Welcome

Dear Colleagues,

Welcome to the first 2015 edition of RGA Australia's ReView newsletter. Last year was packed full of challenges for the life insurance industry, with a lot of public and industry reflection on issues such as sustainability and practices, driving a great many efforts to change these for the better. The momentum generated will continue, ensuring that the life insurance industry provides the necessary security and value to both its customers and shareholders.

In this edition:

- We are pleased to introduce our readers to Geoff Black, the recently appointed Vice President, Business Development, RGA Australia, replacing André Dreyer. Geoff provides his views on the past, current and future state of the life insurance industry, shaped by more than 25 years’ experience at an executive level in the local market.
- A group of local and international RGA associates provide a review of the critical issues that e-cigarettes present to the life insurance industry, regulatory authorities and consumers.
- As the industry continues its focus on the necessary improvement in claims management policies and practices, it is an opportune time for Roger Clark, Senior Claims Consultant for RGA Australia, to recount for readers the takeaway thoughts from his presentation at the 2014 ALUCA conference, “Is work really beneficial – a crucial claims conversation.”
- Interest in wellness programs and what they entail and aim to achieve is increasing, and RGA is active in reviewing and analysing such programs at an international level. Chad Twist, Senior Account Manager, Business Development, RGA Australia, provides an overview of the findings from two recent RGA studies.
- Stephanie Williams, who late last year left Australia to take up the role of Vice President of Global Underwriting Quality and Risk Assurance in RGA’s Global Headquarters in St. Louis, describes for our readers both her new and important international role and some of the experiences of an international relocation from a personal perspective.
- As a supplement to an article in last March’s edition on “The Insurance Implications of Traumatic Brain Injury,” I provide a summary of some important findings revealed in a recent Australian report on serious sporting injuries.
- We are also pleased to introduce you to Meredith Barnes, Zoran Tsangidis and Clement Tam as important new additions to the RGA Australia team.

The RGA team looks forward to continuing to partner with you throughout 2015.

Brian Sussman
Underwriting and Claims Technical Services Manager
RGA Reinsurance Company of Australia Limited
RGA Australia recently welcomed Geoff Black to its executive team as Vice President, Business Development. Geoff comes to RGA with an extensive and impressive background in the Australian life insurance industry, with more than 25 years in senior executive roles at various life companies, including experience as a managing director.

ReView spent some valuable time with Geoff to discuss his thoughts on the current and future state of the life insurance industry in Australia and New Zealand, and to get to know him better. Geoff is looking forward to meeting with as many more of our clients as possible during the coming months and welcomes readers to contact him in the meantime.

How do you see the current state of the market?
I believe we are in the middle of a ‘perfect storm,’ with unacceptable levels of customer complaints, regulatory concerns and unsustainable levels of profitability. We need to make changes across many areas of the market, not just in product design and the pricing of benefits, but also how we engage with and inform consumers. Notwithstanding this, the harsh reality is that this is a capital-intensive business, and if the levels of return on investment are consistently low, then we may see capital withdrawn from the market and deployed elsewhere. That would be no good for either the life insurance industry or the customer, so we need to see change.

What impact do you believe that the Trowbridge Report will have on the life insurance industry in Australia?
I’m hopeful that it will provide an opportunity or act as a catalyst for industry participants to focus on making much-needed and self-regulated change. My concern is this may be the last chance for the industry to control the outcomes. If we do not adequately address consumer concerns, we may find ASIC [Australian Securities and Investments Commission] intervening and, with an election next year, politicians implementing harsh knee-jerk legislation in response to the highly publicised financial planning failures. We need to take control of our destiny.

What has been the biggest change to life insurance over the course of your career?
A couple of things immediately spring to mind.

First, the degree of regulation imposed upon the industry has increased significantly. Although that has increased workloads and significantly
increased costs, it hasn’t necessarily been a bad thing. When I joined the life insurance industry, promotional material was a one-page flyer, and now product disclosure statements in Australia can be 100 pages. In our desire to improve disclosure we seemed to have forgotten who we are communicating to — a case of good intentions poorly executed.

An area of positive regulation is risk management, especially operational risk. Even though as insurers and reinsurers we presented ourselves as experts in this, we did not for many years really appreciate some of our exposures. When the HIH Group collapsed in Australia in 2001, the experience made everyone appreciate the impact and significance of an insurance failure and focussed attention on preventing any recurrence.

Second, technology has had a huge impact on every aspect of the business. The rate book was first replaced by a disk and is now managed online. Similarly, the paper application is now almost redundant, and nobody pays by cheque anymore. Our ability to manipulate and manage data has also increased. I am not sure where it ends, but the transformation has been amazing.

What do you see as the future for both or either of the group and retail insurance markets in Australia and New Zealand, bearing in mind the experiences of the last few years?

I take a lot of comfort in the knowledge that there is always going to be a need for insurance as there is no viable alternative; self-insurance is not the answer. I’m also encouraged by the public’s increasing awareness that some form of insurance is needed, and that it can be obtained through individual policies or superannuation and via advisers, directly from insurers or through their group superannuation arrangements.

