations?
- Does the insurer actively monitor and manage sources and levels of cross-subsidy (including those mandated by government), analyse the marketing and profitability implications and report the position to the Board systematically?
- Is it clear who has the authority to determine acceptable cross-subsidies?

2.7 Product Philosophy

A clearly articulated product philosophy would help ensure close consideration of the approach to product terms, conditions and features. It would set guidelines for management, taking into account strategy, risk appetite, profitability, competition, regulatory matters and community expectations (including ESG), etc..

It would address matters such as:

- constraints (if any) on target market segments for each product line
- clarity of language and transparency of intent in all material
- simplicity vs complexity of product, including possibility of alternative products, and aids to affordability, such as ability for customer to restrict cover
- the sustainability of the product, in the sense of product features that should not need significant change over time (particularly relevant for long-term life insurance)
- minimum claims payout ratio – noting that low ratios can be due to excessive profit margins or high expenses, but in either event may produce poor value for customers
- meeting community expectations, including “can we” vs. “should we”, and offsets to the benefits from social security and other insurance
- responding to corporate values
- assessing the risks of the product against risk appetite.

Questions for the Board

- Does the insurer have a formal product philosophy?
- Does the Board review and sign off the product philosophy?
- Does it address all of the points listed above and/or is there a considered reason for not doing so?
- Does the Board review compliance with the spirit of the product philosophy?
- Would the Board be comfortable if the product philosophy were inadvertently published?

2.8 Pricing Philosophy

Note: The pricing philosophy and product philosophy are related and would need to be mutually supportive.

A clearly articulated pricing philosophy would help ensure close consideration of the approach to pricing. It would set guidelines for management, taking into account strategy, risk appetite, profitability, competition, regulatory matters and community expectations (including ESG), etc..

It would address matters such as:

- technical pricing and market pricing
- what account may be taken of the matter of social licence and trust mentioned in section 2.3 above, and the implications of this for profitability targets, including fair profit margin targets – (see box and footnote 19)?
- use of loss leadership – including intention for future profitability of loss leaders.
- the sustainability of the pricing, in the sense that it should not need significant change over time (particularly relevant for long-term life insurance)
- recovery of past losses from existing and future customers (again, particularly important for life insurance)
- communication of likely price increases at the time of purchase
- pricing for new customers versus established customers
- approach to cross-subsidies in pricing
- aids to affordability, such as monthly payments and associated loadings
- minimum premiums
- responding to corporate values
- assessing pricing risk against risk appetite.

Questions for the Board

- Does the insurer have a formal pricing philosophy?
- Does the Board review and sign off on the pricing philosophy?
- Does it address all of the points listed above and/or is there a considered reason for not doing so?
- Does the Board review compliance with the spirit of the pricing philosophy?
- Would the Board be comfortable if the pricing philosophy were inadvertently published?

Profit

In broad terms, there are various components of pricing and experience (i.e., actual vs. expected performance) where profit emerges.

For example, there is typically substantial capital supporting the ongoing viability of a product, which must be serviced, there are a variety of services provided to customers through the product, which would contribute to cost and profit, and there are risks to the insurer for which the shareholder would seek compensation.

Understanding the margins in the various components and their reasonableness may help the Board in considering this issue.

[19] In the general insurance field in particular, there are various analyses of theoretical fair pricing, which might help management support the Board in these considerations – for example, see https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4437638 and https://www.casact.org/sites/default/files/2021-07/Determination-Optimum-Fair-Ussif-Jones.pdf.

2.9 Claims Philosophy

A clearly articulated claims philosophy would help ensure close consideration of the approach to claims management. It would set guidelines for management, taking into account strategy, risk appetite, profitability, competition, regulatory matters and community expectations (including ESG).

A well-crafted claims philosophy should help in difficult claims decisions, help avoid disputes and help avoid any bias in favour of shareholder profit over claims payments.

It would address matters such as:

- communication, including with claimants with non-English-speaking backgrounds
- meeting community expectations, including "could we" vs. "should we"
- consideration of corporate values
- passive vs. active assistance to claimants – that is, is the insurer's starting position that a claim is valid or that it should be denied until proven valid?
- approach regarding potential fraudulent claims
- promptness of claims finalisation
- operational preparedness for mass claims events (e.g., following a natural catastrophe) and messaging to customers
- responding to corporate values.

Questions for the Board

- Does the insurer have a formal claims philosophy?
- Does it avoid platitudes such as "We pay all valid claims"?
- Does it address all of the points listed above and/or is there a considered reason for not doing so?
- Does the Board review and sign off on the claims philosophy?
- Does the Board review compliance with the claims philosophy in practice and in spirit?
- Has the Board satisfied itself that the claims philosophy will be honoured in the event of a mass claims event (e.g., following a natural catastrophe)?
- Would the Board be comfortable if the claims philosophy were inadvertently published?

