Parliamentary Joint Committee on Corporations and Financial Services

Inquiry into the life insurance industry

Options for greater involvement by private sector life insurers in worker rehabilitation

Patrick O'Connor | Personal Submission | 04/05/2018

Executive Summary

The PJC has been scathing in its assessment of the industry in the area support for the Mental Ill. Calling out numerous systemic issues worsening the lives of these people. Echoing ASIC's 2016 report.

Despite this, the industry has been slow to respond and in fact has further pushed out an implemented response to until 2019 (FSC Code v2.0 and Mental Health Code). The reasoning is that it is a complex issue that needs to be well formulated (FSC). In fact the FSC is pushing back on many of the recommendations for consumer protection in the PJC report. I believe that the FSC members are not aligned on many aspects of its own code of practice in regards to claims. As can be evidenced by the vastly different life insurance business practices, many insurers are far more advanced in enhancing the industry to provide better claims support.

Industry bodies like the AFA and many AFSL bodies have been virtually silent on the PJC claims recommendations, focusing solely on the education standards for advisers & audit proposals. We have an industry that has a robust system to ensure advisers get paid their commission each month. However we have no system or standards to ensure claimants get claims paid each month. Its time the adviser bodies & AFSL directors stood up for the consumers.

I am deeply concerned at the prospect of widening the engagement of life insurers with the Mentally Ill, via worker rehabilitation changes, before the current myriad of issues are resolved and comprehensive consumer protection is in place. ***"How can an industry that admits to supporting surveillance of the mentally ill, be trusted to provide medical treatment to them ? That's before you even consider enormity of the conflicts of the Life Insurer also being the Doctor".***

I would need to understand the final legislation amendments following the PJC report in the areas of 1) Consumer Protection 2) Code of Practice 3) Access to Medical Information and 4) Claims Handling. Only then could the benefits of the worker rehabilitation payments proposal be assessed, and recommendations made.

It is unthinkable that steps are underway which could make a huge problem even worse. We currently operate in an environment in which the FSC doesn't even have financial penalties for Life Insurers breaching its own Claims Code of Practice nor provide financial compensation to consumers. The FSC doesn't deem an enhanced Mental illness Code a priority. How does a mentally ill claimant and advocate support giving this industry greater powers over consumers ?

In know from years of being subjected to the Medicare and private health care system, that the Worker Rehabilitation proposal the PJC is considering will not only improve lives, it will save lives. I will put my support behind the proposal, if the life insurance industry and adviser bodies, will recognise the enormous work that needs to be done in the area of insurance claims support. I am sure these areas can be advanced concurrently, unfortunately from my recent experience, the deeds do not match their words.

ABOUT PATRICK O'CONNOR

Patrick O'Connor is a former executive in the Life Insurance industry. He suffers from PTSD, MDD and Severe Anxiety, which ended his executive career at TAL. He now spends the majority of his time researching advancements in the treatment of mental health conditions from around the globe. He travels to the USA regularly for treatment at a leading mental health facility in Florida, and plans to film a documentary on this is 2018.

Patrick is a highly experienced, professional and skilled financial services executive. The breadth of his experience stems from senior roles in both small business and large institutional organisations. He has extensive experience both as a Financial Adviser providing full advice to consumers, and also as an Executive for financial services product manufacturers. He has also served as a director of an institutionally owned AFSL dealership. This has provided him with a well-rounded, balanced, and detailed level of industry expertise.

His family has been in the Life Insurance industry for over 120 years. In fact, Patrick went with his father, who was an insurance adviser, to personally deliver a life insurance cheque to a widow when he was 13. He is a proud financial supporter of a number of mental health charities and share's his experiences at awareness events. Patrick was recently featured on the ABC 7.30 report, following a lengthy battle with TAL to pay disability benefits due to his illness. He was successful in all claims, and the purpose of the feature was to raise awareness on the need to reform the entire mental health insurance claims process.

http://www.abc.net.au/7.30/former-insurance-executive-calls-out-industry/9548872

http://www.abc.net.au/news/2018-03-14/former-insurance-exec-probe-treatment-customers-mental-illness/9542496

Hi passion is to see the Disability Insurance sector, evolve into being a financial stable, compassionate and financially significant sector of the Mental Health industry. Patrick consults to a number of industry organisations who benefit from his unique perspective and experiences as an insurance adviser, insurance executive and insurance claimant.

https://www.change.org/p/ban-insurance-surveillance-of-the-mentally-ill-in-australia

1) THE CLAIMS DISTORTION

THE POSITIVE INDUSTRY SPIN

When the question is asked about the service delivery of the Life Insurance industry to consumers, there is a number of well-rehearsed responses from the sector;

- **Over the last 12 months the industry has paid out a total of $9.5 billion in claims – FSC March 2018.**
- **Life Insurers pay the large majority of claims that are received. – FSC**
- **ASIC's report 498 (October 2016) 90% of all claims are paid & 96% of death claims (decided claims). – FSC**

CLAIMS THAT ARE CLASSIFIED AS "WITHDRAWN" ARE NOT INCLUDED IN THE CALCULATION.

THIS SIGNIFICANTLY INCREASES THE PERCENTAGE OF CLAIMS PAID AND GIVES AN UNJUSTIFIED POSITIVE RESULT.

THE RESULTS ARE BEING MISREPRESENTED – ASIC REPORT 498

Table 20: Claims outcome rates, by distribution channel (2013–15)

Channel	Declined	Accepted in full	Accepted in part	Withdrawn	Undetermined/ unspecified
Non-advised	12%	74%	1%	11%	3%
Retail	7%	76%	3%	12%	3%
Group	8%	77%	1%	9%	4%

The Industry focuses on the decline rates for claims submitted. As stated before, the headline number looks good.

When presented as a stand-alone statistic, as often quoted by the FSC and other industry bodies, that can lead the reader to assume that all other claims are paid in full i.e. Accepted. ***In reality the amount of claims that are paid in full varies between 74%-76%, a far less impressive statistic.***

That is because the results have an additional 3 categories, rarely referenced from this ASIC report. These claims not paid, fall into the 3 categories 1) accepted in part 2) withdrawn and 3) undetermined/unspecified. The largest part of these 3 is the withdrawn category. While ASIC obtained information from insurers about the number of withdrawn claims, incredibly, the reasons for withdrawals were not apparent from insurers' data or the dispute data.

Further, there is not necessarily a consistent interpretation between insurers about the definition of a 'withdrawn' claim, and when a claim is considered to be 'withdrawn'. ***Hence there exists a real concern that this is simply a "Decline" by another name***. A number of consumer reports highlight that many consumers simply give up on claims due to the excessive and ongoing amounts of information required.

Let's be honest, from a consumers perspective there is only 2 outcomes that they consider as the options at the time of claim, **Will the claim be paid or not paid ?** So reframing the results, the situation looks far less impressive;

CHANNEL	CLAIMS PAID	CLAIMS NOT PAID
Non-Advised	74%	26%
Retail	76%	24%
Group	77%	23%

(ASIC report 498 data)

24% OF RETAIL INSURANCE CLAIMS LODGED

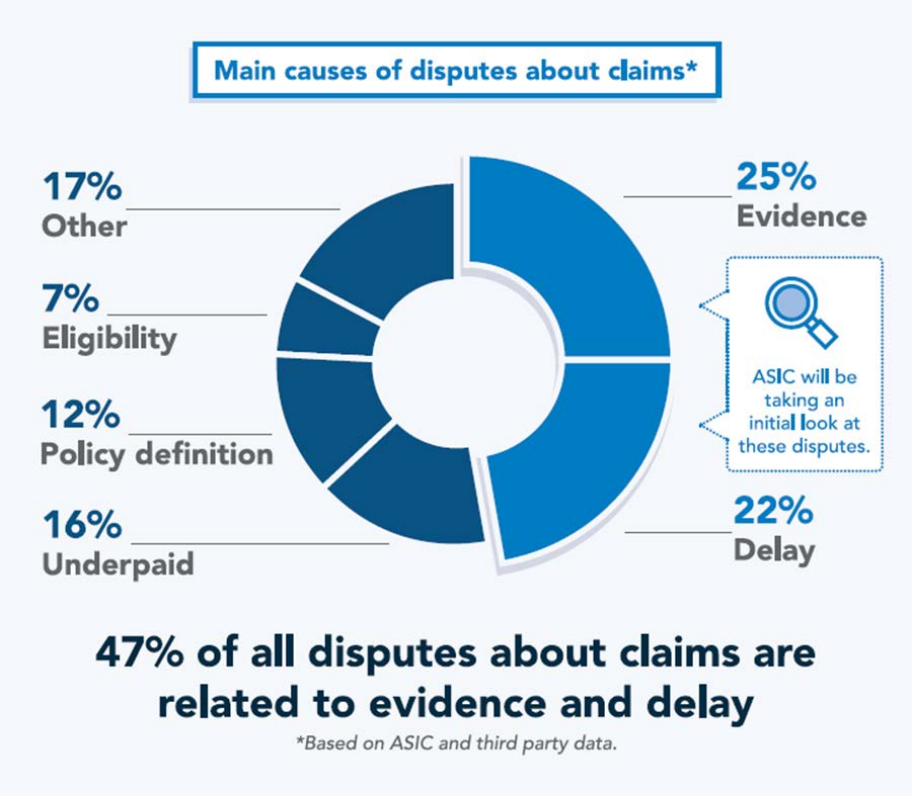
DO NOT GET PAID

Now that we know the data is being distorted, the bigger issue that needs to be investigated is ***WHY is the level of "Claims Not Paid" so high ?***

