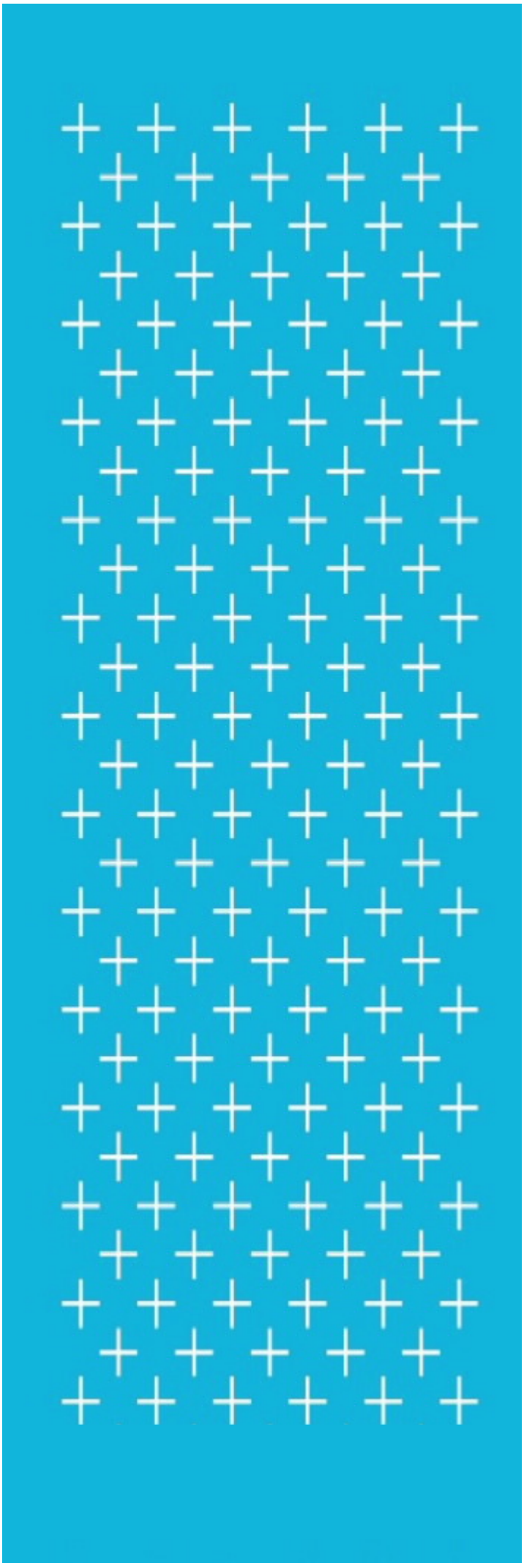

Slater Gordon Lawyers

Royal Commission into the Misconduct in the Banking, Superannuation and Financial Services Industry

Submissions in response to Policy questions arising from Module 6

25 October 2018

About Us

Slater and Gordon Limited is a leading consumer law firm in Australia. We employ over 800 people in 40 locations across Australia. Slater and Gordon's mission is to give people easier access to world class legal services.

As Australia's leading trade union and labour movement law firm, we also have a proud history of partnering with trade unions to defend workers' rights. The firm provides specialist legal and complementary services in a broad range of areas.

Our Superannuation and Disability Insurance practice has been dedicated to assisting claimants for more than 20 years. The area of disability insurance, whether through a group life policy within a superannuation scheme or retail policy, can be challenging and daunting for people suffering from an injury or illness.

The struggle to cope with the difficulties and frustrations that an illness or injury can bring to them and their families' drives us to support and guide them through this complex area both legally and through our dedicated in house social work services.

Introduction

Slater and Gordon welcome the opportunity to provide submissions to the Royal Commission in response to its policy questions arising from module 6. Our submission seeks to address some of the issues raised in the policy questions.

Q1. Is the current regulatory regime adequate to minimise consumer detriment? If the current regulatory regime is not adequate to achieve that purpose, what should be changed?

(1) Slater and Gordon consider that the current regulatory regime falls well short of adequately minimising consumer detriment.

Codes of Practice

(2) It is clear from the voluminous evidence and submissions provided to the Royal Commission and to other recent regulatory inquiries[1] that the Financial Services Councils' Life Insurance Code of Practice ("FSC Code") and Insurance in Superannuation Voluntary Code of Practice ("Super Code") in their current self-regulatory and voluntary form are wholly insufficient to properly protect consumers.

(3) As at September 2018, the number of self-reported breaches by life insurers since the FSC Code took effect was 23.[2] This is not a reflection of strict adherence by life insurers to the FSC Code but instead supports the conclusion that self-regulation is entirely inadequate.

(4) Slater and Gordon strongly advocate for and support the recommendations extensively canvassed by the Parliamentary Joint Committee ("PJC") in its report,[3] for the Codes to require mandatory participation for all industry participants, approval by ASIC and have binding and enforceable consequences for breach.

(5) We also support the Productivity Commission's Draft Recommendation 18, that an Insurance Code Taskforce be established imminently to address and advance the potential benefits of the Code to member outcomes.[4]

---

1 Parliamentary Joint Committee on Corporations and Financial Services Report on the Life Insurance Industry (March 2018); Productivity Commission Inquiry - Superannuation: Assessing Efficiency and Competitiveness – Draft Report (April 2018); Treasury Proposal Paper on Extending Unfair Contract Terms Protections to Insurance Contracts (June 2018).

