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Members in attendance: Senators Ketter, O'Neill, Sterle, Williams and Mr Falinski, Mr Irons, Mr Keogh, Mr Van Manen.

Terms of Reference for the Inquiry:
To inquire into and report on:

a. the need for further reform and improved oversight of the life insurance industry;
b. 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;
c. whether entities are engaging in unethical practices to avoid meeting claims;
d. the sales practices of life insurers and brokers, including the use of Approved Product Lists;
e. the effectiveness of internal dispute resolution in life insurance;
f. the roles of the Australian Securities and Investments Commission and the Australian Prudential Regulation Authority in reform and oversight of the industry; and

g. any related matters.
WITNESSES

BINEHAM, Mr Marc, National President, Association of Financial Advisers ................................................. 41
BINGHAM, Mr Stuart, General Manager, Australian Prudential Regulation Authority ................................. 63
CAIN, Mr Russell, Joint Chairperson, Life Insurance Customer Group ......................................................... 27
CLARKE, Ms Samantha, General Manager, Policy and Professionalism, Association of Financial Advisers .......................... 41
COHEN, Ms Michelle Marie, Senior Solicitor, Public Interest Advocacy Centre .............................................. 1
DE GORI, Mr Dante, Chief Executive Officer, Financial Planning Association of Australia .......................... 41
FOX, Mr Brad, Chief Executive Officer, Association of Financial Advisers ..................................................... 41
GOODSTONE, Ms Alexis, Principal Solicitor, Public Interest Advocacy Centre ................................................. 1
HILL, Mr Damian, Chief Executive Officer, REST Industry Super ................................................................. 53
HOWARD, Mr Andrew, Chief Operating Officer, REST Industry Super ......................................................... 53
KELLY, Ms Alexandra, Principal Solicitor, Financial Rights Legal Centre ...................................................... 18
KENDALL, Mr Neil, Chair, Financial Planning Association of Australia ......................................................... 41
KIRKLAND, Mr Alan, Chief Executive Officer, CHOICE ............................................................................. 10
McCREA, Mr Glen, Chief Policy Officer, Association of Superannuation Funds of Australia .......................... 70
MENNEN, Mr Josh, Spokesperson, Superannuation and Insurance, Australian Lawyers Alliance .................. 18
O'HALLORAN, Mr Xavier, Policy and Campaigns Adviser, CHOICE .......................................................... 10
PERERA, Mr Stephen, Private capacity .......................................................................................................... 27
REESE, Mr Adrian, General Manager, Australian Prudential Regulation Authority ........................................ 63
SCHROEDER, Mr Mark, Life Insurance Customer Group .............................................................................. 27
SUMMERHAYES, Mr Geoff, Member, Australian Prudential Regulation Authority ....................................... 63
SWANSON, Mr Simon, Managing Director, ClearView Wealth Limited ......................................................... 27
WHITTON, Mr Ken, Senior Policy Advisor, Association of Superannuation Funds of Australia ................ 70
CHAIR (Mr Irons): I welcome everyone along today. I declare open this hearing of the Parliamentary Joint Committee on Corporations and Financial Services. Today, the committee is taking evidence as part of its inquiry into the life insurance industry. This is a public hearing and a Hansard transcript of the proceedings is being made. The hearing is also being broadcast via the Australian Parliament House website.

The committee generally prefers evidence to be given in public, but under the Senate’s resolutions witnesses have the right to request to be heard in private session. I remind all witnesses that in giving evidence to the committee they are protected by parliamentary privilege. It is unlawful for anyone to threaten or disadvantage a witness on account of evidence given to a committee. Such action may be treated by the Senate as contempt. It is also a contempt to give false or misleading evidence to a committee. If a witness objects to answering a question, the witness should state the grounds of the objection, and the committee will determine whether it will insist on an answer, having regard to the ground which is claimed. In addition, if the committee has reason to believe that evidence may reflect badly on a person, the committee may direct that evidence be heard in private. Witnesses should be aware that if, in giving their evidence, they make adverse comment about another individual or organisation that individual or organisation will be made aware of the comment and given reasonable opportunity to respond to the committee.

On behalf of the committee, I would like to thank witnesses here today for their time and cooperation. I thank Broadcasting for coming along to broadcast the hearing and I thank the secretariat and my colleagues who are here today, as well. The committee welcomes the Public Interest Advocacy Centre, who made submission 9. I remind committee members and witnesses that, while this is a public hearing, care should be taken to protect the privacy of individuals and that arguments should be made without naming individuals. I now invite you to make a short opening statement. Then, at the conclusion of your remarks, I will invite members of the committee to put questions to you.

Ms Cohen: We have prepared an opening statement that is about five minutes. PIAC is an independent, non-profit law and policy organisation dedicated to obtaining social justice for disadvantaged individuals at the broader systemic level. PIAC has extensive experience providing legal assistance and policy analysis in the area of disability discrimination. Since 2012, we have provided legal advice and representation to over 100 people who have experienced discrimination or who have otherwise been treated unfairly by general and life insurance providers on the basis of a mental health condition. We have identified systemic problems with industry practise that have failed to protect consumers. Approximately 75 per cent of our work has involved the provision of life insurance products and making claims under these policies. The remainder relates to general and predominantly travel insurance products.

Our submission to the inquiry notes that we have observed the following systemic problems regarding life insurance products and mental health. The first is when an applicant for insurance discloses a past or current mental health condition when applying for life insurance and the insurer refuses to offer insurance, or offers insurance with a broad mental health exclusion in circumstances where a more limited exclusion would have been reasonable, or offers insurance without a mental health exclusion but with an unreasonably high premium.

The second situation is where an applicant for insurance discloses symptoms of a mental health condition when applying for life insurance but has never been diagnosed with a mental health condition and the insurer imputes a mental health condition that is not supported by the information provided by the applicant or by a medical practitioner and refuses to offer insurance or offers insurance with a broad mental health exclusion or offers insurance with a premium.

The third situation is where an applicant for insurance does not disclose a mental health history when applying for cover or to amend existing cover in circumstances where nondisclosure is innocent or the insured has never been diagnosed with a mental health condition. When the insured later makes a claim on the policy the insurer purports to avoid the policy for noncompliance with the insured’s duty of disclosure under the Insurance Contracts Act.

The PIAC submission makes 13 recommendations to the inquiry. I will now briefly summarise those. Recommendations 1 to 5 deal with the need to further reform and improve oversight of the life insurance industry and sales practices. Recommendations 1 to 3 urge the Financial Services Council to commit to a consultative process to establish a further iteration of the life insurance code of practice that sufficiently addresses issues
relating to mental health, without further delay. We identify specific processes to be included in the code of practice and recommend that the code be regulated and enforceable.

Recommendations 4 and 5 relate to the operation of the Disability Discrimination Act. Recommendation 4 seeks that the exemption for insurance and superannuation providers at section 46 of the Disability Discrimination Act be amended to require insurers to produce copies of the actuarial and statistical data that they have relied on to make decisions regarding an offer of insurance and explain what relevant factors it considered in coming to a particular decision and how those factors affected the decision. The DDA should also be amended to clarify what the term ‘other relevant factors’ means to make it clear what information has been considered or may be considered by insurers when they are making decisions.

Recommendation 5 notes that insurers should be required to report decisions to discriminate to the Australian Human Rights Commission in an effort to enhance compliance with the DDA. We make recommendations on what this reporting should include and further recommend that the Australian Human Rights Commission or another appropriate body be empowered to investigate and enforce breaches of the Disability Discrimination Act. At a minimum, we recommend that the Australian government negotiate an agreement with insurers to require them to publish data on which decisions about insurance offerings based on mental health are made.

Our submission makes a number of recommendations in relation to insuring that life insurers do not engage in unethical practices to avoid meeting claims. These recommendations include recommendations 6 and 7, which contain a proposal that both the Insurance Contracts Act and the life insurance code of conduct be amended to ensure that where there is an alleged breach of the obligation of an applicant for insurance to disclose a mental health condition insurers amend and vary rather than avoid policies wherever reasonably possible. Recommendation 8 recommends that insurers be required to report publicly, for example, in their annual reports on the number of policies they avoid each year.

In relation to the effectiveness of internal dispute resolution in life insurance the PIAC submission makes three recommendations. These recommendations seek to remedy the practice identified by PIAC of insurers failing to provide sufficient written reasons for decisions to consumers. That is recommendation 9. Recommendation 10 seeks to improve the process and time frames for processing applications for internal review, and currently there are delays of time frames for up to six months, failures to consult with the applicant as part of the internal review process and an onerous requirement to provide medical reports. In relation to the life insurance code of conduct, recommendation 11 recommends that insurers be required to provide information and undertake internal reviews within a period of 60 days or less.

Finally, our submission makes two recommendations, recommendations 12 and 13, to ensure that insurers and complaint bodies including the Financial Ombudsman Service and the Australian Human Rights Commission advise consumers of all the options available to them if internal dispute resolution fails and also recommend to individuals that they seek legal advice on the choice of jurisdiction and the merits of their matter before the complaint is accepted for conciliation, to ensure that the complaint is lodged in the most appropriate forum.

We want to see change so that insurers do not unfairly discriminate on mental health grounds and do apply sound, effective and proportionate judgement to individual insurance policy applications and claims based on robust, up-to-date statistical and actuarial data. There needs to be better transparency in decision making in relation to matters concerning mental health so consumers understand the basis of the insurance decisions that affect them. Finally, the industry needs to change its practices in order to comply with the legal requirements and avoid and successfully defend legal claims of discrimination. Consumers are increasingly becoming aware of their rights, and they will seek to challenge unfair and discriminatory insurance decisions in higher numbers.

CHAIR: Do you have anything to add?

Ms Goodstone: No, I do not.

CHAIR: Thank you for your opening statement. The evidence we have taken so far—just listening to what you have done with your opening remarks as well—talks about the lack of transparency in the decision-making process of the insurance companies. Could you just elaborate on that a bit, because one of the things that we have found is that there is not enough definition or there is not enough feedback, as you said, in regard to their decisions. At the same time, with the 100 people that you said you have dealt with, what is the type of insurance that they are getting knocked back on most? Is it life insurance, or is it any type of insurance?

Ms Cohen: We have not kept data regarding the kinds of life insurance products, so on the proportion of those, but we do have people who are getting denied applications for total and permanent disability insurance, income protection insurance and life insurance policies. They are also having unreasonable mental health exclusion clauses placed on the policies in particular circumstances and high premiums placed on those policies.

COURTIONS AND FINANCIAL SERVICES COMMITTEE
as well. They are also being denied their claims by having their policies avoided on the grounds of their mental health condition in relation to those three categories of policies.

CHAIR: What about those who are actually getting insurance and then are denied a claim based on a clause that they are not made aware of during the process—

Senator O'NEILL: 'Other relevant factors'.

CHAIR: yes—or 'other relevant factors'? Do you think that in that case they have a claim to say, 'Well, I want my payments given back to me if basically I am uninsured'?

Ms Goodstone: We had a recent situation of a client who was not aware—I think this is what you are referring to—that the policy excluded mental illness. Is that the situation you are referring to, where there is a blanket?

CHAIR: Yes.

Ms Goodstone: There are policies—these are not so common—that just have a blanket exclusion of mental illness so that whoever applies for the policy is not covered for mental illness. More so our clients are people who are applying, disclosing mental illness and then either being denied insurance at all or having very broad mental health exclusions, when those are not justified, because the mental health history being disclosed is very minor, very limited to one particular condition. For example, someone will present with minor depression and have a complete mental health exclusion applied to their policy. The question there is really whether they are at greater risk than anyone else of developing schizophrenia or other mental health conditions that are not related to, for example, depression, which is what they are presenting with.

CHAIR: After the variable conditions, I think you said—was it variable conditions?

Senator O'NEILL: 'Other relevant factors' was the evidence that you gave that seems to be the clause that they rely on.

Ms Cohen: We have not seen insurers necessarily rely on 'other relevant factors' specifically in the claims that we act on on behalf of clients. That part of the exemption in the act only comes in if insurers say that they do not have the actuarial and statistical data that they can rely on. The first test is that they can rely on actuarial and statistical data and all other relevant factors. If there is no actuarial and statistical data then they can only rely on other relevant factors, but we have not had insurers in the life industry in the claims that we are conciliating on behalf of our clients say that there is no actuarial or statistical data. But we have seen the kind of actuarial and statistical data that is presented to us, and we do not think that it reasonably supports the decisions that they are making.

Mr VAN MANEN: Thank you for your opening statement and for your submission to the inquiry. I would like to dig into this a little bit more in terms of the type of policies and the avenue through which your clients have been applying for insurance or the avenues through which they are making a claim and those claims have been denied because of purported nondisclosure. Do you have any statistics on the three main avenues of obtaining insurance such as on a direct basis, where they just ring up a company that advertises on TV or through the newspaper? Obviously group life is a key one with people with superannuation. Or there is the case where they have used a financial adviser and had policies knocked back. Can you give any indication of those hundred-odd people that you have assisted in this particular area? What was the break-down of those three avenues of obtaining insurance, particularly life and TPD income protection?

Ms Cohen: The life products, which include TPD income protection, we have not actually kept statistical data on the exact proportion, but we can say anecdotally that roughly 50 per cent of people apply directly and the other half have obtained the policies through a broker or through their superannuation provider. If you would like further details on the exact proportion, we could take that on notice.

Mr VAN MANEN: I am happy for you to, but that gives us a good guide which goes to some of the other testimony that we have heard, which is that a lot of these issues are arising in the direct space and in the group life space and less so in the other one.

More importantly, from the perspective of the individual consumer who is relying on this insurance, what additional impacts are you seeing on their mental health or their health more generally as a result of them either not being able to obtain cover or, in the event that they go to claim in good faith because they believe they have got cover, being knocked back? What are you seeing are the longer term effects on your clients as a result of that conduct by the insurance companies?

Ms Cohen: We have not analysed the effects on their mental health, if there are any in particular circumstances, because that is not our area of expertise and we have not had a claim where we have had to do that.
to assess damages for our client, but we do take instructions from our client that suggest that they feel hurt, distress and humiliation as a result of the discrimination that they have experienced, particularly where they have never been diagnosed with a mental health condition before and that condition is imputed from notes that are taken on medical records to say that someone is feeling stressed or low.

Mr VAN MANEN: What is the response from the insurance companies in respect of your advocacy on behalf of those clients? Has your advocacy on behalf of those clients succeeded in particular in their claims where they are applying their pre-existing condition as a reason for denying a claim in the first place? Have you had success in managing those claims for your clients? Do they end up getting a pay-out?

Ms Goodstone: Our experience has varied, but, where people's legal challenge is meritorious, the time varies to convince each insurance company but we are managing to get great outcomes for clients where we can put the insurance company to proof: 'Where is your actuarial data?' We can then be provided with the data and be able to point out, for example, that that article relates to a different cohort that our client does not fit into: our client is a woman and the actuarial data they are providing relates to men or the age group is different or it is not relevant or for this reason. So, where we can poke holes in the data that they are providing, we are getting good results in getting people insurance, and also in narrowing mental health exclusions that are unreasonably broad.

Mr VAN MANEN: My final question is around cost. One of my concerns with this is that, in the event that you are successful in getting a claim paid—obviously you guys need to be paid for the work that you do, so the fact that the insurance company is not initially paying the claim on the basis of a pre-existing condition is incurring additional costs to life insured to get that claim rectified—it is another way that the value of their insurance policy or their super fund is being eroded. As a ballpark, what are the sorts of costs your clients would be looking at for you to manage insurance claims on their behalf because of the conduct of an insurance company?

Ms Goodstone: We do not recover our full costs from our clients, because we do not want to leave them with nothing in the hand and we believe that it is worth us putting our resources towards this as a public interest issue and trying to achieve systemic change. In some instances, it would not be worth some claimants engaging legal services, because the value of their claim might not be large enough to cover their legal expenses. So, that is unfortunate. But resolving someone's insurance matter can take anywhere from one day's worth of resources to four weeks or five weeks of full-time resources. It just really depends on the matter and the attitude of the insurance company—how far we need to go. Sometimes we are resolving it via correspondence. Sometimes we are having to lodge complaints with discrimination bodies or with FOS. I think that is probably the range.

Ms Cohen: And the kinds of costs we will seek from our client will depend on the value of their claim and their ability to pay costs to us. But, as Alexis has said, in most circumstances it is a negligible amount of the real legal costs.

Mr VAN MANEN: It is still at the end of the day an erosion of the benefit.

Ms Cohen: We are seeing insurance companies engage solicitors in-house or external to defend the claim, so they are obviously incurring costs.

Mr VAN MANEN: As well. Okay. Thank you. Thanks, Chair.

CHAIR: Senator Williams.

Senator WILLIAMS: Thanks, Chair. Thank you, ladies, for your presence this morning. With the TPD and the insurance, Ms Cohen, imagine I was a shearer and I have had years of shearing sheep and I have got a destroyed back. I have had operations. At the age of 50 I think I want to take some life insurance out. I am going through a financial planner not direct or through my group insurance. That insurance company says, 'Look, we'll give you insurance, but we're not going to cover you for your back'. Would that be fair enough? They look at the history—and I have a couple of problems here. One is that direct insurance just say, 'Here, you've got your premium done over the phone. You're a nonsmoker. You're 42 years old. You're done.' Until they check into your history to pay you, and they say, 'We're not paying you because you've got a history of shearing sheep and your back has been destroyed and you've had this operation and you've been to this chiropractor 100 times,' and so on. So what is wrong with an insurance company saying, 'Yes, we will give you life insurance, but we are not going to cover your back for TPD or loss of income or income replacement'?

Ms Cohen: It sounds like there is absolutely nothing wrong with that, because the exclusion they are providing sounds like it is proportionate to the symptoms and the condition with which you have been diagnosed. And that is a different situation to what we are seeing in mental health, unfortunately. So with—

Senator WILLIAMS: How is it different? For example, I go to the financial planner—Bert van Manen, one of the great financial planners of Australia—and he goes through my questions and health as he checks me all out,
and he says, 'Have you had any mental health issues?' And I say, 'Look, I've had it for decades. I've been on medication', and so on. And that company does not cover me for mental health. How is that different?

Ms Goodstone: I think maybe an analogy is whether you would think it is reasonable that because you have a back injury they would also put on an exemption for cancer.

Senator WILLIAMS: No. That would be totally unreasonable.

Ms Goodstone: Because the conditions are unrelated. So then the question becomes: in the mental health space, is it all right to lump all mental health illnesses in together? Does the medical evidence show that if you have depression you might have an increased risk of developing anxiety? The question is: do you really have an increased risk of developing schizophrenia or psychosis? Also, if your depression was 10 years ago and it related to a marriage breakdown or a death in the family—so it was kind of based on a situation that arose in your life; so it was situational—

Senator WILLIAMS: You make a good point.

Ms Goodstone: So, 10 years later, what is the real risk of you developing, say, schizophrenia or psychosis or anxiety or depression?

Senator WILLIAMS: If I was stressed out because of a death in the family, and then 10 years later I have some other mental issue, then that gives the insurance company an out not to pay me.

Ms Goodstone: Yes.

Ms Cohen: We are definitely seeing situations very similar to that.

Ms Goodstone: So clients just disclosing, for example, that they went to counselling or that they reported to their doctor that they were fatigued or distressed by something, can unfortunately lead to these perverse situations where people are denied insurance. The decisions have to be commensurate with the real risk involved, and that is where the data should come in.

Mr VAN MANEN: But, because they are being underwritten at the time of claim, this is not being picked up until people go to claim.

Ms Goodstone: Yes.

Mr VAN MANEN: Whereas, in an advice situation, as Senator Williams has outlined, a lot of that would be picked up in all the medical questions that are asked—

Senator WILLIAMS: In the examination, yes.

Mr VAN MANEN: in the initial application, because it is underwritten at time of application. And, once it is underwritten at time of application, provided you have exceeded your three-year period if there is something you have missed, you are guaranteed cover. That is the difference. So it is the direct and group life again that are raising these issues.

Ms Cohen: And we are seeing that in the application process. A person might be asked whether or not they have ever suffered from anxiety, whether they have ever seen a counsellor, and then that application will be automatically processed according to underwriting guidelines, and the individual is not given an opportunity—before a decision is made to decline a policy or offer a condition that is unreasonable on the policy—for them to provide further information. So insurers are not making the necessary inquiries to distinguish between different kinds and severities of mental health conditions.

Mr VAN MANEN: I would say—

CHAIR: Can I just interrupt there because I want to put some other questions down here at this end.

Senator WILLIAMS: But I might have another one as well. I have lost the

CHAIR: There is limited time—

Mr FALINSKI: Is every insurance company doing this?

Senator WILLIAMS: I only get one question, do I?

CHAIR: You had three.

Senator WILLIAMS: I did not. I had one.

Mr FALINSKI: It just seems like one when it is from you.

Senator WILLIAMS: Let's call a private meeting.

Ms Goodstone: We are certainly seeing a range of respondents and a range of insurers engaged in these practices.
Mr FALINSKI: So, as Senator Williams and Mr van Manen are pointing out, what is stopping someone—if they have been declined by one insurance company or if an insurance company has indicated they will not cover certain symptoms—just shopping around?

Ms Goodstone: Certainly, consumers can do that; although, we all know if you are declined, you have to disclose that. If your next insurer asks you, 'Have you been declined insurance?', you have to disclose that. So that is a red flag to a bull.

Ms Cohen: People are shopping around without success.

Ms Goodstone: Yes.

Ms Cohen: So they are getting the same problems from a number of insurers.

Mr FALINSKI: You are saying that, and that is important. Is that universal or is that just anecdotal? That is the experience you are seeing?

Ms Cohen: That is the experience that we are seeing. I would say that more often than not people are coming to us—if there has been a decline, people are coming to us to try to remedy that as soon as possible, because of the significance of having to disclose later on that you have had a policy declined.

Mr FALINSKI: I get that. But that is a bit different to the question I am asking. You are having people come to you saying that no insurance company will cover them? Or you are having people once they have been declined by one insurance company?

Ms Cohen: We have both of those situations that arise. Yes.

Mr FALINSKI: Okay.

Senator KETTER: Are there particular companies that are worse at declining or treating people with mental illness? Are you prepared to name names? Alternatively, are you able to tell us companies that are doing the right thing?

Ms Cohen: Unfortunately, we are not able to say companies that are doing the right thing because we do not see those companies come through our door. In terms of who is worse and who is making the worst decisions, we have not collected that data.

Ms Goodstone: I do not think we are confident enough to name at this stage.

CHAIR: Senator O'Neill.

Senator O'NEILL: Thanks, Chair. One of the things that we have heard in the course of our hearings this week is that there is one company, which was named in Melbourne—MLC—that has a blanket exclusion for young men aged 22 to 44. They cannot get a policy from MLC; there is a blanket exclusion for mental health. Is that your experience? Can you verify that?

Ms Goodstone: We have not seen that particular policy.

Senator O'NEILL: We will follow up on that. Could I ask you to name the insurance companies that you have had to make claims with for your clients?

Ms Cohen: If we could take that question on notice.

Senator O'NEILL: That would be great. We would like to get an idea.

Ms Goodstone: In case we forget someone!

Senator O'NEILL: Exactly. Name them all as carefully as you can, because of course they come and give evidence to us. They speak to us and tell us that there is no problem here. I am very impressed by your submission to us. Thank you very much for the clarity of your recommendations. You spoke about the imputation of a mental health condition. I think it would shock a lot of people that, if you have been stressed at any point in time, without a doctor's say-so the insurer decides that you have a mental health condition and therefore they are not going to pay out your claim. Is that really happening?

Ms Goodstone: It is really happening, yes.

Ms Cohen: Or people are getting general, broad mental health exclusion clauses placed on their policy, which they come to us about because it seems so unreasonable.

Ms Goodstone: At time of application, we are seeing it where it is a symptom, it is low level, and they are being slapped with a proper mental health exclusion, even though there is no proper diagnosis. I think what you are talking about is that, at claim time, insurance companies are looking back and seeing just symptoms of fatigue or an applicant says to the doctor, 'I feel stressed.' There has been no diagnosis but the insurance companies are saying, 'No, no; you had an obligation to disclose that,' even though the question on the application form said:
'Have you been diagnosed with depression, anxiety' et cetera. So there is that issue of: does the duty to disclose include symptoms or those things that we are talking about like 'I'm feeling stressed' et cetera, or does it just include you having been diagnosed and your doctor has actually said to you, 'You've got depression,' or 'You've got anxiety.'

Senator O'NEILL: At the time insurance is being sought and at the time of claim are two different things, and we are hearing about the concerns there, but you just indicated that there is a problem at both points. There is a problem at the point of application, for instance, if you say that you have got stress at all then it could be the case that you are told, 'Well, there'll be no mental health cover for, thank you very much.'

Ms Cohen: That is correct.

Senator O'NEILL: Then there is the other problem, because people are buying insurance and it is not underwritten at the time of insurance, and then afterwards they become unwell and that same problem emerges but perhaps at a more critical moment.

Ms Goodstone: Yes. To show you another example, it could be that an insured gets cancer, seeks to claim on their policy and then the insurer goes back into their medical records and finds some kind of mental health concern there and says, 'Hang on, you didn't disclose that you had depression so we are now going to avoid the policy, even though what you are claiming for now is cancer.'

Senator O'NEILL: That's outrageous.

Ms Goodstone: Yes. And the law allows them to do that if they can establish it was a genuine nondisclosure, and that is because of the changes to section 29 of the Insurance Contracts Act, which were made recently and which we think should be changed back to the previous situation, which would be that, if it is an unrelated issue, you cannot rely on that nondisclosure to not pay the claim.

Senator O'NEILL: You make a recommendation about that, as I recall.

Ms Goodstone: We do.

Ms Cohen: The recommendation is that the amendments that came in 2014 be reversed.

Senator O'NEILL: Is that recommendation 5?

Ms Cohen: It is recommendation 6.

Mr VAN MANEN: Can I just clarify: if the policy is underwritten at time of application and you have passed the three-year period then you are right. It is only if it is a direct or a group life policy where it is being underwritten at time of claim that that is an issue. Correct?

CHAIR: You can take that one on notice.

Ms Cohen: We will take that one on notice as well.

Senator O'NEILL: That is federal legislation—


Senator O'NEILL: that needs to have that amendment to it. Do you know anything of the background? Can you take on notice the background of that, how it came about. We would be interested to know what the industry and what your sector have to say about that.

Ms Cohen: Sure.

Senator O'NEILL: You make a recommendation about varying the policy, which is going to the 'reasonableness', I think, that Senator Williams has been talking about, that people should be offered a variation on the policy. So if you have had a period of depression that it would be excluded, that you would be covered for depression going forward, and for other illness that you might be insured.

Ms Goodstone: That is right, and in the situation I am talking about where you develop cancer and they are looking back and saying, 'Hang on, You did not disclose at the time that you had depression.' Instead of avoiding the policy, we say that the policy should be varied to then put on an appropriate mental health exclusion but continue your policy and pay your claim relating to cancer.

Ms Cohen: Under the Insurance Contracts Act insurers can vary a policy at any time.

Senator O'NEILL: I want to take you to recommendation 9, which is another recommendation for amendment. Can you flesh that out a little? This is the writing of responses. You believe that this needs to be dealt with legislatively?

Ms Goodstone: Yes. We have laws to protect people from being discriminated against, but we are seeing that insurance companies are not necessarily complying with the laws, so it is about compliance. You have a little
individual with not many resources and knowledge about their rights and what is going on and you have a big insurance company with access to the actuarial data and everything like that. If we want to increase people's ability to understand their rights and to get good sound insurance policies, we need to have insurance policies making better, more transparent decisions so that individuals know why they are being denied insurance or why a mental health exclusion is being put on their policy. This is about trying to make sure that insurers provide proper reasons for their decisions and that they explain on what basis they have made their decision so that people can then, for example, seek advice about whether that is a reasonable decision or whether that can be challenged under antidiscrimination law.

**Ms Cohen:** We find it very difficult and our clients find it very difficult in circumstances to get written reasons. We do not see that that provision of section 75 is complied with very well and even when written reasons are provided they are so general—it may say 'based on your medical history' or 'based on your mental health' and not go further into what part of that medical history or mental health the insurance company has relied on and why they have made that decision.

**Senator O'NEILL:** Given the digital capacity to have all documentation available and for people to be able to just click on things, are there any exemplars of good practice where a person's application, the process that is being undertaken and all the information that is going in is transparently available to them? Who could be more interested in what is in there than the person whose claim is advancing?

**Ms Cohen:** Not that we are aware of.

**Senator O'NEILL:** There is no one who provides access to all the information about that person?

**Ms Cohen:** Not in the claims we have seen.

**Senator WILLIAMS:** I think in about 2014 there was a class action against the reinsurer Munich. Were you involved in that?

**Ms Cohen:** No.

**Senator WILLIAMS:** I do not know if any result came out of one of the issues. I am informed that, once mental health discrimination occurs by one insurer, that client is blacklisted by all insurers for life. Do you know anything about that?

**Ms Cohen:** I do not know anything about that but we do know that they would have to disclose that they have been declined and that could have an impact—

**Senator WILLIAMS:** No doubt the insurance companies talk to each other as well. You would think they would have a quiet beer on a Friday night or something at the end of the week's work.

**CHAIR:** What are you insinuating?

**Senator WILLIAMS:** I am just thinking that there would be some communication—

**Senator O'NEILL:** That they drink beer instead of wine!

**Senator WILLIAMS:** I want to take you to the life insurance code of conduct that has been drawn up by the Financial Services Council. Have you been involved in that?

**Ms Cohen:** We made submissions to the Financial Services Council about what should be included in the code. That is reflected in recommendation 2.

**Senator WILLIAMS:** Do you know when that code is going to be finalised?

**Ms Cohen:** The first iteration of the code was released I think at the end of last year.

**Senator WILLIAMS:** The first draft.

**Ms Cohen:** We were disappointed because it does not deal with mental health and the submissions we made prior to the release of that code as part of the consultation process were not taken into account. We have been advised that there will be a second iteration of the code that will include mental health and that that could take up to 18 months to be released. We certainly were disappointed that mental health was not included in the first iteration of the code because the submissions that we made to the Financial Services Council are the same or very similar to those that are in this submission and they had that before them at the time when they were releasing the first code.

**Senator WILLIAMS:** If the voluntary code drawn up by the FSC is not suitable or not good enough, would you support a mandatory code drawn up by the government?

**Ms Cohen:** It would depend on the process that is undertaken, because there needs to be—

**Senator WILLIAMS:** There would be a lot of consultation for sure.
Ms Cohen: consultation, and the content of that code as well.

Senator KETTER: Is there a standardised definition of 'mental health' that you would find useful, or is there one out there?

Ms Cohen: We are not medical practitioners, so we are not best placed to answer that question, but we understand that there are documents that medical practitioners rely on.

Senator KETTER: What about the insurance companies?

Ms Goodstone: When they exclude mental health, they tend to name a whole string of illnesses and categories of illnesses that are excluded rather than use the term 'mental health', if that answers your question in another way.

Senator KETTER: But you mentioned that there was an exclusion for minor depression in one case.

Ms Goodstone: Are you asking where does that definition, for example, come from?

Senator KETTER: Yes.

Ms Goodstone: The DSM.

Ms Cohen: The Diagnostic and Statistical Manual of Mental Disorders.

Ms Goodstone: A medical manual that defines different mental illnesses. They are the definitions that I understand insurers use.

Ms Cohen: From what we see, as Alexis said, insurers are defining mental health very broadly, because we see the claims denied for reasons including minor anxiety, minor depression and so forth, and symptoms.

Senator KETTER: Is there work being done to clarify the definition, to where it ends and begins?

Ms Goodstone: Not by us at this stage.

