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18 November 2016

Committee Secretary
Parliamentary Joint Committee on Corporations and Financial Services
PO Box 6100
Parliament House
Canberra ACT 2600

By email corporations.joint@aph.gov.au

Dear Secretary

We welcome the opportunity to provide a submission to the Committee's Inquiry in to the Life Insurance Industry.

Please do not hesitate to contact me and my colleagues if we can further assist with the Committee's important work.

Yours sincerely,

Greg Tucker
Chief Executive Officer
MAURICE BLACKBURN

SUBMISSION TO THE PARLIAMENTARY JOINT COMMITTEE ON CORPORATIONS AND FINANCIAL SERVICES

November 2016

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Introduction

Maurice Blackburn Pty Ltd is a plaintiff law firm with 32 permanent offices and 29 visiting offices throughout all mainland States and Territories. The firm specialises in personal injuries, medical negligence, employment and industrial law, dust diseases, superannuation (particularly total and permanent disability claims), negligent financial and other advice, and consumer and commercial class actions.

Maurice Blackburn employs over 1000 staff, including approximately 330 lawyers who provide advice and assistance to thousands of clients each year. The advice services are often provided free of charge as it is firm policy in many areas to give the first consultation for free. The firm also has a substantial social justice practice.

Our Superannuation business

Maurice Blackburn assists more Australians every year in making TPD and other insurance claims under their Superannuation policy than any other law firm.

Through the hundreds of clients we assist, we see the best of intentions and the best of performance from Superannuation Funds and their insurers. We unfortunately also see the worst of culture and behaviour that has real and profound consequences for their members and our clients at a time they can least cope with such difficulty.

Many of these poor experiences have been reflected by media coverage of the wider life insurance industry. Most recently, this has included unethical behaviour by certain insurers such as disputing claims using out-of-date medical definitions, and delay tactics to avoid claims.

Default TPD in superannuation is a critically important resource for fund members. It is the means by which a disabled member can top up the shortfall in their superannuation retirement savings caused by the premature end to their career.

We know the personal story behind each of the claims we assist with each year, and the difference the financial assistance through superannuation based insurance makes in difficult personal and family circumstances.

As the recent Productivity Commission draft report articulates, this resource is of great importance given the underinsurance problem in Australia. The KPMG study cited in the 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".*[1]

A further study cited in the Productivity Report, undertaken for 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" and that the "underinsurance gap is large, but would be much larger if cover was not provided through superannuation funds".[2]

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[1] PC (Productivity Commission) 2016, *How to Assess the Competitiveness and Efficiency of the Superannuation System,* Draft Report, Canberra, p.145..

[2] Rice Warner *Insurance Administration Expenses (ASFA)* August 2014 *https://www.superannuation.asn.au/ArticleDocuments/359/InsuranceAdministrationExpenses_Aug2014.pdf.aspx page 6*

Intent

The Super System Review Final Report of 2010 – also known as the Cooper Review – provides guidance as to the role of TPD and Life Insurance policies:

> *…for a significant number of members each year, total and permanent disability (TPD) or premature death mean that they or their dependents need to call on their superannuation savings much earlier and for a longer period than they would have expected. Insurance plays a crucial role in allowing those needs to be met. An IFSA survey of its life insurance members (covering 90 per cent of the market) found over $2.3B in claims were paid in the 2008 calendar year on nearly 35,000 policies. Most Australians do not have life or TPD insurance cover outside superannuation.*[3]

The Government response to the Cooper Review accepted the proposition that insurance be offered on an "opt out" basis; and set out key regulatory and policy settings that are still in place today.

Definitions

The Committee Inquiry Terms of Reference includes "the need for further reform and improved oversight of the life insurance industry". A key issue is the manipulation and revision of TPD definitions.

Over recent years, some insurers have effectively created "junk insurance" through new, unreasonable thresholds, eligibility rules and definitions, and disallowing entitlement to claim where a member has multiple policies despite continuing to receive premiums for the product.

The most pervasive change across the industry is the subtle but highly consequential substitution of the key legal test of "unlikely" with the more onerous "unable".