A guide can be found in the section of the ASIC report that covers complaints. Complaints around "evidence" and "delay" total 47% of all complaints. That suggests that the claim decision has not yet been reached due to these reasons. It is also fair to assume that an individual that is experiencing these issues, has a high chance of not proceeding with a claim. This is a clear flag that the claims process is not delivering the decision in a timely manner or even a decision at all.

Wide spread evidence from multiple sources confirms that claimants are simply giving up on the claim process. Whilst they may not have recovered medically, they see returning to work as the only option to survive financially.

Further, in the area of mental health claims, strong evidence supports the view that the complexities of the claims process, is having a negative impact on the claimants mental illness. It is entirely possible that a person could be incapacitated to an extent that they are unable to handle the claims process alone. Insurers have no requirement to follow these claimants up with support to make sure they are mentally and physically safe. They have a duty of care that is not being exercised.



Claims data: Limitations (ASIC report 498)

- A key observation from ASIC's review is that there is clear need for better quality, more consistent and more transparent data about insurance claims. As far as we are aware, this is the first time that this type of data has been collected. Many insurers found it challenging to provide the data requested by us in the review. Life insurers will have to continue to invest in their systems to be able to provide robust and granular data. This data will then be more useful in identifying trends and issues within a product, an insurer or the industry as a whole. Quality data will provide

management with important insights into portfolio experience, and the ability to enhance claims handling procedures.

We will work with APRA, the insurance industry and stakeholders to establish a consistent public reporting regime for claims data and claims outcomes, including claims handling timeframes and dispute levels across all policy types. It is expected that data will be made available on an industry and individual insurer basis. This will help ASIC and APRA to monitor claims trends and identify any potential issues of concern from changes in data.

The outcome is that there does not exist a reliable, consistent reporting standard across the industry for Life Insurance claims. Hence any reliance on the data reported, must be measured with this fact.

2) THE LIFE INSURANCE INDUSTRY - CLAIMS FRAMEWORK

Before we examine the expansion of the scope of the claims industry, to consider worker rehabilitation, let's review the claims existing framework.

ASIC - REGULATION OF CLAIMS HANDLING.

The PJC report has recommended that ASIC be given powers in relation to 'claims handling', as this is currently excluded from the definition of 'financial service'. This exclusion in the Corporations Regulations means that ASIC has limited powers to take action where they have concerns about conduct in relation to claims handling.

The excluded obligations include requirements on the insurer:

(a) to do all things necessary to ensure that it provides financial services efficiently, honestly and fairly;

(b) to have in place adequate arrangements for the management of conflicts of interest that may arise in the provision of financial services; and

(c) to take reasonable steps to ensure that its representatives comply with the financial services laws.

ASIC - REGULATION OF INSURANCE ADVICE.

"ASIC's recent general surveillance and enforcement work reflects similar rates of non-compliant life insurance advice to that set out in REP 413, that is, we have not seen changes in this trend,"…"The problems were more acute in the independently owned financial advice licensees. In this segment of the market, over half the advice failed to comply with the law," ASIC. ***In April 2018, at the Royal Commission hearings, ASIC has confirmed that the level of audits undertaken needs to be dramatically increased and more resources are needed.***

LEGISLATION

There exists no mandatory regulatory requirement for an insurance adviser to provide any service/support/advice to a client at claim time.

Take a moment to reflect on that fact.

Despite all the regulatory focus on conflicts, vertical integration, disclosure, remuneration, audits, compliance, reviews and education, there is no legal requirement to ensure that advised insurance clients receive adviser support at the most important part of the process, the claim. Direct and Non-Advised Sales are not models that offer personalised advice, however it is difficult to imagine that advised insurance clients do not expect the same level of support at claim time as at initial advice time.

How has the industry been allowed to evolve to a situation that all the focus is on the "Implementation" of Insurance Advice, however there is virtually no focus on the "Execution" of the advice (claim time). Can any definition of consumers "Best Interests" really fail to include the legal requirement for insurance advisers to provide support to clients when they are at their most vulnerable ? ***At the very least, advisers should provide an "opt in" facility to clients when the original SOA is provided.***

FEE FOR NO SERVICE

As with Financial Planning, it's the role of ASIC to ensure that clients receive the advice & support they pay for. Whilst it is not a mandatory requirement to assist their clients at the time of claim, it is a regulatory requirement on advisers, if this support is part of the ongoing service agreement that the client is paying for.

If the adviser has included in the FSG, SOA, or Ongoing Service Agreement, that support at claim time is part of the services they will provide, then it is required by law to be provided.

In my professional career, I have had contacted with over 2000 different insurance advice professionals. With a high degree of certainty, I can state that at least 30% of these individuals actively (and proudly) include claims support as a core part of their service offering. That is to say that they operate as if it was a mandatory requirement under Financial Services Legislation.

However I am not aware of ASIC or a large Tier 1 AFSL;

- asking their authorised representatives if claims support is included in FSG, SOA, or Ongoing Service Agreement.
- ever auditing their authorised representatives on the provision of claims support.
- taking action against an adviser who didn't provide support to their clients at claim time.
- taking action against an adviser who could not produce file notes providing evidence that claims support has been provided.

I am unable to reference in any legislation any definition or explanation of the service an insurance adviser should provide at claim time.

ASSOCIATION OF FINANCIAL ADVISERS (AFA)

Est. 1946, the AFA is Australia's oldest association representing financial advisers ***and the value of advice***.

AFA Code of Conduct – Principles of Practice

The 6 Principles of Professionalism set out the minimum professional practice and ethical standards for members of the AFA when providing financial services. The central objectives of the Code are the achievement of good consumer outcomes and fostering and enhancing the professional reputation of financial advisers.

Consider this:

- **The AFA Code of Conduct doesn't mention the word "claim" once.**
- **The AFA has no "best practice" standards in adviser practice claims management.**

AFA Awards Recognising Excellence

We believe that recognising excellence is integral to building a strong profession. Each year the AFA, together with our partners, announce five prestigious awards for quality advice and an award for Life Company of the Year.