Senator O’NEILL: And in the meantime you had better not ever tell anybody you are stressed, especially your doctor.

Ms Goodstone: That is the other by-product of this situation. People are consciously not even seeking mental health assistance, so that it is not on their record. It is not just a question of not disclosing it. Your insurance company can eventually seek access to all of your medical records when you make a claim. So it is not just not talking about it; it is actually not doing it. It is preventing some people from getting that on their record at all, by not seeking assistance when they need mental health support.

Senator O’NEILL: That backs up the evidence that we got in Melbourne. That is a very significant problem. The government is investing millions of dollars in encouraging people to undertake health-seeking behaviours, to go and seek intervention early, particularly around mental health, and the flowback from the insurance company is that it is deterring people from seeking that help. That is a very big problem.

Ms Goodstone: It is.

CHAIR: We have just about come to the end. I am going to pull rank and ask the last question. Do you think, if an insurance company came to some of your clients and said, 'If you get cancer we're not going to insure you because you went and saw a consultant 25 years ago,' they would still pay the premiums?

Ms Goodstone: I think the answer is no.

Senator O’NEILL: I will put some more questions on notice. I particularly wanted to talk about human rights matters and the apparent abuse of data that you talked about, such as deliberately using statistics for men to deny a claim for a woman. That is pretty outrageous.

CHAIR: Answers to questions taken on notice, which you have just been told you are going to get, should be provided by 17 March 2017 to the secretariat. I think we had some previous ones. We thank you for attending the hearing and for your evidence today. We do appreciate your cooperation and your submission as well.
KIRKLAND, Mr Alan, Chief Executive Officer, CHOICE

O’HALLORAN, Mr Xavier, Policy and Campaigns Adviser, CHOICE

[09:44]

CHAIR: I remind committee members and witnesses that, while this is a public hearing, care should be taken to protect the privacy of individuals and that arguments should be made without naming individuals. I now invite you to make a short opening statement, and at the conclusion of your remarks, I will invite members of the committee to put questions to you.

Mr Kirkland: In opening our comments to the committee today, I would say that life insurance is not like any other product. CHOICE is involved in looking at products across a range of product and service markets, and life insurance stands out from all of them for a number of reasons. It has some special features that require special treatment in order to protect consumers. One of those features is that it is a kind of credence product. The consumer cannot assess its value, or features of the benefits to the consumer, at the point of purchase. Its value only becomes evident upon the consumer’s death.

This brings into play another special feature of life insurance: that claimants upon life insurance policies are, by definition, extremely vulnerable. The right to claim comes about as a result of a death, which usually swamps surviving dependants with a whole range of complex decisions that they have never encountered before, not to mention the emotional impact of having lost a loved one. This raises the third feature I would highlight, which is the fact that claiming life insurance is a one-off event. Consumers have no learnt experience about how to navigate the system, and so, when they hit a system that is foreign and that alienates them, it is even more bewildering. All of these features mean that consumers need special protection when it comes to life insurance.

Even if you set those issues aside and take a pure economic perspective on life insurance, the other thing that is remarkable about it is that the information asymmetry is extreme compared to other types of products, due to the length of policies and complexity of the concepts and terms that are embedded within them. This creates a massive power imbalance between consumers and insurers.

How do we address some of these deep and serious problems? At the moment, the way we are trying to address information asymmetry is through product disclosure statements that stretch to hundreds of pages, and are quite often not even provided to the consumer at the point of purchase. This is a perverse response to that problem. We need to instead look at measures like better disclosure; not just lengthy up-front disclosure, but learning from the best of behavioural economics to recognise that consumers do not behave rationally. The best way to respond to that is through communication that is relevant, point in time and based on testing what is most effective at driving consumer responses in their own interests; and communication about important product features and issues that consumers should be considering throughout the life cycle of the product, not just up-front.

That has to start from the point of sale, where the information at the moment is currently next to useless, and it needs to continue through the life cycle, responding to key triggers in that life cycle, such as premiums ceasing to be paid. That better disclosure has to be supported by better digital tools, which are a key way to reduce information asymmetry. There are digital tools at the moment, but they are virtually all provided by insurers that are operating in their own interests and are unable to provide good market comparisons for consumers. So better digital tools mean we need to have better information available for third parties trying to help consumers.

There are obviously some issues specifically about life insurance within super. Consumers often do not even know that they have got it; even worse, they often have multiple policies that they do not know that they have got that are eroding their super balances. But within super, conversely, there are even more points to engage with consumers. Super funds are already communicating regularly with consumers and have rich access to data that would help them act to better engage consumers in thinking about what life insurance they have, and how they should better manage it.

Two final points: one, which is perhaps one of the most important ones we would make to the committee today, is that protection from unfair contract terms is even more important in life insurance than in any other market. Consumers are currently protected from unfair contract terms in a gym contract, but not in a life insurance contract, and there is no justification for this. Practices such as relying on outdated or unfair medical definitions, or exclusions that mean that the average consumer would not get cover for a condition, for which cover is purported to be provided, would face much greater scrutiny if consumers had protection from unfair contract terms in insurance, as they do for every other product and service in the Australian market.

Insurance is the only product that has a carveout from protections against unfair contract terms, and insurers—particularly life insurers—have demonstrated that they do not deserve that special carveout. So that would be the
most important message that we would leave with the committee today: there has to be an end to unfair contract terms in insurance.

One final point is that we have to talk about conflictual remuneration. We welcome the government's recent changes to reduce commissions in life insurance but the evidence is clear: when people are paid to push products, the more they sell the more money they make. That produces bad outcomes for insurers. We need to see the recent reforms as a first step and recognise that consumers will not be fully protected until we have completely removed conflicted remuneration from financial services, and particularly life insurance.

CHAIR: Thank you, Mr Kirkland, for your opening remarks. On that last issue you raised: who sets the commissions? It is not the financial advisers; it is the insurance companies who set the commissions, isn't it?

Mr Kirkland: In a way it is not an issue that concerns us. What we really—

CHAIR: But you just raised it, and so—

Mr Kirkland: Who sets the commissions is, respectfully, not an important question in our view. What we are interested in is the behaviour that is being driven. If the behaviour is that people are receiving products that do not meet their best interests as a result of the way in which remuneration drives behaviour and encourages intermediaries to push particular types of products, that is what we are concerned about. We do not think you can fix that without removing conflictual remuneration. The government's recent legislation is a really good step in reducing the risk to consumers.

Mr VAN MANEN: I find your point interesting, given my personal experience in the industry prior to entry into parliament. I do not know any bad advisers—and there are exceptions in the industry, I take that on notice—but equally there are bad accountants and solicitors. New Zealand went through almost exactly the same process we have been through, yet commissions for advisers in New Zealand are closer to 200 per cent of the first year's premium and they came to a completely different conclusion. No-one yet has demonstrated and none of the reports have demonstrated how changing the remuneration structure is going to produce a benefit for the consumer.

If you have a look at the ASIC report, particularly report 498 on claims experience, it clearly demonstrates that those people who have life insurance and who have an adviser involved as their advocate have the best outcomes at time of claim. All the testimony we have heard this morning and on Wednesday clearly demonstrates that is the people who have group life get insurance on a direct basis—bearing in mind that in group life none of the commissions or other payments back to the super funds are disclosed in any manner. I note with great interest that CHOICE has made no comment or public statements about that whatsoever. Why are you taking one position without any demonstration of public benefit when the report showed that the public benefit is actually to have an adviser? Why are you demonising one section of the industry that has demonstrated that it provides the best long-term service to lives insured?

The other important aspect of this is: in the event of claim, advisers very rarely charge their clients for claim because the commission they are paid up-front in the longer term provides the revenue to pay for that claim's management process. Yet we have seen over the past few days any number of representatives from the legal industry here testify that they have built their business on assisting people with insurance claims which enormously erode the final value of the insurance payout that those people receive on a direct and group basis. Yet I have heard CHOICE make no comment about that whatsoever. I know it is a long statement—

CHAIR: It is very long.

Mr VAN MANEN: and there were a few points in there—

Senator O'NEILL: Do you agree?

Mr Kirkland: I am very happy to respond to that. It is a useful introduction to the issue. It is a complex issue and we do recognise that the claims process is really difficult to negotiate. In an ideal world consumers probably can never negotiate by themselves, and so you would have trusted intermediaries to help consumers but without some of the risks that sometimes come with that. Indeed, sometimes significant legal fees can be a risk to consumers, although bodies like PIAC, who were here earlier, help to manage some of that risk. If there were more of them, it would be less of an issue.

Mr VAN MANEN: Your actual policy position is going to push more people into that model rather than inspire discussion.

CHAIR: We do not want to have a discussion.

Mr Kirkland: I am trying to answer the question. But I guess the issue around claims experience is different to the issue of whether people are paying out money through premiums or through eroded super balances for
products that are not going to meet their needs. That is, in our view, the greater concern because it potentially impacts a much greater number of consumers, so it has to be given significant weight. Obviously we need to find solutions that are right for each market.

Mr VAN MANEN: I do not disagree with that; I agree with it.

Mr Kirkland: Which highlights the complexity of the issue, I think. We need to find solutions that are right for each market. But, in terms of Choice's general policy position, whenever we, or bodies like ASIC, have looked at conflicted remuneration, we have certainly not said the entire industry is broken or sick or behaving badly for consumers, but we have said that there are significant risks shown by the empirical evidence.

So, on financial advice, some years back we did a shadow shop that showed that conflicted remuneration was leading to very poor outcomes for significant numbers of consumers in financial advice. ASIC then did a follow-up shadow shop, and that led to significant reform, which ultimately had bipartisan support. In mortgage broking, Choice did a similar shadow shop several years ago and found similar issues. We believe similar issues, through a different methodology, are borne out in the ASIC life insurance report. The common theme for us is that conflicting remuneration creates significant risks for consumers, and we believe in the long term it really does need to be removed from financial services in order to ensure that consumers are adequately protected.

Mr FALINSKI: Thank you for coming today, Mr Kirkland. You mentioned that there are a lot of comparisons in the marketplace between life insurance. While I could not do it during your testimony, because it was so compelling, I did Google it after you had finished and noticed that, just on my phone, there are five websites that compare different life insurance policies that you can get. They are not adequate in your view?

Mr Kirkland: Choice has published quite a lot of material on some of the challenges with current comparison models.

Mr FALINSKI: Indeed. I was about to say one of the websites was yours.

Mr Kirkland: We would say that we generally fail in producing useful comparison of life insurance for consumers because it is very difficult to do. If we, as an organisation that has considerable expertise in comparing financial products, cannot do it—we can do it for health insurance. And just to explain why we can do it for health insurance: it is because there are quite detailed disclosure requirements about how information on policies is produced, which means that intermediaries like us can actually genuinely go out and compare the market and provide useful tools to help consumers. You cannot do that in life insurance.

There is a lot of the discussion that the government is leading at the moment about greater sharing of data and greater release of information to help drive more competition, in financial markets in particular. We think that insurers need to release more information. They need to give more information to consumers themselves, so they are being more proactive about trying to help consumers up-front, but they also need to release more information to help intermediaries help consumers by doing genuine product-on-product comparison.

Mr FALINSKI: Is one of the problems that people's life circumstances are all very different and these policies are tailored to each individual's circumstances?

Mr Kirkland: I would not say they are all tailored. I guess if it is an underwritten product, then individual circumstances are considered in the underwriting process, but they are generally products for a category of people like most insurance products. Some of the problems I mentioned at the beginning are: the fact that it is not a product that most consumers ever engage with, let alone more than once in their lives; they are doing it at a moment of extreme vulnerability; and the information asymmetry. If you compare it, to say, a home insurance product, a health insurance product, a banking product, the information asymmetry is vastly greater when it comes to life insurance.

Mr FALINSKI: Is that asymmetry due to the fact that the information is not available, or it is so dense that it becomes unavailable?

Mr Kirkland: Some of it is inherent in the product. There is always going to be a significant amount of information asymmetry in life insurance, but that is compounded by fact that what information is released is released in forms that are not useful. There is some information that would be very helpful to consumers, like information on the claims payout ratios and behaviour of insurers. That would be of vast value.

Senator KETTER: The previous submitters, the Public Interest Advocacy Centre, talked about each insurer being required to report publicly on the number of policies that it had voided in the past 12 months. With your recommendation that we introduce a key fact sheet that is pushed out to consumers, do you see some merit in that type of information being pushed out—for example, the number of claims avoided and perhaps some information...
about the types of behaviours like, 'If you claim for minor depression, we are likely to exclude you because that is what we have done in the past 12 months'?

Mr Kirkland: Yes. I think, ultimately, our position is that the detail of these sorts of things needs to be tested with consumers to work out what information is most useful and drives the most behaviour. While we have criticised product disclosure statements, it is people like us that helped to create them by saying you need to disclose the details. So we need to get the detail and the way it is communicated right based on actual testing. That is what behavioural economics is all about.

But, to answer your question, in general, some of the information that is provided needs to include the actual claims experience information, because the ASIC report shows there are massive differences in the way in which insurers as a whole are processing claims. There are various reasons for that, but it is information that consumers should have access to at the point of making decisions about whether to take out life insurance.

Senator KETTER: Secondly, Chair, if I could just go to your comments about structuring default death insurance to only commence around the age of 30 under the group insurance situation. Can I just ask what sort of research you have in relation to that. In the interests of full disclosure, I was an alternate director on an industry super fund. I, unfortunately, had to deal with cases where young people were involved in car accidents, and we then had separated parents involved and people making disputed claims as to life insurance. In fact, in some cases you found that those young people were caring for an aged relative. So I am interested in how you have come to that conclusion.

Mr Kirkland: You will note in our submission that we have not made a firm recommendation about what those changes should look like because we think it is a really complex area. But we think that there is probably value in drawing a line somewhere at 30 or below as the point at which default death cover kicks in. I guess you are weighing up the likelihood that it will provide a benefit to the insured party or their dependents versus the risks of them paying out money in premiums and eroded super balances as a result.

We think more work needs to be done in this area. There is some thinking about that is coming through the insurance working group—the working group on insurance within super. I do not think that will come up with the final answers, but it will help to advance the debate. So we really are just flagging it as an area where we think there needs to be change, but that change needs to be very carefully considered.

CHAIR: As all change should be.

Mr Kirkland: Indeed.

Senator KETTER: Okay. Thanks, Chair.

Mr FALINSKI: If I am understanding you properly, which I may not be, this particular product is particularly complex and dense.

Mr Kirkland: Yes.

Mr FALINSKI: Therefore it is probably one product area in which, in relation to professional advice, it is not something you should recommend. It is a bit like: any lawyer that has himself as a client has a fool for a client—that type of thing. In that case, going back to Mr van Manen's questions earlier about commissions and talking about conflicted incentives, are you not worried that some of the recent changes, in particular with up-front payments that can then be clawed back by the insurance company, puts an adviser in the position where, when a better product emerges for their particular client's need, in the back of their mind there will be: 'Well, I actually want to advise them to move to that better product because I will have last year's earnings clawed back by the insurance company'?

Mr Kirkland: I understand the risk that you are describing, but I just do not think the life insurance markets change that quickly. It is an area that tends to move fairly slowly. I think the likelihood of that risk realising—of there being significant changes and a significantly different product appearing within the clawback period—is reasonably low.

Mr FALINSKI: So can I change it around and say: what if your client's circumstances have changed and that then makes them better suited for a different product? Have we created an incentive system in which that now makes it difficult for the adviser?

Mr Kirkland: Theoretically. But I guess what we are weighing up here is competing risks. We are weighing up the evidence around risks to a large class of consumers that comes with conflicted remuneration versus potential risk, as yet unknown, to what would probably be a smaller number of consumers. So, ultimately, we would say, 'Let's try and protect the masses.' That is a more important imperative, given the amount of money that is at stake.
Senator STERLE: On that issue: maybe you can transfer your phone contracts, but you have to pay out—maybe that is an option they should look at. Do you believe that consumers understand the trade-offs being made with respect to their insurance premiums and the ultimate impact on their retirement incomes when their super is used to pay for their insurance?

Mr Kirkland: In general we do not think that consumers do understand the trade-offs that are being made in premiums—whether we are talking about insurance inside or outside super. We think there is poor understanding about the impact of insurance on super balances. The evidence around the number of people who have multiple super funds—and, associated with that, multiple insurance policies—suggests that people do not really understand the interaction between insurance and super. That is obviously a particular issue with income protection, where you are not going to get multiple payouts.

But, as we say in our submission, we do not think the case has been made for getting rid of default group insurance within super. We think there are, at this stage, considerable benefits from that. But we need to optimise it. We need to get it working better for consumers. We think the super system is in a unique position to play a role with that. As I said in the beginning, super funds are communicating regularly with consumers. They know a lot more about consumers than other types of insurers. If we can get them to use some of that data to provide more information that is situationally relevant to consumers—triggering them to think about their insurance and to think about some of the decisions they might need to make—we could get significantly better consumer outcomes.

Mr VAN MANEN: Given about 70 per cent of insurance in this country is written through group insurance, what work are you doing in the space of group insurance to deal with the issues in group insurance that have been recognised over the past couple of days, early this morning and even in your evidence so far?

Mr O’Halloran: We have been working with industry as part of the Insurance in Superannuation Industry Working Group. I am on the governing body of that group. We have been looking at ways for us to better communicate with consumers when they have multiple policies and to streamline the whole process so that, if it is identified that they do have multiple policies, a fund might be able to automatically consolidate them for that consumer—if they ask them in advance and get permission to undertake that work. We think that would probably be one of the most effective ways to reduce duplicate insurance through super and the erosion of balances. As part of that, we are also contributing strongly to looking at how insurance products are designed within superannuation—to make sure they are actually matching member needs. As was raised earlier, there is, for example, the question of whether $200,000 worth of death cover for a 19-year-old is the most appropriate level of insurance for someone who has, in most cases, no dependents.

Senator WILLIAMS: And no mortgage!

Mr O’Halloran: Exactly.

Mr VAN MANEN: I would ask you to consider this in your deliberations on that. One of the points of discussion around group life insurance is the issue of pre-existing conditions. The later in life you get insurance, the higher the risk of you having a pre-existing condition. Even though somebody is 19 and they are getting a reasonably high level of cover—the premium is going to be reasonably cheap—the chances are that they are going to have a much lower risk of having a pre-existing condition. Therefore, at the time of claim, there is going to be less risk that that will get knocked back because of a pre-existing condition. I ask you to consider that in your deliberations on that particular matter.

Mr O’Halloran: I agree. It depends on system design. If people are maintaining a minimum level of group insurance right throughout their life—and that is adjusted over different life stages, which is what the Insurance in Superannuation Working Group is looking at doing—that kind of extra underwriting that might happen later if they did apply for insurance at a later date, when the pre-existing condition might exist, would not necessarily be a guiding factor. They would still have a level of insurance, which would be great.

Senator O’NEILL: One of the key points you made was about protection from unfair contractors. Can you give us a bit of a history of how we ended up with this carve-out for the industry? Are you aware of that?

Mr Kirkland: When the protection against unfair contract terms was introduced as part of the Australian Consumer Law and applied to financial services products as well, the insurance industry argued quite powerfully that it was special and that it should not be covered. Those arguments were ultimately successful. The argument from the insurance industry is that there is an obligation of utmost good faith in the Insurance Contracts Act, and they say it delivers the same thing.

Senator O’NEILL: Yes, we heard about that in Melbourne. It does not look like it is working.
Mr Kirkland: No, and it is by no means the same. It is very clearly not the same. It tends to go more to conduct and how insurers behave than to the actual terms of policies. I will just go back to what I said at the beginning: there are actually much stronger arguments to apply unfair contract terms protections in insurance, and particularly life insurance, than in many other goods and services where they already apply. There are strong economic arguments for actually having consistent law that applies across product and service markets. It has been reviewed several times by government agencies and there have been multiple recommendations that this problem be fixed. We actually think it could go to the heart of some of the cultural problems in the insurance industry in terms of the conduct they consider acceptable and how they treat consumers.

Senator O'NEILL: So it would lift the bar for those who are not compliant?

Mr Kirkland: It would definitely lift the bar, and we think it would have an impact on some of those issues that we are dealing with in a scrappy, issue-by-issue ad hoc way—in silos, if you like—such as some of the mental health issues. Some of the issues around how particular medical conditions are treated would actually be addressed by a general protection against unfair contract terms.

Senator O'NEILL: You spoke about the life insurance code of practice. I am assuming you were in the room when we heard the evidence from the previous witnesses around—

Unidentified speaker: I do not think they were.

Senator O'NEILL: You were not here?

Mr Kirkland: Not for all of it, no.

Senator O'NEILL: Just towards the end they indicated that they had been part of a consultation process. I know consultation processes are not the perfect solution for devising perfection heading forward, but I think their articulation of a massive gap with regard to attending to mental health in the current code is an alarm about the nature of the way these things are cobbled together. As an advocate body, do you have any views about the mental health dimensions of the code of practice? I ask that because you have a recommendation here around—

I would say, because we are active across a range of markets—although it is a very different product—that the other area where we see these sorts of exclusions around mental health in insurance is in travel insurance, which always does a lot of work. We used to have arguments that it is impossible to provide cover for people with mental health conditions in travel insurance. That is no longer the case. We have major insurers who are actually offering policies for people with mental health conditions. Obviously they have been able to access the actuarial data that gives them the confidence that they can offer those policies while still turning a profit. We really challenge some of the arguments that are made by the industry that it is just too hard.

Senator O'NEILL: Are you able to name those good providers of that service? We do want this to turn into an insurance-bashing event, but there are people who seem to be doing good things and there are others who may not. Who is doing the good things in the travel insurance space?

Mr Kirkland: We will provide those on notice to make sure I have it right, but CHOICE has certainly reviewed a range of travel insurance policies. We have produced clear guidance on some of the policies that do actually offer cover for mental health conditions. Some of them are offered by major insurers, but we are happy to provide that on notice.

Senator O'NEILL: Thank you very much. Could I ask if you are aware of blanket exclusions of mental health within the insurance industry? Are consumers speaking to you about this problem that was well argued for in the first submission today?

Mr Kirkland: Obviously PIAC has significantly more expertise from its casework in this area. We have seen more around the application of mental health exclusions in relation to travel insurance, which is where we tend to do more work, but we see similar issues to the sorts of problems that PIAC disclosed where, again, it is the interaction between the information asymmetry and the foreignness of the system and these mental health issues that causes the problems. When consumers are asked about pre-existing conditions, it is in no way obvious to them that they should be disclosing—if, indeed, they remember—that they once saw a doctor for insomnia or
stress and that this might, in fact, mean that way down the track the policy they have been paying for all these years is not going to be of any benefit to them.

Senator O'NEILL: You are hearing that? Is that increasing?

Mr Kirkland: We certainly see those issues in our work, more in travel insurance than in life insurance. But it is basically the same problem.

Senator O'NEILL: With regard to income protection insurance, do you have any evidence that would be useful for the committee to hear? Are you hearing anything about that space?

Mr Kirkland: We are not hearing directly from consumers on many of those issues, but I am aware that, particularly for group insurance, about half the funds are selling income protection as part of their default superannuation offer. Given that around 43 per cent of consumers have multiple accounts, they are potentially racking up multiple income protection policies, and they cannot claim against two of them, so they are essentially paying for useless policies. I think, again, this is something that has been flagged with the life insurance in super working group, and they are developing options that might be able to solve that. But, at the end of the day, whatever is created out of that group, it is really importantly that we have an enforceable code that consumers can trust. The key part of that will be getting it registered with ASIC. We think that is a really important step that needs to be taken.

Senator O'NEILL: Thank you.

CHAIR: My understanding is that Choice covers many aspects of industry. What level would the life industry be on your radar from your customers? Is it a thing that you have to deal with daily from people ringing in or are there other issues that are bigger that cross your desk?

Mr Kirkland: We do not get a high volume of complaints about life insurance, but that reflects the characteristics of the product. While many people may have life insurance, there is a much smaller number of people who ever have to claim upon it. The low incidence does not necessarily indicate the level of risk. If people are paying out premiums for a product that is never going to be of benefit to them, they do not know to complain about that, so we do not necessarily see that in our work.

CHAIR: So what is the hot topic coming across your desk?

Mr Kirkland: In general, it would be consumer guarantee issues—consumers buying a product that does not do what is says on the label or does not do what the salesperson said. That is essentially one of the things at the heart of life insurance.

CHAIR: A bit like the life insurance industry. If you were going to suggest to the life industry how they could make things clearer to their customers, what would be the process? Would you tell them to provide a basic life insurance policy and say, 'If you want to be covered for this, add it in', so that people actually know what they are buying?

Mr Kirkland: What you have described is very similar to what we are talking about in terms of key fact sheets—that is, simple ways of expressing the core and most important aspects of a policy. Based on research and testing about what is most important to consumers, that would be an important change. The other one would be communicating more regularly and more meaningfully with customers. To give you an example drawn from general insurance, somebody said to me the other day, 'I have just noticed that my car insurer sends me a text message to say it is about to hail. Did you know that?' That is a very different type of product, but life insurers do not think about their customers in those types of ways or think, 'What do we know about this person that means there might be some reason we should communicate with them to get them to remember that they have this product?' and 'Maybe our customer should be thinking about taking some action that would protect their best interests.' Taking that more proactive, consumer centred approach to communication would be a big and valuable change.

CHAIR: You are saying that they are not customer focused?

Mr Kirkland: We do not believe that life insurers are customer focused, and that is one of the big things that needs to change.

Senator O'NEILL: On the information inequities that you describe, or the power differentials sometimes, given the capacity of modern digital interactions for all documents to be available to both the insurer and the person who is insured as they negotiate the process for timelines to be clearly indicated, is there any insurer that you know of that is operating in that model of best practice?

Mr Kirkland: Not that we are aware of—

O'Halloran: You are talking about in terms of at the point of sale—
Senator O'NEILL: Who should I get my insurance with if I want to be confident that I am going to see the whole process clearly, that all their doctors' claims are going to be put up and that my doctor's claims are going to be there so that we both have access to the information that is going to impact on my life in a fairly significant way?

Mr O'Halloran: That is the kind of data at a broader level that we would like to see—claims process ratios, how successful different claims are and how that compares to industry averages or industry best practice—and that data is just not available at the moment. That is the kind of thing that ASIC has been, I think, calling for, and we would definitely support that call.

Senator O'NEILL: Do you think ASIC is the place at which it needs to be housed, or does the sector have a responsibility to provide a space in which that can be found?

Mr Kirkland: We think the responsibility lies in both courts. ASIC is good at collating information and making it available to others, but there is a significant obligation that lies upon the industry to get better at how it deals with consumers particularly through the claims process. Again drawing comparisons to general insurance, if your home is damaged or destroyed in a major weather event, you can make a claim over the phone, and many good insurers now, if you ring them up, will not be just focused immediately on managing their own risk; they will actually be trying to manage your immediate needs as a human being. Life insurance claim processes, on the other hand, are paper based, really unfriendly and fail to recognise the emotional situation that the claimant is in, and that is one of the key things that needs to change.

Senator O'NEILL: That is probably not in every insurance company. There is probably differentiation between one and the other.

Mr O'Halloran: Yes, and it would be great to draw that out and make that something either that the insurers were showing to consumers, or that third parties like the media or CHOICE could include in the information that we are sharing with consumers about whom they should purchase an insurance product off.

Mr VAN MANEN: Mr O'Halloran and Mr Kirkland, I think you have spent the last five minutes making an extraordinarily good case for people seeking advice. What are CHOICE doing proactively as a consumer organisation to work with the financial advice industry to get on the same page?

Mr Kirkland: What we want to see is a financial advice industry that people can—

Senator O'NEILL: Trust?

Mr Kirkland: have trust in, so that people can go to a financial adviser pretty much anywhere and think, 'The chances are very strong that I'm going to get good advice that's in my best interest.' The most important thing that we have been doing is working with a range of industry groups connected with government processes around improving standards within the industry. I think we have had a really effective dialogue with a number of the key industry groups and with the key agencies within government around setting up the new professional standards body, and we will be working with that body, once it is properly established, to see that work carry through. Some of these are changes that will take time to have an impact on the universal experience of advice at the front end.

Senator O'NEILL: 2021.

CHAIR: Mr Kirkland and Mr O'Halloran, thank you for coming in today. Answers to questions that you have taken on notice should be provided to the secretariat by 17 March 2017. Again, thank you for attending the hearing and for your evidence today.

Proceedings suspended from 10:22 to 10:37
KELLY, Ms Alexandra, Principal Solicitor, Financial Rights Legal Centre

MENKEN, Mr Josh, Spokesperson, Superannuation and Insurance, Australian Lawyers Alliance

CHAIR: I now reopen the hearing into the life insurance industry and the committee welcomes the Financial Rights Legal Centre and the Australian Lawyers Alliance. I remind committee members and witnesses that while this is a public hearing care should be taken to protect the privacy of individuals and that arguments should be made without naming individuals. I thank both witnesses for attending today and I invite you each to make a short opening statement. At the conclusion of your remarks I will invite members of the committee to put questions to you. Ms Kelly, I invite you to go first.

Ms Kelly: Thank you so much for having us today. I want to briefly set out who I am and what my service does. The Financial Rights Legal Centre is a community legal centre based in New South Wales and we operate two hotlines. One is a state based hotline based on financial difficulty called the National Debt Helpline and also we run a national hotline called the Insurance Law Service. That commenced operation in 2007. Initially we would receive a few hundred calls a year and now we receive about 19,000 calls a year for assistance on the Insurance Law Service, however we are answering only about 45 per cent of those calls to our service on our current funding levels.

Our involvement on the Insurance Law Service is that we get a lot of inquiries around life insurance across the whole spectrum of a consumers experience from purchase, premiums and claims handling. We did an analysis of the sorts of queries that we were receiving in response to an ASIC notice after the release of their report. In reviewing our 1,200 calls that we received in respect of life insurance over that period of time we were able to see the biggest bugbears of consumers who were conducting our service. They included issues dealing with superannuation and life insurance; claims handling and hardship brought about by delays in respect of claims on life insurance; unreasonable requests for information and piecemeal evidence gathering; mis-selling of funeral insurance; bad or poor internal dispute resolution; premium increase complaints and issues; accusations of nondisclosure or misrepresentation and the consumers trying to deal with those sorts of accusations.

In response to the ASIC inquiry there was the life insurance code of practice, and we were actually on the steering committee of the life insurance code and put in a lot of time and effort in trying to assist the industry in coming together with the code of practice. We were trying to match what our consumers were telling us with what we saw needed to be improved. Whilst the first iteration of the code goes a modest step in moving it away from a regulatory approach with no foundation in contract. I think that is the end of my statement. Thank you.

CHAIR: Thank you. Mr Mennen.

Mr Mennen: The Australian Lawyers Alliance has 1,500 members, approximately, and they represent up to 200,000 people each year, largely consumers. Many of those are consumers of insurance or other financial service products. We feel that, as advocates in that space, we are well placed to comment on these terms of reference. The three main points that I want to discuss in my opening address are, firstly, fairness and sustainability of superannuation based insurance; secondly, claims assessment practices including surveillance delays and denial rates and then, thirdly, what we see as an inherently conflicted vertically integrated sales model which is being practised particularly in the banking sector.

Starting off, perhaps where my friend left off in relation to the FSC code, we believe that the code does not cover the superannuation industry—that is a matter of fact—therefore there is a vast gap in its effectiveness. That means that the vast majority of life insurance does not fall within its mandate. The FSC code also gives insurers too much wiggle room, and we do not believe that it will generate the cultural change necessary to reform the industry. Westpac's BT admitted to TPD decline rates of 37 per cent, which is more than double the industry average of 16 per cent. Presumably Westpac do not warn customers that its products are harder to claim under when they are selling them.