The Superannuation Industry (Supervision) Act (The SIS Act) allows for early release of funds in a members' retirement saving account in limited circumstances including 'Permanent Incapacity', which applies the "unlikely" test and is defined as:

> *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.*

Any TPD insurance definition must be 'consistent' with that condition of release[4], however the industry interprets that to mean it cannot be less onerous, and has, in recent years provided TPD definitions that depart substantially from this 'Permanent Incapacity' requirement.

Any comparison of products should consider whether there is departure from the SIS Act and whether the definition is onerous.

"Unlikely" has been interpreted by Australian Courts to require a consideration of "the real world", namely market conditions and the practical prospects of the disabled job applicant

[3] Treasury, *Super System Review Final Report – '*Cooper Review', http://www.treasury.gov.au/~/media/Treasury/Consultations and Reviews/Reviews and Inquiries/2009/supersystem/Documents/Final Report/PDF/Final_Report_Part_2_Chapter_5.ashx, p.6.
[4] Superannuation Industry (Supervision) Regulations 1994 - REG 4.07D.

obtaining and maintaining employment in those conditions, in assessing whether the person is unlikely to return to work given their injuries or illness.

By contrast, industry applies “unable” as a medical assessment without consideration of the “real world”. For instance, it is possible to argue that even a quadriplegic is theoretically capable of work and may not satisfy an “unable” definition, notwithstanding that their actual employment prospects in a competitive employment market are negligible.

As a consequence, the insurance effectively becomes junk insurance.

In 2014, a major fund 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”.

That fundamental deviation from the regulatory threshold for early release on incapacity was a deliberate decision intended to limit their liability to pay claims by toughening the test for claimants. Further, the standard of work that is considered appropriate is lower than that provided for in the Regulations. Ultimately this means that claimants can have claims rejected, even if it is unlikely that they will engage in employment similar to that which they were performing before the accident.

The NSW Court of Appeal 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.” We advocate that such a test is sufficiently onerous.

It is pleasing to see that some other major funds have resisted pressure from insurers to depart from the ‘Permanent Incapacity’ test and have kept the “unlikely” definition. The fact that such definitions are being retained by some confirms the viability for doing so across all insurers.

Multiple Policies

It has come to our attention that one Fund and Insurer has chosen to incorporate a new form of exclusion clause where an individual holds another insurance policy – whether that be a retail policy or through a second superannuation fund.

Of course, Australians being members of multiple funds is commonplace.

The full Clause in question is

> *“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 had 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.

It is unclear whether this particular clause is specific to the fund/insurer or more widespread across the sector.

Another client example is this clause from a current insurance policy:

4.2 Pre-existing conditions
An insured member who became covered for TPD Cover under automatic acceptance or transfer terms is not covered for total and permanent disability that is caused directly or indirectly, wholly or partially, by a pre-existing condition if a similar benefit could be claimed by the insured member under another insurance policy.

Recent APRA Superannuation Statistics state there are 30 million superannuation accounts. There are approximately 15 million Australians of working age. The ATO stated in 2015 that 45% of working Australians have multiple superannuation accounts.

As such, these particular insurers have deliberately chosen to exploit this multiple policy dynamic. This is blatantly unfair, given members continue to pay premiums unaware that the policy excludes them from making a claim.

Such exclusion clauses also undermine the crucial role of group insurance in mitigating against the underinsurance problem, and is irreconcilable with the insurance industry's perennial assertion that Australians need more insurance.

Barriers and Delays

The Committee Inquiry Terms of Reference includes "whether entities are engaging in unethical practices to avoid meeting claims".

Our experience in working with our clients has created concern that insurers and funds are using barriers to application and delays as a means of avoidance.

