

# Individual Disability Income Insurance in Australia

Submission to the Actuaries Institute

27 October 2020

## Contents

Who we are .....	3
Introduction.....	4
Responses to Consultation Document A: .....	5
Chapter 3: Customer and Community Interests .....	5
Chapter 4: Consumer Protection and Advocacy .....	7
Chapter 5: Features of the Product/Market .....	12
Chapter 7: Regulation and the Law .....	14
Chapter 8: Financial Advice .....	15
Chapter 9: Underwriting and Claims Management .....	17
Responses to Consultation Document C: .....	19
In relation to the Sound Insurance Principles: .....	19
In relation to the Overarching Philosophies:.....	21
In relation to Key Product Elements:.....	23
In relation to the Explanatory Notes: .....	27
Conclusion .....	30

## Who we are

The Australian Lawyers Alliance (ALA) is a national association of lawyers, academics and other professionals dedicated to protecting and promoting justice, freedom and the rights of the individual.

We estimate that our 1,500 members represent up to 200,000 people each year in Australia. We promote access to justice and equality before the law for all individuals regardless of their wealth, position, gender, age, race or religious belief.

The ALA is represented in every state and territory in Australia. More information about us is available on our website.<sup>1</sup>

The ALA office is located on the land of the Gadigal of the Eora Nation.

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<sup>1</sup> [www.lawyersalliance.com.au](http://www.lawyersalliance.com.au).

## Introduction

1. The ALA welcomes the opportunity to have input into this inquiry.
2. The ALA congratulates the Actuaries Institute on the conduct of this consultation process, and the extraordinary amount of work that has been put into the development of the consultation documents.
3. ALA members provide legal representation to thousands of Australians, covered by these products, who will be impacted by the Taskforce's work.
4. We note the concerns outlined in the Summary section of Document A, which note the taskforce's observations that:

*The IDII product provides critical cover for many members of the community who may suffer loss of income because of disability. The IDII product has become more and more complex over time, making it difficult for customers to understand and be satisfied with claims outcomes.*

*At the same time, affordability and accessibility for those needing cover is declining. Increasingly, those with cover are finding the cost prohibitive, and the more-healthy policyholders are then likely to not maintain cover.*

*Meanwhile, insurers have been losing very large sums on IDII business, as claims have climbed in frequency and amount, and price increases have not been enough to compensate. Some insurers and reinsurers have effectively withdrawn from the market.*

*The market is at risk of failure.*

5. Ensuring a balance between consumer needs, and commercial viability is important. In this submission, we outline a number of concerns in relation to the contents of the consultation documents.
6. It is our view that some of the proposed product design reforms, which significantly diminish practical consumer benefits, may be disproportionate to the problem of sustained losses, or is at least lacking in actuarial or other modelling to support the need for such a pendulum swing. Obviously if the IDII product we are left with is too limited in its benefits, it will not be saleable, thereby causing market failure.

7. These concerns are drawn both from our expertise in the legislative environment in which these products exist, and the lived experience of consumers who rely on their insurances in the event of injury or incapacity.
8. In particular, we draw the Taskforce's attention to the following issues:
  - Whilst the consultation is primarily concerned with what is essentially a set of individual insurance products (IDII), there is a significant amount of detail in the consultation papers that relates to group insurance products.
  - We are not convinced that the recommendations detailed in Document A reflect the totality of the issues raised, or assertions made, in the rest of the documentation – especially the Reference Product (Document C).
  - There are a number of areas where we believe more work needs to be done to ensure that some of the proposals in the documentation align with the current legislative environment.
  - We are concerned about any attempts at curtailing consumer rights to seek legal assistance or advice in making disability insurance claims.
  - The Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry (the Royal Commission) highlighted a number of areas for improvement in how insurance customers' best interests should be made the primary consideration.
9. We ask you to take our comments into account when considering the outcomes of the consultation process.
10. We would be pleased to meet with you to discuss in more detail the legal provisions that have informed the submissions which appear on the following pages.

## **Responses to Consultation Document A:**

### **Chapter 3: Customer and Community Interests**

11. The ALA shares the Taskforce's concern, expressed on page 14 of Consultation Document A:

*The Taskforce was concerned that the concept of pooling of risk as an inherent feature of insurance was not well understood by all Participants in the IDII ecosystem; in particular, the link between claims experience and ultimate premium rates charged.*

12. We therefore agree that actions that improve consumer/policy holder understanding of insurance pooling concepts would be a worthy outcome of this review.

13. We suggest caution, however, in what data is used to inform this educative process.

14. We note the following dot point in the list of examples of the risks of overly liberal IDII benefits (provided on page 14 of Consultation Document A):

- *For consumers en masse (the community): if fewer people return to active employment as a result of being incentivised to stay on claim by liberal benefits, a drag on productivity will emerge as well as a drain on care and other support offerings*

15. The ALA questions the premise that people will avoid returning to work, despite being able to, because they are financially better off remaining on benefits. APRA has already taken measures to ensuring IDII benefits do not exceed the policyholder's income at the time of claim, and ceasing the sale of Agreed Value policies<sup>2</sup>. Indeed, in our experience, claimants covered under indemnity policies are often underinsured (less than 75% of pre-disability income) due to their income increasing after the policy commencement without an increase in the insured benefit. Such a gap already provides a significant incentive to return to work. The setting of any cap below 75% would require clear empirical evidence to have credence.

16. Our experience is that disabled persons aspire to recovery and to return to work - but unfortunately that is often not possible despite their best efforts for a range of reasons including:

- The lack of medical improvement despite treatment; and
- The risk of re-injury which diminishes their employability.

17. It is also worth noting the distinction between:

- those have suffered psychological injury, and

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<sup>2</sup> <https://www.apra.gov.au/news-and-publications/apra-intervenes-to-improve-sustainability-of-individual-disability-income>.

