Chapter 10

Claims handling

Introduction

10.1 Claims handling practices by life insurers are subject to certain legislative requirements as well as commitments made by life insurers who are subject to the Financial Services Council's (FSC) self-regulatory mechanism known as the Life Insurance Code of Practice (Code). Work is also being done by the Insurance in Superannuation Working Group to establish the Insurance in Superannuation Code of Practice (Super Code) in relation to both default and retail group insurance and trustees. The Super Code is currently in draft form and the Insurance in Superannuation Working Group envision that it will also consist of commitments similar to the FSC's Code, some of which will govern claims handling processes.[1]

10.2 This chapter considers the evidence provided to the committee during this inquiry regarding claims handling by life insurers. The evidence highlighted the concerns held by a number of individuals and groups that certain claims handling practices may be used by life insurers as a means to delay or deny a claim or limit the amount of payment made when a claim is successful. This chapter also considers the evidence submitted regarding the developments in the life insurance industry in response to claims handling concerns.

10.3 The following issues are discussed in this chapter:

- Oversight of claims handling practices;
- A policyholder's right to reasons where a claim has been denied;
- Inconsistency in claims handling data;
- Definitions in insurance policies;
- Pre-existing conditions and non-disclosure;
- Mental health claims;
- Delays;
- Independent medical examiners;
- Incentives for staff to reject or delay claims;
- Underwriting direct insurance;
- Legacy products; and
- Early intervention—rehabilitation payments.

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1 The Insurance in Superannuation Working Group, *Discussion Paper*: *Claims Handling*, pp. 5, 6.

Oversight of claims handling practices

10.4 The Australian Securities and Investments Commission (ASIC) informed the committee that Corporations Regulation 7.1.33 excludes certain insurance claims handling activities by advisers and life insurers from being defined as a 'financial service' for the purposes of sections 766A(1)(b) and 766A(2)(b) of the *Corporations Act 2001* (Corporations Act).[2]

10.5 As a result, ASIC's powers under the Corporations Act generally do not apply to oversighting the conduct of insurers and financial advisers in this claims handling context, including whether insurers have provided financial services in an efficient, honest and fair way.[3]

10.6 Additionally, ASIC informed the committee that the current exemption limits ASIC's ability to respond to conduct such as:

> (a) an insurer relying on the terms of the contract to deny a claim (even where the exclusion clause relied on may be outdated or restrictive);
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> (b) unnecessary or extensive delays in handling claims;
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> (c) incentives for claims handling staff and management, including whether they are in conflict with the insurer's obligation to assess each claim on its merit; and
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> (d) surveillance practices by investigators, particularly for mental health claims.[4]

10.7 ASIC acknowledged it is aware of arguments that sector-specific legislation through the *Insurance Contracts Act 1984* (Insurance Contracts Act) should be sufficient in ensuring claims are handled appropriately. However, ASIC was of the view that claims handling practices, like other financial products and activities, should be captured under the Corporations Act.[5]

10.8 Doing so would provide ASIC with greater scope to address non-compliance with the matters that are currently excluded. It would also allow the overarching requirement to act efficiently, honestly and fairly to be applied to the claims handling processes.[6]

10.9 Treasury explained that the government is considering the merits of ASIC's recommendation that would mean the claims handling processes of insurers would be captured under the definition of a financial service in the Corporations Act, thereby

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2 Corporations Regulations 2001, s. 7.1.33; Australian Securities and Investments Commission, *Submission 45*, p. 21.

3 Australian Securities and Investments Commission, *Submission 45*, p. 21.

4 Australian Securities and Investments Commission, *Submission 45*, p. 21.

5 Mr Peter Kell, Deputy Chairman, Australian Securities and Investments Commission, *Committee Hansard*, 8 September 2017, p. 39.

6 Mr Peter Kell, Deputy Chairman, Australian Securities and Investments Commission, *Committee Hansard*, 8 September 2017, p. 39.

allowing ASIC to address claims handling conduct.[7] Treasury has conducted targeted consultation on the matter and is now determining the best way forward prior to providing advice to the Minister.[8]

10.10 Consumer and not-for-profit groups, such as the Financial Rights Legal Centre (FRLC) and the Consumer Action Law Centre, supported ASIC's proposal to remove the exemption in Corporations Regulation 7.1.33.[9]

10.11 Both the FRLC and the Consumer Action Law Centre were also of the view that the review of ASIC's penalty powers should include consideration of more significant penalties in relation to claims handling misconduct.[10]

Committee view

10.12 The committee notes that Corporations Regulation 7.1.33 excludes certain insurance claims handling activities by advisers and life insurers from being defined as a 'financial service' for the purposes of sections 766A(1)(b) and 766A(2)(b) of the Corporations Act.

10.1 The committee recognises that the ability of a regulator to oversight the claims handling processes of insurers and address non-compliance is crucial to ensuring that consumers are protected through means that are both appropriate and transparent.

Recommendation 10.1

10.13 The committee recommends that the Australian Government review Corporations Regulation 7.1.33 to ascertain whether the exemption provided by this regulation limits in any way ASIC's ability to oversight the claims handling processes of insurance companies.

A policyholder's right to reasons where a claim has been denied

10.14 As discussed in chapter 8 on access to medical information, the *Disability Discrimination Act 1992* (Disability Discrimination Act) exempts life insurers from its application in order to assess an individual's risk when setting premiums or policy terms. However, insurers can only use the exemption to make decisions that are based

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7 Department of the Treasury, answers to questions on notice, 22 August 2017 (received 6 September 2017); Mr James Kelly, Principal Adviser, Financial Systems Division, Treasury, *Committee Hansard*, 8 September 2017, p. 63.

8 Mr James Kelly, Principal Adviser, Financial Systems Division, *Committee Hansard*, 8 September 2017, p. 63.

9 Financial Rights Legal Centre, *Submission 17*, pp. 15–16, 33; Consumer Action Law Centre, *Submission 27*, p. 3.

10 Financial Rights Legal Centre, *Submission 17*, p. 15–16, 33; Consumer Action Law Centre, *Submission 27*, p. 3.

on actuarial or statistical evidence and in the case where no such evidence exists, have regard to other relevant factors.[11]

10.15 This exemption was further explained by Dr Stephen Carbone, Policy, Research and Evaluation Leader at beyondblue, who noted that while a consumer has a right to know how an insurer reached its decision under section 75 of the Insurance Contracts Act, the customer must ask for such reasons. This means that there is no positive obligation for insurers to explain to a consumer why an application has been denied.[12]

10.16 Additionally, Ms Michelle Cohen, Senior Solicitor at the Public Interest Advocacy Centre (PIAC), told the committee about how it is difficult to obtain written reasons for why a decision has been made. Ms Cohen stated that even where written reasons are provided under section 75 of Insurance Contracts Act, they are not targeted to the part of a person's medical history relied on by the insurer when making a decision.[13]

10.17 PIAC suggested that insurers who rely on the exemption under the Disability Discrimination Act should be required to provide copies of the actuarial and statistical data or any other material relied on, along with a plain English summary to the insured party. Furthermore, PIAC argued that this documentation should be provided to the insured party without them needing to contact the insurer or lodge a formal complaint to the Disability Discrimination Commissioner.[14]

Committee view

10.18 The committee notes that section 75 of the Insurance Contracts Act already provides that policyholders have a right to know how a life insurer has reached a decision. However, the committee also notes that there is currently no positive obligation on an insurer to provide the reasons for a decision to a policyholder.

10.19 The committee recognises the importance of transparent processes in enabling consumers to understand how the decisions made by life insurers have been reached.

10.20 To this end, the committee is of the view that life insurers should be required to provide a policyholder with written reasons when making a decision to reject an application or deny a claim for life insurance. Furthermore, these reasons should be provided as a plain English summary of the evidence and should be targeted to the part of a person's medical history relied on by the insurer. The committee is also of the view that any statistical and actuarial evidence and other material relied on by the insurer should be made available on request.

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11 Department of the Treasury, answers to questions on notice, 22 August 2017 (received 6 September 2017).

12 Dr Stephen Carbone, Policy, Research and Evaluation Leader, beyondblue, *Committee Hansard*, 22 February 2017, p. 18; See also, *Insurance Contracts Act 1984*, s. 75.

13 Ms Michelle Marie Cohen, Senior Solicitor and Ms Alexis Goodstone, Principal Solicitor, Public Interest Advocacy Centre, *Committee Hansard*, 24 February 2017, pp. 7–8.

14 Public Interest Advocacy Centre, *Submission 9*, pp. 11–12.

Recommendation 10.2

10.21 The committee recommends that a requirement be inserted, where necessary, into both the *Insurance Contracts Act 1984* and the *Disability Discrimination Act 1992* to the effect that an insurer must provide a person with written reasons when an application for insurance has been rejected or an insurance claim denied. The committee further recommends that the written reasons be provided as a plain English summary of such evidence and be targeted to the part of a person's medical history relied on by the insurer. The committee also recommends that the statistical and actuarial evidence and other material relied on by the insurer be available on request.

Inconsistency in claims handling data

10.22 ASIC's report on claims handling in the life insurance industry (Report 498) did not identify any cross-industry misconduct in relation to the payment of life insurance claims or claims procedures within the life insurance industry.[15]

10.23 Report 498 found that once claims decisions are made, 90 per cent of claims are paid, with 96 per cent of death claims being paid once decided.[16]

10.24 However, Report 498 also identified the need for data on life insurance claims to be consistent and more transparent. Report 498 proposed that ASIC and the Australian Prudential Regulation Authority (APRA) work with insurers and other stakeholders in order to establish a consistent reporting regime regarding claims data, outcomes, timeframes and disputes across policy types that is publicly available.[17] The FSC submitted that it will be working with both ASIC and APRA to develop a consistent reporting framework.[18]

10.25 The FRLC also recommended a public reporting regime similar to the one proposed in Report 498. However, the FRLC proposed that data regarding claims and claims outcomes be made available to consumers when purchasing and renewing a life insurance policy and that such data include the names of insurers alongside claims rates.[19]

10.26 The committee notes that on 9 November 2017, ASIC and APRA released the initial results from the pilot data collection on life insurance claims. The initial data complemented ASIC's finding in Report 498 that insurers pay 90 per cent of life

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15 Australian Securities and Investments Commission, *Report 498 Life insurance claims: An industry review*, 12 October 2016, p. 6.