In terms of overall retail product design and pricing, I can foresee a need for more rational behaviour. By that I mean developing products based on consumer needs rather than with the aim of securing the best possible rating from a research house or winning the support of advisers through attractive remuneration models. I think if insurers and reinsurers are brave enough the future lies in taking advantage of the data we have, understanding customers’ needs and behaviours, and developing products and services that meet these needs. The old saying that life insurance needs to be sold is often used to justify existing practices. I think it will always need to be sold but not necessarily using the existing formula. Building awareness and understanding through better engagement and then delivering to that is, in my mind, the future. The group market has been enormously successful in providing consumers with a minimum level of life insurance. We just got the implementation completely wrong in that we provided an unsustainable solution. Lack of alignment among all stakeholders — including the consumer — is a big factor here. The opportunity does exist to correct this position, and I am very optimistic about this market.

What new advance or development in insurance excites you at the moment?

Smaller markets such as Australia and New Zealand tend to be more innovative because of the degree of competition. In many larger markets, organisations can become satisfied with their share of the pie, accept the status quo and therefore can be less innovative. I am confident we will see some advances locally as a result of moves to digital distribution and the use of big data.

Products that address the longevity risk are clearly needed, but there are no obvious solutions, and some complex issues, such as those mentioned in the Intergenerational Report 2015, need to be tackled.

One area that I think needs to be addressed relates to the “lump sum” mentality in Australia. This applies to both insurance TPD benefits and superannuation. The average person is not equipped to manage a substantial lump sum when he or she gets it, and it also can foster unhelpful behaviour among those involved in TPD claims, including claimants, insurers, medical and legal professionals, and the judiciary. The focus on a financial windfall would be removed if all benefits were structured as an income stream.
What are you most proud of in your career?
Encouraging and influencing the people I have worked with over the years, either having brought them into the industry or managed them, and seeing them go on to reach greater achievements is very satisfying. I constantly strive to empower and support people to grow and reach their potential. For all the change that occurs, at the end of day it’s the people you deal with — colleagues, customers and even competitors — that get you out of bed every morning. People determine whether or not a business succeeds.

What is your favourite film and why?
I can’t single out a specific movie, but I am big fan of action movies with Arnold Schwarzenegger. I know I am showing my age now.

What is the last book you read?
I tend to only read for leisure when on holidays and like thrillers by authors such as James Patterson and Jo Nesbo.

Where in the world would you most like to live?
I’m already living in the most wonderful city. I left New Zealand in 1983 to see the world and chose Sydney as a home. It offers the sophistication of a big city along with an outdoor lifestyle, and of course the climate is second to none.

If you could be a superhero, what power would you possess?
My 10-year-old son loves all the current superheros and constantly asks me this. Being old school I have to go with Superman. He’s the classic superhero with strength and speed in addition to being a regular guy.

What’s your biggest weakness?
I have three children and am clearly the ‘soft touch’ around the house when it comes to letting them get away with things. I am also partial to dark chocolate — very nice with a glass of red.

Questions or comments? Contact the author: ReViewANZ@rgare.com
E-Cigarettes: A Global View

Introduction

Electronic cigarettes are rapidly growing in popularity and may even eclipse traditional cigarettes in the future, barring any restrictive regulations. E-cigarettes were developed in China just over a decade ago, so the long-term health consequences are not yet known. The current consensus is that e-cigarettes are generally safer to the user as well as those exposed secondhand than traditional cigarettes. However, the devices still emit toxins that may be harmful to the health of the user as well as those nearby.

There are three categories of e-cigarette users: experimenters, dual-users and former smokers. Research has found that experimenters are more likely to try traditional cigarettes, which could lead to an increased prevalence in cigarette use. Because the liquid used in e-cigarettes can contain flavours that are appealing to children, there is concern that young people could become experimenters, leading to increased nicotine addiction in minors.

Population-based studies on the users of e-cigarettes conclude that dual-users are the most frequent users of e-cigarettes. Dual-users are those who continue to use traditional tobacco cigarettes but occasionally use e-cigarettes for convenience in places where e-cigarettes are allowed but traditional cigarettes are banned. These users may also be easing their way into e-cigarettes in an attempt to quit smoking traditional cigarettes.

E-cigarettes may be used as a smoking cessation device, especially since the liquid used in the devices can contain varying amounts of nicotine. Studies regarding the effectiveness of e-cigarettes in smoking cessation have produced conflicting results, though the World Health Organization (WHO) maintains there is insufficient evidence that e-cigarettes will decrease the prevalence of traditional cigarettes.

