

November 2016

# Inquiry into the life insurance industry

Parliamentary Joint Committee on Corporations and  
Financial Services

## ABOUT US

Set up by consumers for consumers, CHOICE is the consumer advocate that provides Australians with information and advice, free from commercial bias. By mobilising Australia's largest and loudest consumer movement, CHOICE fights to hold industry and government accountable and achieve real change on the issues that matter most.

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## INTRODUCTION

CHOICE thanks the Parliamentary Joint Committee on Corporations and Financial Services for its important and timely review of the life insurance industry.

Life insurance is a product that gives people comfort at some of the most challenging times in their lives. Given the inherent vulnerability of consumers when they come to claim against a policy, this sector has a special responsibility and should be held to the highest standards. In contrast, the evidence shows an insurance sector that is failing in its duty to put consumers' interests first.

Recent scandals have demonstrated that when a consumer claims on life insurance there can be a big gap between the quality and coverage that is expected and what is actually delivered. This appears to be, in part, because it is extremely difficult for consumers to understand and compare insurance policies either on quality measures or price. Consumers also can't trust that an insurer will treat them fairly, especially if they need to make a claim. Finally, poor system design means that many people hold unsuitable or multiple insurance policies without realising. The sector needs to be shaken up to address issues with product quality through better regulation, fairness, disclosure and system design.

While disclosure alone cannot remedy all problems, there are a number of lessons from other sectors where it has been more successfully applied and subsequently improved consumer outcomes. A more thorough application of the learning from behavioural economics and a move away from a reliance on Product Disclosure Statements (PDS) is central to overcoming this challenge.

Industry self-regulation in the form of the Life Insurance Code of Practice and the development of a code for life insurance in superannuation are both encouraging steps. However, efforts to date have not gone far enough in targeting key concerns around enforceability, compliance monitoring, sales practices and lengthy delays in claims processes.

The current exemption from a prohibition on unfair contract terms that the insurance sector enjoys further compounds consumer harm. Consumers are being exploited by fine print terms hidden away more than 100 pages deep into a PDS. Central to restoring confidence in this sector will be giving assurance to consumers that products reflect their expectations and that they won't be denied claims on the basis of fine print technicalities.

Despite reform efforts, conflicted remuneration remains a problem in this sector. Serious responses need to recognise that banning conflicted remuneration is the only real solution to a problem which is causing demonstrated harm to consumers.

Finally, there is serious need for better targeting and disclosure for insurance offered in superannuation. Modelling indicates that Australian consumers are potentially losing over a billion dollars each year due to duplicate insurance through superannuation. Younger consumers in particular are paying for insurance which does not match their needs and is eroding retirement balances.

Tangible savings could be made if insurance in superannuation was better targeted to consumer needs. Using current ATO figures on the number of duplicate accounts, up \$1.96 billion across the economy every year is potentially lost due to duplicate insurance, an average of \$131 per account holder.<sup>1</sup> Modelling from the Financial System Inquiry found that removing duplicate accounts could increase superannuation balances at retirement by around \$25,000 and retirement incomes by up to \$1,600 per year.<sup>2</sup> About two thirds of this cost or \$16,000 was due to duplicate insurance. This is clearly not an efficient use of resources, with fund erosion due to fees ultimately leading to an increased impost on the aged pension.

## Summary of recommendations

- Introduce a Key Fact Sheet to aid consumer comprehension and comparability of life insurance products. Life insurers should be required to provide consumers with this document prior to purchase. The document should be ‘pushed’ to consumers (e.g. sent through email, provided in a letter or in person) rather than requiring consumers to search and ‘pull’ the information themselves (e.g. having to request the document over the counter, search a website to download the document). The design and contents of the document should be optimised through real-world testing with consumers.
- That Key Fact Sheets include “product scorecards” based on ASIC-collected data about claims handling. The scorecard should include information about insurance policy claims

<sup>1</sup> APRA data shows there are almost 29 million accounts (<http://www.apra.gov.au/Super/Publications/Documents/2016ASBPDF201506.pdf>), of which 14 million are duplicate (<https://www.ato.gov.au/About-ATO/Research-and-statistics/In-detail/Super-statistics/Super-accounts-data/Super-accounts-data-overview/>). The final assumption is that each duplicate account is paying \$140/year in insurance (2014 average). The ‘per account holder’ figure is derived by dividing \$1.96 billion by the total number of Australians with a superannuation account (14.9 million)

<sup>2</sup> Modelling prepared for the Financial System Inquiry using Treasury models, October 2014. Based on assumptions of 37 years of work with an average of 2.5 accounts over a person’s working life, fixed fees of \$80 per account and \$140 for insurance per account per annum (in 2014 dollars)

ratios, claims acceptance rates, claims frequencies and average claims payouts for specific policies. This information would be most useful if presented to consumers at or before the point of purchase.

