

Inquiry into the life insurance industry

Submission to the Parliamentary Joint Committee
on Corporations and Financial Services

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Who we are

The Australian Lawyers Alliance is a national association of lawyers, academics and other professionals dedicated to protecting and promoting justice, freedom and the rights of the individual.

We estimate that our 1,500 members represent up to 200,000 people each year in Australia. We promote access to justice and equality before the law for all individuals regardless of their wealth, position, gender, age, race or religious belief.

The ALA started in 1994 as the Australian Plaintiff Lawyers Association, when a small group of personal injury lawyers decided to pool their knowledge and resources to secure better outcomes for their clients – victims of negligence. While maintaining our plaintiff common law focus, our advocacy has since expanded to criminal and administrative law, in line with our dedication to justice, freedom and rights.

Our members act for consumers who are dealing with the life insurance industry every day. They represent people in direct communication with financial advisers, life insurers and their representatives, in and out of courts and tribunals. They are witness to the day-to-day conduct of life insurers and their representatives and are very well placed to comment on the joint committee's terms of reference.

The ALA is represented in every state and territory in Australia. More information about us is available on our website.¹

¹ www.lawyersalliance.com.au.



INTRODUCTION

1. The ALA welcomes the opportunity to have input into the Parliamentary Joint Committee on Corporations and Financial Services inquiry into the life insurance industry. Our submission responds to terms of reference a, b, d and g.
2. The ALA is calling for a three part reform in the life insurance sector based on:
 - Identifying bad behaviour and calling it out;
 - Confirming the minimum standards that insurance policies should meet, particularly in relation to total and permanent disablement (TPD) policies provided via superannuation funds; and
 - Encouraging and ensuring higher standards of behaviour and conduct within the sector.
3. In response to poor profit numbers in 2012 and 2013 life insurers have overreacted by significantly increasing premiums, restricting policy definitions and tightening their claims handling processes to increase the decline rate of claims.
4. It has become apparent that the life insurance industry has lost the trust and confidence of consumers as a result of these practices and other bad behaviour.
5. Negative publicity about claims handling practices has resulted in the introduction of a self-regulated code of conduct, developed by the Financial Services Council (FSC). The code does not cover the superannuation industry, where the vast majority of life insurance is managed. It lacks any firm commitment to improve standards above those already required by the existing law. It contains too many exceptions and exclusions (just like an insurance policy), is confusing for consumers and does not provide sufficient oversight to guarantee the level of cultural change necessary to reform the industry.
6. Opt out cover in superannuation is indispensable, but the products available and claims conduct by insurers requires improvement to balance consumer rights with market viability. There is a need for government regulation of the industry to protect vulnerable consumers and to ensure government does not end up footing the bill for injuries or illnesses that should rightfully be covered by the policies that insurers have been receiving premiums for. Affordable, accessible and effective coverage will inevitably disappear if the current path, of harder definitions resulting in junk insurance, higher premiums and higher



levels of rejected claims, remains the trajectory. People will be left to claim government benefits, losing the chance to turn their lives around and remain productive members of society that is offered by life insurance.

7. A life insurance claim is often a person's last resort and sometimes their only resort in circumstances where other forms of compensation are simply not available to them or not adequate. Given the trend at a state level of reducing access to common law damages for negligence, the need for a fair and effective life insurance industry is greater than ever.



SUMMARY OF RECOMMENDATIONS

Recommendation 1 – Mandate the use of standard insurance definitions for permanent incapacity in group insurance policies.

Recommendation 2 – The standard insurance definition for permanent incapacity should not be linked to catastrophic injury in group insurance policies.

Recommendation 3 – Mandate the use of standard definitions for the terms "Sickness" and "Injury" across all life insurance products to ensure that an insurer and a consumer are afforded the protections of s.29 ICA.

Recommendation 4 – Amend the ICA so that for an insurer to satisfy the requirement to clearly inform, they would need to provide the information concerning the deviation from Standard Cover "in a prominent, clear, concise and effective manner".

Recommendation 5 – Restrict the use of pre-existing condition exclusions in some circumstances in group insurance policies.

Recommendation 6 – Insert provisions within the ICA which mirror the requirements of s.24 ACL in relation to the meaning of fairness.

Recommendation 7 – Amend the ICA to mandate a timeframe of six months from lodgement of a claim for insurers to make a decision to accept or reject the claim.

Recommendation 8 - Improve measures of performance for the life insurance industry and make the data de-identified, publicly available and free of charge.

Recommendation 9 – The decisions of FOS, the SCT and any other external dispute resolution provider must name the parties involved and specifically identify the particular product concerned other than in exceptional circumstances.

Recommendation 10 – Any report published by the LCCC about code compliance must identify those who have been found to breach the FSC Code other than in exceptional circumstances.

Recommendation 11 – ASIC should design a new Life Insurance Code of Conduct with input from all stakeholders in the industry to be binding on all life insurers and superannuation trustees.



Recommendation 12 – Life insurance cover within MySuper products remain ‘opt out’, with minimum lump sum benefit amounts prescribed by reference to age to ensure adequate cover.

Recommendation 13 – Approved Product Lists must include a balance of affiliated and non-affiliated products, and/or a minimum proportion of non-affiliated products.

Recommendation 14 - If a Statement of Advice (SOA) produced for a customer recommends an affiliated product, that should be disclosed and the SOA should show a comparison with one or more non-affiliated products to demonstrate that the affiliated product is more appropriate.