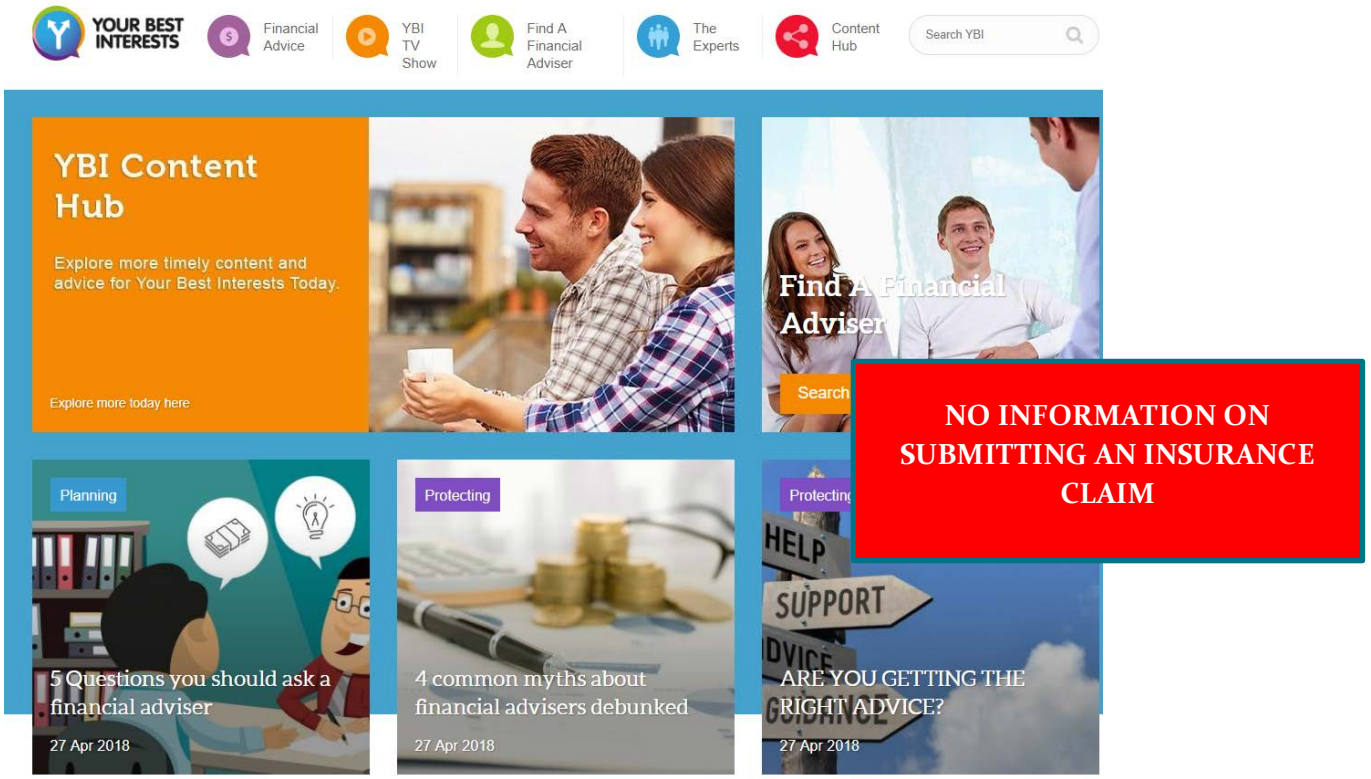
The adviser awards presented each year;

- AFA Adviser of the Year
- AFA Practice of the Year
- AFA Rising Star
- AFA Female Excellence in Advice
- AFA Life Company of the Year Award
- AFA Excellence in Education

So why is there is NO award that recognises "Excellence in Claims Support" ????

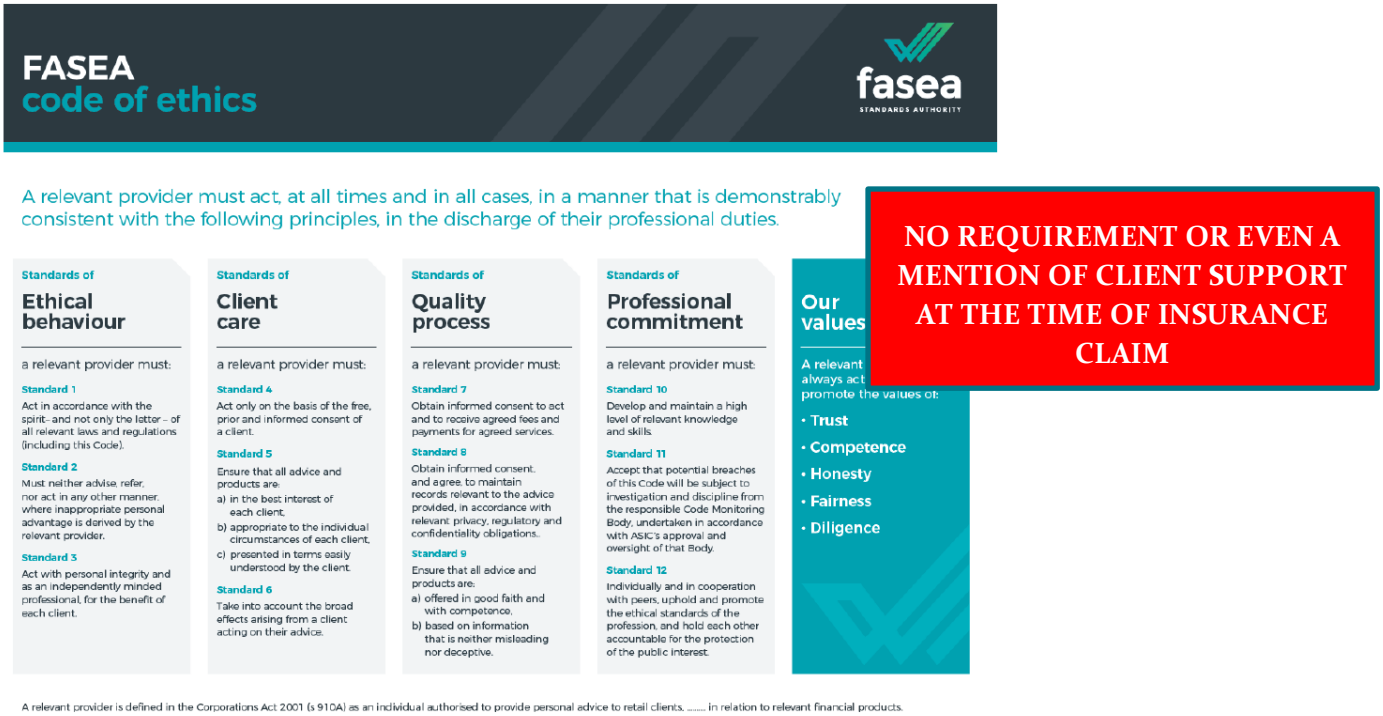
If the industry is guided by the principle of operating the clients best interests, and insurance is the foundation of the advice given, then why is there not an award for "Excellence in Claims Support". If the AFA feels handing out an award for Education is worthwhile, then surely Claims should be there too. If not for those reasons, then surely it is a great statement to consumers as to why build a relationship with an AFA adviser.

The consumer educational website https://www.yourbestinterests.com.au provides no information on how best to proceed with an insurance claims.



Financial Adviser Standards and Ethics Authority - Code of Ethics for Financial Advisers

Exposure Draft of Proposed Standard



LIFE INSURERS

It has been around 15 years since the first online insurance application system was introduced into Australia. The industry has invested tens of millions of dollars since then, to rapidly advance the onboarding technology. Now every Life Insurer has a platform to seamlessly accept applications online, signature free, with speed and the customer experience front of mind. It is the battle ground for differentiation to win & retain adviser support, especially in a "me too" product development world.

In comparison, the investment in the technology to assist in claims processing has been substantially less, non-existent for many of the large industry players. Very few insurers have anything that resembles a robust online claim submission & processing system. In fact, ***scanned paper documents are still the industry norm for submitting claim forms***. Tele Claims services are available with some, but this cannot be described as a technological advancement.

- Why has the industry been so single focused in the application of technology ?
- In a digital age, with the technology available, why are consumers completing generic claim forms ?
- Why has APRA not questioned such a large investment misalignment, especially with the increasing level of claims year on year ?

At best it could be described as short sighted capital investments. However the issue goes much deeper than that. Could it be that the Life Insurance Executives see no potential benefit from a quicker process of paying out claims ? Why has the Insurance Adviser community, not demanded better interfaces with them & the claimants ? It is reasonable to imagine that the first mover advantage for a Life Insurer, that delivers a technology solution (similar to the underwriting technology), would be substantial. Wouldn't all Life Insurers want to strive to be the leading provider of claims technology & process ?

INSURANCE ADVISERS

Australian Securities and Investments Commission offers these seven steps as a "safe harbor for complying with the best interests duty":

1. identify the client's financial objectives
2. identify the subject matter of the advice sought
3. understand the client's financial circumstances
4. assess whether you have expertise to provide the advice sought – if not, decline to give advice
5. research products that might achieve the client's objectives
6. base all judgments on the client's relevant circumstances
7. take any other step in the client's best interests.

Question's; ***Advisers have to give advice that is in their clients best interests, is an adviser who does not provide support at claim time meeting this requirement ? If an adviser does not provide this service at claim time, do they explicitly disclose this to their clients at the time of advice ?***

RG146 QUALIFICATIONS FOR LIFE INSURANCE ADVICE

A2.6 Insurance

RG 146.146 Given the nature of the insurance sector, the following specialist knowledge category for advisers on insurance products has been divided into core insurance knowledge and type of insurance product. This has been done to recognise industry feedback that there is a body of core insurance specific knowledge (separate to generic knowledge) that should also be understood by those operating within this sector.

A2.6a Core insurance knowledge, all categories (i.e. general, life and broking)

RG 146.147 An adviser providing advice on insurance products should be able to apply the following knowledge (where applicable).