16 Australian Securities and Investments Commission, *Report 498 Life insurance claims: An industry review*, 12 October 2016, p. 6.

17 Australian Securities and Investments Commission, *Report 498 Life insurance claims: An industry review*, 12 October 2016, pp. 10–11.

18 Financial Services Council, *Submission 26*, p. 12.

19 Financial Rights Legal Centre, *Submission 17*, p. 18.

insurance claims in the first instance. ASIC and APRA also released an information paper outlining common data quality issues and the next steps in their joint data project. The information paper announced a second round of pilot data collection and highlighted that definitions for insurers regarding claims handling terms will be released shortly.[20]

10.27 ASIC informed the committee that the consistent reporting regime and the final data collected is expected to be released sometime in 2018.[21]

Committee view

10.28 The committee recognises that with three different distribution channels operating in life insurance—retail, direct, and group—a consistent and publicly available reporting regime regarding claims data, outcomes, timeframes and disputes across policy types is of vital importance.

10.29 The committee welcomes the collaboration between ASIC and APRA on this project and looks forward to the findings from the next stage of the joint data project.

10.30 The Committee acknowledges that APRA previously gave evidence that it was concerned that insurers do not have a sufficient understanding of declined claims data which may present a prudential risk if not rectified soon. ASIC later stated that it is working with APRA to establish a transparent public reporting regime for life insurance claims information.[22]

Definitions in insurance policies

10.31 This section considers policy definitions used by life insurers and specifically, concerns related to life insurers relying on inconsistent and out-dated definitions for certain conditions during the claims assessment process. Arguments were made to the committee for the standardisation of policy definitions across life insurance products.

10.32 Report 498 found that while the overall number of disputes about policy definitions in life insurance was low, policies that have traditionally technical definitions such as Total and Permanent Disability (TPD) and trauma policies had higher decline rates.[23]

10.33 The Financial Ombudsman Service Australia's (FOS) submission also highlighted a potential misalignment between community expectations and insurance

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20 Australian Prudential Authority, *APRA and ASIC publish key industry data on life insurance claims*, 9 November 2017, http://www.apra.gov.au/MediaReleases/Pages/17_43.aspx (accessed 9 November 2017).

21 Mr Michael Saadat, Senior Executive Leader, Deposit Takers, Credit and Insurers; Regional Commissioner, New South Wales, Australian Securities and Investments Commission, *Committee Hansard*, 8 September 2017, p. 41.

22 Mr Geoff Summerhayes, Member, Australian Prudential Regulation Authority, *Committee Hansard,* 24 February 2017, p. 68; Mr Peter Kell, Deputy Chair, Australian Securities and Investments Commissions, *Committee Hansard*, 8 September 2017, p. 37.

23 Australian Securities and Investments Commission, *Report 498 Life insurance claims: An industry review*, 12 October 2016, p. 65.

definitions and noted that disputes regarding policy definitions occur in circumstances where the definition is ambiguous, restrictive and does not reflect current medical understanding.[24]

10.34 Report 498 found a variance in the definitions used for medical conditions across the industry and that even a subtle difference in definitions affected the amount of cover provided.[25]

10.35 Report 498 also found that claims had not been paid by some insurers due to a technicality or an out-of-date policy definition while other insurers did provide a claim payment as an ex-gratia payment even where a definition was not satisfied, as the payment reflected the intent of the policy.[26]

10.36 Mr John Berrill of Berrill and Watson Lawyers explained the problem of out-of-date definitions with the example of a trauma policy that included definitions for a number of conditions such as heart attack, cancer and stroke. With changes and advances in medicine over time, the way conditions are defined change as well. However, if a policyholder held a trauma policy for 20 years prior to having a heart attack, the definition of a heart attack would be the definition in the 20 year old policy and would not reflect new medically approved definitions. As Mr Berrill pointed out, this could render the policy useless despite the policyholder meeting the current medical definition of a heart attack.[27]

10.37 Life insurers noted that they are aware of the potential for misalignment between medical definitions and policy definitions. In response to such misalignment, the FSC stated that under the Code, life insurers who are FSC members will be required to 'review key medical definitions every three years for relevant policies and update them where necessary to ensure definitions remain current'.[28]

10.38 As at July 2017, the Code has minimum standards for Trauma/Critical Illness, Cancer, Heart Attack and Stroke. In November 2016, the FSC informed the committee that the consultation process for such definitions would include external medical specialists, be subject to approval from the Australian Competition and Consumer Commission (ACCC), and will provide confidence to those policyholders with trauma insurance that they have a base level of cover.[29]

10.39 In terms of implementation and oversight of the minimum standards committed to in the Code, FOS recommended that the new standards set out in the Code be:

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24 Financial Ombudsman Service Australia, *Submission 28*, p. 15.

25 Australian Securities and Investments Commission, *Report 498 Life insurance claims: An industry review*, 12 October 2016, p. 65.

26 Australian Securities and Investments Commission, *Report 498 Life insurance claims: An industry review*, 12 October 2016, p. 65.

27 Mr John Berrill, Berrill & Watson Lawyers, *Committee Hansard*, 22 February 2017, pp. 29–30.

28 Financial Services Council, *Submission 26*, pp. 10–11.

29 Financial Services Council, *Submission 26*, pp. 10–11.

- extended to all medical definitions;
- kept up to date with medical practice and community expectation;
- easier to understand; and
- standardised against a minimum benchmark.[30]

10.40 The Association of Financial Advisers (AFA) proposed the establishment of a medical advisory board, subject to public scrutiny, to conduct an independent review every three years of definitions used in insurance and to determine whether an upgrade of policy definitions is required.[31]

10.41 Mr Brett Clark, Chief Executive Officer and Managing Director of TAL, stated that TAL has used the minimum standards set out in the Code and backdated definitions in polices to August 2009 to reflect the Code's minimum standards.[32]

10.42 Similarly, Ms Helen Troup, Managing Director of CommInsure, explained that CommInsure had backdated the definition of heart attack to 2012 in their policies to reflect the universal definition of a heart attack. In terms of rheumatoid arthritis, CommInsure had backdated the definition by two years to reflect advancements and understanding in medicine.[33]

10.43 Ms Annabel Spring, Group Executive Wealth Management at the Commonwealth Bank of Australia, noted the work the FSC has done in creating minimum standards around trauma, with the FSC definition now covering 80 per cent of claims. However, Ms Spring proposed that there should be a standard definition for TPD.[34]

10.44 Both the Australian Lawyers Alliance (ALA) and Ms Kim Shaw, a Principal at Maurice Blackburn Lawyers (Maurice Blackburn), also raised specific concerns with how TPD is currently defined for insurance within superannuation. These concerns focused on the differences in how 'permanent incapacity' is defined by the *Superannuation Industry (Supervision) Act* 1993 (SIS Act) and how TPD polices are defined by insurers. Specifically, concerns related to differing views on a person being 'unlikely' to return to work versus being 'unable' to return, as well as the type of employment such a person could return to.

10.45 Maurice Blackburn explained that the most prevalent change to the group insurance industry is the shift by insurers away from the legal test of 'unlikely' in

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30 Financial Ombudsman Service Australia, *Submission 28*, pp. 16–17.

31 Association of Financial Advisers, *Submission 22*, p. 7.

32 Mr Brett Clark, Chief Executive Officer and Managing Director, TAL, *Committee Hansard*, 18 August 2017, p. 1.

33 Ms Helen Troup, Managing Director, CommInsure, Commonwealth Bank, *Committee Hansard*, 8 September 2017, pp. 3, 4.

34 Ms Annabel Spring, Group Executive, Wealth Management, Commonwealth Bank, *Committee Hansard*, 8 September 2017, p. 2.

relation to a person's ability to return to work to that of 'unable'. The 'unlikely' test in relation to 'permanent incapacity' is defined by the SIS Act as:

> …if a trustee of the fund is reasonably satisfied that the member‘s ill health (whether physical or mental) makes it **unlikely** that the member will engage in **gainful employment for which the member is reasonably qualified** by education, training or experience.[35]

10.46 While under Regulation 4.07D of the Superannuation Industry Supervision Regulations 1994, TPD definitions for group insurance must be 'consistent' with the 'unlikely' test, insurers have moved away from this.[36] Maurice Blackburn submitted that in 2014 a fund with over a million members removed the word 'unlikely' from the definition of TPD and replaced it with a requirement that a person be 'unable' to ever engage in any employment for which, through education, training or experience, they are or may become suited to.[37]

10.47 The interpretation of 'unlikely' by Australian courts in relation to TPD includes consideration of the job market and the prospects of a disabled job applicant obtaining and maintaining employment. [38]

10.48 However, Maurice Blackburn were of the view that the life insurance industry determine whether someone is 'unable' to return to work based only a medical assessment that is separate from real world considerations, noting:

> …it is possible to argue that even a quadriplegic is theoretically capable of work and may not satisfy an “unable” definition, notwithstanding that their actual employment prospects in a competitive employment market are negligible.

10.49 Maurice Blackburn argued that the move away from the 'unlikely' test is evidence of a clear intention by insurers to limit the amount of claims they have to pay. This is despite the fact that the claimant may never be able to work at a level similar to that before the claim was made.[39]

10.50 The ALA also submitted that insurers are moving away from the requirements of 'qualified' as contained in the SIS Act towards requirements of 'any employment' for TPD claims. The ALA noted that the SIS Act definition of 'permanent incapacity' does not refer to any employment that a person is or may become suited to through retraining or further education.[40]

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35 Maurice Blackburn Lawyers, *Submission 12*, p. 4; Superannuation Industry (Supervision) Regulation 1994, reg 1.03C. The committee has used bold text for emphasis; See also, Australian Lawyers Alliance, *Submission 20*, pp. 9–11.