2 Life Code Compliance Committee Annual Report FY17 (18 September 2018) page 3.

3 Parliamentary Joint Committee on Corporations and Financial Services - Report on the Life Insurance Industry (March 2018).

4 Productivity Commission Inquiry - Superannuation: Assessing Efficiency and Competitiveness – Draft Report (April 2018) page 63.

Insurance Contracts Act

(6) Consumers are also inadequately protected under the Insurance Contracts Act 1984 Cth ("ICA") by virtue of the carve out provision in section 15, which precludes insurance contracts from attracting the unfair contract terms protections afforded to consumers of other financial products by virtue of the Australian Consumer Law ("ACL").

(7) The purpose of the ACL was to ensure consistency in application as well as in remedy. Current consumer protections for insurance contracts fall short of what is required to adequately protect consumer rights and entitlements.

(8) Slater and Gordon support the Parliamentary Joint Committee's Recommendation 3.1[5] and are on record[6] as avid supporters of the Treasuries[7] proposed amendment to section 15 to allow unfair contract term consumer protection laws to extend to insurance contracts, to uniformly cover all life insurance sectors, participants and products. This will ensure alignment and consistency with protections afforded to consumers of other financial services and products.

(9) We do not believe that consumers are protected by virtue of section 13, a conclusion reached by the ACL Review Final Report of March 2017, whereby it found that the duty to act in utmost good faith provided less consumer protection than that provided by ACL.[8]

(10) The interpretation and scope of section 13 has long been the subject matter of industry, academic and Court consideration and conjecture, based upon the difficulty in the scope and application of the duty of utmost good faith.

(11) The interpretation and application of the duty of utmost good faith by the Courts has generally centered upon the honesty and integrity of the insurer in its dealings and processes around the contract, and not upon the fairness of the particular terms therein.[9]

---

5 Parliamentary Joint Committee on Corporations and Financial Services Report on the Life Insurance Industry, (March 2018), page 48.

6 Slater and Gordon Submissions to the Treasury Proposal Paper on Extending Unfair Contract Terms Protections to Insurance Contracts (August 2018).

7 Treasury Proposal Paper on Extending Unfair Contract Terms Protections to Insurance Contracts (June 2018).

8 Consumer Affairs Australia and New Zealand, Australian Consumer Law Review (March 2017) page 53.

9 CHOICE, Submission 49 to the Parliamentary Joint Committee on Corporations and Financial Services Report on the Life Insurance Industry (November 2016) page. 14.

(12) The duty of utmost good faith cannot be seen to be an effective mechanism for preventing the inclusion of unfair contract terms in insurance contracts, nor does it provide adequate power to remedy when a consumer is affected by an unfair contract term. The Australian Securities and Investments Commission ("ASIC") has previously raised its concerns regarding the present inadequacy of the penalty provisions for breach of duty of utmost good faith.[10]

(13) We consider that the proposals outlined by the Treasury,[11] including the intervention enforcement powers of ASIC, provides an increased incentive for insurers to ensure that contract terms are clear and transparent, and to either remove or reasonably justify the need for unfair contract terms within their policies.

(14) The implementation of unfair contract terms protections to this area would ensure that the onus is upon insurers to properly consider the appropriateness of exclusion clauses and unfair terms.

(15) As observed by Lauren Wright,[12] 'consumer confidence is detrimentally affected where consumers and the community as a whole perceive systemic unfairness in financial products, or in dealing with financial service providers in respect of those products.' This can be no truer a description of the current state of play between consumers and industry, given the immense divide between community expectations and insurer conduct. The proposal by the Treasury is the appropriate step towards correcting some of the current imbalance for consumers and small business with insurers.

---

[10] Mr Peter Kell, Deputy Chairman, Australian Securities and Investments Commission, Committee Hansard, 8 September 2017, p. 38.

[11] Treasury Proposal Paper on Extending Unfair Contract Terms Protections to Insurance Contracts (June 2018).

[12] Utmost Good Faith and Fairness in Life Insurance: Restoring Consumer Confidence [2017] UNSWLawJlStud 3, page 1.

B. DISCLOSURE

Q4. Is the current disclosure regime for financial products set out in Chapter 7 of the Corporations Act 2001 (Cth) and Division 4 of Part IV of the Insurance Contracts Act 1984 (Cth) adequately serving the interests of consumers? If not, why not, and how should it be changed? In answering these questions, address the following matters:

4.1 the purpose(s) that the product disclosure regime should serve;

4.2 whether the current regime meets that purpose or those purposes; and

4.3 how financial services entities could disclose information about financial products in a way that better serves the interests of consumers.

(Despite the reference to the Insurance Contracts Act 1984 (Cth), this question is not limited in scope to contracts of insurance.)

(16) The purpose of the product disclosure regime under the Corporations Act 2001 (Cth) was, in part, to provide consumers with a more consistent framework of protections in which to make informed financial decisions.

