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Ms Julia Agostino
Parliamentary Joint Committee on Corporations and Financial Services
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Parliament House
CANBERRA ACT 2600
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Dear Ms Agostino

RE: Inquiry into the life insurance industry

BT Financial Group (BTFG), welcomes the opportunity to provide feedback to the inquiry into the life insurance industry.

We note that the FSC is intending to make a submission to this inquiry and while, at the time of writing that is not yet finalised, we broadly support the direction taken by the FSC. Our submission compliments and, in certain areas, expands on the FSC submission.

We strongly support the desire to increase transparency and accountability across the industry and to achieve this, we support in this submission five measures to improve the claims function of life insurance.

More broadly, we believe it is important to acknowledge that the life insurance industry is adapting to a period of significant change. The Life Insurance Framework (LIF), Life Insurance Code of Practice, Professional Standards requirements and ASIC lapse reporting are measures which either have or will shortly commence. Additionally other important recommendations of the Financial System Inquiry are expected to be implemented during the current term of government.

Collectively, the measures will foster trust, transparency and accountability across all aspects of an industry which plays a critical role in Australia's economy, mitigating financial risks for individuals, businesses and in turn government.

At the same time, the industry must also continue to balance medical advancements, evolutions in health and well-being and changes in demographic, social and employment patterns to ensure insurance continues to meet the needs of consumers and community expectations. Importantly, during this transition affordability must be managed so that issues associated with under-insurance are not compounded.

It is important that Australia has an efficient and effective life insurance industry from an individual, social and government perspective. The current level of underinsurance across the community negatively impacts individuals and families, as well as being a drain on government expenditure. Underinsurance for disability represents the greatest cost to government – estimated to be $1,258 million per year[1] for total and permanent disablement (TPD) cover alone.

We have set out in this submission a number of additional positive measures the government could consider to drive further improvements across the industry and we would welcome the opportunity to discuss these with the Committee.

Yours sincerely,

Sue Houghton
General Manager, Insurance
BT Financial Group

[1] Rice Warner Underinsurance Report 2015.

1. Underinsurance

The impact of under insurance is felt both socially and economically. Individuals and families that are unable to meet their basic needs in a time of personal crisis can suffer in many ways, amplifying the overall cost to society well beyond the initial under insurance gap, expressed in dollar terms. Such costs can spill over into mental health, family breakdown and in the case of underinsured businesses, loss of employment.

For the year ended 30 June 2016, at least $8.2 billion in net policy payments were made by life insurers[2], though Australians still remain significantly underinsured. Current research indicates that the median level of life cover meets only 61% of basic needs, defined as the minimum required to pay all non-mortgage debt and sustain the current living standard until age 65 or until children reach age 21[3].

The underinsurance gap for parents with young children is much greater - a couple aged 30 with young children needs the equivalent of nine to 12 years of income for the higher-earning partner to provide a basic level of life insurance protection for the family[4].

Superannuation plays a critical role in addressing this problem, and has helped to close the gap in recent years through the opt-out model for default members. However, the median default cover of superannuation meets only about half of the basic death cover needs for households with no children and a much lower proportion for families with children (less than 25% for families with one child)[5].

Increasing trust and transparency is critical to addressing the underinsurance problem, and we examine how this can be achieved in the next section. Superannuation and the importance of the opt-out model is addressed in Section 3.

2. Claims

We broadly support the recommendations contained in the recent *ASIC Report 498: Life insurance claims: An industry review.*

It is noteworthy that this report found no evidence of cross-industry misconduct in relation to claims payments and procedures. In particular it found that where a decision had been made, approximately 90% of claims were paid in the first instance.

However concerns were raised in relation to declined claim rates and claims handling procedures associated with particular types of policies (especially TPD), particular insurers, and particular causes for consumer disputes.

ASIC made five recommendations, notwithstanding the further work indicated in the report. In summary these were:

1. Establishing a public reporting regime for claims outcomes;
2. Strengthening the legal framework covering claims handling;

[2] ASIC Report 498 - Life insurance claims: An industry review.
[3] Rice Warner Underinsurance Report 2015.
[4] Rice Warner Underinsurance Report 2015.
[5] Rice Warner Underinsurance Report 2015.