A. THE NEED FOR FURTHER REFORM AND IMPROVED OVERSIGHT OF THE LIFE INSURANCE INDUSTRY

8. The Australian life insurance industry has been found wanting in recent years. Minimum standards are required and must be incorporated into the law to enable meaningful policing of those standards and remedies for consumers.
9. People who are covered by group life cover are particularly vulnerable. Those who have access to advice from insurance brokers and advisers are better placed to ensure their coverage is matched to their circumstances. A need for reform persists, however, to ensure more consistency in definitions and the management of claims and decision making processes across the entire sector.
10. Life insurers who are involved in both the individual and group sectors should welcome the reduction in complexity that will come from standardised definitions. This will make it easier for the insurers to price their product and it will also allow consumers to compare products easily when it comes to price.
11. Throughout this submission, the term 'fund' is used to identify a superannuation fund, which receives regular deposits from employers and account holders. It is the trustee that holds and manages account holders' superannuation. The term 'insurer' refers to the life insurers that the funds contract with to provide life insurance for the account holder as a part of their superannuation policy.
12. Life insurance that comes with superannuation is generally known as 'group insurance', because it comes automatically with superannuation and is available to the group without reference to their individual circumstances. Other types of life insurance include retail life insurance, where people get independent advice and enter into their own policies (which can be inside or outside of their superannuation) and individual policies, where people contract directly with the insurer without getting advice.
13. This submission is predominantly about group insurance, being life insurance that comes automatically with many or most superannuation policies. Some of the recommendations regarding definitions would be equally applicable to all other forms of life insurance.



STANDARD DEFINITIONS

14. Life insurance is an essential resource for the Australian public. Consumers are entitled to minimum standards and clear definitions. This is particularly so in the group insurance sector where commonly people are either not able or concerned to understand the differences in coverage available. The consequences of not having adequate coverage can mean families are placed in extreme financial hardship in the event of unexpected injury or illness. They then become reliant on government welfare and the public health system if they do not have adequate insurance coverage. This leads to significantly reduced quality of life, with hardship becoming ongoing and self-perpetuating.
15. Terminology in the sector is confusing. “Total and permanent disablement” (TPD) is often used to describe both catastrophic injury and disability causing permanent incapacity for work. The ALA believes this is confusing. We believe the preferred terminology is “permanent incapacity”, as reflected in the *Superannuation Industry (Supervision) Regulations 1994* (Cth) (SIS Regulations). This term is defined as follows:

“a member of a superannuation fund or an approved deposit fund is taken to be suffering permanent incapacity if a trustee of the fund is reasonably satisfied that the member’s ill-health (whether physical or mental) makes it unlikely that the member will engage in gainful employment for which the member is reasonably qualified by education, training or experience.”²
16. TPD should only be used to describe catastrophic injury. Ordinary people would not generally classify someone as being totally and permanently disabled if they cannot return to work within their field (in view of their education, training and experience) but who might be able to work again after significant re-training. The reality however for that person is that they cannot work, and their incapacity will have a lasting impact on their ability to earn money and live a fulfilling life.
17. The ALA believes that the two parts of the common TPD definition should be split, with both the catastrophically injured and those who have lost the ability to work who do not fit within the definition of TPD being eligible under standard policies.
18. Losing the ability to work due to ill health within a person’s current education, training and experience has a very serious impact on not only their immediate financial position but

² Reg 1.03C, SIS Regulations.

their future ability to save for retirement. These people need help from the life insurance industry. If they have paid for coverage, that coverage should be available when it is needed most. If they are to exercise any capacity to work they commonly will have to start a new career after significant re-training or re-skilling. They will commonly be reduced to lower levels of employment at lower rates of pay for less hours. That translates to a loss of income, a loss of superannuation contributions and a consequent loss of security in retirement which should be covered via life insurance.

19. Separating out the catastrophically injured from those who have lost the ability to work due to ill health should also make it easier for the insurance industry to price coverage. The rarer catastrophic injury can be covered presumably for a much more modest rate than perhaps permanent incapacity for work in its truest sense.
20. The Parliament has for decades now had in place a fair definition of permanent incapacity which strikes a balance between the needs of those who cannot work due to ill health and the public interest to ensure funds are preserved for the purposes of superannuation and only released in exceptional circumstances, extracted above.
21. The insurance industry has acknowledged that the design of policies should take into account the suitable customers for the product, and that benefits should cover genuine risks that generally affect the relevant customers.³ It is submitted that the general working population requires cover that will pay when they cannot work, not in the most unlikely scenario that they will become catastrophically injured by losing two limbs or becoming blind in two eyes. Standard definitions in line with the SIS Regulations will be of immense assistance in this regard.

Standard definition of “Injury” and “Sickness”

22. There has been a recent trend in many life insurance contracts for insurers to include a definition of sickness or injury such as *sickness means a sickness which occurred during the period that this policy is in force*. Of course, in practice that operates as an exclusion for a consumer to claim in relation to any pre-existing medical condition. However, often when an insurance policy is taken out an insured will go through an underwriting process

³ Life Insurance Code of Conduct at clause 3.1 (a) and (b)

in which they will disclose a number of pre-existing medical issues which, after consideration by an insurer, an insurer agrees to cover.

23. An insurer has protections against consumers who have misrepresented or failed to disclose medical or other matters at the time that a policy was taken out pursuant to s.29 ICA. Section 29 ICA, aside from protecting an insurer, also ensures that a consumer is treated fairly in any retrospective underwriting consideration. These protections are important and require an insurer to show what other reasonably prudent insurers would have done. However, an insurer who defines sickness in the manner suggested above could circumvent the requirements of s.29.

