SUPERANNUATION CONSUMERS' Centre

CHOICE

25 OCTOBER 2018

Misconduct in the Banking, Superannuation and Financial Services Industry

Submission to the Royal Commission - Insurance Round

ABOUT US

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

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The Superannuation Consumers' Centre was formed in 2013 as a not-for-profit to advance and protect the interests of superannuation consumers. The SCC aims to educate, advocate on behalf of and directly assist superannuation consumers to improve the standard of living for people of retirement age.

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INTRODUCTION

We appreciate the opportunity to respond to the Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry on questions it raised regarding the insurance industry. Insurance is a financial product that people rely upon to manage their financial risk. However, the evidence presented to the Commission clearly illustrates that the current regulatory regime is failing to protect consumers..

There are failings in:

- the laws and regulations as they currently exist;
- the compliance of the industry with these existing laws and regulations; and
- the tools available to regulators to effectively enforce compliance and penalise non-compliance.

These failings have created systemic problems in the industry that can only be addressed through significant reforms. This should include a decisive move away from self-regulation and towards a model that involves more direct regulatory involvement and oversight. We need to move away from regulatory responses that ask industry if they would like to fix the problem to responses that force industry to fix the problem, while only consulting with them on options to implement reform. There must also be major reforms to incentive structures in the insurance industry, which have been the primary contributor to its systemic culture of non-compliance.

The most toxic practices and products should be addressed directly and banned outright. These include sales practices such as the direct sale of insurance via outbound call centres and add-on insurance via car yards and low-to-no-value insurance products such as accidental death and injury.

Finally, superannuation trustees have failed to act in the best interests of members when it comes to insurance in superannuation. For too many, this product inappropriately erodes retirement savings and offers restriction laden cover. A combination of market failure and trustee inaction has caused this problem and it is time to develop a clear purpose for insurance in superannuation. From this purpose we can design a system which provides for people in tough situations but not leaving most people with far too little in retirement.

Summary of recommendations

Recommendation 1:

- That the Federal Government legislate to give ASIC the capacity to administer mandatory industry codes to allow code development and reviews to be conducted by an independent party.
- If this option is not pursued, the Federal Government should progress with the co-regulatory model for the insurance sector, as proposed in Chapter 4 of the final report of the ASIC Enforcement Review Taskforce. Under this model:
    - Codes should require ASIC approval and be subject to monitoring;
    - All industry participants should be required to subscribe to an ASIC approved code;
    - In the event of non-compliance with a code, an individual customer should be entitled to seek appropriate redress through the participant's internal and external dispute resolution arrangements; and
    - Failures to comply with codes should constitute a failure to comply with section 912A of the *Corporations Act 2001* and other ASIC-administered legislation.[1]

Recommendation 2:

- That the Life Insurance Code of Practice be amended to ensure all insurance products, including those not on-sale, are required to be regularly assessed on their medical definitions.
    - Any review of medical definitions should be done in consultation with independent medical specialists.
    - Information about the outcome of reviews should be made publicly available.

Recommendation 3:

- That the Federal Government extend protections from unfair contract terms to the insurance industry.

Recommendation 4:

- That the Federal Government ban all bonuses, including commissions and non-monetary incentives and sales competitions, in the insurance industry outright.

[1] The *Australian Securities and Investments Commission Act 2001*, *National Consumer Credit Protection Act 2009* and *Competition and Consumer Act (2010).*

    - At a minimum, the Government should eliminate the exceptions for general insurance and life risk insurance from the ban on conflicted remuneration in Division 4 of Part 7.7A of the *Corporations Act 2001*.

Recommendation 5:

- That the Federal Government urgently act on the recommendation of the ASIC Enforcement Taskforce Review to expand the civil penalty regime.
    - Obligations in section 912A of the *Corporations Act 2001* must apply to all aspects of the provision of insurance, including the handling and settlement of insurance claims.

Recommendation 6:

- That the Federal Government urgently act to increase penalties across all ASIC-administered legislation to the same level.
    - For corporations, penalties should be raised to be the greater of 50,000 penalty units (currently $10.5 million), three times the value of benefits obtained or losses avoided or 10% of annual turnover in the 12 months preceding the contravening conduct.
    - Penalties should not be capped in a way that limits them from acting as an effective deterrent, i.e. at a minimum penalties for breaches must at least equal the value of the benefits obtained or losses avoided. If this figure cannot be calculated, penalties should be the greater of 50,000 penalty units or 10% of annual turnover in the 12 months preceding the contravening conduct.

Recommendation 7:

- That the Federal Government ban the sale of accidental death policies.

Recommendation 8:

- That the Federal Government reform life insurance products in the following ways:
    - Insurers should be prevented from denying claims based on the existence of a pre-existing condition that is unrelated to the condition that is the basis for the claim.
    - Insurers should not be able to seek medical information when handling claims that is not relevant to the claim being made.

Recommendation 9:

- That the Federal Government ban the direct sale of insurance via outbound call centres and add-on insurance via car yards.

Recommendation 10:

- That the Federal Government establish an independent inquiry to consult with consumers and industry to develop a clear purpose for default life insurance in superannuation.

Recommendation 11:

- That the Federal Government to develop a set of universal set of coverage requirements, key terms and exclusions based on the purpose for default life insurance.

Recommendation 12:

- That the Federal Government legislate to ensure group life insurance policies offered to MySuper members use a definition of "total and permanent incapacity" that does not derogate from the definition of "permanent incapacity" contained in regulation 1.03C of the Superannuation Industry (Supervision) Regulations 1994 (Cth).

Recommendation 13:

- That the Federal Government pass the 'Improving Accountability and Member Outcomes in Superannuation' Bill 2017.

Recommendation 14:

- That the Federal Government pass the 'Protecting Your Superannuation Package' Bill 2018.

Recommendation 15:

- That the Federal Government legislate to make adoption of the Insurance in Superannuation Voluntary Code of Practice a mandatory requirement of funds to obtain or retain MySuper authorisation.

Recommendation 16:

- That the Federal Government establish a joint regulator taskforce to improve the consumer protections contained within the Insurance in Superannuation Voluntary Code of Practice.

Effective regulation

It is clear that self-regulation has failed consumers. Industry codes have proven to be inadequate in minimising consumer detriment. The policy questions posed by the Commission suggest several measures which would strengthen these industry codes as a first step to addressing shortcomings. While we support these measures we believe that they by themselves will not be sufficient in minimising consumer detriment and will fail to address the systemic issues exposed by the evidence presented to the Commission.

First, the industry codes lack regulatory oversight and monitoring. In fact, only two of the eleven codes in the financial services industry has been formally approved by ASIC and only one of these currently applies to industry.[2] Second, compliance with industry codes is largely voluntary and not all firms in a subsector will subscribe to the relevant codes. Finally, code development is currently run by industry, for industry. While consumer groups and regulators may be consulted, their capacity to influence decisions is often constrained. Industry are still making the primary decisions about what is covered in codes and how it will be addressed. Even if significantly reformed, industry codes will still fail to protect many consumers in the industry.

We believe that codes can play an important role in protecting consumers and lifting industry standards. In order to be effective, codes must:

- Be led by an independent party and shaped by consumer needs rather than industry preferences.
- Be supported by accurate and unbiased research into the problems they seek to solve.
- Be developed by asking the right questions of industry, i.e. how protections could be operationalised rather than whether protections should be implemented at all.