36 Maurice Blackburn Lawyers, *Submission 12*, pp. 4–5.

37 Maurice Blackburn Lawyers, *Submission 12*, p. 5.

38 Maurice Blackburn Lawyers, *Submission 12*, pp. 4–5.

39 Maurice Blackburn Lawyers, *Submission 12*, p. 5.

40 Australian Lawyers Alliance, *Submission 20*, pp. 10–11, 14.

10.51 It was the ALA's view that a person's inability to return to an occupation that reflects their current education, training and experience will impact on both their financial position and their ability to save for retirement. Where an insurer requires a person to return to employment in a new field, this is often only possible after significant re-training. However, it is not clear who is responsible for paying for the re-training. Furthermore such employment would likely be at a lower level and salary. In the ALA's opinion these consequences are ones that should be covered by life insurance, not created because of it.[41]

10.52 Conversely, the Association of Superannuation Funds of Australia (ASFA) submitted that the regulatory definition for TPD as stated in the SIS Act has caused difficulties and drawn out decision making processes as the SIS Act definition does not make provision for any future rehabilitation or changes in technology that may allow the TPD claimant to return to work. Additionally, a one-time assessment of disability to determine whether it meets the SIS Act definition may in fact incentivise a claimant to not recover some ability due to fears of not being paid a lump-sum TPD benefit.[42]

10.53 The ALA asserted that minimum standards and clear policy definitions for group insurance, including medical and policy definitions, must be legislated. Those covered by group life insurance are vulnerable as they do not receive any advice on whether their group coverage is correctly matched to their circumstances. Legislated minimum standards and clear policy definitions in group insurance are required to:

- protect consumers and provide certainty that the product matches their needs;
- reduce complexity for insurers by making it easier for them to appropriately price products; and
- ensure that there is meaningful oversight of the implementation and use of the standards and definitions.[43]

10.54 The consultation paper for the draft Super Code notes that the Insurance in Superannuation Working Group considered the extent to which the standardisation of definitions in insurance within superannuation can occur, but concluded that this is a longer term project that will be considered in future iterations of the Super Code.[44]

Committee view

10.55 Evidence to the committee highlighted that policies with technical definitions can have high decline rates. This suggests that there may be a significant gap between how society may define a certain event, such as a heart attack, and how the same event is defined by life insurers. The move by life insurers away from the common

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41 Australian Lawyers Alliance, *Submission 20*, pp. 10–11, 14.

42 Association of Superannuation Funds of Australia, *Submission 29*, p. 3.

43 Australian Lawyers Alliance, *Submission 20*, pp. 9, 10.

44 The Insurance in Superannuation Working Group, *Consultation Paper: Insurance in Superannuation Code of Practice*, September 2017, pp. 10–11.

understanding of TPD and an individual's ability to return to employment, as encapsulated in the SIS Act, also demonstrates this gap.

10.56 The committee notes the work being done by the FSC to ensure policy definitions of certain conditions are up-to-date. The Insurance in Superannuation Working Group's position that it will consider the standardisation of definitions in the future iterations of the Super Code is also noted. However, the committee is concerned that the Insurance in Superannuation Working Group has postponed consideration of minimum standardised definitions.

10.57 In this regard, the committee is firmly of the view that all definitions should be up-to-date and standardised across all types of life insurance policies. This would provide certainty to consumers and policyholders about what they are covered for, including the extent to which any associated conditions that may arise from the initial condition, such as mental ill health, are covered by the insurance policy.

10.58 The committee also believes that the FSC and the Insurance in Superannuation Working Group should seek the views of a panel of independent medical experts—that is, medical experts independent of the life insurance industry—when reviewing the appropriateness of all definitions, noting a review may need to occur more frequently than every three years.

10.59 As detailed in chapter 4 of this report, the committee supports the co-regulatory approach outlined in ASIC's Enforcement Review position paper, particularly the requirements for codes to be registered. Such a co-regulatory approach will allow for appropriate oversight of the commitments made in a code, including those relating to keeping policy definitions up-to-date and ensuring review of these definitions occur in a timely fashion.

Recommendation 10.3

10.60 The committee recommends that in relation to definitions in life insurance policies, the life insurance industry must:

- **regularly update all definitions in policies to align with current medical knowledge and research;**
- **standardise definitions across all types of polices;**
- **use clear and simple language in definitions; and**
- **clearly explain which associated conditions that may arise from the initial condition, including mental ill health, are covered by the insurance policy.**

Recommendation 10.4

10.61 The committee recommends that the Financial Services Council's *Life Insurance Code of Practice* be updated to reflect Recommendation 10.3.

Recommendation 10.5

10.62 The committee recommends that the Insurance in Superannuation Working Group's *Insurance in Superannuation Code of Practice* be updated to reflect Recommendation 10.3.

Pre-existing conditions and non-disclosure

10.63 In the context of life insurance, pre-existing conditions are illnesses or conditions that a consumer may have had prior to obtaining an insurance policy. Life insurance policies often contain exclusions for some or all pre-existing conditions.

10.64 As discussed in chapter 8 on access to medical information, under the Insurance Contracts Act, a consumer must disclose all relevant information to an insurer. This means that where a consumer has a pre-existing condition this must be disclosed to the insurer when applying for insurance.

10.65 Where relevant information has not been disclosed to the insurer, section 29(3) of the Insurance Contracts Act allows an insurer to avoid the policy within the first three years, even in circumstances where the failure to disclose was not fraudulent. Remedies for insurers other than contract avoidance due to non-fraudulent non-disclosure also include adjusting the monetary amount that is insured and the retrospective varying of the contract to allow the insurers to be placed in the position they would have been in if the non-disclosure did not occur. If the failure to disclose was fraudulent, section 29(2) of the Insurance Contracts Act allows an insurer to avoid the contract at any time.[45]

10.66 In Report 498, ASIC found that the definition for pre-existing condition exclusions varied greatly across policies and that, in general, for policies that were non-advised such as direct and group policies, all pre-existing conditions were excluded from coverage.[46]

10.67 ASIC also found that pre-existing condition exclusions did not necessarily require the diagnosis of the condition but rather whether symptoms existed that would lead a reasonable person to obtain medical treatment or assistance.[47]

10.68 ASIC also noted that non-disclosure of pre-existing conditions happened for a number of reasons, such as the policyholder not being formally diagnosed with the condition or being told that they have been cured of the condition. There can also be disagreement between insurer, policyholders and doctors about whether a pre-existing condition relates to a claim.[48]

10.69 Mr Peter Kell, Deputy Chairman of ASIC, discussed ASIC's concerns over life insurers looking at a customer's medical history to identify a pre-existing condition that was not disclosed in order to inappropriately deny claims. Mr Kell stated that

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45 *Insurance Contracts Act 1984*, s. 29.

46 Australian Securities and Investments Commission, *REP 498 Life insurance claims: An industry review*, 12 October 2016, p. 67.

47 Australian Securities and Investments Commission, *REP 498 Life insurance claims: An industry review*, 12 October 2016, p. 67.

48 Australian Securities and Investments Commission, *REP 498 Life insurance claims: An industry review*, 12 October 2016, p. 67.

ASIC is of the view that law reform regarding how insurers use medical evidence to identify pre-existing conditions may be beneficial.[49]

10.70 The committee received evidence about insurers determining a person had a pre-existing undisclosed mental health condition despite a lack of evidence to support such a conclusion. For example, beyondblue submitted that in some cases where claims have been denied or contracts avoided due to the insurer's determination that a customer did not disclose a past mental health condition, the insurer has actually only relied on the fact the person had a single mental health episode, or simply required assistance with managing every day stress, or made a passing comment about their mood to a treating doctor.[50]

10.71 Likewise, PIAC observed that an insurer usually only makes an allegation of non-disclosure against the policyholder after the policyholder has made a claim for a benefit.[51] Ms Michelle Marie Cohen, Senior Solicitor at PIAC, referred to the distress and humiliation felt by a client of PIAC when an insurer imputed that they had a pre-existing mental health condition.[52]

10.72 The labelling of a mental health issue as a pre-existing condition also concerned some witnesses such as Dr Kym Jenkins, President Elect Royal Australian and New Zealand College of Psychiatrists, who informed the committee that insurers use a one-size-fits-all approach that views mental illness as a homogenous illness with no regard to severity or length.[53]

10.73 Additionally, Dr Carbone argued that the term pre-existing is too broad and questioned why a condition that was present a decade or two ago can be seen as pre-existing to circumstances that exist currently.[54]

10.74 Dr Carbone also drew attention to the adverse consequences of people not seeking medical treatment due to a fear of insurers using mental health as a pre-existing condition to deny claims.[55]

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49 Mr Peter Kell, Deputy Chairman, Australian Securities and Investments Commission, *Committee Hansard*, 8 September 2017, p. 54.

50 beyondblue, *Submission 18*, pp. 16–17; Ms Nadine Bartholomeusz-Raymond, General Manager, Education, Families and Diversity and Access, beyondblue, *Committee Hansard*, 22 February 2017, p. 13; Dr Stephen Carbone, Policy, Research and Evaluation Leader, beyondblue, *Committee Hansard*, 22 February 2017, p. 14.

51 Public Interest Advocacy Centre, answer to questions on notice, 24 February 2017 (received 16 March 2017), pp. 2–3.

52 Ms Michelle Marie Cohen, Senior Solicitor, Public Interest Advocacy Centre, *Committee Hansard*, 24 February 2017, pp. 3–4.

53 Dr Kym Jenkins, President Elect, Royal Australian and New Zealand College of Psychiatrists, *Committee Hansard*, 22 February 2017, p. 17; See also, Mr John Berrill, Berrill & Watson Lawyers, *Committee Hansard*, 22 February 2017, p. 31.

