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TRANSCRIPT OF PROCEEDINGS

O/N H-919883

THE HONOURABLE K. HAYNE AC QC, Commissioner

**IN THE MATTER OF A ROYAL COMMISSION
INTO MISCONDUCT IN THE BANKING, SUPERANNUATION
AND FINANCIAL SERVICES INDUSTRY**

MELBOURNE

9.45 AM, WEDNESDAY, 12 SEPTEMBER 2018

Continued from 11.9.18

DAY 52

MS R. ORR QC appears with MR M. COSTELLO as Counsel Assisting with MR M. HOSKING and MS S. ZELEZNIKOW
MR P. SILVER appears for Freedom
MR J. KARKAR QC appears with MS Z. HILLMAN for CMLA

<CRAIG FRANCIS ORTON, ON FORMER AFFIRMATION [9.45 am]

<CROSS-EXAMINATION BY MS ORR

THE COMMISSIONER: Yes, Ms Orr.

MS ORR: Commissioner, before we resume with this witness we want to correct one matter from the opening statement on Monday. In the course of the opening statement we said that in the five-year period from 1 July 2013 to 30 June 2018, MetLife had paid more than 390 million in commissions to financial advisers or financial advice entities whose clients purchased its products. That was an error and we should have said more than 390,000. The precise figure is $406,500. And we apologise to MetLife for that error.

Now, Mr Orton, I want to turn to a new topic which is the retention strategies employed by Freedom?---Okay.

Now, I asked you a bit about the training of retention agents and took you to a document yesterday. How many retention agents does Freedom currently employ?---I believe 29.

29. And how many sales agents?---It fluctuates from about 65 to 100.

Now, why does Freedom need so many retention agents?---The retention agents, as I explained yesterday, are – their job is to provide alternatives for customers.

Their job, as you explained it yesterday, also included attempting to save the sale, save the policy?---Correct.

And do you need retention agents in part because a significant amount of your business is brought in through the Freedom Protection Plan which doesn't require premiums to be paid on the funeral expenses product in the first 12 months?---To a degree that's right. Not on every occasion, but these retention agents also actively call customers prior to the expiry of the 12-month period, to ensure that the product is – remains suitable to their needs.

So they actively call to ensure the product remains suitable to the customer's needs?---Correct.

Why are they doing that?---People's circumstances change during the year. And they may call to say if that cover still suits them. They may have decided to include additional family members on their cover during the free period but no longer wish to pay for it, and that's perfectly okay.

But how does Freedom select the people it's going to call to ensure the product is still suitable for them?---It tends to call some of the customers who have chosen a higher number of lives or cover to ensure that it remains affordable for them.

And the call happens in the 12-month free period. Is that right?---Correct.

So once customers are required to start paying premiums after the expiration of that 12 months, do you find that people want to cancel the product?---Some people do. Some people – and that's okay, because the product is a true free period. So if some people decide to have that protection for 12 months and not continue to pay, that is fine by us.

You say a true free period but you told us yesterday that you are now moving to an opt-in system rather than an opt-out system to ensure that it was a true free period?---Yes. Look, my words yesterday on true free period were not great. I think they've both been true free periods but if there's any doubt at all, now that it's an opt-in, I think it makes it very clear.

Freedom has recently had contact with ASIC about its retention strategies, hasn't it?---It has.

And on 30 June this year, ASIC asked Freedom to provide a statement to it containing certain information about its retention strategies?---Correct.

And ASIC asked for information about the number of customers who have called Freedom to attempt to cancel their policies since 1 June last year?---Correct.

And ASIC also asked for information about the reasons that customers gave for wanting to cancel their policy?---Correct.

And about the number of customers who ultimately retained their policies after having called to cancel?---That's right. Yes.

And Freedom gave that information to ASIC a couple of weeks ago, on 15 August?---That date – that date sounds right, yes.

Yes. And you included the request for that information from ASIC as an exhibit to your statement?---Correct.

But you didn't exhibit your response to ASIC to your statement?---I'm not sure. I mean, I'm sorry if that was the case but we've tried to provide every document that was necessary.

Right. But the response was not part of your statement. We have a copy of that document. And I will show it to you. It's ASIC.0068.0001.0024. Have you seen this letter before, Mr Orton?---I have, Ms Orr.

You recall that it's a letter under your hand, dated 15 August this year?---Yes.

And we see from the first page of this letter, at paragraph 1.1, that Freedom identified that in the period from 1 June last year to 30 June this year, it had received 37,584 telephone calls seeking to cancel policies?---That's correct.

And 28,445 of those calls had been linked to an identified consumer?---Correct.

What does that mean?---They may call – the customer may call on another telephone line rather than the numbers that we've got, and it's difficult for us to determine or impossible for us to determine who that customer was.

I see. So 37,584 calls were made attempting to cancel policies, and you can identify 28,000-odd of those as belonging to particular customers - - -?---Correct.

- - - of yours. I see. Now, using the figure for the calls that you can link to one of your policyholders, on our calculations, over the relevant period, the one year, that's an average of about 72 cancellation calls a day? That's 28,445 divided by the 394 days in the period?---Okay. Yes.

72 cancellation calls a day. Does that figure trouble you, Mr Orton?---It doesn't trouble me considering the 12-month period if people have had the 12-month period and they've enjoyed the coverage and they haven't paid any premium, but, you know, any cancellation is troubling. It's – of course.

What does it say to you about whether people wanted the policy in the first place?---And I will stick to – Ms Orr, I will stick to the main product, which is the Freedom Protection Plan.

Yes?---Some customers will take that knowing that it's a 12-month period and will take it knowing that they will cancel but have the protection during that time. And it's a true protection. We paid seven and a half million dollars worth of claims just for that product in the free period. So if they decide to do that, that's okay, and that's – that's their prerogative.

You know at Freedom, don't you, that many customers will not go to the trouble of calling Freedom and cancelling that policy at the end of the 12-month free period?---The model is certainly not intended to do that, and very often – very often if a customer pays a few – a few premiums and says, "I didn't mean to", we will simply refund it.

Well, let's look at a bit more of the data that you provided. If we go to the following page of this letter, 0025, and we look at paragraph (iii), we see that 3585 of the calls were made during the cooling off period?---Correct.

So that was approximately 13 per cent of the cancellation calls?---Correct.

So the remaining 87 per cent were made after the cooling off period had ended?---Correct.

And we see from (v) on this page that Freedom only began recording the reason why a customer wanted to cancel their policy a few months ago, in March?---Correct. That's something that I implemented.

Why wasn't it recorded before then, Mr Orton?---I really don't know but it's very difficult to understand what a customer feels about the product if you're not recording that, which is something that I wanted to do.

And since that time, when you've started recording that information, just under half of the policyholders who called to cancel their insurance said that it was because they were unable to afford the cover. You see there 47 per cent of them said that they couldn't afford the product?---That's correct.

And if we go over the page to 0026 – perhaps if we could have both pages on the screen together – we see that just over a quarter, 28 per cent, said that they were cancelling because they didn't want the cover?---Correct.

Is that a figure that troubles you, Mr Orton?---They may have taken it out for the free period but if they don't want the cover and there's other reasons, then it does trouble me, I agree. We need to break that down further in the future. It's a start, learning about the customers and how they – how they feel about the cover. There is a lot of work going on within the retention area at the moment. I've instigated an independent review by a company called LimeBridge Consulting who have experience right around the globe dealing with customer service, retention, customer care, for telcos, for life companies, for banks, for a range of companies, and I really want an independent review of how that is operating, both from an efficiency point of view and, most importantly, to ensure that the customer outcomes are the best that they can be.

Well, these figures that I've been taking you to, and will continue to take you to, are troubling in terms of the customer outcome, aren't they?---It needs to be – it needs to be taken in line with the 12 month cover.

Well, let's come to what level of success the customers have when they attempt to cancel their policy. So the figures I've taken you to so far are about how many people call and attempt to cancel and the reasons that they give. We see from the figures in (v) that despite 70 per cent – sorry, 75 per cent of policyholders indicating that they either don't want the cover or can't afford the cover, only a relatively small number of the policyholders are successful in cancelling their cover?---Correct.

If we look at (vi), we see that only 8118 calls – that's 28.5 per cent of the calls – resulted in the caller successfully cancelling their policy?---I can't work the numbers out at the moment. Yes, I can, yes.

(vi), subparagraph (b)?---Yes.

And a much larger number, 12,720 calls, or 44.7 per cent, resulted in a retention of the cover without change?---Correct.

And 7598 – or 26.7 per cent of the calls – resulted in a retention of cover with alterations made to the terms of the cover?---That's right. Correct.

And then we see from paragraph (d) on this page that of the 12,720 calls that resulted in a retention of cover without change – so the person called to cancel but was unsuccessful in doing that – 3960 of those policies have since been cancelled or lapsed?---That's right.

So on our calculations, that means that at the time Freedom provided this letter to ASIC in the middle of August, approximately 69 per cent of Freedom customers who had called to cancel their policy still held that policy without change?---I can't do the numbers in my head at the moment but if that's what you say the numbers are, then I'm okay.

So more than two-thirds of the people who called to cancel their policy were persuaded to hold on to the policy without change? Does that trouble you - - -?---Not without change. It doesn't – it doesn't ring true to me it would be that high without change.

That's the result of the numbers in this letter, Mr Orton. I will take you to the numbers that deal with retention with a change. I'm dealing at the moment with retention with no change. They called to cancel and after the call nothing has changed. They still hold the same policy. 69 per cent of them?---Okay. I'm struggling to get the 69 per cent but – okay, it's – it's – it's a high amount, though, Ms Orr, I agree. Retention is an area, as I said, is a key focus of mine to improve. This is – this is the LimeBridge Consulting areas. The Commission has heard a lot over the last couple of days of some things that need to improve. I agree. I'm not making excuses for some of the things that need to be improved. That's the reason that I've been brought on, to improve these things. But at the core of the company there is a customer focus. It just needs to improve because of the growth.

Well, where do we see the customer focus, Mr Orton, in the fact that 69 per cent of people who call and ask for their policy to be cancelled are unsuccessful and leave that call with their policy intact?

MR SILVER: Commissioner, the 69 per cent has not been explained and the witness doesn't accept it other than on the say-so of Counsel Assisting. So perhaps it could be justified and then the witness can answer it more meaningfully.

MS ORR: Well, it's an arithmetic calculation based on the figures that you've provided.

THE COMMISSIONER: Well, we might need to unpack it a bit, Ms Orr.

MS ORR: Yes.

THE COMMISSIONER: It's 12, is it?

MS ORR: That's right. It is.

THE COMMISSIONER: 12,000 of?

MS ORR: So 12,720 calls - - -

THE COMMISSIONER: Out of, 28?

MS ORR: Yes.

THE COMMISSIONER: That isn't 69. 12 of 28 is less than half.

MS ORR: We will just look into that, Commissioner. It is the aggregation of a couple of parts of this statement because – I'm sorry, of this letter because we've deducted the people whose policies were lapsed or cancelled after their attempt to cancel the policy. So it requires a few figures to be put together. I will articulate the formula for getting to that in just a moment. But and can I move to the other part of the figures that's dealt with in subparagraph (c) and come back to the 69 per cent. Subparagraph (c) tells us that of the 7598 calls that resulted in a retention of cover on amended terms, 2382 consumers changed their level of cover?---Correct.

And 5216 removed an additional life or a benefit component from their cover?---Correct.

The figure I want to put to you, which I will double-check while we're discussing this, is that that means, on our calculations, that at the time this letter was produced, 85 per cent of the customers who tried to cancel their policy but were convinced by Freedom to keep that cover on amended terms, continued to hold the policy. So they're the two figures that I will explain in more detail to you. But while we do that, can I put to you that the figures that you have provided to ASIC show that your retention strategies have been highly successful?---I agree. I agree.

And what do you put that success down to?---I put it down to – what it should be put down to, is the right product and good customer outcomes. I think that retention has been – has been too strong. And I don't know another way to describe that, but it has, perhaps, offered too many options to customers and gone too far. Like I said, Ms Orr, it's a focus of the company, it's a focus of mine to change this. It's not just about having a consulting company come in either. It's about good conversations with customers, making sure that they want the product, making sure that they are given some reasonable options, and that they do understand either what they're

giving up or what their financial options are with that particular product. But it needs to improve.

So you - - -?---The board has endorsed that. The board has endorsed improving this area. And I agree that this is an area that needs continued focus, and that's one of the reasons I've been brought on.

So you said in that answer retention has been too strong, customers have been given too many options and retention has gone too far?---Yes.

It's not about customers having been given too many options, is it, Mr Orton; it's about customers not being permitted to cancel their policies when they call up with that intention and express that intention?---I agree, Ms Orr. I think there's difficulty in cancelling at the moment that needs to be sorted.

Why does Freedom make it so difficult for customers to cancel their policies?---It shouldn't make it so difficult. I agree. Like I've said a couple of times over the last couple of days, I think offering options is okay, but it – but it is too difficult to cancel, in some circumstances. We must remember that we're talking about – even with the sales structures, that our – our customers rate the company quite highly. The difficulty is that we have sections of the business that need to be improved. In sales, we get a rating of nine out of 10 from our customers at the end of a call. In retention, it's lower. It's – it's about 8. And there's – that's not the important part. The important part is looking at those people who rate the experience as one or two or three, and that's the area that we need to concentrate on.

Have you included information about either of those ratings that you've just referred to in either of your statements?---I haven't because it's later information but I – I can – I can provide it.

You've expressed concerns to ASIC about the quality of your retention calls, haven't you?---Yes, I have.

You told ASIC that you had listened to 400 retention calls?---I don't think they were 400 retention calls, Ms Orr, but 400 – at least 400 calls and there were a few retention calls in there. It was a split between sales and retention. Let's call it half/half. Regardless, it's a lot of calls I listened to.

And why did you do that?---That was part of the ASIC notices that we received, and we wanted to ensure that we listened to those calls. In the first meeting that I had with ASIC, I highlighted the fact that I had some concerns with retention, and that it was a focus to improve it.

And after listening to those calls, what view did you form about the retention calls?---That it needed a lot of work, that in some instances it was far too difficult for customers to cancel, and that we needed to rework that from a customer perspective and from a process efficiency perspective.

What were the key problems that you heard in those calls?---The key problems that I heard were not taking no for an answer on certain calls. And that cannot be the case. That's something that I will not allow to happen in the future.

You told ASIC that the tone and the manner of some of the calls was unacceptable?---I did. That was very early on. We – we requested a meeting after the notice to ensure that we were working cooperatively with the regulator. At that stage, I believe that we listened to only some of the calls. I – I can't remember if all the calls were put in at that stage. But personally, I – obviously, I can't listen to 400 calls. The time to do that is – is just – it just takes too long but I was getting feedback from others that these were – these were – it was too difficult.

Yes. And you agree that you told ASIC that the tone and manner of - - -?---Yes.

- - - retention agents was unacceptable?---I agree.

- - - in a number of those calls. Are you aware that ASIC has considered reviews of Freedom made on publicly available websites as well as complaints made direct to ASIC by Freedom customers?---ASIC did mention to me that they had had some specific complaints as well as doing the direct life review. Yes, on websites there are some concerning comments. I agree. We try to address those wherever we can. But I would also point out that our rating on – our online rating on companies such as Google Reviews is amongst the highest in the market.

Well, I want to show you a document, but before I do that, could I tender your letter to ASIC from 15 August.

THE COMMISSIONER: Letter Freedom to ASIC 15 August '18, ASIC.0068.0001.0024, exhibit 6.94.

EXHIBIT #6.94 LETTER FREEDOM TO ASIC DATED 15/08/2018 (ASIC.0068.0001.0024)

MS ORR: Can I show you an ASIC internal document, which is ASIC.0068.0001.0032. Now, this is not a document I expect you will have seen, Mr Orton. And if we could, perhaps, have the first and second pages of that document on the screen together. You will see that it's an internal ASIC document prepared for a meeting with you on 23 May. And it's a summary and set of discussion points. Do you see that?---I do. May I read it just for a minute?

Sorry, did you ask if you could read it, Mr Orton?---Yes. Yes.

Yes, of course. Commissioner, Freedom's counsel have raised with me a concern about a particular part of this document that they believe is covered by a non-

publication direction. We are not certain that that is the case, but could we, in the meantime, take down the first page.

THE COMMISSIONER: Take it down.

MS ORR: Mr Orton, have you finished reading that page?---Yes, I have.

Perhaps if we could take that page down as well. Now, the questions I want to ask you about that document don't traverse the topic that has been raised as potentially covered by a non-publication direction, and we will examine that. But did you – do you recall reading on the first page, Mr Orton, towards the bottom of the page, a reference to issues that had been raised in customer complaints and in reviews of Freedom on publicly available websites?---Yes, I did.

And do you recall that the issues raised included that customers were being told that they could only cancel Freedom policies by phone, not in writing, and that they were being put on hold for long periods?---Can I answer that – both those questions separately?

Yes. First, can I just ask you to confirm that you saw that?---I saw that, yes.

And, yes, you would like to comment on that now?---Yes. I'm not aware of any direction where customers are required to cancel by writing. I – I am aware of some inefficiencies in the call centre which I'm addressing in terms of being able to get through to our customer care agents, our customer service agents, retention agents, which I am addressing at the moment. So I accept the second part, absolutely. The first part, I do not believe that there has ever been a direction that it needs to be in writing.

But you see that customers have told ASIC that that was their experience?---I see that.

Or put that on a publicly available website?---Yes, I see that.

That was the other source of information. And the websites and complaints also included statements about Freedom representatives not accepting cancellation requests?---Yes. I would need more information on that, but I did see that, yes.

And that customers have also said that they were being questioned at length by the Freedom representative when trying to cancel their policies?---Correct.

And that sometimes Freedom's representatives had just hung up on customers who were attempting to cancel their policies. Did you see that reference?---Yes, and I'm – I did see the reference in there.

So are you aware that customers are having those sorts of issues when they attempt to cancel their policies with Freedom?---I'm aware of some of those issues. I'm not

aware of customers being hung up on. I am aware of some wait times. I – I suspect – and I don't know – but I suspect that if you would like to call through is an option on – or send a note is an option because they've contacted us via another means, via – via email or via whatever it may be, I'm not sure but they're certainly not advised that they can only cancel if they write in.

But you see from that document - - -?---I see that.

- - - that some customers believe that is what's happening to them?---I do.

Now, Freedom has received a number of complaints directly from customers about experiences with attempting to cancel their policies?---Yes, it has.

And the document that you provided to the Commission in response to the request for acknowledgements of any misconduct or conduct falling below community standards and expectations, disclosed about 27 instances of retention conduct that Freedom conceded fell below community standards and expectations?---Okay. Yes. Yes, it did.

And the vast majority of those complaints were received since the start of February this year?---Yes.

And the complaints we see, from the document that you provided, relate to issues such as Freedom failing to cancel in accordance with a request, and premiums being deducted after someone has cancelled their policy?---Yes.

And you told ASIC in the meeting that you had in July that you considered that the retention problems arose, at least in part, because there wasn't enough focus on quality assurance. Do you recall that?---I don't recall that but it's – I imagine it's something that I would – I would say, yes.

And was that only one of the difficulties that led to these problems, do you think?---No. No. And I would also like to put that ASIC meeting in some context. That ASIC meeting was a very initial meeting designed to really just engage with the regulator and explain to them that we are very keen to deal through any issues and to work cooperatively. It wasn't intended as a detailed meeting on any of these issues.

It may not have been, Mr Orton, but you expressed a number of views in that meeting, did you not?---I did.

Yes. And do you maintain those views or have you modified those views?---I maintain those views but I agree with you as well, that there are issues in terms of retention that need to be fixed.

Is the bigger problem with retention that your processes and procedures are geared towards ensuring that your retention agents do everything possible to retain a policy

that a customer wishes to cancel?---I think the retention has been too strong, and the processes have been too strong. I agree with you.

And do you agree that they are told, the retention agents, to do whatever possible to try and retain that policy?---No, I don't agree with that, Ms Orr. I don't agree that they're told whatever possible.

They've got KPIs, don't they, Mr Orton?---They do.

And one of those KPIs you told me yesterday was a save percentage?---Correct.

And that's about how many policies they save from cancellation?---Correct.

How does that feature in the KPIs?---Quite highly in the KPIs.

How highly?---I'm not sure of the question. I mean, there's a number of KPIs. But that is – that is a key measure of their success.

It's the primary KPI?---I would say so, yes.

And are there other KPIs that are applied to them?---Yes, there is.

And what are they?---There's – there's quality KPIs included, and – and a number of other areas that I would have to see the document first, but quality is included but - - -

The primary KPI is how many policies they manage to save from cancellation?---That's correct.

And how are your retention officers currently remunerated?---They're currently remunerated on a base salary, plus a commission, only a very small proportion of those retention agents currently receive a commission, 20 to 30 per cent, but as I explained yesterday, removing that completely.

So 30 per cent of them currently receive commissions. Is that what you were saying?---Yes.

And what proportion of their remuneration tends to be from commissions?---I can't guess at that but some of them would earn decent – decent commissions. Probably similar to the sales agents, if not higher.

And those commissions are calculated by reference to how many policies they've saved from cancellation?---Yes. With a quality overlay.

And you've indicated yesterday and today that commissions for the retention agents won't continue in the future?---Correct.

And have you done that in recognition of the fact that a commission structure for agents who are handling requests from consumers to cancel their policies is likely to lead, and has in fact led, to poor customer outcomes?---I think there's occasions of poor customer outcomes here, definitely, which is why I want to focus on this area.

And you accept that the commission structure was a driver for that?---I think the commission structures can be a driver for that. I agree, Ms Orr.

And it was?---Yes.

Yes. Can I ask that you look at FIG.0008.0008.0181. Now, this is Freedom's retention cancellation call guide?---Correct.

It's provided to your retention agents?---Correct.

And it sets out the four main stages of a cancellation call?---Correct.

The first is to set the scene?---Yes.

And that involves finding out the underlying reason for wishing to cancel and offering to review and run through scenarios?---Correct.

And if we go to the second page of this document, 0182, we see a call guide to personalise objection handling, which is to be used depending on the reason that the customer gives for wanting to cancel the policy?---Yes.

And one of the reasons, we see if we go to 0184, one of the reasons that Freedom expects a customer to give is:

> *Not required. I don't want it.*

Do you see that, on the left-hand side of the page?---Yes, I do.

To which Freedom retention agents are told to respond:

> *What plans do you have in place once the cover is removed to cover the costs of the funeral should you pass away?*

That's what your retention agents are told to say in that instance?---From this document, yes. Yes.

And if the person wants to cancel accidental death or accidental injury cover, your agents are told to say:

> *Well, what alternative have you put in place to cover you for a lump sum payment should you pass away unexpectedly or incur an injury that results in unexpected medical expenses or possible loss of income?*

?---Yes.

So your retention agents are trained to respond to a request for cancellation by asking the customer to explain to them the alternative plans that they have made once the cover is removed?---From this document, yes. And I agree that that's not appropriate.

That is an intrusive and inappropriate line of questioning for your retention agents to take in that setting, isn't it, Mr Orton?---I agree.

It's designed to make the policyholder feel sufficiently anxious that they will change their mind about cancelling their insurance?---I agree.

And if we go back to the second stage of the call at 0181, the second stage of the call is to ask questions?---Yes.

With the purpose of getting information that can then be used in the third stage, which is about providing personalised solutions?---Correct.

And the intention of the personalised solutions is for Freedom to do whatever it can to encourage the policyholder to retain their insurance?---I – I can't see that it says that, Ms Orr, but - - -

Well - - -?--- - - - it does go through some options here.

Yes, these are the options you have referred to a number of times, Mr Orton. The options include lowering the sum insured, reducing the level of cover, reducing the number of lives, changing the payment frequency, skip a payment and align to payday, alternative product or upsell to accidental death or accidental injury. Only as a solution to a problem or to match a competitor offer.

?---Yes, I see that.

Now, that is the training currently in place for your retention officers?---Yes.

I tender that document, Commissioner.

THE COMMISSIONER: Freedom retention cancellation call guide, FIG.0008.0008.0181, exhibit 6.95.