- those who have developed psychological injury as a result of a dispute with their insurer, in the course of disputing liability for a physical or psychological injury, or pressuring them to return to work too early.
18. We are not aware of any systematic occurrence of instances where an insured would be financially better off not working and therefore foregoes viable return to work opportunities. If this is the industry experience, the ALA suggests that inferences drawn should be supported with data and case studies - otherwise the education processes risk being based on false assumptions which reflect poorly in the life industries attitude towards its customers' motivations.
19. The risk with such an assumption is, of course, that it be used to justify harsh measures against a claimant under cover of an unfounded suspicion of malingering. For example, a justification for cutting off their benefits where they are not co-operating with a rehab program that the insurer has unilaterally deemed appropriate, despite it being in the insurer's financial interests to deem it so. The ALA considers this to be of greater concern than the somewhat pejorative assumption that disabled claimants avoid return to work due to too-liberal benefits.
20. The ALA would be delighted to be involved in the development of the community education campaign espoused in Recommendation 3.1.

## **Chapter 4: Consumer Protection and Advocacy**

21. The ALA congratulates the Actuaries Association on its consultation process in the development of this paper. We work closely with AFCA and CALC, and understand and appreciate the tremendous work they do on behalf of victims of poor insurer behaviour.
22. We also note that those discussions included conversations with one consumer advocate lawyer which we support. We further suggest that consulting with industry peak bodies, such as the ALA, may add more credence to such consultations.
23. We note that Consultation Document A lists, (on page 16) several learnings that came from those discussions, namely:
- *There may be merit in standardising some policy terms and conditions (note: the Taskforce believes that this could stifle innovation and previous attempts at standard definitions have acted as minimum definitions and, as such, failed to achieve the objective);*
  - *There may be benefits in reducing product complexity;*

- *Medical advances may benefit the industry as much as it disadvantages;*
- *Inadequate sales processes and commission structures also drive premium increases;*
- *It may be more appropriate to use treating specialists to assess disability than other professionals;*
- *Insurers need to be clear on their promises to consumers. If the product provides cover against heart attack, the definition should be updated over time to ensure that the promises are met.*

24. All of the above points were, to varying degrees, clear outcomes of the Royal Commission.

25. We make the following observations:

- The adoption of universal terms was a clear recommendation of the Royal Commission.<sup>3</sup>
- We agree that it is important that the standardisation of policy terms does not stifle innovation. It is important to ensure that there remains sufficient flexibility by insurers in product design and pricing to retain a competitive market. This, we believe, should be a guiding principle of this consultation process.
- Treasury is currently in the process of developing legislation in relation to universal terms,<sup>4</sup> and unfair contract terms.<sup>5</sup> This work has been delayed as a result of the COVID crisis, but will come into effect in due course.
- ALA members have a significant library of case studies where insurers have relied on outdated medical definitions to deny claims.
- The Royal Commission dedicated 18 pages of its report to poor sales processes of insurance products. Please see our response to issues raised in Chapter 8 for more on commission structures. We agree that these actions drive premium prices.

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<sup>3</sup> <https://www.royalcommission.gov.au/sites/default/files/2019-02/fsrc-volume-1-final-report.pdf>; ref Recommendation 4.13.

<sup>4</sup> <https://treasury.gov.au/consultation/c2019-t370846>. Note, this is specific to insurances within MySuper products.

<sup>5</sup> <https://treasury.gov.au/consultation/enhancements-unfair-contract-term-protections>; <https://treasury.gov.au/consultation/c2019-t372650>.

- In relation to using treating specialists to assess disability rather than other professionals, unless the treater’s opinion can be impugned as lacking in credibility, it should be the paramount opinion in assessing the disability. Treaters’ opinions are based on in-depth insight, and often long-term therapeutic relationship. This view is supported by the courts: *Brown v Hannover Life Re of Australasia Ltd* [2020]<sup>6</sup> tells us that an insurer “*must give weight to treating and consulting practitioners of the insured to the extent that their views are rational and apparently well-founded, with the advantage of close familiarity with their patient*”.
- Attempts by insurers to push for greater involvement by private sector life insurers in worker rehabilitation<sup>7</sup> were rejected<sup>8</sup> by the Parliamentary Joint Committee on Corporations and Financial Services.

26. We note the section of Consultation Document A, page 17, entitled “Lawyers acting for claimants”.

27. Whilst the question of a party’s use of a lawyer is not relevant to the matter of IDII sustainability (or life insurance sustainability more generally), given it has been raised the ALA makes the following points for your consideration.

28. Insurers often engage lawyers in-house or externally during the claims process. Such advice covers strategy, tactics, presentation etc. directed towards the insurer’s interests and not the insureds. Related documents are often the subject of claims for legal professional privilege in subsequent court proceedings. This is not a criticism - It is their right to do so, just as it is the right of a claimant to use a lawyer. This is a fundamental starting point.

29. The legal profession is subject to robust professional standards and accountabilities in respect to conduct (e.g. the Australian Solicitors Conduct Rules, statutes, regulations, cost assessment regimes, Law Society oversight, Legal Services Commissions). These include best interests and other duties, as well as weighty disciplinary sanctions. Consumers are required to be provided with extensive disclosure as to their rights, to facilitate the making of an informed decision.

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<sup>6</sup> FCA 1391 at [113].

<sup>7</sup> [https://www.aph.gov.au/Parliamentary\\_Business/Committees/Joint/Corporations\\_and\\_Financial\\_Services/Rehabilitation](https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Corporations_and_Financial_Services/Rehabilitation).

<sup>8</sup> [https://www.aph.gov.au/Parliamentary\\_Business/Committees/Joint/Corporations\\_and\\_Financial\\_Services/Rehabilitation/~media/Committees/corporations\\_ctte/Rehabilitation/report.pdf](https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Corporations_and_Financial_Services/Rehabilitation/~media/Committees/corporations_ctte/Rehabilitation/report.pdf); see recommendation 5.

30. Commissioner Hayne made the following observation in the final report of the Royal Commission:  
“The asymmetry of knowledge and power between consumers and financial services entities has been evident throughout the Commission’s work”.<sup>9</sup>

31. He added “Aggrieved customers can try to negotiate directly with an entity, they can commence legal proceedings, or they can go to alternative dispute resolution. In each case, *the existing asymmetry means that legal assistance is often of critical importance to the customer’s position*”<sup>10</sup> (our emphasis).

32. Whilst it is true that a legally represented claimant might be readily paid by the insurer without legal help, many disabled claimants choose to be assisted by a lawyer in case of problems or complexities in their claim, which we know from experience and data, do regularly arise. Such claims are understandably crucially important to them and they wish to be guided and supported throughout.