Co-regulation: a small evolution for the code making process

At a minimum, code development processes could be evolved to a co-regulatory model as proposed in Chapter 4 of the final report of the ASIC Enforcement Review Taskforce. As the Taskforce explains:

> *ASIC can achieve greater regulatory oversight through a co-regulatory model by exercising its power to approve codes. Under such a co-regulatory model codes would remain industry-led and not mandated by legislation, but would require ASIC*

[2] The Financial Planning Association Professional Ongoing Fees Code and the ABA's Banking Code of Practice, approved by ASIC to commence from mid-2019
https://asic.gov.au/about-asic/news-centre/find-a-media-release/2018-releases/18-223mr-asic-approves-the-banking-code-of-practice/

> *approval and be subject to monitoring. Under this model, industry participants would be required to subscribe to an ASIC approved code, and in the event of non-compliance with the code, an individual customer would be entitled to seek appropriate redress through the participant's internal and external dispute resolution arrangements.*[3]

It should be noted that this option still leaves industry to lead development of codes. It does not deal with the conflict at the heart of self-regulation: that industry has little interest in addressing problems it is currently profiting from.

The Federal Government's response to the Taskforce agreed in principle with its recommendation to move to a co-regulatory model.[4] However, the Government also deferred implementing the recommendations to enable it to take account of findings arising out of the Royal Commission.

Under the co-regulator model, all insurers would have to subscribe to the relevant code for their category of business, including the Life Insurance Code of Practice and the General Insurance Code of Practice. Compliance with the codes would be monitored by a monitoring body comprised of industry, consumer and expert members. This body would need adequate resources to conduct its job properly, something that hasn't always occurred in practice. Insurers would be required to report periodically to the monitoring body, which would be able to refer companies to ASIC. In order for this to be effective, codes must have roots in legislation to provide remedies to both consumers and regulators in instances of non-compliance. Therefore, CHOICE supports making failures to comply with codes a failure to comply with section 912A of the *Corporations Act 2001* and other ASIC-administered legislation.[5]

A stronger option - code development steered by a regulator acting in consumer interests

Co-regulation is unlikely to solve the deep and persistent problems uncovered by the Royal Commission. This model still leaves key decisions and processes in the hands of industry groups, typically the parties that commercially benefit from current practices and have little incentive to support change. The code development process needs greater independence to really address problems.

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[3] The Treasury, 'ASIC Enforcement Review Taskforce' December 2017, p. 31. https://static.treasury.gov.au/uploads/sites/1/2018/04/ASIC-Enforcement-Review-Report.pdf
[4] The Australian Government, 'Australian Government response to the ASIC Enforcement Review Taskforce Report' April 2018, pp. 5-6.
[5] The *Australian Securities and Investments Commission Act 2001*, *National Consumer Credit Protection Act 2009* and *Competition and Consumer Act (2010).*

Strong co-regulation should involve independent development and reviews of codes.[6] However, these processes typically feed back to an industry group to make the decision final reforms, such as occurred with the latest version of the ABA's Banking Code of Practice where several independent recommendations weren't progressed.

The content of codes should not remain up to industry to determine. Instead, a better option when issues are raised would be for ASIC to administer codes of conduct, similar to how it oversees the e-payments code.[7] With this code, ASIC has the power to initiate and conduct regular reviews. The regulator is in charge of steering discussion about reform, rather than industry. ASIC also has the power to monitor and enforce the code, although this could equally be done by code compliance committees, as under the co-regulatory model. Ultimately, for a code to successfully address issues, it needs to be initiated, led and delivered by a party truly independent from industry.

Superannuation code case study - demonstrating the need for independent code development

Leaving code development in the hands of industry allows sectors to scope and frame reform to their commercial advantage. This is most obvious in industry use of research as part of current code development processes.

In 2017 CHOICE was involved in the self-regulatory efforts of the industry in developing the Insurance in Superannuation Voluntary Code of Practice.[8] Our experience in this process is typical of our involvement in self-regulatory measures generally. The industry had reached crisis point after a string of public cases of consumer harm. Government had indicated it was likely to legislate unless industry acted. The sector established a working group comprised of the four lobby groups that represent the area as well as a number of life insurers and superannuation funds. The regular group of 16 or so stakeholders included a single consumer representative.

The group was able to determine the headline problems, which were all evident based on public reporting, including:

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[6] For example, as outlined in the Consumer Federation of Australia's Good Practice Principles for code development
http://consumersfederation.org.au/wp-content/uploads/2018/05/Guidelines-Codes-EDR-Schemes.pdf
[7] See ASIC Enforcement Review Taskforce, p. 33
[8] Insurance in Superannuation Voluntary Code of Practice, available at:
https://www.superannuation.asn.au/ArticleDocuments/498/Insurance_in_Superannuation_Voluntary_Code.pdf.aspx?Embed=Y

- Improving cost impacts on account balances for consumers, including the right cover for young people
- Addressing multiple default insurance policies
- Providing better assistance to consumers during claims
- Improving superannuation fund member communications on insurance.

Next came a major research project to better understand the drivers of these problems, in particular quantifying the erosion caused to retirement incomes by life insurance premiums. The draft analysis in this research highlighted a very clear problem, particularly for people on low incomes who stood to lose more than 50% of their retirement incomes to insurance premiums. In response, the industry was keen to counterbalance the evidence with a strong defence of the benefits of life insurance in superannuation. This included drawing attention to government savings due to people being less reliant on the Disability Support Pension. The figures showing the impact on people on low income incomes were moved from the headline to several pages deep in the final report.[9]

As discussed in more detail later in the submission, the end result was an unenforceable code, with no monitoring. For the most part this code maintained the fund eroding status quo in terms of insurance product design for people on low incomes. Many of these decisions to water down the code were made in the later stages of the process, once it became clear what the consumer protections would mean in terms of changes to existing products. It was also at this point that the impact on profitability of the changes was finally known by the insurers. The insurers were some of the most active voices in opposing reforms at this stage. Again, this is typical of our experience in self-regulatory processes, once consumer protections threaten profit, the industry waters them down. Where there is close scrutiny these efforts are relatively transparent and in this case a combination of political interest and consumer organisation involvement has eventually led to the introduction of legislation to fix the failings on industry. However, the current process of self-regulation means an adequate solution is delayed while consumer groups are forced to expend limited resources in often fruitless industry led exercises.

Even the research on which the industry's self regulatory effort was based was subsequently found to be deeply flawed. The Productivity Commission released research which showed the industry study had failed to factor in the increased reliance on the Age Pension due to insurance costs. This increased reliance came about because, particular people on low and middle incomes, retirement balances were so eroded due to insurance premiums that these people required access to the Age Pension at a earlier and greater rate than would otherwise be the

[9] KPMG, 2017, 'Review of default group insurance in superannuation', available at: https://assets.kpmg.com/content/dam/kpmg/au/pdf/2017/default-group-insurance-superannuation-review.pdf

case.[10] This drives home the need for a major rethink of code regulation including the need for it to be supported by accurate and unbiased research into the problems it seeks to solve.

Recommendation 1

- That the Federal Government legislate to give ASIC the capacity to administer mandatory industry codes to allow code development and reviews to be conducted by an independent party.
- If this option is not pursued, the Federal Government should progress with the co-regulatory model for the insurance sector, as proposed in Chapter 4 of the final report of the ASIC Enforcement Review Taskforce. Under this model:
    - Codes should require ASIC approval and be subject to monitoring;
    - Industry participants should be required to subscribe to an ASIC approved code;
    - In the event of non-compliance with the code, an individual customer should be entitled to seek appropriate redress through the participant's internal and external dispute resolution arrangements; and
    - Failures to comply with codes should constitute a failure to comply with section 912A of the *Corporations Act 2001* and other ASIC-administered legislation.