Junk insurance

24. Over recent years, the quality of definitions being written have reduced some superannuation funds' offerings to 'junk insurance', effectively collecting premiums from policy holders while providing little to no genuine prospect of insurance coverage in the event of serious injury or illness. They use new and unreasonable thresholds, eligibility rules and definitions, and create redundancy where a member has multiple policies despite continuing to receive premiums. Examples are as follows:

Capacity: unlikely vs incapable

25. Recently Australian Super, with over a million members, changed its TPD definition to remove the word "unlikely". It now requires claimants to demonstrate that they are "incapable of ever engaging in any occupation for which [they are] or may become reasonably suited by education, training or experience".
26. This is very much intentional: The threshold "incapable of ever engaging" is much higher than "unlikely", which is found in the *Superannuation Industry (Supervision) Act 1993* (Cth) ('SIS Act') and SIS Regulations.⁴

⁴ See the definition of 'Permanent Incapacity' provided for in reg 1.03C of the *Superannuation Industry (Supervision) Regulations* (Cth) 1994: "a member of a superannuation fund or an approved deposit fund is taken to be suffering permanent incapacity if a trustee of the fund is reasonably satisfied that the member's ill-health (whether physical or mental) makes it unlikely that the member will engage in gainful employment for which the member is reasonably qualified by education, training or experience."



27. Further, the standard of work that is considered appropriate is lower than that provided for in the SIS definition. Ultimately this means that claimants can have claims rejected, even if it is unlikely that they will ever engage in employment similar to that which they were performing before the accident.
28. The NSW Court of Appeal⁵ recently considered the “unlikely” TPD test and found that “A real chance that a person will return to relevant work, even if it is less than 50%, will preclude an Insured Person being unlikely ever to return to relevant work.” Surely that test is sufficiently onerous.
29. It is pleasing to see that some funds, such as CBUS, have resisted pressure from insurers to depart from the SIS “Permanent Incapacity” test, retaining the “unlikely” definition. The fact that such definitions are being retained by some confirms the viability for doing so across all insurers.

Retraining clauses

30. The SIS Regulations definition of Permanent Incapacity gives rise to coverage where an incapacitated member of the fund is unlikely to engage in gainful employment for which they are reasonably qualified by education, training or experience. There is no reference to retraining subsequent to the injury or illness in assessing eligibility under the policy. A number of policies that are currently being used, however, depart significantly from this definition, effectively reducing the coverage available to policy holders.
31. The current Australian Super/TAL policy contains the following provisions regarding retraining:

“In forming our opinion we will have regard to factors including but not limited to:

- i. Any retraining, re-skilling, work or voluntary work that has been undertaken by the time we form our opinion;*
- ii. Any retraining, re-skilling that could reasonably be expected to be undertaken by the insured member within a reasonable time period;*

⁵ *TAL Life Ltd v Shuetrim; MetLife Insurance Ltd v Shuetrim* [2016] NSWCA 68 at [89]



iii. Any rehabilitation that has been undertaken by the time we form our opinion, or could reasonably be expected to be undertaken by the insured member within a reasonable time period;

iv. All evidence available to us for the period up to the time we form our opinion."

32. It is not clear who would pay for the retraining or re-skilling envisaged at point (ii). Further, if the cost of the retraining is greater than the prospective insurance benefit, what happens? Finally, if the policy holder withdraws their account balance under the SIS Permanent Incapacity grounds, will the Fund Trustees continue to help a non-member retrain or rehabilitate? Policy holders deserve clear answers to these questions. Such clauses could also act as an incentive for Fund Trustees to delay their assessment of claims to allow time for retraining to occur, effectively reducing their liability.

Ongoing care

33. The current MTAA/Metlife policy contains the following definition for regular and ongoing care. It means the person:

"a. Is under the regular and ongoing care of a medical practitioner who has given a clear prognosis that the Injury or Illness will continue throughout the life of the Covered Person (including after the expiry of the cover and the commencement of retirement) without any prospect of an improvement which would lead to a return to work (whether or not for reward) in any capacity; and

b. Is complying with reasonable medical advice and treatment; and

c. Has, in our opinion reached the maximum level of medical improvement possible for that Covered Person based on their Injury or Illness."

34. This is perhaps the most severe departure from the SIS definition (which determines eligibility by reference to a member's education, training and experience).
35. This is junk insurance. The chances of a claim being admitted are deleteriously low due to the difficulty a claimant will have procuring such unequivocal medical opinion, which effectively requires that a doctor assure against future improvement. Few doctors would provide such a pessimistic message to their patient.

36. The definition also expressly enables the insurer to decline claims where a claimant may be able to do some unpaid work. Compare that to the definition of gainful employment in the SIS Regulations: *“employed or self-employed for gain or reward in any business, trade, profession, vocation, calling, occupation or employment”*.

37. This is a further damaging deviation from the guiding principles of orthodox life insurance cover.

Coverage exclusions

38. An NGS Super/CommInsure policy contained the following exclusion clause:

“Excluded Member Means a Member to whom any of the following applies:

(a) A terminal illness, total and permanent disablement, trauma or similar benefit has been paid or is payable or can be claimed in respect of the Member under any insurance policy, whether that policy be owned by the Member or another person (including the Fund or another superannuation scheme);

(b) the Member has received, or is eligible to receive, a benefit, or has had a claim for a benefit admitted, from:

i. the Fund; or

ii. another superannuation scheme;

on the basis the fund or scheme has found the Member to suffer from ‘permanent incapacity’ or a ‘terminal medical condition’ under the Superannuation Industry (Supervision) legislation or any legislation which replaces it; or

(c) the Member has or was eligible to have cover under any group life policy issued to the Fund and the Member:

i. opted out of being covered; or

ii. cancelled the cover; or

iii ceased being a member of the Fund.”

39. This clause effectively excludes coverage for most potential claimants. Many workers in Australia have multiple superannuation policies and thus would have had multiple group life insurance policies. To exclude coverage in the circumstances described below means that policy holders will have been paying premiums for a policy that would never be likely to afford them any coverage in the event of serious or catastrophic injury or illness.