54 Dr Stephen Carbone, Policy, Research and Evaluation Leader, beyondblue, *Committee Hansard*, 22 February 2017, p. 16.

10.75 The FSC stated that insurers only investigate a policyholder's non-disclosure in specific circumstances. Triggers for an investigation can include the amount of time between a policyholder acquiring a policy and making a claim, with a longer period between acquisition and claim unlikely to be a trigger, and where a treating doctor has mentioned a non-disclosed condition in a report relating to a claim.[56]

10.76 The FSC explained that insurers assess the non-disclosed condition by reviewing sufficient medical information regarding the policyholder's history. The FSC assert that where the non-disclosure is not relevant to the claim, policyholders are protected by the following principles as established by courts and disputes bodies:

> 1. The non-disclosure has to be significant enough for an underwriter to deem that the insurer would not have accepted the risk on the same terms.
>
> 2. The insurer has to be satisfied that a reasonable person would have disclosed the condition.[57]

Committee view

10.77 The evidence submitted by the FSC emphasised the obligations insurers are under to ensure that non-disclosure can only be used to deny a claim or avoid a contract in circumstances where the disclosure is significant enough that the insurer would have charged higher premiums had it known about the pre-existing condition and where a reasonable person would have disclosed the condition.

10.78 However, other evidence provided during this inquiry suggests that life insurers use pre-existing conditions to unfairly deny claims. The committee heard that this can occur when a life insurer imputes that a policyholder had, for example, a pre-exiting mental health condition despite their being little evidence on which to base such a claim.

10.79 The committee is particularly concerned about allegations that seemingly benign information, such as a discussion with a doctor about a mood, is used by life insurers as a basis for determining someone has a pre-existing mental health condition. The committee is concerned that such behaviour, or the perception of such behaviour by life insurance companies, is highly likely to dissuade people from seeking appropriate treatment and evidence was presented that this was already occurring. Furthermore, such behaviour is inimical to the proper recognition of the complex and non-homogenous nature of mental health conditions.

10.80 The committee is of the view that its recommendations in chapter 8 regarding an insurer's access to medical information may help prevent the inappropriate use of information to determine the non-disclosure of a pre-existing condition.

10.81 Nevertheless, in addition to those earlier recommendations, the committee is also of the view that the FSC should include explicit commitments within its Code to

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55 Dr Stephen Carbone, Policy, Research and Evaluation Leader, beyondblue, *Committee Hansard*, 22 February 2017, p. 19.

56 Financial Services Council, *Submission 26.1*, pp. 8–9.

57 Financial Services Council, *Submission 26.1*, p. 9.

the effect that a pre-existing condition is to be used by an insurer as the basis for denying a claim or avoiding a contract only where a direct medical connection between the pre-existing condition and the claim can be established. Furthermore, the Code should require the life insurer to provide the statistical and actuarial evidence and any other material used to establish a pre-existing condition, as well as a written summary of the evidence, to the policyholder.

Recommendation 10.6

10.82 The committee recommends that the Financial Services Council's *Life Insurance Code of Practice* include explicit commitments that:

- **where a pre-existing condition is to be used by an insurer as the basis for denying a claim or avoiding a contract a direct medical connection between the prognosis of a pre-existing diagnosed condition and the claim must be established; and**
- **the statistical and actuarial evidence and any other material used to establish a pre-existing condition, as well as a written summary of the evidence in simple and plain language, be provided by the life insurer to the consumer/policyholder on request.**

Mental health claims

10.83 Report 498 found that policyholders making a mental health claim face a challenging burden in demonstrating to insurers the validity of their condition. ASIC noted that the evidence required for a mental health claim is substantial and includes 'the need for policyholders to attend psychiatric assessments, complete activity diaries, submit regular progress claim forms, provide medical reports and attend interviews with private investigators, as well being the subject of surveillance'.[58]

10.84 Based on its findings, ASIC concluded that industry standards for the assessment of mental health claims are required in order to adequately protect policyholders.[59]

10.85 beyondblue submitted that a person's mental health condition can be exacerbated or re-emerge in response to an insurer, or a specialist working for an insurer, questioning the validity of their mental health claim.[60] Dr Michelle Blanchard,

58 Australian Securities and Investments Commission, *REP 498 Life insurance claims: An industry review*, 12 October 2016, pp. 62–63.

59 Australian Securities and Investments Commission, *REP 498 Life insurance claims: An industry review*, 12 October 2016, p. 62.

60 beyondblue, *Submission 18*, p. 16.

General Manager of Research, Policy and Programs with SANE Australia provided several case studies that reinforced beyondblue's evidence.[61]

10.86 Dr Kym Jenkins, President Elect of The Royal Australian and New Zealand College of Psychiatrists, was critical of the way that life insurers have a tendency to treat mental health as a homogenous issue. She also questioned the selection of data used by life insurers to assess a mental health claim, and also whether such data is up-to-date.[62] Other witnesses including representatives from Mental Health Australia, the National Mental Health Commission and SANE Australia raised similar questions.[63]

10.87 Evidence was presented to the committee that individuals may not seek treatment for mental ill health due to concerns of how this information will be used by life insurers.

10.88 In terms of how the life insurance industry has responded to mental health claims, the FSC stated that the industry pays a large and growing amount of benefits in response to mental health conditions The FSC also noted that the industry is considering mental health as a potential area of focus for the second iteration of the Code and will require life insurers to ask specific and clearer questions in relation to mental health issues.[64] However, the FSC have stated that they 'are not going to have a specific mental health chapter'. The FSC has also established a steering group with mental health representatives to better understand mental health conditions that may lead to impairment or absence from work. The FSC has also held two roundtable sessions with mental health advocacy groups such as the National Mental Health Commission and Mental Health Australia.[65]

10.89 Under Standard 21 that sits alongside the Code, life insurers who are FSC members must have a minimum standard mental health education and training program that staff interacting with customers must undertake to ensure that staff have adequate mental health awareness. The FSC was of the opinion that many insurers go

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61 Dr Michelle Blanchard, General Manager, Research, Policy and Programs, SANE Australia, *Committee Hansard*, 1 December 2017, p. 3; SANE Australia, *Experiences of people with mental illness with regard to life insurance*, December 2017 (tabled 1 December 2017).

62 Dr Kym Jenkins, President Elect, The Royal Australian and New Zealand College of Psychiatrists, *Committee Hansard*, 22 February 2017, p. 12.

63 Mr Joshua Fear, Director, Policy and Projects, Mental Health Australia, *Committee Hansard*, 1 December 2017, pp. 1-2; Mrs Lucinda Brogden, Co-Chair, National Mental Health Commission, *Committee Hansard*, 1 December 2017, p. 2; Dr Michelle Blanchard, General Manager, Research, Policy and Programs, SANE Australia, *Committee Hansard*, 1 December 2017, p. 3.

64 Financial Services Council, *Submission 26.1*, p.3; Ms Sally Loane, Chief Executive Officer, Financial Services Council, *Committee Hansard*, 1 December 2017, p. 22.

65 Ms Sally Loane, Chief Executive Officer, Financial Services Council, *Committee Hansard*, 1 December 2017, pp. 22, 27; Mr Jesse Krncevic, Senior Policy Manager, Financial Services Council, *Committee Hansard* , 1 December 2017, p. 27; See also, Mrs Lucinda Brogden, Co-Chair, National Mental Health Commission, *Committee Hansard*, 1 December 2017, p. 6; Mr Joshua Fear, Director, Policy and Projects, Mental Health Australia, *Committee Hansard*, 1 December 2017, pp. 6, 7.

beyond the minimum standard required.[66] The FSC also asserted that there is a trend amongst insurers to have mental health claims teams, most of which consist of allied health professionals and relevant medical expertise.[67]

Surveillance

10.90 Viewed as a necessary part of the claims process, insurers believe surveillance provides them with a way to guard against false claims and fraud.[68] However, ASIC's Report 498 noted that five per cent of the evidence-related disputes that it examined concerned allegations of surveillance practices that were seen as unfair or even caused a person's mental health condition to worsen.[69]

10.91 Mental health professionals provided real life examples that reflected ASIC's finding. Dr Jenkins explained to the committee that for someone who has made a mental health claim, it can be destructive to subject them to surveillance when their mental health has since improved and they are trying to move forward.[70]

10.92 In terms of how insurers engage with surveillance practices, the FSC informed the committee that only an estimated one to five per cent of claims are subject to surveillance. The FSC believe that surveillance in relation to mental health is even rarer.[71]

10.93 Additionally the Code provides commitments that life insurers will only use surveillance, which must be undertaken by a legitimate investigator, where there is an inconsistency in the information provided. The Code also contains a commitment that surveillance will cease where it is shown that it is negatively impacting the claimant's recovery.[72]

Committee view

10.94 Mental health advocacy groups advised the committee that it remains unclear what data is used by life insurers to assess mental health claims and whether this data is up-to-date.

10.95 The committee believes that providing consumers and policyholders with appropriate written reasons, as discussed earlier in this chapter, will illuminate the nature of the actual data that is being used by insurers in relation to both assessing mental health claims and in their determination of whether there has been non-disclosure of a mental health pre-existing condition.

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66 Financial Services Council, *Submission 26.1*, p. 6.

67 Financial Services Council, *Submission 26.1*, p. 5.

68 Financial Services Council, *Submission 26.1*, p. 6.

69 Australian Securities and Investments Commission, *REP 498 Life insurance claims: An industry review*, 12 October 2016, p. 63.

70 Dr Kym Jenkins, President Elect, Royal Australian and New Zealand College of Psychiatrists, *Committee Hansard*, 22 February 2017, p. 19.

71 Financial Services Council, *Submission 26.1*, p. 6.

72 Financial Services Council, *Submission 26.1*, p. 6.

10.96 Furthermore, the committee believes that the release of such data will allow for a conversation between mental health advocacy groups and the life insurance industry regarding the appropriateness of the data.