- Support the creation of digital decision making tools by requiring the release of relevant industry data on demographic risk profiles.
- Include key information summaries, including key terms and fees for default levels of coverage, about life insurance products upon sign up and via product dashboards.
- Remove the exemption insurance has from the prohibition on unfair contract terms. This could be achieved by amending section 15 of the Insurance Contracts Act (1984) so that the provision which currently excludes insurance contracts from the operation of any other Commonwealth, State or Territory Act allows the unfair contract terms provisions in the Australian Securities and Investments Commission Act (2001) to apply.
- That the current timeframes for claims handling processes be reviewed with the intention of creating efficiencies and ultimately reductions in length.
- That the Life Insurance Code of Practice be registered with ASIC in accordance with Regulatory Guide 183.
- That the *Corporations Amendment (Life Insurance Remuneration Arrangements) Bill 2016* is passed immediately
- That ASIC reviews the impact of the Bill and include a glide path to the complete removal of commissions as part of this process.
- Change default group life insurance for younger people to better match member needs.

## Improving consumer engagement through enhanced product disclosure

Due to information asymmetry it is incredibly difficult for someone to find the right life insurance product for their needs at a competitive price. For consumers, the price of life insurance can vary significantly but price isn't necessarily a good guide of quality or product suitability.

A CHOICE investigation from September 2015 found that life insurance purchased from the ten largest industry superannuation funds costs between \$156-500 for a 30-year-old to \$1,132-4,848 for a 60-year-old. Retail life insurance from 15 major insurers could cost between \$240-423 for a 30-year-old female to \$4,069-5,349 for a 60-year-old male.<sup>3</sup> Quality assessments of products were impossible to make without information about claims handling experiences consumers would face.

Further steps must be taken to give consumers the information they need about the price and quality of life insurance products.

CHOICE is concerned that current efforts to address a lack of effective disclosure are failing consumers. The Financial Ombudsman Service (FOS) received 1,095 life insurance disputes in 2015/16.<sup>4</sup> Denial of claim (26%) was the most common reason consumers came to the FOS with a life insurance dispute. Often the causes of these disputes arise in the sales process when an expectation is created about what a product will cover. It is not until a claim is made that the difference between expectations and reality becomes apparent.

Improving disclosure requirements is often pointed to as the solution to this problem; however recent efforts have failed to deliver on 'effective disclosure' or disclosure which adequately takes into account a consumer's ability to comprehend complex information. While disclosure requirements *alone* are unlikely to improve consumer outcomes, improvements to the current disclosure regime could improve a consumer's ability to make better product comparisons.

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<sup>3</sup> <https://www.choice.com.au/money/insurance/life/articles/life-insurance-review-and-comparison>

<sup>4</sup> FOS, 2016, 'Annual Review 2015-16' p.90

## Behavioural biases

A way forward is to more closely align disclosure requirements to an understanding of behavioural finance. Traditionally the role of disclosure was based on a theory that consumers are rational agents who will make welfare maximising decisions if provided with full information.<sup>5</sup> While this theory has long been questioned, policy and regulation has been slow to catch up. Traditional models assume economic agents, such as consumers, have an infinite capacity to take in and process information; are neutral to how it is presented; can anticipate and take the future into account; care only about self-maximising; and treat gains the same as losses.<sup>6</sup> In contrast, behavioural economics recognises that consumers have limits on the amount of information they can take in; are affected by presentation; tend to be poor at anticipating the future; care about people and fairness; and are more concerned about losses than gains.<sup>7</sup> These are known as 'behavioural biases'.

The impact of these behavioural biases is compounded in life insurance because the nature of the product means it is usually only relied upon in the future, if at all. This makes it difficult for a consumer to adequately assess their needs against the product offering. In addition, the presentation of terms, in the form of lengthy Product Disclosure Statements (PDSs) is not conducive to consumer reading and comprehension. This leaves many with poor knowledge of what a policy actually covers them for.

## Clearer information

Clear information presentation is not just important for aiding consumer understanding of a single product, but it can assist comparison across multiple policies. The goal of a properly functioning market should be to assist product comparison to drive competition and ultimately deliver products that are better aligned to consumer need. The current framework does not adequately allow for comparability across products because of differences in the way information and content are presented in PDSs.

From a disclosure perspective, the problem of lengthy and complex information has been addressed in several markets, including home and contents insurance and home loans through Key Fact Sheets (KFS) and telecommunications through Critical Information Summaries (CIS).

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<sup>5</sup> Johnston, K., Tether, C., Tomlinson, A., 2015, 'Financial Product Disclosure: Insights from behavioural economics', Ministry of Business, Innovation & Employment, p.iii

<sup>6</sup> Office of Fair Trading, 2010, 'What does Behavioural Economics mean for Competition Policy?', March 2010, p. 5

<sup>7</sup> Office of Fair Trading, 2010, 'What does Behavioural Economics mean for Competition Policy?', March 2010, p. 5

These are usually one-to-two page documents that contain key product information. For example, in insurance, the document contains a list of prescribed events for which the policy provides cover and any other key terms.