<u>Barriers and hurdles created</u>

The recent ASIC Report in to Life Insurance highlights the fact that claims procedures are creating a barrier for consumers. The report states:

40 As well as finding that most life insurance disputes are about claims procedures, we also found that claims procedures can be complicated for consumers and can lead to adverse outcomes.
41 We found that deficiencies in claims procedures are adversely affecting policyholders' experiences and claims outcomes, particularly the evidence required to assess a claim and delays in claims decisions and payments.
42 We identified that there is scope to raise standards and improve consistency. Improvements to claims handling procedures so that they are less complicated for consumers could improve both consumer outcomes and consumer

> *understanding of insurance, and help to build trust and confidence in the industry.*[5]

We have regular experiences with particular insurers and funds creating unreasonable delays in processing claims and creating barriers in the application process.

A recent Fairfax media article by Adele Ferguson explained the journey of one of our clients:

> *…Take for instance, Eric McQueen, whose life started to unravel in September 2011 when he was medically retired from the Queensland Police Service with post-traumatic stress disorder. A series of shocking and violent incidents, encountered while on the job, had taken their toll physically and emotionally.*
>
> *After he "retired" from the police force, his mental health continued to deteriorate, leaving his wife Kate to pick up the pieces and become his full-time carer, while raising their two young sons. "Being there to help your husband off a ledge is draining but I love him to bits and I made a decision to be around him 24/7," she said.*
>
> *The family's money troubles mean that Eric can't see a psychiatrist regularly. They have been pinning their hopes on an insurance claim for total and permanent disability (TPD).*
>
> *The McQueens are just one of many Australian families locked in grueling disputes with life insurance companies over policies paid for through superannuation.*
>
> *Eric, like millions of Australians, had TPD coverage through his super – in his case, through Queensland-based Sunsuper, a $35 billion fund into which he had contributed since he was 14. Sunsuper's life insurance contract is with insurance giant AIA.*
>
> *A second fund, QSuper, accepted his TPD claim and paid him out immediately. But Sunsuper refused.*
>
> *"Sunsuper has been despicable," Kate says. "When I first tried to put the claim in they said he wasn't covered, when he was." She then contacted Maurice Blackburn. "We have been battling ever since."*
>
> *In sharp contrast, QSuper were brilliant, she says. "They did independent reviews, looked at psychiatrist reports and did various assessments then paid it out straight away."*
>
> *But the medical bills kept mounting, adding to the financial strains facing the family. "I had to sell everything to keep food on the table. We came close to having to sell the house," she says.*
>
> *The McQueens' situation raises some interesting questions about what is going on in the sector and how we can fix it. Sunsuper dragged its heels, QSuper didn't. Are the trustees to blame? The life insurer? The quality of the policy? Or are there too many gaps in a system that allows trustees and life insurers to put claimants last?*

[5] Australian Securities and Investment Commission 2016, *Life Insurance Claims: An Industry Review,* Report 498, http://download.asic.gov.au/media/4042220/rep498-published-12-october-2016a.pdf, p.10.

> *We know some super funds get rebates when claims are kept below a certain level. This can be lucrative and help bolster returns. Unquestionably it is a massive conflict of interest.*
>
> *Perhaps Sunsuper should take a leaf out of the QSuper trustee notebook on how to advocate for members, quickly and with respect.*
>
> *Late on Friday, Fairfax Media was told that the McQueens' claim would be paid by the insurer, AIA…*[6]

These forms of unnecessary delay are one example of creating a barrier and a deterrent to members accessing their policies.

Another example is to create an onerous application process – for instance, one private superannuation fund has a 42 page TPD application form.

Unlike workers compensation where insurers are required by law to decide claims speedily (usually within one month), there is no legislated time limit imposed on superannuation insurers. Consequently delays of 12-18 months before making a decision are commonplace.

Periodic Payments

Some insurers are moving away from a single lump sum payment to instalment payments, typically over a period of five years. Claimants are then required to prove annually they remain unable to return to work in accordance with the definition. 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).

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 TPD 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.

[6] Adele Ferguson, '*Lipstick on the piggy banks won't cut It,' The Sydney Morning Herald*, 6 August 2016. http://www.smh.com.au/business/comment-and-analysis/stop-pussyfooting-around-and-call-a-royal-commission-into-banks-20160805-gqlo32.html.