33. That sentiment is not surprising given the poor recent history of industry conduct as established for example:

- Royal Commission case studies including where TAL admitted that it ‘had no regard for the wellbeing of the insured, and was on a mission to stop her from receiving benefits under the policy’ when it paid a private investigator to follow and record a former nurse as part of an attempt to discredit her and void an income protection policy. It also demanded daily diary entries from her despite the evidence from her doctors saying this is exacerbating her conditions;<sup>11</sup>
- ASIC’s September 2018 Report 498 *Life insurance claims: An industry review* which identified high rates of declined and withdrawn claims, and poor claims processing times;<sup>12</sup>
- ASIC’s October 2019 Report 633 *Holes in the safety net: A review of TPD insurance claims* which ‘identified that insurer practices such as difficult lodgement processes, poor

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<sup>9</sup> <https://financialservices.royalcommission.gov.au/Pages/reports.aspx>. P.490.

<sup>10</sup> Ibid.

<sup>11</sup> <https://www.royalcommission.gov.au/sites/default/files/2019-02/fsrc-volume-2-final-report.docx>. P.336 (ASIC subsequently sued TAL over its alleged breach of law: <https://asic.gov.au/about-asic/news-centre/find-a-media-release/2019-releases/19-357mr-asic-commences-proceedings-against-tal-life-limited-for-handling-of-insurance-claim/>).

<sup>12</sup> <https://asic.gov.au/regulatory-resources/find-a-document/reports/rep-591-insurance-in-superannuation/>.

communication practices, multiple requests for medical assessments, and excessive delays were just some of the problems consumers found during the claims assessment process’.

- The findings by the Life Code Compliance Committee (LCCC) of 315 claims handling code breaches within a 6-month period (based on a sample of one law firm representing a small fraction of all claimants);<sup>13</sup>
- The LCCC’s findings that it was not confident that all subscribers had robust frameworks in place, ‘that not all significant breaches are being reported’ and that ‘subscribers must take their code compliance far more seriously than they have to date’.<sup>14</sup>

34. There is a profound difference between an injured person engaging legal support/advice early in a claim, and prematurely engaging in legal action. In principle, the ALA does not support the later. The Consultation Document doesn’t make that important distinction.

35. In any case, insurers have rights of response if they believe that a claim has been escalated to litigation too early.

36. The paper notes that lawyer engagement in lump sum claims is, according to FSC statistics, higher than for IDII claims. ASIC Report 633 tells us that:<sup>15</sup>

- Less than 20% of claimants have legal representation.
- claimants are less likely to give up due to claims fatigue or other reasons if they have legal support – 3.8% give up where they have legal support versus 14.7% give up where they do not.
- ASIC noted *“Our consumer research identified mostly positive consumer experiences of engaging lawyers to help with a claim”*.

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<sup>13</sup> <https://lifeccc.org.au/resources/claims-and-complaints-handling-obligations/>

<sup>14</sup> <https://lifeccc.org.au/app/uploads/2020/09/LCCC-2019-20-Annual-Report.pdf>.

<sup>15</sup> <https://asic.gov.au/regulatory-resources/find-a-document/reports/rep-633-holes-in-the-safety-net-a-review-of-tpd-insurance-claims/>.

37. These products are often provided through superannuation. Recent research<sup>16</sup> has found that the inability to deal with a legal problem in the absence of legal advice was greatest in the area of superannuation law. The level of complexity in superannuation law, with its multiple layers of statutory regulation imposed over trust law and policy changes requires our highly specialist legal expertise.
38. Given the above, the concern underpinning Recommendation 4.1 and 4.2 that ‘private lawyers may get involved in claims unnecessarily early’ area is unsupported by the evidence.
39. Any additional layer of regulation imposed on lawyers and consumers – such as that suggested in Recommendation 4.2 - would be unnecessary, unworkable, and contain double standards.
40. Finally, it is noted that the ALA supports the promoting better, more cooperative relations between superannuation funds, insurers, claimant lawyers and other claimant advocates. We are eager to engage with all relevant stakeholders to improve the fairness and sustainability of the sector, however that conversation should, as a starting point, respect a claimant’s right to seek legal help.

## Chapter 5: Features of the Product/Market

41. In the discussion on the effect of guaranteed contract terms, Consultation Document A tells us (p.21):

*Some interviewees considered the Life Insurance Act should be changed to allow more flexibility than it currently does with respect to possible changes to policy conditions during the policy term.<sup>17</sup>*

42. It is a core principle of contract law that, once a bargain is struck, a party cannot unilaterally change the terms. This enables the parties to have certainty in its terms across a long-term relationship. Therefore the ALA firmly believes that any significant product design changes must be prospective unless they are agreed to by consumers in fair circumstances. Any purported deviation from this norm would be unlawful and likely catalyse much legal disputation.
43. Given the major shifts being proposed in product design will create a gulf in quality between the new ‘on market’ products and what will be legacy policies, the ALA advocates for safeguards against

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<sup>16</sup> Duffy, M; Coleman, A & Nichol, M. (2019). *Access to Civil Justice Measurement Project: Final Survey Result*. Monash University.

<sup>17</sup> p.21.

insurers imposing unsustainable premium increases across legacy product books, as this may lead the selective lapsation of legacy products, regardless of the insurer's intentions. Whilst Section 9A(5) of the *Life Insurance Act 1995*<sup>18</sup> requires such premium alterations be made on a 'simultaneous and consistent basis', insurer may interpret this to mean increases need only be consistent 'within the envelope' of that particular product generation. Such an outcome risks unfairly exposing older consumers who would be unable to get new cover to the loss of their carefully procured cover through no fault of their own.

44. Consultation Document A also tells us that:

*There were views that the current practice of providing long term guarantees of policy conditions in a rapidly changing world was in effect providing a one-way option to customers and no longer workable. Indeed, APRA has recognised the high levels of uncertainty associated with long-term guarantees as a prudential risk for insurers (see its letter<sup>11</sup> of 2 December 2019). Its proposal to have 5-year contracts with guaranteed renewability on updated terms has resonated with many interviewees. There was quite a lot of support for this APRA proposal, including by CEOs. There were also some reservations about how customers would be protected at the 5-year rollover, and this would need careful consideration by insurers.*<sup>19</sup>

45. The ALA submits that it is important to ensure that no consumer is prejudiced in their ability to renew based on any change in their health or other personal circumstances since the policy was first incepted.