Global trends

E-cigarettes are gaining popularity in many countries; however, views on safety and regulations on e-cigarettes vary widely. In some countries, such as Austria and New Zealand, e-cigarettes are categorised as medical devices and their sales are restricted. Other countries have banned them entirely, including Australia, Brazil, Finland, Lebanon, Malaysia, Mexico, Panama, and Singapore. E-cigarettes are banned in Hong Kong as well.
Current E-Cigarette Regulation by Country Count and Population %

According to 2014 WHO Survey

<table>
<thead>
<tr>
<th>E-cigarette regulated as:</th>
<th>Type</th>
<th>With nicotine</th>
<th>Without nicotine</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consumer Product</td>
<td>14 (27%)*</td>
<td>23 (35%)</td>
<td></td>
</tr>
<tr>
<td>Therapeutic Product</td>
<td>12 (6%)</td>
<td>0 (0%)</td>
<td></td>
</tr>
<tr>
<td>Tobacco Product</td>
<td>22 (10%)</td>
<td>18 (7%)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>11 (6%)</td>
<td>12 (2%)</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>59 (49%)</td>
<td>53 (44%)</td>
<td></td>
</tr>
<tr>
<td>Not regulated or unknown</td>
<td>135 (51%)</td>
<td>141 (56%)</td>
<td></td>
</tr>
</tbody>
</table>

*The figure in parentheses after the number of countries indicates the percentage of the world population living in these countries.


Although e-cigarettes were originally invented in China, their local popularity has not kept pace with that of other countries. Smokers in China do not face the same bans on smoking in public places or the relatively high cost of tobacco cigarettes. In addition, there are no public health campaigns discouraging tobacco cigarettes or encouraging a move to e-cigarettes.

In the U.K., more than 2 million people use e-cigarettes, and it is estimated that the number of users has tripled in the past two years. A study of e-cigarette use in the U.K. concluded that the majority of users are attempting to quit smoking traditional tobacco cigarettes, while only 1% are new users or experimenters who did not previously smoke tobacco cigarettes. Approximately 700,000 are former smokers, while about 1.3 million are dual-users. E-cigarettes have become the most popular tobacco cessation device in the U.K., as 25% of those attempting to quit choose e-cigarettes.

E-Cigarettes as a smoking cessation device

WHO reported in August 2014 that there is insufficient evidence that e-cigarettes can help smokers break the habit, and it is urging regulatory action to ban e-cigarette manufacturers from making such claims. It advises that smokers should opt for one of the currently approved smoking cessation products instead, such as nicotine patches and gum or prescription medications.

However, studies have reached varying conclusions on this issue. One study carried out by the University College London concluded that smokers were nearly 60% more likely to succeed in their attempts to quit smoking if they used e-cigarettes as opposed to other smoking cessation devices or no help at all. Approximately 6,000 smokers who had tried to quit within the past 12 months were surveyed for this study, which was carried out from 2009 to 2014 and published in the journal Addiction. At the time of the survey, 20% of the participants reported that they had stopped smoking conventional cigarettes with the aid of e-cigarettes. This was a higher quit rate than any of the other study groups experienced without e-cigarettes.

E-Cigarette Regulation in Asia

<table>
<thead>
<tr>
<th>Location</th>
<th>Current Access</th>
<th>Approach to Sales</th>
</tr>
</thead>
<tbody>
<tr>
<td>China</td>
<td>Permitted</td>
<td>No regulations</td>
</tr>
<tr>
<td>Hong Kong</td>
<td>Banned</td>
<td>Sale, possession of e-cigarettes currently prohibited</td>
</tr>
<tr>
<td>India</td>
<td>Permitted</td>
<td>No regulations</td>
</tr>
<tr>
<td>Indonesia</td>
<td>Banned</td>
<td>Imports banned, deemed dangerous by national drug agency</td>
</tr>
<tr>
<td>Japan</td>
<td>Restricted</td>
<td>Nicotine-containing versions considered as medical products under Pharmaceutical Act</td>
</tr>
<tr>
<td>Malaysia</td>
<td>Restricted</td>
<td>Nicotine is a regulated poison under 1952 Poison Act</td>
</tr>
<tr>
<td>South Korea</td>
<td>Permitted</td>
<td>Products containing nicotine regulated as tobacco; products without nicotine regulated as pharmaceuticals</td>
</tr>
<tr>
<td>Vietnam</td>
<td>Banned</td>
<td>No manufacturing, buying, selling, importing, storing, or transportation of articles that resemble tobacco products or related packaging allowed</td>
</tr>
</tbody>
</table>

On the other hand, a study published online in JAMA Internal Medicine found that e-cigarettes do not help people quit smoking. Researchers studied the 12-month quit rates of smokers who used e-cigarettes both with and without nicotine (an e-cigarette with 0 mg of nicotine in the e-liquid) as well as the quit rates of those who used a nicotine patch. There were no differences in the quit rates. The study concludes, “when used by a broad sample of smokers under ‘real world’ conditions, e-cigarettes did not significantly increase the chances of successfully quitting cigarette smoking.”11

Another study of tobacco quit-line callers over a seven-month period found that the probability of quitting cigarettes was lower for e-cigarette users compared to those who did not use e-cigarettes. Among those surveyed, the probability of quitting was 31.4% for those who had never tried e-cigarettes, 21.7% for those who had used e-cigarettes for longer than a month, and 16.6% for those who used e-cigarettes for less than one month.2