Table A2.6a: Insurance (core knowledge)

Life insurance	• types/classes of life insurance products/policies • standard cover (and deviations) • product development • policy wordings • underwriting • insurance claims • premium rating/risk assessment • investment strategy (investment component of life insurance products)

Insurance Claims is a core knowledge requirement under RG146.

However DFP 1 & 2 education modules contain NO Insurance Claims training ?

DFP 1 - Financial Advice
Australian Industry Essentials and Fundamentals of Financial Advice must be the first subject completed before any of the specialist knowledge subject(s).

Australian Industry Essentials

Part 1	Australian Economy
Part 2	Australian Financial Markets
Part 3	Investment Funds
Part 4	Corporations Act
Part 5	Regulatory Environment
Part 6	Licensees & Representatives
Part 7	Ethics

Financial Advice Fundamentals (to be completed for personal advice)

Part 1	Personal Taxation
Part 2	Social Security
Part 3	Wealth Creation Fundamentals
Part 4	Estate Planning Fundamentals
Part 5	Establishing Client Relationship
Part 6	Identify Client Objectives & Financial Situation
Part 7	Analyse Client Objectives & Financial Situation
Part 8	Develop Strategies & Solutions
Part 9	Present Strategies & Solutions
Part 10	Implement Agreed Plan
Part 11	Provide On-going Advice

DFP 2- Insurance
This specialist knowledge area will equip you with the expertise and technical skills to provide compliant life insurance advice to clients on:

Core Area

Part 1	Understanding Insurance
Part 2	Operation of Insurance Markets
Part 3	General Insurance
Part 4	Personal Insurance
Part 5	Advisory Functions
Part 6	Legal Obligations and Compliance

Specialist Area

Part 1	Life Insurance Market
Part 2	Term Life Insurance
Part 3	Total and Permanent Disability (TPD)
Part 4	Trauma Insurance
Part 5	Income Protection Insurance
Part 6	Business Insurance
Part 7	Life Insurance, Taxation and Superannuation
Part 8	Role of the Adviser

INSURANCE ADVISER CRM – DATA FEEDS

Life Insurer's provides data feeds to CRM & commission platforms like Xplan, Coin, Adviserlogic, etc. This enables the advisers to run reports around the current benefits insured, premiums, lapses and the amount of commission the adviser receives. This an example of the policy information TAL provides to IRESS.

iress TAL Frequency: Daily

Client data

Client data					
Client ID	✓	First Name	✓	Surname	✓
Date of Birth	✓	Address	✓	Contact details	✓

Insurance data

Policy data									
Owner	✓	Policy Number	✓	Plan Name	✓	Status	✓	Inception Date	✓
Beneficiaries	✓	Premium Frequency	✓	Policy Fee	✓	Total Premium	✓	Premium Payer	✓

Cover details – Life policies									
Life Insured	✓	Type	✓	Issue Date	✓	Sum Insured	✓	Benefit Status	✓

Cover details –TPD policies									
Life Insured	✓	Type	✓	Issue Date	✓	Sum Insured	✓	Benefit Status	✓

Cover details – Trauma policies									
Life Insured	✓	Type	✓	Issue Date	✓	Sum Insured	✓	Benefit Status	✓

Cover details – Income policies									
Life Insured	✓	Cover Escalation	×	Definition	✓	Issue Date	✓	Benefit Status	✓
Benefit Amount	✓	Benefit Frequency	✓	Accident / Benefit Period	✓	Sickness Period	✓	Accident Short Waiting Period	✓

Cover details – Business expense insurance									
Life Insured	✓	Type	✓	Benefit Amount	✓	Benefit Frequency	✓	Waiting Period	✓

Cover details – Additional rider insurance									
Life Insured	✓	Type	✓	Benefit Amount	✓	Benefit Frequency	✓	Waiting Period	✓

Data feeds of claims information is not provided. ***Thus creating a situation in which an adviser can see with meticulous accuracy, the remuneration they are receiving from a client, but nothing about the claims benefit a client is receiving.***

This would then suggest that the adviser has to source this information directly from each insurer. I believe around half of the major insurers enable advisers to access information on claims, via that insurers adviser website. A lot do not. Some provide this information in email communication or as individual claims are updated. In relation to ongoing communication from Life Insurers, the experience once again

varies from company to company. It is obvious that the process across the industry hardly provides the adviser network with the frequency and depth of information that is required to enable them to provide claims support in the most effective and efficient manner. ***It is even clearer that the workflow systems that Life Insurers provide for new business applications is demonstrably superior in every aspect to the claims alternatives.***

Which begs the question, if advisers are delivering support to their clients at claim time, how do they do it with these inadequate platforms ? Why is it not an industry wide complaint ? Why are AFSL directors not demanding this is rectified ?

It seems more than a tad hypocritical for Life Insurers to champion the working partnership they have with advisers at claim time, when the process of engagement looks like this.

If an adviser was audited, does their CRM facilitate reporting capability of the claims that they have supported over a period of time ? Preliminary discussions with CRM platforms suggests that there does not exist an "out of the box" capability in this area.

INSURANCE ADVISER ROLE AT CLAIM TIME

This survey was taken online by an adviser industry media publication – riskinfo. Obviously a large amount of confusion exists in the adviser industry.

riskinfo

Claim Time – Advisers Seek Greater Clarity

May 23, 2017

Do the respective roles of adviser and insurer need to be better defined at claim time?

CLAIMS SUPPORT

To assist a client with a claim, does the adviser staff member need to be qualified to give personal advice, general advice or is there no requirement ?

- What base level of claims training do AFSL's provide ? What ongoing claims skilling is provided ?
- Are these areas audited for compliance ?
- Is there a best practices training provider to deliver these skills to the industry ?
- ***More basically, do advisers have a automated claims management system to track claims as part of their CRM work flow, just as they have for new business applications ?***
- If they don't, how can they guarantee they are structured to provide ongoing support at claim time ?
- What service agreement/standards/commitments around claims support are they giving to their clients ?

3) FSC – CODE OF PRACTICE

The Financial Services Council (FSC) has over 115 members representing Australia's retail and wholesale funds management businesses, superannuation funds, life insurers, financial advisory networks, licensed trustee companies and public trustees. The Financial Services Council promotes best practice for the financial services industry by setting mandatory Standards for its members and providing Guidance Notes to assist in operational efficiency.

The FSC is the major advocate for life insurers to have great involvement in worker rehabilitation. This change, will impact the mental health claim area the most. The FSC has been criticised for failing to implement the substantial improvements required by life insurers in the area of mental health. Are they now looking for the silver bullet to improve profitability ? or have they genuinely displayed a deep drive to improve the claims process for the mentally ill, and this is the final step ?

FSC TIMELINE ON MENTAL HEALTH REGULATION since 2003

FINANCIAL SERVICES COUNCIL FOR MENTAL HEALTH CONDITIONS September 2003 FSC Guidance Note No. 14

"CLAIMS GUIDELINES"

https://www.fsc.org.au/resources/guidance-notes/14gn_claims-guidelines_0309-updated.pdf

No update has occurred since this date.

Press release – 6 March 2016 Sally Loane (FSC)

"The FSC also recognises the rising number of claims for mental health related conditions. In July 2014 we introduced a new Mental Health Training Standard which requires our members to provide training for all front-line staff to ensure they have a suitable understanding about mental health conditions to support them with their work in underwriting and claims processes. This is a very complex area that will require considerable work to arrive at an outcome that creates positive change for those with a mental illness while ensuring the overall sustainability of the life insurance industry."

Press release – 16 March 2016 Sally Loane (FSC)

"We are developing this (Life Insurance Code of Practice) to show how serious we are about improving our industry for the benefit of customers and consumers. We want to re-build trust. We want Australians to understand that life insurance can and does measurably improve lives."

"We are looking at the sort of additional support that vulnerable consumers may need if they are having difficulty with the process of buying insurance **or making a claim**. This could include identifying and supporting people suffering from **mental illness…**" "Through self-regulation, the Code gives the industry the ability **to update standards quickly** to deal with changing conditions,"

Press release 8 April 2016 Sally Loane (FSC)

"A Royal Commission would be unnecessary and an ill-considered use of time and resources at a time when business, particularly the financial services sector, is looking for greater growth as Australia transitions from a resources economy to a services driven economy."

Press release 11 October, 2016

The Financial Services Council (FSC) is pleased to launch the life insurance industry's first-ever industry-led consumer Code of Practice.

"The Code is built on some fundamental principles - honesty, transparency, fairness and timeliness."