As these summaries and fact sheets are relatively new, there is limited evidence of their long-term impact in improving consumer decision making. However, the preliminary research indicates that consumers who use them benefit, although there are still problems with awareness of their existence.

A study into the use of KFS for home loan products found they effectively enhanced a consumer's ability to identify the cheapest loan package from among several alternatives.<sup>8</sup> Although the study demonstrated low levels of awareness among consumers of the existence of KFS, it showed that this was likely due to poor levels of information provision and staff training by insurers. Shadow shopping exercises indicated consumers were unlikely to receive a KFS unless they specifically asked for a 'Key Fact Sheet', even where they requested information for the same purpose. This indicates that mandatory requirements for businesses to provide useful information at key points in consumer decision making are necessary for effective disclosure measures to make a difference.

In telecommunications, the findings of a knowledge test discovered that consumers with 'terms and conditions' (akin to a PDS) performed more poorly than those given a Critical Information Summary (akin to a KFS).<sup>9</sup> This is despite the Terms and Conditions document containing much more information. The test was 'open book' in an attempt to re-create product understanding at purchase. This study shows that providing consumers with more information, rather than relevant targeted information, actually hinders their understanding of a product.

## Recommendation

- Introduce a Key Fact Sheet to aid consumer comprehension and comparability of life insurance products. Life insurers should be required to provide consumers with this document prior to purchase. The document should be 'pushed' to consumers (e.g. sent through email, provided in a letter or in person) rather than requiring consumers to search and 'pull' the information themselves (e.g. having to request the document over

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<sup>8</sup> Skelton, R.A., 2015, 'The Impact of Home Loan Key Facts Sheets on Borrowers' Comparisons of Loan Costs', QUT, available at: [http://eprints.qut.edu.au/91053/4/Ross\\_Skelton\\_Thesis.pdf](http://eprints.qut.edu.au/91053/4/Ross_Skelton_Thesis.pdf)

<sup>9</sup> Harrison, P., Hill, L., and Gray, C., 2016, Confident, but Confounded: Consumer Comprehension of Telecommunications Agreements, Australian Communications Consumer Action Network, Sydney. P.44

the counter, search a website to download the document). The design and contents of the document should be optimised through real-world testing with consumers.

## Information about product quality and claims handling

CHOICE supports the findings and recommendations of the ASIC Report 498 into life insurance claims. We are concerned that evidence of high claim denial rates may be directly linked back to problems in advertising and sales practice. Many of the expectations about what a consumer can claim for are created during the sales process. This is supported by the fact that the highest rates of denied claims came from non-advised sales (12%) where unlike retail (7%) and group channels (8%) consumers do not have the benefit of advice or a trustee acting in their interests.<sup>10</sup>

Relatively high decline rates in Total and Permanent Disability insurance (16%) are of particular concern. Westpac was identified by *The Australian* as having a decline rate of 37%, more than double the average.<sup>11</sup> CHOICE is pleased to see ASIC intends to conduct a follow-up investigation into individual insurers with high decline and dispute rates. Without a strong, well-resourced regulator this type of practice would never come to light.

The Financial Conduct Authority, the financial regulator in the United Kingdom, is currently part-way through a twelve-month trial of an insurance scorecard for general insurance. At the end of the trial they will assess whether to roll out the scorecard to other products.<sup>12</sup> A scorecard measure that provides information about claims processes for each product, not just insurer or product type, could help consumers more thoroughly assess products. We recommend that ASIC's data gathering initiatives are applied in a way to easily help consumers compare the quality of insurance.

## Recommendation

- That Key Fact Sheets include “product scorecards” based on ASIC-collected data about claims handling. The scorecard should include information about insurance policy claims ratios, claims acceptance rates, claims frequencies and average claims payouts for

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<sup>10</sup> ASIC, 2016, 'Report 498: Life insurance claims: an industry review', p.7

<sup>11</sup> The Australian, 2016, 'Westpac revealed as rogue after rejected 37 per cent of insurance claims' 15/10/2016, available at: <http://www.theaustralian.com.au/business/westpac-rejected-37pc-of-insurance-claims/news-story/5de39419d72dc4c0cd3be721e40a785a>

<sup>12</sup> <https://www.fca.org.uk/publications/feedback-statements/fs16-1-feedback-statement-dp15-4-%E2%80%93-general-insurance-value-measures>

specific policies. This information would be most useful if presented to consumers at or before the point of purchase.

## Alternatives to general information

Continued reliance on general information, not tailored to individual needs, will not improve consumer outcomes.<sup>13</sup> This was confirmed in CHOICE-commissioned qualitative research which found consumers did not want to be 'educated' but wanted short-cuts to decisions.<sup>14</sup> Participants highlighted a need for digital decision making tools that streamline decision making, simplify options and recommend the best product. Importantly, consumers want this information to be personalised to individual needs.

Consumers would be able to make better decisions if they had access to industry data on demographic risk profiles. For example, data which displayed the likelihood of various claim events occurring based on demographic data known about the consumer could help them select products which best matched needs.

## Recommendation

- Support the creation of digital decision making tools by requiring the release of relevant industry data on demographic risk profiles.