(17) The Key Fact Sheet ("KFS") pursuant to Division 4 of Part IV of the ICA was intended to provide simplicity, consistency and comparability for consumers when making decisions on Home Building and Home Contents ("HBHC") insurance policies through increased familiarity with the meaning of insurance terms and concepts. This followed the realisation that many Australians affected by the natural disasters in 2010 and 2011 were inadequately insured, by virtue of consumer confusion in relation to definitions in HBHC insurance contracts.[13]

(18) Yet, the requirement for provision of a KFS is not applicable to life insurance contracts, which are not classified as prescribed contracts. This again, is a protection the life insurance industry currently holds, to the detriment of consumers, and one we would call to be rectified by amendment to the ICA.

(19) According to Rice Warner,[14] 92% of working Australian consumers had some form of life insurance cover by virtue of group life insurance policy benefits procured through their superannuation fund membership. Accordingly, the majority of consumers have little, if any input or understanding of the different forms and levels of cover available or the definitions to be satisfied.

---

[13] Insurance Contracts Amendment Bill 2011 Explanatory Memorandum, pages 4-7.

[14] Financial Services Council Submission 26 to the Parliamentary Joint Committee on Corporations and Financial Services Report on the Life Insurance Industry (November 2016), page 20 (referencing Rice Warner Underinsurance in Australia – published in August 2016).

(20) The ‘standard’ TPD definition test of ‘unlikely ever’ was predominantly aligned with the Permanent Incapacity test set by the Superannuation Industry (Supervision) Act 1993 (Cth) (“SIS Act”) and, specifically, regulation 1.03c of the Superannuation Industry (Supervision) Regulations 1994 (Cth) (“SIS Regulations”) being :

> 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.

(21) However, life insurers have increasingly sought to constrict definitions with the primary motivation being the reduction of liability to pay on claims, particularly given the increased number of claims that sent the industry into financial meltdown in 2009. Some definitions have tightened to the extent that they are all but worthless to the beneficiary member of the policy, becoming nothing more than junk insurance.

(22) An example of policies that provide limited prospect of payment of a benefit for illness or injury include ‘Hazardous’ and ‘Special Risk’ exclusions. A number of employer sponsored superannuation group life policies offer default TPD and life insurance, but widely exclude a number of occupations on the basis that they are ‘hazardous’ or ‘special risk’. In some instances, this can exclude a large number of the employees under such plans.

(23) This changes the test to be satisfied by the claimant from the standard ‘unlikely ever’ test to an Activities of Daily Living (“ADL’s”) definition which requires the person to be certified by a medical practitioner as being permanently unable to perform at least two ADL’s such as bathing, dressing, eating, toileting and transferring.

(24) The result is that the majority of injured workers who, under a standard TPD policy definition, would be entitled and successful at obtaining a TPD benefit, are unable to claim with little or no awareness that the cover they are signed up to is of no benefit to them by virtue of the occupation exclusion therein. The list of occupations is not enclosed with any documents provided, and some insurers assert privilege over requests for release of the document.

Capacity test

Unlikely ever → Unable ever → Incapable ever → Impossible ever

(25) The continued evolution of the TPD capacity test burden on claimants is far more strenuous than the standard TPD 'unlikely ever' threshold in the SIS Regulations. The meaning of these terms has been subject to much judicial interpretation, with the Courts consistently concluding that the 'unable ever' test sets a far higher burden on the claimant.[15] Yet, many claimants have no idea or understanding of how these non-standard terms affect their entitlements to claim should they be faced with serious injury or illness by virtue of nil or limited disclosure of the non-standard test.

(26) Looking at the TPD insurance definitions of some of Australia's largest industry funds by membership:

(a) Sun Super[16] has not only changed its capacity test from 'unlikely' to 'unable', but has also introduced the payment of the benefit over a stagnated 5 year period, whereby the claimant needs to annually re-establish permanency. This requirement is completely inconsistent with the requirements of the TPD definition to satisfy initially being the 'unable ever' test.

(b) AustralianSuper[17] has a policy definition of TPD which requires a member to satisfy an 'incapable ever' test. The definition also allows the insurer to consider any 'retraining, reskilling, or voluntary work' undertaken or that could reasonably be undertaken within a reasonable period following the time the insurer forms its opinion.

(c) CBUS has the same insurer as AustralianSuper for its group life cover, yet has continued to offer TPD cover based upon the 'unlikely ever' test. But, the definition does allow the insurer to take into account the member's education, training or experience "up to the time of assessment of the claim".

---

[15] Ivkovic v Australian Casualty & Life Ltd (1994)10 SR (WA) 325, 270; Davis v Rio Tinto Staff Superannuation Fund Pty Ltd [2002] FCA 376, 118; Constantinides v Du Pont Superannuation Fund Pty Ltd (2002); In Dumitrov v SC Johnson & Son Superannuation Pty Ltd [2006] NSWSC 1372, Gzell J held it was a "harsher test"; InManglicmot v Commonwealth Bank Officers Superannuation Corp Pty Ltd [2011] 282 ALR 167 at 88, it was regarded as "quite emphatic"; TAL Life Ltd v Shuetrim; MetLife Insurance Ltd v Shuetrim [2016] NSWCA 68, at 64 – unlikely ever is a lower test than unable ever and at 89 – A person is unlikely ever to engage in employment if there is 'no real chance' that they will ever return to relevant work. A 'remote' or 'speculative' chance will take them outside the definition.

[16] The sixth largest super fund by membership (as at 16 February 2018)- See https://www.canstar.com.au/superannuation/largest-super-funds/.