Obligation to clearly inform

40. The ALA has proposed in this submission that there be a standard definition of “Total and Permanent Disablement” as well as “Sickness” and “Injury”. As with other insurance contracts, such as home and contents insurance, it is proposed that an insurer would be able to deviate from the standard definitions, but only if they clearly inform a consumer of the fact that the policy is below the standard that is set by law. The obligation to clearly inform has been set out in s.35(2) ICA. Section 35(2) has been the subject of judicial consideration which resulted in a finding that it may be sufficient for an insurer to simply provide a consumer with a Product Disclosure Statement (PDS) or a copy of the policy. Of course, in real terms it is understood that consumers rarely read every page of an insurance policy or PDS, and are sometimes not capable of understanding the complex terms used. Unfortunately, as the common law stands, the obligation to clearly inform provides policy holders with little if any protection in a practical sense. Legislative reform is required to remedy this deficiency in line with Recommendation 6, below.

Recommendation 1 – Mandate the use of standard insurance definitions for permanent incapacity in group insurance policies.

A minimum standard insurance definition for permanent incapacity, which applies to group claims where people are unable to work due to injury or illness, should be legislated. The definition should be based on the current permanent incapacity definition contained in Regulation 1.03C of the SIS Regulations (an example definition is provided at annexure 1). Insurance law already has standard cover for many general insurance products such as accident and sickness, flood insurance and motor vehicle. That requires an insurer to provide minimum types of benefits and can only deviate from that cover if they “clearly inform” an insured of the changes. This proposal would see those standards extended to group life insurance cover.

Recommendation 2 – The standard insurance definition for permanent incapacity should not be linked to catastrophic injury in group insurance policies.

A separate minimum standard insurance definition for group disability claims for total and permanent disablement caused by catastrophic injury, based on major named injuries and illnesses and injury and illness which restricts the ability to perform certain activities of daily living without assistance, should be introduced (an example definition is provided at annexure 1).

Recommendation 3 – Mandate the use of standard definitions for the terms "Sickness" and "Injury" across all life insurance products to ensure that an insurer and a consumer are afforded the protections of s.29 ICA.

The definition of Injury should be: "Physical or mental harm done or suffered by a person".

The definition of Sickness should be: "An illness, disease, syndrome, ailment or other disorder of the body or mind".

Recommendation 4 – Amend the ICA so that for an insurer to satisfy the requirement to clearly inform, they would need to provide the information concerning the deviation from Standard Cover "in a prominent, clear, concise and effective manner".

It is recommended that the ICA be amended so that for an insurer to satisfy the requirement to clearly inform, they would need to provide the information concerning the deviation from Standard Cover "in a prominent, clear, concise and effective manner". It is anticipated that if the obligation includes a requirement for the information to be displayed prominently, it will give a consumer the greatest opportunity to be aware of any deficiency in the insurance product.



EXCLUSION CLAUSES, LIMITED COVER AND FULL COVER

41. The use of exclusion clauses for pre-existing conditions, particularly in group coverage, is open to abuse. For example, many group superannuation insurance policies will only provide 'limited cover' unless and until the member satisfies an 'at work' or 'active employment' definition. Limited cover typically pays only for claims arising from new events only, whereas full cover pays for claims arising from any medical condition even if it arose prior to the commencement of the risk. Despite reduced coverage, however, limited cover does not attract a lower premium. That is because neither funds nor insurers know which group members will be deemed to have limited cover until after a claim is lodged.
42. That is clearly inadequate: insured members ought to have certainty regarding the insurance cover they hold to enable them to determine whether such cover is adequate and if not to seek additional or alternative cover. Blanket underwriting, whereby the same coverage is provided to all members regardless of their personal circumstances, is not the problem per-se. It is too costly to individually underwrite millions of policy holders. However 'at work' or 'active employment' definitions vary widely from one policy to another, and minimum standards should be developed to provide for full cover as long as members meet minimum work attendance.
43. Full cover should be granted where either of the following has occurred:
 - A certain qualifying period of unrestricted employment has passed; or
 - A member's compulsory super guarantee contributions made to the Fund by the employer is above a threshold set by the Fund/insurer.
44. Neither of the above are burdensome administratively as Funds obviously have that data on their members' contribution periods and amounts ready to hand. Using that data, Funds and their insurers could easily determine the scope of cover for each member, and clearly disclose same to them in their periodical membership statements. It is submitted that the above approach is workable and reasonable: if after a qualifying period of employment a pre-existing condition has not caused a member to cease work, or within that qualifying period they are working sufficient hours to attract a certain level of super guarantee contributions, then any such pre-existing condition's effect on risk is much diminished and the insurer ought to recognise that.



Recommendation 5 –Restrict the use of pre-existing condition exclusions in some circumstances in group insurance policies.

The ICA should be amended to void the use of exclusion clauses for pre-existing conditions in circumstances where:

- (a) the insurer does not require any declaration as to health at the time coverage is effected or provides automatic coverage;*
- (b) the insurer is advised of the pre-existing condition before providing coverage and accepts the risk without specific exclusion of any condition;*
- (c) a certain qualifying period of either unrestricted employment or unrestricted enjoyment of the activities of daily living has passed. It is suggested a period of 12 months be applied, or within that qualifying period a member’s super guarantee contributions reach a certain threshold.*

UNFAIR CONTRACTS

45. In 2016 there has been a number of instances revealed in which consumers have been adversely impacted as a result of an insurance policy which contains a definition, for example of heart attack, which has not kept pace with advances in medical science. Accordingly, the definition is no longer relevant or applicable and has the effect of denying a premium paying consumer their rightful entitlement under the policy. Currently, pursuant to s.15 *Insurance Contracts Act 1984* (ICA) an insurance contract is not subject to the Unfair Contract legislation contained within the Australian Consumer Law (ACL). Accordingly, whilst an insurer may owe a duty of utmost good faith, pursuant to s.13 of the ICA, that duty does not in real terms provide a consumer with adequate protection from an unfair contract term.

46. To ensure consumers are adequately protected, the ICA ought to be amended to provide protection to consumers from unfair contract terms. Importantly, insurers would still be able to offer insurance which is difficult to claim on. This provision would only be enlivened if the particular provision of the policy operated in an “unfair” manner.