The Code goes beyond the existing law in many areas, and fills in detail where the law is silent in relation to customer service, such as detailed plain-English disclosure, a requirement to review and update medical definitions, detail around how sales must be conducted and monitored, remedies for mis-selling, a clear process for claims handling, and standards for claims investigations, including interviews and surveillance.

Mental-health specific standards - The next iteration of the code will seek to increase obligations on insurers when interacting with consumers suffering mental health issues. The FSC will work with groups like Beyond Blue, Lifeline, Mental Health Australia and the Public Interest Advocacy Centre to determine how to better serve those consumers with mental health issues.

23 November 2016 Parliamentary Joint Committee on Corporations and Financial Services - Inquiry into the Life Insurance Industry

The claims process is fundamental to the customer experience and often experienced when people are at their most vulnerable. The Code demonstrates insurers' commitment to treat claimants with compassion and respect and make decisions on claims in a timely fashion.

Press release 31 March 2017

"Far from ignoring calls to address community concerns about the treatment of mental illness by life insurance companies, our members are united in prioritising this issue and the FSC is engaged with leading mental health and consumer advocacy groups". Sally Loane, CEO, Financial Services Council

26 May 2017 - FSC Supplementary Submission to the Parliamentary Joint Committee on Corporations and Financial Services - Inquiry into the Life Insurance Industry

"The FSC is also continuing to improve our code of practice by working on the next iteration, ***which will contain further measures relating to customers facing mental health conditions***. We are bringing together mental health stakeholders with the life insurance industry to better understand the issues affecting people with mental health conditions and to improve our wealth protection offerings, and better explore and take the opportunities arising to improve the mental conditions of Australians."

Furthermore, insurers will discontinue surveillance where there is evidence that it negatively impacts the recovery of the claimant.

Press release 30 June 2017

"As part of the second iteration of the Life Insurance Code of Practice we are committed to considering ASIC registration."

Press release 4 Sept 2017 Sally Loane (FSC)

"...life insurers wish to make targeted rehabilitation payments for medical treatment or therapy that they determine to be relevant, appropriate and necessary to return the claimant to work."

"Providing flexibility around circumstances in which life insurers may pay medical and other such treatment costs in disability insurance claims would enable life insurers to better facilitate early claims intervention. This would allow payment of medical treatment in circumstances where treatment supports and aids the early return to work."

Dec 4 2017 Sally Loane (FSC)

The FSC last year released its first code of conduct for the life sector, with Ms Loane saying "version 2.0" will ***require insurers to ask more specific questions in regards to mental health, but said there would be no specific chapter on mental health. "I think we can actually have a code that makes sure that issues of mental health are through every part of that code for consumers to consider,"*** she said.

March 2018 FSC Conference

FSC Chief Executive, Sally Loane said version two of the code would come into force next year and the FSC was meeting with ASIC with the intention of having the Code approved by the regulator.

"Although the first version of the Code has only been in place for nine months, work is well underway on the second version of the FSC Life Code of Practice," Loane said, addressing attendees at the recent FSC Life Insurance Conference.

"We're looking to get Code 2.0 out for public consultation later this year with it coming into force by 1 July 2019. One key question is about getting ASIC approval of the Code. We're meeting with ASIC regularly to discuss this," Loane added.

A panel session at the conference heard the second version of the Code would include more details around how insurers should handle mental health issues, and improvements to rules around claims handling.

3 April *Sally Loane (FSC)*

The FSC has already responded with a statement that the ***updated Code of Practice plus Mental Health Code, is due late in 2018 will implementation in 2019.***

> FSC CEO Sally Loane said: "Self-regulation can be implemented much faster than costly and time-consuming legislation. The Code has the capacity to evolve and change with consumer needs, and will deliver consumer benefits in a much more efficient and timely way than waiting for complex legislation.

Summary

The FSC failed to include any meaningful support for mental illness claimants in version 1 of the code of practice. Version 2.0 of the Code of Practice and the Mental Health Code has continued to be pushed further and further out into the horizon. This is a clear failure of the FSC & the industry to address the urgent and critical improvements that are required in the area of mental health claims standards.

4) HOW THE FSC CODE IS FAILING MENTAL HEALTH

INFORMATION REQUIRED

The 2 biggest complaints according to from claimants according to ASIC encompass 1) the amount of information requested and 2) the time taken to make a decision. This is directly as a result of the Reinsurance process.

ASIC: "The proportion of disputes about evidence required for mental health claims was substantially higher than the proportion of disputes about evidence for all claims (51% of all disputes about mental health claims compared to 25% of all claims-related disputes). The timeframes for decisions to be made could be better. According to ASIC this was the 2nd biggest area of dispute (22%)".

FSC CODE: "We will only ask for and rely on information and assessments that are relevant to your claim and policy, and we will explain why we are requesting these."

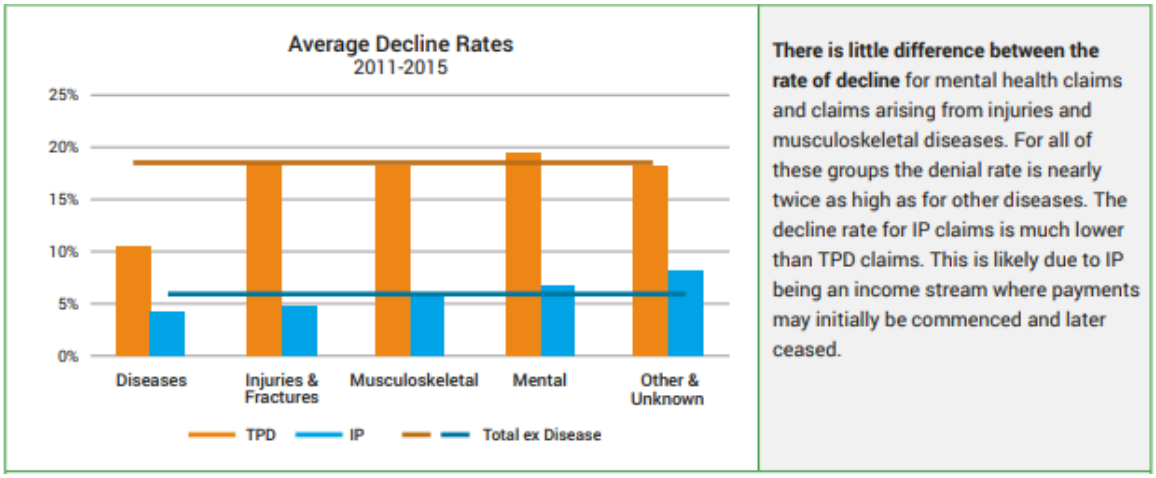
This is about as weak and as broad as anything I have ever seen. The amount of information Life Companies can collect at claim time is not limited by the code. So the status quo remains. They can still get PBS, Medicare, Health Insurance, Doctors & IME.

In my claim I provided:

- PBS
- Medicare records – From 1984

- Health Insurance Records
- 5 different GPs
- Psychologist
- 2 Psychiatrists
- 2 TAL's Doctors
- My doctors had to pass on complete medical histories instead of specific reports related to an area of claim.

ASIC' "it is clear that policyholders with a mental health condition face a challenging burden to establish that their condition entitles them to make a valid claim."



Actuaries Institute "Mental Health and Insurance" Green Paper OCTOBER 2017

The above table casts doubt on why such an excessive amount of information is required by life insurers in the area of mental health claims vs other claim conditions. Despite the amount of information obtained, the rate of decline is the same. Suggesting that the same decision can be obtained with less information.

TIMEFRAMES FOR DECISIONS

"All efforts will be made to meet the timelines required by the Code. However, timeframes for making claims decisions can be affected by factors outside our control (Unexpected Circumstances). Examples of this include the time taken by a superannuation trustee to review our decision or fulfil its legal obligations, or the time taken by you or your treating doctor to provide information. Where we cannot comply with a deadline required by the Code due to a delay that is out of our control, we will not have breached the Code." FSC Code of Practice

The code has specific timeframes for decisions to be made. However the loopholes around these timeframes need to be removed. Especially the exclusion of Reinsurers. For example, any period of time a claim file is with a Reinsurer, counts as "unexpected circumstances" despite the fact it is a contractual commitment for them to send the file to the Reinsurer. ***Why does this time period be allowed to NOT count towards the timeframe for decision.***

Also, they ***completely overlooked setting any timeframe for ongoing Disability Insurance (Income Protection) Claims***. That means that they have deadlines/rules around the initial decision process. However after that there is no "ongoing claim rules", hence insurers can operate with no standards at all for the duration of an Income Protection claim, which could be 40 years. "For income-related claims, we

will let you know our initial decision no later than two months after we are notified of your claim or two months after the end of your waiting period (whichever is later), unless Unexpected Circumstances apply (reinsurers count as unexpected circumstances).