Financial Advice

Maurice Blackburn has represented numerous victims of unlawful or negligent financial advice in individual civil actions and class actions, including in respect to the sale of life insurance products. The Terms of Reference include: "(d) the sales practices of life insurers and brokers, including the use of Approved Product Lists".

Recent history

In recent years the life insurance industry has been exposed as having deeply flawed sales practices, whereby advisors are incentivised through large commissions to recommend inappropriate products to their customers, often leading to devastating consequences for customers who later have their claims declined. These commissions were often as high as 120% of the premium a customer was to pay for their policy in the first year.

ASIC's Review of retail life insurance advice dated October 2014[7] reported that ASIC reviewed 202 life insurance advice files, and found that 37% of customers had received advice that did not comply with the law. It also found that the likelihood of advice breaching legislative standards was dramatically increased where the advisor received an upfront commission from the insurer: 45% of upfront commission advice failed ASIC's tests, whereas only 7% of non-upfront commission advice failed.

ASIC also reported high insurance policy lapse rates, caused in part by "incentives for advisers to write new business or rewrite existing business to increase commission income".

A 2009 Parliamentary inquiry observed: *"A significant conflict of interest for financial advisers occurs when they are remunerated by product manufacturers for a client acting on a recommendation to invest in their financial product"*[8].

The 2013 Future of Financial Advice (FOFA) reforms which sought to address the remuneration conflicts in the financial industry by banning commissions and volume-based payments[9] did not extend to life insurance advice.

The Corporations Amendment (Life Insurance Remuneration Arrangements) Bill 2016 (the Bill) has been developed by the Government to address these ongoing life insurance sales problems.

The Bill imposes a cap on the commissions an advisor may receive, and also seeks to neutralise the 'churning' incentive using a 'clawback', where a certain portion of the upfront commission is paid back to the life insurer by the financial adviser in the event that the policy is cancelled or the premium is reduced in the first two years.

Whilst these reforms are a welcome start, they do not address other systemic flaws in the life insurance sales system that are a root cause of poor customer outcomes, namely:

- the pervasive vertically integrated cross selling practices by large institutions through overly narrow Approved Product Lists (APL);
- the payment of Shelf Space Fees by insurers to advisers to have their product listed on the adviser's APL.

[7] Report 413
[8] "Inquiry into financial products and services in Australia" by the Parliamentary Joint Committee on Corporations and Financial Services 2009
[9] Section 761G *Corporations Act* 2000 (Cth) for definitions of retail client and wholesale client.

Vertical Integration and narrow APLs

Vertically-integrated advice is where an adviser recommends purchase of a financial product (including life insurance) from entities with which they are associated. This is often to the exclusion of more suitable non-affiliated products.

ASIC has described the vertically-integrated advice model as being inherently conflicted, and lacking in customer transparency. For example, ASIC's submission of December 2014 to the Scrutiny of Financial Advice Inquiry noted:

> *The inherent conflict of interest created by vertical integration may not be readily apparent to clients, particularly if the product manufacturer and advice parts of the business operate under separate licences and business names. Roy Morgan Research found that 55% of surveyed consumers receiving financial advice from an entity owned by a large financial institution, but operating under a different brand name, considered it to be independent—in contrast, only 14% of consumers considered financial planners working under the brand of the same financial institution to be independent. This was also an issue identified by the Financial System Inquiry, which recommended that advisers be required to disclose ownership structures of the advice firm to consumers.*[10]

The vertically-integrated players are predominantly owned and controlled by the big four banks, AMP (including AXA) and Macquarie Bank. These dealer groups collectively account for around half of the total market share in the financial advice sector, and their stake is increasing.

Dealer groups utilising a vertical integration model are not obliged to have any retail life risk insurance product on their APLs other than their own affiliated product.