Recommendation 6 – Insert provisions within the ICA which mirror the requirements of s.24 ACL in relation to the meaning of fairness.

A suggested form of the recommended provision is set out below:

"Meaning of 'Unfair'

- (1) *A term of an insurance contract is Unfair if:
 - (a) *it would cause a significant imbalance in the parties' rights and obligations arising under the insurance 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 an insurance 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 insurance 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 consumer 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."*

MANDATED DECISION TIMEFRAMES

47. A common complaint for those claiming on life insurance is the lengthy delays in the assessment of claims. Of note in this regard, the recent ASIC report⁶ highlighted when analysing decline rates that some insurers had even higher withdrawn claim rates for some types of cover. For example, for TPD cover, one insurer's withdrawn claim rate was 33 per cent and for income protection another insurer's was 30 per cent. For one insurer, the trauma cover withdrawn claim rate was 26 per cent.
48. The fact that so many people withdraw their claims is concerning. It could indicate that the process is taking too long and is too complex, resulting in them becoming worn down. It might also suggest that claimants are being intimidated or otherwise treated unfairly by insurers.
49. The current version of the FSC Life Insurance Code of Conduct provides for a six month timeframe for decisions in TPD claims, but there are many loopholes in the Code where that timeframe can be extended. The common law recognises that where an insurer has taken too long to assess a claim and has not made a decision then the court can step in and make the decision for them.
50. A clear timeframe should be legislated, with consequences following for insurers who do not meet it. The appropriate timeframe would be six months, as outlined below in recommendation 7.

Recommendation 7 – Amend the ICA to mandate a timeframe of six months from lodgement of a claim for insurers to make a decision to accept or reject the claim.

Where a decision is made after the six month timeframe then it is deemed that the decision is neither fair nor reasonable and both the Superannuation Complaints Tribunal (SCT) and the courts can automatically move to consider the merits of the claim.

⁶ Australian Securities and Investment Commission Report 498 "Life Insurance Claims: An Industry review," October 2016 at paragraph 194



ROBUST STATISTIC GATHERING AND TRANSPARENT REPORTING

51. Making available regular statistics about the claims experience across the industry such as rates of decline compared to claims made is crucial to identifying bad behaviour and calling it out. This will in turn change culture in the industry because consumers and superannuation trustees, who commonly negotiate coverage on behalf of their members, will vote with their feet when it comes to their perceptions of poor standards and high decline rates. For consumers and other stakeholders to assess data meaningfully will require some standardisation of policies and/or definitions across the industry.⁷
52. ASIC has identified this as a key observation from their recent review of the industry.⁸ In the ASIC report data provided especially by the industry is quoted, but the insurers who were found to have abnormally high rates of decline are not named. There is no better way to change culture than by the reported measures that an industry is held to.
53. To date it appears the only time the industry strives to change practices is when profits decrease. This is because they are measuring profit. If rates of decline were measured and reported on then the industry will have an incentive to reduce those rates of decline where they appear to be above the average. Community standards should be reflected in the measures that life insurers are held to. If the community does not accept abnormally high rates of decline above the industry average, then that statistic should be monitored. If the industry does not accept abnormally long claims assessment periods then that statistic should be monitored.
54. The industry has demonstrated that it cannot currently be trusted to act on data behind closed doors. The data should be publicly available and transparent so the community can see how the sector is performing and act when parts of the sector are underperforming. An insurer that is acting in good faith and who respects the community will have no problem with transparent recording and publication of claims performance data. If an insurer suggests that the data might somehow be misconstrued then it is incumbent on

⁷ As has been recognised in the UK by the Association of British Insurers as reported in the Australian Securities and Investment Commission Report 498 "Life Insurance Claims: An Industry review," October 2016 at page 10; see further <https://www.abi.org.uk/Insurance-and-savings/Industry-data>.

⁸ Australian Securities and Investment Commission Report 498 "Life Insurance Claims: An Industry review," October 2016 at paragraph 43 and 46



that insurer to explain the data; it is no reason to refrain from recording and monitoring the data in the first place. In the UK data is available but at a cost. It is submitted that in Australia the data ought to be available without cost and that access not be limited in any way. Otherwise the average consumer will not have access to the data except as it is summarised and presented to them by those with vested interests.

55. Claims data, particularly the data around declined claims, must take into account those claims where an insured person makes an inquiry about claiming and are told they cannot claim by the insurer or their representative. Basing decline rates only on those claims which are actually being lodged provides a potentially distorted view of what an insurer's true decline rates are.
56. Public reporting of cases and decisions in this sector is routinely de-identified. The Financial Ombudsman Service (FOS), the Superannuation Complaints Tribunal (SCT), APRA and ASIC all de-identify data, decisions or publications involving the industry. If we are to have a truly transparent, workable system, particularly when it comes to complaints resolution then publication of decisions must be fully made without de-identification except in those rare cases where that might be appropriate. Justice must not only be done but must be seen to be done.
57. The current FSC Life Insurance Code of Conduct provides for annual reporting on code compliance by the Life Code Complaints Committee (LCCC) on a de-identified basis. This is a document created by the insurers. It is in their interest for such matters to be anonymous but it is not in the interest of consumers or the community as a whole.
58. At the end of the day the provision of and access to life insurance is too important to people's quality of life to leave these things to chance. In a free market place consumers are entitled to be able to access robust and transparent data about the industry to then make informed choices about which insurer they will trust to insure their life and their capacity to earn a reasonable living and provide for their families.



Recommendation 8 - Improve measures of performance for the life insurance industry and make the data de-identified, publicly available and free of charge.

Recommendation 9 – The decisions of FOS, the SCT and any other external dispute resolution provider must name the parties involved and specifically identify the particular product concerned other than in exceptional circumstances.