It is also clear from ASIC's report into the life insurance industry, which was released last year, that some insurers have under unacceptably high withdrawn claim rates. For example, one insurer's withdrawn claim rate
was 33 per cent for TPD. That suggests that the claim process is too long, too complex and results in thousands of
claimants giving up. It might also suggest that claimants are being intimidated or otherwise treated unfairly by
insurers. The use of surveillance is of particular concern. I have acted for scores of New South Wales police
officers who were subjected to ongoing surveillance and tailing by their TPD insurer, Metlife. That exacerbated
their psychological trauma, and for all that it produced nothing of any value in relation to the claims process.

The FSC code provides for a six-month timeframe for decisions in TPD claims but there are many loopholes in
the code where the timeframe can be extended. We have long sought to consult with industry to develop a proper
code for super based insurance claims and retail insurance claims with clear timeframes and consequences for
noncompliant insurers, and we continue to do so. In fact the ALA drafted a code of its own which it has tabled
with the industry.

In relation to vertically integrated sales models I have a few brief words on that. The newly introduced cap on
financial advisers commissions for selling life insurance policies does not address what we see as being the
elephant in the room, and that is cross-selling. Cross-selling is systemic within banks who have herded their
customers into their own insurance and manage investment products, including superannuation products, which
tend to have higher fees than the industry super products. There is presently nothing to stop a financial adviser
from having only in-house products on its approved product list, nor do advisers have to disclose their approved
product lists. I know, through acting in disputes, it can be very difficult to get access to a financial adviser's
approved product list. This means that there is a transparency problem for consumers who tend to assume that
their financial adviser is genuinely sourcing the market for the best product.

We call for a requirement that advisers' approved product lists include benchmark, non-affiliated products and
that any advice to buy in-house products must be given with a clear comparison, for example, in the statement of
advice, with one or more non-affiliated products to demonstrate why the in-house product is more appropriate.
This would be an important step to towards reducing the systemic conflict of interest and help restore consumer
confidence in the industry.

In relation to the question of fairness and sustainability within insurance based superannuation, I have quite a
bit to say about that. Perhaps I can put my views on that in discourse with you because I anticipate some questions
about that issue. Thank you.

CHAIR: Deputy Chair, do you want to start?

Senator O'NEILL: Yes. We have heard a lot about the vertical integration model and the way in which it
compromises selling to people. We heard some evidence on Monday, which I do not know if you heard, from the
financial sector, the Financial Services Union, around the nature of the workplace and a description of the decay
of the workplace, the selling culture of the banks that people had left to try to find a better culture in insurance,
which are now rapidly being taken over by the same sorts of behaviours. In your evidence you were talking about
the 19,000 calls?

Ms Kelly: Yes, 19,000 calls.

Senator O'NEILL: And you are only able to respond to half of those?

Ms Kelly: About half, that is right.

Senator O'NEILL: What happens to the other half?

Ms Kelly: We do not have the data to know whether we do eventually get to the consumers because they just
keep ringing back and we eventually speak to everyone, whether we are dropping those calls, or whether those
calls are being left unanswered with no free access to advice or information.

Senator O'NEILL: Where do you get your funding?

Ms Kelly: Our funding has just recently been secured through the Commonwealth legal services fund which is
a portion of our funding; about 1½ solicitors. Then we just received a one-off funding, which should improve
delivery of services, and we are currently recruiting to increase it, and that was misconduct money from an insurer
that was directed to us from ASIC. That should ensure the existence of the Insurance Law Service for a few years
to come, but probably will not be enough to hire enough people on a sustainable basis going forward.

Senator O'NEILL: So you are actually in an existential threat, is that what I heard?

Ms Kelly: In effect, yes. For the last seven or 10 years of the services existence we have come to funding
cliffs at times where we have had to dramatically reduce our services is down to three days a week just because
we have lacked the funds for solicitors to answer the line. We have just been lucky. We were about to hit another
funding cliff this financial year with the cuts to community legal centres, however we were ironically saved by
misconduct money that was directed to us from some mis-selling by an insurer in relation to some consumer credit insurance products.

Senator O’NEILL: So you were lucky to continue to exist.

Ms Kelly: That is right.

Senator O’NEILL: Given the expertise you have from that wide range—and I would love to ask some more questions about the vertical integration, but I do not think we are going to have enough time—can I go to the mental health issues that you raised. One of the concerns that is becoming more apparent to me as we hear this evidence is that the financial services code of practice has represented parts of the industry but not all of the industry. There was evidence from previous witnesses this morning that they had input around mental health but it did not come in. You have indicated that you had input. Did that show up in the code of practice?

Ms Kelly: It is more that what we were left with was a promise that they would address that in future iterations more so than anything concrete in the current code.

Senator O’NEILL: And you went to key areas. Can I ask you to speak about the mental health exclusion and the mental health standards?

Ms Kelly: Sure. The FSC is committed to increasing obligations on insurers when interacting with consumers. In the code currently, if a consumer says, 'I've got a mental health issue,' the insurer may address or deal with the consumer in a specific way in claims handling. It is not very clear to what extent. In respect of actually changing policy or increasing policy wording to include mental health or to reduce discriminatory exclusion clauses in respect of mental health, the extent to which they have addressed it in the code is to simply try and come up with a memorandum of understanding with some peak bodies in respect of trying to work on that in the industry. It is not clear exactly what that will mean, what sort of time frame they are looking at. Are we looking at the next iteration, which may be in 18 months? Or are we looking into years of work before they will come up with anything concrete in respect of any mental health type exclusions or dealing with the potential discrimination that people suffering from mental health suffer?

Senator O’NEILL: We have heard quite a bit of evidence around people having to pay a higher premium if they disclose. We actually heard about people having symptoms that were seemingly diagnosed over the phone by a claims officer and were then considered to have a mental health problem, without actual proper diagnosis.

Ms Kelly: That is right. When insurers require you to disclose, they ask you some very broad questions about when you may have seen a doctor. A lot of people may not have recalled seeing a doctor and mentioning they are stressed. Sometimes they have not even said that to the doctor—the doctor has just written in the notes that they seem a bit stressed. With that failure to disclose they will then say, 'That was a fraudulent non-disclosure. You should have known about that at the time. Therefore we're denying your whole claim.' That can lead to really unfair outcomes for the consumer.

Senator O’NEILL: Can I go to the surveillance issue that you mentioned and the comment you made about TPD and thousands of claimants giving up. Could you speak more about that from your experience?

Mr Mennen: Yes. We do a huge amount of advocacy for individuals who are pursuing their claims for superannuation based insurance or retail based insurance—disability claims. Quite often insurers adopt a standard procedure where they will engage in surveillance operations. Sometimes they are done in the field, where they get an agent to tail the claimant for a period of time and film them. Sometimes they are done with what is known as desktop surveillance, which is essentially looking at things like their social media activity.
The purpose of all of this in theory is to find an inconsistency between the basis of the claim and the observed behaviour. However, because it is done quite often routinely and because it is done for individuals who are making mental-health based claims, its utility is questionable.

For example, I acted for a New South Wales police officer who had suffered significant trauma during her working life. Part of her role was to view hours and hours of footage of sexually explicit material involving children. This was terribly upsetting for her and it caused her to cease work. It caused her to make a claim under what was known as the blue ribbon insurance benefit. She pursued that claim, and MetLife was the insurer. She was followed by surveillance and was followed while she was with her children, and her children were filmed. She was also followed whilst she was shopping. Then, as part of what is known as the procedural fairness process, the insurer then put that material to her.

Upon viewing that material, she became horribly distressed, and it exacerbated her condition. She got to the point where she was inclined to want to give up the claim because it was putting her through far too much. Ultimately, we had her claim accepted, and she was paid. After we had to take the step of suing the insurance company it was ultimately accepted, because they presumably decided they would lose.

That is how far it needed to be pushed in order for clearly what was a genuine claim to be accepted, and I use the New South Wales police officer's situation as an example because it was done so systematically by the insurer in those cases. Lots of doctors will say that the utility of a photograph or footage of somebody walking around and conducting some social activities, when they are making a psychological-based claim, is of little or no value. So, what other purpose could it be for?

Senator O'NEILL: That is very concerning. You both spoke about claims-handling as a concern, and you mentioned delays, and a number of submissions have indicated that there needs to be timing around this. You also, for the first time I heard, identified six months as the time that seems to be indicated in this code of practice, but there are many levels. Can you tell me about the timing and the loopholes of claims and the processes?

Ms Kelly: From my experience in speaking to consumers, time frames vary, and one of the top questions that we are asked on our advice line is, 'How long should this take?' And what we found, leading up to it, is that there was a vast variation across the industry as to how long it would take and the kind of information and follow-up that was forthcoming from the insurers themselves.

We would speak to consumers who were sitting, waiting for a decision some two years after making a claim or a couple of months after making a claim. And they had absolutely no idea of where it was going, where it was up to, whether or not they were required to provide any more information or whether or not they were awaiting the decision of the insurer. There was very little transparency in respect of how long should it be taking and whether or not they had a legitimate issue to start pushing the insurer to make a decision on or not.

If we draw an analogy with some of the other areas, like in general insurance, there is a general insurance code of practice. It sets out some clear time frames, which is 10 business days for a normal claim, up to 4 months if it is slightly complicated and up to 12 months if there are exceptional circumstances. From our point of view, that is something that you can benchmark in terms of where you are up to compared to the best industry standard. That was one of the main things we were pushing when we were asked to contribute to the life insurance code of practice, which is: what are some of the time frames; what are the industry benchmarks, as to what they are aiming for in their resolution of consumers’ disputes? From my understanding in some of the early meetings, there was great variation around systems and what each individual insurer was doing. So the code put in place what was seen to be best practice in the industry, and then they had to take into account that different claims are more or less complicated than others. That is why they have put in six months for income-protection related decisions, and then higher, up to 12 months, for more complicated type decisions.

However, the loopholes include where there are issues around getting information where the insurer has certain concerns about whether or not the information provided to them is accurate. That then enables them to extend out the time frame in respect of making a decision. We left it as a compromise. It was not necessarily what we as a consumer group saw as ideal. However, it was better than nothing, and what we had was nothing. So it would be something that we would want to see ASIC have some oversight on to ensure that the industry is actually complying with the benchmarks that they set in their own code, and with a view that, if it can be, it should be faster going forward; and if they are overly relying on the loopholes that the code provides, that the future iterations tighten up those loopholes in order to prevent insurers being able to avoid its operation.

One of the biggest gaps is superannuation, which is not quite covered in the code currently, in respect of time frames, because they could not find the super fund. The super fund has a key role right at the beginning, so the insurers will say, 'Well, it is not our fault if you make a claim to the super fund and the super fund does not pass...
on the claim for months or weeks, or does not pass on the information to us.’ The time frames trigger for the insurer from when the super fund provides them all the relevant information, so that is another significant loophole.

Senator O’NEILL: What is a reasonable time for a super fund to get the material together—

Ms Kelly: We would say as soon as a complainant or a consumer indicates they want to make a claim. The super fund should not really spend a lot of time pre-assessing it, or if there is some sort of pre-assessment, what time frames—

Senator O’NEILL: 14 days?

Ms Kelly: It should be something. What they really need to deal with in the superannuation code of practice is what the best practice for the superannuation funds themselves is, in passing on the information to the insurers.

Senator WILLIAMS: On that very issue, why should a super fund be assessing an insurance claim anyway? They are not an insurance company. The super fund is here, underwritten by the insurance company there, and the member is there. If the member has a complaint, should the complaint go straight through the super fund direct to the insurance company and let the insurance company handle it? What experience does an industry super fund have in insurance?

Ms Kelly: Exactly—I have absolutely no idea. I do not quite see what its role is in being a gatekeeper to an insurance claim. That is a big concern for a consumer, because their relationship is not with the insurer. Their relationship is with the super fund. They do not have any right to go to the insurance fund and get a copy of their product disclosure statement, for example, to actually know what it is that they are claiming on. For a lot of consumers, their frustration with us is, ‘What is the definition you need to meet when you are making your claim?’ ‘I don’t know.’ ‘Can you get the product from the super fund?’ The super fund says, ‘No!’ The insurer says, ‘No.’ So the consumer is in the dark as to what it is that they are actually claiming on. What do they need to meet in order to get a successful claim through? It is a real problem that super funds do create a barrier for consumers, just to have a decision made and to understand what it is they may or may not be entitled to.

Senator WILLIAMS: The solution is? What do we recommend the government change to get the super—

Ms Kelly: The super funds need to get on board and be far more transparent about providing documents to their insured.

Senator WILLIAMS: Millions don't even know they are insured.

Ms Kelly: That is right. So there needs to be work done by the super funds.

Senator WILLIAMS: They might have three super funds and three lots of insurance and not even be aware of it. But there is the problem itself—the transparency and the awareness. Perhaps that comes back to the education system?

Ms Kelly: Financial literacy is often put up as the solution for things, but the problem is, who is going to provide that literacy or provide that education?

Senator WILLIAMS: Well, it is already going through schools, with ASIC’s programs et cetera—60 per cent of the schools.

Ms Kelly: They are very complex products. So, even with that level of education, it is possibly still not enough to know exactly how it works and those situations.

Senator WILLIAMS: You support a one-stop shop to handle complaints, obviously?

Ms Kelly: Yes.

Senator WILLIAMS: We come back to year 10 and year 11 or whatever and prepare our youngsters for when they leave school to get out into the big, wide world, to actually have an education about how their super will have life insurance in it et cetera, and monitor it and see what it is.

Ms Kelly: They are very complex products. So, even with that level of education, it is possibly still not enough to know exactly how it works and those situations.

Senator WILLIAMS: You support a one-stop shop to handle complaints, obviously?

Ms Kelly: Yes.

Senator WILLIAMS: Good. That might even relieve a bit of pressure from you, Mr Mennen—or cut you out of work even!

Mr Mennen: Well, the superannuation funds do have an important role in the administration of claims, and that is that they have fiduciary obligations to their members to assist them in pursuing those claims under the CIS Act. So, it is very important that they fulfil that function properly, and there have been examples where that has not been done, so the superannuation industry has to take responsibility for this and make sure that they are going in to bat for their members who are making legitimate claims. That involves more than just passing on the bundle
of documents as a PO box. It should involve them advocating on behalf of their members, particularly where their members are vulnerable.

**Senator WILLIAMS:** Not to be a roadblock.

**Senator O'NEILL:** But we did hear that from the trustees in Melbourne—that they saw that as their responsibility.

**Mr Mennen:** That is something that the insurance and super working group, in its attempts to develop a code which binds the entire industry, is looking at trying to augment.

**Senator WILLIAMS:** So, we have a problem here where the life insurance code being developed does not include group insurance. Correct?

**Mr Mennen:** The life insurance code which has been developed by the FSC does not bind superannuation fund trustees.

**Senator WILLIAMS:** And 70 per cent of life insurance with superannuation?

**Mr Mennen:** I am not going to dispute that figure.

**Senator WILLIAMS:** So, we have a code being put forward that excludes 70 per cent of the life insurance in Australia? That, to me, would be a very inefficient code, wouldn't you think?

**Mr Mennen:** We are on the public record as criticising that enormous gap within the FSC code, and we are actively engaging with the insurance in super working group to develop a code with ASIC oversight which does fix up these issues and fill those gaps.

**Senator WILLIAMS:** And my final question: you would have a lot to do with people who have complaints about direct insurance, where they have the advert on TV and with a five-minute phone call—Ms Kelly is nodding her head—and a credit card number, it is debited every month and you have a policy; you beauty! Then they go to put in a claim and find that they have not been underwritten, and the insurance company goes back through their history and says: 'Oh: you're going for a crook back, but you've been a shearer and you've been to the chiropractor 100 times and you've had an operation on your back. We're not going to insure you for your TPD for a crook back.' Is that the case?

**Ms Kelly:** Direct insurance has its own issues in respect of wide pre-existing condition clauses, premiums that go up to extraordinarily high—

**Senator WILLIAMS:** Because you do not get asked the detailed questions, do you?

**Ms Kelly:** That is right. With limited underwriting—and there is a real mismatch between advertising and what they say on television, about up to 64 and no medical checks—the consumer assumes that they are going to be covered for everything, and they are not, and then they are disappointed at claims time.

**CHAIR:** Mr Mennen, could you just explain whether there are any rules and regulations around investigations and surveillance regarding claims? Are there any overarching rules?

**Mr Mennen:** There is the Surveillance Devices Act, which has some broad benchmarks in play. For example, a surveillance operator is not able to take audio recording, only visual, without the subject's consent. And also they are not able to commit trespass, essentially. But below those very basic and, you would have thought, obvious standards, there is not much, save for what has been incorporated into the FSC's code of practice. We made submissions that the surveillance regulations in the FSC code of practice should go substantially further, but one thing that it has done is put some reasonable restrictions or some basic restrictions around who can be filmed and where filming can be conducted. But in our view it just has not gone far enough. One of the additional things it has done is that it has said that the insurer ought not engage in surveillance unless it has a reasonable basis to believe that there is some inconsistent behaviour going on, and it should have some evidence of that. But that is a completely opaque test that we would never be able to understand as consumers.

**Ms Kelly:** If I could also just make a comment on that, we produced a report called *Guilty until proven innocent* where we were looking at general insurance claims, largely, rather than life insurance. In our recommendations we indicated that there was a complete mishmash of rules around private investigation and surveillance, and it is not consistent across the states. One recommendation we would push for would be some national standards to be put in place, because there is a vast difference around private investigations as well as surveillance in every state, and that can be very confusing, both for the insurer and for complainants, who might look up what is happening in WA and not realise that it is not the case in New South Wales.

**Mr VAN MANEN:** Thank you both for your contribution this morning. I was interested, Mr Mennen, in your comment about super funds and their conduct of claims management and the acknowledgement that trustees have
of fiduciary duty to their members. Would you be concerned—and I asked this question of industry super funds the other day and did not get an answer that really suffices, but it has been brought to our attention, and this is alleged, that an industry super fund received a very significant rebate from its insurance companies because the claims experience for that particular year did not meet what had been budgeted for. Is that potentially a conflict of interest in the claims management process? Is it an issue that those payments are in no way disclosed publicly anywhere by any of those parties? And, given your earlier comments about vertical integration, I would be interested in your comments also on some of the bank activities and what they are doing in that space, but particularly that industry super fund issue.

Mr Mennen: Yes, it is an important issue. The question of whether profit sharing is appropriate in group life products is a good question, and it deserves some scrutiny. On the face of it, there does appear to be a conflict of interest, which could lead to an incentivisation by funds to see claims declined. I am not suggesting and have not seen evidence that they have engaged in that conduct before that reason, but it is perhaps not a good look. And it is probably the case that, if it is going to occur, there needs to be a great deal more disclosure in relation to it so that if people choose to become members of that fund or an employer chooses to make that fund its default fund for contribution for its members it is very clear to them that it does engage in profit sharing. I think it is a fair point to raise. We see anecdotally situations in which people will call up their superannuation fund to inquire about their rights and entitlements. They will ask, ‘Do I have insurance?’ And the superannuation fund will say, ‘No, you don’t have insurance.’ But that is not necessarily the end of it, because this individual making the call may have had insurance at the time they stopped work because of their medical problem but their insurance has since lapsed because it is contribution based. That is just an example of where someone can fall flat at the first step—find a dead end—when really the fund should be trying to do more to explore those issues and should have the expertise to try to help people along with that process.

Mr VAN MANEN: Have you come across cases where people have been told that their insurance has lapsed for whatever reason yet premiums for that insurance were still coming out of their fund?

Senator WILLIAMS: I have.

Mr Mennen: We see quite often situations where an individual stops work and no contributions are made into their fund but their insurance continues nonetheless and then perhaps they go back to another job and stop work again, because it is a failed attempt to return to work, and then when they go to make a claim they are told, ‘No, your TPD insurance is no longer valid because you have not had a contribution made for X period of time—

Mr VAN MANEN: Even though they are still taking premiums out?

Mr Mennen: but we have taken the premium because you have remained insured for death cover.’ This is one of the reasons why we broadly support a decoupling of death and TPD so that they are not subject to one premium under the same policy and so there is greater flexibility so that those sorts of issues do not arise.

CHAIR: Do you think people understand the definition of TPD on their insurance? Do they understand that it is total and permanent, or do you think people think that if they get their arm chopped off they can get TPD coverage for the rest of their life?

Mr Mennen: The definitions vary so much from one fund’s insurance policy to another that of course nobody knows of a standard definition. The SI(S) Act has a standard definition for the early release of superannuation, which is supposed to in my view dovetail with the insurance definition which the funds are covering their members for, but what we have seen is a dramatic departure in the insurance policies from that benchmark definition with the introduction of ‘unable’ as the language used instead of ‘unlikely’, retraining clauses and different benefit payment designs so instead of paying a one-off lump sum, which empowers somebody to invest it, pay down debt and take control of their future while they move into medical retirement, they pay them on a sort of drip-feed basis where they have to annually continue to demonstrate to the insurer that they should be entitled to a further benefit amount. That all paints the picture that what we are seeing is a real departure from the traditional purpose of TPD based insurance. I know that is a digression from your original question somewhat, but that is a concern. What we need to see is a standardisation and reining in of that definition. Perhaps some regulation in relation to that is the answer. We have proposed in our submission a standard definition for TPD.

Senator KETTER: Mr Mennen, you indicated that you thought there might be a potential conflict of interest for a superannuation fund to receive a rebate from the insurance company based on claims history. If that rebate goes back to the superannuation fund and then is passed onto members somehow in the form of improved benefits somewhere else, does that affect your conclusion?

Mr Mennen: I think it is a bad look potentially for a fund to receive any sort of financial incentive to put a lid on claims. I am not suggesting that it is in itself going to cause any conflict, but I am just saying that I can
understand why the public might have concerns about it. Just in terms of the timing of when the rebate occurs, it had occurred to me that that may be a rebate which comes back to a different set of members to the ones who have paid the premiums in the first place so I query the equity involved in it for the fund members more broadly.

Senator KETTER: If it went back to those members who are insured in terms of lower premiums or improved coverage or superior provisions in the policy, would that sort of thing be more equitable?

Mr Mennen: I think that might be because it is going back to the members who originally paid those premiums. I think this is an issue that deserves some consideration and thought.

Mr KEOGH: Ms Kelly, your organisation has had more than a tenfold increase in demand over the last seven years or so. Can you tell us what that is? You mentioned that you currently have 1,200 life insurance calls. Is life insurance one of the increasing parts of demand for your service?

Ms Kelly: The demand for our service can vary according to lots of different factors, including referral pathways. For example, the Financial Ombudsman Service is one of our biggest referrers of consumers to obtain assistance. Someone might contact the Ombudsman because an insurer is obliged to tell them about the Ombudsman. The Ombudsman might say, 'We are not sure you have got a dispute. Get some legal advice', and that is how we get the inquiry. We have entrenched our service as being somewhere that you can get access to advice. Those referral pathways have been maintained with good relationships over time and as a result we have other kinds of stakeholders getting those referrals so that we can provide the advice. That explains a lot of the increase in demand. We also have spikes around issues when there is media attention. Media attention around a life insurance scandal prompted people to contact us to get advice. Natural disasters and other general insurance type issues also result in increased demand for our service.

Mr KEOGH: You have indicated that you have been fortuitous in getting some funding through ASIC because of your activities. Where does that funding take you up to?

Ms Kelly: That funding is approximately $2.3 million. We are looking at using that kind of funding in order to be meaningful. There would not be any point in spending it all at once, providing a great service for a year and then having nothing. It would be more about using it over time to increase our capacity to answer calls for a time of, perhaps, four to five years. That funding will increase our ability to answer calls and increase our capacity by one or two solicitors. That should increase our capacity from where we are currently.

Mr KEOGH: Do you keep any stats as to where your complaints come from by state?

Ms Kelly: Yes. We try to match it so that we are population based and we do tend to meet that. Where our complaints come from tends to match where the population bases are, with slightly higher representation in Victoria and New South Wales—but minor.

Mr KEOGH: In terms of the surveillance of claimants, you indicated that you are looking for a uniform private investigator set of licensing regulations and an enforceable code of conduct. I notice that there are exemptions in some of the states for the types of surveillance that can be captured. You talk about participant monitoring exceptions in Queensland, Victoria and the Northern Territory. Could you please elaborate on those?

Ms Kelly: I will have to remind myself about what they are. I will have to take that on notice because I cannot quite remember.

CHAIR: Yes, take that on notice. We have heard from previous witnesses about potentially unfair contract terms protection introduced into insurance and superannuation policies. What are your thoughts on that?

Mr Mennen: We would support the coverage of unfair contracts laws to include life insurance and general insurance products.

Ms Kelly: We are supportive as well. The industry's position is that they have a duty of utmost good faith and therefore they do not need it. I do not think they make their case at all in that regard. If you already do not have unfair contracts terms, why not?

CHAIR: On Wednesday we heard from a witness on good faith, and he said they do not use it. He felt that his claim was denied and that he was a victim of them not implementing that clause.

Ms Kelly: That is right. The insurers, both in general insurance and life insurance, indicate that they do not really need that additional level, for they have that duty of utmost good faith. Our view is that if you are already complying with it, then you should not have any issues with an unfair contract terms regime applying to your contracts.

CHAIR: You could wave it as a banner—as a selling tool, couldn't you?

Ms Kelly: Exactly; that is right.
CHAIR: Thanks for coming along today. If you have been asked to answer questions taken on notice, can you provide those to the secretariat by 17 March? Thank you.
Friday, 24 February 2017

JOINT

Page 27

CORPORATIONS AND FINANCIAL SERVICES COMMITTEE

CAIN, Mr Russell, Joint Chairperson, Life Insurance Customer Group

PERERA, Mr Stephen, Private capacity

SCHROEDER, Mr Mark, Life Insurance Customer Group

SWANSON, Mr Simon, Managing Director, ClearView Wealth Limited

[11:25]

CHAIR: Welcome. I remind committee members and witnesses that while this is a public hearing care should be taken to protect the privacy of individuals and that arguments should be made without naming individuals. I invite you to make a short opening statement—emphasis on short, because we want to put some questions to you—and at the conclusion of your remarks I will invite members of the committee to put questions to you. I know Senator Williams is itching to ask some questions.

Mr Perera: The life insurance industry is a pillar of Australia's financial system. The critical work undertaken by the various stakeholders transfers the financial risks of death or disability from the taxpayer to the private sector through the use of insurance contracts.

Statistics from The Risk Store anecdotally quantify the value of the work that the industry does on behalf of the taxpayer, given that almost $7 billion was paid out in claims in 2015. This equates to $27.6 million paid to Australians every working day. Family homes are saved from foreclosure, businesses are able to remain viable, and widows and children can afford the dignity of maintaining their lifestyle.

Given these vital functions of our industry, it is essential that all stakeholders have confidence in the industry. Taxpayers and governments need to ensure that the welfare burden is not exacerbated due to Australians relying on social security as opposed to buying life and disability insurance. Financial advisers such as myself, who have the unenviable task of convincing consumers to spend their money protecting an intangible asset, need to ensure that our businesses are viable. Insurance companies need to remain profitable and sustainable to ensure that they are able to honour the promises that they make to their customers.

All stakeholders need to work in tandem to ensure that more Australians are taking informed steps to protect against the risks of death and disability. However, this is not the reality. The industry is currently in disarray, with deep mistrust among the critical stakeholders. Animosity reached fever pitch at various times during the recent life insurance reforms.

The best interests of the consumer have also been ignored in a number of ways in recent times. Consumers are not benefitting from some of the expensive and poor insurance contracts that are currently being sold to them. When compared with retail insurance solutions, consumers are not benefitting from the poor claims outcomes that result from direct and group insurance contracts that are being sold to them.

Consumers will not benefit from the recently enacted life insurance reforms. These reforms were pushed by vested interests, with a single focus on increasing profitability, and by those who have ideological biases. By capping remuneration, the reforms have almost halved the placement fees that advisers like me can earn for advising consumers to become better purchasers of insurance. Not one consumer benefit has been pronounced by the proponents of this reform. In fact, the reforms will result in fewer Australians obtaining advice to become better purchasers of insurance. For many Australians it will not be viable to be served by advisers like me due to its being commercially unviable.

I submit that the most important work of this committee is to safeguard the consumer and safeguard the consumer's ability to access advice. Consumers become better purchasers of insurance when they are advised by insurance specialists compared with the other distribution channels. Insurance can be cheaper, contracts will be broader and the assistance and advocacy of claim time results in better claims outcomes, as recently proved in ASIC report 498. Consumers are best served with an insurance specialist in their corner.

Mr Swanson: I would like to begin by thanking the committee for the opportunity to appear today. ClearView is an ASX-listed financial services provider which provides life insurance, superannuation and financial advice. The company aims to provide better products, value and quality advice to clients in a sector that is dominated by a small number of large, established players. We now have more than $2½ billion in funds under management and $170 million of premiums in force. I have served as ClearView's managing director since its establishment in its current form. Prior to this, I worked for over 25 years in the sector, including senior executive roles in Australia, Asia and the Pacific.

I have no doubt that life insurance fulfils a vital function in our society. It is also fairly generally accepted that many Australians today do not have the cover that they or their families actually need. I also strongly believe that
the life insurance industry is characterised by a high degree of mediocrity. By this, I mean that many parts of the industry are characterised by restrictive practices that stifle competition and innovation, and there are, in many instances, glaring conflicts of interest. In addition, it has been chronically underinvested in by its shareholders, as they have chosen to chase the mandated money in the superannuation system. I want to acknowledge that the government has done some good work in improving regulation of our sector, particularly in relation to professional standards and adviser remuneration. However, the essential reform is far from complete, particularly in dealing with conflicts of interest.

While the government has recognised the important issue of opening up approved product lists, APLs, the industry group charged with making this happen has failed to make any progress at all in 18 months. The highly vertically integrated nature of the dominant players means significant movement is highly unlikely in the absence of regulatory reform. That is because APLs are a key to the big verticals controlling and forcing sales flows into their own products as well as key to larger advice businesses extracting both volume bonuses and shelf space fees from life insurers. The core issue discussed in our submission to the committee is APLs. I would also be happy to answer any questions from the committee on other issues.

Mr Cain: Thank you very much for giving us the opportunity to present to you. Following an industry-first survey to risk advisers, it was clear that we needed some better representation in our industry to talk about the issues that face risk advisers, so we started the LICG and we rapidly grew to 3,000 supporters. We have always, from the beginning, been open to change. However, consumers should be the primary beneficiaries of any changes and not insurance companies.

The ASIC 498 report was a fantastic report. For the very first time, we saw industrywide, statistically relevant data where we had direct against retail against group. Some of the revealing data that I can share with you I am sure you have heard and read before, but one of the key things which we were fundamentally passionate about is that the retail direct-distribution channel had a 71 per cent better claims outcome rate than direct and 14 per cent better than group. This fundamentally highlights that advisers have been doing fantastic work in this sector for a very long time. It takes years and years before claims actually hit the books. The other thing that I thought was very strong in this paper was a mere two per cent of adviser misconduct complaints from 5,438 complaints analysed by ASIC.

The fundamental basis of the proposed LIF is that misaligned remuneration models in place cause advisers to provide inappropriate advice and to act in their own interest and not in the best interests of their clients. If churning of policies materially existed in the retail sector we would see two clear indicators of this. Firstly, the percentage of higher denied claims would be higher than in the other sectors. Secondly, adviser misconduct figures would be a lot higher. The 498 clearly refutes the entire basis of the LIF.

I would also like to bring your attention to the recent ACCC ruling which has just come through—a draft determination. Sixteen insurers were looking to cap commissions paid to car dealers for insurance product sales. The proposed cap is unlikely to result in a public benefit. While insurers would benefit, this conduct—this cap at the expense of car dealers—is likely to lessen competition, including by creating greater opportunity for explicit and tacit collusion.