[17] The second largest super fund by membership (as at 16 February 2018) - See https://www.canstar.com.au/superannuation/largest-super-funds/.

(d) MTAA Super requires its members to be 'unable' to work in any occupation or work for which he / she is, or may become, reasonably suited by education, training or experience, considering any future retraining or rehabilitation that the member could reasonably undertake or has undertaken. If a member is successful at procuring their TPD benefit, they will only receive 80% of their insured benefit amount, (despite paying premiums on 100%), unless they are also unable to perform three everyday working activities (such as walking / bending, reading, lifting, manual dexterity or communication) permanently and irreversibly.

(27) Such definition changes in policies are a significant shift away from the test prescribed by the SIS Regulation above, the requirement of Regulation 4.07D and consumer understanding of the benefit entitlement. Yet, other industry super funds, including REST[18] and HostPlus[19] have maintained the 'unlikely ever' standard TPD definition in their group life policies for members, indorsing the value of the standard TPD product to their insured members, and more consistent with the SIS Regulations.

(28) A final example of an abhorrent policy is a CommInsure stand-alone Accident Policy with a TPD definition that goes one step further and requires the insured to have become permanently incapacitated so as to render it 'impossible' for the life insured to ever resume or commence any work for gain or reward. This policy also sets the lowest of standard for an employment test, and far below 'reasonably qualified by education, training and experience' test in the SIS Regulation. The disabled claimant with this policy had no idea of the severity of the definition he was insured for, nor that he would never theoretically be able to satisfy the definition.

(29) Had he, and many other affected working Australians had access to a KFS, their decisions regarding life insurance could have been informed, with increased understanding of life insurance terms and concepts, and may have prevented defective, low quality cover.

---

[18] The third largest super fund by membership (as at 16 February 2018) - See https://www.canstar.com.au/superannuation/largest-super-funds/.

[19] The seventh largest super fund by members (as at 16 February 2018) - See https://www.canstar.com.au/superannuation/largest-super-funds/.

(30) This is but one of the reasons that Slater and Gordon would advocate for life insurance contracts to be deemed 'prescribed contracts' to enable them to be captured by Part IV of the ICA. This will not only bring uniformity to the industry and provide a positive step towards ensuring that working Australians make informed decisions on their insurance cover, but will go some way towards lightening the reliance upon the Government for welfare and the public health system.

Q5. Is the standard cover regime in Division 1 of Part V of the Insurance Contracts Act 1984 (Cth) achieving its purpose? If not, why not, and how should it be changed?

(31) The standard cover regime is meant to ensure that any exclusions or restrictions not standard in relation to a particular insurance contract are brought to the attention of an insured prior to any insurance contract being entered into. The regime works well for those consumers that are captured by it. It would seemingly also achieve its purpose if it were to apply to insured's under a life insurance contract.

(32) We refer the Commission to our response to question four, supporting the amendment of the ICA to capture life insurance contracts as prescribed contracts, to include relevant life insurance terms. This will immediately provide protection to consumers who enter into retail life insurance policies. For this to extend to consumers insured under a superannuation group life policy and MySuper members, amendment will also be necessary to section 37 to oblige the insurer to disclose unusual terms to the third party beneficiary.

Q6. Is there scope for insurers to make greater use of standardised definitions of key terms in insurance contracts?

(33) Yes. Not only is there scope, there is a necessity for the use of standardised definitions for key life insurance terms.

(34) Given the continued unilateral change to TPD definitions by life insurers, which is out of line with consumer understanding and expectations of such cover, Slater and Gordon support recommendations in relation to the standardisation of insurance definitions for transparency and consumer protection. In particular, we would advocate for TPD definitions to be consistent with the definition of 'permanent incapacity' as prescribed by Regulation 1.03C of the SIS Regulations. This would address the concerns raised about complex and problematic policy terms and conditions.[20]

[20] CHOICE submissions to the Parliamentary Joint Committee on Corporations and Financial Services report on the Life Insurance Industry (March 2018), Submission 71, page. 11.

(35) Other common yet complex terms in group life policies relate to eligibility criteria of an individual member for the insurance cover offered. For example, 'at work' and 'active employment' definitions vary between policies and are similarly complex and problematic in their wording in that they do not align with their plain English meaning. A member may therefore be granted automatic acceptance to a group policy, reflecting an insured amount on their annual superannuation statement, yet never qualify to make a claim due to not meeting the employment eligibility test requirements. In some cases, they may be limited to a claim under an ADL[21] or 'total loss of use' definition, both harsh definitions with limited prospects of ever being satisfied.

(36) The definition of 'total loss of use' generally requires the disabled claimant to establish that they have suffered total and irrecoverable loss of use of multiple limbs (ie feet, hands etc) or of sight. The High Court considered this policy definition in Johnson v American Home Assurance Co.[22] The case highlights just how limited such a clause is to consumers based upon the specificity of the events covered, but also how complex the interpretation and understanding of such clauses can be.[23]

(37) Consumers cannot be expected to interpret the meaning of a complex policy definition or what the insurer intended by the inclusion of complex and legally worded clauses or terms. This means that currently, consumers are faced with the prospect of pursuing a legal complaint through a court or tribunal in such circumstances, which places an unrealistic and prejudicial burden on individual consumers.