3. Strengthening the dispute resolution framework;
4. Targeted follow up work on areas of concern; and
5. Strengthening industry standards including the enhancement of the new Life Insurance Code of Practice.

The profound financial and psychological consequences for consumers of poor claims decisions requires a greater level of intolerance for the exceptional cases which do go wrong.

In particular we submit that the following measures will improve consumer confidence and reduce the likelihood of poorly handled claims:

1. Greater transparency of claims handling processes and claims outcomes, including public reporting of claims decisions, consumer benchmarking on service, publishing of claims philosophies and transparency on internal dispute resolution processes and outcomes.
2. The strengthening of dispute resolution frameworks, particularly internal dispute resolution.
3. Continued strengthening of industry standards whereby insurers abide by the new Code of Practice. In addition to this we recommend that insurer Claims Philosophies should be made public and that claims performance should be assessed against these.
4. Standardised formal accreditation for claims handlers.
5. Support for the growing movement in disability compensation systems, led by the Royal Australian College of General Practitioners which seeks to improve health outcomes for consumers who make disability claims.

Greater Transparency of claims handling processes and claims outcomes

We support the recommendation made in ASIC Report 498 for the public reporting of claims decisions, with the objective of creating greater transparency of claim outcomes across the life insurance industry. This will help restore confidence and enable consumers to make more informed choices when they purchase Life Insurance.

However it is important to recognise the complexity giving rise to the variations in claims decisions. An overly simplistic approach that does not compare “like for like” risks misinforming consumers.

Achieving the goal of transparency will require an industry response that includes:

- Mandatory public reporting of “like for like” claim decisions;
- Independent benchmarking reports of consumer claim experiences and claim decision processes;
- Reporting of service standards on timeliness under the FSC Code of Practice; and
- Transparency on the internal dispute resolution process and its outcomes.

In order to achieve comparability the following parameters will require a consistent industry wide approach:

a) **Definition of a claim -** there is significant variation across the industry with respect to how a claim is defined. Presently, claims can be counted either when a customer first notifies an intention to claim, when the customer sends in the first claim requirements (usually a claim form) or when the customer forwards complete requirements.

b) **Definition of claim decisions -** there is significant variation in the definition of a claim decision across the industry. In particular the treatment of "withdrawn" and "ineligible" claims will have a material impact on claim statistics.

c) **Timeframes -** in the recent ASIC report into claim handling, the periods for counting claims were similar however the dates at which claims decisions were counted varied. As there are time lags between the date claims are made and the date decisions are made, distortions can arise.

Notwithstanding the above, even with standardised definitions there are risks that consumers may be misinformed.

There are also other risks in decision reporting which could lead to customer misinformation. We provide below two examples illustrating when distortion can arise in a comparison. These examples show potential distortion for insurers with 'younger' insurance books and insurers where the average ages of the lives insured are younger.

Example 1: Reporting distortion based on methodology

The Association of British Insurers counts existing and new Income Protection claims and uses these as a denominator for decision rates in their published statistics. Existing claims are much less likely to be declined.

In the illustration below, both Company A and Company B decline 10% of their new income protection claims and 2% of their existing claims, though Company B has fewer existing claims.

	Company A	**Company B**
New Claims Per Year	1,000	1,000
Existing Claims	3,000	1,000
New Claims Declined (10%)	100	100
Existing Claims declined (2%)	60	20
Decline Rate	160/(3,000 + 1,000) = **4%**	120/(1,000 + 1,000) = **6%**

In this example the counting of existing claims distorts the real decline rate for the consumer and disadvantages the company with fewer existing claims.

Newer companies with younger insurance books are likely to have fewer existing claims. This potential distortion against newer companies may also flow from the nature of their consumer demographic.

Example 2: Reporting distortion based on variations in consumer demographic

The decline rates for Total & Permanent Disability (TPD) insurance vary with age. Consumers under the age of 40 are less likely to have a TPD claim admitted because they generally have a much higher chance of re-entering the workforce.

In the illustration below, company A and Company B both decline 34% of TPD claims for customers under 40 and 25% of claims for customers over 40.

	Company A	**Company B**
New Claims Per Year	100	100
Customers under 40	20	70
Customers over 40	80	30
Declines under 40	6.8	23.8
Declines over 40	20	7.5
Total Declines	**26.8%**	**31.3%**

In this example, Company B, with a younger demographic, could appear to have a higher decline rate when both companies have exactly the same approach.