Recommendation 10 – Any report published by the LCCC about code compliance must identify those who have been found to breach the FSC Code other than in exceptional circumstances.

AN ASIC APPROVED CODE OF CONDUCT

59. A code of conduct is one method to encourage higher standards of behaviour in the sector. It is highly recommended and long overdue. The code must however have credibility and be developed with broad input across the industry including from consumers. It must have the power of government backing behind it.
60. The FSC Life Insurance Code of Conduct (the FSC Code) is of limited scope and coverage. There are many questionable aspects to it and in some parts it does not do enough to protect the rights and interests of consumers. It provides no real remedy for its breach and therefore no incentive for compliance. It is not ASIC approved. The FSC Code does however contain some worthwhile standards that can be adopted and built upon.
61. The FSC is a membership based organisation. Its membership is limited to financial services providers (insurers) and their consultants. It does not allow consumer groups or advocates for consumers to be members. It is a closed shop. Not all financial services providers are members. For example the life insurance company owned and operated by ANZ, One Path Life Limited, is not a member of the FSC. It cannot be bound by the FSC Code.
62. The life insurance industry includes insurers and consumers, not just insurers. For an industry based code to be effective it must have some consensus across the industry not just from one part of the industry. The ALA made two extensive submissions to the FSC



about the FSC Code before it was published. Very few of the ALA's recommendations were taken up. Those recommendations are available for the use of any further body considering a similar code. It is recommended that the industry regulator ASIC be charged with creating a comprehensive code to ensure a balanced input from all sides of the industry.

63. Of particular concern is the fact that the current FSC Code does not bind superannuation trustees.⁹ A large consumer of life insurance in Australia is the superannuation sector and the trustee companies that manage superannuation on behalf of all Australians. Individual consumers most commonly access life insurance through their super fund and have to deal with the trustee of the super fund to access benefits. The trustees have real influence when it comes to how claims are assessed and paid.
64. The FSC Code provides for the LCCC to monitor and enforce it. The first and most striking weakness of the LCCC is that it cannot take any direct action to assist a consumer who is invariably going to be the victim of any breach. The LCCC can impose rectification steps but they are not defined. The strongest identified sanction that can be imposed by the LCCC is that the insurer will have to write to the consumer about the issue. The scope for dispute by an insurer as to whether the LCCC has power to impose a particular rectification step is wide. Does the LCCC for example have the power to order an insurer to make a decision on a claim within a certain period of time? Can they order a refund of improperly deducted premiums or to pay a benefit due under a policy? The specific rectification powers of the LCCC should be identified as part of the FSC Code so it is clear what they can and cannot do. This is essential so a consumer can decide if the LCCC is the appropriate forum for their dispute.
65. There are some parts of the FSC Code that adopt sound standards for the industry to be held to. For example the industry's concession in clause 3.5 that pre-existing injury exclusions should not be used where the insurer was aware of the condition at the time of underwriting the risk but accepted the risk anyway.

⁹ Clause 2.2 FSC Life Insurance Code of Conduct



Recommendation 11 – ASIC should design a new Life Insurance Code of Conduct with input from all stakeholders in the industry to be binding on all life insurers and superannuation trustees.



B. ASSESSMENT OF THE RELATIVE BENEFITS AND RISKS TO CONSUMERS OF THE DIFFERENT ELEMENTS OF THE LIFE INSURANCE MARKET, BEING DIRECT INSURANCE, GROUP INSURANCE AND RETAIL ADVISED INSURANCE

66. Australia already has an underinsurance problem. The recent Draft Report of the Productivity Commission's Study of the Efficiency and Competitiveness of the Superannuation System¹⁰ emphasised the great importance of superannuation based insurance given the underinsurance problem in Australia, and the potential cost to the taxpayer. The KPMG study cited in the Draft Report found that:

“the typical person targeted in the analysis required cover of \$570 000, that 19 per cent of families did not have cover, and that underinsurance levels varied significantly by age group, gender and geographical location. Australians in the 18–29 age bracket were the most underinsured for this cover”.¹¹

67. A further study cited in the Draft Report, undertaken for the Association of Superannuation Funds of Australia (ASFA), stated that “the median underinsurance gap (in dollar terms) was 36 per cent for (basic) life, 58 per cent for (income replacement) life, 86 per cent for TPD, and 84 per cent for income protection cover”¹² and that the “underinsurance gap is large, but would be much larger if cover was not provided through superannuation funds”.¹³ This all translates to risk and pressure on the welfare system which is ultimately funded by government. There is already a looming impact on the budget from an ageing Australia. Group life insurance is therefore a critical source of protection for consumers and plays a very significant role in the economy more broadly. Default coverage on an "opt out" basis must be retained in Australia's superannuation system. Trustees and insurers are unanimous in their agreement on this point.

¹⁰ <http://www.pc.gov.au/inquiries/current/superannuation/competitiveness-efficiency/draft/superannuation-competitiveness-efficiency-draft.pdf>

¹¹ At 145.

¹² Ibid.

¹³ Ibid.

68. In addition to the above concerns regarding insurance definitions within superannuation, there has been a troubling shift by some Trustees and insurers away from a single lump sum life insurance payment to instalment payments, typically over a period of five years. Claimants would then be required to prove annually they remain unable to return to work in accordance with the definition. An example of this is the new definition introduced by Sunsuper as at 1 July 2016 which requires re-certification of TPD every 12 months for six years. This results in claimants being required to undergo numerous medical and other checks over a period of years, despite the fact – given their guidelines – the condition or injury is always permanent or irreversible (eg a loss of limb), unnecessarily and unreasonably increasing stress on the claimant and costs for the insurer.
69. More generally, this is likely to increase legal conflict, escalate administrative costs and is unfair to claimants with conditions that have no prospect of improvement. There is diminished financial utility in payments over time rather than a one off larger lump sum (eg paying off a mortgage). Presently life insurance lump sums are tax free and do not impact on Centrelink benefits. It is unclear whether the change to instalment payments alters their tax and Centrelink status.