2.10 Individual Customer Disputes

There are various areas of insurance arrangements where misunderstandings or disagreements can emerge with individual customers. They include:

- the scope of coverage – for example, whether a free-standing garage is covered against fire under the home insurance policy;
- the wording of policies – for example, how a definition of disability may be interpreted. This can lead to disputes over eligibility for a claim;
- the pricing model used by the insurer – for example, this model could produce markedly different premium rates for risks that, to the layperson, appear similar;
- reasons for increases in premiums – for example, why life insurance premiums may have increased so much in recent years;
- customers seeking payments that are not technically covered by the policy, though they think they should be; and
- fraudulent claims.

Concerns of this nature, particularly if numbers are high, may indicate some underlying unfairness. Analysis of complaints information from multiple sources (internal records, Australian Financial Complaints Authority (AFCA) records, surveys of complainants, surveys of intermediaries, etc.) will provide useful insights.

Questions for the Board

- Does the Board regularly review underlying reasons for complaints to gain insights into fairness?
- Does the Board draw on multiple sources of information to gain those insights, and do they go as deep as they should in order to understand fairness?

2.11 Quality of Customer Relationships

Most insurers will assess the relationship they have with customers and other interested parties. Typically, the Board will be provided periodically with a summary. This summary may include, for example, Net Promoter Scores[20] for various segments of customers, including those making claims.

A significant failure of typical methods is that they rely on averages. That is, they provide an average score. The Royal Commission showed that, even when average experience seems reasonable, those who have a poor experience can have a very poor experience indeed. This can be lost in average scores, and the lessons missed, accordingly.

One relatively simple way of dealing with this is to analyse the views of people in the "tail" – that is, those who have had poor experiences. For example, the analysis of the end-to-end experience of customers who have complained through the insurer's internal complaints resolution process or to the AFCA.

Analysis of ex-gratia payments may also provide useful insights – for example, high levels may indicate a tendency to deny claims until claimants push back, and the type of claims and product for which ex-gratia payments are made may indicate problem areas.

For life insurers, APRA and ASIC data about claims disputes[21] would add further richness. These could give considerable insights to management and the Board.

The fairness of treatment by any intermediaries used by customers, such as financial planners for life insurance and brokers for general insurance, is important for the insurer, and intermediaries can help customers with fairness concerns. The management of fairness by intermediaries is outside the scope of this paper; however, insurers would benefit from analysis of this and the implications for both treatment of customers and the quality of the intermediaries.

Comment

There are various more sophisticated methods for assessing the quality of customer relationships – see for example: The Social Condition Report – A Suggestion for Financial Services Businesses.[22]

Questions for the Board

- Does the Board regularly review the quality of customer relationships?
- Is the methodology used a simple one based on averages, or does it use sophisticated analysis to provide deep insights and nuances, especially concerning those customers who have been treated poorly, complained and/or been given ex-gratia payments?
- Does the insurer assess the fair treatment of customers by intermediaries and consider the implications for the insurer?

2.12 Agency Risk, Incentives and Culture

Any business is exposed to the risk of management making decisions – deliberately or otherwise – in their own interests, rather than in the interests of shareholders and/or policyholders as needed. This is known as agency risk.

In the case of insurance companies, there is also the risk of management not giving due consideration to the interests of customers, and indeed, the community.

Remuneration, incentives and recognition could all encourage behaviour and decision making, which could lead to unfairness.

Culture, and its cousin, risk culture, are equally critical in maintaining fairness over time. Attitudes to fairness in staff and management should be considered in any assessment of culture.

Under the Financial Accountability Regime (to apply from March 2025) it would be helpful if fairness were specifically addressed in Accountability Statements.[23]

Questions for the Board

- Does the Board apply a customer fairness filter when setting and assessing remuneration, incentives and recognition?
- Does the Board formally assess agency risk, and is it included in its Risk Appetite Statement?
- Does the Board specifically assess culture against its fairness expectations? For example, does it assess attitudes and behaviours concerning respect for customers?
- Do Accountability Statements clearly address fairness?

[20] https://en.wikipedia.org/wiki/Net_promoter_score

[21] https://www.apra.gov.au/life-insurance-claims-and-disputes-statistics

[22] https://actuaries.asn.au/public-policy-and-media/our-thought-leadership/dialogues/the-social-condition-report---a-suggestion-for-financial-services-businesses

[23] https://www.apra.gov.au/financial-accountability-regime

3. Conclusion and Response

3.1 Critical Role of the Board

Current community concerns with fairness in insurance require attention at the highest levels in the insurance industry.

Because of their accountabilities – corporate values, culture, risk appetite, strategy, ESG stance, customer interests, remuneration and incentives, and compliance – insurer Boards are in a critical position and thus must closely oversee the fair treatment of customers.

In other words, fairness should be put on a pedestal, and the Board can do that best.

3.2 How Might the Board Respond to the Challenge in This Paper?

It would be easy for management and/or Board to ignore the challenge – perhaps because of a belief that "there is nothing to see here".