(38) While insurance premiums are sometimes reimbursed in circumstances where the cover was limited or not applicable, the critical issue is that the disabled member is uninsured, and unable to now procure a different life insurance policy by virtue of their disability. This leaves disabled members and their families' dependent upon Centrelink and the public health system for long term support.

(39) Again, this is where the standardisation of these life insurance contract terms and clauses, and the provision of a KFS, would address the concerns and problems encountered by consumers.

---

[21] Refer to page 7 paragraph 23 above.

[22] Johnson v American Home Assurance Co (1998) 192 CLR 266.

[23] Ibid at paragraph 19.

(40) Slater and Gordon are on record as supporting the recommendation by the Australian Lawyers Alliance in its submission to Productivity Commission[24] of the introduction of a tiered rating system to assist consumers to understand the implications of the varying products of insurance that fall below the standard set by Regulation 1.03C, and make an informed decision on their insurance needs.

E. CLAIMS HANDLING

Q18. Should ASIC have jurisdiction in respect of the handling and settlement of insurance claims?

(41) There is a complete lack of transparency, and significant inconsistency in claims handling processes by life insurers, which neither the FSC Code nor the Super Code adequately address for consumer protection and industry integrity.

(42) We have voiced concern regarding the lack of hard timeframes for assessment and payment (save for initial payment) of income protection benefits.[25] While income protection benefits are largely a temporary disablement benefit, we often see clients reliant on them long term after eventual acceptance, and often subsequently claiming a total and permanent disability claim.

(43) As a consequence of the claims handling delays and payment, medical treatment is often also delayed, as the claimant is reliant on the accessibility of treatment through the public health system. This is particularly problematic for claimants with mental health conditions.

(44) We often see claimants with physical injuries develop psychological conditions due to delayed treatment and the additional stress of financial hardship, which in turn delays or impedes a return to work. Hard time frames on continuing assessment could reduce these occurrences.[26]

(45) Hard time frames for assessment of claims would also inhibit unscrupulous insurers from delaying determination of a claim in circumstances where it would be in their vested interest to do so - for example – where the TPD policy definition allows them to consider reasonable retraining between the date of disability and forming an opinion.

---

[24] Australian Lawyers Alliance submissions to the Productivity Commission - Superannuation: Assessing Competitiveness and Efficiency (11 July 2018) page 8, paragraph 28.

[25] Media Release – Parliamentary committee stance does not address income protection delays (April 2018).

[26] See Slater and Gordon case studies which form part of the written document tendered by the Australian Council of Trade Union in its Response to Questions Taken on Notice at the Parliamentary Joint Committee on Corporations and Financial Services - Options for greater involvement by private sector life insurers in worker rehabilitation Hearing (19 June 2018) page 9 of 10.

(46) In its industry-wide review of claims handling processes, ASIC recommended a change to the law to allow it enhanced capacity to seek improvements in claims handing processes, which are currently outside its regulatory powers. [27]

(47) As outlined above at page three, Slater and Gordon strongly support the PJC's Recommendation 4.1[28] that all insurers, including life insurers, be required to be bound by and observe a Code of Practice that is ratified by ASIC, applicable to all industry participants, and with enforceable ramifications for breach.

(48) Application of the recommendation of the ASIC Enforcement Review Taskforce Report of a co-regulatory model would also enable individual consumers to pursue reparation through internal and external dispute resolution processes for non-compliance.[29]

Life insurance

Q19. Should life insurers be prevented from denying claims based on the existence of a pre-existing condition that is unrelated to the condition that is the basis for the claim?

(49) There is a fundamental flaw in the law as it currently stands that allows an insurer to rely upon historical clinical entries and unconfirmed diagnoses without the necessity of further investigation much less a causal nexus between the pre-existing condition and the claimed condition, to substantiate its assertion for avoidance of cover and denial of a claim. It is our experience that insurers will utilise any matter discovered during the 'review' of a claimants medical records to allege a breach of the insured's duty of disclosure.

(50) Currently, insurers are unreasonably advantaged by the protections afforded under the ICA. Section 29(3) makes it too easy for an insurer to avoid cover and thus deny legitimate claims – as all it needs to do is prove it would not have entered into the policy on the same terms. This is despite the alleged non-disclosure being innocent, and that save for the alleged non-disclosure, the insurer would otherwise have accepted the risk and provided a policy (albeit on different terms which may have included a premium loading or exclusion clause).

---

[27] Australian Securities and Investments Commission, Report 498: Life Insurance Claims: An industry review, (October 2016) page 4 ("Report 498").

[28] Parliamentary Joint Committee on Corporations and Financial Services Report on the Life Insurance Industry, (March 2018), page 63.

[29] ASIC Enforcement Review Taskforce, Position and Consultation Paper 4 Industry Codes on the Financial Sector, 28 June 2017 pages xi, xv and Chapter 4.

(51) As has been evidenced voluminously by the written submissions and oral evidence given to this Commission, policies are often avoided on the basis of alleged non-disclosure / misrepresentation following a fishing expedition through a claimants medical history, often for what can only be viewed as an attempt to adduce a reason to reject legitimate claims and avoid cover.[30]

(52) While section 31 of the ICA confers upon a Court some power to disregard avoidance in circumstances where it would be harsh or unfair to allow the avoidance to stand, this remedy is only applicable to fraudulent non-disclosure or misrepresentation, leaving a significant proportion of claimants whose cover has been harshly or unfairly avoided based upon innocent non-disclosure, without protection from the Court.

