



**Submission by the  
Financial Rights Legal Centre  
Consumer Action Law Centre  
CHOICE**

The Treasury

Making insurance claims handling a financial  
service

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January 2020

### **About the Financial Rights Legal Centre**

The Financial Rights Legal Centre is a community legal centre that specialises in helping consumers understand and enforce their financial rights, especially low income and otherwise marginalised or vulnerable consumers. We provide free and independent financial counselling, legal advice and representation to individuals about a broad range of financial issues. Financial Rights operates the National Debt Helpline, which helps NSW consumers experiencing financial difficulties. We also operate the Insurance Law Service which provides advice nationally to consumers about insurance claims and debts to insurance companies, and the Mob Strong Debt Help services which assist Aboriginal and Torres Strait Islander Peoples with credit, debt and insurance matters. Financial Rights took over 22,000 calls for advice or assistance during the 2018/2019 financial year.

### **About the Consumer Action Law Centre**

Consumer Action is an independent, not-for profit consumer organisation with deep expertise in consumer and consumer credit laws, policy and direct knowledge of people's experience of modern markets. We work for a just marketplace, where people have power and business plays fair. We make life easier for people experiencing vulnerability and disadvantage in Australia, through financial counselling, legal advice, legal representation, policy work and campaigns. Based in Melbourne, our direct services assist Victorians and our advocacy supports a just market place for all Australians.

### **About CHOICE**

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.

## Introduction

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Thank you for the opportunity to comment on the Treasury's exposure draft legislation and materials re: Making insurance claims handling a financial service – implementing recommendation 4.8 of the Banking, Superannuation & Financial Services Royal Commission, including:

- Exposure Draft—*Financial Sector Reform (Hayne Royal 4 Commission Response—Protecting 5 Consumers (2020 Measures)) Bill 2020: claims handling (ED)*;
- Exposure Draft Explanatory Materials (EM);
- Exposure Draft Explanatory Statement.

This is a joint consumer submission from the Financial Rights Legal Centre (**Financial Rights**) Consumer Action Law Centre (**Consumer Action**) and CHOICE. Our organisations made comprehensive contributions to the Financial Services Royal Commission that led to an examination of the claims handling practices of insurers, and ultimately recommendation 4.8.

From a consumer perspective, claims handling is the most critical part of the insurance process, and one of the most problematic. Placing an obligation on insurers to ensure that the process is efficient, honest and fair will ensure that consumers can expect the same standard from insurers handling claims as they can expect from other financial service providers. We agree that 'the intrinsic value of an insurance product lies in the ability to make a successful claim when an insured event occurs,' as stated by both the Financial Services Royal Commission in its Final Report<sup>1</sup> and the Explanatory Memorandum.<sup>2</sup> Commissioner Hayne also found when examining the claims handling practices and the existing exemption under the *Corporations Act 2001 (the Corporations Act)*, that:

*There can be no basis in principle or in practice to say that obliging an insurer to handle claims efficiently, honestly and fairly is to impose on the individual insurer, or the industry more generally, a burden it should not bear. If it were to be said that it would place an extra burden of cost on one or more insurers or on the industry generally, the argument would itself be the most powerful demonstration of the need to impose the obligation. The argument can be made only if claims handling is not now conducted efficiently, honestly and fairly. And if that is the case, it should no longer be tolerated by the industry or by the law.*

We strongly support the *Financial Sector Reform (Hayne Royal Commission Response—Protecting Consumers (2020 Measures)) Bill 2020: claims handling* that will remove the exemption of handling

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<sup>1</sup> Financial Services Royal Commission, Final Report, Volume 1, p 309.

<sup>2</sup> Para 1.2, *Financial Sector Reform (Hayne Royal Commission Response- Protecting Consumers (2020 Measures)) Bill 2020 Exposure Draft Explanatory Materials*  
[https://www.treasury.gov.au/sites/default/files/2019-11/36687\\_em\\_fsrc\\_rec\\_4.8\\_insurance\\_claims\\_handling.pdf](https://www.treasury.gov.au/sites/default/files/2019-11/36687_em_fsrc_rec_4.8_insurance_claims_handling.pdf)

and settlement of insurance claims, or potential insurance claims, from the definition of 'financial service' under the *Corporations Act*.

However we make the following recommendations to improve the implementation:

- for-profit Insurance Claims Management Services acting on behalf of a consumer should be included in the list under Item 9, paragraph 911A(2)(ek);
- the Statement of Claim Settlement Options should also apply to life insurers and not be confined to general insurers only – similar issues arise with respect to the choice of taking a life insurance lump sum and where it is paid, such as to the person or a superfund;
- that the policy basis for an exemption for unauthorised foreign insurers be reconsidered for removal through the loopholes and exemptions review in response to Recommendations 7.3 and 7.4 of the Royal Commission Final Report;
- that there needs to be some ability to amend a decision to accept a Cash Settlement so that if an insured accepts a cash settlement early and then works out something is missing or incorrect, the insured can return to the insurer and have it amended;
- that ASIC collect data from insurers and survey consumers on different aspects of the Statement of Claim Settlement Options including but not limited to:
  - rates of take-up for cash settlements;
  - rates of reading, comprehension and influence on decisions; and
  - length of time for a decision to be made;
- that ASIC develop regulatory guidance for claims handling including specific guidance on the content of the Statement of Claim Settlement Options; and
- that Statements of Claim Settlement Options should be consumer tested by insurers before being settled.