10.97 The committee agrees with ASIC's position that industry standards for the assessment of mental health claims are needed. A suitable way to achieve this may be through a separate Code with commitments specific to mental health claims and other related issues. The committee notes that if ASIC's proposal for a co-regulatory system, as discussed in chapter 4, is implemented by the government the enforceability of such a code would be strengthened.

10.98 With around half of Australians expected to experience a mental illness at some point during their life and evidence presented to the committee suggesting that 'psychological conditions are the most common reasons for patients to visit a GP in the first place',[73] the committee is strongly of the view that mental health needs to be addressed in a specific manner by life insurers.

10.99 In addition, the committee is highly concerned about evidence presented that individuals are not seeking treatment for mental ill health due to concerns about the use of this information by life insurers. This is undermining our public health message which continues to work to reduce the stigma that remains around mental health experiences. Any role life insurers have in impacting on individuals seeking necessary treatment must be addressed.

10.100 The committee deals with rehabilitation below, and for sound reasons as articulated in the section on early intervention and rehabilitation payments at the end of this chapter, is cautious about allowing insurers to be directly involved in funding rehabilitation. However, the committee considers that broad-based preventative initiatives is in a different category, and believes that consideration should be given to allow insurers to more actively promote and fund evidence-based best-practice preventative health measures targeted at promoting good mental health at a general level.

Recommendation 10.7

10.101 The committee recommends that after consultation with relevant medical professionals independent of the life insurance industry and mental health advocacy groups, the Financial Services Council establish a mandatory and enforceable Code of Practice for its members, or a dedicated part of its existing Code of Practice, specifically in relation to mental health life insurance claims and related issues.

10.102 The committee further recommends that these consultations discuss requiring insurers to:

73 Dr Seidel, Royal Australian College of General Practitioners, *Committee Hansard*, 1 December 2017, p. 13.

- **ensure that applications for insurance that reveal a mental health condition or symptoms of a mental health condition are not automatically declined;**
- **refer applications for insurance that reveal a mental health condition or symptoms of a mental health condition to an appropriately qualified underwriter;**
- **give an applicant for insurance the opportunity to either withdraw their application or provide further information, including supporting medical documents, before declining to offer insurance or offering insurance on non-standard terms;**
- **where an insurer offers insurance on non-standard terms, for example, with a mental health exclusion or a higher premium than a standard premium, specify:**
  - **how long it is intended that the exclusion/higher premium will apply to the policy;**
  - **the criteria the insured would be required to satisfy to have the exclusion removed or premium reduced;**
  - **the process for removing or amending of the exclusion/premium; and**
- **develop, implement and maintain policies that reflect the above practices.**

Recommendation 10.8

10.103 The committee recommends that consideration be given to allowing insurers to more actively promote and fund evidence-based best-practice preventative health measures targeted at promoting good mental health at a general level.

Delays

10.104 The committee received evidence about the financial and health burden delays during the claims process may cause. The committee also heard allegations about life insurers deliberately delaying the assessment or payment of claims. However, while evidence also pointed to a lack of transparency around the claims process, life insurers did inform the committee of the measures they are taking to improve communication and reduce delays when making a claims decision.

10.105 Report 498 found that a life insurer's requests for evidence and claims management practices, such as the handling of documentation, contributed to delays

in the claims process.[74] Delays also occurred as a result of matters such as the level of insurance cover and the complexity of the claim.[75]

10.106 The Code contains a commitment that life insurers who are FSC members will make all efforts in meeting timeframes prescribed in the Code. The Code outlines that for non-income related claims, a decision will be made in 10 working days, once the life insurer has all the information that it reasonably requires.[76]

10.107 However, such a commitment comes with the caveat that unexpected circumstances may affect how long it takes for a claims decision to be made. Examples of unexpected circumstances include where a superannuation trustee is carrying out their legal obligation to review the life insurer's decision, as well as the time a policyholder or their doctor takes to provide information to the life insurer.[77] If such unexpected circumstances have occurred, a life insurer will make a decision within one year after it is notified of the claim.[78]

10.108 In addition, the Code also contains a commitment that life insurers will assist a policyholder during the assessment of their claim where the policyholder can demonstrate that they are in urgent financial need.[79]

10.109 In terms of default and retail group insurance in superannuation, Berrill and Watson Lawyers submitted that delays may be a result of the claims being passed back and forth between the life insurer and the superannuation trustee in circumstances where the life insurer requests more information from the policyholder and the trustee must carry out their obligation to review each of the life insurer's requests and decisions.[80] Mr Berrill told the committee that there are no statutory time limits for the processing of life insurance claims in superannuation, unlike those that are applicable to workers compensation insurance.[81]

10.110 The Insurance in Superannuation Working Group has created non-statutory timeframes in its draft Super Code for the processing of life insurance claims in

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74 Australian Securities and Investments Commission, *REP 498 Life insurance claims: An industry review*, 12 October 2016, p. 87.

75 Australian Securities and Investments Commission, *REP 498 Life insurance claims: An industry review*, 12 October 2016, p. 86.

76 Financial Services Council, *Life Insurance Code of Practice*, October 2016, Clauses 8.14, 8.15.

77 Financial Services Council, *Life Insurance Code of Practice*, October 2016, Clause 8.14.

78 Financial Services Council, *Life Insurance Code of Practice*, October 2016, Clause 8.17.

79 Financial Services Council, *Life Insurance Code of Practice*, October 2016, Clauses 8.27–8.30.

80 Berrill & Watson Lawyers, *Submission 19*, p. 8.

81 Mr John Berrill, Berrill & Watson Lawyers, *Committee Hansard*, 22 February 2017, p. 31.

superannuation. The draft Super Code builds on the timeframes currently committed to in the Code.[82]

10.111 Industry Super Australia stated that the new code for group insurance will improve communication with consumers and policyholders about how long a claim will take to be assessed.[83]

10.112 Mr Shane Tregillis, Chief Ombudsman at FOS, informed the committee that while the Code has commitments regarding timeframes for claims; such commitments must be implemented. Mr Tregillis was of the view that timeframes regarding claims should be clearly communicated to policyholders and only deviated from by insurers in exceptional circumstances, with such circumstances explained to the policyholder.[84]

10.113 The FRLC expressed concern that delays serve as an unethical way for insurers 'to drag out claims'. Policyholders when faced with a heavy financial burden and subjected to invasive practices become worn out and, as a result, withdraw their claims.[85]

10.114 The FLRC were of the view that, due to its self-regulatory and unenforceable nature, the Code was insufficient to prevent unreasonable delays in claims assessment and that law reform was therefore necessary to protect policyholders.[86]

10.115 It should be noted that Report 498 found that 3 out of 14 insures had high rates of withdrawn claims ranging from 20 to 24 per cent. However, ASIC were unable to draw any conclusions as to why high claims withdrawal rates occurred. This is in part due to varying definitions of 'withdrawn' amongst insurers. ASIC noted that it will explore the issue of withdrawn rates as a part of its further work.[87]

10.116 The ALA, like the FLRC, argued for legislation to be enacted for group insurance regarding timeframes for claims handling. The ALA noted that while the common law allows a court to make a decision in circumstances where an insurer has taken too long to assess a claim, legislated timeframes for a claims decision along

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82 The Insurance in Superannuation Working Group, *Discussion Paper*: *Claims Handling*, April 2017, pp. 5, 6, 7–9; The Insurance in Superannuation Working Group, *Consultation Paper: Insurance in Superannuation Code of Practice*, September 2017, pp. 11–12, Appendix 1, pp. 12–17.

83 Mr Richard Watts, Consultant, Industry Super Australia, *Committee Hansard*, 22 February 2017, p. 54.

84 Mr Shane Tregillis, Chief Ombudsman, Financial Ombudsman Service Australia, *Committee Hansard*, 22 February 2017, p. 65.

85 Financial Rights Legal Centre, *Submission 17*, p. 16.

86 Financial Rights Legal Centre, *Submission 17*, pp. 16, 18; see also Ms Julia Angrisano, National Secretary, Finance Sector Union of Australia, *Committee Hansard*, 22 February 2017, p. 50.

87 Australian Securities and Investments Commission, *REP 498 Life insurance claims: An industry review*, 12 October 2016, pp. 57–58.

with consequences for non-compliance need to be enacted as this will allow for an accountable, clearer and more transparent process.[88]

10.117 As noted in earlier sections, the assessment process for making a mental health claim for life insurance can place substantial additional stress on a policyholder. In addition to those elements already discussed, mental health advocates, such as beyondblue, informed the committee that delays in claims due to multiple requests for evidence and a number of medical assessments can cause a person's mental health condition to worsen.[89]

10.118 In a survey conducted by the Mental Health Council of Australia and beyondblue, respondents shared their experiences of increased stress as a result of the insurance claims process. This was particularly the case where the claims process was delayed due to extensive requests for evidence by insurers, including requests to undertake medical examinations by examiners not known to the person making the claim.[90] It was unclear to Dr Carbone why multiple medical assessments are needed, other than to allow for insurers to find an assessment that would allow it to deny a claim.[91] Dr Blanchard from SANE Australia provided several case studies to the committee that reinforced the findings made by Mental Health Australia and beyondblue.[92]

10.119 Berrill and Watson Lawyers noted that there is a lack of transparency around claims handling processes, particular in relation to timeframes. Berrill and Watson Lawyers explained that all insurers have claims manuals which outline to staff the claims assessment process, the documents that are required for claims assessment, and the processing timeframes. However, in its experience 'claims manuals have sometimes operated as a blunt instrument to delay claims'.[93]

10.120 Based on its observation of industry practice, Berrill and Watson Lawyers recommended that claims manuals be provided to customers in order to improve the transparency of the process.[94]

10.121 In response to these concerns, BT Financial stated that the Code will positively influence the claims process and encourage timely management of claims.[95]

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88 Australian Lawyers Alliance, *Submission 20*, p. 21.