The U.S. Food and Drug Administration (FDA) has not yet approved the marketing of e-cigarettes as a smoking cessation device. The FDA has not fully studied e-cigarettes and states on its website, “consumers currently don’t know the potential risks of e-cigarettes when used as intended, how much nicotine or other potentially harmful chemicals are being inhaled during use, or whether there are any benefits associated with using these products.”12

Health impact

Many traditional cigarette users believe that e-cigarettes are a safer alternative. This is mostly due to e-cigarette manufacturers’ marketing campaigns promoting the benefits of e-cigarettes, or vaping, over traditional smoking. A study published in the American Journal of Preventive Medicine reviewed the marketing claims found on 59 e-cigarette websites in 2012. Of these websites, over 90% implicitly or explicitly claimed that e-cigarettes have a health benefit, 76% claimed the product does not produce secondhand smoke, and 64% advertised that e-cigarettes can help users quit smoking.2

Switching entirely from traditional cigarettes to e-cigarettes exposes the user to fewer toxins for the same amount of nicotine. However, most dual-users continue to smoke traditional cigarettes along with e-cigarettes. Many smokers believe that cutting down on the number of traditional cigarettes smoked per day will benefit their health. However, the effect that smoking has on one’s health is proportionate to the lifetime accumulation of exposure to tobacco and wears off only very slowly once tobacco consumption stops or is reduced. The effect of smoking on the heart and blood vessels occurs even at very low levels of smoking — indeed, smoking only one to four cigarettes per day has been associated with increased risk of cardiovascular disease, so even if a smoker is able to cut back to only a few traditional cigarettes a day, there may not be much benefit to his or her health.2

Many e-cigarette manufacturers also claim they are healthier to the public because they do not produce secondhand smoke. While e-cigarettes may produce a lower volume of toxins, they may still contain nicotine and other harmful toxins and carcinogens. Non-smokers who are exposed to secondhand vapours from an e-cigarette have been found to have similar levels of cotinine in their blood as they would have from being exposed to traditional cigarette smoke. Another study tested the aerosol exhaled from e-cigarettes and found low levels of formaldehyde, acetaldehyde, isoprene, acetic acid, 2-butanodione, acetone, propanol, propylene glycol and nicotine, although the toxins from the aerosol were at a lower level than from conventional cigarettes. These findings contradict a common advertising claim made by e-cigarette manufacturers that they only submit a harmless “water vapour.”2

The general consensus seems to be that one puff of an e-cigarette is less harmful than one puff of a traditional cigarette, but neither is good for you. If someone insists on smoking or vaping, e-cigarettes are probably less hazardous, but they are not benign. Dual-use may lead to a greater public health concern if smokers continue to smoke tobacco cigarettes for a long period of time at a lower rate rather than using other methods to quit smoking entirely.
Commentary: How Insurers Currently View E-Cigarettes – The Underwriting View

Those who continue to be addicted to nicotine are at a high risk of using tobacco, so they must be regarded as smokers until we have further evidence that e-cigarettes can help them stop tobacco permanently, and evidence on the long-term health effects of e-cigarette use.

Underwriters are generally familiar with the challenges presented by e-cigarettes, or electronic nicotine delivery system (ENDS). We have been dealing with similar issues presented by nicotine patches and gum for decades. Use of nicotine gum, patches and now ENDS, while admirable for attempting smoking cessation, does not offer a high enough success rate to justify treating an applicant as a non-smoker. An additional underwriting concern is that ENDS may provide a new entry point for experimenters to the more traditional nicotine delivery systems, and underwriters will need to assess the risks appropriately.

Underwriters must accept the fact that we cannot currently distinguish what delivery system is used when we test, as is done in North America, for the presence of cotinine in urine. The fact that we will not be able to differentiate the type of nicotine delivery in the near future using laboratory studies also places all nicotine users in the same assessment category.

Additionally, the safety of ENDS use is not yet confirmed. Looking only at nicotine, we realise the drug is both psychoactive and addicting. While low doses may have no more mortality or morbidity consequences than caffeine, the evidence is not compelling enough to confirm that assumption. In truth, we could say the jury is still out on caffeine as well; certainly there are still arguments for and against its safety. Nicotine’s traditional delivery systems are different than caffeine’s and are known to have adverse implications for health and longevity. ENDS use and traditional methods are not, and are unlikely to become, mutually exclusive. This is the same problem we have with nicotine gum or patches. So how would an underwriter justify treating them differently?

At this point, there are too many unknowns to justify changes in how we assess nicotine use. So, until such time as the preponderance of evidence indicates an adjustment of our assessments, underwriters should continue to treat all nicotine users similarly.