## Life insurance product disclosure in superannuation

Inadequate disclosure is particularly problematic in insurance offered as part of superannuation. The Association of Superannuation Funds of Australia (ASFA) research shows that 70% of consumers do not read PDSs or are not aware of them.<sup>15</sup> This is unsurprising when we consider the length of some superannuation PDSs; one study found PDSs ranged between 46-154 pages.<sup>16</sup> PDSs can also vary in the amount of jargon and other technical language they contain, and the way information is presented.

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<sup>13</sup> Harrison, P., Hill, L., and Gray, C., 2016, Confident, but Confounded: Consumer Comprehension of Telecommunications Agreements, Australian Communications Consumer Action Network, Sydney. P.45

<sup>14</sup> CHOICE, 2016, 'Project Superpower', by Pollinate, available at: <https://www.choice.com.au/money/financial-planning-and-investing/superannuation/articles/why-consumers-avoid-thinking-about-super-20161024>

<sup>15</sup> ASFA, 2016, 'Keynote address delivered by Dr Martin Fahy CEO ASFA National Conference', available at: <http://www.superannuation.asn.au/media/speeches>

<sup>16</sup> The Provision of Consumer Research Regarding Financial Product Disclosure Documents. Susan Bell Research. Report for the Financial Services Working Group. December 2008.

Superannuation funds are required to offer life insurance on an opt-out basis. Application forms frequently present this choice in a confusing way, without information about the cost of default cover.<sup>17</sup> Instead consumers are directed to supplementary documents, such as 'Insurance Guides' and PDSs. These often display the cost for units of cover which may differ across age groups, requiring consumers to conduct mathematical equations to discover the cost of life insurance premiums.<sup>18</sup> Given what we know about the small percentage of consumers that read a PDS, let alone understand it, it is unrealistic to expect consumers are making informed decisions when deciding whether to opt-out of insurance.

Some of the solutions can also be found in how superannuation products are dealing with disclosure. Superannuation 'Product Dashboards' have been introduced as an important measure to provide basic information about products' historical returns, target returns, fees and costs, and risk in an easy to read format that must be publicly available on a fund website. CHOICE maintains that this type of product disclosure is important in aiding consumer comprehension of key terms and significantly reducing the time it takes to compare key features of multiple products.

Despite life insurance being one of the major features of many superannuation products, with default options required to offer it on an 'opt-out' basis, life insurance is not included in these dashboards. We believe there would be significant value in disclosing key terms and fees for default levels of life insurance (if offered) via product dashboards. This would save consumers the time and effort currently involved in comprehending a PDS, something which the evidence suggests is too onerous for the overwhelming majority of consumers to attempt.

## Recommendation

- Include key information summaries about life insurance products, containing key terms and fees for default levels of coverage, upon sign up and via product dashboards.

<sup>17</sup> Catholic Super, 2016, 'Member Application for Employees', available at: <http://csf.com.au/documents/forms/MemberApplicationforEmployees.pdf> ; REI Super, 2016, 'Membership application form', available at: <https://www.reisuper.com.au/docs/default-source/super/rei-super-membership-application-form.pdf?sfvrsn=30>

<sup>18</sup> Australian Super, 2016, 'Insurance in your super', available at: [https://www.australiansuper.com/~/\\_media/Files/Guides/InsuranceGuide%20Finsuper.ashx](https://www.australiansuper.com/~/_media/Files/Guides/InsuranceGuide%20Finsuper.ashx)

## Increasing fairness: addressing the unfair contract terms prohibition

All businesses selling to consumers are prohibited from including unfair contract terms (UCT) in a standard form contract, except insurance.<sup>19</sup> There are sound policy grounds for the prohibition on UCT and these grounds apply equally to insurance. The UCT provisions were established to overcome consumer confusion in understanding complex contract terms in standard form contracts, where there was no possibility for a consumer to negotiate terms as part of the transaction.<sup>20</sup>

Laws aimed at tackling UCT have been used around the world including the United Kingdom, European Union, Japan and South Africa. Australia has considered expanding them to insurance as recently as 2013; however, the Bill lapsed at the change of government. In light of recent evidence of practice in the insurance sector it is time to introduce a prohibition on UTC.

In many respects insurance is the ideal case study for why a prohibition on UTC should exist. Life insurance contracts are so complex that consumers need an additional layer of protection against harmful terms. Contracts extend over pages of information, there is evidence that few people read or understand them, and they contain complex terms and medical definitions which most consumers are unlikely to understand. As a consequence, consumers suffer detriment by having claims denied due to the mismatch between what they thought the policy covered and what was actually covered.

Allowing insurance contracts to include provisions that are unfair leaves consumers open to exploitation. For example, life insurers should not be able to deny claims based on unfair or out dated medical definitions.