Reforms to industry codes

The current voluntary codes are inadequate and reflect the interests of the industry rather than those of consumers. Evidence before the Commission illustrates this. For example, there has been a clear failure of insurance providers to keep their medical definitions up-to-date and this has caused significant consumer detriment.[11]

There is no legitimate reason why an insurer should intentionally keep any of its customers on policies which have out-of-date medical definitions. This is a clear failure to meet community expectations. The average consumer does not have the required expertise to assess a policy's medical definitions themselves. Consumers will reasonably believe that their insurance policy will have definitions congruent with the available medical consensus. We support amending the

[10] Productivity Commission, 2018, 'Supplementary Paper - Fiscal impacts of insurance in superannuation', available at: https://www.pc.gov.au/__data/assets/pdf_file/0017/232352/superannuation-assessment-insurance-supplement.pdf

[11] Illustrated by the CommInsure case.

Life Insurance Code of Practice to ensure all insurance products, including those not on-sale, are required to be regularly assessed on their medical definitions.

The Life Insurance Code of Practice currently requires the medical definitions of (on-sale) policies to be reviewed every three years. However, we echo concerns raised by other consumer advocates that the process by which this occurs, as detailed in the code, is inadequate.[12] Under the current code, reviews of medical definitions must be done in "consultation with relevant medical specialists".[13] This gives insurers the discretion to decide which specialists are involved. The clause should instead call for consultation with "independent" medical specialists. In addition to this, advocates and the general public need to be given information to trust that the reviews of definitions have been done properly and adopted by the insurer. Industry must commit to transparency about its review process to restore faith that its definitions are up-to-date and fair.

Codes governing the insurance industry more broadly can be better utilised to enforce standardised definitions across the industry. As above, it is essential that a code review process is led by an independent party like a regulator to deal with industry conflicts of interest.

Consumer protections in the general insurance space have been too focused on disclosure to inform consumers of detailed policy rules. These protections are extremely limited and frequently lead to insurers failing to live up to community expectations. Consumers are presented with long and complex terms and conditions and expected to understand them. A good disclosure process can also be defeated if key definitions are not standardised. This is particularly the case in insurance where a definition, potentially hidden a hundred pages deep in a Product Disclosure Statement, can radically alter the value of a policy. Standardising definitions and ensuring that products available on the market are appropriate will be more effective in minimising consumer detriment than disclosure.

However, we reiterate that voluntary industry codes suffer from a number of other deficiencies in how they are applied and monitored. As the extended delays on reaching a standard definition of a 'flood' clearly illustrates, self-regulation alone will not achieve acceptable outcomes for consumers. Amendments to the codes must be coupled with a move towards independent code development and review.

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[12] Financial Rights Legal Centre and Consumer Action Law Centre, ' Submission to the Financial Services Council Draft Minimum Standard Medical Definitions' November 2016.
[13] Life Insurance Code of Practice, 3.2. Available at https://www.fsc.org.au/policy/life-insurance/code-of-practice/life-code-of-practice.pdf.

We also support extending prohibitions on unfair contract terms to the insurance industry, as currently proposed by the Treasury.[14] This would obviate the need for some code reforms, including those under consideration by the Commission such as changes to cash settlement under the General Insurance Code of Practice. Ending insurance's exemption from unfair contract terms will also help address some of the problems created by inconsistent definitions.

Recommendations 2 and 3

- That the Life Insurance Code of Practice be amended to ensure all insurance products, including those not on-sale, are required to be regularly assessed on their medical definitions.
    - Any review of medical definitions should be done in consultation with independent medical specialists.
    - Information about the outcome of reviews should be made publicly available.
- That the Federal Government extend protections from unfair contract terms to the insurance industry.

Incentive structures

The evidence before the Commission illustrates that incentive structures have been the primary driver of the poor and at times illegal behaviour in the financial services industry. As the Commissioner's interim report notes, "[a]ll the conduct identified and criticised in this report was conduct that provided a financial benefit to the individuals and entities concerned".[15] This is especially the case for the insurance industry. Through the distribution of monetary and non-monetary benefits sales agents have been rewarded for aggressive sales practices, whilst quality assurance has been deemphasised and left unpunished. This has been the primary contributor to the systemic culture of non-compliance within the industry.

We support eliminating the exceptions for general insurance and life risk insurance from the ban on conflicted remuneration in Division 4 of Part 7.7A of the *Corporations Act 2001*. However, the problems with incentive structures in the industry are much deeper and relate to the use of bonuses (i.e. performance incentives for sales and retention agents) overall. This includes non-monetary benefits such as overseas and domestic trips, Vespa scooters, cruises and gift cards offered through competitions.[16] As the Commission heard in the case of ClearView,

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[14] The Treasury, 'Extending Unfair Contract Terms Protections to Insurance Contracts' Proposal Paper June 2018.
[15] Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry, 'Interim Report Volume 1' September 2018, p. 301.
[16] Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry, transcript, 11 September 2018, Day 51, pp. 5388-92; 5466-73.

non-monetary incentives have been used in attempts to circumvent bans on conflicted remuneration under FOFA reforms.[17]

Conflicted remuneration

The amount of bonuses paid to sales staff in the insurance industry has been significant. For example, from 2013 to 2015, insurers paid more than $600 million in upfront commissions to car yard intermediaries for the sale of add-on insurance products, while receiving $1.6 billion in premiums for these products and paying out just $144 million in claims.[18] These figures illustrate that these products were of low value, having a claims ratio of just 9%. Further, they illustrate that acquiring new customers was a much higher priority for the industry than meeting the needs of existing ones. The amount spent on commissions was over four times that paid in claims. Testimony from IAG acknowledged that add-on insurance sold at car yards was of poor value. IAG also acknowledged that the company viewed car dealers, and not consumers, as its primary customers, and tailored policies to meet the needs of the dealers and not policyholders. [19]

The systemic problem created by commissions has been acknowledged by the insurance industry itself. A working group within the Insurance Council conceded that commissions on add-on car insurance were inappropriate; however no industry actor was willing to reform their incentive structures alone. Instead, by the industry's own reckoning, industry-wide reform is required.[20]

Monetary and non-monetary benefits paid to sales staff creates perverse incentive structures that reward aggressive and even illegal activity. This is particularly apparent in the sale of life risk insurance products. Financial benefits awarded in commissions on the sales of life insurance equalled $6 billion for ten insurers over a five year period. Consequently, commissions have made up large proportions of the overall remuneration of sales agents. For example, in 2016 sales agents for Freedom's life insurance and Freedom Protection Plan products derived 32 percent of their overall remuneration from commissions.[21] Freedom has recognised the link between its remuneration structures and it's mis-selling to vulnerable

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[17] Ibid, p. 5390.

[18] Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry, transcript, 17 September 2018, Day 55, pp. 5900-1.

[19] Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry, transcript, 19 September 2018, Day 57, p. 6141.

[20] Ibid, p. 6126-7.

[21] Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry, transcript, 12 September 2018, Day 52, p. 5463.

customers.[22] It also accepted that its remuneration structure incentivises aggressive sales practices from its workers.[23]

Incentive structures in the industry are also driving poor practices outside of sales. For example, 30 percent of Freedom's retention agents are paid commissions which, as a proportion of their overall remuneration, are "similar to the sales agents, if not higher".[24] This incentivises the same aggressive practices exhibited by company's sales agents – as the case of Grant Stewart's son clearly illustrates. Only 28.5 percent of customers who called Freedom to cancel their policies were successful.[25] Internal ASIC documents noted numerous problems faced by consumers when calling to cancel their policies. This includes Freedom agents ignoring their directions and even hanging up on them.[26] Freedom has since announced that it intends to end commissions for retention agents.