E-cigarettes present another challenge to the life underwriter and the insurance industry in general. They can be used to deliver other drugs and substances besides nicotine. Law enforcement agencies have already noted that THC, the psychoactive chemical compound found in marijuana, has quickly found its way into the vaping culture. Because so many drugs can be converted to a dissolved or liquid form, underwriters should not be surprised if there is a spike in drug experimentation and usage, especially in the younger age groups that are prone to such experimentation. Of course, as with all drug usage, we can’t focus exclusively on that group as the usage will likely cut across all demographics eventually. Given that currently there is little regulatory control, and that the e-cigarette provides camouflage for drug usage, we should expect some future arguments about whether the use of ENDS should be legal or if they should be regulated as drug paraphernalia.

Mark Dion
Vice President, Strategic Underwriting Innovation
RGA Reinsurance Company
Smoking Behaviours and E-Cigarettes: The Latest Scene in Australia and New Zealand

Australia

The smoking trends in Australia have continued to decline. The Australian Institute of Health and Welfare National Drug Strategy Household Survey in 2013 revealed that between 2010 and 2013 the proportion of people aged 14 or older smoking daily had declined from 15.1% to 12.8% and has almost halved since 1991 when it was 24.3%.13

The report also revealed that fewer young people are taking up smoking. The proportion of people aged 12 to 17 who have never smoked remained high at 95% in 2013, and between 2001 and 2013, the proportion of those aged 18 to 24 who had never smoked rose from 58% to 77%.13

One in 5 smokers had successfully given up for at least a month before the survey. Unfortunately, 3 in 10 of those smokers who tried to quit were not successful.13

The 2013 edition of the survey was the first to inquire of respondents about the use of e-cigarettes. It revealed that:

- 1 in 7 (14.8%) of smokers aged 14 or older had used battery-operated electronic cigarettes in the previous 12 months,
- younger smokers were more likely to have used an e-cigarette than older smokers, and
- male smokers were generally more likely than females to use e-cigarettes.13

The importation and sale of e-cigarettes in Australia are governed by an array of national and state laws. Under national legislation, products claiming to help people quit smoking are regarded as therapeutic goods and require authorisation by the Therapeutic Goods Administration. This means nicotine products that claim to be therapeutic cannot be sold...
unless they are approved for therapeutic use or are a device similar to traditional cigarettes. The Therapeutic Goods Administration has not as yet approved an e-cigarette product on the therapeutic goods register. However, there is a loophole that allows Australians to access a limited supply of e-cigarettes containing nicotine by importing them from overseas.

Nicotine is classified by law as a dangerous poison. The regulation of poisons falls under the legislative responsibility of the individual states and territories, and their attitudes vary markedly, with some actually prohibiting the marketing of any products that resemble tobacco products.

New Zealand

The 2013 census records 463,194 smokers in New Zealand. The overall prevalence is 13.7%.14

The Ministry of Health has not approved e-cigarettes for sale. In New Zealand e-cigarettes are categorised depending on how they are presented for sale, including the intended use claimed for the product by the supplier and whether this use has a therapeutic purpose. Medsafe, the body that administers the government’s medicines legislation, has provided guidance on the legal status of e-cigarettes when they are used for possible therapeutic purposes under the Medicines Act 1981. According to Medsafe, under the Act, e-cigarettes are categorised for such purposes as follows:14

- Electronic cigarettes are medicines when they are supplied for use as an aid to smoking cessation and with one or more cartridges.
- Electronic cigarettes are medicines when supplied with one or more cartridges containing nicotine even if they are not represented as aids to smoking cessation.
- Electronic cigarettes are medical devices when they are supplied for use as an aid to smoking cessation and without cartridges.
- Electronic cigarettes are not therapeutic products when they are supplied as a ‘gadget’ that consumers may choose to use as a social prop or as an item that is to be used interchangeably with cigarettes.

Works Cited

Health Benefits of Work

I was privileged to deliver a presentation called “Is work really beneficial—a crucial claims conversation” at the 2014 ALUCA conference. This discussion evolved as a consequence of increasing recognition of the health benefits of work and the resultant integration and implementation of this idea into the life insurance industry.

This presentation was intended to examine the view that work is beneficial and how as claim assessors we should encourage it. The difficulty for insurers, of course, is that as soon as returning to work is mentioned to a claimant, there is the connotation that the insurer is merely attempting to reduce its risk, without providing a service.

In this discussion, work was seen as a means of connecting people, giving people a purpose, encouraging discipline and providing physiological and physical stimulation. I also spoke about what happens to people when they don’t work. Research suggests it causes a breakdown in identity, decreased self-esteem, social isolation, and loss of structure and career path. The medical implications of not working are profound: Waddell and Burton (2006) suggested in their study that long-term worklessness increases the chance of heart disease, lung cancer, susceptibility to respiratory disease, psychological distress and poorer mental health.

Feeling that one is a member of the community is an extremely important psychosocial human need, and work plays a huge part in giving people that sense of belonging. A person who is not working is isolated and does not feel connected to the larger community, and often feels shame about not working. The promotion of work and its role in returning to wellness is a message that needs to be constantly reinforced by everyone involved in the return-to-work process, including doctors, insurers, rehabilitation consultants and employers.
The main theme of my presentation, however, was what we can do as claims assessors to promote the benefits of work and the idea that returning to work is part of the holistic process of recovery.