EXHIBIT #6.95 FREEDOM RETENTION CANCELLATION CALL GUIDE (FIG.0008.0008.0181)

MS ORR: Now, I want to look at how this training played out in the conduct by the Freedom staff who dealt with Mr Stewart's attempt to cancel his son's policy. I want

to start with the first call that Mr Stewart made to Freedom to attempt to cancel the policies, which involved the customer service staff rather than the retention staff, it appears to us. Is that correct?---Yes.

So if we could go to FIG.0001.0001.0258. Now, at the time of this call no one within Freedom appeared to have listened to the call in which Mr Stewart's son had purchased the insurance. Is that correct?---That's correct, Ms Orr.

But when Mr Stewart told the customer service consultant on the following page, 0259, that his son had been signed up for a policy regardless of his intellectual disability, her response was – do you see towards the top of the page:

> *But just saying, the agent probably didn't know at the time.*

Can you see that?---I do.

And after Mr Stewart asked to speak with the customer service consultant's manager, she assured him that Freedom would listen to the call in which the sale was made, and then call Mr Stewart back later that afternoon. Do you see that further down the page?---Yes, I do.

Now, what I want to take you to now is what this customer service consultant did after this call from Mr Stewart. Could I show you FIG.0001.0001.0069. Now, after the customer service consultant finished the call with Mr Stewart, she emailed another customer service consultant at Freedom, didn't she?---Yes, she did.

Now, if we look at the email at the top of the page, we see – this is at 12.17 pm on 15 June:

> *Hi girl, policy owner's dad called in angry as he thinks the sales agent took advantage of policy owner who is disabled by selling him funeral cover. Can you see from the sales agent call what actually happened, please.*

Do you see that?---I do, Ms Orr.

And the response that she received below from the second customer service consultant was:

> *No.*

?---Childish.

To which the first customer service agent, speaking of childish, Mr Orton, responded by sending 25 sad face emoticons to the second customer service consultant?---What can I say, Ms Orr. It's 2016. I was very disappointed when I saw this. Things are changing. It's why I'm here is to make some changes like this. That sort of

behaviour, it was a young company at the time. It's totally inappropriate particularly given the gravity of the situation.

What does this say about the culture within Freedom that this is how your sales agents are communicating with each other about the situation of Mr Stewart as reported by him in the call that we just looked at?---It's a very bad representation of the culture of the company at that time. I agree. And that's what I'm here to improve.

If we go over the page to 0070, we see that the second customer service consultant's assessment, after listening to the call, was this:

Hey –

First person:

I've had a listen to the call. Not once does the policy owner mention anything about being disabled or not being able to make decisions for himself, etcetera. So it would have been hard for the sales agent to assume that the policy owner had a disability. So no, I would not say we took advantage of him. Can you please get in contact with the father and just apologise and make let him know we were not aware he was disabled and let him know we will cancel the policy off for him.

That was the assessment?---You know my view on this, Ms Orr.

I heard your view on this yesterday, Mr Orton. I assume that view is unchanged and is inconsistent with the view expressed by this sales agent?---Totally inconsistent with the view that's expressed by this agent. I cannot understand how that – how you could listen to that call and come to that conclusion.

I tender that document, Commissioner.

THE COMMISSIONER: Emails of 15 June '16 concerning Stewart, FIG.0001.0001.0069, exhibit 6.96.

EXHIBIT #6.96 EMAILS DATED 15/06/2016 CONCERNING STEWART (FIG.0001.0001.0069)

MS ORR: And despite that second customer service consultant instructing the first person to contact Mr Stewart to apologise and to clarify that Freedom was not aware that Mr Stewart's son was disabled and confirm cancellation of the policy, the first sales agent didn't do that, did she?---No, she did not.

And as a result, Mr Stewart had to call Freedom again, a couple of days later, on 17 June?---Correct.

And can I take you to the transcript of that call, FIG.0001.0001.0261. So on this occasion, Mr Stewart spoke firstly with the customer service team, a sales agent, and then he was transferred to the retention team. Is that right?---Correct.

Now, the first Freedom person who spoke to Mr Stewart and his son, we see from this page, 0261, was the sales agent, and she asked why Mr Stewart's son wanted to cancel the policy. Do you see that?---Yes, I do.

And Mr Stewart's son said:

> *I don't want it.*

?---Yes.

And the sales agent responded:

> *Okay. That's fine. No worries at all then.*

And Mr Stewart said:

> *Okay.*

And if we go over the page, we see he said:

> *Okay. So that will be cancelled?*

And the agent responded:

> *No, I will have to pass you on over to cancellations department. One moment, please.*

So that's where we see the transfer. We see that Mr Stewart tried to resist this, but the agent told him that there was a legal declaration that Freedom had to read to him over the phone?---That's correct.

Which the agent implied was the reason for the transfer?---Yes, and it's not the reason for the transfer.

It's not, is it?---No.

The reason for the transfer is to send the call through to the specialist retention officers?---That's correct.

Who are incentivised to save the policy?---That's correct.

And after Mr Stewart was transferred to the retention team, we see that the retention agent told him that Freedom hadn't yet got back to him. If we could bring the next page up at the same time:

Hadn't yet got back to him because Freedom was investigating the call.

Do you see that?---That's right, Ms Orr. And this is a very poor customer experience throughout the entire process. These are the things that we're working to improve.

Freedom had, in fact, by this time, already formed a view on the call, hadn't they?---I believe so, from the previous – yes.

Yes. So the view that had been formed was that Mr Stewart should be contacted, that he should receive an apology, and the policy should be cancelled?---Correct.

But instead, what we see happened was that the retention officer attempted to explain the benefits of the policy to Mr Stewart at length?---I wouldn't say at length with this. And – and while I agree that the retention agents have not taken no for an answer on a number of occasions, on this occasion I think she was actually trying to calm the situation down by saying that there was a free cover period, and she didn't do it in a good way. It sounded – and I can understand how Mr Stewart would potentially think that they were trying to save the policy at that stage. So I will give her the benefit of the doubt personally on that one, but it has still been a terrible process for Mr Stewart.

Well, if she was trying to calm things down, the best way to do that would have been to cancel the policy - - -?---Cancel the policy.

- - - in accordance with Mr Stewart's request - - -?---I agree.

- - - wouldn't it?---I agree.

Now, in your statement you say that you don't consider that this was an attempt to persuade Mr Stewart that the policy was worthwhile?---That's what I just said. That's what I was saying.

You say it was an attempt to ensure that before making a final decision, Mr Stewart was aware of the benefits provided under the plan?---For that part.

And that he understood that the first 12 months was provided at no cost?---Correct.

I see. Now, could I ask that you look again at 0263. In the passage that we've just discussed, the retention agent mentioned on a number of occasions that the final expenses cover was free for the first 12 months. We see that twice on this page?---Yes.

And she failed to mention that Mr Stewart's son had also taken out accidental death and accidental injury cover?---Yes, she did.

Both of those policies had premiums that were payable three days later?---Correct.

Now, why did that happen? Was that to understate the extent of financial commitment that had been made by Mr Stewart's son?---Ms Orr, listening to that call and listening to all these calls when the company was quite young, the operator – the customer service retention agent was very nervous and was – her words were not flowing. I don't think that there was any intention then to say that the – that the cover was – wasn't being charged for. But it should have been. It definitely should have been.

You heard the part of the call that we played yesterday where the retention agent, after going away for a period, comes back and tells Mr Stewart that the call has been listened to, and it's not obvious that his son has a disability?---You know I don't agree with that, Ms Orr.

What do you think about the words that she used at 0264 when she confirmed that the policy would be cancelled but said to Mr Stewart:

> *You've got to understand where we're coming from at the end of the day.*

?---Sorry, I just - - -

Towards the bottom of the page:

> *It goes for every company. You've got to understand where we're coming from at the end of the day.*

?---My view is that she didn't – if she didn't believe that Mr Stewart's son was vulnerable, then – and it is difficult on occasions to know if someone is a vulnerable customer, you can't always pick it up. In that – in – in this particular case, absolutely. It should have been picked up. But I think that's what she's talking about.

Well, her tone changed dramatically after she engaged with Mr Stewart's son, didn't it?---It did.

And she said twice after that that she understood where Mr Stewart was coming from?---Yes.

And then following that call, this retention agent had an Instant Messenger conversation with the second customer service consultant from the exchange that we saw before?---Yes.

You've seen those documents?---I have.

That the second customer service consultant was the one who had formed the view that an apology should be given and the policy cancelled. If we go to FIG.0001.0001.0071. We see in Instant Messenger chat between the two, we see at the top that the retention agent told the sales agent that Mr Stewart had cancelled the policy. And had referred to his earlier email with Freedom?---Yes.

To which the sales consultant replied:

Bloody whinger.

?---Totally inappropriate. There's not much I can say about this one, apart from say that – apart from say that the – the people involved have been counselled by me directly. Both in – verbally and in written format. And it's totally unacceptable and against the cultural values that I expect of our employees.

The retention agent went on to say that Mr Stewart would be expecting to hear from Freedom in the next three days?---Yes, that's right.

And she then said:

His son sounds not normal, though. Strange. But the dad sounds like he's going to take it further.

?---Yes.

To which the sales agent said:

Well, I don't know what he expects to get out of it lol

?---It's totally inappropriate, Ms Orr. Totally inappropriate.

This is a fairly damning indictment of the culture of Freedom at this time, is it not, MRORZ?---It doesn't bode well on Freedom. I agree.

I tender that document, Commissioner.

THE COMMISSIONER: Instant messaging chat, 17 June '16, FIG.0001.0001.0071, exhibit 6.97.

EXHIBIT #6.97 INSTANT MESSAGING CHAT DATED 17/06/2016 (FIG.0001.0001.0071)

MS ORR: Freedom didn't in fact communicate further with Mr Stewart or provide the call recordings that he had requested, did it?---Not at the time in 2016, no.

And you say in your statement that this was because Freedom thought that the complaint had been dealt with to the satisfaction of Mr Stewart in 2016?---Yes, I did.

But this Instant Messenger chain doesn't suggest that Freedom thought the complaint had been dealt with to Mr Stewart's satisfaction, does it? It suggests the contrary?---It does.

And do you accept that Freedom's failure to ensure that the call recordings were sent to Mr Stewart in a timely way was conduct that falls below community standards and expectations?---In hindsight, I agree with you. I can understand from a process perspective why they thought the issue was closed. What – what Mr Stewart should have been given at the time, immediately, was a formal apology and not had to go through that process. He should have been sent those recordings. Eventually he was sent those recordings but I agree, they should have been sent and it should not have been closed without contacting and making sure that that customer was – was satisfied with the outcomes.

Do you accept more broadly that Freedom's conduct in trying to convince Mr Stewart to retain his son's policies, in circumstances where he had made clear that his son didn't understand those policies, also fell below community standards and expectations?---No, I don't, Ms Orr. I explained that before. My view is - - -

You think that is appropriate?---No, I don't think it was appropriate. I don't think it was appropriate that it occurred that way and came across that way to Mr Stewart, but I do believe that that operator was actually – or that customer service agent was actually just saying, "This is what the cover is." I don't think at that stage she would have been trying to save that policy.

I'm struggling a little to understand the distinction that you're drawing, Mr Orton. You say it was not appropriate?---Mmm.

But you don't agree that it was conduct that fell below community standards and expectations?---I don't think it's appropriate because it didn't come across the way that I think she wanted it to come across. I'm going to give the benefit of the doubt to her in – in that situation, but considering that Mr Stewart took it a different way – and I can perfectly understand why he did – then yes, it's conduct below consumer expectations.

Since the policies were sold to Mr Stewart's son, the retention strategies that Freedom has employed have become a bit more creative. Do you agree with that?---I think there has been some – some different retention activities, yes.

Yes. So since at least September last year, Freedom has used what it refers to as retention initiatives to assist its staff to dissuade policyholders from cancelling their policies?---Correct.

And there seem to have been a number of different types of retention initiatives, some of which were focused on retaining people who wanted to cancel their policies, and others were focused on regaining policyholders who had already left Freedom. Is that right?---Correct.

Could I ask that you look at FIG.0004.0003.1057. So this is an example of a retention initiative from September 2017. Do you see the date in the top left-hand corner?---I do.

And Freedom retention agents were authorised to offer an incentive if a policyholder wished to cancel their policy, and hadn't already been dissuaded from doing so by a reduced level of cover or a review of their cover?---Yes.

And in those circumstances, retention agents were authorised to make the policyholder the offer that's set out under the heading Positioning:

> *If you decide to keep your cover today, I can offer you our special Christmas promotion which is only running for the next two weeks. With this promotion, you would receive a Christmas Visa card to the value of dollars which you can use anywhere that accepts Visa or EFTPOS. All you have to do is pay your premiums on time for the next three months and then call us up to request your card and we will send it out to you in time for Christmas. You can use it for Christmas shopping or to buy groceries or anything you want. We've never done a promotion like this before so it's a great offer.*

So that was a retention initiative from September last year?---It was, Ms Orr. And I've ceased all of these vouchers.

Why have you ceased them, Mr Orton?---I don't believe – I don't believe in them.

Do you accept that these retention initiatives are likely to lead to poor customer outcomes?---I think they can possibly lead to poor customer outcomes, and I don't think it's appropriate to be offering these incentives just – just - - -

To people who are trying to cancel their policy?---No, I don't. I don't.

I tender that document, Commissioner.

THE COMMISSIONER: September '17 Christmas Visa promotion, retention initiative, FIG.0004.0003.1057, exhibit 6.98.

EXHIBIT #6.98 SEPTEMBER '17 CHRISTMAS VISA PROMOTION, RETENTION INITIATIVE (FIG.0004.0003.1057)

MS ORR: And these retention initiatives of this nature were still running as recently as May this year?---I believe so, yes.

Now, if I could ask that you be shown FIG.0008.0008.0179. We see that this is a cancellation recovery call guide. Have you seen this document before?---I have, Ms Orr.

- - - Mr Orton?---Yes.

And can you explain what it is?---It's for customers that have cancelled recently and contacting them to see if they would like to reconsider their decision and while they remain within the period that the policy can be reinstated.

So it's a script to be used in that situation?---Correct.

And we see from 0180 that if the person's response – we see this next to Objection Handling – if the person's response was that they did not wish to reinstate their cover the retention agent was authorised to attempt to overcome their objection to reinstating the policy?---Yes, from this, that's right

That's despite the person has already clearly told Freedom on a previous occasion when they cancelled the policy that they didn't want it?---Correct.

And do you think the community expects that in those circumstances, when a policyholder has called up to cancel their policy and, against the odds it seems, successfully done that, you would then leave the customer alone rather than continuing to call them and trying to persuade them to reinstate their policy?---Most companies will try to win customers back but the way in which this was done is not customer-focused.

Is this still in operation, this script?---No, it's not still in operation.

When did it cease to be in operation?---I don't know the date, but certainly prior to June.

I tender that document, Commissioner.

THE COMMISSIONER: Cancellation recovery call guide, draft version 1, FIG.0008.0008.0179, exhibit 6.99.

EXHIBIT #6.99 CANCELLATION RECOVERY CALL GUIDE, DRAFT VERSION 1 (FIG.0008.0008.0179)

MS ORR: Can I ask that you look now at FIG.0004.0003.1054. So this document is from July this year, and shows us that in July Freedom began an incentive campaign

geared towards reversing cancellation requests that were received via email or via post. Do you see that from the first sentence under Summary?---Correct.

So this sort of incentive campaign was going as recently as July?---It seems to be, yes.

And 3 July, the date of this document, was a few days after the letter from ASIC, dated 30 June, asking for information about your retention strategies?---It would be, yes, Ms Orr.

So Freedom was on notice at the time it created this retention campaign of ASICs interest in its retention practices?---Personally, Ms Orr, I wasn't aware of this, but from the dates you're correct.

Well, Freedom launched this campaign, we see from the document, because it was receiving approximately 60 written cancellation requests per day?---From the document, yes, correct. It sounds right.

And we see that Freedom was concerned that year to date written cancellations had resulted in close to $500,000 in lost annualised premium?---Correct.

And we see also from this document that despite making three attempts to call customers who had cancelled in writing, Freedom was still only reaching around 25 per cent of customers?---Correct.

That was the problem?---Correct.

And so Freedom developed this written cancellation win-back policy in which it would attempt to win back customers who had cancelled in writing by making a phone call or sending a text to them?---Correct.

And the principal features of the campaign were that if the customer was still in the free premium period and they decided to keep their policy, they would get a $50 gift card after paying their first premium. It's right down the bottom of the page - - -?---Sorry.

- - - Mr Orton?---Sorry. Yes.

And if we bring up the next page at the same time, we see that if they were a premium paying policyholder, they would be entitled to the gift card after paying their next premium and any arrears?---Correct.

But in either case, they had to call Freedom to redeem their gift card after they made the payment?---Correct.

And we see, if we could leave 1055 on the screen and bring up 1056, we see that this document outlined the expected response to this program and the cost of the program?---Correct.

Of 1200 written cancellations per month, Freedom expected to be able to contact 300 policyholders by phone?---That's right, Ms Orr.

And you expected that 30 of them would reverse their cancellation?---That was – this is a business case. I mean - - -

Yes?--- - - - this is just the expectation.

And that would give a combined monthly premium of about $30,000?---Correct.

And we see on that page that Freedom expected that it could make an additional $15,000 a month from cancellation reversals in response to a text?---Correct.

So that would bring the total estimated monthly premium intake from this campaign to $45,000?---Correct.

And the campaign was only going to cost Freedom $1687 a month to run. Do you see that? Plus $78 to send the texts?---Plus the – yes, plus the staffing cost.

And that cost was calculated on the assumption that only half of the people that you made this offer to would follow through and seek to redeem their gift card?---Correct.

I tender that document, Commissioner.

THE COMMISSIONER: Retention marketing campaign, 3 July '18, FIG.0004.0003.1054, exhibit 6.100.

EXHIBIT #6.100 RETENTION MARKETING CAMPAIGN DATED 03/07/2018 (FIG.0004.0003.1054)

MS ORR: So this is a very recent retention campaign, Mr Orton, one that was commenced in the period when Freedom appreciated that it was under scrutiny from ASIC for its retention practices. Should it have been initiated?---No, it definitely should not have.

The processes and incentives that all of these documents record are designed to make it as difficult as possible for people to cancel their policies. Do you agree?---I think that has been the outcome and that has been clear from some of the calls and some of the things that I've seen.

Designed to do everything possible to win people back after cancellation?---Yes, in this particular instance, yes. I agree.

Does Freedom intend to stop campaigns of this nature?---Absolutely.

And what will the retention strategies be moving forward?---Retention strategies, like I mentioned before, the removal of commissions, making sure that through the new sales process, that people are given the opportunity at the end of that 12 months to opt in, which should remove the need for the retention agents in general, but they will have the responsibility to explain options to customers, complete review of processes, complete review of the customer experience, and that's what we've already commenced with LimeBridge Consulting. It's what I will be focusing on to ensure that customers are getting the right outcomes. This is an area, Ms Orr, that we need to focus on. I agree.

Now, I want to ask you a few questions in closing, Mr Orton, but before I do that, I want to come back to the calculations in the document that I referred to earlier today. That was ASIC.0068.0001.0024. And we were looking at 0026 in that document. And I put to you that on our calculations, at the time Freedom provided this letter, approximately 69 per cent of Freedom customers who had called to cancel their policy still held that policy without change. Do you see that from (d)(i)? The 69 per cent you recall?---Yes, I do.

Now, the 69 per cent is 3960 policies had been cancelled or lapsed. Do you see in (d)(i)?---Yes.

Divided by the 12,720 who had retained their policies without change, gives us 31 per cent. Therefore, 69 per cent of those who retained policies without change still had their policy?---That's right.

And the other figure that I put to you was 85 per cent. I put to you that over the page on – I'm sorry, we still need this page on the screen. I put to you that on our calculations at the time Freedom provided this letter, 85 per cent of the customers who tried to cancel their policy but were convinced by Freedom to keep it on amended terms continued to hold their policy. Do you recall that?---I do.

And that 85 per cent we start with (c)(ii)?---Yes.

7598 consumers retained their policy and made changes, and 6866 – I'm sorry, 466 or 85 per cent still held their policy as at 30 June 2018?---Correct.

Do you see where those two figures come from now?---I do now. Thank you for clarifying.

No, thank you. My apologies for not being able to do so at the time. Now, the last questions I want to ask you, Mr Orton, are about where Freedom currently sits in the direct life insurance market. Where – what sort of market share does Freedom

have?---It depends on whether you're looking at it from a new sales perspective or an in-force premium. From a new sales perspective, probably 10 or 11 per cent.

And from an in-force?---In force much lower. I can't – I don't know the actual numbers for the business. You may have them there, Ms Orr, and I could probably clarify them if you gave them to me but we're still quite a young company from an in-force perspective but from a growth perspective it has been strong.

In recent months Freedom has issued a number of media releases about its strategic direction?---Correct.

And we see from those media releases that Freedom is acquiring St Andrews from the Bank of Queensland?---That's correct, Ms Orr.

And when does Freedom expect that acquisition to complete?---We're not aware when that will complete now, Ms Orr. We've advised the market within financial year '19.

And we see from the media releases that Freedom expects that acquisition to assist it to diversify its products, including in loan protection products and life insurance cover. Is that right?---Correct.

Can you explain what that diversification will be?---The main diversification is that the St Andrews business is a strong business for loan protection type covers. It comes with an extremely strong management team who have been committed to – to join along with the acquisition. They do offer some life products as well and loan protection. Having both general insurance and the life company means that you can develop products that are industry leading for loan protection. It means you can cover things like someone's mortgage when they're unemployed, so there is some value – value in that. It's a very different model. It's a business to business model. Whereas the Freedom business has very much been business to consumer. And it offers an opportunity for us to diversify our business.

Could I ask that you look at one of the media releases issued in recent weeks which is RCD.0006.0011.0002. This was a media release issued last Thursday, 6 September?---Correct.

And we see from this media release that Freedom announced that the board had initiated a review of strategic options for the company?---Correct.

And that Freedom linked this to the release of ASICs report on direct life insurance, and to an initial discussion with ASIC regarding that review. Do you see that?---That's correct, yes.

And then the media release says:

Specifically, the board notes that a significant proportion of Freedom's upfront commission revenue is derived from the sale of funeral insurance by the company's direct sales team and that changes to a number of lead sources would be required to continue to meet the expectations of the regulator.

?---That's correct.

Continuing:

Consequently, in order to protect and maximise shareholder value, the board has commenced a broad-based review which will consider matters including strategy, business structure, operating model, and internal practices and procedures.

?---Correct.

What is that broad-based review, Mr Orton?---Everything here is a broad-based review, looking at the options that we've been – and we've already started with the changes to the accidental death, looking at lead sources, which is mentioned in here, looking at every option that is – that is viable. I really cannot say a lot more than what's said in that about what the review entails.

What's the connection between that review and the decisions that you notified the Commission of at 3 o'clock on Monday of this week?---It was – some of those decisions were included but this – this came out of the same board meeting where we made the changes to commissions.

So the minutes of the board meeting that are tendered in evidence reflect the decision to commence a broad-based review - - -?---I can't remember.

- - - which is - - -?---I can't remember exactly if they do.

What is the relationship between the broad-based review and the board meeting that we have minutes for?---Look, I would have to see the board minutes again to see if they were actually included but it was soon after that that the discussion was that what are we – what are we moving forward with, because there has been a lot of regulator activity, there has been changes in consumer expectations. The market – we've had questions from the market. We are a listed company. And we're ensuring that we're looking at whatever is the best option for our customers and for our shareholders.

You say there's been a lot of regulator activity. You're referring there to the direct life report?---Yes.

Are you referring also to the breach reports that you filed after this media release last Friday with ASIC?---I wasn't specifically referring to that, no, but I was referring more to the direct life review.

Last month, there was another breach report from Freedom in respect of contraventions of the anti-hawking provisions. Is that right?---Correct.

So multiple breaches reported to the regulator on Friday last week. I took you through the different sorts of breaches that were reported in that notice. An anti-hawking breach notified a few weeks earlier. Is this part of the regulatory activity or scrutiny - - -?---No, it's not.

- - - that sits behind the broad-based review?---No, it's not.

We know that ASIC is currently looking at your retention strategies and sales practices as well?---Yes, they are.

Is that part of what has precipitated the broad-based review?---Everything is on the table, Ms Orr.