Scorecards don't address conflicts, they hide them

Some companies have moved to so-called scorecard schemes that ostensibly broaden commission incentives beyond sales to include quality assurance. However, scorecards are not an adequate solution. First, they are complex and may be poorly understood by staff.[27] Second, advocates and regulators are unlikely to have access to information about how scorecards are constructed or work in practice. They tend to hide the problem underneath a headline commitment to better practices. Finally, the primary purpose of commissions remains the same - to incentivise high sales volumes.[28] Other considerations, such as quality assurance, remain auxiliary and exist only to act as a halo for the primary goal of increasing sales. Sales agents continue to be rewarded for selling insurance policies, whether these policies actually meet consumer needs or not. This is particularly important considering the poor value of products subject to large commissions, such as such as accidental death and injury and those sold through car yards.

Consequently, while extending the bans on conflicted remuneration would be a welcome reform, it is clear that it would not be a sufficient one. We recommend that bonuses, including

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[22] ASIC.0073.0001.0001; Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry, transcript, 11 September 2018, Day 51 p. 5453-4.
[23] Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry, transcript, 11 September 2018, Day 51, p. 5463-4.
[24] Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry, transcript, 12 September 2018,Day 52, p. 5509.
[25] Ibid, p. 5502.
[26] ASIC.0068.0001.0032.
[27] Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry, transcript, 11 September 2018, Day 51, p. 5454.
[28] Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry, transcript, 10 September 2018, Day 50, pp. 5358-61; 11 September 2018, Day 51, pp. 5454-8.

commissions and non-monetary incentives and sales competitions, be banned in the insurance industry outright.

Recommendation 4

- That the Federal Government ban all bonuses, including commissions and non-monetary incentives and sales competitions, in the insurance industry outright.
  - At a minimum, the Federal Government should eliminate the exceptions for general insurance and life risk insurance from the ban on conflicted remuneration in Division 4 of Part 7.7A of the *Corporations Act 2001*.

Penalties

The culture of financial service providers has been scrutinised by the Commission and has featured prominently in the insurance round. We firmly believe that cultural issues have been driven by incentive structures. Eliminating bonuses to sales agents will directly address poor sales cultures which emphasise aggressive selling and retention strategies. However, this alone will not be enough. As the Commissioner notes in the Interim Report, “eliminating incentive based payments for front line staff will not necessarily affect the ways in which they are managed if their managers are rewarded by reference to sales or revenue and profit”.[29] That is, there is a need to address the incentive structures for managers and executives as well.

While bonuses have encouraged aggressive sales at the expense of compliance, non-compliance itself has not been adequately reprimanded. For example, the agent responsible for selling a funeral insurance policy to Grant Stewart’s son had numerous performance issues prior to the sale, but was not reprimanded sufficiently. In fact, they continued to be praised for their high sales numbers.[30] Scorecards attempt to address this by including quality assurance in commission schemes. However, we question whether quality assurance should be incentivised at all. Surely complying with law is a minimum requirement of all occupations. Including quality assurance in commission scorecards suggests to sales agents that compliance is optional, or at the very least something that is traded-off against sales targets. Rather than rewarding compliance companies must reprimand non-compliance.

We believe that both of these issues can be addressed through stronger penalties for financial service providers when they contravene the law. Again, the Commissioner’s Interim Report

[29] Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry, ‘Interim Report Volume 1’ September 2018, p. 308.
[30] Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry, transcript, 11 September 2018, Day 51, p. 5485.

acknowledges this also in arguing that "regulator[s] must do whatever can be done to ensure that breach of the law is not profitable".[31] Increasing penalties will create incentives for managers and executives to properly monitor their staff and reprimand non-compliance. This is because, if raised to a sufficient level, penalties would significantly threaten the profitability of organisations. This in turn will encourage managers and executives to create a culture among their staff that takes quality assurance and compliance seriously.

Penalties are clearly not at a sufficient level at the moment. For example, an ASIC investigation concluded that CommInsure's trauma policies had medical definitions that were out of date with prevailing medical practice. Following this investigation, CommInsure updated its definition and reviewed denied claims.[32] This resulted in a payout of $4 million and a fine of $300,000. Because CommInsure reimbursed consumers for their out of date definition, overall they lost $300,000. However, had they not been subjected to an ASIC investigation, they would have saved at least $4 million. With a fine that is so small comparative to the potential savings (just 8% of what they had amassed before ASIC action), penalties are not providing the required disincentive. In order to address this, we make the following recommendations.

First, we support the recommendation of the ASIC Enforcement Taskforce Review to expand the civil penalty regime to the provisions included in Table 1 in the appendix, which includes section 912A of the *Corporations Act 2001*. Furthermore, obligations in section 912A must apply to all aspects of the provision of insurance, including the handling and settlement of insurance claims.

Second, penalty units must be increased. This includes those in section 12GXC of the *Australian Securities and Investments Commission Act 2001.* However, as the ASIC Enforcement Taskforce Review noted, there is a discrepancy across the ASIC-administered legislation. We support the recommendation of the Taskforce to increase the penalty units across all ASIC-administered legislation to the same level. For corporations, this creates a maximum penalty of 50,000 penalty units (currently $10.5 million), three times the value of benefits obtained or losses avoided or 10% of annual turnover in the 12 months preceding the contravening conduct – whichever is greater.[33] However, we believe that the recommendation of the Taskforce should be modified in two ways.

First, we recommend that penalties should, at a *minimum*, equal the value of benefits obtained or losses avoided. This will ensure that a breach of the law is not only unprofitable, but that

[31] Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry, 'Interim Report Volume 1' September 2018, p. 296.
[32] Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry, transcript, 10 September 2018, Day 50, p. 5281.
[33] The Treasury, 'ASIC Enforcement Review Taskforce' December 2017, p. 73.

there is scope for an added deterrent to disincentivise misconduct. In the event that the value of benefits obtained or losses avoided cannot be determined, then the greater of the alternate penalty options (50,000 penalty units or 10% of turnover), can be used. As we have seen in the 'fees for no service' enforcement action taken by ASIC the true detriment to consumers is constantly being revised up as the banks discover more impacted customers. It is not uncommon for the true detriment to be realised years into the future, potentially after court enforcement has taken place. This means a properly designed penalty regime cannot rely too heavily on a determination of detriment to function.

Therefore, we do not agree with the Taskforce that the 10% of turnover penalties for corporations should be capped at a million penalty units ($210 million). A cap, even one at a high level such as this, undermines the strength of the scheme devised by the Taskforce: that contraventions can result in penalties which are, at the very least, three times greater what companies sought to gain by breaching the law. It must be noted that many Australian financial institutions have extremely high turnovers, and even a penalty of $210 million could be borne with relative ease by the largest market players. Commonwealth Bank, for example, had a turnover of more than $26 billion in the 2018 financial year.[34] In the context of a business of this size, a $210 million cap represents less than one percent of revenue. This would be a grossly inadequate penalty for major financial services firms.

The proposed law essentially creates a lower disincentive for larger corporations. Any businesses with a turnover greater than $2.1 billion would have less than 10% of its revenue under threat due to misconduct. By contrast any business with less than $2.1 billion in annual turnover could be subject to the full 10% of revenue penalty.

Recommendations 5 and 6

- That the Federal Government urgently act on the recommendation of the ASIC Enforcement Taskforce Review to expand the civil penalty regime.
    - Obligations in section 912A of the *Corporations Act 2001* must apply to all aspects of the provision of insurance, including the handling and settlement of insurance claims.
- That the Federal Government urgently act to increase penalties across all ASIC-administered legislation to the same level.
    - For corporations, penalties should be raised to be the greater of 50,000 penalty units (currently $10.5 million), three times the value of benefits obtained or losses

[34] Commonwealth Bank, 2018, 'Profit announcement', available at: https://www.commbank.com.au/content/dam/commbank/about-us/shareholders/pdfs/results/fy18/fy2018-profit-announcement.pdf

avoided or 10% of annual turnover in the 12 months preceding the contravening conduct.