Recommendation 12 – Life insurance cover within MySuper products remain ‘opt out’, with minimum lump sum benefit amounts prescribed by reference to age to ensure adequate cover.



D. THE SALES PRACTICES OF LIFE INSURERS AND BROKERS, INCLUDING THE USE OF APPROVED PRODUCT LISTS

70. The recent announcement by Minister Kelly O'Dwyer in relation to adviser remuneration¹⁴ fails to address significant concerns regarding approved product lists (APLs). The practice of providing vertically integrated advice whereby advisers recommend financial products (including life risk insurance) of entities to which they are associated, to the exclusion of more suitable non-affiliated products is widespread in the industry.
71. The government previously entrusted the industry with responsibility for widening APLs through the development of a new industry standard. The latest statement gives no update on that. A passive response is inappropriate given the industry's poor track record of self-regulation and its manifest commercial interest in continuing to sell in-house products.
72. Legislative reform is needed now to require financial advisers to demonstrate that they consider and recommend both affiliated and non-affiliated products. Specifically, that could be achieved by making the following improvements:
- Requiring that APLs include a balance of affiliated and non-affiliated products, and/or a minimum proportion of non-affiliated products.
 - Requiring that, if a Statement of Advice (SOA) produced for a customer recommends an affiliated product, that should be disclosed and the SOA should show a comparison with one or more non-affiliated products to demonstrate that the affiliated product is more appropriate.
73. These measures would provide prescriptive requirements to support compliance with the Future of Financial Advice (FOFA) best interest test reforms. These measures are also directed towards achieving the recommendation of John Trowbridge, the author of the

¹⁴ Media Release by The Hon Kelly O'Dwyer MP, The Minister for Revenue and Financial Services, "Government releases revised life insurance remuneration regulations for consultation", 19 October 2016



Review of Retail Life Insurance Advice, Final Report,¹⁵ that APLs be reformed to “ensure competitive access and choice for all advisers and their clients”.¹⁶ These improvements are necessary because the expansion of APLs alone will not necessarily be effective in practice if the advisers in question consistently recommended just the one insurer's products despite being officially permitted to recommend others.

74. Requiring advisers to give customers disclosure of comparative non-affiliated products in the SOA, will help achieve a range of important outcomes including:

- compelling advisers to genuinely source a reasonable range of available products on the market to best suit their client’s circumstances;
- help avoid the presently common situation whereby the product most appropriate for a consumer is in fact a non-affiliated product that the consumer is never told about and cannot access through his/her adviser;
- help reduce conflicts of interest;
- help preserve the integrity of the advice given through openness and transparency; and
- help restore consumer confidence in an industry beleaguered by misconduct and controversy.

¹⁵ Released 26 March 2015, [http://www.fsc.org.au/downloads/file/MediaReleaseFile/FinalReport-ReviewofRetailLifeInsuranceAdvice-FinalCopy\(CLEAN\).pdf](http://www.fsc.org.au/downloads/file/MediaReleaseFile/FinalReport-ReviewofRetailLifeInsuranceAdvice-FinalCopy(CLEAN).pdf).

¹⁶ Ibid, recommendation 4, p 9.



Recommendation 13 – Approved Product Lists must include a balance of affiliated and non-affiliated products, and/or a minimum proportion of non-affiliated products.

Recommendation 14 - If a Statement of Advice (SOA) produced for a customer recommends an affiliated product, that should be disclosed and the SOA should show a comparison with one or more non-affiliated products to demonstrate that the affiliated product is more appropriate.

G. ANY RELATED MATTERS

75. The following case studies are provided by way of illustration of poor practices in the life insurance industry.

CASE STUDY 1

76. 'Ms Davidson' held TPD cover through AON, and was insured by AIA Australia. Ms Davidson stopped work as a result of cerebral palsy, as well as a number of other health issues. AIA rejected her claim on the basis that she would be able to work as a telephone call centre operator. This decision was arrived at because the insurer had arranged a "desktop" employability assessment. That is, the person providing an expert opinion about the claimant's employability had never met her or examined her – all they did was review the insurers file. As a result of Ms Davidson's cerebral palsy she has severely impaired speech, and could barely speak. She certainly could not have worked as a call centre operator. However, the employability assessor was unaware of the speech impairment because they had never met her – this resulted in an utterly absurd opinion being provided that she could work in a call centre, and in turn led AIA to reject the claim, despite all of the other medical evidence.

77. The matter became the subject of media coverage, and once it did, the insurer revisited the claim and paid the benefit. This case was an example of sloppy claims assessment practices. Unfortunately for consumers "desktop" employability assessments are commonly relied on in rejecting legitimate claims.

CASE STUDY 2

78. Janelle ceased work as an Administration Assistant in December 2010 due to chronic lower back pain and stiffness. She was age 50. She lodged her claim for TPD with AMP in early December 2011 with AMP. Despite her doctors' opinions that she would never return to work, AMP continued to delay the claim, requesting a suite of different documents in a piecemeal fashion. In July 2016, she obtained legal representation as the claim had still not been determined. Her lawyers began proceedings to sue AMP on her behalf. Shortly after the court papers were served, AMP accepted the claim. AMP are continuing to dispute her claim for interest on the lump sum, which she says is payable due to the unreasonable delay.



CASE STUDY 3

79. A 49 year old male former drilling rig worker suffered an L4/5 disc protrusion and consequent adjustment disorder with mixed anxiety and depression. He requested advice from lawyers as to his rights and entitlements and prospects of succeeding in a claim. The super fund, Sunsuper took two months, and three follow up requests, to provide a copy of the client's policy, claim documents and a member's statement to the lawyers.