What do you mean by that, Mr Orton? What is on the table?---I have been here to look at customer outcomes and see how we can improve what we are doing, what's the best thing for the customers, what's the best thing for the shareholders. So we're looking at – at a range of options. We are looking, of course, very closely at what the regulator expects of us and how we can improve processes. I've committed today to you to improve the retention activities. I'm improving the sales process, making sure that customers have that opportunity before they provide banking details, to be given multiple bits of information so they understand their coverage. We're trying to work and move to the situation where we've got customers understanding and being happy with the products that they have and when they need to leave them or they don't want them any more, the cancellation process is not onerous. When I can do that and I've got happy customers, then I've got a thriving business.

We know from your earlier evidence that Freedom intends to continue to sell life insurance directly to consumers?---Are you talking – sorry, Ms Orr, were you talking funeral insurance?

I'm talking about all forms of the life insurance, the six products. All forms of them you continue to - - -?---We still intend to sell it.

- - - intend to sell directly to consumers?---Directly to consumers. That's right.

But you only intend presently to sell funeral insurance and loan protection cover in outbound sales calls?---Not loan protection cover either.

Just funeral insurance?---Correct.

And against the backdrop of your concerns about regulator activity and economic viability, do you consider that it is possible for Freedom to sell funeral insurance in outbound sales and life insurance more broadly on a direct sales model in a way that

is financially viable and legally compliant?---I believe – let me separate those two, if I can. From a legally compliant point of view, absolutely I do. From a – from a financial point of view, yes, I do as well. But there will be changes to the model. And that's the – that's the strategic review.

All right. I will tender this document, Commissioner.

THE COMMISSIONER: Freedom ASX media release, 6 September '18, RCD.0006.0011.0002, exhibit 6.101.

EXHIBIT #6.101 FREEDOM ASX MEDIA RELEASE DATED 06/09/2018 (RCD.0006.0011.0002)

MS ORR: And I have no further questions for Mr Orton.

THE COMMISSIONER: Thank you. Mr Silver.

MR SILVER: No questions, thank you.

THE COMMISSIONER: Thank you. You may step down, Mr Orton. You're excused.

<THE WITNESS WITHDREW [11.06 am]

MS ORR: Commissioner, as you've heard our first two case studies raised questions about the value of accidental death policies to consumers. And the Commission obtained a number of witness statements which reinforced those concerns. And I want to say something about each of those statements. Now, before I turn to those statements, I want to say something further about ASIC report 587, which is the Sale of Direct Life Insurance Report released by ASIC on 30 August this year. In that report, as you've heard, Commissioner, ASIC expressed a number of concerns about accidental death policies.

One overarching concern raised by ASIC was that accidental death insurance was unlikely to perform in the way that the consumer or their family or dependants expected at claim time due to the product and its exclusions being poorly described on sales calls. The data brought in by ASIC indicated that between 2014 and 2017, only 26 per cent of claims on accidental death policies were accepted. 36 per cent of accidental death claims were declined. And 38 per cent were withdrawn. ASIC also identified concerns about the value of the product. It noted that the claims ratio for the financial years 2015 to 2017 were 16.1 per cent, meaning that for every $1 of premiums paid, only 16 cents was paid out.

The Commission obtained statements about accidental death cover from 10 entities, Auto & General, CommInsure, Greenstone, MLC, OnePath, Suncorp, Westpac and Zurich, as well as Freedom and ClearView from whom we've already heard. These entities were variously the manufacturers and distributors or distributors only of accidental death policies. The statements sought since 1 January 2013 information about the accidental death policies offered by the entity, including the key terms of the products, the circumstances in which the products were offered to customers, and the handling of claims under the policies. They also sought data relating to the sale of the policies and the entities' claims handling practices.

We will summarise some key aspects of each of the statements dealing first with Auto & General, which provided a statement from Mr Warren McAlpine, the associate director of Auto & General Services Proprietary Limited. Auto & General ceased offering all life insurance products, including accidental death policies on 30 June this year. Prior to that, from November 2013, Auto & General had been a distributor of accidental death products issued by Hannover. Auto & General distributed its products through two brands, Budget Direct and Ozicare. Over the last five years Auto & General sold 1684 accidental death policies. It received approximately $775,000 in premiums. No amounts were paid towards claims in any year. And Auto & General received only one claim which was denied in full. And that claim was denied because the death was not accidental. I tender the statement of Mr Warren McAlpine, dated 27 August 2018.

THE COMMISSIONER: That will become exhibit 6.182.

EXHIBIT #6.182 STATEMENT OF MR WARREN McALPINE DATED 27/08/2018

MS ORR: We turn next to ClearView. As you've heard, Commissioner, ClearView provided statements from Gregory Martin, the chief actuary and risk officer. During the relevant period ClearView offered four types of policies that it classified as providing accidental death cover, two were accidental only versions of life cover, one was direct to market accidental death cover, and one was direct to market injury cash insurance. ClearView currently offers only one accidental version of life cover through its retail channel. The direct to market products have not been offered since the closure of ClearView's direct life insurance business on 30 June last year.

Over the last five years, ClearView sold 14,036 accidental death policies. It received approximately $38.8 million in premiums. And it received a total of 37 claims, of which 38 per cent were denied in full, 43 per cent were allowed, five per cent were withdrawn, and 14 per cent were pending. The claims ratio ranged between one per cent and 87 per cent, and the claims ratio across all years was 26 per cent. For the 14 claims that were denied, 10 were denied because the death was not accidental, two were denied as the accident occurred while the life insured was intoxicated or

committing a criminal act. One claim was denied because the beneficiary murdered the life insured, and one was denied due to suicide.

We turn to CommInsure which provided a statement from Ms Helen Troup, the executive general manager. As you heard yesterday, CommInsure provides life insurance through the Colonial Mutual Life Assurance Society which is frequently referred to as CMLA. CMLA principally offered accidental death cover through its direct and retail channels. CMLA ceased offering cover through its direct channel in 2013 but continues to offer the cover through its retail channel. Over the last five years, CMLA has sold 18,928 accidental death policies with the significant majority being sold in 2013. CMLA received approximately $121 million in premiums and received a total of 1829 claims, of which 88 per cent were denied in full, three per cent were allowed, seven per cent were withdrawn, and two per cent were pending. Excluding 2018, the claims ratio ranged between 3.42 per cent and 23.03 per cent.

For some of the relevant period, CMLAs information storage system did not allow it to readily identify why a claim had been denied. However, CMLA could provide that information in respect of 643, or approximately a third of the claims denied. In respect of those claims, 96 per cent were denied on the basis that the cause of death was not accidental. Five claims were denied because they involved suicide or self-harm, and four were denied due to an excluded condition. I tender the statement of Ms Helen Troup, dated 27 August 2018.

THE COMMISSIONER: That will become exhibit 6.103.

EXHIBIT #6.103 STATEMENT OF MS HELEN TROUP DATED 27/08/2018

MS ORR: We turn to Freedom. And as we've heard, Freedom provided statements from Mr Craig Orton, the chief operating officer, and the data provided by Mr Orton showed that over the last five years Freedom sold 65,485 accidental death policies with the number of sales increasing each year. And between 2014 and 2018, Freedom received approximately 5.3 million in premiums. A total of 55 claims were received of which 13 per cent were denied, 47 per cent were allowed, nine per cent were withdrawn, and 29 per cent were pending. The claims ratio ranged between zero per cent and 55 per cent. Of the seven claims denied in full, five were denied on the basis that the death was due to a non-accidental cause, two were denied on the basis that the drug and alcohol exclusion applied.

We turn to Greenstone Financial Services Proprietary Limited, which provided a statement from Mr Brenard Grobler, the chief executive officer of Greenstone. Greenstone is a distributor of accidental death products distributing products offered by Hannover Re and Swiss Re Life & Health Australia Limited. Over the last five years Greenstone sold 21,908 accidental death policies and received approximately $46.5 million in premiums. Greenstone received a total of 42 claims of which 55 per

cent were denied in full and 44 per cent were allowed. And excluding 2018, the claims ratio ranged between 7.1 per cent and 25.4 per cent.

Of the 23 claims denied in full, 17 were denied as a result of not meeting the definition of accidental death, and six were denied because an exclusion applied. Of these, three related to intoxication, two to the consumption of drugs, and one to suicide or attempted suicide. I tender the statement of Mr Brenard Grobler dated 27 August 2018.

THE COMMISSIONER: That becomes exhibit 6.104.

EXHIBIT #6.104 STATEMENT OF MR BRENARD GROBLER DATED 27/08/2018

MS ORR: We turn to MLC. MLC provided two statements on the topic of accidental death policies. One from Mr Sean McCormack, the chief customer officer for retail advised insurance of MLC, and one from Ms Natalie Cameron, the chief claims officer. Mr McCormack explained that MLC offers accidental death policies online, by telephone and through financial planners. Over the last five years, MLC sold 1684 accidental death policies with the majority sold in 2013 and '14. MLC received approximately $34.2 million in premiums and received a total of 103 claims of which 61 per cent were denied in full, 36 per cent were allowed, two per cent were withdrawn and one per cent was pending.

The claims ratio ranged between 19.1 and 3.1 per cent. I'm sorry, that was provided as a ratio rather than a percentage by MLC. 19 – between 19 to 1 and 3 to 1. Of the 63 claims that were denied, 60 were denied because the death was not accidental. I tender the statement of Sean McCormack dated 3 September 2018.

THE COMMISSIONER: That becomes exhibit 6.105.

EXHIBIT #6.105 STATEMENT OF SEAN McCORMACK DATED 03/09/2018

MS ORR: And the statement of Natalie Cameron, dated 3 September 2018.

THE COMMISSIONER: 6.106.

EXHIBIT #6.106 STATEMENT OF NATALIE CAMERON DATED 03/09/2018

MS ORR: We turn to OnePath. OnePath provided a statement from Mr Gavin Pearce, the managing director insurance for ANZ Wealth Australia, a division of ANZ. Since 1 January 2013, OnePath has offered two standalone accidental death policies. Over the last five years, OnePath sold 3200 accidental death policies, and received approximately $57.6 million in premiums. OnePath received a total of 435 claims and of those claims 14 per cent were denied in full, 69 per cent were allowed, 13 per cent were withdrawn, and three per cent were pending. Excluding 2018, the claims ratio ranged between nine and 22 per cent. Of the 63 claims denied, 50 were denied because the policy terms were not satisfied, 10 were denied because an exclusion applied, and three were denied due to eligibility, for example, because the policy was not active at the time of the death. I tender the statement of Mr Pearce, dated 27 August 2018.

THE COMMISSIONER: That becomes exhibit 6.107.

EXHIBIT #6.107 STATEMENT OF MR PEARCE DATED 27/08/2018

MS ORR: We turn to Suncorp. Suncorp provided a statement from Mr Christopher McHugh, the executive general manager, personal injury portfolio and product of Suncorp Life and Superannuation Limited. Suncorp Life offers cover for accidental death as a standalone policy direct to customers online or through contact centres. Over the last five years, Suncorp Life sold 1838 accidental death policies. It received approximately $3.9 million in premiums, and it received a total of 10 claims, of which 40 per cent were denied in full, 50 per cent were allowed, and 10 per cent were withdrawn. Excluding 2017 and 2018, the claims ratio ranged between eight and 85 per cent. The ratio was not calculated for 2017 or '18 because no claims were paid in those years. The four claims that were denied in full were denied because the deaths were not accidental. I tender the statement of Christopher McHugh, dated 4 September 2018.

THE COMMISSIONER: Becomes exhibit 6.108.

EXHIBIT #6.108 STATEMENT OF CHRISTOPHER McHUGH DATED 04/09/2018

MS ORR: We turn to Westpac. Westpac provided a statement from Ms Susan Houghton, the executive director of the board of Westpac Life Insurance Services Limited. From 2013 to 30 September 2015, Westpac Life offered two products that provided accidental death cover. Westpac Life no longer offers either product due to limited sales volumes and increasing costs. Between 2013 and '15, Westpac Life sold 2178 accidental death policies. Between 2013 and 2018, Westpac received approximately $103.6 million in total premiums. Between 2013 and 2018 Westpac Life received a total of 108 claims, of which 49 per cent were denied in full, 40 per

cent were allowed, and 8 per cent were pending. And between 2013 and '17, the claims ratio ranged between seven and 15 per cent.

Of the 53 claims denied, 49 per cent were denied because the death was not accidental, 43 per cent were denied because the death was caused by suicide or intentional self-inflicted injury, and the remainder were denied because the death was drug or alcohol related. I tender the statement of Susan Houghton, dated 30 August 2018.

THE COMMISSIONER: Exhibit 6.109.

EXHIBIT #6.109 STATEMENT OF SUSAN HOUGHTON DATED 30/08/2018

MS ORR: Finally, we turn to Zurich. Zurich provided a statement from Mr Timothy Howell, the head of propositions, life and investments. Since 2013 Zurich has offered two accidental death products. One of these products ceased to accept new business in May 2017. Over the last five years, Zurich sold 484 accidental death policies. It received approximately $490,592 in premiums. It received no claims under the policies, and there was, therefore, no calculable claims ratio as no amounts had been paid. I tender the statement of Timothy Howell, dated 3 September 2018.

THE COMMISSIONER: Exhibit 6.110.

EXHIBIT #6.110 STATEMENT OF TIMOTHY HOWELL DATED 03/09/2018

MS ORR: Based on that data, some observations may be made about themes common across the statements. First, a significant number of entities had extremely high claim denial rates. Auto & General was the highest because it denied the only claim that it received. Auto & General was followed by CMLA which denied about 88 per cent of claims. MLC, which denied about 61 per cent of claims. Greenstone, which denied about 55 per cent of claims, and Westpac Life which denied about 49 per cent of claims. Second, by far, the most common reason for denial of a claim under an accidental death policy was that the cause of death was not accidental.

This was the case for all of Suncorp and Auto & General's denied claims. It was the case for 96 per cent of the claims denied by CMLA for which a reason for denial could be identified. It was the case for 95 per cent of MLCs denied claims, 74 per cent of Greenstone's denied claims, 71 per cent of each of ClearView and Freedom's denied claims. As you will recall, OnePath told the Commission that 79 per cent of its denied claims had been denied because the policy terms were not satisfied, but it did not specify the way in which the terms were not met. Some or all of these denials may also have related to the cause of death not being accidental.

For most, if not all, of these entities, a death would only fall within the terms of the policy if the accident causing the death was the sole and direct cause of the death, independent of any other cause. As ASIC observed in report 587, this would mean that a claim could be denied where a person died as a result of multiple factors, even if their death was partly or predominantly due to an accident. The third observation we make is that a number of entities had received few or no claims under their policies. Zurich, which was selling an average of approximately 96 policies a year, received no claims.

Auto & General which was selling an average of approximately 336 policies a year, received only one claim. Suncorp Life which was selling an average of approximately 367 policies a year received 10 claims. These rates may suggest that these products have extremely limited utility to consumers. Finally, a number of entities have ceased selling at least some of their accidental death products. Auto & General and Westpac Life have ceased offering their accidental death products, the former because it has ceased offering life insurance. ClearView, CMLA, Freedom and Zurich have all ceased selling at least one of their accidental death products in the last five years. This development may also suggest that entities are recognising that accidental death products have limited value to consumers.

Taken as a whole, the information provided to the Commission by the 10 entities is consistent with the view recently expressed by ASIC that accidental death products have substantial limitations and limited benefits for consumers. Commissioner, if that's a convenient time, we might take a short break before commencing the next case study.

THE COMMISSIONER: If I come back at 25 to midday.

MS ORR: Thank you, Commissioner.

THE COMMISSIONER: Yes.

ADJOURNED **[11.27 am]**

RESUMED **[11.36 am]**

THE COMMISSIONER: Yes, Ms Orr.

MS ORR: Commissioner, the next two case studies will consider the handling of claims under life insurance policies. And before we call the witness in relation to the first of those case studies, we want to make some observations about the handling of claims in the life insurance industry more generally. In our opening statement on Monday, we explained that we had sought witness statements from 10 life insurers, and we summarised what those insurers had told us about the sale of life insurance

products. As well as asking for information about the sale of those products, we also asked the insurers to explain their practices for handling life insurance claims, to provide us with data about the life insurance claims they had handled in the last five years, and to explain how they remunerate the personnel involved in handling life insurance claims.

We want to say something about what the 10 life insurers told us on these topics. The first topic that we will deal with is the insurer's practices for handling claims. The insurers told the Commission that a person who makes a claim under a life insurance policy must usually complete a claim form setting out certain information about the claim. The person will be assigned a claims manager or a claims consultant who will be responsible for the steps involved in handling the claim. Depending on the type of claim, it might be necessary for the claims manager to collect additional information about the claim. This is more likely in relation to a TPD or trauma claim where complex factual questions can arise in relation to whether the insured person is totally and permanently disabled or has suffered a particular defined medical condition.

The insurers told the Commission about the different sources of information and advice available to claims managers when handling claims. Among other things, claims managers can access medical advice from internal and external medical consultants, and can arrange for surveillance of claimants. We will return to the topic of surveillance later in the week. Once the claims manager has gathered information about the claim, he or she will then assess the claim against the policy terms. There are many different reasons why a life insurer might decide to deny a claim. Some of those reasons are specific to different kinds of life insurance policies and we will come to those shortly.

We asked the 10 life insurers to provide us with information about the most common reasons why they denied life insurance claims. Those reasons included lack of eligibility, either the claimant did not meet the eligibility terms or was not covered under the policy at the relevant date; because the claim definition was not met, for example, because the insured did not meet the definition of total and permanent disability or of a specified illness under the policy; because the claim related to a pre-existing medical condition which was excluded from the cover; because there was an applicable policy exclusion clause other than a pre-existing medical condition exclusion; or because the insurer denied the claim on the basis of non-disclosure or a misrepresentation by the claimant. Some of these reasons for declining claims will be examined in the next two case studies.

The second topic that we will deal with is the data that the life insurers provided us about the claims they've handled in the last five years. In our opening statement on Monday, we explained that there are four main types of life insurance policy: life cover, which pays a set amount of money to beneficiaries on the death of the policyholder, total and permanent disability or TPD cover which pays a lump sum to assist with rehabilitation and living costs if the policyholder becomes totally and permanently disabled, income protection cover which replaces income lost by the

policyholder through inability to work due to injury or sickness, and trauma cover, which provides cover to the policyholder if they are diagnosed with a specified illness or injury.

Each of these types of life insurance presents different issues when an insured person makes a claim. Some of these differences are illustrated by the data that the life insurers provided about the rates of declined claims, and the resolution times for claims for each of the four types of life insurance policy. Before we come to that data, we note that the different insurers recorded or accounted for the information that the Commission asked for in different ways. This means that there were differences in the ways that information about claims was reported across the different statements. The relevant differences are explained in detail in the insurers' statements.

Could we bring up RCD.0026.0002.0001. This chart shows the percentage of declined claims as a proportion of all claims received by the 10 insurers for each policy type for the 2017-18 financial year, with the exception of MetLife which provided data for the 2017 calendar year. As we can see from the chart, life cover claims are declined the least frequently of the four policy types at approximately 1.7 per cent, and trauma claims are by far the most frequently declined, with more than one in every 10 claims declined. I tender that document, Commissioner.

THE COMMISSIONER: Exhibit 6.111, chart of declined claims as percentage of all claims by product type, 1 July '17 to 30 June '18, RCD.0026.0002.0001, exhibit 6.111.

EXHIBIT #6.111 CHART OF DECLINED CLAIMS AS PERCENTAGE OF ALL CLAIMS BY PRODUCT TYPE, 1 JULY '17 TO 30 JUNE '18 (RCD.0026.0002.0001)

MS ORR: Could we please now bring up RCD.0026.0002.0002. This chart shows average or mean claim resolution time by policy type, being the number of calendar days that elapse between the date of receipt of the claim form by the insurer and the date on which a decision is made about the claim. As we can see from this chart, decisions are made most quickly in respect of life cover claims, averaging approximately 27.5 days after receipt of the claim. Decisions in respect of claims for TPD take significantly longer than the other three types of policies, averaging more than 92 days to resolve. Because of these differences between the time taken to resolve claims for the different types of life insurance policy, we want to make some further observations about each type of policy in turn. Could I tender this document, Commissioner.

THE COMMISSIONER: Average number of days to resolve claims by product type, 1 July '17 to 30 June '18, RCD.0026.0002.0002, exhibit 6.112.

EXHIBIT #6.112 AVERAGE NUMBER OF DAYS TO RESOLVE CLAIMS BY PRODUCT TYPE, 1 JULY '17 TO 30 JUNE '18 (RCD.0026.0002.0002)

MS ORR: And before we turn to the different types of policy in turn, we do note that the data provided by the 10 life insurers shows that the average time to resolve claims has decreased from 2013 to 2018, and this is broadly consistent across all four types of life insurance policies. The first type of policy cover that we will deal with is life cover. As we've mentioned, life cover pays a set amount of money to beneficiaries on the death of the policyholder. Earlier today, I tendered a number of statements concerning accidental death cover. While accidental death cover is a form of life cover in that it pays a benefit on the death of the policyholder, we've excluded accidental death cover from the data that we're about to discuss. Could we please show document RCD.0026.0002.0003.

Now, this chart shows for each of the 10 insurers the percentage of claims declined as a proportion of all life cover claims received in 2017 to 2018. And as we can see from the chart, the proportion of declined life cover claims ranges from .3 per cent of claims in the case of AMP, to approximately 4.4 per cent of claims in the case of Suncorp Life. I tender that document, Commissioner.

THE COMMISSIONER: Chart of declined life claims as a percentage of all life claims by entities, 1 July '17 to 30 June '18, RCD.0026.0002.0003, exhibit 6.113.

EXHIBIT #6.113 CHART OF DECLINED LIFE CLAIMS AS A PERCENTAGE OF ALL LIFE CLAIMS BY ENTITIES, 1 JULY '17 TO 30 JUNE '18 (RCD.0026.0002.0003)

MS ORR: Could we please show RCD.0026.0002.0004. This chart shows the average time, that is, the mean time it took each of the 10 insurers to reach a decision in respect of claims received under life cover policies received in 2017 to '18. As we can see from this chart, average resolution times ranged from 10 days for TAL to 78 days in the case of AMP. I tender that document, Commissioner.

THE COMMISSIONER: Chart of average days to resolve a life claim by entity, 1 July '17 to 30 June '18, RCD.0026.0002.0004, exhibit 6.114.

EXHIBIT #6.114 CHART OF AVERAGE DAYS TO RESOLVE A LIFE CLAIM BY ENTITY, 1 JULY '17 TO 30 JUNE '18 (RCD.0026.0002.0004)

MS ORR: The second type of policy is TPD cover which pays a lump sum, as we've said, to assist with the rehabilitation and living costs of a policyholder who becomes totally and permanently disabled. Where an insured person makes a claim

under a TPD policy, one of the main areas of dispute that can arise is whether the insured is totally and permanently disabled within the meaning of the policy. As explained in background paper number 29 published on the Commission's website, different TPD policies use different definitions of total and permanent disability. The most common requires that the insured is incapacitated to such an extent as to render him or her unlikely ever to engage in or work for reward in any occupation or work for which he or she is reasonably qualified by education, training or experience.

Some definitions require that the insured not be able to engage in any occupation. Others require only that the insured not be able to engage in his or her own occupation. Some also require that the insured be under regular medical care. Whatever definition is used, determining whether the insured meets that definition can involve complex questions of fact and disputed evidence. That is reflected in the higher average claim resolution times for TPD claims, as compared to other types of claims that we saw earlier. It's also reflected in a witness statement that we sought from MLC concerning its handling of four specific claims made under TPD policies.

In each of those four cases, the insured person commenced legal proceedings against MLC in connection with MLCs handling of their TPD claim. In each of those four cases, MLC later settled the claim with the insured. In each of the cases, MLC has accepted to the Commission that it engaged in misconduct. In the first case, MLC accepted that it had breached its duty to act reasonably in considering and determining whether the insured satisfied the TPD definition in the policy. MLC said that the claims assessor did not give sufficient weight to the reasonable and consistent explanations forthcoming from several sources that addressed the various matters that she considered adverse to the insured's claim. MLC also said that a preliminary view was taken toward the claim which proved resistant to the further evidence subsequently received.