- Penalties should not be capped in a way that limits them from acting as an effective deterrent, i.e. at a minimum, penalties for breaches must at least equal the value of the benefits obtained or losses avoided. If this figure cannot be calculated, penalties should be the greater of 50,000 penalty units or 10% of annual turnover in the 12 months preceding the contravening conduct.

Accidental death and accidental injury insurance

All insurance products should meet consumer needs. So-called 'junk' policies which come with excessive restrictions and exclusions fail to provide consumers with the protection they need in managing their financial risk. CHOICE investigations have uncovered junk policies across various insurance products, including car insurance and health insurance.

Effective regulation can help minimise the amount of junk insurance policies in the market, whilst encouraging effective competition leading to better value policies. However, accidental death and accidental injury products themselves are low-value. This is illustrated by their low claims ratios. As the Commission heard, the claims ratio for accidental death policies from 2015 to 2017 was a mere 16.1 percent.[35] The claims ratio for ClearView's accidental death policies reached a low of just one percent over one year. This illustrates the low value consumers gain from these products.

It is particularly concerning that accidental death and accidental injury products have been suggested to consumers as an alternative to life insurance or marketed to consumers who are unable to secure life insurance policies due to medical reasons.[36] In fact, the Freedom Protection Plan product disclosure statement describes the product like so:

> Freedom Protection Plan provides a range of life insurance benefits designed to help protect your family against the financial impact of a family member dying or suffering a serious injury as a result of being involved in an accident.[37]

Accidental death and accidental injury products (such as the Freedom Protection Plan) are not alternatives to life insurance, as they offer a significantly lower level of protection.

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[35] Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry, transcript, 12 September 2018, Day 52, p. 5527.

[36] Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry, transcript, 11 September 2018, Day 51, p. 5432 (Freedom); 10 September 2018, Day 50, p. 5322 (ClearView).

[37] https://www.freedominsurance.com.au/assets/forms/FreedomProtectionPlanPDS.pdf

This misleading marketing is one reason consumers don't understand these policies and what they cover. Between 2014 and 2017, only 26 percent of claims on accidental death policies were accepted.[38] Over a five year period, CommInsure accepted just 3 percent of accidental death claims, whilst rejecting 88 percent in full.[39]

The evidence before the Commission clearly illustrates that accidental death policies are low value and poorly understood. We believe that they should no longer be offered to consumers.

This should not preclude changes to life insurance products as well, which also frequently fail to meet community expectations and cause consumer detriment. We support reforms to life insurance products, such as preventing insurers from denying claims based on the existence of a pre-existing condition that is unrelated to the condition that is the basis for the claim. Insurers should also not be able to seek medical information when handling claims that is not relevant to the claim being made.

Recommendations 7 and 8

- That the Federal Government ban the sale of accidental death policies.
- That the Federal Government reform life insurance products in the following ways:
    - Insurers should be prevented from denying claims based on the existence of a pre-existing condition that is unrelated to the condition that is the basis for the claim.
    - Insurers should not be able to seek medical information when handling claims that is not relevant to the claim being made.

Sales practices

The evidence before the Commission has illustrated various problems with the sale of insurance products to consumers. Particularly concerning have been direct sales via outbound call centres and as add-on via car yards. In fact, the inherent problems with these sales models were acknowledged by the companies engaged in the activity. Both Swann Insurance (owned by IAG) and ClearView identified increased regulatory scrutiny as risks facing their businesses in internal documents.[40] This illustrates that the companies were aware that their practices would

[38] Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry, transcript, 12 September 2018, Day 52, p. 5527.
[39] Ibid, p. 5529.
[40] Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry, transcript, 10 September 2018, Day 50, pp. 5311-31; 18 September 2018, Day 56, p. 6099.

likely not meet their regulatory obligations and that scrutiny from regulators would uncover breaches. This, of course, proved to be the case.

The direct sale of insurance via outbound call centres and add-on insurance via car yards were done as general advice. Recommendation 10.2 from the Productivity Commission's report on Competition in the Australian Financial System says that general advice is a misleading term that should be renamed.[41] We agree with this recommendation, but notes that it will not be sufficient in and of itself to address consumer detriment. The sale of financial products to consumers for whom those products are not appropriate has been driven by other factors, such as the incentive structures discussed above.

We also believe that the direct sale of insurance via outbound call centres and add-on insurance via car yards should be banned outright. As discussed above, the products sold through these channels have been of poor value to consumers (having low claims ratios), and primarily benefited the insurance companies and the sales agents. However, more generally insurance products are complex and require consumers to spend considerable time considering the PDS, their needs and circumstance and possible alternatives. The direct sale of insurance over the phone or as an add-on product is antithetical to this. A deferred sales model for add-on insurance is a second-best option only.

Recommendation 9

- That the Federal Government ban the direct sale of insurance via outbound call centres and add-on insurance via car yards.

Insurance in superannuation

Should universal:

- **minimum coverage requirements; and/or**
- **key definitions; and/or**
- **key exclusions,**

be prescribed for group life policies offered to MySuper members?

The need to provide economically for people who through death or disability are unable to provide for themselves or their dependents is a fundamental requirement of any good society.

[41] Productivity Commission, 29 June 2018, Inquiry Report, 'Competition in the Australian Financial System'.

The question that remains is how best to design this protection. The current design principles give an extraordinary amount of discretion to superannuation trustees. This has not led to the best outcomes for people requiring appropriate, affordable cover. In many cases this discretion has led to the erosion of retirement savings due to inappropriate and duplicate cover and left some unable to claim because of restrictive definitions.

There are two main methods of protecting people from the economic loss suffered by death or disability. The first is a publicly provided safety-net, which can be seen in policy measures such as the Disability Support Pension and compulsory workplace insurance. The second main method is privately purchased life insurance. In Australia we have a combination of public and private measures.

The most compelling argument for creating a universal life insurance market is that it will lead to increased competition, which will hopefully benefit consumers through lower prices and better quality products. Under the right conditions this competition can be a force for improving social welfare as market players improve products in order to compete for market share. However, the opt-out life insurance in MySuper market currently displays none of the conditions of a properly functioning market.

Properly functioning markets see bad behaviour punished, usually in the form of people 'voting with their feet' and moving provider. For this to work people need to know they are being treated poorly in the first place, however around a quarter of people do not even know if insurance is attached to their superannuation account.[42] Indeed, only 12% of people claim to know a lot about the insurance included in their fund.[43] Pro-consumer outcomes cannot be achieved where a low number of people even know they are purchasing a product. Instead a level of consumer protection is required to fix the fact that adequate market conditions are not present.

Mysuper insurance arrangements erode retirement savings

The current protections for people with life insurance through a MySuper product are inadequate.

Fund trustees are bound by their trust obligations to operate in the best interests of beneficiaries (the members). In the explanatory memorandum for the MySuper reforms the purpose of insurance was described as providing:

[42] Productivity Commission, 2018, 'Superannuation: Assessing Efficiency and Competitiveness – Draft Report', p.422
[43] Ibid, p.331

> *"…benefits [to] protect members against the risk of not being able to accumulate sufficient retirement savings, for themselves or their dependents, due to having to cease work as a result of injury or illness or as a result of death."*[44]

While there is mention of protecting against the risk of not being able to accumulate sufficient retirement savings, there is no explicit reference to the degree to which this risk should be protected against. In combination with the insurance covenants in the *Superannuation Industry (Supervision) Act 1993* there is specific direction to:

> *"only offer or acquire insurance of a particular kind, or at a particular level, if the cost of the insurance does not inappropriately erode the retirement income of beneficiaries."*[45]

It is clear from the legislation that the quantum of insurance offered through superannuation needs to balance the risk of insufficient retirement savings due to disability or death while not inappropriately eroding the retirement savings of a fund member. Unhelpfully there was very little prescription over how to balance these two competing interests. As a result, we have seen a proliferation of policies with vastly different levels of cost and coverage.