The language we use with claimants is extremely important in supporting their recovery. We should begin with a collaborative approach, and it is essential that we utilise a ‘partnership style’ of communication to reinforce the idea that we want to help them rather than force them back to work so the insurance company can save money. Examples of how to frame the conversation in this style are, “Help me understand what you can do” and “How can we assist in this process?” or “Help me understand what your duties were and how we can assist you in moving toward increasing your level of functioning.”

Claims assessors must understand what a claimant can do and work with him or her on these strengths, and understand what the claimant perceives as the barriers to returning to employment. We also have a duty to assist claimants to return to their pre-disability level of health and well-being rather than just provide financial benefits.

In addition to the claimant and the claims assessor, the other key stakeholder in this process is the treating doctor, who is constantly balancing the wishes of the patient with understanding the patient’s occupational duties, which is so crucial in claims assessment.

While there is still work to be done, advocating for the health benefits of work is part of a vital shift in effective claims management and overall duration control. It is important to always remember that allowing people to remain off work can be extremely detrimental to their long-term physical and psychological health as well as to the industry’s bottom line.

Questions or comments? Contact the author: ReViewANZ@rgare.com

References
Wellness Programs and a South African Benchmarking Tour

The RGA Global Research and Development team recently published a report on wellness programs from around the globe, and late last year RGA conducted a benchmarking tour on behalf of Japanese clients to research wellness programs, specifically in the South African market. This article presents our findings from these two studies.

Global learnings

Wellness programs are becoming more prevalent as insurance providers try to lower costs of chronic diseases, employers strive for a healthy workforce, and individuals become motivated to take control of their own health through technological advances that quantify wellness. While there are many differences in the details of each wellness program, most have similar objectives: increase engagement and participation to improve healthy living.

Three key components support most wellness programs:
1. An initial Health Risk Assessment that provides health information to individuals to measure their baseline health status.
2. Health tracking/analysis tools that provide ongoing, individualised data and allow for setting measurable goals and tracking progress.
3. Incentives to attract new participants and maintain current participant engagement.

Program effectiveness is difficult to measure. However, evidence suggests that effective wellness programs that focus on improving lifestyle behaviours such as reducing smoking, improving diet and increasing physical activity can reduce the economic burden of chronic diseases. Most programs must be in force for at least five years before achieving measurable health benefits exceeding program costs.

Wellness programs are commonly part of corporate schemes, either as a supplement to insurance coverage (in some markets overseas) or as an additional feature. Group benefit packages often include life and disability insurance policies, and, suitably constructed, wellness programs could assist with the underwriting and pricing of these policies.

One development in the wellness arena is premium discounts on individual protection cover. Coupling a life insurance policy with a wellness plan encourages consumers to take action to improve their personal health as well as reduce their premiums. The insurer may realise improved experience and be able to develop new and innovative products.

South African learnings

Multiply and Vitality are the largest wellness providers within a crowded market. Both share attributes such as allowing participants to accumulate points, achieve status increases and receive rewards for healthy behaviour, while also considering the financial wellness of the insured customer. Rewards range from insurance premium discounts and cheaper movie tickets to gym memberships and a host of other services.

By Chad Twist
Senior Account Manager
RGA Reinsurance Company of Australia Limited
Insights

- Each company’s goal was to use behavioural economics to make people healthier, using incentives to encourage healthy behaviour and to ultimately help improve claims experience and customer loyalty. The key benefit of wellness programs is the ability to identify and help change the modifiable health behaviours that drive health care costs.
- Programs tend to work better with individuals as their level of engagement is often increased due to their making a conscious decision to join.
- Groups can be a little harder to engage with, and success is often tied with harnessing the power of the group – using group dynamics, gamification and peer pressure to influence change.
- The greatest health benefits are actually realised from those who were not already active or less conscious about their health.
- All providers interviewed stressed the importance of data. Wellness programs serve many functions, but in particular they allow companies to collect health-related and customer data, increase customer engagement and attract and retain the best risks.

Key learnings

- If there is a fee for the wellness program, customers are more motivated to use the service and to value what is on offer. However, it is important that the perceived benefits of the program outweigh the actual cost of membership. One way of facilitating this is by setting aspirational targets for customers to achieve.
- The economics need to work for both the insurance company and the suppliers. In particular, system implementation costs need to be funded from somewhere.
- Having a strong program is not enough; scale is required in order to attract great partners, as most will be looking to increase their market share rather than cannibalising their existing customer base.

RGA’s deep research emphasises our interest in developing wellness programs further with our clients, where we see this as a strong growth area in both the independent financial adviser (IFA) and group markets. Consumers’ growing awareness of illness prevention and their utilisation of wearable devices present a huge opportunity for the life insurance industry, but one that necessitates a shift in thinking.