89 beyondblue, *Submission 18*, p. 16.

90 Mental Health Council of Australia and beyondblue, *Mental Health, Discrimination & Insurance – A survey of consumer experiences 2011*, 2011, p. 45.

91 Dr Stephen Carbone, Policy, Research and Evaluation Leader, beyondblue, *Committee Hansard*, 22 February 2017, p. 20.

92 Dr Michelle Blanchard, General Manager, Research, Policy and Programs, SANE Australia, *Committee Hansard*, 1 December 2017, p. 3; SANE Australia, *Experiences of people with mental illness with regard to life insurance*, December 2017 (tabled 1 December 2017); See also, Ms Jenny Branton, Executive Officer, Mental Health Carers Australia, *Committee Hansard*, 1 December 2017, pp. 2–3, 6.

93 Berrill & Watson Lawyers, *Submission 19*, pp. 5–6.

94 Berrill & Watson Lawyers, *Submission 19*, pp. 5–6.

10.122 BT Financial acknowledged that while training and accreditation in relation to claims handling exists, there is no industry standard or prescribed continuing education. BT Financial therefore saw an opportunity for the Australasian Life Underwriters & Claims Association and the FSC to create an industry accredited program for claims handlers.[96]

10.123 The committee was also informed of initiatives being undertaken by life insurers in order to alleviate claims delays. For example, MLC are continuing to improve their claims handling processes and reduce delays by working towards customers having a dedicated case consultant to ensure proper communication between parties and faster decision making.[97]

Committee view

10.124 The committee acknowledges the commitment made in the Code to timeframes an insurer must abide by when assessing a claim. The committee also recognises that life insurers to whom the Code applies have only recently been bound by the Code and are still taking steps to implement the Code's commitments.

10.125 Nevertheless, based on the evidence received, the committee recommends that the FSC and the Industry Superannuation Working Group should consult with financial legal services and mental health advocacy groups to determine appropriate timeframes for claims decisions. The Code and the draft Super Code should be updated to reflect the outcomes of such consultation. This approach will ensure that the timeframes committed to in each code will balance the needs of the life insurance industry and policyholders.

10.126 Furthermore, the committee received a body of evidence that policyholders may have to undergo multiple medical assessments, the reasons for which appear, at times, unclear to a policyholder. The committee is concerned that multiple medical assessments can delay a claim, have a detrimental effect on a policyholder's health, and create a financial burden.

10.127 The committee is concerned that there does not seems to be an upper limit on the number of medical assessments that life insurers can ask a policyholder to undergo. While the committee is not inclined to prescribe an upper limit on the number of medical assessments, the committee is firmly of the view that the FSC and the Industry Superannuation Working Group should consult with relevant stakeholders, including medical professionals that are independent of the life insurance industry and mental health advocacy groups, to determine an acceptable upper limit for medical assessments to be included in both the Code and the Super Code.

10.128 As stated in the sections of this chapter on definitions and mental health claims, the committee supports the co-regulatory approach outlined in ASIC's

95 BT Financial, *Submission 13*, p. 6.

96 BT Financial, *Submission 13*, p. 8.

97 MLC Life Insurance, *Submission 30*, p. 6.

Enforcement Review position paper, particularly the requirements for codes to be registered. Such a co-regulatory approach will allow for appropriate oversight of the commitments made in a code to timeframes for claims decisions and the number of medical assessments to be undertaken by a policyholder.

Recommendation 10.9

10.129 The committee recommends that the Financial Services Council and the Insurance in Superannuation Working Group consult with financial legal services and mental health advocacy groups to determine appropriate timeframes for claims decisions and that the *Life Insurance Code of Practice* and the *Insurance in Superannuation Code of Practice* be updated to reflect the outcome of such consultation.

Recommendation 10.10

10.130 The committee recommends that after consultation with relevant stakeholders, including medical professionals that are independent of the life insurance industry and mental health advocacy groups, the Financial Services Council and the Insurance in Superannuation Working Group mandate through the *Life Insurance Code of Practice* and the *Insurance in Superannuation Code of Practice* an upper limit on the number of medical assessments that can be requested of a policyholder and the specific circumstances in which this upper limit could be deviated from.

Independent medical examiners

10.131 A life insurer may use an Independent Medical Examiner (IME) to provide a medical report on a policyholder's claim before it makes a claims decision. IMEs are usually registered medical practitioners and as such are subject to the same legal and ethical obligations and standards as all other registered medical practitioners.[98]

10.132 The FSC explained that an IME will be used particularly in circumstances where there is a difference of opinion between a policyholder's General Practitioner and their specialist.[99]

10.133 The committee was also interested in understanding how the IME market operates as well as the market share of different medico/legal businesses. The committee was keen to ascertain whether any undue concentration of power may exist in this market that could impact on the practices of IMEs.

10.134 While not willing to share its exact market share, Mr Tim Morphy, Director and Chief Executive Officer of MedHealth, told the committee that MedHealth owns

98 Ms Anne Trimmer, Secretary General, Australian Medical Association, *Committee Hansard*, 8 September 2017, pp. 23–24.

99 Financial Services Council, *Submission 26.1*, p. 7.

and operates six business units, all of which mostly facilitate the provision of IMEs to life insurers in Australia.[100]

10.135 In answers to questions on notice regarding the growth of MedHealth's medico/legal businesses, Mr Morphy stated that during 2014–2016, the medico/legal business of MedHealth has had an average organic growth rate of 6.3 per cent per annum.[101]

Committee view

10.136 Despite numerous requests to witnesses and research into the matter, the committee was unable to obtain information on the market share of medico/legal businesses providing IME services. The committee is concerned that this information either does not exist or is not easily accessible. Understanding market concentration is important for determining the competitiveness of the IME market. A lack of competitiveness in the IME market may lead to a risk that IME businesses will not maintain appropriate practices for both quality assurance and managing conflicts of interest between an IME as a medical professional and the commercial objectives of the IME business.

10.137 The committee is also unclear about the extent to which the IME market is currently monitored. To this end, the committee is of the view that the IME market is worthy of greater scrutiny and oversight to ensure that appropriate practices are adhered to.

Recommendation 10.11

10.138 The committee recommends that the concentration of power in the Claims Management Industry, as well as the Independent Medical Examiner market be monitored by the Australian Competition and Consumer Commission to ensure appropriate quality assurance practices are in place and conflicts of interests are managed.

10.139 During the course of the inquiry, the committee was particularly concerned to hear allegations that medical reports had been altered in order to enable life insurance companies to avoid paying claims. Senator Williams spoke to two doctors who stated that they had completed medical reports for independent medical examination companies, only to find out later that important elements of their reports had been altered before transmission to the life insurance companies. The committee was unable to call the doctors before it out of regard that their professional identities not be revealed.

10.140 Nevertheless, the committee is of the view that the seriousness of the allegations merits further investigation in order to determine whether malpractice is occurring and, if so, the extent to which it is occurring. The committee recognises that

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100 Mr Tim Morphy, Director and Chief Executive Officer, MedHealth, *Committee Hansard*, 26 May 2017, p. 43.

101 Mr Tim Morphy, Director and Chief Executive Officer, MedHealth, answers to questions on notice, 26 May 2017 (received 9 June 2017).

one way forward would be for an audit to take place. That audit would compare the original medical reports as drafted and kept on file by doctors with those used by life insurance companies as the basis for the decision.

10.141 The prospect of a comprehensive audit should be sufficient to ensure that the highest standards of probity pertain to the entire independent medical examination process. At the very least, if no evidence of report tampering is found, such an audit should restore confidence in the independent medical examination process. On the other hand, if evidence of report tampering is found, the legal consequences are substantial.

Recommendation 10.12

10.142 The committee recommends that the government consider establishing mechanisms to ensure the appropriate bodies are able to undertake random audits of both historical and future medical reports procured by independent medical examination companies, comparing the original reports as drafted by doctors with those used by life insurance companies as the basis for the decision.

Incentives for staff to reject or delay claims

10.143 During the inquiry, the committee examined whether life insurers incentivise staff to reject claims through key performance indicators and other benefits. Ms Julia Angrisano, the National Secretary of the Finance Sector Union, discussed with the committee how call centre staff had a target imposed on them regarding the number of policyholders they referred to the retention team, who would then try to convince the policyholder to hold off from seeking payment for a claim.[102]

10.144 Mr Kell informed the committee that in relation to CommInsure and its claims staff, ASIC had found that 'net-loss ratios and income protection termination rates' were a part of claims staff's key performance indicators. ASIC found this to be an unacceptable conflict of interest.[103]

10.145 However, Mr Kell observed that CommInsure had since removed these key performance indicators, and that the Code now prohibits such incentives.[104]

Committee view

10.146 The committee is very disturbed by any incentives that life insurers had in place to incentivise staff to reject claims through key performance indicators and other benefits. The committee considers this to have been particularly egregious. As noted

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102 Ms Julia Angrisano, National Secretary, Finance Sector Union of Australia, *Committee Hansard*, 22 February 2017, p. 50.

103 Mr Peter Kell, Deputy Chairman, Australian Securities and Investments Commission *Committee Hansard*, 8 September 2017, p. 48.

104 Mr Peter Kell, Deputy Chairman, Australian Securities and Investments Commission *Committee Hansard*, 8 September 2017, p. 48; See also Financial Services Council, *Life Insurance Code of Practice*, October 2016, Clause 4.3.

in chapter 5 of this report, the then ASIC Chairman Mr Greg Medcraft has stated on several occasions that incentives send signals and the wrong type of incentives send the wrong signals.

10.147 The committee notes ASIC's monitoring of these matters and welcomes the move by the FSC to prohibit such incentives within the Code.

10.148 At the risk of being overly repetitive, however, the committee reiterates its support for co-regulation of industry codes as a means to ensure that measures such as the prohibition of perverse incentives are not only mandatory, but also enforceable.