46. Any alteration of terms must be adherent to the Unfair Contract Terms (UCT) provisions due to commence from 5 April 2021 pursuant to Recommendation 4.7 of the Royal Commission. Those changes provide that If an insurance contract is subject to the UCT regime, a term in an insurance contract may be declared unfair and therefore void if it:

- a) would cause a significant imbalance in the parties' rights and obligations arising under the contract; and
- b) is not reasonably necessary in order to protect the legitimate interests of the party that would be advantaged by the term; and

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<sup>18</sup> <https://www.legislation.gov.au/Details/C2018C00074>.

<sup>19</sup> P.21.

c) would cause detriment to a party if it were to be applied or relied on.

47. We note that revised UCT provisions are discussed in Chapter 7 of Consultation Document A.

48. We further note that Consultation Document A tells us that:

*In addition, claims can sometimes be notified to the insurer many months or even years after the disability commences. This can make the fair assessment of a claim challenging and largely removes the opportunity for the insurer to assist the customer minimise the insured loss. It should be in the interests of both customers and insurers that claims are notified early, considered expeditiously and strategies put in place to speed recovery of the customer to minimise the insured loss.<sup>20</sup>*

49. Section 54 of the *Insurance Contracts Act 1984*<sup>21</sup> addresses this issue by enabling an insurer to reduce its liability to the extent it is prejudiced by the late notification of any claim. For example, where an insurer can show that if a claimant had notified the claim sooner the claimant would have been able to return to work, it may be placed in such a position.

50. This legal principle of proportionality should be reflected in Recommendation 5.6.

51. The existing body of case law on this issue provides a robust framework and should not be disturbed.

## **Chapter 7: Regulation and the Law**

52. We note that, in the section detailing the role of Treasury in the legislative and regulatory environment, Consultation Document A notes that:

*1. Payment of rehabilitation costs by a life insurer for an IDII claimant could potentially help the customer return to work more quickly. However, the law restricts the ability of life insurers to do this. This was explored in detail by a submission by the FSC to the Productivity Commission in 2018. Appropriate changes to legislation would benefit both customers and insurers.*

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<sup>20</sup> p.22.

<sup>21</sup> [http://classic.austlii.edu.au/au/legis/cth/consol\\_act/ica1984220/s54.html](http://classic.austlii.edu.au/au/legis/cth/consol_act/ica1984220/s54.html).

53. As noted earlier, this FSC suggestion was dismissed<sup>22</sup> in a report by the Parliament Joint Committee on Corporations and Financial Services, following a thorough investigation in 2018. We suggest that should be noted in this section of Consultation Document A.

54. The same section notes, under point 2 that:

*Section 48 of the Life Insurance Act deals with the requirement to give priority interests to policyholders. Its implications for the complexities and uncertainties inherent in IDII should be carefully considered, particularly in the context of the long-term sustainability of the IDII product being in policyholders' interest.*

55. The ALA notes that one of the core themes arising from the Royal Commission was the need to ensure that the consumer's best interest is the primary consideration in any financial arrangement – including in insurances. The above point seems to be in direct conflict with Commissioner Hayne's views.

56. For more information on best interest duties, please see our response to Chapter 8.

## **Chapter 8: Financial Advice**

57. We refer to the section of Consultation Document A that refers to Best Interest Duty and Commission.<sup>23</sup>

58. The final report of the Royal Commission frequently makes the observation that product recommendations driven by commission incentives are the antithesis of best interests of the consumer.

59. The ALA believes that this is just as true in the insurance sector, as it is in the investment sector. A history of soft underwriting and liberal policy conditions have been driven in part by commission incentives for risk advisers to sell particular products, often in-house products. The result is that

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<sup>22</sup>See: [https://www.aph.gov.au/Parliamentary\\_Business/Committees/Joint/Corporations\\_and\\_Financial\\_Services/Rehabilitation](https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Corporations_and_Financial_Services/Rehabilitation); and [https://www.aph.gov.au/Parliamentary\\_Business/Committees/Joint/Corporations\\_and\\_Financial\\_Services/Rehabilitation/~media/Committees/corporations\\_ctte/Rehabilitation/report.pdf](https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Corporations_and_Financial_Services/Rehabilitation/~media/Committees/corporations_ctte/Rehabilitation/report.pdf); see recommendation 5.

<sup>23</sup> p.33 and p.35 respectively.

consumers may have been inappropriately underwritten leading to a greater proportion of higher risk insureds thus increasing negative claims experience.<sup>24</sup>

60. ASIC has described vertically integrated advice models as being inherently conflicted, and lacking in customer transparency, and resulting in poor customer outcomes. We note, for example, the following passage from ASIC's submission of December 2014<sup>25</sup> to the Senate inquiry into the scrutiny of financial advice:<sup>26</sup>

*The inherent conflict of interest created by vertical integration may not be readily apparent to clients, particularly if the product manufacturer and advice parts of the business operate under separate licences and business names. Roy Morgan Research found that 55% of surveyed consumers receiving financial advice from an entity owned by a large financial institution, but operating under a different brand name, considered it to be independent—in contrast, only 14% of consumers considered financial planners working under the brand of the same financial institution to be independent. This was also an issue identified by the Financial System Inquiry, which recommended that advisers be required to disclose ownership structures of the advice firm to consumers.*

61. This has been ameliorated somewhat by:

- the Life Insurance Reform Legislation<sup>27</sup> which has capped commissions and applied claw back disincentives for policy churning behaviour; and
- Large banks exiting wealth management thereby reducing the focus on pushing in-house insurance products where it is not best suited to the consumers' needs, along with the expansion of approved product lists.

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<sup>24</sup> A leading example of this being *Commonwealth Financial Planning Ltd v Couper* [2013] NSWCA 444 (16 December 2013).

<sup>25</sup> <https://www.aph.gov.au/DocumentStore.ashx?id=20facfd2-e9ad-4196-a333-84df95c0760c&subId=302489>; para 245.

<sup>26</sup> [https://www.aph.gov.au/Parliamentary\\_Business/Committees/Senate/Economics/Scrutiny\\_of\\_Financial\\_Advice](https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Economics/Scrutiny_of_Financial_Advice).

<sup>27</sup> <https://treasury.gov.au/consultation/life-insurance-reform-legislation>.