Another point I would like to highlight is the challenge of direct insurance. In the book in our folder, you will see one particular example: a 55-year-old looking for $500,000 worth of life-insurance. For that particular contract the cost is $397 per month. It comes with a five-year, pre-existing medical exclusion and it comes with a five-year suicide exclusion. It also clearly highlights on page 8 that if you have high blood pressure—and 33 per cent of Australians over the age of 18 have high blood pressure—and you were to pass away from a heart attack then you would not be paid. Between the ages of 15 and 44, suicide is the leading cause of death in Australia, and that has a five-year exclusion. The policies that we represent cost the Australian consumer $170.26 per month. Imagine how much commission that direct insurance comes with only a 13-month suicide exclusion.

You will also find in our folder that we have recently conducted a survey into group reinsurance and have come up with a couple of ideas and suggestions. Some of the recommendations that we have are to eliminate profit-sharing arrangements; to implement a two-year active consent measure—almost an opt-in, where consumers have to actively consent to the current charges following the policy benefits and exclusions being clearly communicated by the insurer; and also to implement churning measures—there are no measures in group-churning conduct.

The other challenge that we see with the LIF is the financial implications of driving consumers from retail into direct and group contracts. As we can see from the evidence from the 498, higher claims being denied means straightaway that consumers are in a worse position. They are also paying 50 to 100 per cent more for their direct
insurance and they are also cancelling their contracts sooner because—I do not know about you, but I cannot afford it—they cannot afford $397 a month.

This is one of the challenges of the LIF. The financial impact study that was conducted claimed that the impact is only $27 million and to business only. We estimate it to be $1.8 billion per annum in denied claims, increased premiums and the cost to government to pick up the tab for those displaced families who now need financial support.

We see some huge challenges in the FSC Code of Conduct. Also revealed in the report you will see that general insurance is 1½ to six times more likely to have a dispute than in the current life insurance sector. And the FSC Code of Conduct currently mirrors, or comes close to mirroring, the general insurance industry. We feel that if we go down this path it is only going to be a further disaster for consumers.

As for inappropriate claims processes, you will also see in our folder there that across insurance companies we see insurers pre-populating Medicare data forms past policy inception dates—retro underwriting. There is a good example there—

Senator O’NEILL: Excuse me, could you repeat what you just said then? I lost concentration for a moment.

Mr Cain: Sorry. What insurers companies do when you lodge a claim is to pre-populate Medicare data forms so they can get access to your medical history past your policy inception date. Fundamentally, a customer has a duty of disclosure up until the inception date. But they are now requesting the medical file past that date, as you can see evidenced in the folder.

Senator WILLIAMS: Is the inception date the date you take out the policy?

Mr Cain: Yes. And that goes back to the insurance company, and they use that as a mystery shopping opportunity.

Senator WILLIAMS: So they go right back through your medical history?

Mr Cain: But they should not go past policy inception date.

Senator WILLIAMS: But they do.

Mr Cain: As you will see. That is one of many I can show you. Retro underwriting guidelines are mysteriously different to new business underwriting guidelines. There are recorded calls by claims departments where customers have no idea of the implications of what is happening in that recorded call. They have no understanding of why the assessor is asking a question or how their response may negatively impact on their claim. They have no idea if a question is appropriate or of their rights during that phone call. Claims staff often lack training and have little understanding of the benefits under the PDS.

We see a fantastic opportunity in the retail sector and we do not understand why this sector has been targeted, given that it has superior claims outcomes and low levels of complaints. This channel should be nurtured and not dealt with the way it has been—the LIF is fundamentally looking to eliminate IFAs within the market, leaving only vertically integrated businesses.

I will not bore you with all our recommendations. They are all in the book. I have added a little tool at the back of the book, just by the tab. There are a couple of different ideas about how some of the policies or some of the opportunities could be used as a sector specific measure or an industry-wide measure—such as standard claims procedures, enforceable claims procedures, minimum policy standards et cetera.

Senator WILLIAMS: Mr Swanson, you talk a lot about APLs. Can you explain to the committee what an approved product list actually is?

Mr Swanson: There is a life insurer, a dealer group and an adviser. The life insurer owns the dealer group. The dealer group would restrict the number of products that an adviser can recommend to a customer—in some cases to only the products of the life insurer and none of the other—

Senator WILLIAMS: As an analogy: I want to buy a car and I see a car salesman, but there are a restricted number of cars I can look at?

Mr Swanson: Correct.

Senator WILLIAMS: But there are actually a lot more cars available on the market?

Mr Swanson: Yes.

Senator WILLIAMS: Who restricts this?

Mr Swanson: It is controlled by the dealer groups themselves. It is controlled for two reasons.
Mr Swanson: They are Financial Wisdom, the bank owned dealer groups, AMP's dealer groups et cetera. Out of the 1,300 dealer groups in Australia, this issue only applies to about 20— but those 20 dealer groups represent about 44 per cent of the advisers in the industry. I will explain why they do it. The first reason is to restrict the adviser so the adviser can only sell their own product, so to speak. With a number of large dealer groups, there is another reason—to extract shelf space fees from life insurers. Those are the two reasons why APLs are in place.

Senator WILLIAMS: Can you give us an example of why this is a problem for people who wish to be insured?

Mr Swanson: There are 11 life insurers out there. We are asking advisers to be professional. We are now asking them to have a degree qualification and to do professional development and so on. The analogy I draw is this: a pharmaceutical company owning a medical suite and then requiring each doctor in that medical suite to recommend only the pharmaceuticals produced by that pharmaceutical company. That is why it is wrong. It is a clear conflict of interest.

Senator WILLIAMS: It leads to more vertical integration?

Mr Swanson: Correct.

Senator WILLIAMS: Who else is talking about these limited APLs? You brought it to the attention of the—

Mr Swanson: The Financial Planning Association.

Senator WILLIAMS: Who else is complaining about this?

Mr Swanson: I think the Financial Planning Association has made it clear in their submission. I know some of the people at this table would have a view on that as well. We are asking people to be professional. They should be able to represent all the companies in the market to provide solutions that meet the needs of their customers.

Senator WILLIAMS: You are telling me that your company has products—

Mr Swanson: Yes, we are vertically integrated.

Senator WILLIAMS: but if I go to invest in them, I cannot get access to them. Are your products—you are going to be biased about this—better than some available on the market now?

Mr Swanson: Let me answer it this way: our products will not be the best for every circumstance a customer might be in. We have 100 per cent open approved product lists. We pay no bonuses to anyone for volumes or persistencies, and we pay no shelf space fees. That is why we have been excluded from the approved product lists of a number of companies. I will make the observation that, with the results we announced to the ASX yesterday, we are now on the approved product lists of 293 boutique licensees or dealer groups. But we cannot get on to the big ones because we refuse to pay shelf space fees, full stop.

Senator O'NEILL: How much is a shelf space fee and how does that transaction occur?

Mr Swanson: Basically, you go along and you pitch to a company your credentials as a product provider. They will say, in some cases, that the fees are up to $650,000 per annum; in some cases it is $80,000 per annum, and so on. It is just a straight bribe.

Senator WILLIAMS: You said in your opening report that there are glaring conflicts of interest. Can you expand on that, please.

Mr Swanson: The conflicts of interest that occur are things like shelf space fees; things like volume bonuses and persistency bonuses paid to dealer groups and advisers. Where the product is placed should be neutral, based on the needs of the customer.

Senator WILLIAMS: Would someone like me call these bonuses a kickback?

Mr Swanson: Yes, you could call it that.

Senator WILLIAMS: You said in your opening statement that the industry group has no reform. Who is the industry group?

Mr Swanson: The Financial Services Council has made no progress on this issue in the last 18 months.

Senator WILLIAMS: So it has been a failure?

Mr Swanson: That is a fair summary.

Senator WILLIAMS: And the Trowbridge report—you were telling us that Mr van Manen addressed this issue, but nothing has progressed from it. Is that right?
Mr Swanson: The Trowbridge report recommended that half the insurers should be on an approved product list; I have no idea how Mr Trowbridge came to that conclusion. To me, it should be up to the adviser, who is a professional, to make the appropriate recommendation for the client.

Senator WILLIAMS: So, in simple terms, if I am an adviser and you want to buy a car, I advise you to buy the best car suitable for your conditions and your future, regardless of what car yard it comes out of?

Mr Swanson: Correct.

Senator WILLIAMS: Thank you.

CHAIR: Before we go to another question, how many independent—I guess you could call them retailers—have multiple, or more than, the APLs that are on the big ones? What would be the standard amount of policy options they would offer to a client from an independent?

Mr Swanson: In reality, of the 1,300 dealer groups in Australia, over 1,200 are able to recommend all the companies in the market as a solution. If you think about life insurance, we have a different premium for each age by gender, by occupation, by smoker and non-smoker. There is no company in this market that can hold themselves out as the best provider in the market—period—you have to have choice, because the circumstances of each individual are different. That is why I suspect the independent boutique dealer groups are more successful than the bank-owned ones, because there is open architecture.

CHAIR: What are your thoughts on greater transparency in regard to contracts and also to definitions across the board, where people know that your definition is the same as AMP's definition and MLC's definition in the contract?

Mr Swanson: There are research houses, and this is why you do need a financial adviser to actually go through the definitions and make recommendations. Our issue has been to contend that we believe in financial advice, and we believe that most people are not planning to fail; they are just failing to plan. That is why they need a financial adviser for both their life insurance and superannuation. The issue for us is to make sure that it is focused on the customer needs and the solutions that are relevant to them. The adviser's role is to opine on that.

CHAIR: But if there was a move to standardise definitions, would you agree with that? I will get everyone to answer that one.

Mr Swanson: I will give you an example. We have a guarantee of claims accountability in our policy wording in our contract with the customer about the way we will approach management of the claim. That came up in earlier sessions today. That is to our competitive advantage today, because advisers acknowledge that process is clear and transparent to customers. That is part of why we have been growing strong. If you standardise things like that, naturally you make the industry less competitive.

CHAIR: Any thoughts on that?

Mr Cain: We agree with the theory of minimum standards across the entire sector in policy definitions and exclusions—group direct to retail.

CHAIR: Mr Perera, as a financial adviser, would it make your job easier having standard definitions?

Mr Perera: It would make my job easier, but I do not know if that is the best outcome for consumers. A surgeon, for example, would want broader language in relation to their disability cover than would an office clerk. If you try and have the same standard across income protection covers for all occupations and for all clients, someone is going to be gaining some and someone is going to be losing some. I do not know if that is the solution; maybe in the areas of TPD, or TPD in—

CHAIR: I was going to ask about TPD.

Mr Perera: Total and permanent disability cover.

CHAIR: Yes. If there is a standard contract, what commercial advantage could be given to vary a TPD? If you are basing use on the SIS Act, then the only commercial change would be your customer service.

Mr Perera: I would argue that even with TPD the definitions will almost read the same across the companies, but it is the interpretations of those definitions. And when the doctors and lawyers get involved, that is when the SCT starts getting clogged up, when the claimants are butting their heads against the insurers. It is not the language itself, it is the interpretation of that language, where you need medico-legals et cetera involved.

Senator O'NEILL: My question was around the language. It is okay for the insiders who want to talk about how variations might be interpreted and for lawyers to be involved in it, but part of the problem is that the ordinary punter, who does not really engage with this until they need to, wants to have some certainty—that brain cancer means brain cancer. They want some certainty around these terms.
We need to make it clear to the public. There is a huge trust deficit here, clearly. There are all sorts of conflicts going on within the industry sector itself and the consumer seems to be the great victim of that debate and argument. Part of the trust problem is not having any understanding that the words they read are the words they understand in common parlance. You do not want an interpreter to have to speak English for you when you are speaking English. You want to be able to understand what you are reading.

Mr Perera: One of the recommendations to address is that disclosure itself, in its current form, does not work, because a product disclosure statement could be up to 100 pages in length.

Senator O’NEILL: Yes, and people will not read it.

Mr Perera: To me, the ultimate quality of an insurance contract is if it works at claim time. If you pick up a PDS and open up the front page, in glaring writing is: 'This is the success rate of this product'—so for every 100 claims that walk in the door we pay 80 of them, by product range, within the PDS. So a consumer does not necessarily have to pour through the 100 pages. They can have a quick, I suppose, reckoner, in terms of the quality of the product. That would also enable them to distinguish between the different channels, the direct and the group. The direct channel, because it is not underwritten, is going to have successful claims rates.

Mr KATTER: Would it be onerous to further drill down into the types of claims that are not being approved or 'If you make a claim for this you’re not going to get it accepted,' just something that puts people on notice as to the most common reasons for claim denial?

Mr Perera: That was part of it as well—aside from just putting statistics, in terms of the overall acceptance rate or denial rate of claims, to drill down a little bit further into a table and say a claim was denied due to non-disclosure or a claim was denied because the claimant did not meet the terms and conditions of the policy et cetera. A one-page snapshot would sort out this disclosure issue, because you cannot expect a consumer to read through the PDS and you cannot expect us to take a consumer through the entire 100-page PDS.

Mr Swanson: If you add on also a 60-page statement of advice on top of 100 pages.

Senator O’NEILL: Yes, I know. It is hard enough to get people to read when they are studying for their degree, let alone read their insurance papers.

CHAIR: I have a question relating to a personal experience. A member of the family was diagnosed with breast cancer, made the claim, fought the insurance company for 18 months before settlement, and the only way she could achieve settlement was by getting the right question from the financial adviser to ask the insurance company. She had a mastectomy and the insurance company said, 'It’s not radical surgery.' So the question her financial adviser told her to ask was: 'What more radical can it get?' Then the insurance company paid out.

What is in the psyche of an insurance company when they delay—fight—something like that for 18 months? Where is their mentality on that? This could be an opportunity for you to tell us how good your services are.

Mr Swanson: We are pleased with the results of the ASIC survey because our claim denial rates are below the average. To my point about shareholders and lack of investment, this industry was originally a mortality based industry—that is, life insurance only. As we have become more complex with the issuance of income protection and trauma insurance products, which everyone forgets to mention when they talk about group insurance, they are not available in a group insurance. It has become far more complex and the industry has not invested in the appropriate skill for the underwriting and claims people to actually—

Senator WILLIAMS: A lot of those are not available in group insurance. Sorry for interrupting.

Mr Swanson: So critical illness insurance, heart attack, cancer and stroke lump-sum payouts.

Senator WILLIAMS: For trauma—

Mr Swanson: Yes—are not available in group insurance.

Senator WILLIAMS: Just trauma?

Mr Swanson: Yes, just trauma insurance.

Senator WILLIAMS: I am sorry to interrupt.

Mr Swanson: We do not believe the industry has invested enough in the underwriting and claims skill to execute on some of the more complex claims. I would not suggest that that is a complex claim, but certainly, some of their mental illness claims that go on are very complex. ClearView does not do any group insurance because we do not believe group insurance is a sustainable operating model. The implications of having a trustee in there makes the whole process of managing claims way too complex. It makes it extremely difficult to get early interventions going, because of some of the issues around superannuation trustees.
Senator WILLIAMS: Can you just expand on that about group insurance? That is very interesting, given that, I believe, 70 per cent of the life insurance in Australia is under group insurance. You are saying it is not sustainable.

Mr Swanson: Yes, I do not believe it is sustainable, because you are actually moving into a community-rated model today. Younger people are now subsidising older people inside group life and superannuation. The same issues happen in health insurance, as I am sure you are all aware, where younger people are leaving the system. That is not a good outcome. I will not go on with all the other issues. Our view is that group insurance should be on an opt-in basis, so people can see what they are getting transparently.

Mr Shroeder: If I could add my concerns about group insurance: one of the things is, obviously, that it is not underwritten at time of inception. Moreover, the pricing for group insurance is up to double what it would be for retail, if you are paying half of retail and you are getting an adviser as well compared to group. Then, of course, there is the claims payment record, which is quite low. Then we roll into the incentive not to pay claims, because there is a kicker at the end if you do not spend enough on claims. The owner of the policy is the trustee, not the client. If you look at the statistics, 70 per cent of people have group and 30 per cent have retail, but it matches the same statistic that 70 per cent of Australians are under-insured. Most of those are because they rely on their group insurance, which is woefully inadequate because average insurance rates are around the $200,000 to $250,000 mark, where most people, in our experience, need to list $1 million. Yet, they are paying the same fees for about $1 million, whereas in retail they would be paying less. We have a lot of issues with group insurance.

Senator WILLIAMS: Are you saying that group insurance is expensive and inefficient?

Mr Shroeder: Yes, it is more expensive than retail, you are not advised, you are not underwritten at the time and you do not own the policy.

Mr Swanson: I think there is also an equity issue in group insurance. As I said earlier, younger people are, effectively, subsidising older people at the time they can least afford that subsidy. You know the power of compound interest and compound investment returns. A young person is taking out, effectively, life insurance inside superannuation when they should be building their balances, and the premiums are being deducted.

Senator KETTER: I am just returning to the approved product list. When a customer goes into one of these advisers who is part of this conflicted approach that you are talking about, is there any requirement for the customer to be told that there is a restricted product list that the adviser will be using?

Mr Swanson: No, not at all. If you go back in judgements, there was a court case some years ago, Commonwealth Financial Planning v Couper, where the judge came out very strongly and said that the approved product list was the proximate cause of the policy being rolled from a Westpac policy to a CommInsure policy.

Senator KETTER: Your solution is what you call an ‘open architecture product list’?

Mr Swanson: Yes.

Senator KETTER: You are saying that the FSC have not come to that at this point in time?

Mr Swanson: They have made no progress after 18 months. To be fair, the government has made progress in 18 months. I just put it out there. To us, the most fair and equitable solution is for the government to ask ASIC to put a licence condition on AFSLs, or Australian Financial Services Licence holders, to actually have every APRA-licensed insurer on their approved product list.

Senator KETTER: You also make the point in your submission about subsidies for training and education, which seem to equate to the shelf space kickback that has been talked about.

Mr Swanson: Yes that is true.

Senator KETTER: That seems to be unrelated to the actual cost of training and education.

Mr Swanson: Our view is that it should be a per capita spend on the number of advisers in the dealer group rather than just the lump sum paid to the dealer group itself. It has to get through to the advisers.

Senator KETTER: What concerned me is that if the FSC draft standard proceeds, you are saying there is a serious risk of the people who adopt it not meeting their legal obligations to clients in respect of the best interest duty and other fiduciary duties. Surely that must be one of the fundamental purposes of the—

Mr Swanson: And there are real life situations. I have had a situation in New Zealand where twins had cover with the same company. One got rolled to another company, and they both got the same cancer. Have a guess what happened? One was covered and one was not covered—a massive change in outcomes.

Senator WILLIAMS: Why?
Mr Swanson: Because the wording of this one was not available over here because of the dealer group that adviser was in.

Senator WILLIAMS: With the restrictions on APLs, Mr Swanson, am I being too cynical in saying that this sends a clear message about vertical integration? If the big end of town are controlling the products for sale and have hundred and hundreds—even thousands—of financial planners, does that mean they are guiding more of the investors and clients into their products?

Mr Swanson: Of course. That is the purpose of having a restricted APL. The issue in vertical integration is that clearly it is conflicted. It is true, dare I say, of industry funds—as per Senator Ketter's response—vertically integrated banks and so on and so forth. It is how you manage the conflict of interest. You do that by removing the volume bonuses, which is in the LIF reforms, because it will be pro for like, if I can call it that. You do it by taking away the shelf-space fees and you do it by having open architecture. What that does at the end of the day is to change the industry—we are all victims of it in this room—from a product flogging industry to talking about customer needs and customer outcomes.

Senator WILLIAMS: It sounds good to me.

Senator O'NEILL: A service based industry rather than a product flogging industry.

Mr Perera: In the investment space there is an argument for APLs as a risk management and as a governance matrix to say these are the flags in the investment space.

Senator WILLIAMS: On investment products? So you have not got dog products where you can lose your money—we have seen enough of those! But you are saying that in the life insurance industry—

Mr Perera: In life insurance, where there are only 11 insurers, it is not a conversation, but in the investment space where there could be thousands of different products, there is an argument that it is a governance and risk management tool.

Senator WILLIAMS: So we have to be very careful to separate the two—

Mr Perera: That is right.

Mr Swanson: Correct.

Senator WILLIAMS: if it came to some sort of deregulation because when it came to investment products, we could just let free a heap of mongrel dogs that will fall over, or something like that—you know what I mean.

Mr Swanson: A very sophisticated analogy. If I can say it this way—

CHAIR: He was a shearer.

Mr Swanson: I like shearsers. I have done that myself. I only got to 60 sheep a day.

Senator WILLIAMS: That would not buy you a beer today!

Mr Swanson: I know that! And it didn't! With respect to investments, they are regulated by ASIC under a managed investment scheme. There is not a prudential capital requirement inside a managed investment scheme. Life insurance—as Sam alluded to—is regulated by APRA. There are very strict capital requirements. So there you can say that you can have that open on investments. In our case, we have about 240 different investment funds on our platforms—we are comfortable with that—but there will be some MISs we will never let on to our platform, for the reasons you alluded to.

Mr Schroeder: May I make a comment about the vertical integration part of the argument?

Senator WILLIAMS: Please do.

Mr Schroeder: That is pretty much what drives most of it, particularly the LIF reform. In the life insurance industry, you have the vertically integrated big end of town that owns roughly 50 per cent of the advisers. They also represent about 90 per cent of complaints. The concern I have is that if you look at all of the headline issues with advisers, they tend to be in a vertically integrated group. We mainly represent the non-vertically integrated. So the vertically integrated are inherently conflicted because if you own the product you own the distribution, and there is obviously a push to drive the product; whereas, we represent the other half of the industry which is not well represented by other groups. Our job is to have open APLs, and the statistics show that pretty much all of us have open APLs. We try to do the right thing by the client by finding the best product to match the client's needs. because that is what best interest is all about, so we have no conflict in that regard.

My concern is that most of the headline issues that created the LIF addressed issues that are systematic in the conflicted remuneration side—excuse my jest. A lot of the people who are doing the right thing by the client are being affected by LIF to the point of being not viable. The issue is that banks and insurance companies who are conflicted are causing most of the problems, but their competition, which are the people who actually talk to
clients every day, are being made unviable because of the changes that come in that do not take into account the fact that the majority of the people in the non-conflicted space have, in fact, one per cent of the complaints to the FOS. That is the issue I have. We speak to clients all the time. I cannot tell you how many times I have sat with a widow and explained how I am going to advocate for them to get the underwriter to pay their claim or launch the fight for my small percentage of the $170 a month that it costs to make it happen. That is the issue, I feel.

Senator WILLIAMS: I am sure you make a very valid point, but it is a case of 'shut the gate, the horse has bolted' on the LIF issue. The reason being that some on the other side of politics have done away with commissions totally. Who knows if that is something to be talked about.

Mr Schroeder: I agree with that. The problem is, though, that if you remove commissions totally then you go to a salary model, and the only people who can afford the salary model are the integrated businesses.

Senator WILLIAMS: Especially with life insurance. It is all right if you win the lottery or your grandmother dies and leaves you $10 million. You have money to go to a planner and say: 'I'm prepared to pay you a fee. I've got the money.' But, when it comes to life insurance, people say: 'I'm not prepared to pay you a fee because I don't have the money. In fact, I've got less money and I want to have life insurance in case I run out of money and get bumped of or whatever.'

Senator O'NEILL: It is lucky you have some in super then, hey?

Mr Schroeder: We are hoping to continue to advocate for—

Senator WILLIAMS: As long as they are not getting ripped off on that as well!

Senator O'NEILL: Agreed, but it is doing the job. It is actually giving people insurance—

Senator WILLIAMS: You will get more evidence later on this afternoon, Senator O'Neill, I can promise you.

Mr Schroeder: We are happy to advocate for as long as it takes to try and get the remuneration set around about the hybrid level, which is 80/20, because our modelling shows us what is viable. Most of our costs when dealing with a client and giving them the range of products is right up-front.

Senator WILLIAMS: Can you charge a small fee? As I said, the horse has bolted here. Now it is going to land in 2021 on 60/20, right? Over a seven-year average loan of a life insurance policy, that is 180 per cent, right? At the moment you are getting 120 per cent and six years at 10 per cent, which works out, over seven years, to be 180 per cent—the same rate. You are just going to have a bit of a drought on the way through the first few years.

Mr Schroeder: I have never believed that the current up-front levels are sustainable. What I do note though—

Senator WILLIAMS: Do you reckon the 120 per cent ought to go higher?

CHAIR: Let him finish, Senator.

Mr Schroeder: We are on the same page; we should not be fencing. The fact is that I do not believe 115 per cent is sustainable. I think it should be less than 115 per cent of the policy. However, just briefly, if you look at the New Zealand experience, it is up to 230 per cent. If you look at the churn rates, they are exactly the same as Australia's, so I do not think there is a relationship there. Although, I do not believe it should be more than 100 per cent. All I want is to be able to pay my staff. If the net difference of going to the LIF reforms makes little change in remuneration then I would ask: why the change? Particularly as there is no evidence that this is going to have a benefit for the consumer. However, where it does affect us is: in our business we have over 200 staff and I cannot go to them and say, 'I'm going to cut your remuneration down to 60 per cent, but in a few years it's going to catch up.' I cannot do that because my up-front costs are right when I speak to the client. When I am trying to make sure the client—

Senator WILLIAMS: Can I say something?

Mr Schroeder: Yes.

Senator WILLIAMS: We had the consultation LIF that went through months ago. Now we are looking at the insurance industry going ahead. Perhaps we should concentrate on that?

Mr Schroeder: I do not think that the majority of the non-conflicted advisers were represented in that argument at all.

Mr Swanson: In the future, the world has to get to—and it will take a decade or two to get there—what we would call strategic advice, whereby an adviser sits down with a customer and actually goes through their whole plan, understands their assets, liabilities, revenues and expenses and actually does proper cashflow modelling. Then, they put in place debt consolidation strategies, debt recycling strategies, the appropriate life insurance cover and the appropriate superannuation plan for their needs. In doing it that way, you actually will get to a position where we can have a fee-for-advice model. I do not like fee-for-service because every adviser who turns up brings
a wealth of experience to the conversation, so it should be a fee-for-advice-model. However, that will take a long time to get to because it needs a whole industry to be retrained because the culture has been, up until now, a product-flogging culture.

Senator O'NEILL: Yes, and RG 146 is a qualification. There are a thousand more of them that have just come in the last year. It is wholly inadequate. There is no trust. I hear you saying this, and I am thinking of all the people I doorknocked to across the Central Coast and how many of them would think that they could trust their financial adviser now.

Senator WILLIAMS: It's a good thing I brought it out in the public, isn't it?

Senator O'NEILL: It is so compromised.

Mr Perera: Can I just add quickly: in terms of the percentage amount, you looked at the dollar amounts. If we are saying an average Australian is going to spend $2,000 a year on insurance premiums, the 60 per cent will pay us $1,200. That does not cover our costs of providing that advice. I take your point that there is a recurring revenue stream, but the cost of advice has roughly been placed at about $2½ thousand.

Senator WILLIAMS: There's the problem.

Mr Perera: Yes, there is the issue. So you could say that, yes, you are going to recover it over the long term, but it just cuts out a whole segment of the market that really need our help.

Mr Swanson: To give you an example, a statement of advice to be generated by a para-planner costs about $800, on an outsourced basis, because you are doing a 40, 50 or 60 page statement of advice tailored to an individual's needs, comparing three products and so on. It is a complex process.

Senator O'NEILL: And I guess it becomes more complex as people's work becomes more precarious.

Mr Swanson: Yes.

Senator O'NEILL: We could have a long conversation about that. I appreciate the information you have given about the APLs and the vertical integration, which was the key area I wanted to ask questions about. Could I ask you for some evidence around mental health claims, because we have been hearing quite a bit about changing definitions of mental health and an aggregation of multiple forms of mental health and illness being put under an umbrella. We have been hearing about people having premiums significantly increased. You are coming at the industry from a slightly different perspective. I would be interested in your views of what is going on in the mental health space in all parts of the insurance sector.

Mr Swanson: Firstly, about 20 to 25 per cent of income protection claims in Australia are mental illness of one form or another. It is a very extremely complex issue. If you sit back and think about a person, what they want in their life is financial wellbeing, physical wellbeing and mental wellbeing. When you sit down on exclusions—and I think this is part of your question—it is complex. Someone can actually have a broken leg and have complexity in the recovery of that, which then leads to depression and so on and so forth. So, for us, the most important thing is to get the right information at the start in the underwriting process and be very transparent in the claims process, and actually give people appropriate assistance early. For example, that is why we do not do group insurance: it is because we do not believe we can get to the claimant fast enough to intervene to get them back to a good lifestyle, so to speak. So mental illness is a very complex area. No different—we assume that physical wellbeing is not complex. There are about 26,000 moving parts in your body that can go wrong today. We have just assumed that over time. We have only in the last 10 to 15 years got to really understand mental illness as a disease in society. It has really only been there in life insurance, in suicide exclusions. That is the only place it has been, up until about 15 years ago. The industry has a lot of work to do to better underwrite and better manage claims of mental illness. I would not deny that.

Senator O'NEILL: Have you been managing claims for people, and what sort of impediments have you been reaching?

Mr Swanson: Some of the impediments in the Australian market are to do with privacy laws. Senator, you referred to a medical impairment bureau model that is used in some countries around the world, where you can actually come in and get a lot more information about clients to get them back to work more effectively. I think a lot of the impediments are actually in the industry rather than in the providers to the industry.

Mr Perera: A client walked in to my office and they had some mental health issues. Even if it was undiagnosed stress or anxiety, it would be nearly impossible to get them insured for mental illness. There would generally be a broad exclusion put on the policy, but they would be aware of that. So they would buy the income protection policy but they would be aware that mental health would be excluded from the policy at the outset. They would have a good understanding, so there are no issues at claim time.
Where I think there is a problem and where I am seeing some trends is with people who have mental health issues who attempt to claim on some of their group insurance, which may be in their superannuation fund, and it is the lack of a scorecard, if you like, to assess mental health claims against TPD definitions. I think that is what the industry is struggling with. If we were to improve it, I think that is the area we need to look at. How do we come up with a scorecard to help assess TPD claims for mental health.

Senator WILLIAMS: Isn't that the big question: how do we improve it?

Mr Perera: I think it is up to the doctors and lawyers to agree and come up with a matrix that we all agree on. It is far better than standardising definitions. If they tick XYZ, yes, it is a claim; if they don't, it is not.

Senator O'NEILL: In terms of 15 to 44-year-old males, we have heard that there are some companies that have no mental health insurance provided in their life insurance policies. Are you aware of that? Are there companies that you cannot sell, because they have not got any suicide—

Mr Swanson: It is not our case—it is not us.

Mr Perera: Out of any of the 11 insurers that we deal with, there is no blanket mental health exclusion per se. If they purchased a direct policy, I do not know. But if they came through me and had not used any one of the 11 insurers, there is no blanket mental health exclusion per se.

Mr Cain: I think one of the other issues with mental health disclosures is actually at the time of application, when you are asked the question 'Have you had any previous mental health conditions? A lot of people do not realise that stress, anxiety or postnatal depression et cetera is a mental health condition that they need to disclose in the application. I think consumers are totally unaware of the implications of not answering that question correctly at application time. That is another challenge.

CHAIR: If they answer yes then automatically they are cut out, aren't they?

Mr Cain: I think fundamentally the benefit of underwriting is that you are signing to understand that the insurance company is going to pay—if you get your underwriting done up-front—so long as you meet the condition of the PDS. There is a huge amount of benefit to being open and up-front and having the insurer clearly and accurately understand your position before they are willing to enter into that contract with you. There is a huge argument for being open and transparent, and that is why the premiums are a lot cheaper, because you are painting a better picture of your circumstance to the insurer.