### Case study – Critical illness claim

As reported on ABC's 7.30, a consumer was denied a critical illness claim under a MLC life insurance policy after a near death experience in which they had to spend a week in intensive

<sup>19</sup> *Insurance Contracts Act 1984* section 15

<sup>20</sup> *Trade Practices Amendment (Australian Consumer law) Bill 2009* second reading

care. Under the policy a claim is only paid out if the claimant is intubated for 10 consecutive days (24 hours per day).<sup>21</sup> During the patient's recovery they were intubated for 7 days, so the claim was denied.

Evidence from the Australian Institute of Health and Welfare indicates the average length of intubation for an intensive care event is just over 4 days. Patients intubated for at least 10 days have over a 20% chance of dying. Despite the patient spending almost twice the average time intubated in intensive care and medical evidence which suggested the case was serious, the insurance policy did not deem this a critical illness.

This case is illustrative of the detriment consumers suffer due to the lack of UCT protections in insurance. The headline offer for the policy clearly states that "Critical Illness insurance pays a lump sum that lightens the financial load of a serious illness, so you can concentrate on getting better" with "cover for the most common critical conditions".<sup>22</sup> On the facts it appears the consumer even had the 'Critical Illness Plus' policy which went further to provide "cover for an extensive range of critical conditions". Researching beyond the sales pitch to read the PDS the consumer would have discovered on page 19 that the policy did in fact cover intensive care as one of its critical conditions.<sup>23</sup> It is not until reaching page 111 of the PDS that they would have discovered the term which eventually denied the claim. The policy defines intensive care as "mechanical ventilation by means of tracheal intubation for 10 consecutive days (24 hours per day) in an intensive care unit of an acute care hospital." The UTC prohibition exists to stop exactly this type of practice. Hiding a term over 100 pages in to a contract and expecting a consumer to not only read but understand the implications of intubation times on a claim is unrealistic and ultimately unfair.

According to the report MLC defended its policy by stating that it was unaware of any policy available in Australia which offered critical illness cover for less than 10 days of intubation. This points to a systemic problem with critical illness life insurance policies, which make it so difficult to claim under the intensive care provisions that someone may have to die in order to claim, in which case they may also be ineligible.

Similar unfair terms exist in superannuation life insurance contracts.

<sup>21</sup> MLC, 2016, 'MLC Insurance – Product Disclosure Statement', available at: [https://www.mlc.com.au/content/dam/mlc/fb/common/application-forms/84052\\_mlc\\_insurance\\_pds\\_brochure\\_combined.pdf](https://www.mlc.com.au/content/dam/mlc/fb/common/application-forms/84052_mlc_insurance_pds_brochure_combined.pdf) p.111

<sup>22</sup> MLC, 2016, 'Critical Illness', available at: <https://www.mlc.com.au/personal/insurance/products/critical-illness/at-a-glance>

<sup>23</sup> MLC, 2016, 'MLC Insurance – Product Disclosure Statement', available at: [https://www.mlc.com.au/content/dam/mlc/fb/common/application-forms/84052\\_mlc\\_insurance\\_pds\\_brochure\\_combined.pdf](https://www.mlc.com.au/content/dam/mlc/fb/common/application-forms/84052_mlc_insurance_pds_brochure_combined.pdf) p.19

### Case study – life insurance in superannuation

An illustrative example comes from a story reported by Adele Ferguson in the *Sydney Morning Herald*. It is that of the family of a young man and their battle to gain a life insurance payout after he took his own life. He had a life insurance policy through his superannuation fund, REST. The \$92,000 claim was rejected by REST and the insurer AIA on the basis that his account had fallen below \$1,200 and no contributions had been received for at least 62 days. This was despite REST continuing to take premiums from his account up until his death.

In situations when premiums are paid up there is no legitimate reason why an insurer should be able to deny a claim based on the balance of their superannuation account. The current UCT exemption allows clauses like these to persist, causing substantial harm to consumers.

### Why the duty to act in utmost good faith is an inadequate consumer protection

The insurance industry has claimed that the duty to act in the utmost good faith under the *Insurance Contracts Act 1984* is sufficient protection for consumers and that an UCT prohibition is not required.<sup>24</sup> The utmost good faith clause in the Insurance Contracts Act is unclear and jurisprudence is imprecise. This makes application of the law particularly difficult. The leading High Court case notes utmost good faith is more commonly applied in relation to requirements of honesty in the dealings and processes around the contract.<sup>25</sup> This does not go to the fairness of particular terms to a contract. To date, the utmost duty of good faith has not put an end to the types of clauses outlined above.

It should also be noted that the prohibition on UCT defines the meaning of ‘unfair’ in a way which is proportionate and would allow an insurer to continue to use a term where it is reasonably necessary in order to protect its legitimate interests.<sup>26</sup> Using the example above, it may have been reasonable for the insurer in order to protect its legitimate interests to limit critical illness claims to those who were actually critically ill. However, to lift the bar so high that

<sup>24</sup> Insurance Council of Australia, 2016, ‘Submission to the Australian consumer law review’, available at: [https://cdn.tspace.gov.au/uploads/sites/60/2016/07/Insurance\\_Council\\_of\\_Australia.pdf](https://cdn.tspace.gov.au/uploads/sites/60/2016/07/Insurance_Council_of_Australia.pdf)

<sup>25</sup> *CGU Insurance Limited v AMP Financial Planning Pty Ltd* [2007] HCA 36

<sup>26</sup> *Australian Consumer Law*, Sch2 s24(1)(b)

you would have a high probability of actual death before a critical illness claim would be valid would likely go beyond what is a legitimate interest.