(53) Slater and Gordon vehemently support the PJC's Recommendation 10.82 that the FSC's Life Insurance Code of Practice explicitly include a commitment that where a pre-existing condition is to be used by an insurer as the basis for denying a claim or avoiding a contract that:

* The insurer must establish a direct medical connection between the prognosis of the pre-existing condition and the claimed condition; and

* That the insurer provides statistical and actuarial evidence coupled with any other material used to establish a pre-existing condition.

(54) We consider this recommendation to be the minimum standard of change needed, and that further law reform of the currently disproportionate advantage held by insurers in such circumstances be considered.

Q20. Should life insurers who seek out medical information for claims handling purposes be required to limit that information to information that is relevant to the claimed condition?

(55) While there is no denying that it is reasonable for an insurer to source medical information as part of its risk assessment against potential prejudice from non-disclosure at the underwriting stage and for fraud management at claim stage, there is a clear need for strict parameters and limits to what is reasonable in seeking medical information.

[30] See for example - TAL Group Submissions to the Royal Commission Into Misconduct In The Banking, Superannuation And Financial Services Industry - Sixth Round Of Public Hearings: Life Insurance (1 October 2018).

(56) Beyondblue in its submission to the PJC[31] raised concerns highlighted by ASIC[32] that in some mental health claims, life insurers were examining the claimant's medical history as far back as two decades. This is clearly an abuse of power and an example of a deliberate attempt to find a justifiable reason to avoid payment on the claim. A specific period of time should be established as a mandate for insurers to make reasonable medical history enquiries.

(57) We support Recommendations 8.1 through 8.7 of the PJC in particular that:

* The FSC and the Royal Australian College of General Practitioners collaborate to prepare and implement agreed protocols for requesting and providing medical information; and

* Requests be specifically targeted to the subject matter of the claim.

(58) We consider that this approach will remove the practice of life insurers in casting a wide medical history net to see what they can catch to avoid a claim. It will also minimise the risk of patients not fully disclosing the extent of their condition or even avoiding medical assistance for fear of how a life insurer might use that information to assess cover or a future claim.

(59) Further, we refer the Commission to our response to question 19.

Q21. Should life insurers be prevented from engaging in surveillance of an insured who has a diagnosed mental health condition or who is making a claim based on a mental health condition? If not, are the current regulatory requirements sufficient to ensure that surveillance is only used appropriately and in circumstances where the surveillance will not cause harm to the insured? If the current regulatory requirements are not sufficient, what should be changed?

(60) This is certainly a consideration with substantial merit given the limitation of current regulatory requirements in relation to surveillance activity by life insurers. The adverse consequences on the mental health of a claimant with a psychological or psychiatric injury by virtue of being subjected to surveillance under the instruction of a life insurer can be significant.[33]

---

[31] Beyondblue submission 18 to the Parliamentary Joint Committee on Corporations and Financial Services Report on the Life Insurance Industry (November 2016) pages 16-17.

[32] Report 498.

[33] Beyondblue, Submission 18 to the Parliamentary Joint Committee on Corporations and Financial Services Report on the Life Insurance Industry (November 2016) page 16; 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).

(61) The insurance industry asserts that it is a necessary part of the claims determination process by affording protection against fake or fraudulent claims.[34]

(62) We agree with the position of ASIC[35] that while there is a place for fraud management in insurance claims, claimants with mental health conditions are particularly vulnerable and this must be an important consideration in such management. We would consider that the 'probative value' of this form of fraud management is meritless when compared with the detrimental risk to those with psychiatric or psychological conditions subjected to surveillance activity.

(63) The FSC Code does not go far enough to protect those with mental illness from surveillance activity. For example, clause 8.12(f) asserts that "we will discontinue surveillance where there is evidence from an independent medical examiner that it is negatively impacting your recovery." This would seemingly mean that the opinion of a treating psychiatrist or psychologist that surveillance is negatively impacting on a claimant would require the life insurer to discontinue the surveillance activity. Further, by use of the word discontinue, the FSC Code leaves it open to life insurers to seemingly ignore independent or treating medical opinion about the detrimental effect of surveillance if the life insurer is yet to instigate surveillance.

(64) Further, while clause 8.12(c) of the FSC Code requires a request for surveillance to be internally reviewed and approved by a senior claims manager, the practice of case managers speaking directly with an investigator during active surveillance has been identified in internal documents disclosed as part of the discovery process of litigated claims. As information relating to the instruction / discussion in such circumstances is not generally recorded, it is difficult to envisage that subsequent instructions given during direct communications are reviewed or approved by a senior case manager.

(65) These ambiguities support the necessity for reform to the regulatory requirements and industry standards for the assessment of mental health claims to ensure consumers are adequately protected.[36]

---

[34] Report 498, page 63, as noted in the Parliamentary Joint Committee on Corporations and Financial Services Report on the Life Insurance Industry (March 2018) page 173;

[35] Report 498, page 63, paragraph 212.

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

(66) We consider that Recommendation 10.101 of the PJC, 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, is an important first step.

F. INSURANCE IN SUPERANNUATION

Q23. Should universal:

23.1 minimum coverage requirements; and/or

23.2 key definitions; and/or

23.3 key exclusions, be prescribed for group life policies offered to MySuper members?