Mr Swanson: It is called the select effect. The more information you have, the better decision you will make and the lower the premium will be.

Senator O'NEILL: The problem is the common parlance and what 'stress' means. Everybody will talk like, 'I'm stressed today. I had a stressful day.' The commonness of that language now is becoming a very big problem in this field, because if you have ever said to your doctor, 'Yes, I was a bit stressed,' and they record it, or, as we have heard today, they observe you and your personal view of you is that you are stressed—and I would say to them they have no idea how stressed you are until they see you putting your children to bed at 6 o'clock or something—then it goes on your record and it is used, as we heard this morning, because it was not disclosed by you, to prevent you from getting a cancer claim. I am not a lawyer and I am not an insurance provider. But as a regular member of the public and from what I think of insurance, that seems entirely outrageous.

Mr Schroeder: The amount of times I have had to go to an underwriter and say, 'What is stress and what is not stress?' is a lot. But this is what we do. As you say—

Senator O'NEILL: But you should not have to do it, Mr Schroeder. That is the point. People should be able to buy that product with some clarity.

Mr Schroeder: I agree 100 per cent. I think the actuarial tables over the years have covered the 26,000 moving parts, but they have not really focused on the mental health side, to an extent. We are getting the feeling, as reinsurers change, as things in the market have moved and as things have gotten tighter, that they are deliberately trying to hold back on making these things clearer, to restrict claims. That is our view. So things like 'what is stress?' should be a priority. There is low stress and then there is a serious pre-existing mental illness, and that needs to be better defined.

Mr Cain: One of the suggestions in our policy paper was to actually use the Medicare data at application time. While we know Medicare data cannot be used in its current format at application time, we should have a 10-year vision where we will be able to use up-front, at the application phase, the data that they use to deny claims. Let us get that Medicare data, innovate with it and show that we structure insurance contracts around that person's medical history and we are actually helping consumers better disclose at application time.

Senator WILLIAMS: So they know what they have got.
Mr Cain: The insurance company would know.

Senator WILLIAMS: With direct insurance, you may go off to bed at night thinking, 'I've done the insurance policy. I've paid the premium. I'm safe. If I get bumped off or I get crippled, the wife and the kids are safe.' The next thing is that they go back to the underwriting at the claiming time and you have not got a thing.

Mr Swanson: To add to Russell's point, access to the PBS would also be useful. If you know what drugs people are taking, you are halfway to knowing their health.

Senator O'NEILL: The problem is a question of trust and privacy, and people not wanting financial advisers—especially if they are in an integrated structure—to have that information. However, it has been put to me by people who have been speaking to me prior to this that it would be very helpful to be able to have access to people's Medicare files, and that would save a lot of trouble. If you just tick off, 'Yes, you can go and check out my Medicare files,' and the doctor says, 'Okay, you gave permission, I'll give it all to you,' there seem to be a few problems with that. What do you think?

Mr Swanson: The difference there is that the medical information coming in should be specific to the underwriting decision. So as an underwriting decision someone may have a broken hip or an illness. The underwriting should be specific to that. I think where it gets very vague is when doctors send in all their case notes, because their case notes can go all over the place. Most people cannot even read the doctor's writing most of the time.

Mr Schroeder: We strongly believe that some form of Medicare summary up-front would save a whole lot of issues with nondisclosure later down the track. It would allow insurance companies to better measure their risk right up-front and to tailor policies in a much better way to assist with actuarial tables. It would clear up a whole lot of issues that happen. A lot of my work is when we have to go back with the client to the insurance companies and fight them on a definition, their interpretation or a possible non-disclosure such as stress for school kids. If the Medicare record or a summary of, say, the major issues could be provided up-front then the client could never be accused of nondisclosure.

Senator O'NEILL: Yes, but they might not be able to get insurance either. We have young people now that—

Mr Schroeder: That will happen later. The problem is if they do get insurance, and then it comes up later, they have paid all those fees and the client claim gets denied. I would rather get it up-front. It is more important to do it up-front.

Senator O'NEILL: It is important to know you cannot get insurance is it?

Mr Schroeder: It is because you are initially better prepared.

Mr Swanson: It is actually. I think the point we miss in all this is the mortality piece of it. People are denied insurance for all sorts of reasons around health, obesity and so on and so forth. Mental illness is another illness. It is a very serious illness in Australian society—there is no doubt about that—but it is another illness and it needs to be treated appropriately. We, as an industry, need to have a far better processes around managing claims and having skilled people being able to do that—whether it is psychologists, psychiatrists and so on and so forth—and actually delivering good outcomes to claimants.

Senator O'NEILL: The problem I am hearing is there are parents now, who are anticipating the challenges that their children are going to face in terms of getting insurance down the track, who are trying to get their treatment for anxiety or a period of mental illness completely off the record so that there is no record of their problem. This is dissuading people from health-seeking behaviour. It is like the financial imperative is driving aberrant health-seeking behaviours. That is a very significant problem in this sector.

Mr Schroeder: I would argue that if we knew the issues right up-front, we could better tailor the products that would best help that client. Maybe something would have to be excluded, but we could cover them on other areas rather than give them no insurance at all.

Senator WILLIAMS: You can pay the premiums from day 1 then find you have no insurance later on. At least if you cannot get insurance, you can put it away in a savings account and build a bit of a nest egg.

Mr Schroeder: There are two sad parts of my job. One is when a client comes to me with an insurable event and they are not insured, and I can tell you that is more often the case. The other one is they have had insurance all their life and the insurance company denies it, because the client inadvertently did not disclose something not related to the actual issue, such as the brain cancer issue. I think to be up-front, because then the insurers can have a better idea of how to tailor the policies rather than just wait 10 years and then cancel it later because they inadvertently did not slash properly.
Mr VAN MANEN: Thank you all for your contribution today. This question is probably to you, Mr Swanson, as you run an insurance company. A number of submissions to the inquiry have suggested we impose some time frames around the processing of claims. I would be interested in your feedback on whether that is workable. Given that advisers now effectively have a two-year responsibility period, as a result of the life insurance framework changes, what would be the impact if, at the same time, we mandated that life insurance companies could only increase their premiums by CPI during the first two years, given that over the past little while we have seen some increases in policies in the order of 10, 15, 20 or more per cent per annum for premiums.

Mr Swanson: I will go on the time frame. We have been very clear in our own PDS around our guarantee of claims accountability. The issue is around communication and transparency of that communication. I think, as someone earlier today very clearly articulated, there needs to be clear communication about what is going on. I think there should be some kind of time frame. Certainly two years seems way too long. I think, Senator, you said something earlier which seemed to be way out of whack. The issue is communication. The issue is also investment in computer systems and the technology to enable people to deliver the service back to the claimants. That is on the first question.

On the second question, with respect to two-year time frames, I think your premium increases are way too low. I think I have seen some of them to 50 per cent in group life insurance and the like. The reason that the premium increases are coming through—if you saw the APRA statistics that came out last week—is that the industry lost $513 million or $517 million in income protection claims last year. That is why the premiums are increasing.

As to your point about the two-year step, it has a lot of merit in it. Perhaps you should actually have to guarantee it for two years at the start, but I can assure you that the implication will be that, if the claims blow out, it will be a very big step at year 3, because our job is actually to be around to pay the claim. That is the point of it. Our business at the end of the day is to give cash to people when they need it most. That is what we should be focused on.

Mr Schroeder: I will take the point on pricing, because we are at the front end and we are face to face with clients every day. If you look at the APRA figures in their horizons report of 2013, they looked at the issue of churning, or product replacement, as they call it, which was the basis of LIF effectively. Our own LICG survey showed that pretty much 95 per cent of a product being changed over or switched or churned is due to pricing increases by the existing provider in the second and third years. There is no doubt about that. You might come to me and say, 'Mark, my policy has gone up 20 per cent,' or, 'Recently an insurer put up the level commissions by 40 per cent’—which is just unheard of, and they are doing it again this year, by the way. They come in and say: 'My level premiums that you promised me would only go up by CPI have gone up by 40 per cent. I want you to fix this. Find me another policy, or I'll find an adviser who can.' If you look at the majority of churning, which is the basis of pretty much everything we hear about in LIF and the basis here, the churning is being driven by the price increases in the second and third year. A lot of that is to do with a lot of insurance companies trying to sell cheap at the front end and paying at the back end.

So, again, the non-conflicted advisers are pretty much paying for the process there, for churning, and yet we can demonstrate that it is in the best interests of the client. I might just quickly refer to a news article that ASIC put out. ASIC actually have said, 'We understand that you have to switch the policy if it is in the best interests of the client,' which pretty much wipes out 413, so that is very important for us. I know the horse has bolted, but I have to be honest with you, Senator: we are going to fight this—

Senator WILLIAMS: But wouldn't the insurance companies ask the people why when they were cancelling their policy?

Mr Schroeder: Yes. We would like to see—

Senator WILLIAMS: The insurance companies would know then why people are churning. You are saying that most of those answers would be, 'Your product's too dear now.'

Mr Schroeder: On the application form where it has medical questions, we would like to see, where it says 'reason for changing product', that the reason would be 'because the existing policy went up by 20 per cent and the client wanted a better outcome'. It is actually really bad. We have seen clients reduce their level of cover to meet the financial burden, where really that is the wrong thing for the client.

I am an independent representing pretty much 3,000 independents. These people have to balance the best interests of the clients. If they do that and they come to a decision where they have a broader range of policy or better definitions and more coverage for a lesser fee and they move the client into that to meet best interests, and then the previous insurance companies say, 'You're a churner,' this is an inherent conflict that should not be there.
**Mr Perera:** We are taking proactive steps. We are now keeping a log of replacement policies and the reasons for those replacement policies. We are going to collect that data over the next three years for when the review comes up so we can present what we believe supports our argument, which is that we are doing it in the best interests of the consumer.

**Senator WILLIAMS:** Which may lead to a case of revisiting LIF in time?

**Mr Perera:** Hopefully.

**Mr VAN MANEN:** That brings me to my final question to Mr Swanson. What are the insurance companies doing to collect the data necessary for this analysis over the next three years and to work with ASIC to ensure that the industry has the proper data when we sit down and do that review in 2021?

**Mr Swanson:** Yes, we do get some of the data, but we do not get every piece of the data, because sometimes a customer has left an adviser so you just get a lapse. We follow up, and they just say, 'It's too expensive.' We try to record all that information. As to the veracity of that information, I am not sure.

**CHAIR:** Thank you, gentlemen, for appearing today. Answers to questions taken on notice should be provided by 17 March 2017, and there may be some further questions on notice coming to you. We appreciate your appearing today. Thank you for attending, and also your evidence was welcome.

Proceedings suspended from 12:29 to 13:11
BINEHAM, Mr Marc, National President, Association of Financial Advisers

CLARKE, Ms Samantha, General Manager, Policy and Professionalism, Association of Financial Advisers

DE GORI, Mr Dante, Chief Executive Officer, Financial Planning Association of Australia

FOX, Mr Brad, Chief Executive Officer, Association of Financial Advisers

KENDALL, Mr Neil, Chair, Financial Planning Association of Australia

CHAIR: I reopen this hearing on the life insurance industry. The committee welcomes the Financial Planning Association of Australia and the Association of Financial Advisers. I remind committee members and witnesses that, while this is a public hearing, care should be taken to protect the privacy of individuals and that arguments should be made without naming individuals.

I will now suspend the hearing until our quorum arrives.

Proceedings suspended from 13:11 to 13:14

CHAIR: We can now reopen the hearing. Senators, just to let you know that we have done the preliminaries and now we can go straight into the opening statements. I now invite witnesses to make a short opening statement and at the conclusion of your remarks I will invite members of the committee to put questions to you. I invite the Association of Financial Advisers first to make their opening statement.

Mr Bineham: I would like to thank the honourable members for the opportunity to speak here today with my colleagues, Brad Fox and Samantha Clarke. I am also pleased to be here with our colleagues from the Financial Planning Association whereby our two associations represent the majority of financial advisers in our profession. Our association, the AFA, has been the voice and the value of financial advice over 70 years for primarily advisers who own and operate their own practice. We have a rich and proud tradition of providing advice and great outcomes were everyday Australians.

Whether Australians are getting life insurance through advisers or over the phone, direct or through their superannuation fund they need to have confidence in the quality of those contracts. That is not the case today. We believe in the work that PJC is conducting as Australians deserve to have confidence in our life insurance industry. This is why the AFA has been supportive of recent government legislation on the life insurance, and the professional standards being passed provide greater consumer confidence in the adviser community. Now though, the AFA believes it is time for other key industry players to pull the weight. It is important to understand that advised life insurance continues to be the best way for Australians to obtain life insurance that they can trust, particularly at the time, compared to direct and group insurance, and this is backed by ASIC report No. 498.

While the life insurance companies now have a code we would want to see that code of conduct go much further than it has until life insurance and superannuation is appropriately included as this covers over half of the life insurance market today. Consumers remain deeply exposed with few safeguards in place. Direct or group insurance needs to measure up to community expectations by ensuring all underwriting is undertaken at the start of the policy not at claim time. Underwriting after death or an illness occurring is unconscionable. The aim of life insurance reform, we believe, is to increase consumer confidence and trust, therefore this kind of insurer behaviour must stop. Thank you.

Mr de Gori: Thank you, Chair. We thank the committee for the opportunity to present the views of the Financial Planning Association of Australia. Today I have with me Mr Neil Kendall who is the FPA chair and also a practising independent certified financial planner who also runs his own Australian financial services licence. The FPA is made up of over 12½ thousand individual members of which 5,600 have obtained that global certified financial planner designation. The majority of our members provide life insurance advice as part of their financial planning services and have direct interaction with the life insurance industry.

The key areas of focus for the Financial Planning Association is education, ethics, professional standards and the provision of quality advice given to everyday Australians. The financial advice provided around the protection of one's life and income for the benefit of their families is an extremely important part of the financial planning process. We demand high values of professionalism from our members when delivering advice. It is therefore our expectation that these same levels of professionalism are delivered when it comes to financial products and services provided by life insurance companies.

Life insurance is a contract of trust. To that end I want to highlight the following issues within the life insurance industry. The first is claims underwriting. There is a need for Australians to be able to access insurance cover in a variety of ways allowing them choice whether through a financial planner, their super fund or directly. However there is a serious problem with the claims underwriting. Claims underwriting is a process where you pay
for insurance and after you die the insurer will then ask for details to decide if you were ever insured. This means that in many cases consumers are paying premiums for no cover at all. This, in our view, is not in the interests of the consumer. These insurance products are sold to consumers on the promise of no medicals and limited questions at time of purchase. Many consumers do not understand or are not aware of the implications of this until it is too late.

The second issue is around group cover especially in sold superannuation. This is an important element in the life insurance industry as this provides millions of Australians with life insurance cover which otherwise would not be available. However there are issues with engagement, awareness, understanding and hidden fine print relating to the group policy conditions that are not disclosed to the members of the super fund. This results in many Australians not being aware of their eligibility to claim or are being charge premiums for cover they are not eligible for under the terms and conditions.

There are real opportunities for this committee to make a difference. We urge you to carefully consider this around claims underwriting with a view to ensuring Australians purchasing life insurance cover can rely on that cover in the instance of claim. Thank you very much.

CHAIR: Thank you for your presentations. Can you both explain to me or expand on this underwriting and the issues? What parts particularly and whether it is group or direct? At what stage is the underwriting or lack of underwriting occurring and which areas need to be fixed?

Mr de Gori: I will go first. Specifically regarding claims underwriting we are talking about certain products that are purchased primarily through the direct channel, that is the consumer going directly to an insurer. The purchase of that insurance policy is not underwritten at all until the time of claim, until the time of an event and the individual puts in a claim to that insurance company. Normally when you buy an insurance policy, through a financial adviser for example, you are underwritten at the time of purchase, therefore you have been accepted and your cover is in place. Then an event occurs and you put in a claim form. Under a direct insurance policy at the time of claim you are being underwritten to confirm whether or not you are actually covered in the first place and whether you are entitled to claim if you are actually covered.

Mr Fox: I might add to that, Chair. What they are assessing in the direct and sometimes in the group space as well by underwriting a claim is the health of the individual not only at the time the policy commenced but also up to five years prior to that time. An example might be that a consumer has hypertension and dies of a heart attack two or three years after paying premiums. The underwriting is then done to expose that he had hypertension before starting the policy or paying the premiums and the claim is denied. That, to us, is unconscionable that a widow, who is expecting $300,000 or whatever the sum might be, now gets nothing. The person was never covered. What she will get is the premiums refunded for the period that they were paid. That is not much of a consolation.

Mr VAN MANEN: Are premium refunds standard across all companies?

Mr Fox: I am unaware of whether it is across all companies, but we have seen practical examples where it happens.

CHAIR: The only thing they are really assessing at the time of underwriting is your ability to pay?

Mr Fox: I guess this is the question. That is the major requirement that they are after. In common practice dialling up and trying to buy insurance direct over the phone you might be asked three, four or five pertinent questions. Your age, your sex and your smoking status are the three most common. That is not underwriting. What it is is just the start of a conversation to see if you will take cover. It needs to go much further than that. It needs to take into account whether or not it will cover you. As Dante has suggested, what it means at claim time is, if you have been underwritten, you know for sure that you are going to be paid. If you are not insurable, you are much better to find that out before you start paying premiums not after. There are also examples around this underwriting issue that Mark might like to touch on.

Mr Bineham: To give an actual example, we have a client who is now a doctor. When he first came in he said that he was fairly covered and that he wanted to talk about superannuation. Part of our due diligence is that we look at insurance as well. He had about 1½ million dollars of cover and he had income protection, and on paper it looked like he was pretty well covered for his circumstances. Once we went further into it it was all insurance that had not actually been underwritten and, more importantly, on his income protection—and we heard earlier about mental illness—it had a mental illness exclusion, and he had had depression for about a year or two, which was quite serious, and he had taken serious medication. What we were able to find from having the adviser input was that that depression was due to a breakup. Three years later he had met someone else, married and even had a child and was no longer on medication. But the insurance company still would have had a mental illness
exclusion even though that was a one-off situation. So we were able to go to an insurance company and explain why that depression was a one-off, and he is fully covered now with an appropriate retail product.

**CHAIR:** What about underwriting with group insurance? A lot of people do not even know they have insurance, so how can they have been underwritten?

**Mr Fox:** They haven't been.

**Ms Clarke:** Unless it is at the very high levels, but it is unusual. And the evidence from the ASIC report 498 as well proves that the claims-denied figures for insurance through the retailer, or the advised channel, is much lower—in other words, much better for the consumer—

**Senator WILLIAMS:** Four per cent.

**Ms Clarke:** than the unadvised channels.

**Mr KEOGH:** I would just like to get a better understanding of what a consumer has with these direct contracts, which you say are underwritten at claim. They enter into an arrangement with the direct insurer, for want of a better description. Does that contract have an exclusion in it that says, 'If this doesn't get underwritten, you have no claim'? Or is that not present? Because what I—

**Mr FALINSKI:** Is the consumer warned?

**Mr KEOGH:** Is the consumer warned, or is it buried? Or are these insurers denying claims that they are actually legally obliged to pay out, and the underwriting is their problem, not the consumer's?

**Mr Fox:** Within the product disclosure statement—the rules, if you like, for the contract—there will be a statement that says you are not covered for pre-existing conditions at the time of initiation of the contract or in many cases for some period prior to initiation. It might be three years or five years. So that wording exists somewhere in the contract agreement, but when you are purchasing over the phone you are not seeing the contract.

**Mr KEOGH:** You do not have the PDS. So underwriting a claim is not so much the issue as the fact that the contract you are signing up for has a big exclusion in it?

**Mr Fox:** It might be two ways of seeing the same problem.

**Mr KEOGH:** The reason I am asking this question is that, if I am an insurance company and I go and say, 'I'm going to insure you for this risk,' and I do not put that big exclusion in it, and then you come to me and claim and I go, 'Oh, I'd better go and underwrite this,' and then I cannot, that is actually not the consumer's problem. That is the insurance company's problem.

**Mr FALINSKI:** Yes is the answer.

**Mr KEOGH:** Yes.

**Ms Clarke:** It is industry practice. Yes.

**Mr Fox:** What I would say there is that you are right. If the contract did not have the ability to exclude pre-existing conditions, it would be a good contract. It means that the consumer is covered for what they—

**Mr KEOGH:** In which case, the insurer is on the hook regardless of the underwriting?

**Mr Fox:** Yes, they would be covered for what they think they are covered for. But because there is this ability to go back and underwrite, not only at the time you started buying the contract or paying for it but for years before, consumers are not aware of that. They are not made sufficiently aware of it.

**Mr KEOGH:** But it is not the underwriting that is the problem; it is the exclusion that is the problem.

**Mr Fox:** It is the lack of underwriting.

**Mr FALINSKI:** It is the lack of underwriting.

**Mr KEOGH:** But regardless of the underwriting or not—because, if the exclusion that says 'if you have a pre-existing condition' was not there, then, underwriting or not—

**Mr Fox:** Then they would be fully covered

**Mr KEOGH:** Yes.

**Senator WILLIAMS:** Mr Keogh, the underwriting means you have actually got the insurance.
Mr KEOGH: No. That is the point I am trying to get at.

Senator WILLIAMS: Does the underwriting mean you have actually got the insurance once it is underwritten?

Mr FALINSKI: No.

Mr KEOGH: No. You are insured regardless.

Mr Fox: Let us try and tackle it a different way perhaps. In a retail policy through a financial adviser, you will be underwritten when you buy the policy—

Mr KEOGH: Yes, I know.

Mr Fox: and, as long as you fully disclose your health history and the investigations of the insurer assess that they will accept you as a risk, you are on cover. In the absence of that, these other contracts are saying: 'We're not going to assess you today. We're going to assess you later, if we have to.'

Mr KEOGH: Yes, which is an exclusion.

Mr Fox: It saves them a lot of money. They are not underwriting everybody. They are only underwriting those that claim.

Mr FALINSKI: Mr Fox, that is not entirely accurate. What they say is that the onus is on you to declare any pre-existing conditions, without running you through what those pre-existing conditions may be.

Mr Bineham: Yes, there is a duty of disclosure.

Mr FALINSKI: On you. But your argument is that consumers are not made aware of that when they buy the—

Mr KEOGH: It is a statutory duty, though.

Mr FALINSKI: Yes, that is true. But the point is more that you ring up to buy those products, and you think at the end of it, 'Well, I answered a couple of questions, so now I'm insured.' No-one says to you in that process, 'You're not insured until you've declared everything, and you have this duty.' Is that right?

Mr Fox: I agree with you.

CHAIR: It is a low-doc policy.

Mr Fox: It is, and we have seen recent research that says—

Mr FALINSKI: Except that with the low-doc policy you are still insured. This is not a low-doc policy.

Mr Fox: There is research recently that says it is a very good experience to buy insurance this way. Well, it would be, because that is only the part where you think you have entered into the contract. It is at claim time you will find out whether it was a good experience or not, and that is the wrong time. That is what we think should be prevented. It simply should not be permissible to bypass the underwriting at the commencement of a policy and instigate it at a time of need and claim.

Mr FALINSKI: Do you think that is the answer or do you think there is an asymmetric information problem here and the consumer needs to be clearly made aware that they have not actually entered into an insurance contract—or a binding contract, at least—until they have gone through that next step?

Mr Fox: Many consumers would not. It would not be fair to expect them to understand what an underwriter might class as serious or not serious. Mental health is a classic. 'I saw a psychologist once on the advice of the GP because I've had a mental break-up and I'm feeling a bit overwhelmed.' You need to declare that.

Senator WILLIAMS: Mental break-up?

Mr Fox: A relationship break-up, mental breakdown. Again, most people would not think they need to declare that. I have had a client that had open-heart surgery and did not record that as a significant health issue because he had fully recovered, in his mind. I think it is much better we provide underwriting than leave this gap there of interpretation and imbalance.

Mr FALINSKI: Ms Clarke mentioned earlier that the 498 report points out that, when going through your channel, denials are at about four per cent. What was the figure for the other channels—group policies?

Ms Clarke: There are ranges, but at the worst extreme of claims denied—

Mr FALINSKI: Please—we like knowing the worst.

Ms Clarke: which is what we are all concerned about from a consumer protection perspective—it is up to three times the claims denied figure.

Mr FALINSKI: So about 12 per cent?
Mr Fox: The highest figure for an individual insurer, given it was sampled that way, was 29 per cent of claims denied in the direct space. The highest in the retail advice space was actually 11 per cent. That was the highest; the average was down at seven.

CHAIR: Excuse me, I have to leave the room for a minute, so I am nominating Senator Williams as the acting chair.

ACTING CHAIR (Senator Williams): Go ahead, Mr Keogh.

Mr KEOGH: What the consumer is confronted with in the direct insurance space, where they see the advertisement that says, 'We just need to know these three questions,' or what have you—I know you are not the ACCC, but doesn't that strike everyone as wholly misleading?

Mr Fox: Perhaps the PJC might like to refer it to be considered.

Mr KEOGH: I get a 'yes' from that.

ACTING CHAIR: Mr Keogh, let me expand on that. In many countries, you have to give details around advertising. I will ask this to all of you here, both organisations: when you see these adverts on TV—that it is just a matter of a phone call and so on, and people take it up—is it worth the ACCC actually looking at that to see if it is false or misleading advertising?

Mr Fox: The AFA would think that it is. I will defer to the FPA.

Mr Kendall: We think it is worth having a look at.

ACTING CHAIR: I am sure, Mr Keogh, that is something we could discuss in our recommendations.

Mr FALINSKI: Recently, there were changes made regarding commissions. Did that impact your members?

Ms Clarke: It affects all personal financial advice—and general advice as well.

Mr FALINSKI: I know that there was a difference of views across the sector in this. Is it your view that that will not have a material impact on advice that people are able to give or constrain advice that advisers feel they can give their clients?

Mr Kendall: Our organisation has just under 10,000 practising financial planners. We did not have any pushback from members directly saying to us that they were going out of business. We have the ability to charge a fee for service if we want to do that. People will need to readjust their business models, but we do not believe that people will not be able to give advice on life insurance as a result of the changes that were made.

Mr De Gori: As I mentioned in my introduction, the majority of our members obviously provide life insurance, but it is actually part of the financial planning process, so it is not just life insurance. As result of that, it is part of their business, not all of their business.

ACTING CHAIR: What about those financial planners who do life insurance only? They would be doing it a bit tough, wouldn't they?

Mr De Gori: They may be. To Neil's point: we obviously had members that did not necessarily support the life insurance framework, but we have not had any members at this stage indicate that it is going to impact their business to the extent that it is going to be a problem.

Mr FALINSKI: One of the specific situations that has been put to me is that people were charging up-front fees of 120 per cent to cover what they say was the exhaustive analysis that was required for someone's personal circumstances—which I think I am hearing is what needs to go on generally speaking. Then they were in a position where, in a couple of years time, that person's circumstances changed—health, financial, family et cetera changes—the call-back provisions that have now been put in the life insurance framework would actively disincentivise them from advising on a better product that may be more suitable to the needs of that particular client.

Mr Fox: I might pick up on that, if I can, Dante. I will answer both that question and your previous one.

Unidentified speaker: Thank you, Mr Fox.

Mr Fox: We do have a number of specialist advisers within our membership. There are advisers who think this will put them out of business, and they are feeling significant anguish and pain about how to change a business model that they may have had in place for 10 or 20 or 30 years. That is a significant challenge for them. We have done the modelling, and it takes about four years for the new commission structure to earn the same amount for an adviser as the current up-front one.

Mr VAN MANEN: On 80-20?
Mr Fox: No, that is even at 60-20, because what is included as commissionable is different under the life insurance framework than it is today. So that is a significant cashflow impact, given the majority of our members are small business owners. We think it is a circumstance that they can adapt to, as other advisers have already built business models that live on the hybrid model and/or a combination of hybrid commissions and fees. It is not easy but it is doable. The issue about whether a two-year call-back is going to make it harder to replace a client's policy: it will not, because of the best interest duty. An adviser is duty-bound to do the right thing by their client, regardless of what the commission, outcome or call-back is. So it will not change the adviser's behaviour. It can challenge the financial metrics of their business. Our greatest concern is how steep increases in premiums within that first two-year period can put a financial adviser at a disadvantage financially if they need to look after moving a client because of significant price or premium increases. That is something they are going to have to adjust to, and it is something that we would like to see addressed in the FSC code.

Mr Falinski: So the framework, as it currently has been designed, will not work against the best interests of the client because of your other duties, but the incentives are now unaligned with the best interests of the client?

Mr Fox: Time will tell.

Mr Kendall: I think that is true. In that situation you describe, where a client has come back and through change of circumstance needs a new policy, if you have written a new policy, one would expect you would be receiving a 60 per cent up-front commission and you would be rebating back some portion of what you previously received. So I do not think it is true to say we are not still able to deliver in the client's best interests.

Mr Falinski: So in year 1 you would get 60 per cent. In year 2, you have to change; you get a new 60 per cent, but you may have to rebate 20 per cent of the 60 per cent from year 1.

Mr Kendall: Yes. And I have never rewritten a policy in that sort of time frame. If you needed to do that, one would expect you would have done most of the work relatively recently so the exhaustive research may in fact only be 20 per cent of what you originally needed to do, because most of your information would be up to date. But I do not think that is the normal event. I would suggest that five-plus years would be the time frame that most people would be rethinking about their insurances, many of them not to change. I do not think there is a lot of business that is rewritten for better advantage in one- or two-year time periods.

CHAIR: Thanks. I might just call Senator Williams. Sorry—Ms Clarke, you wanted to add something?

Ms Clarke: Business viability is a concern. So there are two aspects that can assist these small-business advice professionals in maintaining their business viability. One we would suggest is—for the committee and the life insurers—to look to commit to no premium increases in that two-year period, and that is a commitment that the insurers potentially could make. And, on the compliance side—so the cost of compliance, which you have all heard a lot about today, I am sure, and in previous meetings, in terms of the detailed requirements that advisers must go through in terms of statements of advice and complying with the best interest duty processes, can be enabled to be more efficient through technology and also through the review of SOAs by ASIC. That review is currently underway, and we would encourage progress by ASIC and, once that is defined, for the licensees to embrace a simpler and more efficient SOA regime. That will also lead to better outcomes for consumers, because, all going well, it will be simpler and easier to understand for consumers.

Mr Falinski: And standardised.

Ms Clarke: And standardised. Yes.

Mr Bineham: I have a practical example from my own experience. We had our national conference last year, and there were amazing young new advisers to our industry, who just said: 'We don't even take a commission. We are just fee for service, 100 per cent. This does not affect us at all.' To me, as someone who has been in the industry for 30 years, this was a very foreign approach, because we have been brought up on a commission based system. What it has done is—and I know we spoke earlier about how much it costs to put some insurance in place—show me that I just have to learn to be more innovative. There is software out there that is making it faster to do our reports. We can just—even in the way we help our clients, just in the systems and processes. What may have taken us six steps before; now we are doing it in four steps, still making sure the client gets a great service and value out of this and are appropriately covered. We are using Fintech and we are learning to be more efficient, so we can provide this service for a lower premium. If we really do need to extra work, we will charge a fee on top of that. And that is from someone like me—I have had to adapt my business.

CHAIR: Senator Williams.

Senator Williams: Thanks, Chair. Chair, a motion of no-confidence moved against you when you were out did fail, by the way.
CHAIR: I am sure I had your support.