On cost, the Productivity Commission found that while average premiums hover around $300 per year, they can be as high as $2,000 per year.[46] This indicates that trustees have taken very different approaches to answering the same question of how best to protect their members without inappropriately eroding retirement savings.

To assess how well trustees have exercised their duty to not inappropriately erode retirement savings we can look at how trustees responded to increased claim rates. Premiums from 2013-14 to 2016-17 increased by about 35%.[47] This has in large part been explained by the need for insurers to cover the significant losses experienced which were attributable to "under-pricing of the risk pool".[48] Insurers were arguably shielded from real rates of disability in the community because few people knew they had insurance in superannuation, therefore claim rates were unnaturally depressed. Once awareness increased, claim rates and total benefit payments increased dramatically and in response insurers increased premiums.

This causes a problem in terms of a trustee's duties. At all times they are required to balance the risk of insufficient retirement savings due to disability or death with ensuring there is not

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[44] Superannuation Legislation Amendment (Further MySuper and Transparency Measures) Bill 2012, Explanatory Memorandum, p.21
[45] *Superannuation Industry (Supervision) Act 1993*, s52(7)(c)
[46] Productivity Commission, 2018, 'Superannuation: Assessing Efficiency and Competitiveness – Draft Report', p.317
[47] APRA, 2018, 'Annual Superannuation Bulletin June 2017', Sydney
[48] Rice Warner, 2016, 'Affordability of Group Insurance in Superannuation, December'

inappropriate erosion of people's retirement savings due to insurance. Rice Warner found that, in response to increased claims, funds responded with a combination of increasing premiums and tightening eligibility conditions and definitions.[49] This is not a problem so long as trustees are redesigning cover based on the needs of their membership. Based on the evidence we are concerned that many trustees have a poor understanding of that need and have simply responded by increasing premiums or making terms more restrictive.

The Productivity Commission recently sent out a survey to 208 superannuation funds about investment fees, returns, use of related parties and use of member information to develop insurance cover.[50] Only 114 funds responded. Of those, only 58% answered questions about fund activity and just 17% answered questions about net returns and fees. These are key metrics for a fund in understanding the level of erosion of retirement savings due to insurance premiums. Either funds failed to share the data or they are not collecting sufficient data to design an insurance product which complies with the SIS Act. At the very least this demonstrates poor accountability on the part of the trustees.

Member needs should ultimately be the guide for insurance design but it appears that few funds collect essential data to understand what would work for their members. One of the major pieces of information required for life insurance is an understanding of whether members have dependents. This is core to determining in what age groups death and disability benefits should expand and contract based on the number of people reliant on the insured person's income. The Productivity Commission found that 79.5% of funds who participated in their survey did not collect information about whether members had dependents.[51] On this evidence trustees are not appropriately informing themselves of the most basic information in the design of insurance products.

There are two main ways to deal with this problem. Firstly, we could place obligations on trustees to collect more data on the needs of members and require them to demonstrate how this data has been used to meet the best interests of members when designing default insurance products. This approach would require a lot of extra resourcing, first in terms of collecting the data, but secondly verifying the degree to which subsequent product design matches up with member interests. This would likely require significant resourcing on the part of the regulator and require it to engage in normative assessments of the quality of the product offering in relation to a member's needs, a role the regulator has traditionally not taken an active role in determining.

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[49] Rice Warner, 2017, 'Sorting out insurance in super', available at: https://www.ricewarner.com/sorting-out-insurance-in-super/

[50] Productivity Commission, 2018, 'Superannuation: Assessing Efficiency and Competitiveness – Draft Report', p.31.

[51] Ibid, p.206

However there is a threshold question that should be asked before we go down this path - what is the degree to which product differentiation is actually required in the default group life insurance market? If there are no strong grounds upon which differentiation can be justified then universal coverage requirements, inclusions and exclusions is a much simpler policy response to the current problem. On the supply side, universal design would decrease the cost to funds of:

- reproducing work in understanding the insurance needs of their membership;
- redesigning products in an attempt to cater for perceived differences;
- potential litigation over ambiguous terms;
- having to demonstrate to regulators how their individual product design serves the best interests of members; and
- explaining complex product differentiation to members.

On the demand side the cost of comparison would be greatly reduced for consumers as there would be fewer terms to compare. Universal design principles could be based on actuarial data to take the guesswork out of the needs of different demographics. Similar to compulsory third party insurance over cars, this could ensure people are given the right level of cover based on an identified community need. In developing these design principles, regard should be had to the full spectrum of protections that are available to people who can no longer work due to death and disability. This is important to ensure that life insurance in superannuation has a clear purpose and is not duplicative of other forms of cover.

Genuine unique membership needs may develop during this process, but as with most standard form insurance offers it is not clear the extent to which they are based on the needs of consumers or the needs of the insurer. A much better approach is to first settle on a clear purpose for default life insurance and subsequently determine the extent to which a universal approach to policy design can meet this purpose.

Recommendation 10

- That the Federal Government establish an independent inquiry to consult with consumers and industry to develop a clear purpose for default life insurance in superannuation.

The need for standardisation in insurance in super

Greater guidance in insurance design is something industry itself recognises it needs; the Insurance in Superannuation Working Group (ISWG) was geared specifically towards

establishing some norms on premium affordability and product design.[52] The industry even flagged the need to do more work on standardisation of terms:

> *"The ISWG has considered the extent to which insurance definitions can be standardised across the industry, to assist members to understand the cover they hold. It is recognised that this is a longer-term project, which would require extensive consultation with trustees and insurers, as well as input from regulators. Definition and benefit design standardisation could have an impact on premiums, so would need to be carefully considered."*[53]

This response came after more than a year of intensive work on the part of industry in an attempt to resolve these issues. CHOICE staff represented consumers on the ISWG. Having had firsthand experience of the ISWG and industry attempts at self-regulation generally, we have no faith that industry alone will be able to come to a joint position on standardisation. There is currently far too much product differentiation, most of which appears better adapted to hampering comparability than servicing a particular consumer need. Despite calls from CHOICE the industry failed to commit to a further tranche of standardisation work.

Due to self-interest, creating standardised products is something insurers and trustees are ill equipped to perform. A standardised product would leave insurers and trustees to primarily compete on price, benefit level and claims handling experience. For the most part consumers, with assistance, are much better equipped to make decisions on these features rather than fine print terms. Therefore, it is likely to lead to a nascent level of competition driven by the people who are able to become engaged with a simplified product. The extent to which this competition works for consumers, would be bad for inefficient businesses or businesses that have used disengaged members as an easy source of profit. Exposing these industry players to competition would see consumer friendly improvements in insurance policies.This would be a direct threat to the profitability of these inefficient businesses and making them unlikely to support attempts at standardisation.