One of the benefits of clear legislation, such as that contained in the UCT provisions, is that it can drive change without the need for costly litigation. The UCT obligations are very clear; the legislation even provides an extensive list of the types of terms which would be considered unfair. This is a far cry from the amorphous 'utmost good faith' requirements. The UCT obligations are so clear that the Australian Competition and Consumer Commission and consumer organisations have used the laws to engage directly with businesses around removing unfair terms.<sup>27</sup> This has seen many businesses voluntarily improve their terms. With limitations on regulator budgets and the cost of litigation for business compliance, the UCT provisions should be viewed as balanced best practice regulation.

## Recommendation

- Remove the exemption insurance has from the prohibition on unfair contract terms. This could be achieved by amending section 15 of the Insurance Contracts Act (1984) so that the provision which currently excludes insurance contracts from the operation of any other Commonwealth, State or Territory Act allows the unfair contract terms provisions in the Australian Securities and Investments Commission Act (2001) to apply.

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<sup>27</sup> For example, see ACCAN, 2016, 'Unfair and misleading fine print could be costing you' available at: <http://accan.org.au/hot-issues/726-unfair-and-misleading-fine-print-could-be-costing-you>; ACCC, 2016, 'ACCC warns businesses time is running out to review their standard form contracts for unfair contract terms', available at: <https://www.accc.gov.au/media-release/accc-warns-businesses-time-is-running-out-to-review-their-standard-form-contracts-for-unfair-contract-terms>

## Improving quality through better regulation

CHOICE welcomed the efforts made by industry and consumer representatives in drafting the Life Insurance Code of Practice (the Code). Codifying practice in the life insurance sector is a vital step in ensuring industry and community expectations are aligned. Industry codes play an important role in lifting protections above legislated requirements and providing guidance to industry to better understand its obligations in meeting community expectations. However, we have a number of concerns about the limitations of the scope and content of the existing Code.

### Group insurance

CHOICE is concerned that providers of group insurance policies are not captured by the Code. In the financial year ending June 2015, insurance within superannuation represented \$4 billion in fees and almost \$7.9 billion in premiums.<sup>28</sup> 15.3 million accounts in APRA-regulated institutional funds had life insurance (53 per cent of all accounts), with 13.2 million (46 per cent) having Total and Permanent Disability cover and 5.3 million (18 per cent) having income protection insurance.<sup>29</sup> The life insurance within superannuation market is too large and important for consumers to be excluded from the Code.

We understand that industry is taking steps to develop a standalone code for life insurance in superannuation. We believe there should be close scrutiny of the outcomes of this process, especially given the privileged place default group insurance has within the mandatory superannuation scheme.

### Adequacy of existing timeframes

An effective Code should set hard timeframes for claims handling processes and document requests. We are concerned that the current Code does not set enough firm timelines, and where timelines are set, they are subject to wide exemptions via the 'Exceptional Circumstances' clauses. We understand there may be differences in timeframes, for example, in claims decisions involving multiple parties. However, leaving consumers to wait up to 12 months for a decision should never be seen as best practice claims handling.

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<sup>28</sup> APRA, 2016, 'Annual Superannuation Bulletin', June 2015, (reissued 23 August, 2016), available at: <http://www.apra.gov.au/Super/Publications/Documents/2016ASBPdf201506.pdf>

<sup>29</sup> APRA, 2016, 'Annual Superannuation Bulletin', June 2015, (reissued 23 August, 2016), available at: <http://www.apra.gov.au/Super/Publications/Documents/2016ASBPdf201506.pdf>

## Recommendation

- That the current timeframes for claims handling processes be reviewed with the intention of creating efficiencies and ultimately reductions in length.

## Enforcement

There is no statement in the Code that creates enforceable obligations between consumers and subscribers. This needs to be addressed as a matter of priority. The Code should also be registered with ASIC in accordance with Regulatory Guide 183. Self-led industry compliance measures are an important first step in creating a 'culture of compliance'. However, without graduation to regulatory enforcement there is a significant risk that the industry compliance body will be left with inadequate monitoring and remedies to deal with participants in breach. For example, the Code is heavily reliant on self-reporting of breach and a party is only required to report in situations where it deems its own breach to be 'significant'. Without strong independent oversight and active monitoring there is a temptation to under-report breaches to avoid reputational damage. CHOICE maintains that a strong culture of compliance can only be maintained where the independent regulator has a role in code compliance and monitoring.

## Recommendation

- That the Life Insurance Code of Practice be registered with ASIC in accordance with Regulatory Guide 183.