62. However there is still work to do starting with reduction of commissions as per Hayne Recommendation 2.5 – Life risk insurance commissions:<sup>28</sup>

*When ASIC conducts its review of conflicted remuneration relating to life risk insurance products and the operation of the ASIC Corporations (Life Insurance Commissions) Instrument 2017/510, ASIC should consider further reducing the cap on commissions in respect of life risk insurance products. Unless there is a clear justification for retaining those commissions, the cap should ultimately be reduced to zero.*

63. We note the section on page 36 of Consultation Document A, which reads:

*The Taskforce has consciously not addressed the role of commission payments in the current project, given the heavy attention it has received previously and is likely to be given in the near term, post the Royal Commission. Notwithstanding this, a number of interviewees mentioned commission as a driver of problems, as the commission system encouraged more complex, expensive products.*

*Any review of commissions should consider the matters addressed in this report*

64. We believe that a focus on commission payments, and consumer best interest duties, is an indispensable element of any review of non-default insurance sustainability, including this review. It would help ensure the appropriateness and fitness for purpose of products to consumers without the conflicted incentives that have so often resulted in poor consumer and industry outcomes, thereby improving the integrity of insurer's books.

## **Chapter 9: Underwriting and Claims Management**

65. The ALA notes the views expressed by underwriters and medical practitioners, found on page 38 of Consultation Document A. One of the items in that list reads as follows:

*With respect to GPs and their interaction with the life industry, views included:*

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<sup>28</sup> <https://www.royalcommission.gov.au/sites/default/files/2019-02/fsrc-volume-1-final-report.pdf> page 26.

*GPs must be patient advocates. Their duty must be to 'first do no harm'. Often the line of least resistance for them is to agree with the patient. Anything the life industry does that looks to work against those principles will be met with suspicion or dislike.*

*GPs also get asked to use different forms for each life company, and for workers compensation etc.*

66. The statement that GPs must be patient advocates is a false generalisation. Treating doctors have enhanced insight and their opinions should not be discounted lightly, in relation to work capacity or otherwise. Nor should it be assumed they are acting as advocate (or in any sort of biased manner that supports malingering). On the contrary, treaters are often very conservative in their assessment of impairment by remaining and seeking to keep the patient optimistic of improvement.

67. The list continues:

*GPs are asked to do things by the life industry that they are not skilled to do, nor have the time to do. They are not occupational therapists. They do not understand the details of what determines incapacity for many occupations. The views put forward on this varied, and included:*

*Industry should use a standard form for seeking information. This consistency should make it easier for GPs and they will likely view it as fairer.*

*Industry should stop asking questions as to whether the person meets a definition and not delegate decision-making to the GPs. Instead, GPs should be asked more straightforward/direct medical questions and the life insurer should use that to assess the claim itself.*

68. The ALA points out that case law has established that: *'Where an expert opinion is sought, the expert must also be asked the right questions.'* That would include opinions sought from treating doctors. To not do so has been deemed unsatisfactory conduct by insurers.<sup>29</sup>

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<sup>29</sup> See, for example, *Banovic v United Super Pty Ltd* [2014] NSWSC 1470; BC201411315; *Wyllie v National Mutual Life Association of Australasia Ltd and Others* (1997) 217 ALR 324 at [328, 347].

69. We pose the question: Wouldn't an insurer acting in good faith benefit from an opinion from a treating doctor that believes a patient is disabled as defined? To not do so suggests a reluctance to generate evidence that does not suit the insurer's financial interests.
70. The ALA supports recommendation 9.8 in principle. Establishing a claims ecosystem where Life Insurers engage with other stakeholders in disability support systems to identify systems improvements would be most beneficial.

## Responses to Consultation Document C:

71. The ALA offers the following observations in relation to Document C: Summary of Reference Product, IDII (Document C).

### In relation to the Sound Insurance Principles:

72. The ALA agrees that the listed principles, across the board, are indeed necessary for insurance companies to follow to achieve appropriate ongoing community outcomes.
73. We have some concerns in relation to the third of the listed principles, namely:
- 3. The benefit payment should not exceed the financial loss suffered, after allowing for other sources of financial support.*
74. Offset provisions should also be fair to consumers – not dollar for dollar, but applying a cap of 75% (plus allowance for super if applicable to the income protection product) when combined with other income related to the injury/sickness. This percentage cap is consistent with the purpose of IDII to insure against the loss of personal exertion income not more than a percentage of pre-disability income.
75. Offset clauses should not include any reduction due to the receipt of Centrelink - you cannot receive Centrelink whilst in receipt of IDII. Whilst some insurers have appropriately removed Centrelink offsets from policies, or even better stating in explicit terms that an entitlement to Centrelink will not impact IDII, there are still a number of insurers that try to apply an offset where the claimant is on Centrelink.
76. DII payments are firstly tested under the income test for Centrelink so will reduce it to zero entitlement usually, but where a claimant has been on Centrelink and then claims IDII, the *Social Security Act* explicitly precludes insurers from shifting their liability on to the taxpayer by incorporating IDII payments where an offset in respect to Social Security payments has been applied into the

definition of compensation and reduces the payment accordingly meaning there is nothing to offset, again to stop insurers shifting the burden of a medical condition they agree to indemnify on to the taxpayer.

77. Pursuant to Part 3.14 of the *Social Security Act 1991*,<sup>30</sup> Centrelink is able to recover payments made where a person receives compensation for the same period. Specifically, s 1160 states:

*(1) This Part operates in certain specified circumstances to do one or more of the following:*

*(a) reduce a person's compensation affected payment;*

*(b) render a person's compensation affected payment not payable;*

*(c) require the repayment of some or all of a person's compensation affected payment;*  
because of the receipt of compensation by the person or the person's partner.

78. Section 17 defines 'compensation affected payment' to mean, inter alia, a social security benefit of what the DSP or Newstart is.

79. DII is 'compensation' for the purposes of s 17.<sup>31</sup> It is a series of periodic payments made wholly or partly in respect of lost earnings or lost capacity to earn resulting from personal injury.

80. Put simply, if an insurer elects to offset a DII benefit by a Centrelink payment, the claimant will no longer be entitled to that DII benefit and therefore there is no offset to be applied.<sup>32</sup>

81. It is therefore submitted that the 'Sound Insurance Principle' 3 and the wording of Offsets Amount in the draft Reference Product should reflect the matters discussed herein to ensure DII cover does serve its purpose to insure against the loss of a feasible proportion of pre-disability personal exertion income.