However, systematically considering the series of questions posed in this paper, I would argue, will give the Board insights and understandings that could markedly help improve fairness for customers.

There are various ways this response could be approached. For example, the Board could:

- ask management to review the questions and report back to the Board with management's overall conclusions. However, this could suffer from confirmation bias, and lack independent challenge;
- ask management to prepare a response to each question, with supporting evidence, and then, the Board could discuss/ constructively challenge the outcome; or
- use the paper as the foundation for a workshop with management, perhaps with facilitation by an appropriate executive – for example, by the Appointed Actuary or Chief Customer Officer.

Whatever the response chosen, I hope that it helps the Board with its governance and helps move the industry towards better overall practices and fairer treatment of customers.

Appendices

Appendix A: Drivers of Community Views

Here are some of the issues that may have affected community views about fairness in insurance:

- **Deeper analysis** – improvements in access to data and its analysis has enabled insurers to increase the precision of individual risk assessments. This has meant that prices for some customers have increased because of this alone (though others have benefited).
- **Very large rises in home insurance premium rates**[24] [25] [26] [27] [28] – there are various reasons for this including the preponderance of natural disasters in recent years – which many would argue is at least, in part, a function of climate change – steep increases in the cost of reinsurance for insurers and significant increases in building costs. This has flowed into insurance premiums for home insurance, including for those unaffected by the specific events.[29] AFCA has challenged the justification for an increase in at least one case.[30]

  Note: The cost of home and contents insurance in North Queensland has been particularly controversial in recent years. This prompted Federal Government intervention with the establishment of a special reinsurance pool intended to reduce prices. Amongst other things, this pool introduces inherent cross-subsidies. The ACCC is monitoring its impact.[31]

- **Improvements in flood modelling**[32] – this has resulted in the assessment of flood risk for homes in certain areas changing, with home insurance prices rising (or falling) accordingly.
- **General Insurance industry response to major flood events in 2022** – for example, concerns include extended periods for claims to be settled and accusations of lowball cash settlements[33] – led to an inquiry by the House of Representatives Standing Committee on Economics. The Committee reported in October 2024,[34] with 86 recommendations covering the industry, government and others. The industry was quick to respond, supporting all recommendations.[35]
- **Pricing practices** – some insurers have adopted pricing models, which in seeking to maximise profits, can result in new customers being offered premium rates that are lower than those for existing customers.[36]

  Note:

  a. Following similar concerns in the UK, in 2021, the Financial Conduct Authority issued rules aimed at ensuring that renewing home and motor insurance customers are offered similar terms to new customers. The FCA has also laid down a Consumer Duty which requires amongst other things fair value and regard for certain vulnerabilities.

  b. In life insurance, there can be sound technical reasons for the price quoted for a new customer being lower than that charged for an existing customer of the same age.

- **Pricing Discounts** – when challenged by the customer, general insurers will sometimes discount the premium they had quoted on renewal,[37] giving the customer some satisfaction, but also arousing suspicion that the original price increase was unfair.
- **Hayne Royal Commission**[38] – the Hayne Royal Commission drew out multiple examples of insurer behaviours and practices that did not meet community expectations. This was given considerable publicity at the time.
- **Insights from the AFCA** – AFCA handles many insurance complaints each year. These are normally disputes that have not been resolved by the insurer's internal complaints resolution processes. AFCA monitors trends and (quite rightly) makes public observations about what it finds. There has been a rising trend of complaints for insurance.[39] [40] This could be a function of increasing discontent with treatment of customers by insurers.
- **APRA and ASIC life insurance claims and disputes statistics** – APRA and ASIC monitor claims disputes in life insurance and publish their findings with associated criticism as deserved.

[24] https://actuaries.asn.au/Library/Opinion/Generalinsurance/2023/240229HIAUV2.pdf
[25] https://insurancecouncil.com.au/issues-in-focus/affordability/
[26] https://insurancecouncil.com.au/resource/ica-statement-19-august-2023/
[27] https://www.afr.com/policy/economy/home-insurance-premiums-are-up-56pc-but-insurers-are-making-a-loss-20240402-p5fgt1
[28] https://www.insurancenews.com.au/daily/household-insurance-cost-climb-at-fastest-pace-in-23-years
[29] https://actuaries.asn.au/public-policy-and-media/our-thought-leadership/climate-and-sustainability-thought-leadership
[30] https://www.insurancenews.com.au/daily/insurer-told-to-rethink-home-premium-after-unjustified-increase
[31] https://www.accc.gov.au/system/files/accc-insurance-monitoring-report-december-2023.pdf
[32] https://www.abc.net.au/news/2024-06-13/kensington-banks-melbourne-water-flood-mapping-value-loss-fears/103960736
[33] https://www.insurancenews.com.au/daily/counsellors-flag-widespread-practice-of-lowball-cash-settlements?
[34] https://www.aph.gov.au/Parliamentary_Business/Committees/House/Economics/FloodInsuranceInquiry/Report
[35] https://insurancecouncil.com.au/resource/insurers-welcome-parliamentary-report-into-2022-flood-response/
[36] https://www.smh.com.au/money/insurance/surging-home-insurance-premiums-penalise-loyal-customers-20240201-p5f1rq.html
[37] For example: https://www.abc.net.au/news/2024-06-22/insurance-inflation-sticky-how-i-brought-mine-down
[38] https://insurancecouncil.com.au/issues-in-focus/hayne-royal-commission/
[39] https://www.insurancenews.com.au/daily/still-too-high-afca-insurance-complaints-climb-to-new-record
[40] Five years history can be found here: https://www.afca.org.au/annual-review-overview-of-complaints