In the second case, MLC accepted that it had breached its duty of good faith and fair dealing. It said that it had sufficient medical evidence supporting the insured's TPD claim to make a decision on that claim in late 2014, but unreasonably delayed in making that decision until December 2015. In the third case, MLC also accepted that it had breached its duty of good faith and fair dealing. It said that there was inordinate delay in assessing the claim marked by unnecessary repetition of work. It said that it had sufficient information to determine to admit the claim in November 2014 but did not make a decision until October 2015. It said that its delay suggested that it may not have had due regard to the insured's interests. MLC attributed this delay, in part, to the fact that the claim was handled by four different assessors over the life of the claim.

In the fourth case, MLC also accepted that it had breached its duty of good faith and fair dealing. It said that there was, again, inordinate delay in assessing the claim, marked by lengthy periods of inactivity and a failure by MLC to resolve critical issues that were identified at the stage of initial assessment. MLC said that the delay suggested that it may not have paid due regard to the insured's interests. In the second and fourth cases, MLC said that there were two main reasons for the

unreasonable delay that constituted a breach of its duty of good faith and fair dealing, and, therefore, misconduct in relation to the claim.

First, the process for oversight of claims files at the relevant time was deficient, in particular, because team leaders could not readily identify when no action had been taken on a file for a length of time. And second, the process for hand-over of files from one assessor to another was also acknowledged to be deficient. Commissioner, I tender the witness statement of Luke Hyde dated 28 August 2018 which deals with those four cases.

THE COMMISSIONER: That will become exhibit 6.115.

EXHIBIT #6.115 STATEMENT OF LUKE HYDE DATED 28/08/2018

MS ORR: Returning to the data provided by the 10 life insurers, could we please show document RCD.0026.0002.0005. This chart shows for each of the 10 insurers the percentage of claims declined as a proportion of all claims received in respect of TPD policies in 2017 to '18. As we can see from the chart, the rate of declined claims ranged from approximately two to three per cent for Westpac and AMP to approximately nine to 10 per cent for Suncorp Life and Zurich. I tender that document, Commissioner.

THE COMMISSIONER: Exhibit 6.116, the chart of declined TPD claims as a percentage of all TPD claims by entity, 1 July '17 to 30 June '18, RCD.0026.0002.0005, exhibit 6.116.

EXHIBIT #6.116 CHART OF DECLINED TPD CLAIMS AS A PERCENTAGE OF ALL TPD CLAIMS BY ENTITY, 1 JULY '17 TO 30 JUNE '18 (RCD.0026.0002.0005)

MS ORR: Could we please show document RCD.0026.0002.0006. Now, this chart shows the average or mean time it took each of the 10 insurers to reach a decision in respect of claims received under TPD policies received in 2017 to '18. And as we can see from this chart, the average duration between receipt of a claim and a decision ranged from less than 40 days for Zurich to 184 days in the case of Westpac. We note that although Westpac and AMP had the longest decision times, they also had the lowest rates of declined TPD claims. As we've noted, these are substantially longer periods to resolve a claim than for life cover.

However, the range represents a substantial improvement on the figures for the 2013 to '14 financial years where the average mean time for resolution of TPD claims ranged from 74 days for Westpac to 389 days for AMP. I tender the document, Commissioner.

THE COMMISSIONER: Exhibit 6.117, average days to resolve a TPD claim by entity, 1 July '17 to 30 June '18, RCD.0026.0002.0006, exhibit 6.117.

EXHIBIT #6.117 AVERAGE DAYS TO RESOLVE A TPD CLAIM BY ENTITY, 1 JULY '17 TO 30 JUNE '18 (RCD.0026.0002.0006)

MS ORR: The third type of policy is income protection cover which replaces income lost by the policyholder through inability to work due to injury or sickness. As with TPD cover, when an insured person makes a claim under an income protection policy, one of the main areas of dispute that can arise is whether the insured meets the relevant definition of illness, injury or disability under the policy. Another area of dispute that can arise concerns the determination of the insured person's pre-disability income. Some of the difficulties that can arise in connection with income protection claims are reflected in a witness statement that we obtained from CMLA concerning its handling of a specific claim under an income protection policy.

In the case described in that statement, CMLA accepted that its conduct fell below community standards and expectations, and amounted to misconduct. CMLA declined the insured's claim on the basis of an exclusion in his policy. The insured made a complaint to FOS which made a recommendation in his favour. CMLA agreed with the recommendation and paid the insured. CMLA said that it now considers that it failed to adequately investigate the circumstances of the termination of the insured's employment. It said that this provided the insured with a poor customer outcome and constituted a breach of duty by CMLA in that it failed to take reasonable care. Commissioner, I tender the witness statement of Malcolm Weir, dated 28 August 2018.

THE COMMISSIONER: That statement becomes exhibit 6.118.

EXHIBIT #6.118 STATEMENT OF MALCOLM WEIR DATED 28/08/2018

MS ORR: The difficulties that can arise in connection with income protection claims are also illustrated by the case studies that will be examined in the coming days concerning TAL. Returning to the data provided by the 10 life insurers, could we please show document RCD.0026.0002.0007. And this chart shows for each of the 10 insurers the percentage of claims declined as a proportion of all claims received in respect of income protection policies in 2017 to '18. And as we can see from this chart, the rate of declined claims for income protection claims was broadly consistent across the 10 insurers, ranging from less than three per cent for AMP, Westpac and AIA, to approximately 6.5 per cent in the case of Suncorp Life. I tender that document.

THE COMMISSIONER: Chart of declined income protection claims as a percentage of all income protection claims by entity, 1 July '17 to 30 June '18, RCD.0026.0002.0007, exhibit 6.119.

EXHIBIT #6.119 CHART OF DECLINED INCOME PROTECTION CLAIMS AS A PERCENTAGE OF ALL INCOME PROTECTION CLAIMS BY ENTITY, 1 JULY '17 TO 30 JUNE '18 (RCD.0026.0002.0007)

MS ORR: Could we please show document RCD.0026.0002.0008. This chart shows the average or mean time that it took each of the 10 insurers to reach a decision in respect of claims received under income protection policies received in 2017 to '18. And as we can see from this chart, the average number of days between receipt of a claim and a decision ranged from 23 days in the case of Zurich to approximately 50 days in the case of AMP and AIA. I tender this document.

THE COMMISSIONER: Chart of average days to resolve income protection claim by entity, 1 July '17 to 30 June '18, RCD.0026.0002.0008, exhibit 6.120.

EXHIBIT #6.120 CHART OF AVERAGE DAYS TO RESOLVE INCOME PROTECTION CLAIM BY ENTITY, 1 JULY '17 TO 30 JUNE '18 (RCD.0026.0002.0008)

MS ORR: The fourth and final type of policy is trauma cover, which provides cover to a policyholder if they're diagnosed with a specified illness or injury. One of the main areas of dispute that can arise in relation to claims made under trauma policies is whether the insured suffered from the illness or injury specified in the policy. Trauma policies contain lists of the different medical conditions in relation to which cover is provided, and each medical condition on the list is defined in the policy. Determining whether an insured person's condition satisfies a medical definition under a trauma policy can involve complex questions of fact and disputed medical evidence. Particular issues can arise where medical practices change, but the definition in the policy is not updated to reflect those changes. We will explore some of those issues in the next case study which concerns CMLAs handling of two specific claims made under trauma policies.

Could we please show RCD.0026.0002.0009. This chart shows for each of the 10 insurers the percentage of claims declined as a proportion of all claims received in respect of policies for trauma cover in 2017 to '18. And as can be seen from this chart, the rate of declined claims is significantly higher across the entities than for other policy types, ranging from approximately six to eight per cent for MLC and Zurich, to more than 28 per cent for MetLife. I tender that document.

THE COMMISSIONER: Chart of declined trauma claims as a percentage of all trauma claims by entity, 1 July '17 to 30 June '18, RCD.0026.0002.0009, exhibit 6.121.

EXHIBIT #6.121 CHART OF DECLINED TRAUMA CLAIMS AS A PERCENTAGE OF ALL TRAUMA CLAIMS BY ENTITY, 1 JULY '17 TO 30 JUNE '18 (RCD.0026.0002.0009)

MS ORR: Could we please show RCD.0026.0002.0010. This chart shows the average or mean time it took each of the 10 insurers to reach a decision in respect of trauma claims received in 2017 to '18. And as we can see from the chart, the average number of days between receipt of a claim and a decision ranged from 15 days for Zurich to 67 days in the case of MLC. I tender that document.

THE COMMISSIONER: Chart of average days to resolve a trauma claim by entity, 1 July '17 to 30 June '18, RCD.0026.0002.0010, exhibit 6.122.

EXHIBIT #6.122 CHART OF AVERAGE DAYS TO RESOLVE A TRAUMA CLAIM BY ENTITY, 1 JULY '17 TO 30 JUNE '18 (RCD.0026.0002.0010)

MS ORR: The third and final topic that we will deal with is the remuneration of claims handling personnel. We asked the 10 life insurers to tell the Commission about how they remunerate their claims handling staff. In particular, we asked them to explain what variable remuneration is available to claims handling staff, and what performance indicators are used to determine whether the staff receive remuneration and, if so, how much. When we first asked the life insurers for this information, many of them provided only limited examples of the remuneration arrangements for their claims handling staff.

When we asked again, it became clear from the information received that over the last five years, many life insurers have used performance indicators for their claims handling staff that reward the finalisation or closure of claims. We give some examples. Westpac told the Commission that for the performance review period in 2013, a measure called managing claims results had a weighting in its scorecard. It said that over time there was an awareness that this measure was not focused on the outcomes that Westpac wanted to achieve. It said that this measure was removed from scorecards for claims consultants and claims team managers in September 2015, and from the scorecard for the head of claims management, life insurance, in September last year.

CMLA told the Commission that in 2016, Ernst & Young conducted two reviews of the KPIs for claims personnel from the 2015 and '16 financial years. At this time, its scorecard included references to claims' financial outcomes, such as termination

rates and loss ratios. Ernst & Young considered that given the weighting of other KPIs in the scorecard, the inclusion of these measures was unlikely to have incentivised undesirable behaviour by claims staff. But following the report, CMLA removed any references to claims' financial outcomes from its scorecards.

ANZ told the Commission that before the 2017 financial year, the financial and discipline KPI for most OnePath claims staff generally included objectives in relation to the ratio of premiums received to payments made in respect of claims during the year, and the number of claims closed against overall business plans. In those years, the financial and discipline KPI accounted for 20 to 30 per cent of the employee's scorecard. TAL provided the Commission with copies of its KPIs for 2013 to 2017. In 2015, 50 per cent of TALs scorecard for claims' case managers depended on "business matters". One of the matters taken into account in determining a claim manager's performance in this area was whether he or she had achieved budgeted profit targets by managing claims to outcomes in line with assumptions underpinning loss ratio targets.

In 2016, 20 per cent of TALs scorecard for the claims team manager was managing claims to outcomes, which was measured by reference to whether the team manager met or exceeded particular team-based targets. In 2017, a similar measure entitled manage claims to outcomes achieved claim closure and open claim targets was given a 15 per cent weighting in the scorecards for the claims team manager, senior case managers, and claims case managers. Suncorp Life told the Commission that in the 2014 financial year, profit and financials had a 15 per cent weighting in its scorecard for case managers and claims advisers, and one of the relevant measures was expenditure on individual claims over a 12-month period.

For the 2015 to '17 financial years, profit and financials increased to a 40 per cent weighting. In the 2015 and '16 financial years, one of the relevant measures was claims resolution termination experience. In the 2018 financial year, profit and financials increased again to a 50 per cent weighting, and one of the relevant measures was a life claims resolution target. Suncorp Life also told the Commission about other benefits that it had provided to employees to encourage the resolution of claims. These included a claims resolution drive that it conducted in 2014 and a program called the Choice Awards that it conducted from mid-2016 to mid-2017.

Suncorp Life exhibited a document about the Choice Awards to its statement. And if we could bring that document up. SUN.1601.0400.0003. We see the document exhibited to Suncorp Life's statement, The Choice: Claims Resolution Drive. And if we turn to 0005 in the document, we see that the document shows that claims managers were awarded points for claims resolutions and for release of reserves, which insurance companies are required to hold while claims remain unresolved. And at 0006, over the page, we see that there were cash prizes for individuals and teams with the highest resolution rates and reserve release rates.

Commissioner, I tender the witness statements that set out the information that we have referred to. In relation to TAL, I tender the witness statement of Justin Delaney, dated 27 August 2018.

THE COMMISSIONER: That becomes exhibit 6.123.

EXHIBIT #6.123 STATEMENT OF JUSTIN DELANEY DATED 27/08/2018

MS ORR: In relation to AIA, I tender the witness statement of Michael Thornton, dated 23 August 2018.

THE COMMISSIONER: Exhibit 6.124.

EXHIBIT #6.124 STATEMENT OF MICHAEL THORNTON DATED 23/08/2018

MS ORR: In relation to MLC, I tender the witness statement of Sean McCormack, dated 27 August 2018.

THE COMMISSIONER: Exhibit 6.125.

EXHIBIT #6.125 WITNESS STATEMENT OF SEAN McCORMACK DATED 27/08/2018

MS ORR: The witness statement of Natalie Cameron, dated 28 August 2018.

THE COMMISSIONER: Exhibit 6.126.

EXHIBIT #6.126 WITNESS STATEMENT OF NATALIE CAMERON DATED 28/08/2018

MS ORR: And the witness statement of Russell Jansen, dated 6 September 2018.

THE COMMISSIONER: Exhibit 6.127.

EXHIBIT #6.127 STATEMENT OF RUSSELL JANSEN DATED 06/09/2018

MS ORR: In relation to Westpac, I tender the witness statement of Susan Houghton dated 28 August 2018.

THE COMMISSIONER: Exhibit 6.128.

EXHIBIT #6.128 STATEMENT OF SUSAN HOUGHTON DATED 28/08/2018

MS ORR: In relation to Zurich, I tender the witness statement of Timothy Howell dated 23 August 2018.

THE COMMISSIONER: Exhibit 6.129.

EXHIBIT #6.129 STATEMENT OF TIMOTHY HOWELL DATED 23/08/2018

MS ORR: And the witness statement of Sheriff Hamza dated 23 August 2018.

THE COMMISSIONER: Exhibit 6.130.

EXHIBIT #6.130 STATEMENT OF SHERIFF HAMZA DATED 23/08/2018

MS ORR: In relation to MetLife, I tender the witness statement of Gary Bailison dated 23 August 2018.

THE COMMISSIONER: Exhibit 6.131.

EXHIBIT #6.131 STATEMENT OF GARY BAILISON DATED 23/08/2018

MS ORR: The witness statement of Mark Rabigar dated 23 August 2018.

THE COMMISSIONER: Exhibit 6.132.

EXHIBIT #6.132 STATEMENT OF MARK RABIGAR DATED 23/08/2018

MS ORR: In relation to ANZ, I tender the witness statement of Gerard Kerr dated 23 August 2018.

THE COMMISSIONER: Exhibit 6.133.

EXHIBIT #6.133 STATEMENT OF GERARD KERR DATED 23/08/2018

MS ORR: And in relation to Suncorp, I tender the witness statement of Christopher McHugh dated 27 August 2018.

THE COMMISSIONER: Exhibit 6.134.

EXHIBIT #6.134 STATEMENT OF CHRISTOPHER McHUGH DATED 27/08/2018

MS ORR: And finally, in relation to AMP, I tender the witness statement of Megan Beer, dated 31 August 2018.

THE COMMISSIONER: Exhibit 6.135.

EXHIBIT #6.135 STATEMENT OF MEGAN BEER DATED 31/08/2018

MS ORR: Commissioner, I now call Ms Helen Troup from CMLA.

<HELEN THERESE TROUP, SWORN [12.12 pm]

<EXAMINATION-IN-CHIEF BY MR KARKAR

THE COMMISSIONER: Thank you very much, Ms Troup. Do sit down. Yes, Mr Karkar.

MR KARKAR: Thank you, sir.

Ms Troup, would you please inform the Commission of your full name?---Helen Therese Troup.

And would you give the Commission your business address, please?---1 Harbour Street, Sydney.

You're here to give evidence in response to a summons issued to you by the Commission. Is that correct?---Yes, that's correct.

Do you have the summons?---Yes, I do.

I tender that.

THE COMMISSIONER: Exhibit 6.136, the summons to Ms Troup.

EXHIBIT #6.136 SUMMONS TO MS TROUP

MR KARKAR: Now, Ms Troup, in respect of Rubric 6-17, you have made a statement?---That's correct.

That's correct?---Yes.

And it bears the number CBA.9000.0104.2000?---Yes, it does.

Are the contents of that statement true and correct to the best of your knowledge and ability?---Yes.

I tender that, if the Commission pleases.

THE COMMISSIONER: The statement of Ms Troup concerning Rubric 6-17 dated – Mr Karkar? Have we a date for the statement?

MR KARKAR: Yes. The latest one is dated yesterday, I believe, your Honour. Sorry, sir. 7 September.

THE COMMISSIONER: Statement of Ms Troup concerning Rubric 6-17 of 7 September '18, exhibit 6.137.

EXHIBIT #6.137 STATEMENT OF MS TROUP CONCERNING RUBRIC 6-17 DATED 07/09/2018

MR KARKAR: And, Ms Troup, with respect to Rubric 6-27, you made two statements, each concerning interactions with an insured of CommInsure. Is that correct?---Yes, it is.

Yes. The first one bears the number CBA.9000.0114.1000?---That's correct.

That's correct?---Yes.

And the second bears the number CBA.9000.0113.2000. Is that correct?---Yes, it is.

And the first of them is dated 28 August 2018, is it?---Yes.

Is that correct?---Yes.

And the second is dated 11 September 2018?---Yes.

Yes. Are the contents of each of those statements true and correct to the best of your knowledge and belief?---Yes.

I tender those, if the Commission pleases.

THE COMMISSIONER: The statement concerning Rubric 6-27 of 28 August '18 of Ms Troup is exhibit 6.138.

EXHIBIT #6.138 STATEMENT OF MS TROUP CONCERNING RUBRIC 6-27 DATED 28/08/2018

THE COMMISSIONER: The statement concerning Rubric 6-27 of Ms Troup of 11 September '18 is exhibit 6.139.

EXHIBIT #6.139 STATEMENT OF MS TROUP CONCERNING RUBRIC 6-27 DATED 11/09/2018

MR KARKAR: Thank you.

THE COMMISSIONER: Thank you, Mr Karkar. Yes, Ms Orr.

<CROSS-EXAMINATION BY MS ORR [12.16 pm]

MS ORR: Ms Troup, you've been the executive general manager of CommInsure since April 2014?---Yes, that's correct.

And CommInsure is the name of CBAs insurance business?---Yes.

And CBA has both a life insurance business and a general insurance business?---Yes.

And the life insurance business is run through a company called the Colonial Mutual Life Assurance Society Limited or CMLA?---Yes.

And the general insurance business is run through a company called Commonwealth Insurance Limited?---Yes.

But they're both run under the CommInsure brand?---That's correct, yes.

All right. Now, as executive general manager of CommInsure, you're responsible for both the life insurance business and the general insurance business?---Yes, that's correct.

And what does your role involve? What are the key duties in your role?---Well, I guess I'm the most senior leader of both businesses, and I guess that – if you put it into three categories, it's developing the strategy, implementing the strategy and leading the people.

Now, you've been put forward by CBA to give evidence about CommInsure's life insurance business, and about two specific claims made under CommInsure trauma policies?---Yes.

Now, in 2017 CBA sold its life insurance business to AIA?---Yes.

But at the moment, that business is still part of CommInsure?---Yes. The transaction hasn't completed yet.

Do you know why CBA chose to sell its life insurance business?---I think it's part of the broader strategy of simplifying the bank.

Now, I want to begin by asking you about one of the two specific claims that you've dealt with by statements, and the claim that I want to start with is the claim of a customer who suffered a heart attack. And the name of the customer is the subject of a non-publication direction. So I'm going to just refer to him as the insured?---Okay.

But you understand who I am referring to because it's the customer who had the heart attack?---Yes, I do.

Thank you. Now, the insured took out a total care plan policy with an entity called Colonial in 2000. Is that right?---Yes.

And what is the relationship between Colonial and CommInsure?---So CommInsure today is made up of a range of companies that have been acquired over its history. So Colonial is one of the old companies that is a part of our history.

And the policy for the insured gave him three distinct types of benefits, and they're explained in the information brochure for the policy which you've annexed to one of your statements?---That's correct, yes.

Can I take you to that document, which is CBA.0517.0211.0001. It's exhibit 2 to your statement dealing with the insured. And we see – we will see when that comes up that the brochure is dated November '99 to November 2000. So it would have been current when the insured took out the policy?---Yes.

And if we turn to 0022. We can see a key features statement for the total care plan policy. And under the heading The Plan we see that:

The Total Care Plan is a comprehensive insurance policy with three important benefits: life care, which pays a lump sum in the event of death or terminal illness, recuperator which pays a lump sum on the occurrence of a specified medical condition; and permanent care which pays a lump sum on total and permanent disablement

Now, the recuperator benefit, was that trauma cover?---Yes.

Yes. And the insured elected to have all three of these parts to his plan?---Yes.

And then if we look at 0025, we can see that the recuperator or trauma cover is explained. We see there, towards the top on the left-hand side, that:

Recuperator pays a lump sum on the survival of the insured for 14 days after the occurrence of one of the following.

?---Yes.

See that?---Yes.

And the first heading on the list that follows is Heart Disorders. And under that we see:

Heart attack.

And we also see further down:

Coronary artery angioplasty.

And both of those have an asterisks next to them?---Yes.

And we can see in the next column where the asterisks leads us to, a full description of the policy definitions begins on page 30 is above the asterisk. Then the asterisk says:

No recuperator benefit is payable if any of the conditions marked with an asterisk occurs or first becomes apparent within three months, known as the qualifying period of the date recuperator was added or reinstated to the policy.

?---Yes.

And then if we turn to 0030, we can see a list of recuperator policy definitions. And in the second column, we can see the definition of heart attack?---Yes.

Continuing:

The death of part of the heart muscle, myocardium, as a result of inadequate blood supply. The diagnosis is based on clinical electrocardiogram, ECG and biochemical assessments with the following criteria being present: (1) an electrocardiogram showing changes resulting from this occurrence and (2) a pathology test which confirms that cardiac enzymes have been elevated above generally accepted laboratory levels of normal.

That was the definition of heart attack in the policy?---Yes, it was.

So if the insured suffered a heart attack as defined here, he would be entitled to the sum insured under the recuperator component of the policy?---That's correct.

Now, the insured selected the amount of $100,000 for the recuperator or trauma cover?---Yes, that's correct.

Now, if we stick with this page at the moment, we can see another relevant definition on this page, which is coronary artery angioplasty. The definition for that condition:

This means the undergoing for the first time of angioplasty, atherectomy, laser therapy or insertion of a stent to the coronary arteries that is considered necessary by a cardiologist to treat coronary artery disease. Payment is limited to the lesser of 10 per cent of the sum insured or $25,000. The sum insured is then reduced by the amount paid, and the premium reduced accordingly. Other intra-arterial procedures or non-surgical techniques are specifically excluded. Benefits are only payable once under this condition.

So we see from that that if the insured had a coronary artery angioplasty, he would be entitled to a lesser benefit. In this case, it would have been $10,000 which was 10 per cent of the $100,000 that he had as the sum insured?---That's correct, yes.

And finally, if we turn to 0034, under the heading Guarantee of Upgrade, we see that the insured was told:

If future versions of this product are introduced, your policy will automatically be upgraded to the new contract within a reasonable timeframe (generally on the next policy anniversary date) provided the insured will not be disadvantaged by any terms and conditions of the new policy.

?---Yes.

So the medical definitions in the policy would be updated from time to time?---That's correct, yes.

And you tell us in your statement that if a medical definition was updated, the insured would be entitled to rely either on the definition that applied at the time of purchasing the policy or an updated definition. Is that right?---That's correct, yes.

And an insured person would not be, we see from this page, disadvantaged by any change of definition?---Yes.

Now, these terms that I've taken you to were reflected in the policy document itself, which you've also exhibited to your statement?---Yes.

Now, the definition of heart attack was updated over the following years, wasn't it?---Yes.

And you've set out the different definitions that applied in annexure A to your statement. Can I take you to that. It's CBA.9000.0114.1000, at 1017 to 1018. 1017 to 1018. I apologise if I got the number wrong. We've got the first page up, Ms Troup, and I think the second will be following. So we can see from the left-hand side at 1017 the definition of heart attack that applied when the insured took out the policy at the top of the page?---Yes.