Senator WILLIAMS: Mr Fox and Mr Bineham. I am very concerned, Mr Bineham—or industrial relations might have been Mr De Gori—when you were talking about the hidden fine print in group insurance. We have this sort of opinion that group insurance is the saviour of 70 per cent of working Australians. What are the problems with that fine print?

Mr De Gori: I will ask my colleague to expand on this and to give you an example. It is more about when you are in an insurance policy through superannuation—unlike purchasing an insurance policy through an adviser, you actually get a policy document that lists the full terms and conditions of your policy and your coverage. When you are purchasing insurance inside a superannuation fund or if you are in that group cover—

Senator WILLIAMS: Everyone purchases it unless they opt out.

Mr De Gori: You automatically have received that—

Senator WILLIAMS: Everyone gets it—

Mr De Gori: That is correct. You have automatically received it. You effectively only have a product disclosure statement of the whole super fund. You actually do not get a copy of your policy document—

Senator WILLIAMS: Doesn't the group insurance cover you warts and all?

Mr Kendall: Let me give you an example of a particular case. A lawyer came to see me about professional negligence insurance advice, so some care was taken. They were members of a—

Senator WILLIAMS: You worked in the interests of the client, did you?

Mr Kendall: Absolutely. They were insured, they believed, for life, total permanent disability and income protection. We sought the information—

Senator WILLIAMS: Through group insurance?

Mr Kendall: Through group insurance, through the group plan they were part of. We asked for the—

Mr KEOGH: Was that in super or was that—

Mr Kendall: It was inside their superannuation arrangements. Given the field of work they were aware there might have been some issues. We did the research. We asked for a policy document. The group insurer had never been asked for a policy document. There is a significant difference between a policy document and a product disclosure statement. What we discovered in the policy document was that that person's income protection benefit, if it was not held within the group—so if they had external income protection—was offset against their total and permanent disability benefit. So, if they received income protection from anyone other than the group insurer, that would reduce the amount of total and permanent disability cover they would receive. If they received it from the group provider, then they would receive what was shown on their member statement. But you had to get a policy document to understand that, and it took us two weeks to find anyone in that organisation that could produce a policy document. That is a lot of detail and depth to go to to discover the fine print, to read the fine print and then to understand the conflict that existed between internally held insurance and externally.

Mr KEOGH: Mr Kendall, that content of the policy document was not replicated or disclosed in the PDS?

Mr Kendall: We did not find it anywhere else.

Mr KEOGH: That would seem to be a grave deficiency in that PDS, at the very least.

Mr Kendall: The difference between a policy and a PDS—certainly, from the PDS we could not—

Mr KEOGH: It seems like a pretty critical term.

Mr Kendall: glean all the information that was required to assess that, and we were not expecting to find that. I have never seen it in any other policy document or PDS. But, when you read it, that is what was written down there.

Mr Kendall: Well, it is the difference between policy and a PDS.

Mr KEOGH: It seems like a pretty critical term.

Mr Kendall: Certainly, from the PDS we could not glean all the information that was required to assist. We were not expecting to find that; I have never seen it in any other policy documents or PDSs. But when you read it that is what was written in there.

Mr Bineham: A perfect example is total permanent disablement under group insurance, where the definitions are changing and most members are unaware to the point that it is really only at claim time that they actually discover that definitions change. It makes it nearly impossible to claim. An example of that is—
Senator WILLIAMS: It makes it nearly impossible to claim? I am working in my job in a shearing shed and I get my handpiece through my back and I am put in a wheelchair. Are you telling me I am not going to be covered for my income? Tell us.

Mr Bineham: In that actual example, under the old definitions it used to be if you were unlikely to return to any occupation.

Senator WILLIAMS: Unlikely to return to any occupation?

Mr Bineham: Any occupation, based on training, education or experience. So in your situation you would actually get paid the claim. I am not an insurer, but that is the way I would read that. Under the latest changes it is if you are never to return to work or unlikely to ever return to work in the future. So you are now getting a doctor saying that you will never be able to work. They have to be a mind reader of what the future will be as well with medical advances. So it is making it a very difficult process for a doctor to sign off on when the definitions change from 'unlikely' to 'never'.

Mr Fox: The structural issue that is different is in retail life insurance it is noncancellable. So once a consumer has the policy and the cover the insurer cannot change those terms to make it a lesser contract. That is not the case with group insurance held inside super funds.

Senator WILLIAMS: The insurer can up the premium, though, can they?

Mr Fox: The insurer can change the premium, yes. But with cover held through group schemes they are cancellable contracts. So you will hear or read about a super fund retendering out for the insurance for its members. What we have seen is a reduction in the quality of the contract terms under which the members are covered. A weakening of the TPD definition is one example. A change in income protection that might exclude medical advances. So the quality of the insurance contracting group can be reduced without any consultation to the member. The member just has a lower quality cover.

Mr VAN MANEN: Where is the trustee's fiduciary duty to the members to look after their best interests?

Mr Fox: That is their statutory duty, but where does it start and finish?

Senator WILLIAMS: And if the dog did not stop for a pee it would have caught the fox as well. If I were 30 years old, just married, buying a house and considering a family, I would opt out of my group insurance and go get a proper policy from a proper adviser to cover me for what I need and my family needs.

Mr Fox: That is actually what people should do. It is what our members’ job is to do—to alert people to that.

Senator WILLIAMS: I am only just learning it through this inquiry. I say again, I think we have millions of Australians who do not even know they have life insurance with their super.

Mr Fox: These sorts of issues could be addressed through the code that is being done with the FSC and life insurers.

Senator WILLIAMS: Let's get to the code of conduct. The FSC have put out a draft, haven't they?

Mr Fox: It is actually in play.

Senator WILLIAMS: It is in play?

Mr Fox: Yes. Version 1 is live.

Senator WILLIAMS: Are you under parliamentary privilege? Give us your honest, frank assessment of it.

Mr Fox: On receiving the draft of the code we provided 29 recommendations to improve it. A small number of those have been adopted. We think it is a beginning and a step in the right direction, but it has a long way to go before it does the job it is intended to do, which is to guide culture around life insurance. It does not cover legacy policies which have been held for a long time and have perhaps been discontinued by insurers. It does not cover anyone's insurance inside their superannuation fund under a group scheme.

Senator WILLIAMS: That is 70 per cent of Australians.

Mr Fox: Yes.

Senator WILLIAMS: What is the point of having an insurance code that eliminates 70 per cent of Australians?

Mr Fox: Work has begun with the superannuation associations, the ISA, AIST, APRA and the FSC to create perhaps a parallel code to cover insurance inside super where there is a trustee involved. We all need to be careful that that does not become window dressing about turnaround times on claims or applications. It needs to go to the
nub of the quality of the contracts held and the ability of the members of those funds to know what they are and are not covered for.

Senator WILLIAMS: Are we getting to the stage where we need to have a mandatory code, put through by government working with the industry and the regulators, to see that everyone who has life insurance is covered?

Mr Fox: Our submission suggests that the review of the initial code in 2019 may require, if it has not been effective, that sort of solution.

Mr De Gori: I will just add a couple of points to that. The first point I want to make is this: I know I raised the issue about group life inside superannuation, but I have to put on the record that, for all its faults, it is actually important for Australians to have life insurance cover.

Senator WILLIAMS: Otherwise they would have nothing.

Mr De Gori: Yes. I wanted to put on the record that I think it is important. Obviously it has its faults and does need to be improved. I echo the comments around the Life Insurance Code from the FSC as well. I also want to make the point that no professional code is perfect. There has to be a starting point and then there have to be iterations. We have to learn from something we have never had before. We have to learn where the gaps are from its operation. It is a work in progress. I add the caution that there is never going to be a foolproof solution. We also need insurance companies to act appropriately—and to be mandated to act appropriately. I think there is an obligation for that to occur as well.

Senator WILLIAMS: We have this point about 'utmost good faith', but I have a final question for Ms Clarke. Why do so many people cancel their policies given that insurance companies have told me their average policy lasts seven years?

Ms Clarke: That is a good question. There needs to be much more information on the public record relating to reasons for cancellations. We would encourage a requirement on insurers to capture more specific, detailed reasons for cancellations and that data should then be fed into the ASIC review.

Senator WILLIAMS: Why do you think people cancel? What is your opinion?

Ms Clarke: There is one main reason and that is affordability. Premium increases is the reason for cancellation that comes through to us.

Senator KETTER: You said that there can be changes to insurance within group cover within superannuation which could either benefit or be to the detriment of the people insured. Are you familiar with the requirements on trustees advising the people covered about what changes to their cover have occurred?

Mr Fox: The same from the AFA, the main reason being that sometimes the cover you get in your first superannuation fund might be the only cover you are ever capable of getting. Health can deteriorate pretty quickly. The incidence of mental health issues between the ages of 18 and 30 is very high. The cover you get at that first stage is possibly the most comprehensive you will ever hold.

Senator KETTER: You said that there can be changes to insurance within group cover within superannuation which could either benefit or be to the detriment of the people insured. Are you familiar with the requirements on trustees advising the people covered about what changes to their cover have occurred?

Mr Fox: We have not seen evidence of how they are communicating it. We have had anecdotal evidence of people saying they were completely unaware that the conditions of their cover had changed. That was a question better directed to the super fund trustees.

Mr Kendall: From day-to-day practical experience, most people who front up think they have insurance in their super and that is the extent of their knowledge. They can give you no detail about amounts or types. Certainly they are ignorant about changes to their super, and I have seen more than one person who was terminally ill and struggling with mortgage payments not understanding that they held insurance—all they had to do was claim it. There is huge level of misunderstanding and ignorance, even among people who are insured and can get claims paid, that it even exists.

Mr Bineham: I can give you two examples from people who have shown me their group insurance statement. On one, there was a small print statement on page 6 of their annual statement that there had been a change. So they did notify them, but you would have to read to page 6, and no-one really gets past page 1 in normal circumstances. In addition, an email went out as one of, say, 15 emails that went out during the year. They may be informed, but is that way of telling them appropriate? I would not think so.
Mr Fox: If I had suggested in a letter, as a super fund to a member, that we had changed the definition of the member's total permanent disability from this to that—would the member understand what they had been told in the letter?

I think there is a collective need to be much better at educating the public around the basic issues of life insurance—a basic understanding of the difference between life, trauma, TPD and income protection. It is not well known, it is not well understood, and we can all carry some of the can to do a better job of that.

Senator KETTER: Do your members speak to many people under the age of 30?

Mr Fox: Our members do. We have a number of members specialising in that market.

Senator KETTER: Earlier witnesses mentioned life insurance for people under the age of 30—there was one comment that 19-year-olds do not need life insurance. Do you have a view about that?

Mr Fox: A 19-year-old apprentice mechanic with $25,000 loan for a lowered ute needs life insurance to pay out his debts unless Mum and Dad want to do it when he goes.

Mr KEOGH: Why does he? If he does not have dependants, why does he need life insurance? Mum and dad do not have to pick up the loan unless they are guarantors.

Mr Fox: Which is often the case when people get their first loan and their first job.

Senator WILLIAMS: Why would you spend 25 grand on your first ute anyway, instead of five?

Mr Kendall: I think also that mechanic may be injured rather than killed, in which case he has a much bigger issue. So the term life insurance generically covers different varieties. There are huge numbers of people in this country who are sole income families with one worker bringing up children, and to say that they did not need insurance probably misses the crux of the problem. That is probably the group that needs insurance the most—they have the least assets, they are starting to buy houses, they are having children and they often have one person out of the workforce. That group probably has more need than anyone else in this country.

Senator KETTER: Finally, I think in one of your submissions there was reference to approved product lists and I am wondering how your members are affected by that?

Ms Clarke: We support, as part of the life insurance negotiations with the government, approved product lists being widened and we would expect there to be a reasonable number of choices on those approved product lists into the future, and we would like to see progress on that front.

Mr FALINSKI: But how?

Senator O'Neill: And what is a reasonable number?

Mr Kendall: The legislation under the best interest duty requires reasonable investigation of products and there are requirements for licensees to facilitate that. So the best interest duty today compels people to do reasonable research. Again, you have to make your own assessment, but I do not think anybody would suggest that a limit of one product would be reasonable.

Mr FALINSKI: But that is for you guys. The majority of platforms are banks and AMP.

Mr Kendall: The licensee still has the same obligations. They are not only giving advices under a licence; the licensee is obliged to support the best interests duty.

Mr FALINSKI: But once they sign up with BT, for example, they are on that platform. They cannot go picking and choosing platforms, can they?

Mr Kendall: With many you can. With many you can certainly choose insurers.

Mr FALINSKI: You can?

Mr Kendall: You can.

Mr FALINSKI: So a BT adviser can say that is a great approved product list but I am going to go and use this other one?

Mr Kendall: Not carte blanche. You have to get approval. You would have to go to your licensee and say, 'I want to use this and these are the reasons.' Certainly, when I was under one of those corporate licences, I have gone to a licensee and said: 'This is not the right thing for the client. This is what I want to do.' And I have done it and they have approved it.

Mr Fox: There is a range of behaviours of licensees under that process, and 'individual permission' is a general term for using a product outside the APL. It can be a long process—delays in getting back to you, letting you know whether it is okay and meanwhile the client walks. There are ways some licensees handle it to make it frustrating for the adviser to do it, and the adviser therefore might choose to go in a different direction.
Senator KETTER: Mr Swanson from Clearview Wealth Limited talked about the fact that the FSC draft standard, as it stands, may place many advisers at serious risk of being unable to meet their legal obligations to clients, in particular with respect to the best interests duty and other fiduciary duties. Do you agree with that?

Mr de Gori: I will answer this one from our perspective. Firstly, the FSC code is a code for insurance companies—that is, insurance companies and their behaviour—and not for Australian financial service licensees who are authorised to provide advice, or for financial advisers who are authorised under the licence. You have to take a step back. The Corporations Act and the provision for providing financial advice governs all individuals whether they work for BT or work on their own licence. The best interests duty obligation is there for everybody. The obligation of the licensee to support the individual in the provision of the best interests duty is an obligation for all licensees. There are thousands and thousands of products, especially in the investment range, so the approved product list is a mechanism licensees use to try to narrow down the selection so that advisers then have some parameters to work within.

In the insurance space there are not as many, but having a completely open architecture also may not be meaningful, because some licensees may choose not to use life insurance companies for a range of reasons. But an adviser’s obligation under the best interests duty is the same. If BT or someone else, a licensee, is slowing down the process or preventing an adviser from acting in the client’s best interests then that is actually a breach of the law. I just think we need to look at how we enforce the law, rather than imposing further conditions around an approved product list.

Senator O’NEILL: How is law enforcement going so far?

Mr De Gori: That is a question you will need to ask the regulator. We are in a process of—

CHAIR: We will ask the regulator, I think. We will go to Mr Van Manen, who has been waiting patiently.

Mr De Gori: We are only a couple of years into the best interests duty regime. I think we need to let that work and be put in place, and then question why it is not if that is the case.

Mr VAN MANEN: What involvement do your organisations have in the SOA review project that ASIC is undertaking, and how is it progressing?

Ms Clarke: The associations have been asked to be involved in the consultation and review of the research, which I believe was undertaken last year and is maybe being finalised now. ASIC inform us that that is forthcoming, and they are also looking to put it to a broader consultation group of advisers. We will see in the coming weeks and months perhaps, and we will be able to answer your question better after that.

Mr VAN MANEN: When we get ASIC in front of us I will be asking the same question.

Mr Fox: We would certainly expect that that work should be finished by 1.1.18, which is when the regime commences for the change of remuneration to advisers. They need the efficiency at the same time they have got a change in their revenue.

Mr VAN MANEN: That brings me to my next point. The average premium for life insurance is around $2,000 per annum for a new policy, and the Trowbridge report recognised that the cost of advice is about $2,500. If you have a 60 per cent up-front commission payment, that is $1,200. Where is the other $1,300 coming from? Zurich, in their submission to the Senate Economics Legislation Committee inquiry on the LIF, said they had surveyed a group of people and that 57 per cent of those surveyed said they would leave the market altogether if forced to pay any amount for advice. Those who were willing to pay were willing to pay a maximum amount of about $600. Therefore, even if you add that $600 to the $1,200, you are going to have a significant shortfall in the cost of covering the provision of that advice.

Mr Fox: In our opening statement today, Mr Bineham said that it was time for others to pull their weight. We have some very inefficient systems across the life insurance market. We need help and improvement from the insurers to make the information flow better, which would save time for advisers. We need the SOA project to be completed by ASIC so that it is faster to provide and create the SOA to go to the client. We also need businesses to make sure they are at the cutting edge of how they go through their advice processes. Mr Bineham suggested earlier that he has needed to change how his business operates. In bringing down the cost of providing advice the onus is shared. At the moment that is a challenge. The regulatory changes we have had—

Mr VAN MANEN: But at the moment it is fair to say that if you moved to a fee-for-service model the client is still going to pay $2,000 for their insurance premium, plus they are going to pay $600 to $1,000 or more as a fee. So the actual cost to the client is going up, not down.

Mr Kendall: But it is not fair to say that you would keep the same premiums. If an adviser chooses to rebate the commission you would typically expect a 30 per cent annual premium discount.
Mr VAN MANEN: Well, name me an insurance company that is reducing their premiums?

Mr Kendall: They do not reduce their premiums. If you rebate the commission back to the client, the premium is reduced by 30 per cent.

Ms Clarke: The costs on financial advisers continue to increase, especially with the new professional standards requirements, education and the new user-pays funding system coming in for regulation. So there are upward pressures on the costs to the small business practitioners.

Mr Bineham: Just on that: if you flip the argument that you are going to receive 20 per cent ongoing rather than the traditional seven or eight per cent, you are actually building a sustainable business. That is my concern for a lot of the advisers in this industry. They were thinking very short term—‘I need this amount of money up-front’. To me that speaks about the inefficiencies of the business, which we as an association want to help our members with. But to me, that 20 per cent ongoing is a far more sustainable business long term than the old traditional model.

Mr VAN MANEN: But give me an example of a business out there in the marketplace which is loss leading to gain business on a regular basis? They lose money up-front in their initial transactions in selling a product for a longer-term revenue stream on a consistent basis that is profitable.

Mr Bineham: Well, then, Medicare—doctors under Medicare. They had to learn to be far more efficient on what they were going to receive if they were going to have a business based on a Medicare payment. So just through software and efficiencies in their business model they would either try to see more clients during the day or try to provide a better service and be able to charge on top of that to show the value. So there are actual examples where people have had to reduce their income and to work out other more innovative ways to supplement that income.

Mr Fox: The overriding thing here is that we are seeing advisers getting much better at working out what their value proposition is. For a specialist now it is often much broader than just providing a connection to product. It is much more about the advice; it is the estate planning that goes with it. Some are branching across into other areas, like cashflow coaching and so on. So advisers are adapting. It is not easy, but they are adapting their businesses to be a broader value proposition to clients.

Mr KEOGH: My last question is about the behaviour of insurers. Are the insurers who are sitting behind the group insurance, direct insurance and advised insurance all the same insurers?

Mr Fox: In most cases—not all. Some do not participate in the retail market but participate just in direct or group.

Mr KEOGH: Right.

Mr Kendall: But behaviour can be very different. We have run across examples of an insurer particularly product managing. So, an old product that was nonprofitable has claims management distinctly different from other ranges of products. So you will find products managed differently based on their profitability.

Senator O’NEILL: I have two to put on notice. Could you give me some more detail—a richer understanding—of the product intervention powers that you recommended from the FPA in your submission? And, with regard to the AFA: you spoke about the use of diaries and the impact on people who are coping with mental health issues. Just a few examples of that would probably be very helpful. Thank you

CHAIR: Answers to questions taken on notice should be provided to the secretariat by 17 March 2017. Thank you for attending the hearing and for your evidence today.
HILL, Mr Damian, Chief Executive Officer, REST Industry Super

HOWARD, Mr Andrew, Chief Operating Officer, REST Industry Super

[14:09]

CHAIR: Thank you for attending. I remind committee members and witnesses that, while this is a public hearing, care should be taken to protect the privacy of individuals and that arguments should be made without naming individuals. Welcome to our new witnesses. I am going to invite you to make a short opening statement, but firstly Senator Ketter would like to make a declaration.

Senator KETTER: Yes, Chair. In the interests of full disclosure I want to put on the record that I was previously an alternate director of REST Industry Super.

CHAIR: I invite witnesses to make a short statement, and at the conclusion of your remarks I will invite members of the committee to put questions to you.

Mr Hill: Thank you, Chair, and members of the committee. REST Industry Super welcomes the opportunity to appear before the committee today. REST has unique insights into the matters before the committee. REST is a not-for-profit public offer industry superannuation fund with 1.9 million members, about one in six of working Australians, and has over $41 billion in member funds under management, so we are significant. We work with around 164,000 employers across Australia, from some of the largest in the country to the small family owned businesses, so we understand the challenges that businesses of different sizes face in keeping track of their workers and entitlement. REST provides insurance to around 1.4 million members, with insurance including income protection, total and permanent disablement and death benefit coverage. This is the largest insurance premium pool in the Southern Hemisphere. The majority of our members are young and many work in part-time, casual and low-paid jobs, so we have insights into the claim rates and insurance needs of young people. For the benefit of the committee, the typical REST member is a 32-year-old female with an approximate balance of $22,000.

Fundamental to everything that we do and are engaged in with our members is our mission to help improve the retirement outcomes of members throughout their lives. We do this by investing profits back into member benefits, through lower fees, through increased investment choices, through access to advice and, importantly, through access to affordable and flexible insurance. REST believes that affordable and quality insurance is an important part of superannuation. We strive to provide to as many members as possible death and disability insurance which meets their needs, is sustainable, is equitable and is easy to understand and which provides members with value for their premium. Our disability insurance also provides support to members who are off work and a rehabilitation program to help members return to work. In the absence of insurance cover provided by REST, many of our members would be unable to access equivalent cover in the retail or direct market and, for those who could, the cost would be much greater. REST believes that the ability to continue to earn a living is a young person's most important asset. This is why REST has led the way in offering income protection cover irrespective of whether a member is employed on a casual, contract or part-time basis.

As CEO, it is my job not only to ensure the smooth running of the fund but also to ensure that the organisation and the people who work within it abide by our key values in order to provide the best service possible to our members. Although we strive for the best, we also recognise opportunities for REST and the industry to learn from experiences and make or influence changes when necessary, as part of a process of continual enhancement. In any significant organisation such as REST it is not uncommon that disputes can arise, but I stress to the committee that these are the exception rather than the norm. Also, in regard to insurance and superannuation, where there is a dispute, REST welcomes the role of external bodies such as the Superannuation Complaints Tribunal in bringing a resolution to what can be complex issues and differing views.

Superannuation, as committee members would know, is subject to constant scrutiny and policy and regulatory changes on a regular basis. REST would like to highlight to the committee what it believes are some current deficiencies and suggest changes that would be of benefit to superannuation fund members: firstly, standardising the claims process across the industry; secondly, allowing insurers to include rehabilitation services within TPD and income protection policies. In REST's experience, the benefits of rehabilitation in assisting members recover from a physical or mental health issue and return to work are clear. Thirdly, REST suggest establishing a central insurance registry to assist in delivering better outcomes for members by ensuring the appropriate level of insurance cover is provided.

The last issue that REST would like to bring to the attention of the committee is policy cessation rules. REST are very conscious that the issue of policy cessation can be confusing, particularly for fund members. The last thing REST want to see is members being disadvantaged by policy cessation rules. We believe that reform is
needed to improve transparency and consistency in these rules across the industry; in particular, disclosure rules for superannuation and how employers notify trustees of when an employee ceases employment. Together, we believe these reforms will assist in balancing the interest of fund members to ensure that the many are not subsidising the few and that employers and super funds do not face unrealistic administrative burdens.

Thank you. I now welcome questions the committee may have.

**Senator WILLIAMS:** In your opening statement, you said 1.9 million workers; you insure 1.4 million. You are saying you have got half a million workers who do not take out group insurance with you?

**Mr Hill:** There are various reasons why those 500,000 members would not have insurance with us. They may have opted out or their account balance may have dropped below some of our policy cessation rules. By and large, as the figures indicate, the vast majority are covered, and we try to cover as many as we can under the terms of the policy.

**Senator WILLIAMS:** Not mentioning any names, but you had a rule that they had to have a minimum of $1,200 balance in their superannuation account before you would pay on a claim—correct?

**Mr Hill:** I would need to clarify that. The rule that you are alluding to—and we know the case that you are referring to—

**Senator WILLIAMS:** We know the case; we do not want any names.

**Mr Hill:** I understand that.

**Senator WILLIAMS:** The fact is that the case was rejected because there was not $1,200 in the super account, even though the premiums were paid up and you were still taking the premium—is that correct?

**Mr Hill:** The $1,200 limit applies when someone has ceased employment and we extend cover. Because we have got a lot of casuals and part-timers, we like to extend cover. At that time, when they changed jobs from one employer to the other, they would be insured for 62 days. At the end of that 62 days, the rule at that time that we are referring to was $1,200. If their balance at that time was below $1,200, the insurance ceased so that there was not undue erosion of their account balance.

**Senator WILLIAMS:** So, if the insurance ceased, did you still take the insurance premiums? You did—didn't you?

**Mr Hill:** Ordinarily, we do not. Obviously, we operate on the information that we have at hand. We need to be advised in those circumstances, either by the employer or the member themselves, that they have ceased employment.

**Senator WILLIAMS:** Wouldn't it be logical that if your premiums are paid up then you have insurance? But you had a policy where your insurance was invalid—you would not pay—unless you had at least $1,200 in your superannuation account. In the case we are talking about, leaving names out, they only had $1,120, hence you did not pay—is that correct?

**Mr Hill:** Those are the policy cessation terms that were disclosed to the member and which we administered consistent with other members at that time, yes.

**Senator WILLIAMS:** You should not have taken a premium if you were not going to pay.

**Mr Hill:** If we had known that the person in question had ceased employment, either from the employer or the member, the premiums would have ceased. We made various disclosures about that and about the need to update that. We regularly follow-up both members and employers to try to get that information. But, in this particular case, we did not have that information in front of us and so we applied the rules on the basis of the information we had.

**Senator WILLIAMS:** Mr Hill, you are not an insurance company; you are an industry super fund.

**Mr Hill:** Correct.

**Senator WILLIAMS:** If I were with you and I had a claim, I would put my claim to you and you would assess the claim—correct?

**Mr Hill:** We would gather the information, assess the eligibility for cover and then pass it on to the insurer for assessment of if there is any medical—

**Senator WILLIAMS:** Shouldn't the insurance company do all the assessment of whether the claim should be paid or not? Do you do any of that?

**Mr Hill:** We do an initial run-through of the eligibility. We have purchased insurance. As an industry superannuation fund, we have purchased an insurance contract, and we do an assessment under that. In the case
that we are talking about, we determined, as the trustee, that they were not eligible, but subsequently that got reviewed by the insurer as well.

**Senator WILLIAMS:** This is the problem I have. When you are not the insurance company, you assess the claim and you decide that it is not eligible to be paid. But you are not the insurance company. I have a problem with that.

**Mr Hill:** What we are talking about here is a death benefit claim, not a disability. I just want to clarify for the benefit of the committee that, where there is medical evidence to be assessed, that is not the assessment that we make; we pass that to the insurer to do that. With regard to a death benefit, and the tragic circumstances of this particular case, it was an initial assessment about: does our policy—the one that we bought—respond to the circumstances at hand? Because of the 62-day limit and the $1,200 account balance, unfortunately it did not.

**Senator WILLIAMS:** Have you changed that now?

**Mr Hill:** We regularly review our insurance to take into account the experiences that we have. Taking this particular case and others into account, we did make changes subsequently to our policy cessation terms. The rules now—

**Senator WILLIAMS:** Is it better now?

**Mr Hill:** In our view, it is. It would respond more favourably in the circumstances that we are talking about. So we continue death cover now. This case highlighted to us the importance of death cover. That goes down to an account balance of zero, so we will continue to provide continued death cover in those circumstances. For our disability insurance, that has increased to $3,000. There are a number of learnings and enhancements that we are looking for.

**Senator WILLIAMS:** You are in a profit-sharing situation with your insurance provider, aren't you?

**Mr Hill:** We have a premium rebate arrangement with—

**Senator WILLIAMS:** This is where people become cynical. You are going to do the assessment for an insurance claim and you can reject it and yet, if you have fewer insurance claims, you get a financial kickback—like in 2014, of $20 million—from your insurer. Do you see where people would become cynical about that situation?

**Mr Hill:** I think it is important to clarify exactly what the nature of premium rebate arrangements is.

**Senator WILLIAMS:** That would be good.

**Mr Hill:** We do have a premium rebate arrangement in place with our insurer. We believe that a premium rebate arrangement maximises the alignment between the insurer and ourselves.

**Senator WILLIAMS:** 'Maximises the alignment'? What does that mean?

**Mr Hill:** If you will let me continue—

**Senator WILLIAMS:** Yes, but I am trying to get you to translate it on the way.

**Mr Hill:** Okay. We think it aligns our claims philosophy behind each other. If I can explain that, what we are trying to do from our side of things is put a cap on the profit that the insurer can get. When the actuaries are pricing a policy, they are taking into account the risk. If the claims experience is lower than what was priced, if we did not have a premium rebate in place, the insurer would just pocket that profit. With a premium rebate in place, that excess premium, that excess profit, comes to us. What we do with it is the important thing then. The two main things that we use this premium rebate for when it comes to us are—obviously there could be future claims for that policy period, so we have to keep that money to cover any of those future claims, and we can only release it back if we get a sign-off from an actuary. That is one of the key things we do. The second thing that we did in the period between 2008 and 2013 is that we subsidised the premium, for a period of five years, for our members. We got the premium, this profit, back from the insurer, and we said, 'How are we going to use this for the benefit of the members?' We have got no shareholders to distribute it to. It is all members' money. We use that to subsidise and reduce their premiums for a total of five years.

**Senator O'NEILL:** Thank you very much, Mr Hill. I want to clarify some evidence that you just gave. For death cover, if there were a death claim for a 27-year-old, for example, when you said it goes down to zero, what did you mean?

**Mr Hill:** If you cease employment with an employer who is paying to REST and we have an account balance, we will continue your death cover and take the premiums out—

**Senator O'NEILL:** For death only?
Mr Hill: If it is above $3,000 we will do death and disability, but at $3,000 we turn off the disability so that we do not unduly erode your account. We know from cases such as the senator was talking about that death cover is really important to families in those circumstances. So it is possible, over an extended period of time—

Senator O'NEILL: To erode that to zero.

Mr Hill: to erode that to zero. But we have set that $3,000, which we think is the right balance here. We are aware of funds that are the zero level for all cover, so they will erode no matter what; and others that have a balance around the $10,000 limit—that is when they start turning off cover. So we are about right in the middle of the industry pack here.

Senator O'NEILL: This is probably a good time for me to ask you about your suggestions about standardisation because, clearly, that is a very differentiated marketplace. For some that is great because it is competition and it means that there are different products out there, but the other side of that is that nothing is clear to anybody who is not a deep reader of the sector. Can I take you to what you were meaning in your first dot point about standardised claims processing across the industry.

Mr Howard: If I may, I might say a few words. There are differences in the way that claims are captured for lodgement, and there are different ways in which the assessment processes work and the time frames by which claims are decided. We think that it is very important that that be worked on effectively and that, if there were consistency in the way things happened and there were greater ways for people to expect how their claims would be managed, that would be good for anybody who is involved in the unfortunate process of making a claim.