- **Increases in life insurance premium rates beyond normal expectations** – the typical individual life insurance policy allows the insurer to increase premium rates during the course of the policy term (over and above increases due to age and indexation of cover). Because claims experience has been higher than allowed for in pricing, premium rates have been increased beyond customer expectations. One significant driver of these rate increases has been changing social attitudes and expectations – for example, customers are now much more likely to make claims under disability insurance for mental health reasons.[41]
- **APRA intervention** – APRA intervened in the disability income insurance market in 2020 because of concerns about sustainability of product and pricing practices. Public statements were made about this.
- **Increases in premium rates for "level premium" life insurance** – policies that have no provision for increases in premium as the customer ages usually allow the insurer to increase premium rates during the term of the policy if there has been high claims experience. This right has been exercised by insurers in recent years, which has surprised some financial advisers and customers.
- **Steep increases in premiums for death and disability cover provided through superannuation funds** – there have been a number of occasions over recent years where significant premium increases were imposed by life insurers, and these were passed on to members of the super funds. This was largely driven by disability claims being more frequent and lodged later than expected.
- **Use of genetic information** – the potential use of genetic information to aid in life insurance underwriting has been a controversial issue for some years and has come to a head more recently, with proposed legislation to ban its use.
- **Protection of and appropriate use of data** – there have been instances of insurer's customer data being hacked, with associated adverse publicity.[42]

  Note: Overseas, there have been instances of inappropriate and potentially illegal use of customer data associated with the use of modern technology (telematics), which may be a risk in Australia.
- **Private health insurance premium rates** – health insurance is unusual in that premium rates require the approval of the Federal Health Minister. Nonetheless, over time the premium rates need to reflect the underlying costs of insured health services.[43] Increases in recent years have been reasonable relative to inflation; however, the absolute cost of health insurance is high and even modest percentage increases can cause financial distress to customers. There have also been significant increases for some health funds[44] and certain products.[45]
- **Adverse publicity about insurer profitability**[46] [47] – as general insurer profits have recovered in recent times from previous poor experience, there has been some quite negative publicity, with suggestions of price gouging. This commentary may not have considered the need to service the substantial capital that insurers are required to hold.
- **Intent of Regulators**[48] – the ASIC corporate plan for 2024–25 was recently published, and includes adverse comments about the treatment of customers – for example: "We will take action against insurers in relation to claims handling, especially in relation to home insurance claims," and "We will also take action in response to harmful product design and distribution practices, including conduct that results in consumers receiving unsuitable products … we will also monitor general insurers' improvements to claims handling and engage with the independent review of the 2020 General Insurance Code of Practice."

Comment

Elsewhere in this paper, there are references to the insurer's corporate values, corporate objectives, remuneration policy, culture, product philosophy, pricing philosophy, and claims philosophy. These drive management thinking and behaviours and hence heavily influence fairness.

It is important, therefore, that all of these are in harmony with each other and with community expectations. This should be considered systematically.

41 https://actuaries.asn.au/Library/Miscellaneous/2017/GPMENTALHEALTHWEBRCopy.pdf

42 https://www.theguardian.com/australia-news/2023/feb/16/medibank-class-action-launched-data-breach-private-information-dark-web

43 https://www.health.gov.au/sites/default/files/documents/2020/12/average-annual-increases-in-private-health-insurance-premiums-list-of-historical-premium-increases-by-insurer-for-2022.pdf

44 https://www.choice.com.au/money/insurance/health/articles/how-to-avoid-health-insurance-premium-hikes

45 https://www.abc.net.au/news/2024-05-23/health-insurance-premium-increase/103883014

46 https://www.news.com.au/finance/business/other-industries/insurer-profits-reveal-huge-greedflation-amid-rising-premiums/news-story/f467dd3da3f484ba535b0c4318cbe10a

47 https://www.aap.com.au/news/crying-poor-claim-as-insurers-accused-of-price-gouging/