And we can see that there was a change in October 2002?---Yes.

And then a further change in July 2005?---Yes.

And then over the page, in August 2013 we can see that the name of the condition changed from heart attack to heart attack of specified severity?---Yes.

But the definition otherwise remained unchanged from the July 2005 definition?---That's right.

And then in March 2016, there was a further change to the definition?---Yes.

But other than the change to the name, there was no change to the definition during the period from July 2005 to March 2016?---That's right.

So almost 11 years?---Yes.

Now, I'm going to come back to the reasons why that definition was not changed in that period, but if we look at the definition that applied during that 11 year period between 2005 and 2016, we can see that it required medical evidence of a diagnosis based on either:

> *...the elevation of cardiac enzyme CK-MB or elevation in levels of troponin 1 greater than 2.0 micrograms per litre or troponin T greater than 0.6 micrograms per litre or their equivalent.*

And certain other things. Or:

> *Other medical evidence that would demonstrate damage had occurred to at least the same degree of severity as would be evidenced by the medical evidence required under the first bullet point.*

?---Yes.

Now, I appreciate that you're not a doctor and nor am I, Ms Troup, but are you familiar in general terms with this definition?---Yes, as long as you don't get too specific, yes.

It will be a race to see which of us knows least about these matters, Ms Troup. One thing I do know – and you can correct me if I'm wrong – is that troponin is a protein that is found in heart cells is that right?---You might be ahead of me on that one. I understand it is something that is released into the bloodstream so, yes, I think we're both on the same path.

And that measurements of troponin in levels can be used in the diagnosis of heart attacks. Is that right?---Yes.

I am going to come back to the definition set out in this annexure but I want to first continue with the case of the specific person, the insured whose policy terms we were just looking at. That insured person made a claim under his policy in January 2014?---Yes.

And you've exhibited a copy of his claim form to your statement. It's exhibit 5, CBA.1004.0096.0503. So this is the insured's claim form. And if we turn to the second page, 0504, we can see that this page is headed Details of Trauma Conditions Claimed. And the insured has ticked heart attack. Do you see that?---Yes, I do.

And recorded that he was hospitalised for this on 5 January 2014?---Yes.

And do you know – from the documents that you've annexed to your statement, I think you do – that upon being hospitalised, the insured was told that he would either need to have bypass surgery or have stents inserted?---Yes, that's what we were told, yes.

And he elected not to have bypass surgery but to have the stents inserted, which happened in three separate operations over the following weeks?---Yes.

Now, on the next page, 0505, which is details of trauma conditions claimed continued, we see that the insured has also ticked coronary artery angioplasty?---Yes.

Now, when CommInsure receives a claim under a life insurance policy like this one, the claim is assigned to a case manager. Is that right?---Yes, that's correct.

And can you explain in general terms the process that the case manager who had this claim would have followed in assessing this claim?---Yes. Well, the first step on receipt of the claims form would be to make an assessment of whether all the relevant medical material has been provided. So you're looking for the evidence of the – that relate to those definitions that we spoke of a few moments ago. If they feel that they need more information, they will go and seek that information, either

through the insured or through a hospital or doctor directly. Once they feel they've got enough information, particularly on trauma, in general terms, it would then go to our medical officer to help with the assessment of how does the diagnostic results reflect in the definition for some advice. Then it would return to the case manager and use that to make a decision on whether to accept or decline the case. Then there are protocols in terms of delegation so I'm not sure if you want me to continue.

No, I think that's fine. As to who can make the decision. Is that what you mean?---Yes. So if there's a recommendation, depending on their delegation they may have to have someone else review that claim.

But at that point the decision is made about whether to approve or deny the claim?---Well, it – if it has to go up a level for delegations.

I understand?---But yes.

So it may go to another person to approve that decision but that's the decision point. Is that right?---Yes. Yes.

So here the insured was making a claim on the basis that he had had a heart attack, and coronary artery angioplasty and, therefore, CommInsure assessed his claim against the definitions of those two conditions in the policy. Is that right?---That – yes, that's right.

And the case manager sought the opinion of one of CommInsure's medical officers, Dr Alan Carless on that point?---Yes, that's correct.

What's the relationship between a case manager and a medical officer within CommInsure?---What – what do you mean by relationship? So - - -

They work independently from each other. Is that right?---Yes. So I would have to think about what period of time that is, but the medical officers report through a different team. I think at that time they came through a team called business services which was different from the medical – sorry, the claims team.

Is the role of the medical officer to assist the case manager to understand the medical evidence but it's the case manager who's ultimately responsible if they have the appropriate delegations for making the decision on the claim?---That's correct, yes.

Okay. Now, Dr Carless' opinion was that the insured met the definition for coronary artery angioplasty?---That's right.

But that there was not enough evidence that he met the definition of heart attack?---That's right.

And the case manager told the insured this?---Yes, I believe so.

And the insured then provided more medical information to CommInsure?---Yes.

And after reviewing that further information, Dr Carless' opinion was that the insured still didn't meet the definition of heart attack under the policy?---That's right.

And, again, the insured was told that?---Yes.

And the insured then gave further medical information?---Yes.

And the information showed, among other things, that the insured's level of troponin 1 rose from .4 micrograms per litre to 1.9 micrograms per litre?---Yes.

And we saw from the definition of heart attack that the first way of meeting that definition was to have a level of troponin 1 greater than 2.0 micrograms a litre?---That's right.

And Dr Carless considered this material again?---Yes.

And he asked for more information?---Yes. I must say I probably lost track of the number of referrals but if that's – if we're in the right line yes, there - - -

These are all referred to in your statement. I'm at paragraph 47?---Thank you.

If that assists in your statement at the moment?---Thank you, yes.

And he considered the further information that was provided and gave another medical opinion?---Yes.

And you've exhibited a copy of that opinion to your statement. I want to take you to that. It's exhibit 12. CBA.1004.0096.0964. And we can see from this document that it sets out the case manager's synopsis of the case and the medical officer's response?---Yes.

Is that right?---Yes.

And we see the medical officer's opinion at the bottom of the page – and perhaps if we could have the second page brought up on the other side of the screen. We see that he says right down the bottom of the page:

> *On the evidence, he has had a small rise in cardiac enzyme CK but not any reported rise in CK-MB and a rise in troponin 1 but to a level less than 2.0 micrograms per litre. There are no confirmatory new ECG changes supporting the diagnosis of myocardial infarction. Further investigations are not required to assist in determining the diagnosis. This does not meet the policy definition for heart attack of specified severity.*

?---Yes.

So that was Dr Carless' opinion. And on the basis of that opinion in April 2014, CommInsure denied the insured's claim to be paid the full trauma benefit on the basis of his heart attack because he didn't meet the heart attack policy definition?---That's right.

But CommInsure decided to pay a partial trauma benefit of $10,000 because he did meet the definition of coronary artery angioplasty?---That's right.

Now, after this, the insured got in touch with CommInsure. He said that he had spoken to his GP who was amazed that CBA did not pay under the heart attack definition. We know that from an email annexed to your statement?---That's correct.

You've seen that?---Yes, I have.

And in response, CommInsure sent the insured a letter explaining the decision and responding to certain questions that the insured had posed, but no change was made to the decision?---That's right.

And then in June 2014, the insured made a complaint about CommInsure's decision?---Yes.

And that complaint was handled by CBAs group customer relations team rather than CommInsure. Is that right?---Yes. Did you say July 2014? Is that what you said?

Yes, I did?---Yes, yes.

In paragraph 68 of your statement?---Yes. Thank you.

So the complaint was handled by the group customer relations team, which is different to CommInsure. Is that right?---Yes, from a reporting perspective, yes, they're in a different part of the group.

But part of CBA?---Yes.

Yes. So it was an internal dispute resolution process?---Yes.

So when a customer makes a complaint that relates to an insurance policy, is that complaint generally handled by the group customer relations team?---Yes.

And what involvement does CommInsure have in the handling of that complaint?---Well, if GCR feel they need advice or opinions from CommInsure, they seek it. So it depends on the nature of the – the complaint.

So in this case, the decision remained after the complaint, a decision was made not to alter it?---That's right.

And the insured did not make a complaint to FOS at this time. I will come to later events. And by July 2014, CommInsure considered that the case was resolved. Is that right?---Yes.

Then I want to take you forward a couple of years to March 2016. In the first week of March 2016, ABCs Four Corners program and Fairfax Media reported on concerns about CommInsure's life insurance business. Do you recall that?---Yes, I do.

And are you familiar with the media reports at that time?---Yes, I am.

You were the executive general manager at the time those reports were published?---Yes, I was.

And those media reports raised a number of concerns – and I don't intend to canvass all of them – but one of the concerns related to the definition of heart attack in CommInsure's trauma policies and a concern that it was out of date?---That's correct.

And in particular, the concern was that the definition required troponin 1 levels of above 2.0 micrograms per litre?---That's right.

And that this requirement was out of date and didn't reflect developments in medical science?---That's right.

And on 5 March 2016, the day after the Four Corners Program went to air, CommInsure issued a media release dealing with its product definitions?---Yes.

And you've annexed that media release to your statement. It's exhibit 37, CBA.0001.0508.0647. Sorry, I'm just finding it, Ms Troup, because there are seven documents annexed behind that tab of your statement – or perhaps – there are seven. And it's the seventh document I'm going to. You can see it on the screen?---Yes.

And we see that the media release said, in relation to the heart attack definition, do you see under the heading Trauma Heart Attack Definition:

> *CommInsure's trauma heart attack definition pays for severe heart attacks and considers a range of medical factors when assessing a claim, not just the troponin levels. Medical advances and improvements in detection technology mean our current definition needs to be updated. We have already commenced work on updating this definition and it was scheduled for implementation in October 2016. This has now been accelerated to be completed as soon as possible.*

So that was the information in the media release as of that date, 5 March. And then five days later, on 10 March, CommInsure issued another media release which you've annexed to your statement. It's the sixth document behind this tab.

CBA.0001.0508.0643. And if we turn to 0644, we see under the heading Improving Our Offer to Customers:

> *CommInsure has accelerated the planned upgrade of its heart attack and severe rheumatoid arthritis definitions in its trauma product. This upgrade will be released in a product disclosure statement by the end of March but coverage will be backdated and apply for all claim events from May 2014 onwards. May 2014 was the date of the last relevant product disclosure statement for the trauma product. CommInsure has also committed to a more regular review of the life insurance offering to ensure definitions reflect evolving medical standards and practices.*

So at the time of these reports, CMLA was already planning an update to its heart attack definition?---That's correct.

That update was due to take effect in October 2016?---Yes.

But CMLA decided to bring it forward to March 2016?---Yes.

And it decided to backdate the application of those changes to 11 May 2014?---Yes.

Now, I want to come back to that decision and deal with that in some detail a bit later. But we see from the annexure to your statement, which I had on the screen earlier, that the update occurred on 10 March 2016?---Yes.

The same date as this media release. And the new updated definition which was backdated to May 2014 did not include the requirement for medical evidence that troponin 1 levels exceeded 2.0 micrograms per litre?---That's right.

Instead, it focused on a diagnosis confirmed by a cardiologist, and evidenced by:

> *...a typical rise and/or fall of cardiac biomarkers, with at least one value above the 99th percentile of the upper reference limit.*

?---Yes.

And just to assist, I will have that brought up on to the screen. CBA.9000.0114.1018 is the part of the annexure to your statement. And it's 1000, the first page of that document. We have it there. So we see the definition as of March 2016, no longer a requirement for troponin 1 levels to exceed 2.0 micrograms per litre. And we see instead a reference to at least one value above the 99th percentile of the upper reference limit for the cardiac biomarkers?---Yes.

Okay. Now, on 9 March 2016, the day before this, and a few days after the media reports were published, the insured who we were discussing earlier, made a complaint to the Financial Ombudsman Service about his trauma claim with CommInsure?---That's correct, yes.

And you've exhibited a copy of the notification of the complaint to your statement as exhibit 20, CBA.0001.0508.0094. Now, at the bottom of that page, if we could have the dispute summary, which is right at the bottom of the page, enlarged. We see the dispute summary provided to FOS by the insured was:

> *Trauma claim for heart attack. At the time of heart attack I was given option of triple bypass or stents whilst on the operating table. The stents ended up being done on three separate occasions within two months of heart attack. Public hospital evidently did not do a specific type of troponin blood test so available readings apparently did not meet CommInsure's definition of heart attack, despite plenty of –*

If we could go over the page:

> *...despite plenty of doctor file notes to the contrary. Resulted in only a partial trauma claim being paid. I have misplaced my copy of the complaint letter and their response.*

So that was the summary of the complaint put forward by the insured in FOS?---That's correct.

And the FOS complaint was also handled by group customer relations in CBA. Is that right?---Yes.

And with input from CommInsure?---Yes, they did ask – you know, get the claim file from us, yes.

Was that the only input from CommInsure?---No. They also asked for medical advice.

Yes. You tell us in your statement that a customer resolution manager – that's someone from group customer relations, is that right?---That's right.

Spoke to the insured about his complaint. This is paragraph 75 of your statement?---Yes.

And the insured had seen the media reports about the heart attack definition and he wanted his claim reconsidered?---Yes.

And the customer resolution manager asked the CommInsure quality assurance team to review the claim?---Yes.

And they referred it to another internal medical officer, Dr Carolynne Darby for her opinion on whether the insured met the new updated heart attack definition?---That's right.

Now, she was not able to say whether he met the updated definition without further information?---That's right.

So the customer resolution manager asked for more information from the insured?---Yes.

But he also told him that the updated heart attack definition didn't apply to his claim, because his claim was made in January 2014 and the new definition only applied from 11 May 2014?---That's right.

So wasn't this likely to confuse the insured or raise his hopes because on the one hand he was being told that the new updated definition didn't apply to him, but on the other hand, he was being asked to provide information for consideration by the medical officer?---Yes.

You accept that that was likely to cause confusion?---Yes.

And to raise the hopes of the insured?---Yes.

And then in early April, the customer resolution manager discussed the claim with Dr Carless, the original medical officer?---Yes.

And the following day, Dr Carless gave an opinion in writing, and you've exhibited a copy of that opinion to your statement. It's exhibit 26. CBA.0001.0508.0475. And we see an email there from Dr Carless to a person in group customer relations. He says at the top:

> *I have reviewed the medical evidence relating to a trauma claim, summarised as follows.*

He then sets out the evidence. And towards the bottom of the page he said:

> *You verbally requested a point by point assessment of this claim under TCP 08/2013 definition of heart attack.*

So is that a reference to the 2013 definition in the annexure to your statement which was in place at the time of the claim?---Yes.

And over the page, at 0476, we see a table with his point by point breakdown. And underneath that table, we see Dr Carless says:

> *Overall, the condition did not meet this definition.*

?---Yes.

And then he says:

You also asked that I comment on whether the following heart attack definition would be met.

And he then set out another definition. Is that the updated definition introduced from March 2016?---Yes.

And underneath that definition he set out his reasoning. He says:

There was death of part of the heart muscle (myocardium) as a result of inadequate blood supply to the relevant area confirmed by a cardiologist. The death was evidenced by a typical rise and/or fall of cardiac biomarkers with at least one value above the 99th percentile of the upper reference limit, assuming the intended meaning of the latter phrase is that there was at least one value above the 99th percentile of the relevant reference range. The cardiac biomarkers thus elevated were troponin 1 and CK. There were signs and symptoms ischemia consistent with a myocardial infarction. Overall, the condition does meet this definition.

?---Yes.

So the insured did meet the updated definition?---Yes.

But that definition only applied to claims made after 11 May 2014?---Yes.

And his claim had been made three months before that time in January 2014?---That's correct.

And having received this opinion from Dr Carless, the customer resolution officer suggested to his superior that consideration should be given to making an ex gratia payment because the claim was only a few months before the definition?---That's correct.

But no ex gratia was made?---That's right.

Why not?---At the time, the consideration was the claim didn't meet the definition at the time and it wasn't considered appropriate for ex gratia.

Despite this claimant missing out on the new definition by three months, and falling very short of the 2.0 micrograms of troponin required in the current definition because he had got to 1.9 micrograms of troponin?---So there's two elements in that. On – on the first element, yes, you're right. On the second element, if I – I interpret the 1.9 a little bit differently. If I could explain. And I think it's referred to in the exhibit that you've got shown. The way it has been explained to me is the actual rise in troponin due to the heart attack is the lower number. The number that goes to 1.9 is due to the angioplasty and so therefore it doesn't meet the definition. So the characterisation of it just being below 2 is not what I understand. But your original question in terms of the three months, that is correct.

You accept the first proposition?---Yes.

But not the second - - -?---Yes.

- - - in my question. I understand. Now, could I ask that you look at exhibit 27 to your statement, CBA.0001.0508.0118. So a few days after Dr Carless gave this medical opinion, the customer resolution officer provided CommInsure's response to the insured's complaint to FOS. And this is the email that the customer resolution officer sent to FOS?---Yes.

Now, at 0119, he told FOS, towards the bottom of the page, that it was still CommInsure's position that the insured did not meet the 2013 definition of heart attack?---That's right.

And in the first page, 0118, we see towards the top of the page that he requested that FOS:

> *Not progress the dispute because the question in dispute was whether CommInsure would pay the claim outside of the policy terms.*

?---Yes.

And, therefore, he wanted to invoke FOSs discretion under clause 5.2A of its terms of reference not to progress the dispute on the basis that it related to a matter of commercial judgment for CommInsure?---That's right.

And FOS rejected that challenge to their jurisdiction?---Yes, they did. Appropriately.

And they sent CommInsure a letter saying that they would proceed with the dispute?---That's right.

Is it standard practice for CBA to look for ways to challenge FOSs jurisdiction when a customer makes a complaint to FOS?---I don't believe so.

Do you know why it was done in this instance?---No.

And then a few weeks after the letter from FOS advising that it would be proceeding with the complaint, on 6 May the FOS case manager who was responsible for the dispute sent a letter to CommInsure which you've annexed as exhibit 31. That's CBA.0517.0208.1914. And we see from the first page of this letter that the FOS case manager set out her understanding of the dispute?---Yes.

And then if we turn to 1916, the third page of the letter, we can see a discussion of the updated medical definition. We see that the case manager said at the top of the page:

CommInsure has recently announced on its website the following change of definition of heart attack for its life and loan protection policies to take effect for new events commencing 11 May 2014.

And she then set out the definition. And further down the page underneath the hyperlink, she said:

The insured's heart attack occurred in January 2014 which predates the stated commencement date of the May 2014 policy definition as announced by CommInsure. Under paragraph 8.2 of our terms of reference, when deciding a dispute and whether a remedy should be provided FOS will do what in its opinion is fair in all the circumstances having regard to each of the following: legal principles, applicable industry codes or guidance, good industry practice, and previous relevant decisions of FOS. In accordance with paragraph 8.2, we advise that we will be reviewing whether the facts of the insured's dispute should also be considered under the May 2014 definition.

And then over the page at 1917, the case manager asked CommInsure to provide certain supporting information. And at point 3 in that list she said:

In your response dated 11 April 2016, you referred to a medical opinion by CommInsure's chief medical officer against the 2013 policy definition. Please provide a copy of this opinion and any other opinions relevant to this dispute.

And at point 4 she said:

Please obtain and provide a statement from CommInsure's chief medical officer in which he conducts a review and provides an opinion of the insured's medical circumstances against the May 2014 policy definition.

Now, at that time, Dr Carless had already provided an opinion about whether the insured met the May 2014 definition, hadn't he?---That's correct.

Now, is it fair to say that the receipt of this letter was a matter of some concern within CommInsure?---Yes.

The customer resolutions manager thought it was highly illogical and unreasonable, the position that FOS was taking, and potentially posed a systemic issue for CommInsure?---Yes.

And his boss, the head of priority customer resolutions and quality, thought it was very challenging for FOS to have taken this approach and that CMLA should push back on this approach?---Yes.

Now, on 19 May after consulting within group customer relations, the customer resolution manager responded to this letter from FOS. And you've annexed that response as exhibit 32 to your statement, CBA.0001.0508.0179. And when we –

before we go to that, can you explain, Ms Troup, what the matter of concern was created by FOSs approach to the handling of this dispute?---I believe the matter of concern was FOS determining what the terms of the contract were.

Is that how you interpret the request that FOS made for the information contained in the medical opinions and its indication that it wanted to assess whether the insured met the May 2014 definition?---Yes. I would express it as an interpretation that FOS were looking to decide when the heart attack definition should apply.

And CommInsure was unhappy with that?---Yes.

And why?---Because, I guess, a tenement of our policies are the contract, and so if FOS could determine when to apply a definition from, that would make it fairly challenging for us to run our business.

I see. So in this communication that we have on the screen now, on 19 May, under the heading Medical Opinion Relating to the Claim, the customer resolution officer responded to the request for the medical officer's opinions. He said at point 5:

> *I have enclosed our medical officer's review of the claim under the heart attack definition which applied from policy commencement until 10 May 2014.*

So under the old definition:

> *We decline your request to obtain or provide a medical report to assess whether the applicant would satisfy the upgraded definition of heart attack. The insured suffered the heart attack in January 2014 and has been assessed under the policy terms which applied at that time.*

And there was a document enclosed with this email that was being referred to in these paragraphs as the second document – it's the second document within the exhibit. If we go to CBA.0001.0508.0195, we see that the document annexed to the email that group customer relations sent to FOS, was a copy of the email that Dr Carless had sent to that customer resolution officer in April containing his medical opinions. We looked at that email before, you will recall?---Yes, we did, yes.

You will recall that the first page had Dr Carless' summary of the history of the matter. And part of the table with the point-by-point assessment of the claim under the old definition. And then if we go over the page to 0196, we see over the page Dr Carless' conclusion that the insured did not meet the 2013 definition. And then the remainder of the medical opinion was redacted?---That's right.

This is the form in which it was provided to FOS?---Yes.

So if we bring up side by side CBA.0001.0508.0475 at 0476 next to this page. We can see that the part of the medical opinion that was redacted was Dr Carless' opinion that the insured did meet the updated definition of heart attack. That was

blacked out in the version of the medical opinion that was provided to FOS?---That's right.

All right. I want to ask you a series of questions about why that occurred, Ms Troup, but perhaps that's an appropriate time to break, Commissioner.

THE COMMISSIONER: If we come back at 2.15.

MS ORR: Thank you, Commissioner.

THE COMMISSIONER: 2.15.

ADJOURNED **[1.06 pm]**

RESUMED **[2.15 pm]**

THE COMMISSIONER: Yes, Ms Orr.

MS ORR: Ms Troup, I want to take you back to the email we were looking at before lunch, the email from the group customer relations officer to FOS, which is CBA.0001.0508.0179. Now, I had shown you before lunch the attachment to this email, which was the medical opinion of Dr Carless with the part of the medical opinion that related to the updated definition blacked out?---Yes.

You recall that?---Yes, I do.

Now, if we return to the email that annexed that medical opinion and look again at paragraph 6, we can see that the explanation given by the customer resolution officer was:

> *We decline your request to obtain or provide a medical report to assess whether the applicant would satisfy the upgraded definition of heart attack.*

Now, do you accept that that sentence conveyed that CommInsure did not already have a medical opinion about whether the insured met the updated definition?---Yes.

When CommInsure did, in fact, have that opinion, and it was favourable to the insured?---That's right.

But a decision was made to redact that part of the medical opinion from the version that was provided to FOS?---That's right.

And this email to FOS was misleading, was it not?---Unfortunately, yes.

So by sending this email, the group customer relations officer misled the Financial Ombudsman Service into thinking that CommInsure did not have a medical report on whether the insured would satisfy the updated heart attack definition. You accept that?---Yes.

Was that acceptable, Ms Troup?---Absolutely not.

Why did it occur?---That's a difficult question to answer. I think – I think the intent was they didn't feel that definition was relevant to the assessment but it's not a decision I would have made.

Well, the assessment of relevance was not one for the group customer relations officer to make, was it?---I agree.

Now, the same email again included a challenge by CommInsure to FOSs jurisdiction to entertain the dispute?---Yes.

And, again, there was a suggestion that this dispute was outside FOSs jurisdiction to consider whether or not the insured met the updated definition?---That's right.