(67) We refer the Commission to our responses to questions four through six regarding reform to the ICA and standardisation of key definitions, which is equally applicable to MySuper members.

Q24. Should group life insurance policies offered to MySuper members be permitted to use a definition of "total and permanent incapacity" that derogates from the definition of "permanent incapacity" contained in regulation 1.03C of the Superannuation Industry (Supervision) Regulations 1994 (Cth)?

(68) We refer to our response to questions four and six.

Q25. Should RSE Licensees be obliged to ensure that their members are defaulted to statistically appropriate rates for insurance required to be offered through the fund under section 68AA(1) of the Superannuation Industry (Supervision) Act 1993 (Cth)?

(69) The MySuper system has been successful in achieving its objectives. Not only has it assisted in the reduction of underinsurance in Australia, the simplified model has enabled consumers to more easily compare products and make informed decisions. In doing so, it has held superannuation trustees to a legislative standard that is enforceable by ASIC.

(70) There is a high level of disengagement of members with their super due to a lack of understanding of how it works, what it offers, and an inability to simply compare the offerings between funds in a simple, plain English manner. As a consequence, it is our experience that members are generally not aware of the limitations or worthlessness of their cover until they need to make a claim upon the insurer or trustee.

(71) Slater and Gordon support the imposition of a statutory requirement pursuant to section 68AA of the SIS Act as a means of setting a minimum standard and clear obligations on superannuation trustees to ensure their members are defaulted to statistically appropriate rates for insurance to be offered through the super fund.

(72) While by its very nature group life insurance structured to cover a 'pool' of members and not tailored to the individual needs and circumstances of each member of that pool, we consider this to be an insufficient reason for trustees and insurers to not comprehensively consider the needs and circumstances of their members on a more individualised level as a means to ensuring that there is some value received from the payment of premiums by all members.

(73) Obviously it is somewhat easier for industry specific super funds such as CBUS and HostPlus to undertake a high level consideration of the needs of all its members to ensure that members receive value for their insurance premiums. However, the Productivity Commission's Draft Report identified other superannuation funds that effectively utilise member information in the determination of group life cover to offer. For example, AustralianSuper which is an industry fund without any specific employee group pool, in its submission to the Productivity Commission identified that it set default insurance cover levels based on its analysis of the age, gender, occupation and salary level of its membership pool, together with the insurance needs and preferences of its members, and affordability.[37]

(74) The imposition of a statutory requirement on all super funds would protect the members of the funds that are not proactive at ensuring value for their members are afforded default cover with uniform outcomes for members, and avoid the unnecessary erosion of members account balances by virtue of premiums for poor value policies.

[37] AustralianSuper Submission 43 to the Productivity Commission Issues Paper on Superannuation: Assessing Competitiveness and Efficiency (August 2017) pages 12 – 13 referenced in the Productivity Commission Draft Report on Superannuation: Assessing Competitiveness and Efficiency (April 2018) page 334.

Q26. Should RSE Licensees be prohibited from engaging an associated entity as the fund's group life insurer?

(75) We have all witnessed just how badly this has proven to be for members of the Commonwealth Bank and CommInsure and AMP Limited and AMP Life.

(76) Slater and Gordon are unable to provide this Commission with an example of a functional and sufficiently independent RSE Licensee with an associated entity as the group life insurer that has demonstrated its ability to consistently act in the best interests of its members. There is an inherent self-serving interest that really prohibits the independency that is required to discharge the requisite duties of each entity to its members.

(77) Accordingly, a prohibition from the engagement of associated entities will safeguard against members receiving sub-standard, poor value insurance cover.

Q27. Alternatively, should RSE Licensees who engage an associated entity as the fund's group life insurer be subject to additional requirements to demonstrate that the engagement of the group life insurer is in the best interests of beneficiaries and otherwise satisfies legal and regulatory requirements, including the requirements set out in paragraphs 22 to 24 of Prudential Standard SPS 250, Insurance in Superannuation?

(78) RSE Licencees that utilise associated entities for group life insurance have already been shown to be non-compliant with the Prudential Standards set in SPS 250. As such, it is difficult to believe that additional legal and regulatory requirements will be sufficient to eliminate the inherent conflict of interest outlined in our response to question 26, and ensure that members are receiving value for their premiums by virtue of transparent consideration of best value policies through insurance tender processes.

Q28. Are the terms set out in the Insurance in Superannuation Voluntary Code of Practice sufficient to protect the interests of fund members? If not, what additional protections are necessary?

(79) The terms of the Super Code do not set a standard anywhere near what could be considered as sufficient to protect the interest of fund members. The biggest concern with the Super Code is that it is voluntary and does not have any independent administrative oversight or enforcement.

(80) The Productivity Commission summarised its status concisely in its Draft Report:[38]

> The recently developed voluntary industry code of practice is an initial step, but falls short of what is needed to effectively address deficiencies in the current arrangements for insurance in superannuation.

(81) Superannuation statistics released by the Association of Superannuation Funds of Australia ("ASFA")[39] identify that, currently, there are 221 corporate, industry, public sector and retail superannuation funds. Of these, 86 are members of ASFA and of those, 65 have registered their intention to be bound by the code.