## Sales practices

The Code does not do enough to improve sales practice standards beyond what is currently required by legislation. The Code should define and prohibit the types of behaviour that have led to poor consumer outcomes. There is substantial room to improve or even prohibit certain practices related to commission based sale models, add-on insurance sales and products such as Funeral Insurance and Consumer Credit Insurance.

## Smart system design for better consumer outcomes

The relative benefits and risks to consumers of the different elements of the life insurance market - direct insurance, group insurance and retail advised insurance - appear to be related to how well a product distribution channel takes account of a consumer's actual needs. There are several barriers to products adequately targeting consumer needs, including:

- Conflicted remuneration;
- Inadequate product disclosure; and
- Lack of demand side competitive pressure in default products.

Effort needs to be placed in addressing each of these problems through smarter system design to prevent poor consumer outcomes.

### Removing conflicted remuneration

The Australian Securities and Investment Commission's (ASIC) research into life insurance advice shows that the way an adviser is paid (e.g. under an upfront commission model compared to a hybrid, level or no commission model) has a statistically significant bearing on the likelihood of their client receiving advice that is not in their best interest.<sup>30</sup> In the study, almost half of advice provided under an upfront commission model did not comply with the law. The research shows that some consumers are being moved into new products regularly, not for their own benefit, but because an adviser will be paid a higher commission for the switch.

With average up-front commissions of about 120 per cent of the first year's premium, the incentive to 'churn' consumers between products is extremely high. This has led to an unhealthy focus on shifting consumers to products which maximise commissions for advisors rather than to products that are in consumers' best interests.

The Federal Government has a Bill before Parliament to create a legislative instrument that will empower ASIC to cap commissions.<sup>31</sup> This Bill will allow ASIC to cap upfront commissions at 60% of the first-year premium, with ongoing or 'trailing' commissions capped at 20%. The proposal also includes 'clawback' provisions if the consumer cancels in the first year of 100% of the commission or 60% if cancelled in the second year. These are promising first steps, but

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<sup>30</sup> ASIC, 2014, 'Review of retail life insurance advice', Report 413, available at: <http://download.asic.gov.au/media/2012616/rep413-published-9-october-2014.pdf>

<sup>31</sup> *Corporations Amendment (Life Insurance Remuneration Arrangements) Bill 2016*

given the overwhelming evidence of consumer harm related to commission based sales, commissions need to be permanently banned, as they are for other types of financial advice.

We acknowledge that ASIC plans to review the impact of these reforms to measure their effectiveness. As part of this review, ASIC should introduce a glide path to zero for the removal of life insurance commissions, with the aim of giving advisors a reasonable timeframe to develop new revenue streams while protecting consumers from further exploitation.

## Recommendation

- That the *Corporations Amendment (Life Insurance Remuneration Arrangements) Bill 2016* is passed immediately.
- That ASIC reviews the impact of the Bill and include a glide path to the complete removal of commissions as part of this process.

## Addressing demand side competitive pressure in default products

Under ideal market conditions, consumers are in a position to make informed decisions about a range of products and purchase those that best meet their needs. Due to a range of factors, from behavioural biases to system design, these ideal market conditions have not been present in superannuation and bundled life insurance products. CHOICE is concerned that too often the focus has been on taking decisions away from consumers rather than empowering them to make better decisions.

As the Government recognised in its terms of reference for its Productivity Commission inquiry, a lack of consumer-driven competition, particularly in the default fund market, has led to poor outcomes and higher fees for consumers.<sup>32</sup> The cause is endemic to any system that replaces consumers directing their own preferences with a third party. Research conducted by the superannuation fund REST found that 42% of employers spent less than five minutes selecting a default fund for their employees.<sup>33</sup> This leaves very little time to consider the merits of the superannuation fund, let alone the bundled life insurance. At the same time consumers are not necessarily making decisions in their best interests, with four in five never analysing the type or amount of life insurance that suits their own circumstances.<sup>34</sup>

<sup>32</sup> Morrison, S., 2016, 'Terms of reference: efficiency and competitiveness of the superannuation system'

<sup>33</sup> REST, 2016, 'Bridge the gap', November 2016, p.20

<sup>34</sup> Zurich Australia, 2014, 'Australians and Life Insurance: Misinformed, Misinsured?', Sydney.

To remedy this problem CHOICE has called for a refocussing of the life insurance market as a whole to concentrate on the long-term interests of consumers. This would involve implementing the assisted decision making requirements already outlined in this submission and at the same time introducing adequate consumer protections to ensure whatever choice a consumer makes there is a safety-net of fairness (e.g. a prohibition on commissions and unfair contract terms). We believe these measures will be particularly effective in improving the direct insurance and retail advised insurance markets.

## Aligning group life insurance to member needs

On group life insurance, we do not believe the case has been made to remove life insurance entirely from superannuation. However, refinements could be made to default insurance to ensure it better aligns with member needs.

The proposed primary objective of the superannuation system is to provide income in retirement to substitute or supplement the age pension.<sup>35</sup> This objective is a useful starting point to assess if funds offer insurance products that meet members' needs at minimal cost.