In reality this means:

- if a claimant has a 1 month waiting period – timeframe for a decision becomes 3 months – which is very soft.
- If they have a 3 month waiting period - timeframe for a decision becomes 5 months – complete rubbish.
- If they have a 2 year waiting period – timeframe becomes 2 years and months.....

ONGOING INFORMATION REQUIRED

FSC Code: "we will not require you to get ongoing statements from your doctor more frequently than reasonably necessary to assess your condition, so that we can determine your ongoing entitlement to benefits. For monitoring purposes, we may seek information from your doctor every six months, even if your condition is stable"

12 months ago, TAL classified me as unable to ever return to my own occupation EVER AGAIN. However, every month for the last 3 years, my doctor and I have to complete the same questionnaire;

1. What is the diagnosis ?
2. What are the symptoms ?
3. Why do these stop me from working ?
4. When will I be fit to go back to work ?
5. What is the treatment ?

"There is evidence to suggest that some people will develop or exacerbate mental health problems as a result of the stresses associated with the claiming process itself. For example Judges in court verdicts frequently comment that the person will be much better once the court case is over. Exposure to perceived discrimination or exclusionary practices can have a negative impact on recovery. Uncertainty, lack of control, and perceptions of being devalued and misunderstood can all trigger feelings of anxiety and depression which may develop into diagnosable conditions in some people.

In addition, financial insecurity and relationship difficulties (often triggered by financial stress) can exacerbate symptoms of anxiety and depression. While many claims staff have received training on these issues and strive to minimise secondary harm, the delays often experienced before the outcome of a claim is known can significantly exacerbate the financial strain and associated anxiety experienced by someone unable to work because of their mental health condition.

Claimants often speak of having to repeat their story many times, sometimes to an insurer-appointed expert whom they regard as against them. There is concern that frequent repetition of the story can re-traumatise and make it more difficult to develop a positive frame of mind.76 NSW Government, 2017, Legislative Council Standing Committee on Law and Justice: First Review of the workers compensation scheme, Parliament of New South Wales, viewed 18 April,https://www.parliament.nsw.gov.au/committees/DBAssets/InquiryReport/ReportAcrobat/6105/ Report%20-%20First%20review%20of%20the%20

Some argue that neuroplasticity may also play a part, and suggest that constant repetition of the story may change the brain such that the individual becomes more unwell regardless of their motivation or honesty.77 Aurbach, R 2015, Better Recovery through Neuroscience: Addressing Legislative and Regulatory Design, Injury Management and Resilience, Presented at Actuaries Institute Injury Schemes Seminar, Adelaide, 8-10 November 2015"

TIMEFRAMES FOR PAYMENT

FSC code of practice covers timeframes for decisions. However no timeframes exist for ***the actual payment of the financial benefits***. Complaints around the handling of income protection claims, include examples were claimants have been paid 3-4 months late for monthly benefits. I can provide evidence that systemic processes have been implemented in many insurers to deliberately delay payments in this "unregulated" area of claims.

CUSTOMER DISCLOSURE

FSC Code: "We will make our customers aware of the Code, which will include providing information about the Code on our websites and in our relevant marketing documents." A well repeated statement is that the Code Of Practice will improve the communities confidence in the Life Insurance Industry.

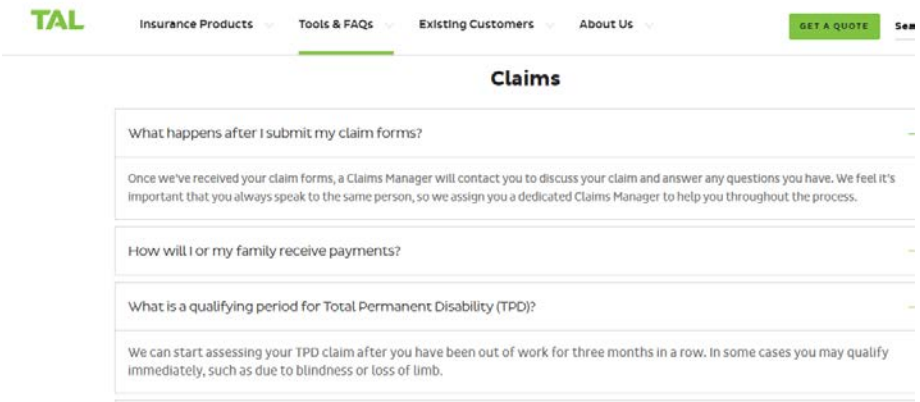
https://www.fsc.org.au/policy/life-insurance/life-insurance-101/the-claims-process/

This is a customer worded explanation of the claims process. It fails to mention the full extent of the information they do request. It also fails to mention the "exceptional circumstances" exemption. Basically it's a very simplified explanation of a code that is supposed to improve consumer confidence.

From my investigation, not a single insurer mentions the timeframes for claims decisions in the PDS, marketing material or website. In fact most companies make a vague acknowledgement of the FSC code at best. If the code is supposed to improved community understanding, then why hide it ? Not disclosing their own code to consumers is a breach of their own code.

TAL Claims FAQ (no mention of the FSC timeframes)

https://www.tal.com.au/tools-and-faqs/insurance-faqs#ec-eg-0B5FFABC84CA4001AA296C4D72A8DF59



INSURANCE SURVEILLANCE - MEDIA

NOVEMBER 20 2016 - 9:00PM

PTSD sufferer speaks out about damage of intrusive surveillance | poll

Lisa Allan Local News

[redacted] has made a conscious decision to ignore in a bid to smash the stigma associated with PTSD. “A lot of people aren’t getting better because they’re hiding away, because they’re afraid about what will be used against them,” she said. “PTSD is a mental health condition. I am medicated to treat and help control my symptoms. Some days are good, even great. Other days are not. I can face certain ‘triggers’ and my symptoms relapse.” “If I am ‘caught’ smiling, laughing, enjoying lunch with my husband, watching (daughters) [redacted] ride in a comp, watching [redacted] perform in a play or I am at the beach playing with [redacted] – how could I have PTSD? Trying to live ‘normally’ can be easily used against me.”

“You become paranoid then. You become paranoid about every single little thing. “Then you think ‘I might just stay inside’ and then a vicious cycle begins. “You get confidence to go out and then you’re faced with this. You may as well stay inside and become a zombie. “There’s no chance of recovery if they are constantly being obstructive in your treatment.”

Attempting to live a “normal” life is a key part of PTSD recovery, according to Belmont psychiatrist [redacted]. “Getting back to as near a normal life as possible is very important,” [redacted] said. “I ask all my patients with PTSD to try to maintain all their pre-illness activities such as exercise, hobbies, and spending time with friends and family.

“One of the problems is that when people become unwell they tend to give up a lot of the things that helped in keeping them well and this serves only to make them more unwell and slow their recovery.” He has joined legal professionals in questioning the usefulness of surveillance and criticising its impact on sufferers. “Some insurers appear to think that (every day) activities are inconsistent with someone suffering with PTSD,” [redacted] said. “I actively encourage my patients to do these activities because it's in their best interests.”

ABC NEWS

Insurers accused of making PTSD worse by placing former cops under surveillance

Four Corners By Tom Allard, Quentin McDermott and Jaya Balendra

Updated 1 Aug 2016, 11:24am

"I was drinking heavily, I was heavily medicated. I was hyper-vigilant, very aware that I was being watched, yet couldn't understand why this surveillance was continuing." In November 2013, [redacted] attempted suicide, his depression exacerbated by the surveillance and news that MetLife would no longer handle his claim and another insurer, TAL, would take over. He was found comatose by his wife and daughters.

Disability insurance claims often more stressful than original injury

The Sydney Morning Herald

"These people brought me to the brink," says 37-year-old single mother, [redacted] had already suffered considerably, having been forced as a young woman to flee a violent family, move interstate and change her name. She was insured with TAL (formerly known as Tower Australia) as part of her super. But rather than help her, she said TAL made her life "unbearable" by stringing out her IP and TPD claims for 15 months.

Despite being diagnosed with PTSD and a major depressive disorder by both her and TAL's doctors, Ames was subject to covert surveillance, more than a year of activity diaries and forensic examination of her medical and financial records. TAL recommended she undergo alternative treatments, and bombarded her with daily phone calls, even after her doctor warned the insurer that such contact was "aggravating [her] condition". TAL eventually paid the claim.