Why did CMLA, or CommInsure, persist with its argument that the dispute was outside FOSs jurisdiction when FOS had already considered and rejected that argument?---I understand from the review of the documents that FOS had replied refuting the jurisdiction, but this particular team member hadn't seen that. So I think there might have been a – a gap in understanding and so they were continuing to pursue their original position.

And how could it be that the group customer relations officer handling the communications with FOS could not have seen an important piece of correspondence with FOS from that earlier time?---The way it has been explained to me is the email had come in while the person was on leave and it hadn't been registered into their case management system until later.

And should it have been?---Absolutely, yes.

Yes?---That was another mistake.

So that's another part of this communication with FOS that was regrettable?---Yes.

Yes. And do you accept that CMLA should not have persisted with its challenge to FOSs jurisdiction to consider this dispute?---Yes, not in the way that they did there, no. That shouldn't have happened.

Once FOS had determined that point, CMLA should have accepted that determination?---That's right.

Yes. Now, a couple of months after this email on 29 July FOS wrote to CMLA again and you provide that letter as exhibit 33 to your witness statement. CBA.0001.0508.0357. And we see from this communication that FOS provided CMLA with further information it had received from the insured, and had asked for CMLAs comment on that information?---Yes.

Do you see that?---Yes.

And FOS also asked for an unredacted copy of the medical opinion of Dr Carless, or an explanation of the basis for the redaction. Do you see that down at the bottom of the page?---Yes, I do.

And over the page at 0358, FOS also asked for information, towards the bottom of the page about:

> *How CMLAs heart attack definition compared to the state of medical practice in August 2013.*

?---Yes.

And FOS asked CMLA in this letter:

> *How CMLAs heart attack definition compared to other insurers' definitions of heart attack at that time.*

?---Yes.

And over the page at 0359, we see that FOS also wanted to know how CommInsure justified its decision to backdate the definition to May 2014 rather than to August 2013, or an even earlier date?---Yes.

Now, this request for information from FOS caused further concern within CommInsure?---Yes.

What was the concern this time?---It would be the same concern in terms of the contract terms.

So at this time, CommInsure decided to put together a working group to develop a response to this request for information?---Yes.

And to refute FOSs position on these matters?---On those last matters, yes, in terms of the definition, yes.

So CommInsure was concerned that FOS would look into the appropriateness of its decision not to update the heart attack definition in the three years between 2013 and 2016, as well as the decision only to backdate to May 2014?---Yes.

Do you agree with that?---Yes.

So rather than responding to FOSs request for information, the group customer relations team decided to enter into some discussions with FOS?---Yes.

And to try and convince them to change their approach?---I think to explain the concerns, yes.

On 9 August, there was a meeting between representatives of group customer relations and the lead ombudsman and another senior representative of FOS. And in that meeting, the challenge to FOSs jurisdiction was again made?---Yes.

Was that an appropriate thing for CMLA to have done in that meeting, Ms Troup?---No.

So you agree that your evidence earlier was that that position should not have been a position that CMLA persisted with after the first determination of the issue by FOS?---Yes.

And why was the challenge to jurisdiction made in this meeting, on 9 August?---Because the team had continued to support their original decision – or the – sorry, their original position.

But was it known by the people who participated in the 9 August meeting that a challenge to jurisdiction had been made and determined by FOS?---Actually, I'm not sure when that reply from FOS was acknowledged. Apologies. I'm not sure of the timeframe.

But we saw it was some time earlier in the chronology that FOS determined that it was rejecting the challenge to its jurisdiction?---Yes. And – and that document hadn't been observed by the case manager at that time. What I'm unsure of, I would have to relook through the files of when they actually acknowledged that - - -

But it's possible they still didn't know at the time of this meeting?---Yes.

Is that - - -?---I would have to check, sorry.

Okay. So you're unable to say whether they didn't know that FOS had made that determination, or whether they knew and decided to persist with the challenge to jurisdiction?---Yes, that's right.

Okay. But FOS wouldn't change its approach after that meeting. Do you agree with that?---Yes.

And after the meeting FOS sent another letter to CMLA re-stating the request for information that it had made in this letter, which is still on the screen?---Yes, it clarified the requirements following that meeting, yes.

Well, it reiterated its request for an unredacted copy of the medical opinion?---Yes.

Do you agree with that?---Yes.

And on 19 August 2016 CBA responded to that request for information, and you've given us that response as exhibit 35 to your statement, CBA.0001.0508.0553. Now, there are some annexures to this email communication – I'm sorry, we've got – we've moved to the letter from 19 August 2016, which had an annexure, which also appears in your exhibit, which was an unredacted copy of the medical opinion. Is that right?---Yes.

So more than three months after FOS had first requested that opinion, on 6 May, CommInsure provided the opinion in an unredacted form for the first time on 19 August?---That's correct.

And if we turn – if we could have on the screen both the first page, 0553, and the second page, 0554, we see that although CommInsure provided the unredacted medical opinion, instead of responding in detail to FOSs request for information about how CommInsure's heart attack definition compared to the state of medical practice in August 2013 and how it compared to the definitions of heart attack used by other insurers at that time, CBA requested another meeting with FOS to explain its position about those matters?---Yes.

So no information was provided in this letter on either of those matters?---That's right.

And instead of providing an explanation of why CommInsure chose to backdate the definition to May 2014, CommInsure said to FOS in this letter that those questions were not relevant. Do you see that on 0554:

> *We consider these questions are not relevant to the assessment of the insured's claim.*

?---Yes.

Now, Ms Troup, are you familiar with ASIC regulatory guide 139?---Yes.

And you know that that's the regulatory guide that deals with ASICs approval and oversight of external dispute resolution schemes like FOS?---Yes.

Now, if we could bring that document up. It's RCD.0021.0016.0019. So this is regulatory guide 139. And if we turn to pages 0043 and 0044. We see that the regulatory guide says, at the bottom of the first page and extending to the top of the second page:

> *There is a general presumption that a scheme member does not have the discretion to withhold documents or information from a complainant or*

disputant of the scheme. We recognise, however, that there may be some limited circumstances where the scheme member might appeal to the scheme to withhold certain information.

Now, CommInsure was a scheme member with FOS?---Yes.

And we see that it goes on, the regulatory guide, to say "These circumstances" – being the circumstances where the scheme member might appeal to withhold certain information:

> *... might include where the release of information would endanger a third party or where it would compromise the scheme member's general security measures.*

You were familiar – you are familiar with these requirements in the ASIC regulatory guide?---Yes, I am.

And I assume – and you can tell me if my assumption is incorrect – that the members of the group customer relations team who deal with FOS on a regular basis would also be familiar with the requirements of this regulatory guide?---I would assume so, yes.

Yes. Thank you. I tender that document, Commissioner.

THE COMMISSIONER: ASIC regulatory guide RG 139 approval and oversight of external dispute resolution schemes, RCD.0021.0016.0019, exhibit 6.140.

EXHIBIT #6.140 ASIC REGULATORY GUIDE RG 139 APPROVAL AND OVERSIGHT OF EXTERNAL DISPUTE RESOLUTION SCHEMES (RCD.0021.0016.0019)

MS ORR: Now, this general presumption that we've seen in the regulatory guide about not having a discretion to withhold documents is also reflected in FOSs terms of reference. Are you familiar with FOSs terms of reference, Ms Troup?---Yes, I am.

If we could bring up RCD.0021.0017.0001. And turn within that document to 0015. We can – 0015, I'm sorry. We can see clause 7.2 of FOSs terms of reference is entitled:

> *Provision of information by the parties to the dispute. FOS may require a party to a dispute to provide to, or procure for, FOS any information that FOS considers necessary. That party must comply with FOSs request within the timeframe specified by FOS, except where the party satisfies FOS that:*

If we could go over the page:

> *(a) to provide information would breach a duty of confidentiality to a third party and, despite best endeavours, the third party's consent to the disclosure of the information has not been able to be obtained; (b) to provide the information would breach a court order or prejudice a current investigation by the police or other law enforcement agency; or (c) the information does not or no longer exists or is not within the party's reasonable possession or control.*

?---Yes.

And, again, is my assumption correct that members of group customer relations would be familiar with FOSs terms of reference, including clause 7.2?---Yes.

Now, did CommInsure seek to satisfy FOS of any of the matters described in clause 7.2 when it withheld information about why it had chosen to backdate the heart attack definition only to May 2014?---Sorry, was it – no, we didn't do that. Is that the - - -

Did – my question was whether CommInsure sought to satisfy FOS of any of these matters?---No. No.

Why not?---I'm not sure.

Well, none of them applied, did they - - -?---That's - - -

- - - Ms Troup?---That's true.

They were not capable of being satisfied in this situation?---That's correct.

Did CMLA seek to satisfy FOS of any of these matters when it withheld part of Dr Carless' medical opinion?---No.

They were also not capable of being satisfied?---That's correct.

FOS – I'm sorry, CMLA simply refused to provide the information sought by FOS on the basis that it didn't believe it was relevant. Is that right?---That's right.

And that was not an approach that was permitted either by the ASIC regulatory guide or by FOSs terms of reference?---That is right.

Do you accept that CommInsure failed to be open and transparent in its dealings with FOS?---Yes.

And that it acted inconsistently with regulatory guide 139 and FOSs terms of reference?---That's right.

Can you offer any explanation for that, Ms Troup?---My interpretation is there – it was a misguided attempt to – as you say, they didn't think it was relevant, and – and that's what they thought was the right – the way to respond. I don't – as I said before, I don't – I wouldn't have made that decision myself.

And they made that decision – they thought it was the right approach in circumstances where they understood the requirements of the regulatory guide and the terms of reference?---Yes.

Now, FOS declined CommInsure's request for another meeting, didn't they?---That's right.

And they instead decided to follow their normal processes and issue a recommendation in the dispute?---That's right.

And before I turn to the recommendation, I will tender the FOS terms of reference, Commissioner.

THE COMMISSIONER: FOS terms of reference, RCD.0021.0017.0001, exhibit 6.141.

EXHIBIT #6.141 FOS TERMS OF REFERENCE (RCD.0021.0017.0001)

MS ORR: Now, the recommendation in the dispute, which is the first formal determination phase of a FOS dispute, was issued on 5 October 2016?---Yes.

And it was in favour of the insured?---That's right.

And CommInsure decided to reject the recommendation?---Yes.

And you've exhibited a copy of the letter rejecting the recommendation to your statement. It's exhibit 39. CBA.0001.0508.0677. And we see from this letter, which is a two-page letter, but you may recall that the second page has only the signature of the author, so the content is all on this first page, CommInsure told FOS that it considered that its decision to backdate the upgrade to the heart attack definition to May 2014 was not reviewable by FOS?---That's correct.

And that having regard to all relevant factors, the choice of May 2014 was reasonable?---Yes.

But the letter went on to say in the second last paragraph on the page:

> *CMLA does acknowledge that as a result of the current recommendation, the insured's expectations have been significantly raised. CMLA also acknowledges that the recommendation in some part arose from assumptions*

made by FOS in the absence of input from CMLA, and is concerned that the determination process would create further delay and customer dissatisfaction. In consequence, CMLA has decided to offer the insured an amount equal to the sum insured less previous partial payments, strictly on an ex gratia basis.

?---Yes.

So CBA accepted that its handling of this dispute had affected the insured?---Yes.

And following some negotiation, CommInsure did settle the matter with the insured on an ex gratia basis?---Yes.

Now, a few months after that, in February last year, FOS wrote to CMLA about the dispute?---Yes.

And if I could ask that you be shown CBA.0001.0528.0763. This is not an annexure to your statement, Ms Troup. This is a copy of the letter that FOS wrote to CMLA in February last year. And we see from the first page, 0763, that it referred to the resolution of the dispute that involved the insured. And then over the page at 0764 it referred to FOSs request for the medical opinions that we have been discussing. And it described CMLAs conduct in response to that request. Do you see that there?---Yes, I can.

And then on the third page, 0765, under the heading Our View, FOS set out its view of CMLAs conduct in response to its request for information. It said:

The CMLA statements misled us to believe that CMLA did not and would not obtain the relevant medical evidence requested. The statements were made despite the fact that CMLA already had that evidence in its possession.

And then two paragraphs down:

In our view, this conduct constitutes a deliberate failure to comply with the requirement in paragraph 7.2 of the FOS terms of reference.

That was the communication from FOS?---Yes.

And further down the page, at the bottom of the page, we see FOS said:

CMLAs conduct had serious consequences. It caused significant delay in the handling of the investigation, it hampered the timely resolution of the matter for the applicant, had the potential to prejudice the outcome of the dispute.

And over the page, at 766, the top of the page:

In all of the circumstances, FOS has formed the view that the conduct referred to in this letter may amount to serious misconduct as defined in paragraph 11.3 of the FOS terms of reference.

And FOS sought CommInsure's response within 21 days, including in relation to steps taken to ensure that this conduct hadn't occurred in connection with any other CommInsure dispute, and that it would not occur in connection with any future dispute?---Yes.

I tender that letter, Commissioner.

THE COMMISSIONER: Letter from FOS to CMLA, 14 February '17 CBA.0001.0528.0763, exhibit 6.142.

EXHIBIT #6.142 LETTER FROM FOS TO CMLA DATED 14/02/2017 (CBA.0001.0528.0763)

MS ORR: Now, a few weeks after that CMLA responded to that letter, CBA.0001.0528.1300 is a copy of CBAs response. And if we go to the second page of that letter, 1301, we see that CBA emphasised that there had not been a deliberate attempt to mislead FOS?---Yes.

And CBA also disputed the effects of its actions, saying – and if I can take you to the heading under – to the heading Consequences of Delay?---Yes.

Continuing:

You have commented –

Third paragraph down:

... that CMLAs conduct had serious consequences. As the matter was resolved in favour of the insured we do not agree that any delay prejudiced the final outcome.

And it resisted the characterisation of its actions as serious misconduct, we see under the heading In Summary:

We acknowledge that the process of information gathering and assessment did not run smoothly, and we regret our contribution to this. However, we do not agree that our actions amounted to serious misconduct, and have found no evidence to support a conclusion that CMLA intended to deliberately mislead FOS as to the existence of the medical opinion.

?---Yes.

Did CBA acknowledge anywhere in this letter what it had been told by FOS, which was that FOS had in fact been misled?---No, I don't think we did in that letter, no.

And did it acknowledge anywhere in this letter that it had not complied with its obligation under clause 7.2 of the FOS terms of reference to provide information to FOS when sought?---No, it did not.

Did it acknowledge that it had not been frank and open in its dealings with FOS?---Not as specifically as what you've just said, no.

No. Not specifically, nor indirectly?---I had a recollection on the first page there was some recognition of – that we hadn't provided the right information. That's - - -

I will take you back to the first page in case that assists, 1300?---I guess it was the – it was more the – should have been dealt with more promptly.

There was nowhere in this letter where there was any acknowledgement by CBA that it had not been frank and open in its dealings with FOS?---Correct.

Do you stand by this as an appropriate response to FOSs letter to CBA?---No.

What should the letter have said, Ms Troup?---The letter should have acknowledged the mistakes that we made through this complaint.

Those mistakes being?---Well, firstly, the redaction, that first reply was not appropriate. Secondly, the continuing of position in the jurisdiction even though that had been already responded to from FOS, and then thirdly, when they asked for more information around our decision around heart attack, we didn't provide that either.

And should it have acknowledged - - -?---Yes.

- - - that CBA had not been frank and open in its dealings with FOS?---Yes.

Yes. I will tender that letter, Commissioner.

THE COMMISSIONER: Letter CBA to FOS, 7 March '17, CBA.0001.0528.1300, exhibit 6.143.

EXHIBIT #6.143 LETTER CBA TO FOS DATED 07/03/2017 (CBA.0001.0528.1300)

MS ORR: And then on 17 March, ten days later, CBA got a response from FOS which is CBA.0001.0513.2849. And FOS said:

We have reviewed and considered your response. We have formed the view that the response is not persuasive and it does not provide an adequate explanation for the conduct raised in our earlier correspondence. We appreciate you have been engaging with ASIC –

Do you see the last paragraph?---Yes.

Continuing:

... in its regulatory review of your organisation on issues related to claims handling in life insurance. As a result, we have concluded that it is appropriate to report the matter to ASIC at this stage for its further investigation and action.

That was the communication from FOS?---Yes, it was.

I tender that letter, Commissioner.

THE COMMISSIONER: Letter FOS to CBA, 17 March '17, CBA.0001.0513.2849, exhibit 6.144.

EXHIBIT #6.144 LETTER FOS TO CBA DATED 17/03/2017 (CBA.0001.0513.2849)

MS ORR: Now, I just want to reflect on where we've got to at this point, Ms Troup. Do you accept that the decision to redact the medical opinion that was provided to FOS was a decision that fell below community standards and expectations?---Yes.

As did the decision not to provide an explanation for that redaction when it was sought?---Yes.

You accept that CBA misled FOS by implying that the medical opinion had not already been obtained?---Yes.

And failed to comply with clause 7.2 of FOSs terms of reference by not providing information that was requested by FOS?---That's right.

Do you also accept that CBAs conduct contributed to delay in the resolution of the particular complaint?---Yes.

And do you acknowledge that the way that CBA handled this dispute affected its relationship with FOS?---Yes.

How did it affect CBAs relationship with FOS, Ms Troup?---I mean, the first word that comes to mind is – is trust. The way we behaved would have been very – when

I put myself in FOSs shoes, would have been – we would have been very – come across as very adversarial and that's not the relationship that we strive to have with FOS.

CBA decided to conduct an audit into its handling of this dispute, didn't it?---Yes. We were very concerned with how this occurred.

Yes. Can I take you to the audit report, which is CBA.0001.0528.2822. Now, the audit report is dated 10 July 2017. Do we see that date at the top of the page?---Yes, thank you.

And on this first page, we can see that the internal audit was engaged to perform an independent targeted review. This is the paragraph before the heading 1.2, an independent targeted review of a number of matters raised by FOS.

Do you see that?---Yes.

And if we turn to the following page, 2823, we can see the matters that were excluded from the scope of this audit report. Scope Exclusions:

> *We have not reviewed any actions taken by group customer relations or CMLA prior to 9 March 2016, the date FOS notified CMLA of the dispute. We have not assessed CMLAs process or rationale in determining the effective backdate for the revised heart attack definition. And we have not made an assessment as to whether the conduct constitutes serious misconduct under the FOS terms of reference, a breach of duty of utmost good faith, or whether it should be reported to ASIC as serious misconduct.*

Now, excluding the first of those matters, why were the second and third of those matters excluded from the scope of the audit?---The primary purpose was to understand the interactions with FOS and not the – CommInsure's decision around the heart attack. So that's why the second bullet point was excluded. And the third scope item there was this was going to be input for management to review those management and legal – because they're – got a legal reference – references in there.

Did management consider those matters, Ms Troup?---Yes.

And what conclusions did management reach?---Well, I think the – as we discussed a few moments ago – well, I know personally that it was misconduct under FOSs terms of reference. We didn't consider the breach of duty of utmost good faith applied in these circumstances. And the conduct had been reported to ASIC and so we didn't feel we needed to consider that further.

Can you explain why the conclusion was reached that this was not a breach of the duty of utmost good faith? You said that you considered that it didn't apply. Why?---I – from memory, I think it was because the duty of good faith applied to the insured, not to our interactions with FOS.

So it applies to the insurer, doesn't it?---Yes, the insurer and the insured, yes. Yes, that relationship.

But you took the view that that didn't extend to the interactions of an insurer with an external dispute resolution body?---I think that was the case, yes.

Now, if we go further down this page, we can see the heading Review Conclusion. And under that we see, the first paragraph:

> *We have not identified any evidence, throughout this review, which indicates either group customer relations or CMLA sought to intentionally mislead either FOS or the insured through their actions and written representations. However, we have made a number of key observations on the actions and written representations of CMLA and group customer relations in resolving this dispute. These observations represent process weaknesses and imprecise decisions in the actions of group customer relations and CMLA in resolving the insured's dispute.*

So, again, we see the focus was on whether there was an intention to mislead FOS?---Yes.

But process weaknesses and imprecise decisions were identified?---Yes.

And we see further down the page that they included, point 1 that:

> *Group customer relation's internal quality review process was ineffective in identifying ambiguous and contradictory messages in responses to both FOS and the customer.*

?---Yes.

And:

> *The decision to redact the medical opinion without providing an explanation for the redaction itself or fully considering FOSs potential interpretation of the redaction was assessed in the audit report to be a poor decision.*

?---Yes.

And over the page at 2824, the audit also found, point 2:

> *In the absence of a prescribed process for uploading key documents to the first point system, a letter from FOS responding to group customer relation's challenge to their jurisdiction was not identified and addressed by group customer relations. This resulted in a prolonged focus on challenging FOSs jurisdiction and not responding to FOSs direct questions.*

Now, is that the matter that you were referring to earlier as to documents not having been uploaded to the system showing that FOS had determined the challenge to its jurisdiction?---That's correct, yes.

And:

> *Group customer relation's escalation of the dispute to CMLA was not done in a timely manner, which resulted in CMLA management not being included in a number of key decisions.*

?---Yes.

Now, the report – the audit report made a number of recommendations to improve CBAs complaint handling processes?---Yes, it did.

All right. Thank you. I tender this document, Commissioner.

THE COMMISSIONER: Internal audit report, 10 July '18 concerning FOS dispute handling review, CBA.0001.0528.2822, exhibit 6.145.

EXHIBIT #6.145 INTERNAL AUDIT REPORT, 10 JULY '18 CONCERNING FOS DISPUTE HANDLING REVIEW (CBA.0001.0528.2822)

MS ORR: And a month or so after this, on 24 August last year, ASIC provided its response to the matter that had been referred to it by FOS?---That's right.

And that is ASIC.0066.0001.0241. So this was the letter that ASIC sent to CMLA dealing with the matter of alleged to be serious misconduct that was referred to it by FOS?---Yes.

And if we turn to 0243, we see at paragraph 9 that ASIC said:

> *Based on our consideration of the issues, we are of the view that CMLA should have, when requested by letter dated 6 May 2016, provided to FOS a copy of the whole (unredacted) medical opinion and that a failure to do so was likely to be contrary to its obligation under clause 7.2 of the FOS terms of reference. The provision of the unredacted medical opinion at the relevant time would not have precluded CMLA from making its submission that FOS did not have jurisdiction to consider the dispute; such submissions were set out in CMLAs email dated 19 May 2016.*

And then in paragraph 10 ASIC said that the wording used in response to the letter from FOS was:

Likely to mislead as it gives the impression that CMLA did not already have the medical opinion in relation to an assessment of the insured's claim against the updated definition.

Do you see that?---Yes, I do.

And ASIC accepted in paragraph 10 that it:

... had not seen any evidence to indicate that CMLA intended to mislead FOS. However, in the circumstances, the practical effect was that it was likely to and in fact did mislead FOS.

?---Yes.

Having reached those conclusions, what action did ASIC take against CMLA?---The letter went on for recommendations for what they encouraged CMLA to do in response to – to their findings.

ASIC encouraged you not to do this again?---Yes.

And said that they expected you to implement the recommendations from your internal audit report that I had just taken you to?---Yes.

Thank you. I tender this letter, Commissioner.

THE COMMISSIONER: Letter ASIC to CMLA 24 August '17, ASIC.0066.0001.0241, exhibit 6.146.

EXHIBIT #6.146 LETTER ASIC TO CMLA DATED 24/08/2017 (ASIC.0066.0001.0241)

MS ORR: Did ASIC implement those – I'm sorry, did CMLA implement those recommendations, Ms Troup?---Yes, we did.

All right. And what changes has CMLA made as a result of this experience with FOS?---Well, those - - -

In general terms, if you could explain the changes that have been made?---Well, I mean, in general terms, it was reinforcing our obligations to be open and transparent across all of our – our team members. Secondly, there were some very practical implementations there of one of the big learnings from myself is the interaction between us and GCR needed to improve. And I think particularly in that first two months we didn't communicate clearly to GCR and we felt responsible for part of that. So there's an element of ensuring that your communication and training is clear. And then thirdly, there was – the sensitivity of these claims and – complaints

and ensuring the right level of review, the right level of seniority to help people with those judgments. They would be the three that I would call out.

Now, while the FOS dispute was going on, ASIC was investigating a number of aspects of CommInsure's life insurance business, wasn't it?---Yes, it was.