Should you be interested to read more on the Global R&D published report, or discuss any aspects of wellness programs further, please contact your RGA Business Development representative.

Questions or comments? Contact the author: ReViewANZ@rgare.com
In November 2014 Stephanie Williams departed our shores to take up a new role within the RGA group. She moved to the RGA head office to join the Global Underwriting team as Vice President, Global Underwriting Quality and Risk Assurance.

Stephanie began her career at RGA in September 2001 as a Senior Underwriting Consultant in the U.K. office. Her strong organizational and technical skills quickly moved her to Executive Director of RGA Asia Pacific based in Australia, where she led the Asia Pacific Regional Underwriting team. In 2007, she was promoted to Assistant Vice President and Regional Chief Underwriter for RGA International Corporation, and in that role, she founded RGA’s GULF training program, as well as managed a senior underwriting team and developed the underwriting infrastructure and tools for seven offices in the region.

Over the last few years, Stephanie had become well known to and respected by RGA Australia clients as the Australia Head of Client Solutions, a role that included responsibility for the Underwriting, Technical Risk and eSolutions teams as well as the Chief Medical Officer.

Now that she has settled into her international role and home, Stephanie has kindly offered to provide some insights on both her new role and the experience of moving to a new country with her family.

It is now more than three months since I relocated from RGA Australia’s Sydney office to take up my new role at RGA’s global headquarters in St. Louis, Missouri, USA.

My new responsibilities include establishing a Quality and Risk Assurance Centre of Excellence for RGA’s Global Underwriting function, as well as providing underwriting metrics and risk analytics. My team oversees and supports RGA’s local business units in their planning and execution of all quality assurance activity and reporting up to the board level.

As a team, our goal is to ensure our Underwriting Quality Assurance framework keeps pace and effectively supports developments in underwriting and the underlying technology for automatically underwritten business. Working alongside our global peers in Claims, Products, and Research & Development will also allow us to expand our cross-functional and portfolio analytics capabilities.
Following an organisational restructure in December last year, I now report to Doug Knowling, Senior Vice President and Head of RGA’s Global Support Team (GST). The GST brings together life and health experts from around the world to enable and govern four core functions of RGA’s business — Underwriting and Medical, Claims, Products, and Research & Development — with the tools, knowledge and capabilities to go to market.

Just prior to my arrival in St. Louis, RGA moved into its new headquarters facility in Chesterfield, Missouri. This 405,000-square-foot complex includes state-of-the-art technology and security features, accommodating 1,450 staff, with room for significant future expansion. The new buildings sit at the crest of a hill alongside U.S. Route 40, a major east-west U.S. Highway, and when I tell people where I work, everyone knows the new buildings — they are quite the local landmark!

I was privileged to attend the 2015 Metropolitan Underwriting Discussion (MUD) Group conference in New York in January. With more than 300 attendees at the InterContinental New York Times Square hotel, it was a fantastic meeting, featuring many great speakers and excellent networking opportunities. The next conference on my calendar is the Association of Home Office Underwriters (AHOU) conference in April. The theme of this year’s meeting, which will be held in Washington, D.C., is ‘Capitalize on Your Future’. I’m looking forward to the opportunity to experience such a worthwhile event — AHOU is the premier underwriting conference in the U.S.

On a personal note, the transition to living in the U.S. has been an interesting ride so far. The schools here are absolutely fantastic, and our kids have settled in very easily and quickly. Since we arrived in early November, which perhaps wasn’t very good timing, we came straight into winter. We have survived three solid months of somewhat mild winter weather (thankfully, we missed last winter’s polar vortex). I learned very quickly how to drive in the snow and ice and even to avoid the odd deer or wild turkey wandering across the road on my way to work in the morning. Overall, we’ve been having lots of fun settling into our new house and using our weekends to get out and about exploring all St. Louis has to offer.

We’re lucky to be located right in the middle of the country, which means we’re only a relatively short flight to any destination across the U.S., and the road trip possibilities are endless. We did a quick round trip to Austin, Texas, to visit some friends over New Year, stopping overnight in Little Rock, Arkansas, (Bill Clinton lived here when he was governor of the state before he became president) on the way there and Tulsa, Oklahoma, on the way back. Seeing my husband eating deep-fried ‘gator strips’ (alligator meat) from a dusty truck stop diner just outside Texarkana was a sight to behold — just like our very own episode of “Bizarre Foods”! Next trip will be in May, when we’ve got our sights set on Nashville, Tennessee, through Alabama to the Gulf Coast in Florida.

If you ever have occasion to travel to St. Louis or you have the opportunity to attend an industry conference in the U.S., please let me know. I’d love to see some more fellow Aussies over here.

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People participate in sports for the thrill, for fitness, to relieve stress and to test one's limits. Testing or exceeding those limits, however, often results in injuries requiring hospitalisation — and possibly even death. The Australian Institute of Health and Welfare examined the number of significant injuries, including those with a high risk of death, per sport and revealed some statistics of interest to our industry.