Actuaries Institute **Mental Health and Insurance** GREEN PAPER OCTOBER 2017

"In circumstances of mental health conditions, the level of unease about surveillance is exacerbated because of how it could further harm the person's mental condition, and the effectiveness is also often lower because symptoms cannot be physically observed and because people have good and bad days" -

FSC CODE OF PRACTICE – INSURANCE SURVEILLANCE

"...surveillance will not be conducted in any court or other judicial facility, in any medical or health facility, in any bathroom, change room, lactation room or inside your house..we will discontinue surveillance where there is evidence from an independent medical examiner that it is negatively impacting your recovery".

SURVEILLANCE OF THE MENTALLY ILL MUST BE BANNED

- There is overwhelming medical support, ***that the knowledge that surveillance is an available tool to insurance companies, has a negative impact on the recovery of mentally ill claimants***. In fact it has been proven to provide a large barrier to the steps that can assist with improving the claimants quality of life.

- ***The FSC has been unable to demonstrate the need for surveillance on any financial level***. They are unable to demonstrate that systemic fraud exists, that offsets the proven negative impact on genuine mental health claimants.

- The FSC is unable to provide the basis for which the independent medical examiner can make any medical diagnosis OR deterioration of health based on a surveillance video, especially in regards to a mental illness and not a physical one.

- The mentally ill are the most vulnerable members of society and need to be protected from such practices. ***The FSC agrees that there is a risk that surveillance can result in claimants committing suicide, yet the practice is still allowed.***

BEDDOES INSTITUTE – 2017 DR REBECCA SHEILS

"There is a need for advisers and insurers to clarify their respective roles in relation to keeping the policyholder informed, coordinating third parties and managing the policy application. Not all insurers and advisers will agree on where the line should be drawn but if these roles and responsibilities are not clarified for large groups of policyholders and claimants, room for misunderstanding and disappointment will continue to exist."

"Once roles are agreed, the expectations of policyholders and claimants can be aligned with these through education and communication in order to optimise their satisfaction and streamline the claims process for all involved. Dr Rebecca Sheils - Director and co-founder of the Beddoes Institute. Source: Riskinfo Magazine 30 (2017)"

5) THE "EARLY INTERVENTION" OPPORTUNITY

There is plenty of evidence to support that "Early Intervention" in Mental Health Claims is an incredible successful strategy. This is where the Insurance Company engages with the Insured as early as possible to work with them, possibly their doctors and employers, to work on a recovery, wellness and rehabilitation plan. Worker rehabilitation covers a much broader area, but mental illness is the area I have personal experience.

Until I got sick I had no idea how hard Mental Illness is to deal with. It's impossible to really put into words the struggle to comprehend being diagnosed with an "invisible" illness. The first 3 months was hell, as you are trapped alone with your own broken mind. Not to mention grappling with the stigma and doubters. Then add the impact of failed medical interventions. Early intervention isn't just about return to work, it's about stopping suicide in its tracks. It's about quality of life, a sense of hope and a support network.

Early Intervention is a strategy that the industry wishes to adopt. As documented in the FSC submission, after 70 days off work the chance of that person returning to work is around 35%, and after 12 months its minimal. So I completely agree that getting in and helping as early as possible has to be the way ahead.

HOW IT COULD IMPROVE THE EXPERIENCE FOR THE MENTALLY ILL

So let's look at it from the perspective that there is 70 day window to really help Mental Health claimants.

So once the claim form completed by the GP hits the Insurer, the choice is do they keep requesting the information that they are currently getting before making a decision or do they go straight into early engagement ?

I haven't seen any data that suggests the current claims process is uncovering a large number of fraudulent claims. So let's take the position that Mental Health claimants are honest and asking for a shopping list of reports is counterproductive.

It would be in everyone's interest to waive the waiting period, hold off on the multiple reports and move straight into supporting the claimant. If the person isn't genuinely ill, then it will be uncovered this through a deeper engagement.

If additional information is needed, then it needs to be obtained, but it can wait a few months. In my perfect world, we move to an industry-wide practice of pay first, ask questions later. This is supported by Margo Lydon, Chief Executive Officer, Company Secretary of SuperFriend.

THE RISK

If allowed to develop their own Medical Centre's, the conflicts of interest become very real. You could have a situation in which a treating physician, is employed by the organisation who is paying the Claim benefits. There must be protection for the claimant against biased medical assessments. Furthermore these Medical Centre's must fall under AMA & Psychiatry Association "early intervention" guidelines (to be established).

6) Parliamentary Joint Committee on Corporations and Financial Services - Life Insurance Industry – REPORT MARCH 2018

The recommendations of the report cover 8 broad ranging areas that require "substantial changes" according to the committee. It details over 60 recommendations.

- **Consumer Protections**
- **Codes Of Practice**
- Remuneration, commissions, payments and fees
- Retail life insurance and approved product lists
- Group life insurance
- **Access to medical information**
- Genetic information
- **Claims Handling**

1) CONSUMER PROTECTION

The committee has concluded that consumer protection for Life Insurance products are weak and confusing for consumers. They recommend they be enhanced and aligned with Australian Consumer Law. This includes the removal of a number of exemptions that benefit the Life Insurance industry. The committee is recommending that the changes uniformly cover all types of life insurance, all sectors (direct, retail and group), and all industry participants.

Critical Inclusions:

I fully support all the recommendations of the PJC in regards to Consumer Protection.

2) CODE OF PRACTICE

The committee is recommending a single Code of Practice be implemented and registered with ASIC. It will be a combination of the codes from the Insurance in Superannuation Working Group and the FSC.

The Code needs to be written in plain English that regulates the conduct of life insurance companies in assessing claims;

- is mandatory for all industry participants;
- is registered with ASIC;
- give the code compliance committees the power to determine whether breaches have occurred
- is enforceable in order to create accountability; and
- provides genuine remedies for its breach, including financial remedies, thereby creating an incentive for compliance.
- covered by an external dispute resolution body such as the proposed Australian Financial Complaints Authority (AFCA). If a consumer lodged a complaint about an insurer's compliance with the code, the external dispute resolution body would apply the code of practice to any dispute between the insurer and the insured

The committee is also recommending that ASIC be given the power to undertake enforcement action in relation to systemic or systematic breaches of codes of practice in the financial services sector, including in the life insurance industry. This is currently excluded under ASIC's power.

Critical Inclusions;

I fully support all the recommendations of the PJC in regards to the Code of Practice.

In addition;

- ***I would strongly request that clear visibility of the full terms of the code be required to be incorporated into the Life Insurers PDS, website, marketing material, etc. In addition, it should be incorporated into the general text of all areas of these documents to assist to provide further context as to when, where and how the code applies. This should be more than simply a reference to the code on the FSC website.***

3) ACCESS TO MEDICAL INFORMATION

The committee is firmly of the view that life insurers should only have access to targeted medical information at application and at claim time. The committee is therefore recommending that the Financial Services Council and the Royal Australian College of General Practitioners collaborate to prepare and implement agreed protocols and standards for

• requesting and providing relevant medical information only, not complete medical files;

• uniform authorisation forms for access to medical information;

• appropriate storage of medical information; and

• real-time disclosure to consumer about the progress of their claim, including requests for medical records.

Critical Inclusions:

I fully support all the recommendations of the PJC in regards to Consumer Protection.

In addition;

- ***The rights of the consumers are not represented the FSC or the RACGP. A mental health advocacy group like Beyond Blue must be part of this process. The majority of medical reports are obtained from mental health professionals and not members of the RACGP. As such these professional bodies should also be represented in this process.***

- ***It is a major concern that Life Insurers will still be able to request broad reaching reports including Medicare reports from 1984, Health Insurance reports, and PBS reports. These organisations will not be party to the agreed PJC standards. These organisations will also not be able to determine what is "relevant" and what is not. They simply provide a data file of all information to the requested party. As such this provides a loophole for Life Insurers to provide "fishing expeditions" into an individual's medical history. I support a total ban on the request of these reports by Life Insurers. If this is not acceptable, I propose the information in these reports be forwarded to the insured's GP and they assess what information is "relevant" and then forwarded to the Life Insurer.***

4) CLAIMS HANDLING

The committee was concerned to hear about claims handling practices that may be used by life insurers as a means to delay or deny a claim or limit the amount of payment made when a claim is successful. The committee is also concerned about the transparency of the claims handling process and the lack of reasons provided to customers when claims are denied. Evidence to the committee highlighted that policies with technical definitions can have high decline rates.