We support mandatory reporting of claims however to protect consumers from distortions that could drive inappropriate choices the principle of "like for like" should be rigorously maintained when designing a statistical solution.

Independent Benchmarking of Consumer Claims Experience

BT has regularly participated in consumer oriented independent studies. These studies provide alternative data from which consumers can assess Life Insurance Companies, and opportunities for insurers to improve their service.

- "C-Map" is a detailed analysis of 136 elements of the Claims Management function covering culture, process and communication. BT participates in this analysis every two years.
- The Beddoes Institute has more recently developed benchmarking for claimant journeys. This approach involves interviewing a statistically significant number of customers who have made a claim. This is a new initiative and BT have participated in this process this year.

We believe that in conjunction with mandatory reporting, customer oriented benchmarking should be standardised across the industry. This will, in part, mitigate some of the compromises that will have to be made in order to simplify mandatory reporting.

Most importantly it will give consumers a voice in the public reporting of claims handling.

Service Standards

We believe the Code of Practice will have a positive effect on claims handling. The timely management of claims will assist in the customer experience, and the reporting of service standards under the FSC Code of Practice will assist in achieving this by reducing the likelihood of excessive claims delays.

Internal Dispute Resolution

Transparency and increased standards in relation to Internal Dispute Resolution (IDR) and External Dispute Resolution (EDR) processes will assist in reducing the number of rare, but severely

consequential poor claims decisions. We strongly believe that IDR process improvement would be one of the most effective instruments to achieve this.

Strengthening the dispute resolution framework for claims

We believe that rationalisation across the Superannuation Complaints Tribunal (SCT) and the Financial Ombudsman Service (FOS) will benefit the life insurance sector. This will be achieved through efficiencies of scale and the provision of a single entity for consumers.

However improvements in Internal Dispute Resolution (IDR) will potentially yield greater benefits. Consumer outcomes are reached much more quickly and with less evidentiary burden when disputes are resolved in the first instance.

Transparency and increased standards in relation to IDR will be one of the most effective instruments to mitigate the issue of the exceptional, but severely consequential poor claims decisions.

By way of example, in 2015 we were notified of 3,017 claims and these generated 90 IDR cases (3%). The outcomes of the IDR reviews were as follows:

IDR Decision	Volume	Percentage
Favour Insured	11	12%
Favour Insurer	53	59%
Mutually Agreed	21	23%
Pending	5	6%

Of the 53 cases notified in 2015 where IDR determined in favour of the insurer, 17 proceeded to EDR (0.6% of claims received).

EDR Decision	Volume
Favour Insured	0
Favour Insurer	11
Mutually Agreed	2
Pending	4
Total	17

Issues around claims handling will become apparent when the proportion of IDR cases per volume of claims is high and also when high proportions of IDR decisions are not upheld at EDR.

The filter effect of IDR means that improvements here will generate proportionally more gains for consumers than improvements in EDR. Utilising broader industry statistics could lead to benchmarks for:

- Number of IDR disputes per 1,000 claims;
- Proportion of IDR disputes that become EDR claims;
- Proportion of insurer IDR decisions overturned at EDR.

Strengthening industry standards

We believe the Code of Practice will have a very positive effect on claims handling in Life Insurance.

In addition to the Code of Practice each insurer has a claims philosophy. These vary significantly across the industry in scope and depth. We recommend that each insurer should publish its claims philosophy and assess claims handling against this. The claims philosophy should be a powerful cultural symbol and be sufficient to guide claims handlers when making decisions.

The BT claims philosophy contains the following:

"*.... If the circumstances of the claim remain unclear according to the policy we will apply the common understanding of fairness and include consideration of what the policy was designed and priced for. Wherever there is ambiguity we will favour the policyholder...*"

This philosophy drives referrals to a process where claims can be paid outside of policy terms when the claims handler determines a decline decision would be unfair.

Of note in these payments are trauma benefits paid when they were strictly outside of definitions. For example in 2011, BT upgraded its heart attack definition and passed it back to earlier policies. Following a review this year, our records showed that heart attack claims that would have met this upgraded definition, but not the applicable definition at the time, were nevertheless paid prior to 2011. This demonstrates how a product is not just a set of terms and conditions but a more holistic consumer-centric offering when combined with an active claims philosophy.