Underwriting direct insurance

10.149 This section discusses the prevalence of underwriting at the time that a customer purchases direct life insurance, as well as arguments put to the committee about consumers not being underwritten at the time of purchasing direct insurance.

10.150 As discussed in chapters 2, 8 and 9 of this report, underwriting can be a process of risk assessment conducted by the life insurer that aims to ensure the premiums paid by the prospective policy-holder are proportionate to the risks faced by that individual.

10.151 As also discussed in chapter 2, retail-advised insurance is underwritten at the time of purchase as part of the service provided by the adviser.

10.152 Retail advisers outlined some of the risks for consumers of not being underwritten at the time of purchasing direct life insurance. The Association of Financial Advisers submitted that if a consumer was not underwritten at the time of purchase, the life insurer would only assess that person's risk, and in turn the level of their cover, at the time of claim. This could mean that the policyholder may be unaware that they were paying premiums for a policy without technically being covered by that policy.[105]

10.153 Mr Mark Schroeder, a financial adviser from Schroeder Capital Pty Ltd, held a similar view and argued that the likelihood of a policyholder being paid at the time of claim was significantly reduced for a direct policy not underwritten at the time of purchase.[106]

10.154 ASIC Report 498 found that across the distribution channels of direct, retail and group life insurance, direct life insurance had the highest decline rate in terms of claims outcomes. For direct insurance 12 per cent of claims were denied, compared with 7 per cent in retail and 8 per cent in group life insurance.[107]

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105 Association of Financial Advisers, *Submission 22*, pp. 9–10.

106 Mr Mark Schroeder, Schroeder Capital Pty Ltd, *Submission 68*, p. 7.

107 Australian Securities and Investments Commission, *REP 498 Life insurance claims: An industry review*, 12 October 2016, p. 53.

10.155 However, Report 498 also found that the claims acceptance rate across the three channels of distribution were fairly similar with direct found to have a 74 per cent acceptance rate, retail 76 per cent and group 77 per cent.[108]

10.156 ASIC did not draw any concrete conclusions about whether the higher claims decline rates were due to underwriting practices at the time of claim by direct insurers. In light of Report 498's findings, ASIC will undertake a review of the direct life insurance industry.[109]

10.157 The FSC pointed out that the perceived higher decline rate for direct insurance in comparison to the other channels of distribution for insurance is likely due to the fact that in retail and group insurance the relevant adviser or trustee will filter out any claims that are likely to be declined prior to submitting the claim to an insurer. As direct insurance does not have an intermediary such as a trustee or an adviser, all claims are submitted to the insurer.[110]

10.158 The FSC submitted that a spectrum of underwriting options existed in the direct market and that underwriting at time of purchase occurs for many direct products. In situations where underwriting did not occur as part of the application process, the insurer would then determine whether the claim met the policy terms and conditions including any exclusions for a pre-existing condition.[111]

10.159 For example, Mr Andrew Hagger, Chief Customer Officer at the National Australia Bank, explained that for those MLC direct products that are not underwritten at the time of purchase, consumers are made aware of policy exclusions through product disclosure statements and the questions that consumers are asked at the time of application.[112]

10.160 Mr Brett Clark, Chief Executive Officer and Managing Director of TAL, stated that TAL offers underwriting to all its direct customers. However, in about 30 per cent of cases the consumer chooses not to complete the underwriting. In such circumstances, TAL offers policies that exclude pre-existing, known conditions for a waiting period comprising the first five years of cover, after which, the customer is

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108 Australian Securities and Investments Commission, *REP 498 Life insurance claims: An industry review*, 12 October 2016, pp. 55–56.

109 Australian Securities and Investments Commission, *16–347 MR ASIC issues industry review of life insurance claims*, http://asic.gov.au/about-asic/media-centre/find-a-media-release/2016-releases/16-347mr-asic-issues-industry-review-of-life-insurance-claims/ (accessed 6 November 2017).

110 Financial Services Council, *Supplementary Submission 26.1*, p. 12.

111 Financial Services Council, *Supplementary Submission 26.1*, pp. 11–12.

112 Mr Andrew Hagger, Chief Customer Officer, Customer Banking and Wealth Management, National Australia Bank, *Committee Hansard*, 26 May 2017, p. 10.

fully covered. Additionally, consumers are fully informed of the status of their cover.[113]

10.161 Mr Richard Enthoven, Chairman of Greenstone Pty Ltd, stated that Greenstone Pty Ltd fully underwrites Real Insurance direct policies at the time of purchase through a tele-underwriting process that involves a series of up to 100 questions.[114] Mr Bernard Grobler, Chief Operating Officer of Greenstone Pty Ltd, explained to the committee that an insurance product will only be sold after the questions have been answered.[115] Mr Grobler explained that this practice provides the customer with the certainty of knowing what their policy covers them for.[116]

10.162 Mr Grobler also informed the committee that in the last 12 months only 33 direct insurance claims were denied, in most cases, due to non-disclosure of pre-existing conditions.[117] Furthermore, where a claim was denied due to non-disclosure, all premiums were returned to the policyholder.[118]

10.163 Similarly, Mr Nicholas Scofield, General Manager of Corporate Affairs at Allianz Australia Insurance, explained that all of Allianz's direct life insurance customers are underwritten at the time of purchase.[119]

Committee view

10.164 Based on the evidence before it, the committee is unable to assess what proportion of direct life insurance is underwritten at the time of purchase.

10.165 The committee notes that ASIC Report 498 found that while direct insurance claims have a higher decline rate compared to other types of insurance, the rate of claims that are accepted is similar across the three distribution channels. It is unclear from the data released by ASIC whether these high denial rates relate predominantly to direct insurance that is not underwritten at the time of purchase.

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113 Mr Brett Clark, Chief Executive Officer and Managing Director, TAL, *Committee Hansard*, 18 August 2017, pp. 9–10; TAL, answers to questions on notice, 18 August 2017 (received 1 September 2017).

114 Mr Richard Enthoven, Executive Chairman, Greenstone Pty Ltd, *Committee Hansard*, 26 May 2017, pp. 18, 19; See also, Mr Bernard Grobler, Chief Operating Officer, Greenstone Pty Ltd, *Committee Hansard*, 26 May 2017, p. 19.

115 Mr Bernard Grobler, Chief Operating Officer, Greenstone Pty Ltd, *Committee Hansard*, 26 May 2017, p. 19.

116 Mr Bernard Grobler, Chief Operating Officer, Greenstone Pty Ltd, *Committee Hansard*, 26 May 2017, p. 24.

117 Mr Bernard Grobler, Chief Operating Officer, Greenstone Pty Ltd, *Committee Hansard*, 26 May 2017, pp. 19, 20, 25; See also, Mr Richard Enthoven, Executive Chairman, Greenstone Pty Ltd, *Committee Hansard*, 26 May 2017, p. 20.

118 Mr Bernard Grobler, Chief Operating Officer, Greenstone Pty Ltd, *Committee Hansard*, 26 May 2017, pp. 19–20.

119 Mr Nicholas Scofield, General Manager, Corporate Affairs, Allianz Australia Insurance, *Committee Hansard*, 18 August 2017, pp. 34, 36.

10.166 The committee also notes the evidence from the FSC that decline rates in direct insurance could be due to the fact that, unlike retail and group insurance, there is no intermediary in direct insurance to filter out the claims that are likely to be unsuccessful.

10.167 The committee is firmly of the view that there needs to be far greater clarity and transparency around the data on the proportion of direct life insurance that is not underwritten at the time of purchase as well as the data on the rates of denied claims within the direct sector including the links, if any, between decline rates and underwriting practices.

10.168 To this end, the committee strongly encourages ASIC to include data on the connection between denied claims and underwriting practices in its review into the direct life insurance industry. ASIC is also strongly encouraged to assess the extent to which advisers and trustees filter the claims that are submitted to an insurer in the group and retail sectors and the effect this has on the rate of declined claims, as compared to the absence of a similar intermediary in direct insurance and the rate of declined claims in direct insurance.

10.169 In addition, the committee is concerned that some consumers may not fully appreciate the claims process if they are not underwritten at the time of sale, and what this may mean in terms of their coverage and any increased likelihood of their claim being denied. The committee endorses the approach taken by Greenstone and Allianz in which a person is underwritten after answering a series of questions at the time of purchasing direct insurance.

Legacy products

10.170 Life insurers produce and release products that reflect the needs of consumers and the market. However, as the social, legal, medical and financial environments continually change, more up-to-date products are released by life insurers. This means that older products, referred to as legacy products, are no longer made available to new consumers but are still administered to the customers who obtained them previously in accordance with the terms of the older policy.[120]

10.171 Mr Stephen Perera, Director of advice firm of Perera Crowther Financial Services, stated that policyholders who have a legacy product are often left isolated and bound by outdated terms and conditions.[121]

10.172 Mr Perera explained that individuals who are healthy would be able to pass an insurance risk assessment that would enable them to access new and better products. However, those individuals with legacy products who are less healthy than they were when they initially purchased the product would be unlikely to pass any risk assessment for a new insurance product. This means that an individual would be

120 Financial Services Council, *Submission 26*, p. 11; See also Australian Prudential Regulation Authority, *Submission 184 to the Senate Economics References Committee – Inquiry into the Scrutiny of Financial Advice*, p. 10.