We agree with the Productivity Commission's observation that:

> *"While comparability for members will always be difficult due to different mixes of insurance types and levels of cover, common eligibility and exemption definitions for insurance types (particularly in the case of TPD insurance) should be introduced to*

[52] ISWG, 2017, 'Joint Media Release: Improving Life Insurance in Superannuation for consumers', available at: https://www.superannuation.asn.au/media/media-releases/2016/media-release-20-december-2016
[53] ISWG, 2017,' Consultation Paper: Insurance in Superannuation Code of Practice', p.10

increase transparency and address the potential use of unreasonable exemptions to address cost pressures."[54]

The scope of this standardisation work cannot be fully gauged in response to the Royal Commission's current inquiry, therefore we see a need for a separate independent inquiry that involves consumer, industry and other relevant stakeholders to settle on a clear purpose for default life insurance in superannuation. This same inquiry would be in a better position to identify terms that require greater standardisation, and subsequently develop standardised terms.

Recommendation 11

- That the Federal Government establish an independent inquiry to use the purpose of default insurance to develop a set of universal set of coverage requirements, key terms and exclusions.

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

The wide discretion given to trustees in defining insurance product design has not led to better consumer outcomes. Instead, what has developed is a confusing array of policies, each with their own terms and exclusions. Many of these differences between policies seem to be based on little or no empirical data about member need. More needs to be done to ensure people who have their careers cut short due to disability are not left with hollowed out insurance cover that they cannot claim upon.

The definition of permanent incapacity contained in the Superannuation Industry (Supervision) Regulations states:

> "…a member of a superannuation fund or an approved deposit fund is taken to be suffering permanent incapacity if a trustee of the fund is reasonably satisfied that the member's ill-health (whether physical or mental) makes it unlikely that the member will engage in gainful employment for which the member is reasonably qualified by education, training or experience."[55]

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[54] Productivity Commission, 2018, 'Superannuation: Assessing Efficiency and Competitiveness – Draft Report' p.348
[55] Superannuation Industry (Supervision) Regulations 1994, regulation 1.03C

By contrast some insurance policies contain a much harder standard to satisfy, commonly in the form of an 'Activities of Daily Living' (ADL) test. For example, MLC's policy for part time, casual or contract worker eligibility criteria states that a member must have:

> "…suffered a total and irreversible inability to perform at least two of the Activities of Daily Living…"[56]

The ADL includes activities such as bathing, dressing, eating, getting in and out of a chair or going to the toilet without the assistance of another person. Importantly, if someone can perform one of these tasks with an assistive aid, then they are deemed able to perform the task for the purpose of the test. This is a vastly higher standard to meet, and in all but the most severe disabilities, would lead to a claim being knocked back.

In the MLC example, workers classified as full time are subject to the more generous TPD definition in line with the SIS Regulations.[57] The more restrictive ADL definition is reserved for workers classified as part time, casual or contract, despite the fact they pay the same premiums as full time workers. Policies like this fail a basic test of fairness and the solution is to introduce a standard definition of total and permanent incapacity that does not derogate from the SIS regulations for MySuper products.

The best argument that might be made for derogating from the SIS regulations definition of total and permanent incapacity is that insurance offered at this standard would be prohibitively expensive to members and unduly erode retirement savings. This argument might be made in the case of particularly high risk occupations where the likelihood of a claim is much higher. Construction work is one of these industries, yet the industry fund coving these workers, CBUS, has still managed to design its insurance product for most members without a more restrictive total and permanent incapacity definition.[58] In turn it has had to dial down the benefits offered to address overall affordability.

This is not to say the CBUS definition has no restrictions, indeed it falls back to the equivalent of and ADL definition for people who have been unemployed for more than 12 months. Again there is a question of fairness given these unemployed members would still be paying the same premiums for a significantly lower level of cover compared to employed members. However the

[56] MLC, 2018, 'MLC Masterkey Super Fundamentals Insurance Guide', p.21, available at: https://www.mlc.com.au/content/dam/mlc/fb/common/packs/73783_mk_super_and_pension_fund_offer_combo.pdf
[57] Ibid.
[58] CBUS, 2018, 'Death and disability insurance guide', p.25, available at: https://www.cbussuper.com.au/content/dam/cbus/files/forms-publications/insurance/Death-TPD-Insurance-Handbook-Industry.pdf

point remains, despite the affordability pressures of insuring a high risk membership CBUS has managed to extend the more generous definition to the bulk of its membership.

At its core a life insurance product within superannuation should provide some financial respite to people who are no longer able to work due to disability. By allowing for overly restrictive definitions we have created a system where one's inability to participate in gainful employment in which they are educated, trained or have experience is decoupled from an insurance benefit being paid. This gets away from the central purpose of life insurance in superannuation, which at inception was to provide:

> *"…benefits [to] protect members against the risk of not being able to accumulate sufficient retirement savings, for themselves or their dependents, due to having to cease work as a result of injury or illness or as a result of death."*[59]

The use of ADLs effectively says to people who are no longer able to work in their profession that they must retrain or take on some lesser job that doesn't require training in order make a living. For a person who has spent a lifetime paying premiums based on the promise that they'll be protected if they have to cut their career short, being confronted by an ADL is a bitter blow. In the context of someone with a recently acquired disability having to prove their incapacity is so significant that they cannot perform basic functions of daily living can actually harm their health. Evidence from Financial Rights Legal Centre indicates that in a similar context of income protection insurance that their clients have felt pressure from insurers to return to work. These people, particularly those with mental health conditions felt their health worsened due to the pressure exerted by life insurers to prove on an ongoing basis their inability to return to work. Given these factors we see a strong need to lift the bar on the definition of permanent incapacity to better align with community expectations.

As outlined in the previous section there are also strong competition arguments for not allowing a derogation of the "permanent incapacity" definition in the SIS regulations. Despite, or perhaps because of the pages of disclosure required on insurance in superannuation only 12% of superannuation members profess to know a lot about the insurance included in their fund.[60] Therefore, it is highly likely the other 88% have no idea how a 'fine print' term like permanent incapacity is defined in their policy. This level of information asymmetry stops a market from operating properly. Under these conditions consumers are not directing preferences towards insurance offers which meet their needs, indeed they may not even be aware of what their needs are. In non-functional markets such as this it is necessary for policy to intervene and correct the imbalance. Creating a standard definition of permanent incapacity which aligns with

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[59] *Superannuation Legislation Amendment (Further MySuper and Transparency Measures) Bill 2012*, Explanatory Memorandum, p.21

[60] Productivity Commission, 2018, 'Superannuation: Assessing Efficiency and Competitiveness – Draft Report', p.331

the SIS regulations will help ensure that disengaged consumers are not left with hollowed out or 'junk' insurance.

Recommendation 12

- That the Federal Government legislate to ensure group life insurance policies offered to MySuper members use a definition of "total and permanent incapacity" that does not derogate from the definition of "permanent incapacity" contained in regulation 1.03C of the Superannuation Industry (Supervision) Regulations 1994 (Cth).

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

The existing obligations on trustees require them to default members into appropriate insurance. On the evidence, trustees are not informing themselves of demographic information about their membership and are therefore not in a position to ensure they are defaulting people into appropriate insurance.

As discussed above, the solution is not to simply require trustees to start collecting this information. Instead we need a stepped process before creating more specific obligations. This includes answering the following questions:

- What is the clear purpose of default life insurance in superannuation?
- To what extent is differentiation in policy terms justified by different needs of the membership?
- To what extent would people be better served by a more standardised default life insurance product?

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

As the Colonial First State (CFS) example from the superannuation round of hearings illustrated, there are conflicts in engaging an associated entity as the fund's group life insurer. The evidence of CFS showed that it had conducted an independent benchmarking review of its insurance offering, which at the time was provided by a related entity, CommInsure.[61] The benchmarking showed the group insurance product performed poorly when compared to the market. Among other things, its risk categories were between 19-132% more expensive than the market median. When asked why CFS stuck with the related entity insurer despite the

[61] Financial Services Royal Commission, 2018, 'Superannuation closing submissions', p.102

added cost to members, the response was that CFS thought it would be better off negotiating with CommInsure as the incumbent rather than selecting a new insurer.