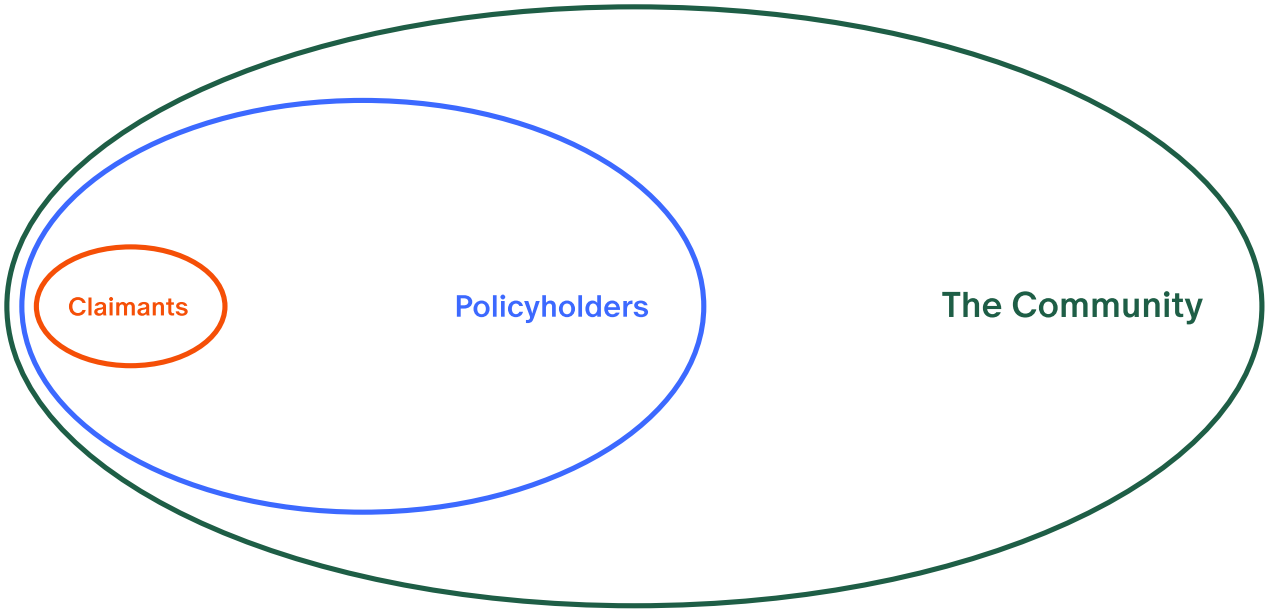
48 https://www.insurancenews.com.au/daily/regulator-s-strategic-plan-targets-insurance-misconduct

Appendix B. Fairness in the Insurance System and Externalities

The Insurance Pool and the Community

There are two primary parties to an insurance contract – the insurer and the customer (including the beneficiary under a claim if not the policy owner). So, considerations of fairness start with these two parties.

However, there are others affected by insurance arrangements between the two primary parties. For example, society has an interest in properties being insured against natural catastrophes, since society often will be called on to help those impacted by a major catastrophe, and insurance can help maintain the economy in such circumstances, to the benefit of all.



Not to scale

As another example, all participants in the risk pool have an interest in the fair payment of claims from the pool. That is, if unnecessary or fraudulent claims are paid then all participants in the pool will eventually pay more.

Arguably this has happened with some types of life insurance, such as trauma or disability insurance.

It can be argued that this is a kind of economic externality. As another example of an externality, the very existence of cover – for example, directors and officers, or cyber insurance – might encourage third parties to take legal action. Another example is that the withdrawal of a particular cover from a geographic area can have profound consequences for society in that area.

Sometimes, a third party might also suffer damage or loss (for example, in a car accident), with compensation dependent on the insurance held by the primary party.

So, any assessment of fairness should also consider the interests of relevant third parties.

Appendix C. Laws and Regulations

There are multiple laws and regulations that address the fair treatment of insurance customers. Many of these are summarised below (however, note that this is not a complete list nor should it be relied on for legal analysis):

The Corporations Act 2001 and ASIC Guidance

S912A of the Corporations Act makes clear that:

" (1) A financial services licensee must:

*(a) do all things necessary to ensure that the financial services covered by the licence are provided efficiently, honestly and **fairly**; and ..."*

That is, the very financial services licence under which an insurer operates dictates that the licensee must act fairly.

There are other aspects of the Corporations Act that relate to fairness – for example, the unfair contract provisions now apply to insurance contracts written after 5 April 2021.

Design and Distribution Obligations (DDO) were included in the Corporations Act from 2021. ASIC addresses DDO in RG 274, which includes this summary:

"
- *issuers must design financial products that are likely to be consistent with the likely objectives, financial situation and needs of the consumers for whom they are intended;*
- *issuers and distributors must take 'reasonable steps' that are reasonably likely to result in financial products reaching consumers in the target market defined by the issuer; and*
- *issuers must monitor consumer outcomes and review products to ensure that consumers are receiving products that are likely to be consistent with their likely objectives, financial situation and needs."*

Under the Corporations Act, insurers are also required to provide a Product Disclosure Statement to prospective customers. ASIC addresses this in RG 168. It makes clear that a PDS must contain sufficient information so that a retail client may make an informed decision about whether to purchase a financial product. The broad objects of a PDS disclosure are to help consumers compare and make informed choices about financial products.