We strongly support a legislative mechanism preventing insurers from incentivising claim declines. The measurement of claims handling performance requires an "input" approach that assesses claims handling in terms of quality of assessment and customer service, including timeframes.

All claims handling "output" measures should be closely aligned to the published claims philosophy statement. For example, at BT we have developed a health outcome measure for income protection customers and include in the assessment of the performance of our claim handlers a requirement to show improvement in the health outcomes for customers following a sickness or injury.

Formal accreditation for claims handlers

Life insurance claims handlers receive training and education in many forms and there are a number of accreditations they can pursue. There is however no overarching industry standard and continuing education is not prescribed.

To date, reinsurers have made a significant contribution in this space by sharing global best practice with the Australian market. But while there has been a tremendous amount of work in this area it has not been effectively co-ordinated at an industry level. There is an opportunity through the sharing of educational intellectual property to create a world leading accreditation program for claims handlers that will lift the standard of the industry and improve the customer experience. This program should be based around standards and principles that align to community expectations for claims management.

We believe that interested bodies such as the Australasian Life Underwriters & Claims Association should be brought together under the auspices of the FSC to develop this program.

Promoting better health outcomes for disability claimants.

The FSC is a signatory to the Consensus Statement for Health Benefits of Good Work. Underlying this are a series of Position Statements which encompass Australian and international research that highlight the issues around compensable disability – namely that people who claim are likely to have worse health outcomes than those who do not with similar conditions.

The inference is that disability compensation systems (including government, CTP and Workers Compensation) in some way contribute to avoidable disability. When one considers that when a young man is off work for more than six months he is forty times[6] more likely to commit suicide, it becomes clear that this must be a priority.

The issue is much broader than claims handling and also includes the medically discretionary off work certification by treating doctors (when work is often the best place to recover) and the lack of flexibility in many employers to accommodate workers' recovery at work.

Many insurers have been wrestling with this problem over recent years and there has been significant investment and rethinking of approaches. This has included:

1. Challenging the traditional approach to claims, which focusses on the distinction between genuine and non-genuine claims, to accommodate a more outcome based and holistic approach. This new approach delivers a better outcome for consumers making claims where objective evidence is hard to provide. This includes some claims where the symptoms may include pain, fatigue or psychological distress.
2. Seeking improved ways of engaging treating doctors and reducing the insurance burden on them.
3. The broad introduction of early intervention vocational rehabilitation for income protection.
4. The development of profiles that permit the rapid resolution of claims. For example BT admits 20% of income protection claims during the initial telephone conversation, and a further 15% when the first forms are received. There is continued innovation across the industry in this area.

In summary, life insurance claims handling has been under significant scrutiny in 2016. There is rightfully a focus on reducing the rare but highly consequential failings in certain cases. There is a continuing opportunity for life insurance claims handling to positively transform, with benefits for consumers and other stakeholders.

In the first instance we would seek government approval of the FSC proposal to allow life insurers to pay for treatment costs associated with consumers' endeavours to return to work.

3. MySuper and the opt-out model

In our view, for fundamental reasons the opt-out model should be retained, though continued improvements to this model should be encouraged and in some areas required.

Minimum default levels of cover for Term Life and TPD insurance are provided to members within a MySuper product, on an opt-out basis. In the Explanatory Memorandum to the Bill introducing this requirement, Treasury noted the following:

[6] Wessely S (2004). Mental health issues. In: Holland-Elliot K, ed. *What about the workers? Proceedings of an RSM Symposium.* London: Royal Society of Medicine Press; 41–46.

Insurance is a key element of the benefits provided to members of a superannuation fund. These benefits protect members against the risk of not being able to accumulate sufficient retirement savings, for themselves or their dependents, due to having to cease work as a result of injury or illness or as a result of death[7].

The nature of the opt-out model has led to concern that cover could be provided to members when it is not needed, or that disengaged members would not be aware of this expense. It has been suggested that an opt-in model may present a better approach, as cover would only be provided when required.

Positioning the debate as a choice between the two models allows only for limited discussion, and ignores the significant improvements that trustees have made in recent years to tailor their default offering to different age groups and industries.