Given the high rate of duplicate accounts and the policy setting of opt-out insurance on MySuper products, there is a strong indication that multiple insurance may be an issue in the system. Further data is needed which identifies the rate of duplicate insurance across various demographics.

An efficient system would result in no duplicate insurance. The Australian Taxation Office (ATO) data indicates that 43% of people have more than one superannuation account, with 18% having three or more.<sup>36</sup> Meanwhile, 53% of APRA regulated institutional fund accounts have at least one type of insurance.<sup>37</sup>

Using current ATO figures on the number of duplicate accounts, up \$1.96 billion across the economy every year is potentially lost due to duplicate insurance, an average of \$131 per account holder.<sup>38</sup> Modelling from the Financial System Inquiry found that removing duplicate

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<sup>35</sup> Superannuation (Objective) Bill 2016

<sup>36</sup> ATO, 2016, 'Super Accounts Data Overview', available at: <https://www.ato.gov.au/About-ATO/Research-and-statistics/In-detail/Super-statistics/Super-accounts-data/Super-accounts-data-overview/>

<sup>37</sup> APRA, 2016, 'Annual Superannuation Bulletin', June 2015, Sydney.

<sup>38</sup> APRA data shows there are almost 29 million accounts (<http://www.apra.gov.au/Super/Publications/Documents/2016ASBPDF201506.pdf>), of which 14 million are duplicate (<https://www.ato.gov.au/About-ATO/Research-and-statistics/In-detail/Super-statistics/Super-accounts-data/Super-accounts-data-overview/>). The

accounts could increase superannuation balances at retirement by around \$25,000 and retirement incomes by up to \$1,600 per year.<sup>39</sup> About two thirds of this cost or \$16,000 was due to duplicate insurance. This is clearly not an efficient use of resources, with fund erosion due to fees ultimately leading to an increased impost on the aged pension.

Group insurance could also be better tailored to member needs. For example, the major reason for taking out death cover is to protect dependents. Given people are generally entering relationships and having children later, there are now longer periods in a person's working life where they are without dependents, but continue to pay for life insurance policies through their superannuation. In 2013, the average age men (31.5) and women (29.5) got married was higher than in 1993, at 28.8 and 26.4 respectively.<sup>40</sup> Also, by the time the average father (33) and mother (30.9) have children they have likely been paying for default death cover through their superannuation for several years.<sup>41</sup>

#### Case study - group insurance for young people

Deborah<sup>42</sup> the mother of two daughters contacted CHOICE to share her concern about default life insurance. Her daughters, both aged 19, were placed into their employers' default funds. They had no knowledge of their life insurance arrangements until one was notified by their fund that they had a low balance. Upon inquiring about the cause, Deborah discovered life insurance premiums had eroded almost the entire balance. Deborah encouraged her daughters to write to their super funds to explain the situation. Both funds agreed to remove the default insurance. One agreed to refund the full amount of the premiums to date, while the other did not. In Deborah's words:

*"Seriously when we buy a car we do not expect to automatically buy a trailer and not be told the features of the trailer and how much it costs? No 19-year-old needs life insurance and there should be a product disclosure statement and a cooling off period like every other insurance policy in Australia."*

The case study above demonstrates a common problem for consumers, particularly younger consumers. The default nature of group insurance and poor product disclosure does not

final assumption is that each duplicate account is paying \$140/year in insurance (2014 average). The 'per account holder' figure is derived by dividing \$1.96 billion by the total number of Australians with a superannuation account (14.9 million)

<sup>39</sup> Modelling prepared for the Financial System Inquiry using Treasury models, October 2014. Based on assumptions of 37 years of work with an average of 2.5 accounts over a person's working life, fixed fees of \$80 per account and \$140 for insurance per account per annum (in 2014 dollars)

<sup>40</sup> ABS, 2014, 'Marriages and divorces, Australia, 2013', ABS cat. no. 3310.0. Canberra: ABS.

<sup>41</sup> ABS, 2015, 'Births, Australia, 2014' available at: <http://www.abs.gov.au/ausstats%5Cabs@.nsf/0/8668A9A0D4B0156CCA25792F0016186A?Opendocument>

<sup>42</sup> Real name changed

encourage engagement. This means many are unaware that they have insurance until several years in to their working life. Some types of insurance, such as TPD, may be appropriate for younger workers, but further thought should be given to the appropriateness of defaulting younger people with no dependents and often part-time or casual work arrangements into death and income protection cover.

Structuring default death insurance to only commence around the age of 30 would be a policy approach better attuned to members' needs. Given the prevalence of multiple accounts and the possibility that these may not be consolidated for many years, there are potentially large portions of retirement balances which are being eroded due to poorly targeted and duplicate policies. Introducing default life insurance part way through a person's working life would also provide a trigger to engage consumers around smaller manageable decisions, such as finding lost super and the benefits of fund consolidation.

## Recommendation

- Change default group life insurance for younger people to better match member needs.