(82) For the interest of fund members to be uniformly protected by the Super Code, it is critical that it require mandatory compliance by all industry participants, approval by ASIC and have binding and enforceable consequences for breach.

(83) Slater and Gordon support the recommendations by the PJC and the Productivity Commission[40] in relation to the Super Code and would seek that the processes to implement the recommendations be actioned imminently.

G. SCOPE OF THE INSURANCE CONTRACTS ACT 1984 (CTH)

Q29. Is there any reason why unfair contract terms protections should not be applied to insurance contracts in the manner proposed in "Extending Unfair Contract Terms Protections to Insurance Contracts", published by the Australian Government in June 2018?

(84) Slater and Gordon are on record as strongly supporting the proposals of the Treasury in its proposal paper on the extension of unfair contract terms protections to insurance contracts.[41]

(85) We understand that life insurance premiums are calculated on the actuarial risk that is assumed by the life insurer. As such, there cannot be a general assumption that the exclusion of some risks and the acceptance of others is necessarily an unfair term, particularly where doing so makes the contract more affordable for the consumer. This is no doubt a complicating factor for the introduction of unfair contract terms.

---

38 Productivity Commission Draft Report on Superannuation: Assessing Competitiveness and Efficiency (April 2018)p.339.

39 Superannuation Statistics (September 2018) ASFA see at https://www.superannuation.asn.au/ArticleDocuments/269/SuperStats-Sep2018.pdf.aspx?Embed=Y.

40 Productivity Commission Draft Report on Superannuation: Assessing Competitiveness and Efficiency (April 2018) p 41.

41 Slater and Gordon submissions to the Treasury Proposal Paper - Extending Unfair Contract Terms Protections to Insurance Contracts (August 2018).

(86) If the decision to offer or not offer certain terms is based upon actuarial data, then the insurer may reasonably justify the need for an unfair contract term within the policy offered. There is a distinction to be drawn between an exclusion clause for the purpose of offering insurance, and unfair contract terms that by their very nature are unreasonable and plainly unfair.

(87) While a relevant consideration, we do not consider that the arguments raised by life insurers regarding costs of compliance to be a legitimate or reasonable basis for unfair contract terms protections to remain excluded from insurance contracts.

(88) The experience of the United Kingdom in relation to the extension of unfair contract terms to insurance contracts should be used as opportunity in which to learn and improve the way that we extend the ACL to insurance contracts,[42] and not as justification for retaining the status quo.

Q30. Does the duty of utmost good faith in section 13 of the Insurance Contracts Act 1984 (Cth) apply to the way that an insurer interacts with an external dispute resolution body in relation to a dispute arising under a contract of insurance? Should it?

(89) Section 13 of the ICA requires each party to an insurance contract to act towards the other, in respect of any matter arising under it, with utmost good faith. Given that any external dispute resolution process relates to a matter arising under the contract of insurance, Slater and Gordon consider that the duty of utmost good faith should continue to apply to all parties involved in an external dispute resolution process.

Q31. Have the 2013 amendments to section 29 of the Insurance Contracts Act 1984 (Cth) resulted in an "avoidance" regime that is unfairly weighted in favour of insurers? If so, what reform is needed?

(90) It has been Slater and Gordon's experience that the amendments have led to an increased reliance by insurers on section 29 in avoiding policies based upon our experience with clients in such circumstances. We refer the Commission to our response to question 19 above.

[42] Mr Nick Kirwan, Policy Manager, The Financial Services Council, Committee Hansard, 1 December 2017, p. 25–27.

H. REGULATION

Q33. Should the Life Insurance Code of Practice and the General Insurance Code of Practice apply to all insurers in respect of the relevant categories of business?

(91) Yes. Slater and Gordon consider that the only way to ensure consistency and adequate protection for all consumers is to have uniformity in application, enforcement, oversight and remedy of all insurance codes of practice. We also refer this Commission to our response to question 18 above.

Q34. Should a failure to comply with the General Insurance Code of Practice or the Life Insurance Code of Practice constitute:

34.1 a failure to comply with financial services laws (for the purpose of section 912A of the Corporations Act 2001 (Cth));

34.2 a failure to comply with an Act (for example, the Corporations Act 2001 (Cth) or the Insurance Contracts Act 1984 (Cth))?

(92) In its current form, breaches of the FSC Code enable the Life Code Compliance Committee ("Life CCC") at its discretion, to impose sanctions that would seek to rectify the breach, but not the damage to the claimant as a consequence of the breach. For example, the Life CCC:

* May require particular rectification steps be taken by us within a specified timeframe
* May issue a formal warning
* May require a Code compliance audit be undertaken
* May require the undertaking of corrective advertising or direct written communication with the customers impacted by the breach
* May require the publication of the non-compliance on the insurer's website or on the FSC website

(93) This Commission has witnessed the significant breaches of statutory regulation by financial service providers. Statutory regulations with significant financial penalties for breach. By comparison, the 'sanctions' to be discretionally imposed for the FSC Code breaches as they stand would barely raise a blink let alone act as a 'preventative' or 'deterrent' measures.

(94) The regulatory framework of the FSC Code must be made mandatory with breaches being regarded as contravention of the relevant Act, and thereby attracting the appropriate enforceable penalties.

Yours faithfully,

Sarah Snowden

Slater and Gordon Lawyers