This inherent conflict has given rise to much litigation in recent years,[11] the most notable case being *Commonwealth Financial Planning Ltd v Couper*.[12] In Couper, the late Mr Stevens was advised by a CBA adviser to cancel his existing Westpac life insurance policy and replace it with a vertically-integrated CommInsure product, which he did. The subsequent claim made by his Estate for his life insurance benefit was declined and the policy avoided on the basis of non-disclosure under section 29 of the Insurance Contracts Act.[13] The Court of Appeal found that the financial advisor was negligent and engaged in misleading and deceptive conduct. The Court noted that while the Statement of Advice did disclose the risk of avoidance for non-disclosure, it failed to disclose the 'three year rule', namely that:

- because his Westpac policy had been on foot for more than three years, it could not be avoided by the insurer except by proving fraud; and
- the CommInsure policy could be avoided for 'innocent non-disclosure' within the first three years from inception, and was therefore an inferior product.

The three year rule was, in the adviser's words "news to me".

[10] Submission No. 88, at [245].
[11] See also *Swansson v Harrison & Ors* [2014] VSC 118
[12] [2013] NSWCA 444.
[13] *1984* (Cth).

These inherent conflicts were highlighted by Roy Morgan research which stated that over a three year period, these dealer groups allocated an average of over 70 per cent of their sales to their own products.[14]

Because the big vertically-integrated players have such vast distribution channels to sell their 'in-house' products, they do not rely on other advice firms to do it for them. That means they are disinclined to take the lead on product design, which in turn leads to inappropriate or defective products being paid for by the client, and often results in the insurer denying liability because of those defects.

Recent controversies have exposed stark examples of this, such as CommInsure's retail Trauma policies, which contained medically-obsolete 'heart attack' and 'severe rheumatoid arthritis' definitions. Despite knowing the definitional flaws, CommInsure relied upon them to decline claims. It took a media expose to prompt CommInsure to update its obsolete clauses.[15]

It is apparent that action is needed now to deal with the vertically-integrated sales model, which remains rife in the advice industry. Yet there is no indication that the Government has any plans to take such action. On the contrary, the Explanatory to the Corporations Amendment (Life Insurance Remuneration Arrangements) Bill 2016 (the Bill) does not discuss these issues directly nor propose any substantive reform.

Nor can this issue be entrusted to the industry to self-regulate on this crucial issue. For reconfirmation of that fact, one needs only look to the Code of Practice developed by the Financial Services Counsel which, despite having a section on sales practices, makes no mention of these consumer issues.

The vertical integration conflict can be addressed best by requiring financial advisers to demonstrate that they consider and recommend both affiliated and non-affiliated products. That could be achieved by making the following improvements, which we recommend:

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

These measures would provide prescriptive requirements to support compliance with the best interest test established by the Future of Financial Advice reforms. These measures are also directed towards achieving the recommendation of John Trowbridge that APLs be reformed to "ensure competitive access and choice for all advisers and their clients.''

Shelf-space fees

These are levies paid by insurers to advisers to have their product listed on the adviser's APL.

Some insurers have themselves called for a ban on these payments, with the ClearView Managing Director Simon Swanson reportedly stating that *"*customers are often

[14] Roy Morgan Research, *Superannuation has become a political football but a new report shows what the members think*, 27 May 2015, http://www.roymorgan.com/findings/6262-superannuation-political-football-but-new-report-shows-what-members-think-201505270222.
[15] Jassmyn Goh, "CommInsure upgrades heart attack definitions" *Money Management* 10 March 2016, http://www.moneymanagement.com.au/news/financial-planning/comminsure-upgrades-heart-attack-definitions.

recommended a product not because it's the most suitable and appropriate, but because of an *insurance company's* willingness and ability to pay shelf space fees*"*.[16]

Despite these concerns, and as with vertical integration, the Government continues to allow the industry to self-regulate on this issue.

We recommend the use of shelf space fees should be either banned or properly regulated by ASIC to ensure robust disclosure obligations, and that it does not cause a conflict that may result in the recommended product not being in the consumer's best interests.