These improvements have been driven by both competitive market forces, and the trustee obligation to only offer insurance if it does not inappropriately erode the retirement incomes of members[8].

Retaining the opt-out model is supported by the following arguments:

- The removal of opt-out, as the basis for a default model, would lead to a significant increase in the number of Australians either underinsured, or holding no cover. This would compound the present state of underinsurance in Australia - for TPD policies, current research suggests that the overall median level of cover held by Australians meets only 13% of TPD needs[9].
- Under a pure opt-in model, those that presented a greater risk of claim (for example, through poor health) would be more likely to take up cover. This in turn would be likely to lead to an increase in premium expense, or additional exclusions.
- Default levels of cover are designed by trustees to approximate the insurance needs of their member base at different ages. For example, under the BT Lifetime Super – Employer Plan, the standard cover provided to a 20 year old female is $70,000 in death and $300,000 in TPD, at a combined cost of $0.80 per week (or $41.60 per annum). Importantly, this cover is customised so that TPD cover significantly exceeds life cover – appropriate for many young members as it represents the greater need at this time. Standard levels of cover then increase to $300,000 (for both death and TPD) at age 35 and then decrease as a member approaches retirement. At age 65, the standard minimum level of opt-out death and TPD cover is only $20,000.

There are a number of mechanisms which can be employed to reduce and mitigate any disadvantages within the opt-out model for default cover. Making such improvements is more pragmatic and sensible than changing the model altogether, and placing at risk the financial protection of many Australians.

In our view, the inquiry should consider the following improvements for further consultation:

- Improved trustee / member engagement - for example, minimum information standards that must be provided to members each year about their type and level of cover, including examples, in plain language, of the circumstances in which a claim may or may not be paid.

[7] Superannuation Legislation Amendment (Further MySuper and Transparency Measures) Bill 2012.
[8] Superannuation Industry (Supervision) Act 1993 - Section 52(7)(c).
[9] Rice Warner – Underinsurance Report 2015.

- A requirement that when a member leaves their employer under which group cover is provided, that member must opt-in to any continuation insurance. This measure would prevent circumstances where the cost of cover significantly increased (for example, from a group to retail rate) without the member's consent. It would also address circumstances where a member retains an income protection policy and acquires an additional policy through a new employment arrangement – in these cases the member is sometimes only able to claim on one policy, depending on the level of the benefit and the member's pre-disability income.

4. Harmonisation between superannuation and non-superannuation policies

Current research suggests that more than 70% of Australian life insurance policies – more than 13.5 million separate policies – are held through superannuation funds[10].

In 2014, under the Stronger Superannuation reforms, changes were made to the Superannuation Regulations[11] which required that policies established through superannuation from 1 July 2014 be consistent with a specified condition of release. This means that the conditions under which a claim can be paid from a superannuation policy is limited, by product design, to the regulations permitting superannuation access.

For example, a non-superannuation TPD policy may provide cover for a person where they are assessed as being unable to work in any occupation for which they are reasonably suited, but still pay a claim where the person is able to work in a significantly reduced earning capacity, limited to 25% of their pre-disability income.

Where such a policy is established through superannuation, the ability to return to work, albeit in a reduced capacity, would preclude the insured from being able to claim.

In our view, consideration should be given to broadening the conditions of release under the current superannuation regulations, to accommodate certain benefits paid from polices of life insurance.

5. Regulator powers

We believe that ASIC's significant existing powers, complemented by the Financial System Inquiry's recommendations to improve ASIC's funding model and capacity to execute its mandate, provide a sound base for ASIC to protect consumers and help promote confidence in the financial system.

The scope of the proposed ASIC product intervention power should be targeted at areas where ASIC's current powers are clearly inadequate, with objective accountabilities that support certainty for financial firms and consumers. We have also indicated above our broad support for the recommendations ASIC made in Report 498 and we look forward to working with ASIC on the implementation of these.

Otherwise, we do not consider that any other powers are necessary or warranted given the broad powers granted to ASIC under the ASIC Act, Corporations Act, Insurance Contracts Act and Life Insurance Act.

[10] http://ricewarner.com/insurance-through-superannuation/
[11] Superannuation Industry (Supervision) Regulations 1994 - Reg 4.07D