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<sup>30</sup> [https://www.legislation.gov.au/Details/C2018C00413/Html/Volume\\_3#\\_Toc527011153](https://www.legislation.gov.au/Details/C2018C00413/Html/Volume_3#_Toc527011153).

<sup>31</sup> See Bryan Bell and Secretary, Department of Social Security [1998] AATA 284; Gentley and Department of Family and Community Services [2001] AATA 561, [69]; Oprea and Secretary, Department of Family and Community Services [2005] AATA 678, [18].

<sup>32</sup> As occurred in *Gentley and Department of Family and Community Services* [2001] AATA 561.

## In relation to the Overarching Philosophies:

82. The second of the overarching philosophies reads:

*The purpose of the Reference Product is to support the customer to Return to Work (RTW) to help shift the focus from how disabled the customer is.*

83. This assumes that a RTW is possible when often it is not. For example, where the condition results in total and permanent disability (TPD), RTW is not possible.

84. Perhaps an additional overarching philosophy (or an extension of this one) should be that if a claimant is TPD then insurers will not pursue RTW actions in the administration of the claim.

85. The third of the overarching philosophies reads:

*In addition to 'income support', actual expenses incurred can be reimbursed where consistent with the RTW purpose. Other than this, there are minimal ancillary benefits.*

86. As an overarching philosophy, this pushes very close to the edge of the legal limitation on insurers to fund medical and rehabilitation expenses.

87. Attempts by insurers to push for greater involvement by private sector life insurers in worker rehabilitation<sup>33</sup> were rejected<sup>34</sup> by the Parliamentary Joint Committee on Corporations and Financial Services (the PJC) in 2018.

88. The PJC's inquiry firmly rejected a proposal by the Financial Services Council (FSC) that life insurers should have an expanded role in the rehabilitation of insured persons. Specifically, the PJC stated:

*The committee has particular concerns about the FSC's answer regarding the provision of discretionary rehabilitation medical treatment. In the committee's view, a system that operates at the discretion of life insurers would appear to provide even less equity of access than a risk-rated system. A risk-rated insurance system at least has identifiable processes that*

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<sup>33</sup> [https://www.aph.gov.au/Parliamentary\\_Business/Committees/Joint/Corporations\\_and\\_Financial\\_Services/Rehabilitation](https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Corporations_and_Financial_Services/Rehabilitation).

<sup>34</sup> [https://www.aph.gov.au/Parliamentary\\_Business/Committees/Joint/Corporations\\_and\\_Financial\\_Services/Rehabilitation/~media/Committees/corporations\\_ctte/Rehabilitation/report.pdf](https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Corporations_and_Financial_Services/Rehabilitation/~media/Committees/corporations_ctte/Rehabilitation/report.pdf); see recommendation 5.

*can be held to account by dispute resolution systems, regulators and the courts. The FSC's discretionary proposal, however, has no equity of access and no accountability.*

And:

*The committee also has concerns about AIA's suggestion that the current prohibition on life insurance in the health sector is a legislative anomaly. Rather, the evidence from the Department of Health indicates that the difference between risk-rated and community-rated insurance stems from the fact that Medicare was designed as a system of universal access for Australians.*

89. The ALA has ongoing concerns regarding instances where insurers have sought to use independent medical examiners to contact claimants' treating doctor(s), ostensibly to discuss treatment issues. The ALA considers such conduct clearly inappropriate for an independent medical examiner appointed by an insurer (and generally briefed with a copy of the Expert Witness Code of Conduct in anticipation of legal proceedings) to seek to involve himself or herself in discussions between the claimant client and their treating physicians concerning their treatment. That would amount to a breach of various statutory provisions.<sup>35</sup>
90. The ALA has called on the FSC Life Insurance Code of Practice to set standards that elaborate on, exceed or clarify this controversial area of law by clearly stating that FSC members are not permitted to and will not provide funding for or otherwise facilitate rehabilitation medical treatment whether as a claim requirement or otherwise.
91. Relatedly, the ALA also has significant concerns about the increasing use of life insurance policies such as the SunSuper Pty Ltd/AIA Australia Limited TPD Assist policy which purports to allow AIA to decline a TPD claim where it decides the claimant has not fully participated in 'an Occupational Rehabilitation Program' to AIA's satisfaction. An ordinary member of the public could not be expected to know the difference between 'an Occupational Rehabilitation Program', which is not prohibited by statute, and 'discretionary rehabilitation medical treatment' which is prohibited. It is submitted that the FSC Code should set standards that elaborate on, exceed or clarify this important distinction.

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<sup>35</sup> *Life Insurance Act 1995, Private Health Insurance Act 2007, Private Health Insurance (Health Insurance Business) Rules 2013, Health Insurance Act 1973 and Superannuation Industry (Supervision) Regulations 1994 (Cth).*

92. If any rehabilitation programs are to be permitted, despite the above objections, the standards for lawful rehabilitation programs be, at a minimum, consistent with the representations of the FSC to the PJC<sup>36</sup> that:

*a. It will only be proposed 'when the [rehabilitation] is cost effective for both the customer and the insurer';*

*b. Any rehabilitation proposal 'would always be arranged through the customer's treating physician, and would be dependent on the customer's agreement and participation';*

*c. 'No consumer will be forced to receive [rehabilitation] they don't want'; and*

*d. Any patient who does not wish to receive [rehabilitation] 'will not have their income protection and TPD insurance payments stopped'.*

93. Perhaps these standards could be reflected in the Overarching Philosophies.

### **In relation to Key Product Elements:**

94. Under Total Disability Definition, Document C notes the following:

*All Periods: The customer is required to comply with the insurer's and health professionals' reasonable requests to participate in rehabilitation and/or retraining. Reasonable job modification is expected if it will allow return to work.*

95. This runs contrary to the representations of the FSC to the PJC, as noted above.

96. The 'reasonable job modification' point assumes that modifications are feasible and will be agreed to by an employer. In our experience, the reality is that:

- Often in these circumstances, the employment relationship has ended.