Something needs to change

We have consistent and regular examples of insurers treating people poorly – and many relate to Maurice Blackburn's clients. Here are some examples from national media earlier this year:

> *March 2016 – Australian Financial Review*
> *"The former chief medical officer of Commonwealth Bank of Australia's life insurance division has pointed to a culture where doctors are pressured to alter or delete medical records and opinions to allow CBA to avoid paying claims…*
> *CBA's insurance division CommInsure has also failed to pay out the claims of two of the bank's former staff members, who were too sick to work at the bank but were told they should be able to work somewhere else."*
>
> *March 2016 - Australian Financial Review*
> *"The joint investigation found that CommInsure has been denying heart attack claims by deliberately using an outdated definition buried in the policy.*
> *…It also found the way it approaches mental health issues and assesses potential policyholders leaves a lot to be desired.*
> *…Other revelations include the refusal to pay total permanent disability (TPD) and terminal illness claims on the chance that a dying person facing organ failure may have their life saved by a transplant. A person can claim their life insurance if they are declared terminally ill by two doctors and deemed likely to die within 12 months."*
>
> *April 2016 – The Australian*
> *"Commonwealth Bank's embattled life insurance arm, CommInsure, repeatedly misrepresented a consultant as a doctor although he did not have a medical degree…*
> *The Australian has obtained details of three disability insurance claims in which CommInsure incorrectly described Sydney psychologist Greg Fathers as a "doctor" and asked clients to attend him for examination. CommInsure rejected two of the three claims…*

These news stories relate to real people who should represent the key beneficiaries of any reforms.

We were disappointed that the previous Senate Economics Committee into the Insurance Industry lapsed and the good work that was already well advanced by the Committee was lost. We note that under Senate Practice, that inquiry could have been recommenced; a

[16] Scott Hodder, "ClearView calls for shelf space fees ban", *Risk Adviser*, 24 February 2015, http://www.riskadviser.com.au/news/13030-clearview-calls-for-shelf-space-fees-ban [emphasis added].

measure that may have helped to ensure findings and recommendations to the many issues identified progressed in a more timely manner.

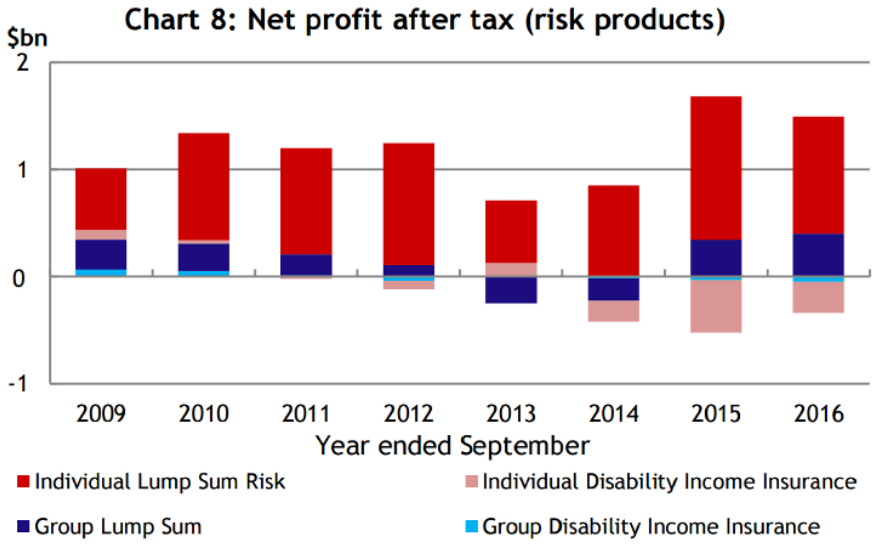
Indeed, many of these significant public scandals were discussed by the Senate Committee and we would encourage the Joint Committee to review these cases.

It was these cases coming to public light that exhausted public patience and created the appetite for change in insurer behavior.

At the same time, the sector has remained in an overall healthy financial position.

Recent APRA statistics state that net profit after tax for Australian Life Insurers for the twelve months to the September quarter 2016 was $2.6 billion.[17]

Chart 8 of that report sets out the NPAT by product group, including the relatively lesser impact that Group Insurance has on the bottom line – and that most of the contemporary loss is due to Individual Disability Income Insurance.



To suggest that the current Group Insurance arrangements are unsustainable is not reflected by these contemporary metrics.

Furthermore, the recent policy changes such as hardening definitions will only lead to positive improvement of Life Insurer NPAT.