Insurance laws

Throughout this legislation and regulation, there are strong obligations placed on insurers to treat their customer fairly. For example, the Insurance Act 1973 states that one of its main objects is *"to protect the interests of customers and prospective customers under insurance policies (issued by general insurers and Lloyd's underwriters) in ways that are consistent with the continued development of a viable, competitive and innovative insurance industry".*

Likewise, the Life Insurance Act 1995 says one of its main objects is *"to protect the interests of the owners and prospective owners of life insurance policies in a manner consistent with the continued development of a viable, competitive and innovative life insurance industry".*

The Private Health Insurance Act 2007 is not as explicit about the interests of customers, though Chapter 5 provides considerable power to the Minister and is intended to protect the interests of customers.

Consumer law

The full text of the Australian Consumer Law (ACL) is set out in the Competition and Consumer Act 2010.[49]

The ACL website explains that ACL includes:

"
- *a national unfair contract terms law covering standard form consumer and small business contracts;*
- *a national law guaranteeing consumer rights when buying goods and services;*
- *a national product safety law and enforcement system;*
- *a national law for unsolicited consumer agreements covering door-to-door sales and telephone sales;*
- *simple national rules for lay-by agreements; and*
- *penalties, enforcement powers and consumer redress options."*

According to NSW Fair Trading,[50] for example:

> "Australian Consumer Law guarantees your rights when you buy goods and services. In fact, most products and services purchased after 1 January 2011 come with an automatic consumer guarantee that the product or service you purchased will work and do what you asked for. **This includes insurance services.**"

[49] https://www.legislation.gov.au/C2004A00109/latest/text

[50] https://www.fairtrading.nsw.gov.au/buying-products-and-services/buying-services/insurance

The Competition and Consumer Act defines an unfair contract:

24 Meaning of *unfair*

*"(1) A term of a consumer contract or small business contract is **unfair** if:*

(a) it would cause a significant imbalance in the parties' rights and obligations arising under the contract; and

(b) it is not reasonably necessary in order to protect the legitimate interests of the party who would be advantaged by the term; and

(c) it would cause detriment (whether financial or otherwise) to a party if it were to be applied or relied on.

(2) In determining whether a term of a contract is unfair under subsection (1), a court may take into account such matters as it thinks relevant, but must take into account the following:

(a) the extent to which the term is transparent;

(b) the contract as a whole.

*(3) A term is **transparent** if the term is:*

(a) expressed in reasonably plain language; and

(b) legible; and

(c) presented clearly; and

(d) readily available to any party affected by the term.

(4) For the purposes of subsection (1)(b), a term of a contract is presumed not to be reasonably necessary in order to protect the legitimate interests of the party who would be advantaged by the term, unless that party proves otherwise."

Anti-discrimination law

Insurance is addressed in the Federal Disability Discrimination Act 1992 (DDA). The Australian Human Rights Commission has produced guidelines for insurance companies.[51] These guidelines state:

"The DDA generally makes it against the law to discriminate against a person because of disability when providing insurance and superannuation. This covers all forms of general, health and life insurance issued by registered insurers, and includes underwritten and non-underwritten applications and policies issued by insurers.

However, the DDA recognises that some discrimination is necessary in the insurance business. It contains a partial exemption for insurance and superannuation providers in s 46. It also contains a general defence which may apply to providers where not discriminating would cause them unjustifiable hardship."

The DDA allows some discrimination in insurance if the discrimination:

- is based upon actuarial or statistical data on which it is reasonable to rely, and the discrimination is reasonable having regard to the matter of the data and other relevant factors (the data limb)

or

- in a case where no such actuarial or statistical data is available and cannot reasonably be obtained – the discrimination is reasonable, having regard to any other relevant factors (the no data limb).

The guidelines go into some detail, expanding on these points. They also say:

"The Federal Court has stated that '[w]hether the discrimination is shown to be reasonable is a question of fact in all the relevant circumstances'. The question of whether the discrimination is reasonable 'is a judgment to be made objectively with the knowledge and in the circumstances of the discriminator, but including factors of which the discriminator ought to have been aware."

APRA

APRA has various requirements set down in Prudential Standards[52] that place specific responsibility and/or accountability on an insurance company Board. It has also issued an Aid for Directors[53] to provide some guidance. While these do not address fairness per se, they do go to sound governance and risk management, which are essential for proper oversight of fairness.