121 Mr Stephen Perera, Director, Perera Crowther Financial Services, *Submission 58*, p. 3.

forced to keep the out-dated legacy product in order to have some form of insurance coverage.[122] Furthermore, Mr Perera pointed out that these policyholders 'are eventually priced out by premium increases'.[123]

10.173 From an industry perspective, the FSC noted that legacy products are difficult and expensive to administer and lead to problems such as economically inefficient products and out-of-date medical definitions within policies.[124]

10.174 The FSC supported the need to address the issues posed by legacy products through reform that allows for product rationalisation.[125]

10.175 The FSC also observed that such reform required legislative change as the law does not allow life insurers to change the definitions and terms of a policy unilaterally.[126] This restriction on life insurers and the need for legislative change was also noted by the Australian Prudential Regulation Authority (APRA) in its submission to the Senate Economics References Committee's Inquiry into the Scrutiny of Financial Advice.[127]

10.176 The FSC observed that consumers would be protected under product rationalisation due to a requirement that changes to policies can only be made by the product issuer where this is in the best interest of policyholders. This would be known as a consumer interest test.[128]

10.177 However, the consumer interest test proposed by the FSC would be applied at the group level, meaning it would be applied to the bundle of rights consumers with the same policy have. As the FSC noted, the application of a group test would not consider the best interest for each individual. The FSC submitted that the consumer interest test should be:

- Based on the monetary benefits and rights enjoyed by the consumer as at the Transition Date (rather than intangible product features, unless these represent a monetary benefit or right);

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122 Mr Stephen Perera, Director, Perera Crowther Financial Services, *Submission 58*, p. 4.

123 Mr Stephen Perera, Director, Perera Crowther Financial Services, *Submission 58*, p. 3.

124 Financial Services Council, *Submission 26*, p. 12; Financial Services Council, Product rationalisation working group proposal, additional information received 12 November 2017, p. 3.

125 Financial Services Council, *Submission 26*, p. 11; Financial Services Council, Product rationalisation working group proposal, additional information received 12 November 2017, p. 3.

126 Financial Services Council, *Submission 26*, p. 11.

127 Australian Prudential Regulation Authority, *Submission 184 to the Senate Economics References Committee inquiry into the Scrutiny of Financial Advice*, p. 10.

128 Financial Services Council, *Submission 26*, p. 12; Financial Services Council, Product rationalisation working group proposal, additional information received 12 November 2017, p. 3; See also Australian Prudential Regulation Authority, *Submission 184 to the Senate Economics References Committee inquiry into the Scrutiny of Financial Advice*, p. 10.

- Determined as the accrued value of those benefits;
- Calculated by an independent expert or the Appointed Actuary; and
- Based on the overall bundle of rights consumers have and not at the individual feature level.[129]

10.178 Evidence to the committee from life insurers such as TAL reflected the FSC's position. Mr Clark from TAL told the committee that the *Life Insurance Act 1995* should be updated to respond to the complexity surrounding legacy products and the burden it places on consumers and industry.[130]

10.179 The Financial System Inquiry recommended that product rationalisation should be implemented to address the problems presented by legacy products.[131] In part, product rationalisation would reduce the number of products available on the market that no longer serve the interest of the consumer. The Australian Government accepted this recommendation and announced that a mechanism would be introduced to 'facilitate the rationalisation of legacy products'. The government also recognised that there should be no disadvantage to the consumer in this transition.[132]

Committee view

10.180 Evidence to the committee from life insurers strongly supported the introduction of a legislative mechanism that would facilitate the rationalisation of legacy products. The committee recognises the administrative burden that legacy products impose on life insurers. The committee also notes that the insurance industry would prefer to rationalise legacy products by applying a consumer interest test at the group level.

10.181 However, the committee is also aware that many consumers still hold, and are potentially trapped into still holding, outdated legacy policies. The committee is keen to ensure that the rights of existing policyholders are protected and that any product rationalisation does not disadvantage this cohort of consumers. To this end, the committee recommends that a 'no disadvantage' rule apply to any rationalisation of legacy products such that existing policyholders would, at a minimum, be no worse off from being transferred to a new policy.

10.182 To be clear, the committee is recommending that the determination of whether policyholders are no worse-off under product rationalisation should be done on an individual case-by-case basis and not by considering what is best for a group of policyholders who hold the same legacy product. Though this may be done on a class

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129 Financial Services Council, Product rationalisation working group proposal, additional information received 12 November 2017, p. 3.

130 Mr Brett Clark, Chief Executive Officer and Managing Director, TAL, *Committee Hansard*, 18 August 2017, p. 2.

131 Financial System Inquiry, *Final Report*, 7 December 2014, Recommendation 43.

132 Australian Government, *Improving Australia's financial system: Government response to the Financial System Inquiry*, 20 October 2015, p. 18.

basis, similar to classes within schemes of arrangement under Chapter 2F of the Corporations Act.

Recommendation 10.13

10.183 The committee recommends that the Australian Government introduce legislation to facilitate the rationalisation of legacy products noting that such legislative change should include a no-disadvantage rule whereby:

- **existing policyholders would, at a minimum, be no worse off from being transferred to a new policy; and**
- **the determination of whether existing policyholders are no worse off should be assessed on an individual case-by-case basis and not by considering what is best for a group of policyholders who hold the same legacy product. Though this may be done on a class basis, similar to classes within schemes of arrangement under Chapter 2F of the *Corporations Act 2001*.**

Early intervention—rehabilitation payments

10.184 The FSC informed the committee about regulatory constraints on the ability of life insurers to provide early rehabilitation benefits and medical expenses.[133] The FSC argued that the potential improvement of an insurance policy over its life would incentivise life insurers to invest in more active rehabilitation strategies and lead to better social outcomes for individuals. In addition, the FSC noted that higher return to work rates would reduce the costs borne by government.[134]

10.185 The FSC argued that current regulations prevent life insurers from funding medical treatment and services to support early return to work. As a result, life insurers are increasingly employing rehabilitation specialists to provide occupational or vocational rehabilitation support to manage ongoing disability claims. The FSC indicated that under current legislation, life insurers are not permitted to provide a benefit to a claimant under a continuous disability policy for treatment costs where either a corresponding Medicare benefit is payable or where the treatment is a hospital treatment or general treatment. The FSC argued that these restrictions should be removed.[135]

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133 Financial Service Council, *Submission 26*, pp. 5, 13, 14; Financial Services Council, Early intervention, additional information received 12 November 2017, p. 1.

134 Financial Services Council, Early intervention, additional information received 12 November 2017, p. 1.

135 Financial Services Council, Early intervention, additional information received 12 November 2017, pp 3–5.

10.186 Some other industry participants also raised the issue of restrictions on rehabilitation payments.[136] The Commonwealth Bank suggested that the government consider reviewing legislation to explore opportunities to allow life insurers to fund rehabilitative treatments and assist workers in their return to the workplace.[137] ASFA argued that members' best interests could be served by modifying or removing the regulatory impediments that prevent insurers from providing targeted rehabilitation benefits and/or staged payments.[138]

10.187 In contrast, Dr Stephen Carbone, Policy, Research and Evaluation Leader at beyondblue, had concerns about some of the early intervention proposals put forward by life insurers. Dr Carbone supported early intervention practices that aimed to prevent the preconditions that can lead to people becoming unfit for work, for example, early intervention practices that aimed to prevent job stress leading to depression. However, Dr Carbone drew attention to a conflict of interest that could arise when early intervention practices are focussed on treatment because the life insurer would be both paying the policy claim and also be closely involved in seeking the early return to work of the policyholder:

> I think there needs to be an arms-length sort of relationship because you can get perverse incentives. You can get pressure on the consumer—the consumer being told that they are better than they believe themselves to be and being forced into work that perhaps they are not ready for or suitable for. It is just a complex situation when the person paying the tab is also the one trying to get you back to work.[139]

Committee view

10.188 The committee acknowledges the importance of early intervention and welcomes proposals that would better enable early intervention and thereby improve the rehabilitation prospects of people who have suffered injury or illness.

10.189 The committee notes the arguments put forward by the FSC for the removal of regulatory constraints on the ability of life insurers to provide early rehabilitation benefits and medical expenses. The committee also notes that there was only limited discussion during the inquiry of the issues raised by this proposal. Due to the late arrival of the much more detailed proposal from the FSC, the committee has not had the opportunity to hear from other witnesses and submitters about any potential unintended consequences that may arise as a result of the FSC's proposals. The

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136 Mr Brett Clark, Chief Executive Officer and Managing Director, TAL, *Committee Hansard*, 18 August 2017, p. 2; Mr Andrew Hagger, Chief Customer Officer, Consumer Banking and Wealth Management, National Australia Bank, *Committee Hansard*, 26 May 2017, p. 9; Ms Alexis George, Group Executive, Wealth Australia, Australia and New Zealand Banking Group Ltd, *Committee Hansard*, 3 March 2017, p. 58; Mr Damian Hill, Chief Executive Officer, REST Industry Super, *Committee Hansard*, pp. 53–54.

137 Commonwealth Bank of Australia, *Submission 24*, pp 10–11.

138 Association of Superannuation Funds of Australia, *Submission 29*, p. 3.

139 Dr Stephen Carbone, Policy, Research and Evaluation Leader, beyondblue, *Committee Hansard*, 22 February 2017, p. 17.

committee is therefore recommending that the government does not progress any reforms into life insurance funding for rehabilitation services until a thorough inquiry or consultation process is undertaken.

Recommendation 10.14

10.190 The committee recommends that the Australian Government conduct a thorough inquiry or consultation process before it progresses any reforms relating to life insurers funding rehabilitation services, including impacts on private health insurance, or Medicare, and any conflicts of interest that may arise for an insurer vis-a-vis their customer and the most appropriate care.

10.191 The committee is concerned that people struggling with dementia are having difficulties claiming on life insurance. More than 500 000 Australians will have dementia by 2025 and dementia is now the leading cause of death for Australian women.

10.192 With this background, the committee is concerned that the Financial Services Council was not aware of instances of those with dementia having difficulties claiming on life insurance.

Recommendation 10.15

10.193 The committee recommends that the Financial Services Council, with the Royal Australian College of General Practitioners and key stakeholders, explore issues around those with dementia claiming on life insurance. Following this, the committee recommends that together they prepare and implement protocols within the Code specifically addressing the treatment by life insurers of those with dementia.

Mr Steve Irons MP

Committee Chair