The committee is therefore recommending that the life insurance industry must:

• regularly update all definitions in policies to align with current medical knowledge and research;

• standardise definitions across all types of polices and use clear and simple language in definitions;

• set industry standards for claim timeframes and limits on the number of medical examinations;

• clearly explain which associated conditions that may arise from the initial condition, including mental ill health, are covered by the policy; and

• develop a mandatory and enforceable Code of Practice for its members in relation to mental health life insurance claims and related issues.

• real-time disclosure to consumer about the progress of their claim, including requests for medical records.

The committee is also recommending that the current exemption under the Corporations law that excludes certain claims handling activities by life insurers from ASIC's oversight should be reviewed.

Critical Inclusions:

I fully support all the recommendations of the PJC in regards to Claims Handling.

In addition;

- ***I believe that the exemption under the corporations law on claims handling activities should be prioritised as urgent & critical. Any consideration around allowing Life Insurer's to be able to fund workers rehabilitation simply cannot proceed until this loophole has been closed. ASIC must have full regulatory powers on both claims and rehabilitation activities.***
- ***The LIF should be amended to require advisers to provide an "opt out" claims service offering to clients. That is, it is mandatory to be provided, unless consumers choose not to take up this service as part of the ongoing fee structure***
- ***Claims service delivery by advisers to clients must be included in ASIC and AFSL audits***
- ***Life Insurers must provide a real time claim information to advisers – data feeds***
- ***Clarification is required to the qualifications that are required for adviser staff to provide claims support***
- ***The education module must be enhanced to include more detailed training around insurance claims for advisers and staff***
- ***Surveillance should be not permitted under any circumstances for the mentally ill. The Life Insurance industry has not been able to demonstrate that the practice has exposed widespread claims fraud, that would counter the serious impact that the practice has on the mentally ill.***
- ***Timeframe for assessment of mental health claims for Income protection is amended to being 3 months from the period of claim lodgement, irrespective of the waiting period.***
- ***Ongoing monthly assessments of Income Protection claims should be limited to 5 days from receipt of the claim information***
- ***Payment of any claim benefit must be made within 5 working days of acceptance and sign off process must me streamlined to provide a quick executive approval***
- ***Reinsurers are no longer excluded from the timeframe for decision making. That is, they no longer fall under the "exceptional circumstances" exemption. Reinsurers are a large and critical part of the Life Insurance industry, they must not fall outside the customer service standards.***
- ***A "duty of care" protocol needs to be designed and incorporated in the Code of Practice. For any mental health claim that is declined, the decision is informed via phone (then letter). The phone call is delivered to the insured by an individual with mental health care training and a "grief" support service is in place for the insured to contact. The Life Insurance company must then immediately contact the claimants treating physician, to inform them of the decision and the reasons. Some privacy and logistic issues need to be sorted, however***

the duty of care needs to be improved here. Simply contacting a mentally ill person and delivering news that will impact their condition without a safety net, must end.

- ***Life Insurers must record the full reasoning and explanation of withdrawn claims for mental health conditions. The Life Insured must be offered the option to have claim matter discussed verbally with a senior claims manager before the file is closed. The insurers need to be absolutely certain the claimant is fully aware of the decision to withdraw and the alternative options available.***
- ***Life Insurers to implement a "priority claims complaint" process for mental health claimants. 5 working day turnaround.***
- ***Mental Health claims are primarily managed by staff with Tertiary Health Care qualifications***
- ***Requirement for Life Insurers to fully disclose Reinsurance involvement to consumers at the time of claim. The real time disclosure the PJC recommends cannot be possible if the client has not been informed and understands the role of the reinsurer***
- ***A full Q&A code of practice document must be clearly displayed on each insurers website and the timeframes for decisions incorporated into claims information. It needs to be incorporated into the PDS and updated once the final mental health code is finalised. The Life Insurers consumer facing material and the workings of the Claims Standards must be deeply intertwined. Consumers should not have to view these as separate parts of the information process nor seek to find the standards in hard to access areas of a website.***
- ***Require the industry to establish an industry funded consumer education organisation, that actively educates consumers on all aspects of insurance and claims***
- ***Suggest more focus is put towards encouraging investment and recognition of advisers in the area of claims support by industry bodies***

Appendix - The Reinsurance Barrier

The least understood area of Life Insurance, is the role of the Reinsurance Companies. Definition: It is a process whereby one entity (the Reinsurer) takes on all or part of the risk covered under a policy issued by an insurance company, in consideration of a premium payment. In other words, it is a form of an insurance cover for insurance companies.

However, the involvement of the Reinsurers in the Australian market goes far deeper than this simplified explanation. In short, **they are the market**. Whilst there are over 200 global reinsurers, around only 7 operate with any size in Australia. This is a reflection of the poor profitability of the market, mainly the Disability Insurance area. They are all financially enormous, global organisations, with the parent company in the USA or Europe.

Around **30%** of the new business written each year is reinsured. Some Life Insurance companies reinsure as much as **90%** of the sum assured. The maximum amount of risk (dollar amount of insurance cover) retained by an insurer per life is called retention. Beyond that, the insurer passes the excess risk to a Reinsurer. The point beyond which the insurer passes the risk to the Reinsurer is called retention limit and that risk amount is referred to as the reinsured amount.

For example, the major Life Insurers will set a retention limit for Life Insurance at $1 million. If an individual applied for $1.5million of cover, the additional $500,000 would be reinsured. The retention limits for different insurance products will also differ. They are higher on profitable products like Life Insurance, however they are much lower for Disability Insurance.

This means that the Reinsurers are actually the entity holding the majority of the risk for Disability Insurance in Australia. Simply put, as the organisations writing the cheques, they are the ones making the rules on Mental Health.

REINSURANCE TREATIES

The term "Treaty" is used to describe the contract between the Insurer and the Reinsurer. The Reinsurer agrees to provide support, training and expertise. Apart from the financial obligations of each party, the Treaty will also document the product and operational obligations. Any product, including the features and definitions, requires Reinsurance approval. The same goes for pricing, with the Reinsurance actuarial team heavily involved with the Life Insurers actuaries. Any changes after the product launch, requires this sign off process to be re-undertaken.

At the commencement, the Reinsurer will provide training and manuals to the Underwriting staff. These manuals outline the process and rules for Underwriting decisions. It will include ratings for occupations, health conditions and pastimes. It will also cover the areas that cover will be excluded or declined. In reality, it is here that the Reinsurers will outline their rules for acceptance, loading, or exclusion for high risk areas like back injuries, heart conditions, high blood pressure and Mental Health.

Critically these standards affect the pricing of the Insurance Product. The more generous the product definitions and the more liberal the Underwriting standards, the higher the price to consumers of the cover. Insurance products that have blanket exclusions for Mental Health claims in the policy wording, are designed that way to offer consumers a low cost alternative to full cover Retail Insurance. Group Products that have reduced cover for Mental Health are generally designed that way by the Superannuation fund to reduce the premium.

REINSURANCE CLAIM DELAYS

Any application that exceeds the retention limit will be forwarded to the Reinsurance Underwriting team for assessment. The Reinsurer may well require additional information to be obtained like medical, financial or a questionnaire.

The situation is the same with the Claims process. These Claims manuals outlines the process and rules for Claims decisions. Any Claim that exceeds the retention limit will be forwarded to the Reinsurance Claims team for assessment. The Reinsurer may well require additional information to be obtained like medical, financial or a questionnaire. Reinsurers do not have the staff resources of an Insurer. As such the process times are a substantial period of the overclaim claim assessment timeframe.

The Claim file is normally only forwarded to the Reinsurance team once the Life Insurance team has obtained all the reports and information required and has made its decision recommendation. It is not uncommon for the reinsurance claims team to then request additional information, essentially starting the process again.

We know from ASIC, that Mental Health Claims obtain the most amount of information for assessment and take the longest time to finalise the decision. Primarily this is due to the large amount of information requested by the Life Insurer. However it is almost inevitable that if the file is referred to the Reinsurer, that they too will require additional information.

It is possible that a Life Insurer can still pay a claim for a policy holder, if the Reinsurer declines to accept the Claim liability. That is rare and tends to occur only if an error has occurred in the underwriting process. It can also occur to preserve commercial relationships with advisers. In those circumstances, the Reinsurance amount paid, comes directly from the Life Insurers profit. It will not have been reserved from a capital perspective. Trust me, it's a very rare occurrence.

Hence, this is why Life Insurers refuse to accept liability and make Claims payments until they have the Reinsurance sign off. For the insured, this creates the absurd situation in which they require the sign off from 2 parties before they can receive their claims benefits. This situation occurs not only with lump sum benefits, but also with ongoing monthly payments like Income Protection.