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<sup>36</sup> Mr Allan Hansall of the FSC <https://parlinfo.aph.gov.au/parlInfo/download/committees/commjnt/49094fee-6d97-4fb3-b5b2-18e6f649e791/tocpdf/Parliamentary%20Joint%20Committee%20on%20Corporations%20and%20Financial%20Services%201806196247Official.pdf;fileType=application%2Fpdf#search=%22committees/commjnt/49094fee-6d97-4fb3-b5b2-18e6f649e791/0000%22> at page 25.

- There is no incentive for a future/potential employer to agree to any accommodations for a disabled job applicant, as there may be in a workers' compensation claim
- Under a statutory compensation scheme, the employer is bound to participate in RTW. This allows for the employer and the insurer to work together to facilitate RTW efforts. Under IDII, no such relationship, not compulsion to participate in RTW, exists.
- "Entitlement to a job" is an abstract concept as it does not follow that even the most motivated employee can successfully obtain and maintain gainful employment in the real-world job market. While insurers and employers are grappling with this abstraction, the injured worker is not receiving income protection.

97. This section goes on to say:

*Excluded: The above definition is different from the current common '3-tiered' definition and does not include hours-based and income-based definitions. The definitional focus on inability to perform work means benefits are not paid simply because appropriate work is not available in a particular location.*

98. The inference in the above appears to be that if a job may be available to a claimant in a different location, they would not be eligible. Case law contains numerous examples<sup>37</sup> where courts have found that this is not the case.

99. It is often the case that a claimant does not have the means to relocate away from or with their family to do such work. Such an approach, aside from being inherently unfair to consumers, especially those in remote and low socioeconomic locations, are reducing the definition to an abstract concept without due regard for the practical realities of working people.

100. This was perhaps most succinctly put by the Supreme Court of NSW as follows:<sup>38</sup>

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<sup>37</sup> See for example: Carroll v United Super [2018] NSWSC at [197] – [207]: <http://www.austlii.edu.au/cgi-bin/viewdoc/au/cases/nsw/NSWSC/2018/403.html>; or MX v FSS Trustee Corporation as Trustee of the First State Superannuation Scheme & Anor [2018] NSWSC 923 at [90] – [100]: <http://www.austlii.edu.au/cgi-bin/viewdoc/au/cases/nsw/NSWSC/2018/923.html>.

<sup>38</sup> Carroll v United Super [2018] NSWSC at [207]  
<https://www.caselaw.nsw.gov.au/decision/5ac2ecf0e4b074a7c6e1dd4f>.

*But it is not realistic to assess the availability of such employment without also taking into account the costs of the claimant relocating or travelling to acquire such employment.*

101. This section goes on to say:

*Whole Person Permanent Impairment (WPPI) test: a Whole Person Permanent Impairment Test may be used as a tool by the insurer to help assess long term disability after the disability conditions have stabilized (that is no further improvements are expected, usually after about two years).*

102. The ALA submits that WPPI tests are not an appropriate tool for demarcating those IDII claimants who may be appropriate candidates for RTW from those who may not be. This is because a claimant may be TPD despite having a relatively low WPPI. WPPI assesses *impairment*, not *capacity*. It is essential that, for WPPI to be useful in RTW assessments, that a capacity assessment tool is used as well.

103. For example, a lifelong process worker may suffer from a joint injury or degenerative spinal condition with associated pain that permanently disables them from work within their ETE and renders them a poor candidate in the 'real-world' job market, yet their WPPI may be below 10%.

104. It would not be consistent with the insurer's duty of good faith to steer such a claimant into futile RTW efforts. The effect of doing so is often retrograde to the claimant's mental health, may lead to litigation, and is therefore counterproductive to the insurer's interests.

105. The proper test is whether the medical consensus is that the claimant is TPD.

106. Under the Basic Sum Insured – Income Replacement Ratio (IRR) section, Document C tells us that:

*Long Term: The long-term maximum IRR is calculated as follows (in 2020 dollars):*

*60% up to \$240,000 p.a.;*

*40% of the next \$240,000 p.a., and*

*20% of the next \$480,000 p.a. (nil thereafter).*

107. The ALA believes that the 60% figure should be 75% at least for the first \$240,000. Document C provides no rationale for how these figures were derived. Please see the submissions at paragraph 15 above in relation to this proposal.

108. Document C goes on to say:

*6 Month Top Up: An additional 25% percent of the long-term IRR scale (e.g. 60%x1.25=75% up to \$240,000 p.a. income) can be payable for a maximum period of 6 months. This supplement is to be payable only if the customer is meeting RTW objectives, reports claims within 12 months of the date the disability was incurred and collaborates with the insurer in seeking ways to return to work.*

109. On the issue of claims lodgement times, the ALA notes the somewhat trite reality that many disabilities manifest gradually over time. This is especially true for mental health conditions where sufferers may lack insight into their disability or lack the capacity to gain such insight. To disadvantage those whose disability materialises over time would court the risk of a discrimination suit on the basis they are being treated less favourably due to a particular attribute.

110. Section 54 of the *Insurance Contracts Act 1984*<sup>39</sup> already provides the framework for the treatment of claimants where an insurer seeks to deny or reduce liability because of an act or omission of the consumer or a third party. The fundamental principle applied in these circumstances is that an insurer may only avail itself of a remedy that is proportionate to the prejudice it has suffered by the relevant act or omission.

111. In the case of a lack or collaboration or delay in claim lodgement, an insurer would need to establish that it is prejudiced and has the onus of proving same. The Reference Product should reflect the statutory framework – this provision fails to do so and is highly likely, in our opinion, to court legitimate consumer complaint and disputation.

112. In the section on Partial Disability, Document C notes the following definition:

*Definition: The customer has reduced work capacity due to injury or sickness.*

113. The ALA submits that this again puts the emphasis on the theoretical capability of a claimant, regardless of whether he/she can obtain or have actually obtained paid work, which makes the product an abstract one divorced from reality. As determined by the Supreme Court of NSW ‘An ability to engage in work should not be governed solely by capacity, but also by opportunity’.<sup>40</sup>

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<sup>39</sup> [http://classic.austlii.edu.au/au/legis/cth/consol\\_act/ica1984220/](http://classic.austlii.edu.au/au/legis/cth/consol_act/ica1984220/).

<sup>40</sup> *Jones v United Super Pty Ltd* [2016] NSWSC 1551 at [66].