We have been working at REST on this over the last 18 months very assiduously. We have taken the view that we need to reduce the number of questions that we ask members in submitting a claim, and we have reduced the number of questions for death claims by 33 per cent, taking 30 minutes out of the process; by 66 per cent for terminal illness, taking 60 minutes out; and, in the case of TPD, 44 per cent of questions, taking up to five hours out for members who are going through what is a difficult process. We would like to encourage the industry to work together to do the same. It is the hard work, it is the graft in insurance to do this work in the process, but it is the most important thing to do for members, because it can be difficult to make claims.

Mr Hill: The flow-on impact—and we have talked about the member impact of the investments that we have made—is that we have seen a great increase in the quality of the information. There has often been a lot of to-ing and fro-ing sending forms backwards and forwards across the industry, back to the members to complete this and that. With that increased quality we can speed up the claims process and, in the case of disability in particular, intervene earlier. Our records show that if you are able to intervene earlier you have a much greater chance of getting someone back to the workforce and being a meaningful part of the community and earning an income etcetera. That is vitally important.

Senator O'NEILL: One of the things we have been hearing about is the underwriting—the point at which it occurs—whether it occurs on acquisition or at the point of discernment of a claim. It strikes me that there were lots of questions that were being indicated as necessary to be asked at the beginning. You are saying that fewer questions are leading to better data, which is quite different from what we have been talking about in the hearing so far. How are you managing to get better information with fewer questions?

Mr Howard: We should possibly make the distinction here between getting cover and making a claim.

Senator O'NEILL: Which part are you talking about?

Mr Howard: I was talking about the claims process. When you go ahead and make a claim there is a number of questions that you need to answer in order for the claim to be assessed. As an industry we have asked a lot of questions, which makes it difficult for regular working Australians to work through the process. I think the work that I spoke about is an effort to make that easier and, in addition to that, we have gone ahead and said to members, 'If you want to make a claim you can also call us, and we will capture your claim over the telephone.' There is a lot of discussion about electronic methods to make claims. What we have also learned about our membership—which is a big membership—is that not everyone has access to a printer. Not everyone works in an office or has a printer at home. Many of them do actually need an effective paper process. So it is an interesting set of issues.

Senator O'NEILL: They cannot afford the internet on their low wages.

Mr Howard: Maybe, yes.

Mr Hill: But it has been quite common for disability claims to ask questions about all medical conditions. That would be part of the form. Part of how we have managed to do it is to bring in behavioural economics. We have gone overseas with our reinsurer and brought back some of their insights about behavioural economics in...
designing and redesigning the forms and working with our insurer about what questions really need to be asked in order to cut that down.

Mr FALINSKI: Can you give us an example of that?

Mr Hill: The most simple example we can give is that often people did not sign the form. That is one thing. You go through a whole process. I am not even getting into any of the medical questions. Just sign the form. It is at the end of whatever. Trying to get them to sign that up-front. Where you position that and the recall to that does make a difference. The quality of the initial claims advice from the member has improved dramatically.

Senator O'NEILL: How quickly do you get from your processes that information into the insurer's book and log for them to deal with? How much repetition of supply of information is required?

Mr Howard: It varies from different claim types as to how long it takes. Obviously some of the claims are a little bit more straightforward, such as the death and the terminal illness claims, because it is a fairly defined part of the claims process, whereas for income protection and TPD it can take longer. Both income protection and TPD also have waiting periods—in our case, for TPD it is three months and for income protection it is 60 days. So there is a period of time to elapse. There is also medical assessment that needs to occur. Often the individual has to provide a statement from their doctor. Then, once that is put together with their own statement and potentially a statement from their employer, the assessment process goes ahead and examines case by case whether further medical evidence is required. But generally speaking it is a function of how quickly the individual can respond to the information requests—or the employer, or the doctors if they are involved. That is tricky.

CHAIR: It would make that hospice pretty hard, wouldn't it.

Mr Howard: Yes, it is tricky.

Senator O'NEILL: If you are sole parent and you are trying to manage all of this while you are managing your illness as well, it can get very difficult.

Mr Howard: It is tricky. Everything we can do as an industry to make that easier is an important thing for us to be doing.

Mr Hill: That is why taking claims over the phone rather than having to appear or spend that time, we think, is a small but important step in improving the experiences of claimants.

Senator O'NEILL: Assuming all the forms are filled in, you hand it on to your insurer.

Mr Howard: That is right.

Senator O'NEILL: How much does your member have to provide additional information to the insurer, do you know?

Mr Howard: I cannot give you any facts and figures on that, but it does really depend on what type of claim it is and what kinds of illnesses or injuries we are talking about.

Senator O'NEILL: What sorts of delays happen there, as well?

Mr Howard: Probably the principle delay is getting information from medical practitioners.

Senator O'NEILL: Can I ask about medical practitioners. There is some concern that there is an industry of medical practitioners who rely on providing reports to insurers as their main source of income. How much does your insurer rely on information from the person's doctor, which is along the continuous relationship for many, or on a single report from an independent medical examiner?

Mr Hill: With regard to individual medical examiners, obviously our insurer relies on the GP and, usually, depending on the type of illness or injury, a specialist. If there is conflicting information or a gap in the information, that is when they would use an independent medical expert. We understand that our insurer uses independent medical experts from a panel of 11 different companies. Our membership covers all aspects of Australia. It is very geographically diverse. We try to find the right type of specialist in the right area to reduce the inconvenience of the member of going to an independent one. But they are not tied into just one independent medical expert or one company; there is a broader panel from which they can choose. They are continuing to look at how they can further enhance that.

Senator O'NEILL: I do not want to put you under too much pressure, but I wonder if you could provide on notice the names of those independent medical examination services that you use.

Mr Hill: We ourselves do not use them. It is the insurer who I know is appearing as a witness next Friday. I thought that may be more appropriate.

Senator O'NEILL: You made two other recommendations. Could you speak to the third one: a central insurance registry to assist in delivering better outcomes for members?
Mr Hill: Whilst there have been some improvements through some of those superstream initiatives, which is the back-office infrastructure supporting the superannuation industry, and that has led to much greater consolidation amongst members so that there are fewer multiple accounts, multiple accounts are still an issue and, when funds are providing default insurance, this can lead to multiple insurances and the potential for overinsurance. In the information that funds provide to the central registry—the tax office at this stage—it is information about superannuation but no information about the existence and what types of insurance are attached to each superannuation account. We think that, by leveraging off the existing infrastructure between the superannuation funds and the tax office, at least some basic information to say that there is insurance on this account of the various types—debt, total impairment, disablement, income protection—actually provides members with a much greater insight into where they have got insurance if they want to consolidate in full knowledge of what they may be giving up.

Senator O'NEILL: And they would get that every year with regard to their income statement.

Mr Hill: And they can search for it any time on the ATO site as well. It is a real-time service that members have.

Mr VAN MANEN: A couple of questions I was going to ask have been asked, so I will go to a different one. What KPIs do you set for the insurance company that wins the provision of the contract to provide business to your members in terms of processing claims?

Mr Howard: I could provide further detail on that on notice, but in essence it is mainly around service, the turnaround time and time to respond to information and processing volumes.

Mr Hill: And that is something that we monitor on a regular basis. You can negotiate the contract up front, but we are talking about over 4,000 claims a year happening. We see our responsibility as the trustee to be very closely managing the insurer, seeing how quickly their turnaround times are happening and, if there are any claims that seem to be falling above and outside reasonable limits, trying to think of how we can intervene. We might be having a problem with a doctor. We might be having trouble from an employer who might have gone out of business or is struggling to get the records. Are there other ways that we can get this claim back on a reasonable path? That is what we have got staff specifically dedicated in rest to do on a continuing basis.

Mr VAN MANEN: How long do those contracted insurer contracts remain in force? How often do you retender your insurance business?

Mr Howard: We look at it generally every three years. It is about reviewing the claims experience, the currency of the policy terms and conditions and any new benefits that might be considered to be added to the policy. From time to time we go to market and assess either the reinsurance or the insurance component for pricing terms and conditions.

Mr Hill: The last time we did it, a few years ago, we looked at the pricing. It was the time when there were quite significant increases in premiums across the group life area. We had one of the lowest increases and were pleased that we were able to retain a disability definition to be an unlikely one from a TPD point of view.

Mr Howard: I should add that we use an independent actuary to help us assess policy terms and conditions, pricing and any new benefits.

Mr VAN MANEN: In that process, have there been occasions in the renewal or replacement of a contract where there has been a diminution of the benefits to the members in the fund?

Mr Hill: In 2008 we made significant changes to our insurance; this was mainly related to our young people. What we found—it is typical in the industry—was that young people were being overinsured, particularly for death cover. Their needs are much lower, and that is where we have particular insight. When you are a young person, the focus should be much more on disability than on death cover. So we changed our cover to lower the TPD cover at young ages but made it an age-60, a long-term income protection, cover for young people. We think that their most important asset is their ability to earn future income.

Mr VAN MANEN: Is that automatic?

Mr Hill: The default cover is death cover and TPD cover. For all people it is all of them, but for a young person it is a small death cover, a small TPD cover to make changes to the home or the car if it was a really serious—

Mr VAN MANEN: Can the TPD exceed the death benefit?

Mr Hill: We have unlinked those. But it is small. It is mainly to do the capital things that you need to do and it is more to do with the ongoing income stream that we provide to hopefully rehabilitate them back into work. That is particularly important with mental health these days. There is a growing incidence of mental health claims.
Whilst some mental health claims are very significant and fully debilitating, a lot of mental health claims are episodic, and intervening and giving them an income early and being part of a retraining and rehabilitation program has much greater success in getting them back into the workforce.

Mr VAN MANEN: So your IP policy is automatically to age 65 or when they return to work.

Mr Hill: Yes. It is to age 60, and it is a two-year benefit when you get to age 58.

Mr VAN MANEN: If you have a claim—you are on claim for a couple of years and return to work—then five years later you have another injury with a period of time off work, there is no restriction on your ability to claim a second time?

Mr Hill: Yes. Indeed, our exclusions for our policy are only with regard to active service in the armed services. We have no mental illness exclusion and no suicide exclusion for our default cover.

Mr VAN MANEN: When you are renewing contracts with your underlying insurer, there is no impact on the qualifying conditions for your members. It is based on when they join the fund, not the date at which your insurance companies may or may not change?

Mr Hill: The terms and conditions evolve over time, usually for the benefit of members. To give you an example, in the early days of this cover you needed to work 30 hours a week in order to qualify for cover. That is what it was. Because of the large pool that we had we were subsequently able to renegotiate that and get that down to 10 hours a week. We did not want those who were working in the middle to miss out. We have subsequently reduced that to zero hours so that casuals, part-timers and contractors are covered. The terms do evolve over time, but we make sure that we move everyone along to those new terms and we spend a lot of time upfront and money in making sure we communicate very clearly and with specific insurance information, not tied up and hidden behind a much broader communication about what the changes are to that insurance.

Senator KETTER: Following on from that, how do you communicate that? Is it in the form of emails? I understand that it is a large membership with a lot of young people, who are potentially disengaged from financial services.

Mr Howard: We have two ways of communicating and we have since added a third in the last 12 months. One is to send what is called a 'significant event notice' to members, and that usually goes by mail to their nominated address. We also can post the same onto the website. In the last 12 months, we have really focused on being able to contact members digitally. We have gone through all our records to see if we can have an address or a mobile phone, with members' consent. Last year, we sent 1.4 million statements out by email or mobile rather than by paper, and we are looking to expand our communication in that way as much as possible, in line with digital disclosure guidance from the regulators. We certainly believe that things have changed since the invention of the iPhone and people are more likely to check their information on a smart phone than they are to empty their mailbox.

Senator O'NEILL: Especially if it is a video.

Mr Howard: That is right. It has been a very big step forward for the fund to have done this. We know when people are opening it, so we get a sense of how well they are receiving the information.

Senator KETTER: Just going to the issue of the premium rebate, some submitters earlier today suggested there is a potential conflict of interest there with the fund receiving a payment from the insurance company. I am looking for some more information as to how that rebate—if you do receive one, and I think most recently you got a $14½ million rebate from the insurer—is applied? Does that go directly to the members?

Mr Hill: Yes. The first part of that is we get it in our accounts, and it is fully disclosed as part of our financials, and we get to invest that to earn income for the members in the first instance. But part of what we receive we need to hold in reserve in case future claims are a bit higher and we have to pay it back to the insurer. But we have it; they are not earning income; they do not have it in their accounts; it is in our accounts. The second thing is that if we find that ultimately the claim's experience is not going to get to where we thought, we have the duty as to how we distribute it back to members. The most recent example is when we had a surplus from that we used it to subsidise premiums between 2008 and 2013 for all our members to the tune of five per cent for that entire period. That eroded what had been built up from the premium rebate. So all that premium rebate is the property of our members. We make no financial gain or benefit out of it. We are a not-for-profit superannuation fund.

Senator KETTER: Earlier submitters have suggested that young people have no need for insurance. In your testimony, you indicated that you have analysed this fairly closely. I notice that there were a number of claims—I think the figure was 278 death claims—
Mr Howard: It was 268 death claims for under-25s and 478 TPD claims for under-25s. That is a reasonably significant percentage of all the claims that we pay. When we consider that there are around 4,000 claims paid in a year, for example, around 20-odd per cent of the death claims that we do pay are for young people. It is also worth noting for the committee that the cost of insurance is quite low for younger members. If you were to take a 25-year-old, they would be paying in aggregate for the default cover $5.65 a week, which is around $294 a year to get a $240,000 death benefit, in the unfortunate circumstance, and $68,000 for TPD. That is because we put the emphasis on income protection where they would attract a benefit of $2,400 per month in income protection should they be unable to work.

Senator KETTER: So instead of $5.65 what did they actually—

Mr Howard: They pay $5.65, and those are the benefits that they would get. I guess the point is that we believe at REST that young people need insurance, we have evidence that they do claim, and the amount of cover is calibrated to what they might need. Mr Hill spoke about lower amounts of death or lower amounts of TPD when you are younger and an emphasis on income protection. That has meant that we have been able to keep the costs modest, whereas you may have encountered discussion around high levels of insurance at younger ages, high death benefits and high TPD benefits which, in our view, do not necessarily suit a younger audience, because their needs are for the most important asset that they have, which is their ability to earn an income.

Mr Hill: In our submission, there was a case study. It is not only that they claim, but they have needs. With disability it is obvious that they have needs, but even from a death point of view the claim that we highlighted was of a 25-year-old who died with five dependent children. We have unique insight because of the number of young people we have there. Usually we find that people who are advocating otherwise have only a very low incidence of young people and do not get the full breadth, particularly at a low income. There are mental health issues particularly growing. It is a particular issue in regional areas as well. That is why we think it is important to provide this. We accept that our insurance is quite different to other benefits for young people.

Senator KETTER: What about your claims acceptance rates? I see 97 per cent for death claims for the period from 1 September 2015 to 2016. How does that compare? Do you benchmark that to see how things are going?

Mr Howard: We do get some comparative information from time to time. From what we can tell, they do compare favourably or at least are in line with industry practice. Those figures were that, of the death claims that we receive in full, 97 per cent are paid, 98 per cent of terminal illness, 80 per cent of TPD and 73 per cent of income protection.

CHAIR: This morning I asked a question of the Financial Rights Legal Centre and the Australian Lawyers Alliance, who spoke to us about mental health coverage and a long bow being drawn that some insurers had not allowed a claim because they had said that the client's cancer was caused by a mental health issue. I thought that was a long bow, and I wondered whether, if the client had known that before they actually started paying premiums, they would actually have taken the contract out. Their thought was: no, they would not have. So do you think the industry needs to make that type of exclusion or that type of information better known to people who are applying for insurance, particularly when it comes to mental health issues?

Mr Howard: Particularly in regard to mental health, I would agree. As I said before, because we are providing cover to such a large number of people, we do not have suicide or mental health exclusions for the default cover. We may have them when you dial up and get underwritten for additional cover, which we would make known to you.

Another role that I play is as the chairman of SuperFriend, which is a mental health foundation that is looking to reduce the stigma of mental health and the incidence of suicide. One of the things that it recently put out, last year, in conjunction with the group insurers, is called Taking Action, and it is about how the industry should deal with psychological claims. They still have to go onto underwriting for those with mental illnesses as well, and there are a few other action items, but that is now being embraced by the industry. Insurers are at different stages of introducing some of those things, but I know that there is also interest from various WorkCovers et cetera to pick that up as well.

CHAIR: One of the other questions I asked someone else was: if, say, we were to bring 20 of your life insurance members in here, do you think that they would fully understand the overall impact of insurance premiums on their eventual retirement income? I know you are saying you are trying to improve your communication.

Senator WILLIAMS: Most of them probably would not know they have life insurance.

Mr Hill: It is a difficult one to answer. Certainly in our submission we quoted a study from AIA that suggested that, over the Australian population, if cover was not provided by superannuation then about half of
them would not expect to have actually taken that cover out anyway. So, we see that it is very important to provide the cover because of the needs in a default system, because young people in particular are not as bulletproof as they say they are. We have certainly been able to provide benefits at times to members who did not know that they had insurance, whether income protection or life insurance.

CHAIR: We heard that you received some payments back from the insurance company. I think it was around $14 million or something like that.

Senator WILLIAMS: It was $20 million.

Mr Hill: It is in our submission.

CHAIR: And that money was not actually credited back to the members' accounts but you said you used it to weigh up for future increases maybe, or you advertised across—to reduce their payments by five per cent. Over what period of time do you calculate that period? Say that for three years in a row you got refunds back from the insurance company. When would that eventually see its way back into the members' accounts?

Mr Hill: It is a good insight, and the whole issue of equity here is one that is at play. When we get it back, we get it back early on. If we consider a policy year, we try to get it back early on and get actuarial advice about how long it is before the claims that are expected—the tail of claims—are such that we will not need to call on that money. That is the first thing we have. It would be terrible to distribute it back to members and then find that we do not have enough money to pay for their future claims. So, we seek actuarial advice before we release that, and then when we release that we try to do it in a reasonably short period of time. You do not know how fast it is going to happen and what the next policy period is. So, we try to make sure that the gap is not too large, but it is a balancing act that the trustee exercises under its fiduciary responsibilities. But it is very conscious of the equity issues that are at play here.

CHAIR: I hear a lot about how the superannuation funds in Australia do not invest heavily in Australian infrastructure. Is that correct? Or would you say your portfolio has a share in equitable investment into Australian infrastructure?

Mr Hill: We have about a five or six per cent exposure to infrastructure amongst our whole portfolio and elsewhere in our portfolio. That includes wind farms in WA, pipelines in South Australia, cropping farms all the way around Australia, roads, airports—and I am trying to think what else I am missing. There are various properties in Australia as well, but we do also have infrastructure overseas. But the way I would describe the state of the market in Australia at the moment is that there is a lot of overseas capital coming into Australia, from the Middle East, from Asia and from Canada, and the price of these assets is being bid up in Australia. So, one needs to be cautious about when to buy those assets. There is nothing worse than buying them at the peak of the property. Your purchase price is a big influence on the ultimate return that you are going to get.

CHAIR: Someone has to buy them at the peak!

Senator WILLIAMS: Just reading the paper from four days ago, analysis of the Australian Electoral Commission data carried out by financial research group Rainmaker Financial Standard alleged that industry super funds donated more than $4.8 million to unions and ALP-associated entities during the last financial year. Did REST pay any money to any unions or any benefits?

Mr Hill: It is our policy that we do not make any political donations to parties on either side.

Senator WILLIAMS: And unions?

Mr Hill: And unions. We do have directors on our board, as you know, in an equal representation model, from the union, and they receive directors fees, as do other directors on the board. And some of those refer those payments back to the union, because they are employed by the union.

Senator WILLIAMS: So, the unions in some way get a little bit of a kickback.

Mr Hill: For the time and commitment that individual directors—

Unidentified speaker: I would not say it was a kickback.

Senator O'NEILL: It is a voluntary—

Senator WILLIAMS: Well, when we have a royal commission we will make sure we include all this and get all the details out there!

Mr Hill: But I will confirm: no political donations to political parties or—

CHAIR: But there are other fees or invoices paid—indirect fees—are there?

Senator O'NEILL: Directors have discretion about what they do with their fees. That is the thing.
CHAIR: Gentlemen, thank you for your time today. We have run out of time. Answers to questions taken on notice should be provided by 17 March 2017. Thank you for attending the hearing and for your evidence today.
BINGHAM, Mr Stuart, General Manager, Australian Prudential Regulation Authority

REES, Mr Adrian, General Manager, Australian Prudential Regulation Authority

SUMMERHAYES, Mr Geoff, Member, Australian Prudential Regulation Authority

[15:01]

CHAIR: Welcome. The Senate has resolved that an officer of a department of the Commonwealth or of a state shall not be asked to give opinions on matters of policy and should be given reasonable opportunity to refer questions to a superior officer or to a minister. This resolution prohibits only questions seeking opinions on matters of policy and does not preclude questions asking for explanations of policies or factual questions about when and how policies were adopted. I particularly draw the attention of the witnesses to an order of the Senate on 13 May 2009 specifying the process by which a claim of public interest immunity should be raised. Witnesses are reminded that a statement that information or a document is confidential or consists of advice to government is not a statement that meets the requirements of 2009 order. Instead, witnesses are required to provide some specific indication of the harm to the public interest that could result from the disclosure of the information or the document. I remind committee members and witnesses that, while this is a public hearing, care should be taken to protect the privacy of individuals and arguments should be made without naming individuals. I now invite you to make a short opening statement, and at the conclusion of your remarks I will invite the members of the committee to put questions to you.

Mr Summerhayes: APRA welcomes the opportunity to make a statement and also appreciates having had the opportunity to make a submission to the committee to aid your important work. As you would be aware, the APRA submission had five chapters, and we hope that was of some use to the committee. We gave an overview of the life insurance industry. We also looked at Australia's financial regulatory framework, including APRA's mandate and the core capabilities that are in place to deliver against that. We also looked at APRA's core functions and discussed the toolkit of responses available to APRA to address emerging issues in the industry, outlined our recent prudential activities in the life insurance industry and had a chapter covering legacy products in the life insurance industry, which is a particular area of focus for APRA at the moment.

I would like to briefly update the committee on matters raised in our submission and in particular recent action APRA has taken since the submission was put to the committee in November. And I want to cover three areas in my opening remarks: claims, legacy issues, and CommInsure. Firstly, regarding claims, APRA has worked closely with ASIC to address any weaknesses identified in the way life insurers are managing claims. Life insurers recently provided both ASIC and APRA with their independent reviews that have been undertaken on their claims handling, and we will analyse these to ensure that they demonstrate adequate governance and oversight by the life insurers of their claims processes. Where necessary, we will raise directly with the insurers any particular issues or prudential concerns that we have.

In addition, arising out of ASIC's report 498 on life insurance claims issued in October last year—2016—APRA is working with ASIC to introduce a regular collection of standardised life insurance claims data. Accurate and timely data is imperative, and a staged development of this process is critical to ensure effective capture of information that is useful for regulators, the industry and, importantly, consumers. We are consulting with industry to design and test this new collection, and we will also consult with consumer groups on the collection of the data. A major milestone of the data collection will be undertaken in May of this year when we start the first collection of data as it relates to that process.

Secondly, legacy issues. We have highlighted in our submission our focus on the complex legacy issue of long-term life insurance contracts and old systems. In a recent speech, APRA chairman, Wayne Byres, said that APRA wanted to see all regulated industries invest appropriately in back-office functions and not only front-end systems. This is especially crucial for the life insurers. As we said in our submission, we strongly support the FSI's recommendation 43 for regulatory reform, as well as a more comprehensive effort by the industry to address legacy issues for the ultimate benefit of policyholders. APRA will continue to increase pressure on insurers to invest more in this area so that insurers' systems and processes are more capable of meeting community and policyholder expectations. To that end APRA is engaging with a range of industry participants, including system vendors as well as insurers, to apprise ourselves of the current industry thinking and plans as part of encouraging life insurers to deal more proactively with this issue.

Finally, CommInsure. Our work on CommInsure has had two main areas of focus. Firstly, APRA has engaged with the board and senior management of CommInsure to gain assurance over the robustness, completeness and independence of the review's commission to investigate the allegations and ensure that stakeholder and community expectations are considered through this process. APRA has met with the independent reviewers, and
these reviews are now complete. APRA is satisfied that the reviews are robust, complete and independent, and APRA will now focus on CommInsure's implementation of the report's recommendations.

Secondly, we have also met with the whistleblower who brought the issues to light and are considering whether the whistleblower provisions of the Life Insurance Act, designed to prevent the identification and victimisation of whistleblowers, have been adhered to. We are now seeking independent advice on these matters in order to conclude our current inquiry. With that update, Chair, my colleagues and I are happy to take the committee's questions.

CHAIR: Thank you, Mr Summerhayes. Just quickly, before we go to the other committee members; you just mentioned that the APRA chairman, Wayne Byres, said that he wanted to see all regulated industries invest appropriately in back-office functions. Can you define what a back-office function improvement would be.

Mr Summerhayes: Yes, sure. Life insurance is one of the more complex sectors of the financial services landscape. In many ways life insurance has almost inbuilt complexity and inbuilt legacy, given the nature of the contracts and the long-term nature of the contracts—that is, those core administration systems that hold the product data and the customer data and the workings of those products has to stay on foot for the life of the contract. In many cases, life insurance contracts extend for many years and, in some cases, decades.

Insurers have done a reasonable job of investing in an array of systems, not only claim systems, underwriting systems, workflow practices and web-based front-end. But in many cases the core administration systems that exist within life insurers, which hold the customer records and the functionality of the product—if you like, the engine room and system of record for the insurers—are, in some cases, 20 and 30 years old. These core systems have not been invested in. While the entities have certainly upgraded an array of IT infrastructure, it is an issue not only for life insurers but the financial services sector more broadly, including insurers and ADIs.

CHAIR: You have said that APRA is satisfied that the reviews on CommInsure are robust, complete and independent. I always have doubts, in that how independent is about who pays for the reviews. Who is the sponsor of the reviews?

Mr Summerhayes: Neither APRA nor ASIC conducted those reviews. Those reviews were conducted by a range of independent legal and accounting firm experts. What APRA was particularly concerned about was that the broader stakeholders in the public, and APRA and ASIC, could rely on those reviews to ensure that they were thorough, complete and independent. It is true that CommInsure has picked up the bill for those reviews but, given APRA's mandate, the way the governance of those reviews took place and the scope of those reviews were of particular focus at the start of the process in the middle of last year.

CHAIR: We all saw during the period from 2008 to 2012 the strength of our banks in Australia due to APRA's regulations. Do you think the insurance industry part of the banks is regulated enough? Are you satisfied that the products that are being given to customers without them seeing them are satisfactory to meet APRA standards?

Mr Summerhayes: It is important to highlight that APRA supervises some 29 life insurers' life insurance licences, including primary insurers and reinsurers, and there are a further 12 friendly societies. As we sit here today, only a small percentage of those 29 are in fact owned by banks and, as time passes, that number is decreasing, which is on the public record. In fact, our submission points out how the life insurance landscape has changed over recent years. There are now three Japanese parents of major and significant life insurers in this market, a significant pan-Asian investor and also an American investor in the top insurers. I want to pick up the point that it is incorrect to characterise the industry as one that is in any way dominated by the banks, notwithstanding that there have certainly been in the public domain issues with banking owned life insurers.

As to APRA's mandate, which is a prudential one, APRA has no current concerns with the prudential soundness of any of the life insurers. The capital adequacy ratios have been built and recovered since the GFC. We certainly have some broader issues of concern, which we have addressed in our submission, but prudential concerns is not one of them.

Senator O'NEILL: You indicated that there are some expectation gaps in the sector. Could you spell out more clearly what those expectations are and how you see them being bridged?

Mr Summerhayes: I will cover that under the broader topic of social licence. I think not only the life insurers but also the financial services sector has operated with an implied social licence for some time. That social licence has in many ways been challenged, particularly over the last 12 months, and the fact that this committee is sitting on this subject is an indication of symptom of that. What has happened? Despite the very good and important work and certainly the intent of what we see of board and senior management to do a good job with the products and services that are offered, there is a gap in community and community expectations on that.
A lot of that has to do, in our view, with the complexity of the environment. This is often characterised as poor behaviour or poor culture, but that is, perhaps, an overly simplistic characterisation of the issues. Where there is a complex environment and consumers do not understand what their cover is, how their cover works and what their rights are under that cover, then when they come to the moment of truth and if they find that they thought they were covered and they may not have been—and legally they might not be covered—there is a breakdown in that trust. I think the sector, which acknowledges this, could certainly to a better job on explaining the role of the offer and the important role it plays in the community, but it could also do a lot more in the simplification of how the products and services are offered, which would improve engagement and improve understanding. In part, this challenge is somewhat compounded by the long string of legacy issues within the sector, which the nature of life insurance, as I said in my opening remarks, almost perpetuates.

Senator O’NEILL: I want to ask you for an opinion, but I will not do that. Could I just go to the evidence that we have received that talked about the carve out for the insurance sector because of the phrase ‘utmost good faith’ and propositions that were put to us today that the carve out that keeps them from having to deal with unfair contract legislation is something that needs to be redressed. Do you have any advice for the committee with regard to the appropriateness of unfair contract provisions now becoming part of the insurance industry?

Mr Summerhayes: Some of those matters are more to do with ASIC’s mandate than they are with APRA’s mandate. You are concerned with the prudential soundness—

Senator O’NEILL: Which you have said is fine. If the reputational damage continues to be hit, ultimately, that is going to have a prudential impact.

Mr Summerhayes: And that is why we are interested in the subject. As to the policy implications of the strategies going forward, we do not traditionally offer a view on those policy positions. We could certainly give a view to the prudential implications of those. I do not know if my colleagues want to comment on that.

Senator O’NEILL: You have some information here about claims, and today we have been hearing quite a bit of information about increased claims for mental health and mental illness. We have also been hearing concerns about the way in which that is managed in multiple ways—the mismanagement of that. Have you any information to share with the committee around mental health from a data point of view and from your insights?

Mr Summerhayes: I might ask my colleague Mr Rees to make some comments, but as an opening position, it is true that the incidence of mental ill health in our community is on the rise. It has been a factor in life insurance claims. It has certainly been a factor in disability insurance income claims, and the disability income product has run at a loss at an aggregate level in the industry for the last three years. That is at significant loss levels. I am not saying that that is due to mental health-related issues. I think the industry would acknowledge that it has been playing catch up on these important issues.

Mr Rees: In regards to the information that we have, it would be fair to say that it is an area where we are considering the claims data collection work that we are doing jointly with ASIC. That would be one of a number of areas where it might not be unreasonable to assume there would be some more granular information available as a result of that collection. We do not collect a lot of information on specific claims issues at present.

Senator O’NEILL: One of the issues that we have struggled with a little bit today is the benefits of standardisation and some clarity around language that might come with standardisation, and the capacity for a differentiated product to be available to meet different needs. With regard to understandings of mental health in particular, standardisation, and terms of understanding of particular terms, seems to be a really pressing matter. Have you done any work on that, or are you aware of any work being done on that? I am sure that is impacting on the sector in quite a significant way.

Mr Summerhayes: APRA has not sponsored any such work. Again, it would not necessarily fit within our mandate, but we are certainly aware of work that the industry has done. While I made some comments that the industry is playing catch-up, my understanding through the industry association is that the FSC in particular has done a lot of work in more recent years on engagement with mental health groups and on improving education and understanding at both the underwriting and claims levels of organisations. But it is not work that APRA has closely been involved in. What we would be focused on is the governance and risk management dimensions of that, and ensuring that insurers are factoring that into their underwriting and claims oversight.

Senator O’NEILL: Did you say what the percentage of claims has been for mental health illness in the last three years, where you have had this change?

Mr Rees: That is not information that we would collect.

Senator O’NEILL: Thank you.
Mr FALINSKI: You said before that the industry is suffering significant losses in TPD insurance. Did I hear that correctly?