As we have outlined in previous submissions, options such as structural separation or a prohibition on engaging an associated entity alone will not necessarily resolve the underlying problem. The potential for misaligned incentives exist wherever a business is not properly accountable to the interests of consumers. In a properly functioning market, competitive pressures would help ensure a level of accountability, as already outlined this precondition in lacking in the default insurance in superannuation market.

Instead we need an option better tailored to the deficiencies of this market, for example extra requirements on a RSE Licensee to demonstrate its choice of life insurer is in the best interests of beneficiaries.

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

There is not a problem with RSE Licensees using an associated entity as the fund's group life insurer per se. Indeed economic efficiency may be derived from a related party offering life insurance, for example where there are aligned systems and processes that drive down costs. However, on the evidence the temptation to engage an associated entity to provide life insurance, even where that life insurer is shown to have uncompetitive cover, has proven too tempting for at least one RSE Licensee.

Paragraphs 22 to 24 of Prudential Standard SPS 250 provide a good starting point for how an RSE licensee can demonstrate that it it meeting the best interests duty of members in relation to its relationship with its life insurer, including:

- An objective selection process;
- Performing due diligence;
- Being able to demonstrate to the regulator its processes; and
- Regular monitoring and communication with the insurer.

These measures could be enhanced by far greater transparency around the decisions that went into the selection process. For example, in the CFS case study the evidence of conflicted decision-making was made clear by the independent report produced by Rice Warner for the

CFS board. Without transparency of these reports there is no opportunity for the regulator or members to be in a position to assess if the best interests duty has been met.

Recent public and regulator scrutiny of life insurance in superannuation has clearly had an impact in increasing competition, as funds review their insurance arrangements. The Productivity Commission requested data from the funds which showed an upward trend in recent years in conducting informal reviews and switching insurance providers.[62] There is a risk that without greater public disclosure requirements the current pressure on funds may dissipate over time.

The 'Improving Accountability and Member Outcomes in Superannuation' legislation currently before Parliament also has the potential to drive better performance among the funds in insurance selection. The legislation, if passed, would place greater obligations on RSE licensees to demonstrate how their insurance offers meet the best interest duty owed to members.

Particularly in cases where engaging a related party entity is being contemplated, this legislation should include a requirement to conduct independent reporting on the insurance offers competitiveness compared to those on the market and make these reports public.

Recommendation 13

- That the Federal Government pass the 'Improving Accountability and Member Outcomes in Superannuation' Bill 2017.

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

The Insurance in Superannuation Voluntary Code of Practice does not go far enough to protect the best interests of members. CHOICE was heavily involved in the drafting process and observed that while there was initial good will in the development of the Code, this was replaced by self-interest in the later stages which significantly compromised the end result.

In particular we are concerned that the industry has made no attempt to find a solution to make the Code binding and enforceable across the sector. Nor is there any code monitoring body to assess whether those who have committed to complying with the Code are actually doing so.

[62] Productivity Commission, 2018, 'Superannuation: Assessing Efficiency and Competitiveness – Draft Report', p.333

The number of carve outs and exceptions in the current draft leave us with no confidence that lasting industry-wide improvement in consumer protection will occur.

For example, one of the key features of the Code is the introduction of premium caps that are designed to improve affordability. As the Code states:

> *"As part of determining affordability when we design insurance benefits for our Automatic Insurance Members, premiums for this benefit design will be set at a level that does not exceed 1% of an estimated level of salary for our membership generally, and/or for segments within the membership"*

And that:

> *"the rationale for instances in which cover has been provided to Automatic Insurance Members with premiums that exceed 1% due to the identification of particular circumstances relating to the membership generally and/or segments within the membership."*

As numerous reports have found salary level is a good indicator of the level of erosion of retirement savings caused by life insurance in superannuation.[63] Despite this fact the above clauses allow a trustee to consider salary at a membership level rather than individual level when determining the appropriate cap. Given the range of incomes across a typical membership, a 1% cap would see those with lower incomes paying a significantly higher portion of their retirement savings out in premiums. So long as a fund gives a reason, the Code also gives an easy out for exceeding the cap. With no monitoring or guidance on the types of reasons that might justify a breach of the cap, the Code does nothing to address poor insurance design and affordability.

As already stated in this submission, self-regulation is not the solution to problems with insurance in superannuation. We first need a clearer understanding of what purpose life insurance in superannuation serves, from this we can rebuild a far more standardised level of cover which better meets the basic needs of default insurance members.

Part of the solution lies in the Protecting Your Superannuation Package Bill currently before Parliament. This Bill seeks to introduce a series of thresholds before which insurance is offered, these are well designed to meet the affordability needs of consumers and are stepped

[63] Productivity Commission, 2018, 'Superannuation: Assessing efficiency and competitiveness - supplementary paper - fiscal impacts of insurance in superannuation', October 2018; KPMG 2017, Review of Default Group Insurance in Superannuation, September; Rice Warner 2015, Group Life and Disability Insurance Claims Experience Study - Insurer Report.

improvements on the Code. This legislation should be introduced to prevent further inappropriate erosion of retirement incomes.

Recommendation 14

- That the Federal Government pass the 'Protecting Your Superannuation Package' Bill 2018.

We agree with the Productivity Commission's draft recommendation that the Code needs to be made mandatory. In addition, more work needs to be done to improve the Code; its current iteration provides a significantly lower standard of consumer protection then that proposed in the Protecting Your Superannuation Package Bill.

As outlined in this submission we also see the need for an independent code development process with regulator involvement in monitoring compliance and undertaking enforcement activity as required. Given the large amount of work required to improve the Code and in line with the Productivity Commission's draft recommendation the Australian Government should immediately establish a joint regulator taskforce to turn the Insurance in Superannuation Voluntary Code of Practice into a clear, enforceable and consumer-focused set of obligations. The taskforce should:

- monitor and report on adoption and implementation of the code by funds
- provide guidance on and monitor enhancements to strengthen the code, particularly implementation of standard definitions and moving to a short-form annual insurance statement for members
- advise the industry what further steps need to be taken for the code to meet ASIC's definition of an enforceable code of conduct.

This taskforce should work in consultation with consumer and industry representatives to improve consumer outcomes.

Recommendations 15 & 16

- That the Federal Government legislate to make adoption of the Insurance in Superannuation Voluntary Code of Practice a mandatory requirement of funds to obtain or retain MySuper authorisation.
- That the Federal Government establish a joint regulator taskforce to improve the consumer protections contained within the Insurance in Superannuation Voluntary Code of Practice.

Appendix

Complete list of new civil penalty provisions

Corporations Act
601ED(5)
670A
727
728
791A
792B
820A
821B
853F(2)
904C(1)
905A
911A
911B
912D
920C(2)
922M
941A

941B
946A
952E
952H
981B
981C
993D (3)
1012A
1012B
1012C
1017BA
1017BB(1)
1020A(1)
1021E
1021G
1309(2)
General Licensee Obligations
792A(a), (c), (d), (e), (f), (g), (h), (i)
821A (aa), (a), (c), (d), (e), (f), (g), (h)
904A(b), (c)
912A(a), (aa), (ca), (d), (e), (f), (g), (h), (j)
Credit Act s47 (a), (b), (e), (f), (g), (h), (i), (j), (k), (l), (m)

Insurance Contracts Act 1984
13(1)
33C(1)
Credit Code Obligations
24
39B(1)
154
155
156(1)
174(3)
179U
179V