114. In the section entitled “Benefit Offsets and Income Tax”, Document C says:

*Offsets: Any benefit payable will be comprehensively reduced for the effect of other ‘disability income support’ payments received by the customer, such as sick leave; workers compensation; other similar income replacement insurance payments; disability support pension or other social security payments.*

115. Please refer to our earlier commentary related to offsets, and related caps, under “Sound Insurance Principles”.

116. In the section on Indexation, Document C tells us that:

*Claims Indexation: No automatic indexing of claim payments. An option for indexation of claims payments may be purchased, with the indexation limited to CPI until age 55 and CPI less 2% after age 55.*

117. The ALA is unsure where the ‘CPI less 2% figure comes from. Perhaps some information on its derivation would be useful.

118. Under the heading ‘Updating Contract Terms at Regular Intervals’, Document C says:

*Product Terms: the policy terms and condition can be updated every 5 years, subject to the customer being treated fairly at the 5 year roll-over.*

119. As mentioned elsewhere in this submission, it is crucial that any changes to the terms and condition of the policy be permitted only if the changes are made to the terms of all contracts of the same kind on a simultaneous and consistent basis, in keeping with the statutory protection at s.9A of the *Life Insurance Act 1995*.

120. In the section on Recovery Management Plan, Rehabilitation, Retraining we once again see reference to products which ‘may include rehabilitation and retraining programme’. Once again, we refer the Taskforce to the outputs of the PJC, as noted elsewhere in this submission. This also applies to reimbursement of costs, under Ancillary Benefits.

### **In relation to the Explanatory Notes:**

121. The comments below relate to sections which appear under “Explanatory Notes”, which commence on page 9 of Document C.

122. In the definition of 'Suitable Work', the document notes:

*In performing this assessment, we will not take into consideration:*

*whether the work or the employment is available;*

*the nature of your pre-injury employment; or*

*your place of residence if you have moved from your pre-disability place of residence to the current residence.*

123. In relation to the first point, such a position divorces the product from reality and is opposed by the ALA for the reasons discussed above.

124. In relation to the second point, the disregard for the nature of pre-injury employment is inconsistent with the proposed definitions of disablement which relate to a claimant's capacity to perform their own occupation or, after two years, any occupation for which the customer is reasonably suited by education, training or experience including the definition of TPD.

125. In relation to the last point, what if it was necessary for the claimant to move in order to get proper care? It would certainly be viewed as harsh and unfair treatment - if they had not moved to get the care the insurer could allege a failure to meet recovery obligations. The claimant would be in a catch-22 situation.

126. In summary, these 'Suitable Work' provisions appear to enable the insurer cut benefits, despite the insured satisfying the insured clauses, if that person has theoretical capacity for work they are completely unsuited for and which is unattainable. That is, with respect, an extremely difficult product for a consumer to claim under and it's difficult to see a properly advised consumer being attracted to pay money for such a product.

127. In the definition of Pre-Disability Earnings (ref page 13), Document C says:

*Pre-disability earnings are your average insurable monthly income, for the consecutive 12-month period immediately preceding the date of your disability.*

128. The ALA recommends that the words "or such shorter period of work" should be included. Otherwise a person who was on sabbatical for say 6 months before working 6 months leading to the disablement would have their pre-disability earnings halved.

129. We also believe that 'Date of your disability' needs clarification. If it is the date of ceasing work, people who reduce their hours and therefore their income before ceasing work as they are 'soldiering on' in good faith, will be deemed to have a lesser pre-disability earnings, thereby disadvantaging them for their good faith efforts.

130. That is bad public policy as the disincentive to 'soldier on' is the antithesis of the stated purpose of the IDII product to help insureds to remain in work. Protective provisions should be included to ensure good faith efforts are not prejudicial to insured entitlements.

131. In the explanatory notes in Offset Amounts (p.13), Document C notes that:

*Where you receive a lump sum disability insurance payment, such as a total and permanent disability insurance benefit, that you insured subsequent to the date we issued you this disability income policy, we may also reduce your monthly benefit amount or monthly partial benefit amount by the monthly income equivalent that would be generated by that lump sum amount.*

132. The ALA sees this as an unfair and senseless provision.

133. Firstly, the ALA does not understand the rationale for TPD cover obtained subsequent to the IDII to trigger an offset. If the reasoning is that insurers do now want the consumer to be over insured, such a proposition is flawed as TPD insurance covers an entirely different risk to IDII in that it is designed to pay down debt in the event of early retirement. An offset against TPD held in super makes even less sense as that is designed to top up the retirement savings shortfall caused by early medical retirement.<sup>41</sup> TPD does not indemnify against personal exertion income as IDII does. If, despite these concerns, a TPD, Trauma or other insured lump sum offset is to be included in a Reference Product:

- It should not include TPD held through super;
- It should break down the lump sum by dividing it by 60 and spreading it out over 60 months as is the industry norm for commuted lump sums;

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<sup>41</sup> See for example

[https://www.superannuation.asn.au/ArticleDocuments/359/1709\\_Insurance\\_through\\_superannuation.pdf.aspx?Embed](https://www.superannuation.asn.au/ArticleDocuments/359/1709_Insurance_through_superannuation.pdf.aspx?Embed), p.4.

- It should only cause a reduction if, when combined with the IDII payment, it exceeds a cap of 75% of pre-disability income;
- It should not apply to lump sum benefits underwritten by the same insurer (who has had knowledge of the duplication/offset whilst collecting premiums for both benefits).

130. It is respectfully submitted that a blunt 'dollar for dollar' offset as proposed, would, over time, neuter the benefit of having both TPD and IDII for thousands of consumers thereby denuding the value of default TPD provided through superannuation products - a traditionally profitable product offering which will be made more vulnerable to criticism under this measure.

130. A similar rationale applies for Trauma cover which is intended to pay out a lump sum of money to cover immediate medical expenses and other financial needs when a critical illness or injury occurs, regardless of whether the claimant is unable to work.

131. In relation to explanatory notes related to Recovery Management Plan and Customer Obligations, the ALA submits that Document C should refer to the outcomes of the PJC inquiry into this issue, as described elsewhere in this submission.

## Conclusion

132. The Australian Lawyers Alliance (ALA) welcomes the opportunity to have input into the Actuaries Institute's consultation on Individual Disability Insurance in Australia. We would welcome opportunity to discuss the contents of this submission with you in more detail.



Josh Mennen  
**Australian Lawyers Alliance**