Mr Summerhayes: Disability income insurance; individual disability and group, yes.

Mr FALINSKI: So those losses are significant in that line of insurance?

Mr Summerhayes: Yes.

Mr FALINSKI: But you do not know whether that has been driven by mental health claims or other claims?

Mr Summerhayes: It has been driven by an inappropriate pricing of the risk of those contracts of which mental health claims are a factor.

Mr FALINSKI: Sorry, just to be clear on this: when you say that, I take it to understand that the product has always been mispriced, or that the product was not mispriced but claims experience has changed so that it is now mispriced.

Mr Summerhayes: In the annexure of our submission, there was some data—I will come back to the reference on that in a moment. It is on page 7 of our submission. Individual disability income insurance was loss-making in 2012, 2014-2015, significantly, and 2016.

Mr FALINSKI: There are a number of ways that this occurs, and what is not clear from your submission—but I am implying from it—is that there has been an increase in claims for disability insurance.

Mr Summerhayes: There has and, in terms of industry practice, this would be a question to put to insurers. The premiums of income protection products are deductible and, as a deductible expense against your income, they are attractive products as part of an overall package of insurance that is offered to a client. As you can see from our data, what is called the term or the life cover is typically more profitable, and the insurers take a position that the package of insurance and the portfolio of insurance on the whole is profitable, but this individual line of insurance—

Mr FALINSKI: This is typically a long-tail insurance product?

Mr Summerhayes: Correct.

Mr FALINSKI: Is there inflation in the claims, or is there an increase in the claim numbers, or both?

Mr Summerhayes: There is a mispricing of risk at the core of the issue.

Mr FALINSKI: What has created that mispricing?

Mr Summerhayes: Typically, competition.

Mr FALINSKI: What has created that mispricing? Typically in long-tail insurance, it is one of two things. It is either claims inflation has taken over, which is in conjunction with either a number of claims or a number of claims on their own.

Senator O’NEILL: Mr Somerhayes just did say it was competition.

Mr Bingham: There are a range of factors that go into the claims experience. There is the claims incidence rate—so the number of claims that occur. And for income protection business there is what is called a termination rate. By its nature, with income protection you make a payment per month for a period of time. As you say, inflation has an impact on it. All of those factors are having an impact on the claims experience in the life insurance industry. So we see incidence rates going up but we see termination rates declining as well. So the combination of that results in the overall claims cost going up. What you see in our results is the reserving impact as well. When you change your assumptions, as many companies have done in the recent past, particularly termination rates, you get a one-off impact on the liability. You must increase your liability, and that is coming through in the results as well.

Mr FALINSKI: In other words, they have kept capital for a period of time and now they have released that capital because they assumed that the inflation rate would be slower in the termination rates.

Mr Bingham: No. The termination rate is when people either go back to work or are no longer eligible for claims. That is not inflation. Inflation is at the yearly interval—

Mr FALINSKI: So they have changed the underlying assumption that the termination rates will be higher than they were before?

Mr Bingham: Lower.

Mr FALINSKI: Lower than they were before.

Mr Bingham: That means people will stay on claim longer.
Mr FALINSKI: Why have they released capital if they believe that to be the case?

Mr Summerhayes: I am not sure whether they have released it. In fact, a number of insurers, certainly the publicly-listed insurers—you would see this in their disclosures—have taken very significant hits on these books of business, as have the reinsurers. We are talking in the hundreds of millions.

Mr Rees: If these results are the worst experience they are seeing, they apply that across the whole book of business that they have. That actually requires them to hold more capital, because they have to increase the liability valuations in their balance sheet.

CHAIR: Just on the previous question—

Mr VAN MANEN: Just to follow on from Mr Falinski question, I think it would be fair to say that particularly in the last seven to 10 years or so you have seen a very increased awareness by consumers and particularly members of industry super funds or super funds more generally of the fact that they might have insurance in large part due to the advertising activities of the legal profession. Have you done any work, or are you aware of any work the industry has done, on the fact that part of the significant reason for the growth in the claims experience of the insurance companies that has occurred in the marketplace is that people are more aware and their old models had never accounted for that; they are maybe only now starting to get up to speed that consumers are much more aware that they have the ability to claim on these insurance policies?

Mr Summerhayes: That is absolutely a factor.

Mr FALINSKI: It is?

Mr Bingham: Definitely.

Mr FALINSKI: To add to that, what types of claims are you seeing the greatest growth in?

Mr Bingham: As Adrian mentioned before, we do not collect the stats on the cause of all the claims; but, anecdotally, we are hearing that mental health is one of the factors. We also—

Mr VAN MANEN: That would be reflecting in an income protection claim, potentially?

Mr Bingham: Yes.

Mr Rees: Certainly for the work we did in the group insurance issues that were raised a few years ago are issues that Mr van Manen referred to. They were the things that insurers told us were causing them issues. Their own financial analysis reporting, which their actuarial people do, highlighted some of those things. Many industry participants have made public comments about that. You mentioned lower involvement in claims as well. That has certainly been cited by industry as a factor. As Mr Summerhayes said, they have all been issues.

Mr FALINSKI: Mr Chair, can I put a question on notice that APRA provide us with some of that commentary around that experience.

CHAIR: Yes.

Mr FALINSKI: If I am occupying too much of the committee's time, I am happy to yield. With capital adequacy ratios, do you give a discount for conglomerates?

Mr Rees: No

Mr Summerhayes: No, we regulate at the entity level.

Mr FALINSKI: So the life insurance business of the Commonwealth Bank would have to have similar capital adequacy ratios as a stand-alone life insurer?

Mr Rees: Absolutely.

Mr FALINSKI: Is that recent or is that an unusual practice, comparing Australia with other jurisdictions internationally?

Mr Summerhayes: I cannot speak to international experience, but we regulate at the entity level—not, in the life insurance sense, at a group level.

Mr Rees: That is not a new requirement from APRA's point of view. It has been in situ for as long as we have been in existence, as far as I know.

Mr FALINSKI: When you said 'entity level', I heard 'the entity level of the life insurance company within the Commonwealth Bank'.

Mr Rees: Yes.

Mr Summerhayes: The APRA regulated entity.

Mr FALINSKI: So they split those entities up?
Mr Summerhayes: In the example you used, they have a number of APRA regulated entities.

Mr KEOGH: Mr Rees, you referred to lawyer involvement being a cited cause of increased claims. What does the industry say that means?

Mr Rees: Insurers have reported to us that they are seeing more frequent incidence of lawyers being involved in claims generally. They have said that they are getting involved earlier in the claims process—not waiting, if you like, for the claim to get to a point of disputation. Instead, sometimes the first contact relating to a claim happening is actually a letter from a lawyer saying, 'Our client is claiming.' Trustees have said the same thing to us. That is what I am referring to.

Mr KEOGH: It was made in the context of their being more claims. I do not understand—

Mr Rees: It was in relation Mr Van Manen's comment about people becoming more aware of their right to claim. One of the things we have heard from life insurers is that if a lawyer has been consulted it is because the person might not be aware of their rights, or they have seen advertisements or promotions for lawyers who can help people with those sorts of claims.

CHAIR: 'Have you been denied a claim?'

Mr Rees: Yes, or 'Have you been injured at work?' I think it is a combination of those things.

Mr KEOGH: The other question I had was on legacy issues. It is in your opening statement, it is in your submission and you have said it in other reports—this concern about, if you like, inadequate back-end systems and imperfect knowledge or lack of knowledge about legacy policies within life insurers. Given that these are long-tail products—there are a lot of products written a long time ago that are still sitting there—does that create a heightened prudential risk within these insurers? Is there prudential risk if there is a great body of policies sitting there that they do not actually know that much about—if they are just trying to analyse actuarial risk?

Mr Summerhayes: If you do not have accurate data and accurate information about your book of business, you are running an operational risk. APRA is concerned about this issue, which is why we have made the statements we have in our submission and why Mr Byres has made the point in statements more broadly about the sector. One of the challenges for insurers is that these are very significant investments over multiple years. In the investment cycle of returns and making investment theses for what, in some cases, are tens or hundreds of millions of dollars of investments in upgrades over multi-year periods, there are often other options in the queue—if I can put it like that—for capital investment in systems. APRA believes that needs to change, and we are certainly signalling to industry that more needs to be done about the core administration systems in insurers and other APRA regulated entities.

Mr KEOGH: And that concern from an APRA angle is not so much about just understanding how long it takes to process claims and what sorts of claims there are—which ASIC may be very concerned about from a consumer angle—but a prudential one. Your concern is prudential: that they do not know enough about their own book.

Mr Summerhayes: If this was allowed to drift for another five years, then we could see a scenario where it would produce, in some cases, unacceptable risks.

Mr KEOGH: If that was to occur, would APRA then look to intervene in how much capital these insurers are being required to hold?

Mr Summerhayes: APRA has a range of measures and powers to ensure that the system is operating appropriately. At the front end of that spectrum is signalling in speeches, submissions and conversations with boards and executives, and that is the point we are at on that particular topic. If we were still having this conversation in three years time, then we would clearly have more—

Mr KEOGH: Some bigger sticks might need to be used.

Mr Summerhayes: Yes.

Senator WILLIAMS: Did you look at the outdated medical criteria with CommInsure in relation to troponin levels—Dr Ben Koh saying, 10 years late, that there are more modern ways of measuring those troponin levels, that you would never get to the two milligrams per litre or whatever the situation was? Did you look at that at all as far as APRA goes?

Mr Bingham: That was part of the scope of the independent reviews that CommInsure has undertaken.

Senator WILLIAMS: Has it all been fixed now?

Mr Bingham: I think—

Senator WILLIAMS: I will put that question to CommInsure; they would be better to answer.
Mr Bingham: Thank you. Those are the words I was looking for!

Senator O’NEILL: A follow-up question to Mr Keogh’s questioning: are there any insurers that are leading with good practice with regard to back office functions? Are there any insurers doing what it is that you believe needs to be done to lessen their prudential risk?

Mr Summerhayes: Certainly there is a spectrum, as there is on any of these issues. But the sector has been characterised by consolidation over the last 10 to 20 years, where, in some cases, multiple insurers have been consolidated under a single entity. In many cases, those licences have been merged, but the systems and the product suites are still sitting on multiple back-end administration systems. The nature of the contracts—different variants of contracts can run into the tens, and in some cases hundreds, of variants of contracts—makes it difficult to merge those together, because you cannot unilaterally vary those contracts. In the superannuation system, for example, you can migrate to a new contract and the provisions of the successive fund transfer and other mechanisms make that easier. There is not such a mechanism in life insurance, which has meant that those products stay on foot and the systems they sit on stay on foot. We think more could be done in that regard. To answer your question specifically, the insurers which have been newer entrants or have started up in the last 10 years, as a generalisation, do not have as many legacy issues as those insurers which have gone through merger and acquisition.

Senator O’NEILL: How does that compare with international best practice?

Mr Summerhayes: It is a not-uncommon situation across all markets, unfortunately.

CHAIR: Does APRA have any areas of priority that they might like to see in law reform in the industry?

Mr Summerhayes: As it relates to life insurance, and as per our submission, the main call-out for life insurance is some assistance with the legacy product issue. That said, I want to reinforce that we think industry could do a lot more and we do not see legislative reform as being the only path to improving that situation. But we are a supporter of FSI recommendation 43, as I said at the outset. As it relates more broadly, the committee would be aware of crisis management and resolution powers that APRA has also been promoting through the FSI inquiry to help with life insurers and other entities should we need them.

CHAIR: We have run out of time. Answers to questions taken on notice should be provided by 17 March 2017 to the secretariat. Thank you for attending the hearing. I think your evidence today has been fabulous. Keep up the good work. I appreciate you taking the time to come in.
McCrea, Mr Glen, Chief Policy Officer, Association of Superannuation Funds of Australia

Whitton, Mr Ken, Senior Policy Advisor, Association of Superannuation Funds of Australia

[15:41]

Chair: The committee welcomes the Association of Superannuation Funds of Australia, who made submission No. 29. I remind committee members and witnesses that, while this is a public hearing, care should be taken to protect the privacy of individuals and arguments should be made without naming individuals. I now invite you to make a short opening statement. At the conclusion of your remarks, I will invite members of the committee to put questions to you.

Mr McCrea: We welcome the opportunity to present today at this hearing. ASFA is a non-profit, non-political national organisation whose mission is to continuously improve the superannuation system so people can live in retirement with increasing prosperity. We focus on the issues that affect the entire superannuation system. Our membership includes corporate, public sector, industry, retail super funds and service providers, representing over 90 per cent of the 14.8 million Australians with superannuation. Insurance and superannuation is about managing the risk of personal catastrophe across the working population. It is about helping people when they really need it. The provision of insurance is about delivering valuable protection to the community whilst meeting the needs of members at a reasonable cost. The provision of group insurance is a crucial part of the superannuation system that assists Australians who suffer misfortune. These arrangements alleviate underinsurance and the potentially devastating economic implications for individuals and their families. Lack of cover adds to calls on the public purse to increase social security, including disability payments and single parent allowances. An analysis of aggregate insurance held inside and outside of superannuation estimates the cost to the government of increased social security payments arising from underinsurance to be in excess of $1 billion per annum.

It is worth acknowledging the substantial benefit of insurance and super: over 71 per cent of total death sums insured in the community, 88 per cent of total and permanent disability sums, and 59 per cent of total income protection. Insurance and super must recognise member needs changing over time as people age and face increased financial responsibility. In addition, it needs to be affordable, as high insurance premiums can impact on members’ superannuation balances and retirement incomes. For individual funds, trustees and insurers, the balancing act required between need and affordability is managed effectively. However, ASFA has identified some opportunities for change, including the relation to duplicate insurance. In addition, ASFA is working as part of a cross-industry insurance group, the Insurance in Superannuation Working Group, to address key issues in the industry, including a code of practice for insurance and superannuation. We consider there is also an opportunity to address the all-or-nothing nature of the regulatory definition of total and permanent disability. A change here would facilitate funds and insurers potentially providing rehabilitation benefits to install a return to work. We welcome questions on our submission.

Senator Williams: Mr McCrea, in the code of practice do you save in insurance and superannuation?

Mr McCrea: Absolutely.

Senator Williams: Has this code been completed for the life insurance industry?

Mr McCrea: What we are looking at here is a broader code than the code that is run by the FSC. This is one that covers the entire industry, including superannuation trustees. I think that is the next step, and that is one of the key responsibilities of this working group. We started that process, in developing a code, that can apply across the entire industry.

Senator Williams: We heard evidence earlier today about group insurance and the fine print, the lack of transparency. One of the groups said they went after the policy document—was it?—and it was like pulling teeth. How can we improve group insurance? It is obviously not perfect.

Mr McCrea: There is a lot we can do to improve it and make it more accessible for consumers.

Senator Williams: I do not know about accessible. We already have a lot of people involved in it. In fact, we probably have millions of Australians who do not even know they have life insurance.

Mr McCrea: Perhaps the term to use is 'more understand' insurance. One of the ideas floated, and it will be interesting to see how it plays out, is a key fact sheet. It has been used in other industries across the economy with some success. The question here is whether it is something that would be useful for consumers. I think that type of idea is worth exploring. At the end of the day, we have to try and develop things that work for consumers. That is the end game. A key fact sheet, as a concept, is something that I think we should explore further.

Mr Whitton: If I could add, Senator—
Senator WILLIAMS: Please do, Mr Whitton.

Mr Whitton: some of the priorities of the insurance and super working group have been set in the areas of the erosive effects of premiums on balances. A project of the working group is to make recommendations to limit that. There already is a good framework within the APRA framework for trustees to only provide a benefit design that is in the interests of members and that has taken into consideration erosion of benefits. Another area is duplicate accounts, as Glen has referred to, and claim handling is a focus priority area for that group.

Mr FALINSKI: The specific incident Senator Williams was referring to was a product liability lawyer whom a financial planner was helping. It turned out that with his group insurance policy, if he had other TPD insurance, his payout or income stream was reduced to the exact amount that he was receiving from someone else. That was not contained in the PDS and it was difficult to get the policy document. Is that something that a key fact sheet would cover?

Mr Whitton: The terms and conditions of insurance and superannuation are many and varied. You would expect that those conditions are disclosed in product disclosure statements. I would also suggest the committee consider the fact that trustees have a legal obligation to advocate and do everything that is necessary to pursue a claim on behalf of a member. It is good to see that that case had a financial planner advocating, but trustees do have an obligation and it is assist covenant, in fact, to advocate on behalf of the member as well.

Senator WILLIAMS: Do you think it would be a good idea to have tailor-made superannuation? What I mean by that is, say I have started work and I am 18 years old. I am an apprentice builder with no liabilities, no wife, no kids, no responsibility and just having a good time. Life insurance probably means very little to me. All of a sudden I am 32, married and mortgaged, having bought a house. How would it be if I went back to my super fund and said, 'Look, I'm opting out but I want you to provide me with a specific insurance policy that suits me and take it out of my superannuation.' Would that be possible—to tailor-make for the individual case through the super? What many people would say is, 'I'll opt out of my life insurance with my super, but I cannot afford a decent policy to pay out of my pocket.' Do you see where I am coming from?

Mr McCrea: Yes. Obviously, there is an option for people to opt out—

Senator WILLIAMS: Of course there is.

Mr McCrea: I think one thing we just need to be clear on about group insurance: the benefit of group insurance is it is a big pool. And the advantage in that—you have got a cross-section of people with different needs, different demographies, et cetera. One of the advantages in that is you can actually provide cover cheaper in group insurance than you can outside, but that does not preclude—

Senator WILLIAMS: We get contradictory evidence on that here today—when financial planners are saying, 'we can specify an insurance policy and it is actually cheaper than the policy—and better—than you are getting in your group insurance.' So what do we do?

Ms O'NEIL: Because it is underwritten at the point of acquisition.

Mr McCrea: So the key principle as to why it is cheaper is that group nature. So when you do an individual, you obviously tailoring it to the individual—

Senator WILLIAMS: Yes, but the point is the group nature is paying for the drinkers, the smokers—everything in that one big policy. Whereas an individual policy, going to a financial planner—like for this man right here—and you are a pretty squeaky-clean-living sort of a person—you can actually get a better policy at a cheaper premium.

Mr VAN MANEN: You can get, in your super fund—so if you have got a super fund and you have got group life cover, if you wish to you can then go to the super fund and get additional cover, over and above that, which is written separately and underwritten separately from your group life. So yes, you can.

Senator WILLIAMS: That is the point I was getting at. You can opt up.

Mr McCrea: Yes; you can opt up, and people do opt up. We have got some evidence from one of our funds, I think it was, that suggests that potentially more people opt up than opt down, which I found really interesting—because people see the value. And to be able to access a level of cover within your super and then, for those people, Senator, as you identified, who might have different needs, the ability to sort of dial up. And I think that is a really good feature—

Senator WILLIAMS: So in summary, when the circumstances change for the worker, the more responsibility falls on their shoulders, they can go to their group super and they can opt up to include a bigger payout with death, a bigger payout with income protection et cetera. And that superannuation fund will then take that premium out of their super.
Mr McCrea: Up to a certain limit. But the other option for them is to also boost up by going outside as well. So obviously there is still the capacity for people to have cover inside insurance and outside of insurance.

Mr Whitton: So there is a capability for people to have a fully tailored insurance plan put together within a superannuation environment, keeping in mind, of course, they cannot have trauma insurance. Superannuation is limited to income protection, death and TPD. But a financial planner can give advice for people to have an absolutely complete tailor-made arrangement in superannuation. Not every single product may be able to provide the full suite, but in today's environment of financial advice, under the best interest rules, most advisers have a range of products that they could recommend to a client if the current product does not suit their needs.

I might add on the point of cost: it is a well-known premise that group insurance is at lower cost than retail policy, so to speak. Keep in mind that there are no commissions within the group structure. So the figures that you may have received may have been a pure wholesale-level insurance rate, being comparable to group insurance, but when commissions are added onto arrangements—

Senator WILLIAMS: There has been profit-sharing, which you could call a commission.

Mr Whitton: That would not be the word that I would use, and it is not—

Senator WILLIAMS: Twenty million dollars back, then it is your super fund—it is not a commission but it is a pretty handy profit share!

Mr Whitton: Absolutely; in terms of group insurance, there are no commissions per se. Commissions are allowable for financial advisers who write insurances on an individual basis, and they can have that removed from the superannuation account, so—

Senator WILLIAMS: And individual advisers do not have a profit share either, do they?

Mr Whitton: Well, they have a profit, because they receive a commission.

Ms O'NEIL: They do.

Senator WILLIAMS: But they do not get part of the company's savings though.

Ms O'NEIL: No; they get part of the client's. They get paid.

Mr FALINSKI: Exactly.

CHAIR: That is who they are working for.

Mr KEOGH: I would like to ask your view. Lots of evidence we have heard has been about this issue of standardising terms, standardising medical definitions, trying to create better transparency and clarity of what insurance covers and what exemptions might be in the insurance. As we have discussed, a lot of people do not even know they have insurance, and if they do they just have this very vague concept of, 'I've got some insurance', and they think they know what that means. Would you see there being some benefit in a regulated or legislative minimum standard type of default insurance that comes with superannuation products or at least with the default superannuation products? It would not remove the capacity for a superannuation member to say, 'I want to opt up on my level of cover or opt into a different version of what your group insurer may provide.' So if you have a MySuper product you get a default insurance product that is clearly articulated and well-understood across the entire industry and, indeed, across the entire country. What would be your view on that?

Mr Whitton: Group cover is certainly a place where you can look at applying some standardisation across the marketplace—no doubt. I do not think you could ever get to a situation of 100 per cent standardisation with all the aspects of group cover. There would be a competition issue with that.

Mr KEOGH: When you say there would be a competition issue, if it were regulated there would be no competition issue in that there would be no infringement of competition law. So are you saying it would be difficult for the private sector of insurers to compete where a lot of the terms are standardised?

Mr McCrea: Are you talking about a legislative solution? At the moment, with standardisation of, say, TPD, I understand there are issues with competition law.

Mr KEOGH: Because you have private competitors trying to basically collude on the terms. The concern is that that amounts to collusion under our law. But I am asking: what if it was a regulated method where there is a default product and you are required to offer this product.

Mr Whitton: There already is a requirement for trustees to offer death and TPD.

Mr KEOGH: They offer a minimum level, but not with standard terms or standard exemptions or anything like that. I am saying enhancing that model—what would be your view on that?
Mr Whitton: I think the model could be enhanced, but you could not get to a situation of full proscription. Trustees, again, are bound by a very strict framework and very strict guidance from APRA as to what they can and cannot provide.

Mr KEOGH: I think you are misunderstanding. The parliament can do whatever it wants.

Mr FALINSKI: Well, there is this thing called the Constitution!

Mr KEOGH: I am asking: if it wants to do that, what would you think about the view.

Mr McCrea: You are absolutely right; the parliament can do what they want.

Mr FALINSKI: Within the bounds of the Constitution.

Mr KEOGH: Within the bounds of the Constitution.

Mr McCrea: It is good we have clarified that! I think one of the things to think about here is what it means for flexibility, for funds and the different groups they have. There are some funds who have people in particular occupations that have particular risks. The advantage with the current system is that it allows flexibility to meet those needs. As we sort of mentioned before, some funds have a lot of younger members and some funds have a lot of older members. One of the challenges with a standardised approach like that is what it means for funds which have particular occupational groups or demographic cohorts. I suppose that would be an observation. If the government or governments went down that path, that would be something they would have to consider.

Mr KEOGH: With that flexibility, we already discussed it a bit today in questions from Senator Williams around whether you really need that level of cover if you have, say, mainly a young cohort in your fund. What about the heightened risk issues that arise in some funds because it they are industry funds that predominantly cover a certain high-risk occupation? Is that an issue of making sure they are required to or at least have the option to increase the level of cover for those members, or is there also an issue around requiring flexibility so they can trade off that additional level of cover against some other terms so that premiums do not go too high?

Mr McCrea: I think it is a perpetual battle between that need and affordability. I think that is the framework for looking at this, at least from our point of view. I think you are absolutely right on both counts. There is a trade-off between the different offerings and there is also a trade-off in terms of how high you can push premiums up to reflect risk. What we are obviously trying to aim for is to get that sweet spot where you balance need and affordability.

Mr KEOGH: So we might be able to constrain, but not entirely define, what a default product might be? It could be standardised but there still has to be that flexibility.

Mr McCrea: There definitely has to be flexibility.

Mr FALINSKI: I have two questions which may take several questions. One is around claims from people who are suffering from mental health episodes—disability claims for mental health. APRA made an unclear statement that they have seen increases in TPD and people staying on disability insurance longer. They did not quite know whether that was mostly due to people claiming for mental health issues or other issues, but they are going to try to find out some more for us. What is your members’ experience? Do you know? should probably be the question.

Mr McCrea: I have not received any direct feedback on the issue of mental health. I do know it is obviously an issue, and it is something that I think funds are looking to address. I think the thing to bear in mind is that there are a number of different tools with which you can try to address it. There is income protection as well, which is a slightly different type of payment to TPD, and one of the things we have flagged in our submission is looking at TPD and trying to change the nature of it in some ways. We are probably not there, and it might be 10 years away, but in many ways IP and TPD almost could be part of the same continuum. I think the key here is: rather than have TPD as a lump sum payment, can you use it to assist people who might be struggling in terms of rehabilitation, whatever that is?

Mr FALINSKI: Could I ask you take that on notice and get back to us if you can; you may not be able to.

Mr McCrea: Yes.

Mr FALINSKI: Right at the end of your opening statement, you made a comment about freeing up the definition of TPD to include rehabilitation services. Did I understand that correctly?

Mr McCrea: Yes.

Mr FALINSKI: No. 1: what do you think the advantages of that are? No. 2: are there any other legislative constraints in terms of innovation in products and services that you have thought about providing but cannot because of the legislative framework that you operate within?
Mr Whitton: We have thought of other things. Firstly, in relation to the definitions of TPD and the constraint there, the nature of the benefit, as per the name, is that it needs to be a total and permanent disablement, so it is an 'all or nothing' situation, and that creates a lot of complications with mental illness, because it is very difficult to determine for an individual that a mental illness, which is quite often short term, is going to remain with someone for the rest of their life. Some flexibility there with rehabilitation would help to facilitate that.

The other point that we made in terms of some legislative flexibility in our submission was that there is a mismatch between the taxation of benefits received by individuals both within and outside superannuation. It is fair to say that it is the superannuation benefit, particularly for younger members, that will be reduced by taxation—quite significantly in some cases. So those people, who quite often have only been paid a modest insurance benefit, will have that reduced to take them forward for, potentially, a number of years.

Senator WILLIAMS: Mr Whitton, if you see a standardisation of TPD, I bet you it will make it harder for the policyholder, not easier. As we have seen over the years, when the surgeon gets his finger cut off and it is his special finger for doing his job and earning half a million a year, the next thing we are seeing is that TPD means you cannot toilet yourself, feed yourself et cetera. If we see standardisation of TPD criteria, won't it simply be harder for the people to be paid on it and easier for the insurance company to save?

Mr Whitton: It depends on that definition, of course.

Senator WILLIAMS: I will bet you it does.

Mr Whitton: If there were flexibility for partial TPD benefits to be made—and there already has been movement in that regard; some funds already have sought private rulings and have releases in instalments to try to instil this situation of people retaining a motive to return to work—insurers have indicated that they would be able to provide rehabilitation benefits if the legislative framework allowed. So your point is taken, Senator, but it depends on that definition. There would need to be a legislative fix to get the definition that would allow that flexibility.

Mr McCrea: The thing I would also add is that, from a consumer-member point of view, it needs to be transparent so they know what the definition is. I think you reflected upon that before; that was one of your concerns.

CHAIR: Just on the definition, is it the definition or the interpretation of the definition that is going to be the problem?

That is currently what some people have said: it is the interpretation of the definition.

Mr McCrea: But if there were a clear—

CHAIR: One lawyer working for one super firm and another one working for another one have different interpretations.

Mr McCrea: Picking up on your point—and I am not sure who raised it—I think that if you standardised clear definitions, if there were a clear definition in law that there had been a proper consultation process, that would make interpretation differences more difficult.

CHAIR: There was a SIS Act definition, wasn't there? People have moved away from that, haven't they?

Mr Whitton: That is part of the issue. We have two definitions that operate in this space. There is the SIS definition that allows a release of money from the superannuation system under a condition of release and there is an insurance definition that often differs from that. They have always run fairly close together, but there are differences. So that could be an area of standardisation that is considered.

Senator O'NEILL: We have talked a little about the industry super funds and their relationship with their insurer and funds returning. Could you explain the relationship with retail super funds and the insurers? What happens with profits?

Mr Whitton: There is an interesting situation in the retail space, because quite often the insurance companies and the superannuation funds are part of a conglomerate. So there is a range of—

Senator O'NEILL: Vertically integrated.

Mr Whitton: Yes, exactly. So there is a range of conflict matters that need to be considered there in a raft of areas, not just in insurance of course. And then, of course, the trustee of the superannuation fund has to demonstrate and satisfy the best-interest test in exactly the same way as industry superannuation funds do. So I would have confidence that all of those conglomerates would have processes in place—separation, segregation of responsibilities and separation of delegations for decision making—and that they would similarly meet the requirements of only participating in those arrangements if the best-interest test was satisfied.
Senator O’NEILL: And if there is an amount left over after all the prudential requirements have been undertaken, where does the money go from there? It does not go back to the insured within the superannuation—

Mr Whitton: Still within the retail environment?

Senator O’NEILL: Yes.

Mr Whitton: In a profit-making entity, of course they have a consideration in the overall operation of their superannuation fund. Profit is returned to shareholders in due course. We would not be able to determine whether a part of these arrangements were included in that or not. They would be matters that you would need to take up with those individual companies.

Senator O’NEILL: But it does not go back to the insured, it goes to the shareholders—if there is profit?

Mr Whitton: I could not answer that for certain.

Mr McCrea: Obviously, in the super system we have industry funds and we have retail funds, but I think there is equivalence in terms of their treatment of risk. That is what the risk-sharing arrangement is on the industry side and, obviously, on the retail side. They manage that risk as well within that broader structure, but I think there is broad equivalence from our point of view in the way they treat those arrangements.

Senator O’NEILL: Were you in the room for the last bit of evidence we had from APRA?

Mr McCrea: For the last two minutes, I am afraid.

Senator O’NEILL: I do not want to misrepresent them but there was some concern about prudential risk that was tied to a failure in the industry to provide adequate hardware in the background of the business—I think they described it as ‘in the back office’—to manage legacy case loads and also to invest in new technologies that managed data in more efficient and effective ways. Are you aware of that problem?

Mr Whitton: Yes, certainly. The framework of insurances in superannuation involves a lot of parties. There is always the insurer, which has its data requirements, there is the trustee and there are quite often administrators. IT and data standards are something that the industry needs to invest in. There are moves in that direction happening. Within the insurance and super working group there is a specific data work stream looking at those matters. But we would support movements in that direction, for some sort of standardisation of the way data is collected, stored and, potentially, accessed by parties in the industry.

Senator WILLIAMS: Stumps!

CHAIR: Stumps! That concludes today's proceedings. I thank all the witnesses who have given evidence to the committee today. Any answers to questions taken on notice should be provided to the secretariat by 17 March 2017. I thank you for attending today and coming along as the last witnesses for the day. I would also like to thank Hansard and broadcasting for their efforts today, and also the secretariat for their contribution in organising all these hearings. I would like to thank my parliamentary colleagues—Bill and Ben down the end there!—and everyone else who has come along today. I declare this hearing of the Parliamentary Joint Committee on Corporations and Financial Services adjourned.

Committee adjourned at 16:10