[17] APRA Statistics *Quarterly Life Insurance Performance* September 2016 (Published 15 November 2016) http://www.apra.gov.au/lifs/Publications/Documents/1611_QLIPS-20160930.pdf page 6

Opt in or opt out

The Committee Inquiry Terms of Reference includes "assessment of relative benefits and risks to consumers of the different elements of the life insurance market, being direct insurance, group insurance and retail advised insurance".

Beyond our own experience in assisting clients accessing Group Insurance at a difficult time in their lives, we would highlight recent data included in the Productivity Commission's Draft report in to Superannuation Competitiveness and Efficiency of August 2016. [18]

We already know that Australia has a significant under-insurance problem, and any move to "Opt in" would exacerbate this problem with direct budget consequences.

Rice Warner's report for ASFA of August 2014 estimates the consequence of effectively ending group insurance is a shift of the financial to the taxpayer of over $400m per annum. [19]

We also know from the October 2016 ASIC Report into Life Insurance that there are issues with specific insurers declining a significantly higher proportion of claims, and that there are also a number of other specific insurers with very high levels of withdrawn claim rates. [20]

Any move to "Opt in" would effectively dismantle this existing safety net, punishing working people and pushing the cost burden on to the taxpayer.

The Committee's time would be best spent on the regulatory and legislative structure that creates standards that improves the behaviour of insurers.

Dispute Resolution and oversight

The Committee Inquiry Terms of Reference includes both "the effectiveness of internal dispute resolution in life insurance" and "… the roles of the Australian Securities and Investments Commission and the Australian Prudential Regulation Authority in reform and oversight of the industry".

While a majority of Funds respect the right of their members to engage legal representation, there is still a minority of Funds that are aggressive and hostile towards lawyers playing any role in a claim. Such culture undermines the effective resolution of the claim and discourages others from making claims.

As we understand it, the vast majority of claims are made without legal representation despite the fact that those insurers employ teams of lawyers to oversee the processing of claims being made.

Funds have regular, ongoing communication with their members. If their members choose not to engage directly on their claim and instead access specialist advice, it is disingenuous and intellectually dishonest to seek to blame others for that choice being made. Members usually engage lawyers because they feel unable, physically and mentally, to handle an insurance fight on their own.

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[18] PC (Productivity Commission) 2016, *How to Assess the Competitiveness and Efficiency of the Superannuation System,* Draft Report, Canberra.
[19] Rice Warner, 2014. *Insurance Administration Expenses,* p.8.
[20] Australian Securities and Investment Commission 2016, *Life Insurance Claims: An Industry Review,* Report 498, p.56.

We have specific concerns relating to the current system of dispute resolution mechanisms and the significant reform that is required to ensure the interests of our clients and consumers more generally are protected. These concerns have been communicated to the Review into Dispute Resolution and Complaints Framework, chaired by Professor Ian Ramsay.

Legacy claims

Our experience is that TPD claim services in geographic markets have developed at different rates at different times. For instance, the Sydney market developed many years before Perth.

Our experience is that a key characteristic of regional markets has been for a large number of older, "legacy" claims to come forward after fund members are made aware of their right and the existence of their insurance policy. Once these legacy claims are processed, demand for services normalises to a significantly lesser amount.

We are concerned that insurers are treating these legacy claims as a lead indicator, whereas they should be treated as a one of demand for services – or, at the least, a lag indicator.

Obviously such treatment inflates the cost and does not reflect the contemporary likelihood of claims coming forward.

Insurers will have the datasets to confirm this processing of legacy claims and normalization of claims by each regional market.

The recent ASIC Report into Life Insurance proposes that ASIC and APRA establish "a new public reopening regime for life insurance industry claims data and claims outcomes".

Transparency will ensure the debate is undertaken on contemporary, lead indicators.

Future Policy Settings

Time for a Code of Practice

Maurice Blackburn, amongst others, believes there is a need for an enforceable Code of Practice to be developed to regulate the conduct of the insurance and superannuation industries. The earlier examples indicate that a self-regulated code will be insufficient, and will represent a wasted opportunity to effect genuine change in the industry.