And that investigation began shortly after the Four Corners and Fairfax Media reports that I referred to earlier?---Yes.

And it took place alongside a broader ASIC inquiry into claims handling practices across the life insurance industry?---Yes.

ASIC looked into the concerns about outdated medical definitions in CommInsure trauma policies?---Yes.

And it also investigated CommInsure's life insurance claims handling practices?---Yes.

And on 23 March 2017, ASIC publicly announced the results of its investigation into CommInsure?---Yes.

And it did this by issuing a media release?---Yes.

And attached to that media release was a summary of ASICs findings. Do you recall that?---Yes.

Now, could I take you to the media release and the attachment. RCD.0021.0016.0077. This was the media release issued by ASIC?---Yes.

And if I could take you to 0080 in that document. We see the first page of the attachment to that media release?---Yes.

I tender the media release and the attachment, Commissioner.

THE COMMISSIONER: ASIC media release 17-076MR, findings of CommInsure investigation, together with its attachment, RCD.0021.0016.0077, exhibit 6.147.

EXHIBIT #6.147 ASIC MEDIA RELEASE 17-076MR, FINDINGS OF COMMINSURE INVESTIGATION, TOGETHER WITH ITS ATTACHMENT (RCD.0021.0016.0077)

MS ORR: Now, the day before ASIC issued that media release, Peter Kell, the deputy chairman of ASIC sent a letter to the chairman of CMLA?---Yes.

And that letter is ASIC.0066.0001.1134. Now, this is the letter from Mr Kell to the chairman of CMLA on 22 March 2017. It was a lengthy letter but I assume you are familiar with this letter, Ms Troup?---Yes, I am.

If we turn to the second page we can see an executive summary of the letter at 1135. Mr Kell says:

> *In this letter we outline our investigation into and our concerns arising from the following issues.*

And then he sets out a list of issues, some of which I want to come back to. And he then went on to say in paragraph 5:

> *Overall, ASICs investigation has concluded that CMLA has not contravened the law (other than in relation to the advertising of trauma cover for events such as heart attack which is still under investigation). However, there are a number of areas of concern where we expect improvements to be made.*

Now, I'm not going to address all of the issues dealt with in this letter, but I want to ask you questions about three of those issues. And the first is the use of outdated medical definitions. If we stay on this page at 1135, we see that the first issue that was identified by Mr Kell in paragraph 4 – we will need to pan up to subparagraph (a) – was described as:

> *Policy terms including the use of out of date medical definitions for terms such as heart attack and severe rheumatoid arthritis in trauma cover.*

And if we turn to the third page of the letter at 1136, we can see where Mr Kell addressed the topic of policy definitions in this letter. And Mr Kell told the chairman of CMLA that ASIC had:

> *... reviewed a range of definitions used in CMLAs life insurance policies that could be separated into medical definitions and TPD definitions.*

And in paragraph 4 he made clear that:

> *ASICs review did not cover all medical definitions used by CMLA. From the review that we undertook, we are concerned about the use of definitions which have become outdated or are not aligned with current medical practices, such as heart attack of specified severity, and severe rheumatoid arthritis.*

As well as:

> *Inconsistent outcomes and the potential for consumers to misunderstand the terms of their policies due to the use of confusing and unclear definitions.*

And over the page:

The use of definitions that fell significantly short of consumer expectations.

You see that, Ms Troup?---Yes, I do.

Now, in paragraph 15, Mr Kell said:

With respect to the use of definitions that have become outdated or are not aligned with current medical practices, ASIC has concluded that CMLAs mere reliance, without more, on outdated definitions as a means of determining whether it has an obligation to pay benefits under the policy is not a breach of the duty of utmost good faith in section 13 of the Insurance Contracts Act. However, ASIC is concerned that this practice falls significantly short of consumer expectations.

?---Yes.

Now, Mr Kell addressed the heart attack definition in more detail later in this letter. If we go to page 16 of the letter at 1149, we see that under the heading Heart Attack, he recorded – he referred firstly to CMLA announcing a change to the medical definition of heart attack on 10 May 2016. And he went on to note, at the bottom of that page and over to the following page that in 2012:

The European Society of Cardiology, the American College of Cardiology, the American Heart Association and the World Health Federation published an expert consensus document about the definition of heart attacks.

?---Yes.

You're aware that that happened at that time, Ms Troup?---Yes.

And that report endorsed the use of troponin as a means of detecting heart attacks?---Yes.

And the report said that laboratories should use a cut-off value of the 99th percentile of a normal reference population to determine whether there had been a heart attack?---Yes.

Do you see that?---Yes, I do.

And he went on to say in paragraph 97 that the decision by CMLA:

To select 11 May 2014 as the effective date of the change does not have a robust rationale given the joint report was published in 2012 and not 2014. While this is not contrary to the law, it is ASICs view that this has unfairly impacted on some consumers and better practice would be to select an earlier date. CMLAs conduct in relation to updating its medical definitions was unreasonably slow in responding to changes in medical practice. CMLAs

internal documents demonstrate that CMLA was on notice that the standard was to be updated and even three years after the joint report was published, CMLA had yet to change its definition. We note seven other insurers had updated their definition by 11 May 2014.

This was the communication from ASIC to the chairman of CMLA?---Yes, it was.

Now, you told us earlier – I will tender that letter, Commissioner, and I - - -

THE COMMISSIONER: Letter from Mr Kell of ASIC to the chair of CMLA, 22 March '17, ASIC.0066.0001.1134, exhibit 6.148.

EXHIBIT #6.148 LETTER FROM MR KELL OF ASIC TO THE CHAIR OF CMLA DATED 22/03/2017 (ASIC.0066.0001.1134)

MS ORR: You told us earlier, Ms Troup, that CommInsure decided in March 2016 to backdate the updated heart attack definition to May 2014?---Yes.

And after it made that decision, CommInsure conducted a review of its declined heart attack claims going back to May 2014?---That's right.

And it paid claims that would have been allowed under the updated definition?---That's correct.

And in its media release, which I took you to earlier, CommInsure said it chose 11 May 2014 because that was the date of the last relevant product disclosure statement?---Yes.

And in your statement to the Commission, you said that CommInsure chose that date because that was the date of the most recent full product review?---Yes.

Are they both different ways of saying the same thing?---Yes.

Was that the only reason why CommInsure chose to backdate the updated definition to May 2014?---It was the primary reason in terms of it was at the time a judgment decision on – on how far to go back and based on the information given to us in March two thousand – I will get the date right – '16, we felt that was the appropriate date at that time.

So you said the primary reason was because that was the date of the most recent full product review. What were the other reasons for choosing that date?---I think it was also the context of when is a reasonable time to implement the updated definition.

Well, what led CMLA to believe that May 2014 was a reasonable time?---It was advice from the product team, in terms of we considered when – how – how many

others had moved in the market, our own working documents in terms of when we had considered it previously.

What were the considerations given to how many others had moved in the market?---Sorry, could you ask that again?

You said that one of the things that was considered was how many others had moved in the market?---Yes.

So how was that factored into the decision?---Well, I think it was, you know, relative. One of the considerations was relative to our competitors, and other movements in the market. How many others had moved and not moved.

Well, how many had moved and not moved as at 11 May 2014. Do you recall?---No. I mean, you've just reminded me by that letter that ASIC said there were seven that had, and I think the market has maybe 12 or 14 providers.

So seven - - -?---A bit over – a bit over half.

A bit over half had already moved by that time?---Yes.

And when had they all moved?---At various times from 2012 through to 2014.

So that was a factor in the decision to choose 11 May 2014?---Yes.

And where do we see that in the media releases explaining 11 May 2014 as the date that was chosen by CommInsure?---It wasn't in the press release.

Why not?---I guess one of the elements in terms of communication and the messages – there's only so much messages that you can convey. So - - -

Well, the real - - -?--- - - - we chose – you know the primary reason was when was the last product update that we should have done it by, and that was May 2014.

Well, was the primary reason, Ms Troup, that 11 May 2014 was in the middle of the range of dates when your competitors had updated their definitions?---As I said, that was one of the reasons, but the - - -

Was that the primary reason?---No.

And having decided that date, you were able to link it to a product review?---Yes. Sorry?

So did you assess whether – what date put you in the middle of the movements of your competitors?---No, the analysis wasn't done with competitors first to find the date. The analysis was done in terms of our product review cycles and when was the

– the last time this should have been done via our normal product review cycle. But the analysis on the market was also done to complement that thinking.

The analysis on the market. What are you referring to there? That's the analysis of the movement of your competitors?---Yes.

It was done to complement the thinking, did you say?---Yes.

Okay. Could I ask that you look at CBA.1004.0003.3949. These are minutes from a meeting of the board of CMLA on 9 March 2016?---Yes.

So that was two days after the Four Corners story was broadcast?---Yes.

And the day after – I'm sorry, the day before – I'm sorry, the day before CommInsure announced that it would update its heart attack definition and backdate the updated definition to 11 May 2014?---Yes.

And if we turn to 3963 in these minutes, we can see there that there was discussion of the proposal to update the heart attack definition and backdate the updated definition. Do you see the references to that in the top part of that page, in the first and the third dot points?---Yes.

The third dot point said:

> *It is now proposed to apply the new definitions from 11 May 2014, which is the date of the last PDS.*

?---Yes.

And underneath the bullet points we see that the board asked questions about the appropriateness of the 11 May 2014 date?---Yes.

Now, you were present at this meeting?---Yes.

But the minutes suggest that you departed the meeting for this discussion. Is that right?---For – for some of it, yes.

And why did you leave the meeting?---I was – I was dealing with the – some of the other matters raised in the – in the media that week.

Right. So it wasn't to do with the content of what was being discussed. It was because you needed to leave to deal with other things?---Yes.

Is that right?---Yes.

Now, the minutes record here that Dr Phillips answered the board's questions about the appropriateness of the 11 May 2014 date?---Yes.

And Dr Phillips was the head of life product and strategy, life product and distribution?---Yes.

In response to questions from the board regarding the appropriateness of the 11 May 2014 date, Dr Phillips explained that:

> *... while the clinical definition of heart attack changed in 2012, this was not immediately adopted, even in medical treatment, and only one competitor updated its definition in 2012 with a partial payment, later moving to a full payment. Many competitors updated their definitions before 11 May 2014, some with partial payments only. The date of 11 May 2014 is in the middle of the range of dates when those competitors who have upgraded their definitions did so, and as the PDS was changed on that date, it is reasonable to adopt that date as the commencement date, being the date on which the company would have upgraded its definition as adopting another date would be arbitrary. In addition, the benefit paid under the new definition is a more generous benefit than the partial payment which some competitors provide under the upgraded definition. The decision taken by the company in May 2014 was to adopt a lesser benefit by applying the definition of a heart attack of specified severity –*

We will just need to go over the page:

> *...in order to keep the product price lower for customers.*

Now, on that page, we see that the board considered the potential financial impacts of the updated definitions and the proposal to backdate them. Do you see that?---Yes, I do.

And the board endorsed the proposed approach?---Yes.

So based on that discussion, I want to suggest to you that a significant factor in the choice of 11 May 2014 as the date to backdate to was that that would put you in the middle of the range of dates when your competitors, who had upgraded their definitions, did so?---Yes, it was one factor, yes.

Yes. Was it a significant factor, Ms Troup?---I wouldn't draw that conclusion.

Was it a factor that should have been made known to the public when you were explaining this decision?---Yes, I would say I hadn't thought of that question prior to now. I – again, we decided that the primary reason was the best communication. There would have been no harm in us explaining that further.

And would there have been any harm in explaining this to FOS when it asked you to do so?---No. No.

I tender the minutes, Commissioner.

THE COMMISSIONER: Minutes of CMLA board meeting, 9 March '16, CBA.1004.0003.3949, exhibit 6.149.

EXHIBIT #6.149 MINUTES OF CMLA BOARD MEETING DATED 09/03/2016 (CBA.1004.0003.3949)

MS ORR: You gave evidence earlier that CommInsure rejected FOSs recommendation in the particular case of the insured which found that CommInsure had not properly justified its choice of 11 May 2014 as the date to which it would backdate the updated definition?---Yes.

But after receiving the letter from Mr Kell, which I took you to earlier, CommInsure decided to change its position and to backdate the revised heart attack definition even further to October 2012. Is that right?---That is correct.

Now, it made that decision, it seems, in 24 hours in time for it to be included in the media release issued by ASIC the following day. Is that right?---That is correct.

So did CommInsure have advance notice of the position that ASIC was going to take in that letter that was sent to the chairman of CMLA the day before the media release?---ASIC had been communicating with us in – in I think the week before, where their investigation was landing, yes.

And so did it have advance notice of ASICs position on this topic, on the backdating of the upgraded heart attack definition?---Hard for me to be definitive, but I would assume yes.

It had received an earlier version of the letter sent by Mr Kell on 22 March. Is that right?---Yes.

And the board of CMLA met on the date of that letter, on 22 March. Is that right?---Yes, they did have a meeting that day, yes.

And if we look at CBA.0002.1223.3231. We see an email here from Mr Austin to a number of people within CMLA, including you. Who was Mr Austin? Who is Mr Austin, Ms Troup?---He's the chairman of the CMLA board.

Thank you. And we can see that the chairman of the CMLA board recorded that:

> *The board considered that there was a sound rationale now for the selection of May 2014 –*

The original selection?---Yes.

Continuing:

...because with the benefit of hindsight the board believed that a decision to change the definition of heart attack at that time would have been a more appropriate decision, both commercially and in the interests of policyholders.

?---Yes.

But they accepted that there was no single right perspective or view.

Do you see that?---Yes. Yes.

So they authorised management, specifically you and Annabel Spring, to decide to backdate the updated definition further. Is that right?---Yes.

We see that from the last paragraph on the screen at the moment. So you were authorised by the board, with Ms Spring, to extend the backdating beyond May 2014?---Yes.

And that happened as a result of a meeting of the board of CMLA following the receipt of the final letter from Mr Kell on 22 May 2017?---Yes.

I'm sorry, 22 March, thank you, 2017. Now, in order to approve backdating the definition further, you needed to get actuarial advice about the cost, didn't you?---Yes.

And that actuarial advice was prepared overnight?---Yes.

And if we go – I will tender that email first, Commissioner.

THE COMMISSIONER: Email from Austin to Troup and others, 22 March '17 CBA.0002.1223. 3231, exhibit 6.150.

EXHIBIT #6.150 EMAIL FROM AUSTIN TO TROUP AND OTHERS DATED 22/03/2017 (CBA.0002.1223. 3231)

MS ORR: And if we go to CBA.0585.0140.1932, we see a copy of the actuarial advice that you received?---Yes.

Is that right?---Yes.

And then if we go over the page to 1933, we can see a reference to CommInsure's earlier estimates of the cost of introducing the updated definition and backdating it to May 2014. So there had been some actuarial work done in 2016 about the cost of backdating back to 2014?---That's right, yes.

And we see that work reproduced in this document. And the bottom table shows that the cost of backdating to May 2014 was originally estimated to be $14.7 million. Do you see that figure in the bottom table under total?---Yes.

With a possible range of $7.3 million to $22 million?---Yes.

But if we go to the next page, 1934, we can see that the actual cost of that decision to backdate to May 2014 ended up being much smaller. It was – and we might need to pan down just a bit – it was $2.5 million?---Yes.

So it was well below the estimated cost of backdating to May 2014?---Yes.

And was that one of the reasons why CommInsure was able to decide so quickly, after receiving ASICs final letter, to backdate the definition further to October 2012?---Yes.

Because you had budgeted up to $22 million for the cost that you would incur as a result of that backdating, and you had incurred only 2.5 million of that possible $22 million?---Yes.

I tender the actuary's report, Commissioner.

THE COMMISSIONER: LPS320 report for further backdating of heart attack definition, 23 March '17, CBA.0585.0140.1932.

MS ORR: Yes.

THE COMMISSIONER: Exhibit 6.151.

EXHIBIT #6.151 LPS320 REPORT FOR FURTHER BACKDATING OF HEART ATTACK DEFINITION DATED 23/03/2017 (CBA.0585.0140.1932)

MS ORR: Now, having received that report from the actuary, you and Annabel Spring made the decision to backdate the updated definition to October 2012?---Yes.

And do you believe that October 2012 was a more appropriate date to take that updated definition back to?---Yes.

Now, do you believe that CommInsure should have backdated to that date in 2016?---Sitting here today, yes.

So the day after the work of the actuary overnight, and the decision that you and Annabel Spring made as a result of the work of the actuary, or facilitated by the work of the actuary, ASIC put out its media release on 23 March. And that media release

announced that CommInsure had agreed to backdate the heart attack definition to October 2012?---Yes, it did.

Yes?---Excuse me, sorry.

So you had conveyed to ASIC that decision in time for it to be incorporated into ASICs media release?---Yes.

How was it conveyed?---Over the telephone.

By who?---By me.

To who?---Michael Saadat.

Yes. And when did that occur?---The night before.

Could I ask that you look at CBA.0585.0140.3517. This is an email chain from 23 March 2017, the day of the media release. And we see that that afternoon Andrew Hall – do you see his name about halfway down the page?---Yes, I do.

Who was from Corporate Affairs at CBA. Is that right?---That is correct.

Andrew Hall sent out an email about ASICs report and the media release?---Yes, he did.

And we see that that email was forwarded to you by Clive van Horen within CBA who said:

Hi, you must be very happy with this – a strong set of findings from ASIC.

?---Yes.

That was the communication you received from Mr van Horen?---Yes, it was.

Were you happy with the set of findings from ASIC?---Yes, I was.

And what were you happy about with those findings?---As you've alluded to, there were some extremely serious allegations made against CommInsure on the Four Corners program and they were found to be unsubstantiated, and that was a very good outcome for CommInsure.

Well, you say they were found to be unsubstantiated. The findings of ASIC were that there had been no contraventions of the law but that in many respects the practices of CommInsure were a matter of concern. Do you agree with that?---There were other areas of – of concern, yes, but when it came to the – if I – if I may explain?

Yes, please?---The heart of the allegation goes to the heart of a life insurance company, you know, in terms of the – the accusation was we were denying claims and – and mistreating our customers. Out of all of the allegations, that's the one that caused me the most concern for myself, my people, my customers. And so for that to be unsubstantiated was quite significant for us.

I understand. And you responded to Mr van Horen:

> *Thanks, Clive. Sorry I was a no show last night. Was working with ASIC until 10 pm. If only I could get the same outcome for CCP.*

That was the credit card protection insurance product that was the subject of a case study in the first round of hearings?---Yes.

Now, you were working with ASIC until 10 pm. What was that a reference to?---To the finalising of our position on the backdating of heart attack.

So what did your work with ASIC involve?---So it was just clarifying what ASICs request was and also confirming the process for what we would use to backdate that definition and find customers that would need to be paid.

And those clarifications and those discussions were held between you and Mr Saadat from ASIC. Is that right?---I – I believe that's right, yes.

All right. I tender the email chain, Commissioner.

THE COMMISSIONER: Emails concerning CommInsure ASIC update of 23 March '17, CBA.0585.0140.3517, exhibit 6.152.

EXHIBIT #6.152 EMAILS CONCERNING COMMINSURE ASIC UPDATE OF 23 MARCH '17 (CBA.0585.0140.3517)

MS ORR: So having made that decision to backdate the updated heart attack definition to October 2012, CommInsure then reviewed its declined heart attack claims going back to that date?---That's right.

And it paid claims that would have been allowed under the updated definition?---Yes.

And following that review, there was a closure report prepared on the backdating issue?---Yes.

And that is ASIC.0066.0005.0011. Now, if we turn to 0015 of this report, we can see a summary of the outcome of the first of two phases encompassed by this work

that was being done. Is that right? There were two distinct phases to the work?---Yes. So the 2014 backdate and then the 2012 backdate.

I see?---Yes.

So the first phase of the review related to the backdating to 2014?---That's correct.

And if we turn to 0015, we can see a summary of the outcome of that phase of the review in the first table that appears on that page. And that review included cases of severe rheumatoid arthritis as well as heart attacks. Is that right?---That's right.

And of the 165 possibly relevant claims identified, 119 were determined to be out of scope?---That's correct.

And of the remaining cases, 23 were found not to meet the new definition?---That's correct.

But 17 heart attack claims that were denied under the old definition were found to meet the updated definition?---Yes.

And on the previous page, 0014, we can see the results of the second phase of the review. So that was taking it back to October 2012. Is that right?---Yes, phase 2 was 2012.

And that only related to heart attack cases. Is that right?---That's right, yes.

And of the 171 possibly relevant claims identified, 146 were determined to be out of scope?---That's correct.

And of the remaining cases, nine were found not to meet the definition?---Yes.

But a further 16 heart attack claims that were denied under the old definition were found to meet the updated definition?---Yes.

And that included the case of the insured person that we were discussing earlier in the day?---Actually, his case wouldn't be there because he had been paid earlier.

Right. So he wasn't included in those numbers?---No. Because he had already been paid.

He had already been given an ex gratia payment?---That's correct.

Now, if we turn back to 0015, we can see that there were a total – this is the second table – a total of 34 heart attack claims that were denied under the old definition that were found to meet the updated definition once we went all the way back to 2012. Is that right?---Sorry, did you say 34 or 33? The heart attack is 33. The 34 includes the - - -

I'm sorry, you're right?---Yes.

33 heart attacks?---Yes.

And 34 included the one case of severe rheumatoid - - -?---Arthritis.

- - - arthritis. Thank you?---Yes. Yes.

Now, the 33 heart attack claims that were denied under the old definition and met the updated definition resulted in CommInsure paying $4.257 million in relation to those claims?---That's correct.

So a significant amount of money was paid to 33 claimants as a result of that decision to backdate to October 2012?---Yes.

Now, you accept, I think your evidence is clear, that you accept that CommInsure ought to have updated the heart attack definition and backdated it to 2012?---Yes, based on everything I know today, yes.

Should it have just updated the heart attack definition in the first place in 2012?---Yes.

And do you accept that the decision not to update the heart attack definition at that time fell below community standards and expectations?---Yes, I do.

Were there any remuneration consequences for anyone at CommInsure arising from all of this?---I don't believe so, no.

Were there any remuneration consequences for you?---Not in the – not in the specifics of heart attack but as a result of the investigations in CommInsure there was an impact, yes.

And what was that impact?---The board, in terms of our yearly STI process, for want of a better word - - -

A short-term incentive?---Thank you.

Yes?---The payment that was due in the middle of the investigation, a proportion of that was held back until the results of the investigations were concluded.

So a proportion of your incentive payment was held back until the investigation was complete?---Yes.

And what proportion?---I think it was a – I'm going to say a third. I would probably prefer to check that detail but I think it was around a third, yes.

And what happened on the completion of the investigation?---That was vested to myself, yes.

So the short-term incentive payment was delayed?---Yes.

But was still paid to you. Is that right?---Yes, once – once the investigation was completed, yes, it was.

I see. Now, in your statement to the Commission you describe CommInsure's decision not to have updated its heart attack definition in 2014 as a commercial misjudgement?---Yes.

Yes. And do you accept that the decision not to update it in 2014 was also a decision that fell below community standards and expectations?---Yes.

Thank you. And we see the consequences of those decisions when we look at these figures that demonstrate the number of people whose claims would have succeeded if the updated definition had been made at either of those two points in time?---That's correct, yes.

Thank you. I tender, Commissioner, the further backdating of heart attack definition closure report, dated 5 June 2018.

THE COMMISSIONER: ASIC.0066.0005.0011 becomes exhibit 6.153.

EXHIBIT #6.153 FURTHER BACKDATING OF HEART ATTACK DEFINITION CLOSURE REPORT DATED 05/06/2018 (ASIC.0066.0005.0011)

MS ORR: I want to take you in just a little bit of detail to the reasons why CommInsure decided not to update the definition at those earlier points in time, Ms Troup. Can you explain, firstly, just the general process for updating medical definitions in CommInsure trauma policies that applied between 2011 and 2014?---So first I think you understand I wasn't in the organisation at that time so based on my reading of the policies and processes. An update to a medical definition is similar to the process for just generally updating a product in terms of we have what's – two frameworks around our product development process, a group framework and a CMLA framework that works us through – the beginning of a project so what ideas people are considering. Then they're assessed in terms of pricing, actuarial competitiveness, research, etcetera. Then they're sought for approval and then they move to implementation. Is that what you were looking for in that question?