The report, entitled “Australian sports injury hospitalisations – 2011-12,” documents the sporting activities that can lead to a range of injuries requiring hospitalisation and potential short- or long-term disablement. (It did not track injuries treated in emergency departments and other health care settings not resulting in hospitalisation.) The report complements an earlier article we shared in the March 2014 issue of ReView on the insurance implications of the increase in traumatic brain injuries (TBI) in sport by looking at serious injuries in various parts of the body. Taken together, these reports give us a picture of the risks assumed by professional and amateur competitors and the potential impact to insurers. We thought it worthwhile to bring the following key points to your attention.

The game's the thing: overall findings

Motor sports, football and water sports accounted for 47% of all sports injury hospitalisations.

- Of the top 10 sports where injuries required hospitalisation, football-related injuries made up 33.9% of the total, but notably the top 10 also included cycling (8%), wheeled motor sports (7.6%) and equestrian activities (4.3%).
- Fractures accounted for nearly half of all sporting injuries sustained, with the most affected areas being the knee and lower leg, elbow and forearm, and wrist and hand. Interestingly, 11% of fractures affected the head.
- One in 10 injuries admitted to the hospital was considered a high threat to life. A high threat to life is when the predicted mortality risk is 6% or higher.
Fortunately, only 31 people died in hospital in 2011-12 from a sports-sustained injury.

**Football–related injuries**
- The various codes of football played in Australia accounted for about one-third of all sports injury hospitalisations.
- Of the football codes, the top three relative percentages of football-related hospitalisations in 2011-12 were for Australian Rules football (26%), soccer (24.2%), and “Football, Other” and “Unspecified” (23.1%). (The “Other” group includes American tackle, Gaelic football and Gridiron, but excludes rugby union, league and touch football.)
- The mean length of stay (MLOS) in hospital after a rugby-related injury was 1.7 days, Australian Rules football was 1.5 days, soccer was 1.8 days, and touch football was 1.5 days.

**Wheeled motor sports injuries**
How dangerous is involvement in wheeled motor sports? According to a Participation in Sport and Physical Recreation, Australia (PSPRA) survey the participation-based sports injury hospitalisation rate for motor sports was high compared to that for other sports.
- The mean length of stay (MLOS) in hospital after a wheeled motor sports injury was 3.5 days.
- The total number of hospital days spent by patients attributable to wheeled motor sports injury was 9,637. This was the highest number of days spent by patients associated with any of the sports covered in the report. (By comparison, the average number of days in the hospital for rugby, soccer and football is around 1.5 days).

**Cycling injuries**
- Sports cycling-related hospitalisations show a substantial increase in such injuries, particularly in ages over 45. This may be reflective of an increasing participation rate in that age group. Fractures were the most common type of injury, accounting for over half (55%) of cases. The next most common injury types were open wounds (12%) and intracranial injury (9%). The head was the most frequently affected body region (20%). Compared with other sports, there were a relatively high proportion of cases where the injuries were assessed as presenting a high threat to life (25%).

**Sports with highest threat to life injuries (based on participation rate per 1,000 persons)**
- Sports cycling (25%), wheeled motor sports (24%) and equestrian activities (23%) had the highest proportion of high threat to life injuries out of all the total number of high threat to life cases.
- Of the football-related codes, the ones that experienced the highest threat to life injuries were rugby union and Australian Rules (5% of cases), and soccer (3% of cases).
- Of particular interest for those involved in risk assessment, the sports associated with the highest rates of life-threatening injuries based on participation rate were motor sports, roller sports (including in-line skating and rollerblading, roller skating, skateboarding and scooter riding in persons aged 15 years or over), and equestrian activities.

Much of the information contained within these and other available reports should be carefully analysed when insurers look to review either their underwriting guidelines for applicants involved in recreational and/or competitive sports or claims guidelines in respect of the prognosis and recovery rates for participants injured whilst participating in sports.

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Meredith Barnes

Meredith joins RGA as Head of Underwriting and Technical Services. Meredith has more than 20 years of life insurance industry experience in product, automated underwriting, claims and operations for direct, bancassurance and adviser-based distribution channels. During this time Meredith was involved in the creation of a new life insurer as well as the integration of two major life companies following their merger. Most recently, Meredith was Head of Claims Policy & Standards at a large life insurer.

Zoran Tsangidis

Zoran joins RGA as an Account Manager in the Business Development team. He brings nine years of life insurance experience in the corporate group risk market. During this time, he worked in the policy operations and claims departments for a major life insurer, and also spent a number of years as an intermediary insurance broker for a large international brokerage firm, regularly consulting with large corporations on their life insurance needs while building and maintaining business relationships with the various Australian life insurers.

Clement Tam

Clement is a new Pricing Analyst with RGA. Prior to joining the company he spent four years with a major life insurer, where he had exposure to capital, valuation and pricing work. Clement is experienced in numerous product lines including retail risk, group risk, annuities and participating conventional and savings products.

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