[51] https://humanrights.gov.au/sites/default/files/AHRC_DDA_Guidelines_Insurance_Superannuation2016.pdf

[52] https://handbook.apra.gov.au/

[53] https://www.apra.gov.au/sites/default/files/aid-for-directors-october-2014.pdf

AFCA

AFCA has a strong focus on fairness. For example, the AFCA Rules include:

"A.2 Principles that underpin the scheme

A.2.1 AFCA will:

...

c) consider complaints submitted to it in a way that is:

*(i) independent, impartial, **fair**,*

*(ii) in a manner which provides procedural **fairness** to the parties,*

(iii) efficient, effective, timely, and

(iv) cooperative, with the minimum of formality;

..."

Life Insurance Code and General Insurance Code

Life insurers and general insurers have each adopted a code of practice.

The AFCA website states the following:

"The Life Insurance Code of Practice (the Code) requires life insurers, friendly societies that offer life insurance products and other industry participants, who have adopted the Code to provide services to their customer of a high standard and in a timely, honest, fair and transparent way.

The Code aims to improve standards of service and practice in the Australian life insurance industry. Life insurers that adopt the code have formally agreed to be bound by its standards.

The Code's standards apply to many features of a customer's relationship with their insurer including when buying insurance, what to expect when making a claim, including timeframes for making a claim decision, and processes for making complaints.

The Code is owned and published by the Council of Australian Life Insurers (CALI) and forms an important part of the broader financial services customer protection framework. All life insurers which are CALI members are required to be compliant with the Code."

and

"The General Insurance Code of Practice (the Code) requires insurers, and other industry participants, who have adopted the Code to provide services to their customers in an open, fair and honest way.

The Code's standards apply to many features of a customer's relationship with their insurer including when buying insurance, what to expect when making a claim, including timeframes for making a claim decision, and processes for making complaints.

The Code also requires insurers to provide assistance to individuals who are in financial hardship and having difficulty meeting their financial obligations to an insurer. This includes:

- *a customer who has made a claim but is experiencing difficulty paying an excess to their insurer, or*
- *a person who owes an insurer money because they caused damage while uninsured.*

In such cases, the Code sets out hardship and debt collection standards for general insurers and their agents to follow.

The Code is owned and published by the Insurance Council of Australia and forms an important part of the broader financial services consumer protection framework."

Note: This code is currently under review[54]: at the time of writing, the review panel had just published their Initial Report with recommendations.[55]

Comment

Compliance with all of the above would be expected by the Board as a matter of course. However, if not managed systematically, non-compliance will likely emerge, potentially undermining fairness. The Board could seek positive assurance from management (rather than limited or negative assurance) of compliance with these fairness obligations from time to time as a basic step.

[54] https://codeofpracticereview.com.au

[55] https://codeofpracticereview.com.au/wp-content/uploads/2024/09/240905_FINAL-GICOP-Review-Initial-Report.pdf

Appendix D. Cross-subsidies

In a basic system of risk pooling, each participant would pay the same amount per dollar of cover, irrespective of the riskiness of the individual participant's cover. I refer to this as ***simple pooling*** of risk.

In a sophisticated system of risk pooling, each participant would pay according to the risk being insured – that is, participants would contribute to the pool according to their particular detailed circumstances; there would be no cross-subsidies between participants in the pool. I refer to this as ***personalised pooling*** of risk.

Simple pooling:

High cross-subsidy

- Everyone pays the same
- Few constraints on participants

Some cross-subsidy

- Some cross-subsidy, perhaps with constraints imposed by legislation

Personalised pooling:

No cross-subsidy

- Each pays according to their particular risks
- Requires underwriting

When considered from the *personalised pooling* perspective, there are cross-subsidies in simple pooling. That is, some members of the pool are paying less for the cover than the risk indicates, and others are paying more.

And of course, there are grey areas in between the simple and personalised systems.

Both personalised and simple systems of risk pooling operate in Australia, depending on the type of insurance. Does this mean some types of insurance are fair and others are not?

Management of Cross-subsidies

An insurer is able to manage cross-subsidies in its insurance offerings in a number of ways – for example:

- through the policy terms and conditions – the tighter these are, the less scope there is for cross-subsidy. For example, a definition of disablement could be loosely worded, allowing for claims with differing degrees of disability;
- through underwriting – this might restrict cover in some way for an individual customer, decline cover altogether, or increase the premium above standard rates. Examples include charging higher premiums for younger drivers or declining flood cover following a better understanding of the risk for a particular property;
- through the use of technology. For example, "telematics"[56] may be used to dynamically assess the quality of a customer's driving, and the premium set accordingly;
- through incentives for the customer to manage the risk. For example, life insurers sometimes offer pricing incentives for customers who engage in ongoing wellness activities; and
- through pricing – the more refined the pricing, the closer the premium will reflect the individual risk.

[56] https://aisgroup.com.au/telematics-continues-to-evolve-in-insurance/

Cross-subsidies in the Open Market

The insurance market is unlikely to maintain substantial cross-subsidies for any particular line of insurance without some intervention by legislation or regulation. This is because, absent any such controls, insurers will compete (with price and otherwise) to attract the lower risk part of the market, and this will lead to the breakdown of cross-subsidies over time.