As I understand it from the documents, the process took place in product development cycles. Is that right?---Yes, that – that would be one of the expressions we would use, yes.

And roughly how often would each medical definition be reviewed?---At that time it would – it would depend. It would depend on – so I guess there's two phases. Every year there is an annual product review where a product is assessed across a range of criteria. And so that would be an opportunity for any medical definition to be reviewed. Second to that, we have research teams that can highlight at any time changes in the market, changes from doctors, changes that need to be considered. And that can come from any area. Feedback can come from our doctors, our customers, etcetera, and so you can initiate a review out of those other cycles. Sorry, the predictable annual cycle.

So we saw earlier that the definition of heart attack in the trauma policies was unchanged between July 2005 and March 2016?---Yes.

But there were times in that 11 year period when CommInsure considered updating the medical definition and decided not to?---That's correct, yes.

And I want to ask you about some of those decisions. But before I do that, I just want to put some propositions to you about developments in the way that heart attacks were detected over that period. Now, as I understand it, troponin is a protein found in heart cells. You referred to it as an enzyme, I think, before?---I think you're right. I think it is a protein.

And that measurements of troponin can be used in the diagnosis of heart attacks?---Yes.

And are you aware that in 2007 a taskforce convened by the European Society of Cardiology, the American College of Cardiology, the American Heart Association and the World Heart Federation published a paper setting out a universal definition of myocardial infarction or heart attack?---Yes.

And there had been an earlier consensus definition of heart attack in 2000. Is that right?---I think you're right, yes.

But between 2000 and 2007, newer more sensitive methods for detecting heart attacks were developed?---That's right, yes.

And in 2007, the taskforce updated the consensus definition to reflect those developments?---Yes, that's – the timing sounds right, yes. From memory, yes.

And their paper said that the preferred way to determine whether there had been a heart attack was by measuring troponin levels?---Yes.

And that laboratories should use a cut-off value of the 99th percentile of a normal reference population to determine whether there had been a heart attack?---Yes.

And this was because different assays or tests for the level of troponin had different levels of sensitivity. Am I right?---I think you are. You're doing very well.

And the 99th percentile would be different depending on the type of equipment that was used to measure?---Yes, that's my understanding, yes.

Now, in 2012, the same taskforce published another update to the universal definition of heart attack?---Yes.

And they again endorsed the use of troponin to detect heart attacks?---Yes.

And the use of the 99th percentile of a normal reference population?---Yes.

And the taskforce recommended that different reference values be used for men and women?---Yes.

But CommInsure's heart attack definition at the time didn't make reference to the 99th percentile of a normal reference population?---That's right.

Instead, the CommInsure heart attack definition required an elevation of troponin I levels that had to exceed that 2.0 micrograms per litre measure?---Yes.

Regardless of the sensitivity of the testing that was done?---Yes.

And regardless of whether the insured was male or female?---Yes.

And they also had to meet certain other requirements in the definition?---Yes, most heart attack definitions have a two tier element.

Yes. And do you accept that within CommInsure it was known from at least early 2012 that CommInsure's definition of heart attack didn't reflect the universal definition of heart attack?---Yes.

There had been a proposal, had there not, in September 2011 to update the definition of heart attack in the next product development cycle?---Yes.

And as part of that change, it was proposed that the requirement that troponin I levels exceed two micrograms per litre be replaced with a requirement that they exceed the 99th percentile?---Yes.

But that proposal was not adopted?---That's correct, yes.

Why not? Do you know?---I mean, I have looked through the documents. Yes, I think it was a combination of factors. They were – they were working through what the appropriate measures were and pricing and things like that, but it's not – it wasn't well documented, the decision why not, at that time.

It's not - - -?---That I could see.

Not well documented. So you're not able to say why that decision was made. But you mentioned pricing as one of the factors?---Well, in preparing for today I've probably looked at a few of those documents through that period so I'm just hesitant to put which one was at which date.

Well, perhaps I can show you a document to assist with that. As it turns out, I can't put a document to you to assist with this because we've been unable to find a document - - -?---Right.

- - - that explains that decision and you're unable to assist with that?---That's right.

Okay. So that was September 2011. There was a proposal to change the definition at that time. And then in February 2012, there was another product design description prepared which noted that:

> *Current movements within the industry are leaving CommInsure behind, especially in regard to the heart attack definition.*

Do you recall seeing that?---Yes, I do.

So that was February 2012 that internally there was discussion of CommInsure being left behind in relation to its heart attack definition. And then in March and April 2012 there were internal meetings to discuss a potential review of the heart attack definition?---Yes.

And one of those meetings was on 27 March 2012. Could I ask that you look at CBA.0001.0526.0592. So this is an email from Glen Aarons who appears to have been a product manager with retail advice products to a number of other people in CommInsure, including Dr Carless, the medical officer involved in the claim by the insured person who we spoke of earlier, and it deals with a meeting that was held earlier that day, on 27 March 2012?---Yes, although I don't see Dr Carless. I see Dr Monday. But was it mentioned in the document?

I'm sorry, that may be my mistake. Let's – let's not – so I will withdraw that?---Yes.

The reference to Dr Carless. You're right to point out that his name doesn't appear in the email recipients at the top of the page. But do you accept that this email records discussion and action points that came out of a meeting that had been held on this date, 27 March 2012?---Yes, I do.

And Mr Aarons says:

> *Earlier discussions were focused on moving to a severity-based definition.*

Do you see that reference? The first dot point under:

> *Below are the discussion and action points.*

?---Yes, I do.

What do you interpret that to mean?---I've interpreted that to mean – I think earlier we took some responses were to pay a partial benefit rather than a full benefit. So often we used the term "severity" to graduate the payment based on the severity of an illness. So that's how I have interpreted, they were debating partial versus full payments.

So was one of the possibilities making clear that the policy would only cover severe heart attacks or was it about it covered all heart attacks but only a partial payment of the benefit amount?---So it would pay a full payment for severe heart attacks.

Yes?---And a partial payment for less - - -

Less severe?--- - - - severe, yes.

Heart attacks because - - -?---Because the new troponin was picking up smaller and smaller heart attacks, and so trying to get that risk balance with the coverage of the policy I think is what they were considering.

So that was one of the ideas that was being discussed, but Mr Aarons goes on to say:

> *However, current movements within the industry and the downgrading of our heart attack definition has forced us to reconsider that direction and to consider current market leading –*

I would say:

> *...definitions with some exclusions around "other" heart attacks.*

?---Yes, I see that.

What do you understand Mr Aarons to be referring to when he talks about downgrading of "our heart attack" definition?---I think he's referring to the concept of research houses, a service provider to the retail market that grade our products and our definitions, and I'm not sure of the timing but heart attack was a definition that was rated in research houses, and as people – as – as a company enhanced their definition, they would get an A and other companies would drop to a B.

And is the rating level A, B or C. Is that right?---It would depend on – there was more than one research house. Some research houses uses numbers but, yes, A, B, C was the one that I've seen through the documents preparing for today.

And Mr Aarons went on to say in the third dot point:

> *Using the 99th percentile aligns us with current AMA and European medical definitions.*

So by March 2012 it was understood within CommInsure that its heart attack definition did not reflect current medical definitions?---Yes.

And underneath this, under the heading Possible Pricing Concerns, there's a reference to:

> *... possible RGA resistance with passing back new definition.*

Now, RGA was the reinsurer for the trauma policy. Is that right?---That is correct.

And we see also from – under that heading that actuarial advice was sought on the pricing impact of changing the definition?---Yes.

And then further down under the heading Action Points, we see that one of the things to be followed up was:

> *Stats on current declined rates if using the 99th percentile definition.*

?---Yes.

And another was:

> *Make contact with RGA to start talks and gather their thoughts on all of the above.*

?---Yes.

What's the role of a reinsurer in decisions about updating medical definitions or changing policy terms?---Well, they're – they're a party to the coverage. And so therefore you – if you've got a reinsurance arrangement, they must approve your product changes for you to continue to be covered.

I will tender that email, Commissioner.

THE COMMISSIONER: Email concerning trauma definition heart attack minutes, 27 March 2012, is it?

MS ORR: Yes, it is, Commissioner.

THE COMMISSIONER: CBA.0001.0526.0592, exhibit 6.154.

EXHIBIT #6.154 EMAIL CONCERNING TRAUMA DEFINITION HEART ATTACK MINUTES DATED 27/03/2012 (CBA.0001.0526.0592)

MS ORR: And could I ask you now to look at some emails from about a fortnight later on 11 April 2012. CBA.0001.0528.0247. Now, we see that following the meeting on 27 March – I want to make sure I get – just excuse me for a moment, please. It's the first email at the top of the page that I want to direct you to. So that's an email from William Monday. Now, at that time, Dr Monday was CommInsure's chief medical officer?---Yes, he was.

And I'm sorry, I'm confusing myself here. Can we start with the email on the bottom of the page which is an email from Lisa Niestroy to Dr Monday who was the chief medical officer at the time?---Yes.

Who was Ms Niestroy?---She worked in the product team.

Okay. And Ms Niestroy says to CommInsure's chief medical officer in this email on 11 April, so about a fortnight after the meeting:

> *We've had another interesting conversation around possible changes to our heart attack definition. Our resident expert, Dr Carless, is keen to see a shift to align with the universal definition of a heart attack.*

And she then set out the definition. And if we go over the page to 0248, we see, right down the bottom of what's on the screen at the moment:

> *We have been talking –*

Sorry about halfway through that email, can you see that bit, Ms Troup:

> *We have been talking about a change.*

?---Yes, thank you.

Continuing:

> *We have been talking about a change in definition for some time (before a shift in the market started to occur) in response to some contentious claims, ie, clients not meeting our definition and therefore being declined for heart attack, though medically they were diagnosed as having had a heart attack.*

?---Yes.

So by April 2012 it was recognised within CommInsure that there were cases where CommInsure customers were being diagnosed by medical practitioners as having had a heart attack but their claims were being denied because they did not meet CommInsure's definition?---That – that is correct.

And Ms Niestroy outlined four options for how CommInsure could proceed. And the first was:

Leave the current definition. However, relabel to indicate heart attack of a particular severity level.

That was the idea that we discussed earlier?---Yes.

Continuing:

(2) Change our standard heart attack definition in line with the universal definition and recent market changes with the PCI exclusion.

Do you know what that's a reference to?---No.

No?---It's – it's an abbreviation of another condition of the heart but - - -

THE COMMISSIONER: It was further up the page, Ms Orr.

THE WITNESS: Yes, I can't - - -

MS ORR: Percutaneous coronary interventions. Thank you, Commissioner?---Yes. Thank you. I will let you both have that one.

Continuing:

(3) Change our standard heart attack definition in line with universal definition with no exclusion for percutaneous coronary interventions.

Or:

(4) In conjunction with option 1 offer a partial benefit under trauma plus for mild heart attacks and align with the universal definition.

And she went on to say:

Dr Carless has conservatively estimated that the increase in MI claims –

And I will wait for the Commissioner to tell me that myocardial infarction would be what MI stands for.

THE COMMISSIONER: You get to an age where these things become very important to you, Ms Orr. Go on.

MS ORR: Continuing:

Had conservatively estimated that the increase in MI claims under the universal definition – so option 3 – would be around 25 per cent. This no doubt would mean an increase in trauma claims of say 8 to 12 per cent. What we would like to understand is what room there is to move, if any, to make

changes. It is expected that other players will move in some way towards the universal definition over coming months as part of their product reviews. As the traditional risk specialists will focus on the best definitions for the top four, we should also be mindful of impacts, lapse, sales experience if no change is made, though as always this is hard to quantify.

Now, the top 4, were they the top 4 conditions in a trauma policy including a heart attack. Is that what that is a reference to?---Yes, it's a reference to what are the most predominant number of claims under trauma, so cancer is the number 1. So we estimate about 60 per cent of all trauma claims are cancer, stroke, heart attack and heart – other conditions.

I see?---So they're considered – they're considered the top four.

So we see from this email that Ms Niestroy's chief concern in choosing between the different options seemed to be the potential cost to CommInsure of each of those options?---Definitely an element of cost. So if you increase claims coverage, it would have an impact on premiums, yes.

And she was comparing the potential cost of increased heart attack claims if you move to the universal definition with the potential cost of increased lapse rates if you didn't move to update your definition?---Yes.

And if we turn back a page, we can see the chief medical officer's response to this email at 0247, top of the page. And we see that he said:

In the ideal world I would personally move to the universal definition from 2007. Depending on the assay used, our troponin level required for current payment can be 20 times above the 99th percentile. As the 99th percentile number varies depending on what machine is used by the lab, our absolute level may discriminate against people. Also, the 99th percentile is lower in women and so it is harder for women to reach our level which is not ideal. I agree with Alan to pay significant infarcts post percutaneous coronary interventions, even if it is a reduced benefit.

So that was the view of CommInsure's chief medical officer?---Yes, it was.

He explained that CommInsure's existing definition in 2012 could discriminate against people depending on what machine was used by the lab?---Yes.

And it could discriminate against CommInsure's female customers?---Yes.

And it required troponin levels 20 times higher than those required by the universal medical definition of a heart attack?---Yes.

And what weight were these concerns of the chief medical officer at CommInsure given in the product development process that followed?---I guess it's difficult for me to ascertain that, given I wasn't there at the time.

Well, unfortunately you are the person I have to ask, Ms Troup?---Sure.

Are you able to assist us at all in understanding what weight was given to the views of your chief medical officer who said he would personally move to the universal definition from 2007?---So I feel through reviewing the documents there was definitely a lot of discussion and so it wasn't – it was considered but unfortunately the business did not move forward on changing the definition.

And should the business have done that?---Yes, they should have.

All right. I tender this email, Commissioner.

THE COMMISSIONER: Emails concerning heart attack definition, product upgrade 11 April 2012, CBA.0001.0528.0247, exhibit 6.155.

EXHIBIT #6.155 EMAILS CONCERNING HEART ATTACK DEFINITION, PRODUCT UPGRADE DATED 11/04/12 (CBA.0001.0528.0247)

MS ORR: And in April 2012 a further product design description was prepared. Have you seen that from the documents?---Yes.

And that document again noted that current movements in the industry were leaving CommInsure behind in relation to its heart attack definition?---Yes.

And it noted that because heart attacks were one of the top four, the big four trauma events that attract adviser attention, CommInsure might start losing revenue if it was not competitive in that space. Do you recall seeing that?---Yes, I do.

And the document proposed as a way forward the fourth option that Ms Niestroy had proposed which was to introduce a partial benefit for minor heart attacks. Is that right?---Yes, I recall reading that, yes.

And that document, the product design description document, which was a formal document in the updating of medical definitions process – is that right?---Yes, it's the document for a product upgrade, but yes, in part – medical definitions would be part of that, yes.

It made no reference to any of the concerns that had been raised by your chief medical officer, did it? The discrimination concerns, his desire to move to the universal definition from as far back as 2007?---Yes, I don't recall reading that in that document, no.

And that proposal, the proposal to introduce a partial benefit for minor heart attacks was provided to the reinsurers, RGA?---Yes.

And there was a workshop involving RGA and CommInsure in August 2012?---I will rely on you for that date, yes.

You don't recall that?---I don't recall the date but I'm – I – there were meetings. I - - -

There were meetings with the reinsurer around that time?---Yes.

Are you happy to accept that?---Yes. Thank you. Thank you.

And on 24 August 2012, the third universal definition of myocardial infarction was published?---Yes.

And then in September 2012 a further product design description was prepared, and it reflected the proposal – the option number 4 proposal to introduce a partial benefit for minor heart attacks, and change the name of the existing heart attack definition to heart attack of a specified severity?---Yes.

But in October 2012, your reinsurer, RGA, told CommInsure that it would not support the introduction of a partial benefit for minor heart attacks?---That's right.

And after this, the product team continued to investigate the introduction of that partial benefit. Is that right?---Yes.

But in March 2013 it was decided that the partial benefit for minor heart attacks wouldn't be included in the forthcoming August 2013 product update?---That's correct.

And the reason given was that:

> *Current experience and risk appetite restricts any movement which would impact profit.*

Do you recall reading that?---Yes, I do.

So commercial factors led to that proposal being dropped?---Yes.

And Dr Monday's concerns about the impact on customers fell by the wayside?---Yes.

Instead, the only change that was made was to rename the existing heart attack definition, heart attack of a specified severity?---That's right.

And not long after that, the next product development cycle began for the May 2014 product disclosure statement?---That's correct.

And in October 2013, a draft product design description was prepared, and it reintroduced the proposal for a partial benefit for a heart attack of limited extent?---Yes.

But in November 2013 RGA again expressed concerns about product changes with costs attached to them?---Yes.

And later that month, the proposed partial benefit was removed from the draft product design description on the basis that it was not supported by the reinsurer?---Yes.

So, again, no change was made to the heart attack definition at that time?---That's right.

But by that stage, in May 2014, a number of other insurers had updated their definitions to reflect the universal definition of heart attack?---Yes, that's right.

And as you said earlier, you accept that CommInsure's failure to update its definition at that stage was a commercial misjudgement?---Yes.

Do you accept that it was a commercial misjudgement that had consequences for CommInsure's policyholders?---Yes, I do.

Adverse consequences?---Yes, I do.

Do you accept that that misjudgement was, at least in part, the result of focusing on commercial considerations and not adequately taking into account the interests of your customers?---Yes, I do.

Or the potential risks associated with not updating the definition, such as reputational risk to CommInsure?---That's right.

And in May 2014, CommInsure's then chief medical officer, Dr Benjamin Koh circulated a paper that again recommended that the heart attack definition be updated?---That's right.

And if we go to CBA.0001.0528.0292, and we turn to, within this document, 0298. Are you familiar with this document, Ms Troup?---Yes, I am.

Yes. And if we turn to 0298. This is a document written by Dr Koh, then the chief medical officer at CommInsure. And we can see his recommendation at the bottom of the final page of the document – I'm sorry – yes, on the bottom of the final page:

Our current definition of heart attack should be reviewed in order that it is aligned to clinical advances and practical concerns of medical assessment of claims. Otherwise, in order to stick strictly to definitional terms, there may be unnecessary time wasted, financial and opportunity costs, legal implications and the tarnishing of brand reputation when trying to decline legitimate claims that would reasonably have been admitted within the spirit of the policy.

That was Dr Koh's recommendation?---Yes, it was.

And Dr Koh recognised the potential legal and reputational risk to CommInsure from not moving to update its definition?---Yes, he did.

I tender that document, Commissioner.

THE COMMISSIONER: Heart attack insurance definition: a review by Dr Benjamin Koh, CBA.001.0528.0292, exhibit 6.156.

EXHIBIT #6.156 HEART ATTACK INSURANCE DEFINITION: A REVIEW BY DR BENJAMIN KOH DATED 09/05/2014 (CBA.001.0528.0292)

THE COMMISSIONER: Ms Orr, the date – do we have a date on it? You said, I think May '14. But have we got any more precise date?

THE WITNESS: I think it is 9 May, Commissioner.

MS ORR: Yes. I'm sorry, we have a covering email that suggests that it's dated 9 May 2014.

THE COMMISSIONER: The date 9 May 2014 will become part of the exhibit.

MS ORR: Thank you, Commissioner.

Then in 2015, the non-executive members of CMLAs board risk committee initiated the Life Claims Customer Advocacy Review Project which is referred to I think in your statement as CCAR?---Yes.

And what did that project involve?---It involved – I think there was nine or 10 themes that were concerns in the business and it involved bringing in an expert from the industry to provide a clarity on those and what potential responses were needed by the company.

So a report from that project was delivered in September 2015?---That is right.

And that is CBA.0001.0527.1967. Now, if we turn to the third page, 1969, we can see the executive summary of this report. And at the top we see an explanation of the aims of the project:

> *To understand how we are positioned in terms of customer advocacy, firstly, but also risk management in key areas of life claims management that have been identified as being potentially complex or prone to error or inconsistent treatment. We will fix any specific claims identified as impacting customers, put in place actions to mitigate further issues occurring in these specific areas, and recommend any additional actions required.*

And beneath that we see the primary findings of the review and the second item in that list is:

> *Some trauma product definitions are either outdated due to medical developments or confusing for customers. For example –*

And one of the three was heart attack. And then the document sets out major recommendations in the executive summary. And the first recommendation was:

> *Consider updating trauma product definitions for bladder cancer, severe rheumatoid arthritis and heart attack.*

And if we turn to 1974, we can see that the method applied by the review is depicted on this page in assessing the themes that were addressed in the review. So this was a review that we can see was focused on customer advocacy?---Yes.

And we see that low customer advocacy is when a:

> *Product definition is confusing to customers, product definition doesn't align with medical advances in treatment and diagnostics, claims assessment is not consistent, medical opinions are not consistent, a high proportion of claims are declined and non-disclosure and non-legitimate claims are not managed effectively, potentially adversely impacting all policyholders.*

So those were circumstances that were characterised as low customer advocacy?---Yes.

And high customer advocacy was when:

> *Policy definition is clear and met customer expectations at claim time, the claims assessment was consistent, the medical opinions were consistent, the decline rate for legitimate claims was low, and non-disclosure and non-legitimate claims are managed effectively, protecting all policyholders.*

Now, if we turn to page 11 in the document, which is 1977, we can see the customer advocacy analysis for the heart attack definition. And we see this page begins with a problem statement:

> *The clinical definition of heart attack has changed and the criteria used to make the diagnosis have also changed in clinical practice as more sensitive tests are now available. Customers may be told they have had a heart attack but they do not meet the CI definition and are unable to claim. Our product definition (and therefore pricing) is no longer in line with the clinical definition.*

Now, these were the issues identified by Dr Monday and Ms Niestroy back in 2012, weren't they?---Yes.

But by late 2015 nothing had been done about those issues?---That's right.

And we can see on the slider depicted on this page that CommInsure recognised that in terms of customer advocacy, it had got worse between 2011 and 2015?---Yes.

Was that acceptable, Ms Troup?---No.

I will tender that report, Commissioner.

THE COMMISSIONER: Life Claims Customer Advocacy Review Report of September 2015, CBA.0001.0527.1967, exhibit 6.157.

EXHIBIT #6.157 LIFE CLAIMS CUSTOMER ADVOCACY REVIEW REPORT OF SEPTEMBER 2015 (CBA.0001.0527.1967)

MS ORR: And following this report, CommInsure began a project to review certain medical definitions including the heart attack definition. Is that right?---Yes, it is.

And then as we heard earlier, in March 2016 there were the media reports about the heart attack definition?---Yes.

And the amendment to the definition was accelerated to occur in March 2016 with effect back to May 2014?---Yes, it was.

Has CommInsure now taken steps to ensure that more than just commercial considerations are taken into account in its product review processes?---Yes, it has.

And could you explain those steps?---Yes. A few examples. Firstly, in – and in terms of our policies and practices, so we talked earlier about one of our product development guidelines. There's specific references now, in terms of customer advocacy, to ensure that the documents are considering that. Secondly, and I think

you might have said this before, a lot of those documents are focused on what is changing as distinct from what's not changing and the implications of that. So now we ensure that we're focusing on both sides of the product development cycle. It would also be fair to say that the experience of the last 18 months and two years has really created a different culture within CommInsure to really reinforce the importance of customer advocacy.

I want to put a series of short propositions to you to conclude this topic that I've been asking you questions about, Ms Troup. You accept, I think, that CommInsure knew from at least 2012 that its heart attack definition didn't reflect the universal definition of heart attack?---Yes, I do.

And you accept that until the name of the definition was changed to heart attack of specified severity in 2013, people reading the policy would have assumed that it was intended to apply to all heart attacks?---Yes.

And do you accept that in making decisions not to update the definition between 2011 and 2016, CMLA was motivated by commercial considerations?---Yes.

And that it did not adequately take into account the interests of its customers in making those decisions?---Yes.

Thank you. If that's a convenient time, Commissioner. I will need to continue with Ms Troup in the morning, but that might be a convenient break.

THE COMMISSIONER: 9.45?

MS ORR: Yes, thank you, Commissioner.

THE COMMISSIONER: Can we have you back in time to begin at 9.45, Ms Troup?---Yes, Mr Commissioner.

We will adjourn until then.

<THE WITNESS WITHDREW [4.18 pm]

MATTER ADJOURNED at 4.18 pm UNTIL THURSDAY, 13 SEPTEMBER 2018

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