CASE STUDY 4

80. A 47 year old male was involved in a motor vehicle accident on 27 August, 2007. He was a senior sales manager who regularly travelled overseas. He had a super fund with Colonial First State who had insurance with CommInsure. The claimant was initially off work from 28 August 2007 until November 2007. He then attempted a return to work a few hours per day two to three days per week from November 2007 to June 2008. He attempted a return to full time work in June 2008 but 30 hours of international travel then exacerbated his medical condition. He ceased all work on 5 October 2008.

81. A TPD and salary continuance claim was lodged on 27 February 2009. The first meaningful response to the claim by the insurer was not provided until 9 October 2009. Throughout October 2009 to March 2010 the insurer made no less than eight separate requests for different strands of information instead of making one request for all of the information upon a proper initial review of the claim. This evidences a piece meal dragging out approach to wear the claimant down. The salary continuance claim was approved in December 2009, 10 months after it was lodged. Each month the claimant had to chase up late payment of his salary continuance payments. Various excuses were afforded by the insurer each month for the late payments. What then followed was a series of extensive delays, despite regular follow up by the claimant.

82. The claimant was forced to engage lawyers in March 2010. After three requests for an update and a copy of their claims file the insurer first responded to the claimant's lawyers in April 2010. No tangible action appears to have been taken by the insurer at all on the TPD claim until March 2011 when new lawyers are engaged. All the time the trustee of the super fund stands by and takes no action against their insurer's delay.



83. Between March 2011 and July 2011, the new lawyers made eight requests for a status update but were told on each occasion that the file was being reviewed by a chief medical officer (CMO). In August 2011 the claimant made a formal complaint to the Fund pursuant to s101 of the *Superannuation Industry (Supervision) Act 1993*. Following the complaint for the first time tangible investigations by the insurer commenced and independent medical examinations occurred. The claim was finally paid in February 2012, three years after it was lodged.

CASE STUDY 5

John Savelberg v United Super Pty Ltd T/as Cbus and Hannover Life Re [2011] NSWSC 5/12/2011

84. Mr Savelberg sustained significant injuries during work on 9 May 2007, which included significant crush injuries to both lower limbs, when he was struck by falling steel components. He has never returned to work since the date of injury.
85. Mr Savelberg's TPD claim was lodged on 28 February 2008 (nine months post-injury). It was abundantly clear from the medical evidence at this stage that he was never going to return to work in any capacity. Mr Savelberg had always worked in heavy labouring jobs due to a poor educational background as a result of his dyslexia. He was unable to read or write, so the usual office alternative work arguments were not going to be successful.
86. On 23 September 2009, 19 months after Mr Savelberg's claim was lodged, it was denied on the basis that he did not meet the TPD criteria. Mr Savelberg was unable to walk without the assistance of walking aides and was hypersensitive in both feet such that he couldn't wear enclosed shoes. Further medical evidence and submissions were made for review of the decision and his claim was again denied on 14 December 2009 (22 months after his claim had initially been lodged). Further submissions addressed a Rehab Vocational Assessment, which again highlighted his inability to wear shoes (no work environment would allow him on site in open 'flip flops'). The claim was again denied, on the basis that he would be able to wear shoes again in due course.
87. Finally, following numerous attempts to address the blatantly obvious facts of the case, legal proceedings were commenced on 28 September 2010. Informal negotiations failed and, on 24 June 2011, after just one day in court, the claim was accepted. The benefit, however, was not paid until September 2011, with arguments made for interest and

costs. Interest was awarded – the court found that the decisions of 23 September 2009 were unreasonable and invalid, and interest granted to date liability was admitted. The TPD benefit claimed was \$100,000.

CASE STUDY 6

88. Ms Jones retained legal representation in January 2013, after being diagnosed with ovarian cancer and ceasing work in July 2012. She had lodged her own claim for income protection (IP) with Sunsuper. Both the fund and the insurer rejected her claim on the basis that she did not meet a clause in the policy, given that her condition had been pre-existing. Ms Jones' lawyer reviewed the Fund's Group IP Policy and, on 27 February 2013, lodged a complaint on her behalf, arguing that under s47 of the *Insurance Contracts Act 1984* the condition was not excluded. On 24 April 2013, the fund and insurer reversed their denials and paid the IP claim.
89. During the process of taking on Ms Jones' IP claim, the lawyer conducted further investigations and discovered that she was covered for TPD lump sum insurance. This fact had not been brought to her attention by either the superannuation trustee or their insurer. The lawyer submitted a TPD claim for Ms Jones in June 2013. In August 2013, when the claim had still not been decided, she was deemed by her doctors to be terminally ill (TI). The lawyer refocused her claim as being one for a TI benefit. Sadly, Ms Jones passed away on 28 August 2013, prior to the TI claim being decided. The lawyer continued to work with Ms Jones' family to pursue a death benefit. That claim was approved shortly after her death. However, the amount paid was less than the TPD/TI benefit amount. The lawyer lodged a further complaint referring the fund to the policy clause that entitled the family to the full amount of \$525,000. The lawyer is continuing to fight for Ms Jones' family in a claim for interest on the benefits due to the fund's and insurer's claim assessment delays.



ANNEXURE 1

Recommended standard form insurance definitions of "total and permanent disablement" and "permanent incapacity."

Total and permanent disablement means:

- (a) the loss of sight in both eyes;
- (b) tetraplegia;
- (c) paraplegia;
- (d) severe traumatic brain injury;
- (e) severe respiratory disease;
- (f) severe psychiatric injury; or
- (g) The inability to conduct two or more of the following activities of daily living without the assistance of another person:
 - (i) Feeding;
 - (ii) Bathing;
 - (iii) Dressing;
 - (iv) Walking;
 - (v) Driving.

Permanent incapacity means

Ill-health (whether physical or mental) which the insurer is reasonably satisfied makes it unlikely that the insured will ever engage in gainful employment for which the insured is reasonably suited by education, training or experience.