Having said that, modest cross-subsidies are likely to be present in many insurance pricing models. Some may be deliberate for marketing or profitability reasons, and in others, it may be a function of approximations in the pricing model or data deficiencies.

In still other cases, cross-subsidies may be dictated by legislation.

Why Might a Government Impose Cross-subsidies?

Insurance often serves a purpose for society at large – that is, beyond the needs of the individual. So, a government might decide that certain types of insurance are mandatory, because that would be in the best interests of wider society. A good example of this is insurance against personal injury to third parties in a motor accident (CTP insurance).

Mandatory insurance does not need to have cross-subsidies, but it would seem that governments tend to include common premiums in the mandatory package – perhaps to avoid accusations that the cost is prohibitive for some people.

Private health insurance is not mandatory, but the federal government strongly encourages it with various incentives and penalties – see the box – which illustrate the difficulty in maintaining voluntary insurance with inherent cross-subsidies. Insurers are required to set a premium rate for a product that applies irrespective of health or age (though there are some rating factors in some circumstances – again, see the box). Annual premium increases for each insurer require approval from the Minister of Health. So, there are high cross-subsidies in private health insurance, with the young subsidising the old and the healthy subsidising the unhealthy.

A more subtle example of enforced cross-subsidies is found in life insurance, where there are restrictions on the use of genetic information to indicate a predisposition to disease. There are sound reasons for this when wider society is considered. At the time of writing, legislation has been proposed to ban the use of genetic information.

Private health insurance incentives and penalties imposed by Government:

- universal access – anyone can join, with little constraint and no underwriting;
- community rated – everyone pays the same rates, so the young and healthy subsidise the old and unhealthy. However, if you start cover after age 30, then, you pay higher premium rates;
- government control of pricing – unlike other insurance, the Federal Minister of Health approves/controls premium rates;
- tax benefits for customers – there are tax rebates on PHI premiums, which are income-tested. So, the taxpayer subsidises those with PHI, particularly lower income earners;
- tax penalties for others – there is a tax surcharge for higher income earners who don't have PHI; and
- insurers share risk – there is a mandatory "risk equalisation" process each year, which forces insurers to share risk amongst themselves. That means one insurer can't get an advantage over other insurers by, for example, focusing on the young and healthy.

Are Cross-subsidies Unfair?

Are cross-subsidies axiomatically unfair?

Can there be good reasons to maintain cross-subsidies in some cases?

If so, who has responsibility to moderate the cross-subsidies and decide what is fair?

Should cross-subsidies apply for risk factors outside the control of the customer?

These questions go to the heart of some of the controversies about fairness in insurance.

In more recent years, general insurers have become increasingly sophisticated in their ability to assess the risk of an individual case. In home insurance, for example, improved flood mapping has meant that flood risk can be assessed at the individual property level, and the insurance has been priced accordingly. As a result, past cross-subsidies have been removed in many cases, and this has driven up prices for affected customers.

As another example, "telematics" technology has been developed which allows the driving behaviour of a motor insurance customer to be assessed in some detail – speed, cornering forces, braking and so on. Insurance has been developed that takes this into account.

In some cases, for marketing or profitability reasons, new customers have lower prices than established customers – with inevitable cross-subsidies in favour of the newer customers.

Who Decides on the Degree of Cross-subsidy?

I have discussed cross-subsidies imposed by legislation above, but who makes the decisions about cross-subsidies in other cases? Is it a technical matter for actuaries? Is it a marketing matter? Is it a decision by senior management? Or is it something the Board should sign off?

First, it should never be a purely technical decision. Yes, technical work is necessary to identify and/or target cross-subsidies and assess their impact on profit. However, the implications of cross-subsidies must be considered in the context of the market, strategy, corporate values, laws and regulations, and community expectations, given their potential impact.

Incidentally, there is a school of thought that cross-subsidies are more appropriate when the customer has no choice or can't mitigate the risk – for example, when an insurer decides to change their assessment of flood risk.

The issues of cross-subsidy are so important to an insurer's relationship with its customers and the community, to its strategy, and to its risk management, that senior management must be fully apprised of, and the Board should sign off on the degree of cross subsidies and where they emerge.

Appendix E. Further Reading

Fairness in the Life Insurance System – Concept Note
https://actuaries.asn.au/Library/Miscellaneous/2021/IDIIConeptNote.pdf

Protecting the Public Interest in Insurance Pricing
https://actuaries.logicaldoc.cloud/download-ticket?ticketId=da93d9b6-a7ef-4664-9dfc-3a4e7cfd1736

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Actuaries Institute.

Actuaries Institute
Level 2, 50 Carrington St
Sydney NSW 2000 Australia

T +61 (0) 2 9239 6100
E public_policy@actuaries.asn.au
W www.actuaries.asn.au