A new Code should ensure that these industries operate in an ethical and fair manner. It should be developed through an open and transparent process, involving genuine consultation with both community representatives and industry groups.

The Code should ensure that the objectives of the SIS Act and the Insurance Contracts Act 1984 (Cth) are met. ASIC's Regulatory Guide 165 regarding time limits for internal dispute resolution should also be reflected in the Code. Consistent with the above concerns, the definition of Permanent Incapacity should reflect that found in the Superannuation Insurance (Supervision) Regulations 1994 (Cth).

The Code should regulate conduct of insurance companies and regulators in assessing claims. It should agree to the fair and reasonable exchange of documentation relied upon in assessing claims. It should include hard time frames. Claims should be assessed in a timely manner and avoid excessive delays. Any delays in assessing claims due to their complexity

should be agreed between the parties. Any claim that is not assessed within a reasonable period of time after an internal complaint is lodged should be assessed in line with ASIC Regulatory Guide 165.

We were encouraged by the announcement of an *Insurance in Superannuation Industry Working Group* to drive improvement and better standards in the insurance and superannuation industries.

To date, measures on reform have largely been toothless and driven by self-interest, with ASIC calling for the "extension and enhancement" of the code developed by Financial Services Counsel just one day after that code's launch.

The *Insurance in Superannuation Industry Working Group* provides a clear process to begin developing and implementing real reforms and a higher standard for the industry going forward.

Maurice Blackburn has consistently called for an enforceable Code of Conduct and it is pleasing to see that the industry peak bodies are now pursuing this, with the Working Group committing to the finalisation of a code by the end of 2017.

Time for consistent definitions

Recent changes by some Superannuation funds to TPD insurance definitions has been contrary to the intent of the SIS Act and has gone some way to creating a new cohort of junk insurance products.

We advocate that the SIS Act be the standard for TPD definitions within superannuation, and not just the loose guidance that many funds and insurers treat it as.

Any comparison of products should consider whether there is departure from the SIS Act and whether the definition is onerous.

Standard definitions should also be regulated in respect to trauma insurance events (covered by policies held outside superannuation). Recent media reports have demonstrated how the insurance industry's failure update its medical definitions in line with medical knowledge resulted in antiquated and obsolete definitions being relied upon to unfairly deny claims.

Time for a new settlement for working Australians

Our third proposal is that the Committee consider an expansion of the insurance safety net for working Australians.

Put simply, there is an underinsurance crisis and the debate should be on how to close the current gap rather than make the situation worse.

If the intent of the superannuation system is to provide dignity for working Australians in retirement, there also needs to be a safety net that provides dignity for those who are injured or are unable to work.

For those who prematurely die, their partner and families should be provided with the same dignity the member would have otherwise had. Similarly if a person prematurely becomes incapable of work they ought to have a reasonable prospect of a decent post work life as a result of an insurance benefit they have paid premiums for during their working lives.

This is of greater importance given the toughening of Centrelink disability entitlements and workers' compensation regimes. There is also a responsibility to protect the interests of the taxpayer in designing the policy landscape.

If the drift from SIS Act definitions continues and new barriers continue to be created by insurers, the cost of the widening underinsurance gap will be met by the social security system and therefore the taxpayer.

We believe there is merit in the Joint Committee considering a renewed and strengthened package of insurance for working Australians be mandated through the MySuper structures.

The key principles would be:

- Opt out is only allowed for young workers (eg under 25) or if a retail policy has been purchased. Group insurance would be mandatory insurance for all other workers.
- A "floor" be established for minimum levels of Life, TPD, Trauma and Income Protection cover and be mandated in MySuper related group insurance products.
- Definitions be adopted for Life, TPD, Trauma and IP that are consistent with SIS Act definition for Permanent Incapacity.
- Insurers would still be free to market different types of life insurance but they would have to clearly explain to individual customer's deviations from the standard cover without burying non-standard terms in the fine print, so they understand what they are covered for.
- Working Australians will be able to easily compare their policy online to understand their own policy relative to other like policies.