We finally note that Superannuation Trustees have not been included in the list of those entities captured under the claims handling oversight – under this exposure draft. We accept this only on the basis that the claims handling role of superannuation trustees are overseen by ASIC under other yet to be drafted reforms arising out of the implementation of Financial Services Royal Commission Recommendations 3.8, 6.3, 6.4 and 6.5.

## Meaning of claims handling and settling service

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Items 1 and 8, section 9 and subsection 766G(1) of the ED contain broad definitions for claims handling and settling services to capture a wide range of activities. This is subsequently

constrained to categories of persons handling the settling of an insurance claim at item 9 of the ED, paragraph 911A(2)(ek).

We support the meaning of claims handling and settling services as currently drafted.

## Provided to whom?

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Item 8, subs. 766G(3) of the ED defines a claims handling service as having been provided to an insured and that this may be a person insured as a third party beneficiary.

We support this exemption as drafted.

## What is not a claims handling and settling service – Lawyer exemption

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Item 8, subs. 766G(2) of the ED exempts all lawyers including lawyers representing insurers and those representing insureds. This reflects the general exemption from the definition of financial product advice in section 766B of the *Corporations Act*.

While we support this exemption as drafted, we do wish to note that continually outsourcing claims functions to external lawyers by an insurer should be a consideration as to what is “fair”. For example, following the 2011 Queensland floods, many insurers’ internal dispute resolution services were outsourced to law firms – a practice widely criticised at the time. This led to poor claims outcomes for consumers when outsourced private solicitors used legal concepts like “legal professional privilege” as a basis for not providing hydrology reports they had relied upon to deny claims.<sup>3</sup>

It would be harmful for policyholders if this carve-out encouraged widespread outsourcing to lawyers to occur. If insurers were to engage in significant outsourcing of claims handling or IDR to private lawyers, the lawyer exemption should be reconsidered.

We recommend that ASIC monitor this issue during the implementation of this reform.

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<sup>3</sup> See joint consumer submission to The Treasury, *Reforming Flood Insurance: Clearing the Waters discussion paper*, 13 May 2011, page 5, available at: <http://consumeraction.org.au/wp-content/uploads/2012/11/Joint-Submission-Reforming-Flood-Insurance-May-2011.pdf>.

## Persons handling and settling an insurance claim required to hold an Australian financial services licence

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Item 9, paragraph 911A(2)(ek) lists the categories of people who handle and settle insurance claims who will be required to hold an Australian financial services licence. We support the inclusion of all those listed under the ED.

We note however that neither superannuation trustees nor insurance claims handling management services have been captured as persons handling and settling an insurance claim.

### Superannuation Trustees

As we understand it, Treasury has decided to ensure that the claims handling role of superannuation trustees be overseen by ASIC via proposed reforms to ASIC powers being implemented under Financial Services Royal Commission Recommendations 3.8, 6.3, 6.4 and 6.5. We have yet to see exposure draft legislation for these recommendations.

If it is the case that the claims handling function will be overseen by ASIC through subsequent reform then we support this, however only do so on this basis.

It is critically important that the claims handling function of superannuation trustees be captured. Trustees play a key role in the insurance claims handling process and should be considered to be handling and settling insurance claims, although they are not acting on an insurer's behalf.

The superannuation trustee's insurance role is complex one in that they:

- deliver life insurance to superannuation fund members;
- approve the design of policies,
- choose an insurer and agree commercial terms;
- act as the policy holder for group insurance; and importantly
- manage the claims experience for members including:
  - advocate for claims with reasonable prospects of success
  - actively engage with the consumer's claim journey to make sure processes are simple, timely and transparent, and
  - manage insurance-related complaints.

In carrying out these services, superannuation trustees have substantial negotiating power and owe statutory<sup>4</sup> and common law obligations to act in the best interest of fund members.

These obligations, however, have not been sufficient to protect consumer interests. Despite a best interests duty, superannuation trustees have a series of fundamental conflicts of duty. It is

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<sup>4</sup> Section 52 of the *Superannuation Industry (Supervision) Act 1993*

unclear whether it is possible for a retail superannuation trustee to act at the same time both in the best interests of individual members and in the best interests of their membership as a whole. The membership as a whole may have an interest in saving money on insurance costs and not having their balances inappropriately eroded, while individual members have a clear interest in accessing insurance that will actually cover them when needed. Trustees regularly benefit in negotiating for cheaper group insurance by lowering the levels of coverage and accepting unfair contract terms as outlined above. Superannuation trustees would argue that this is in the best interests of their members by preserving higher levels of retirement income. But it significantly lowers the ability of member beneficiaries making a successful claim on a product that they pay for.

We note with concern that insurance through superannuation has been effectively excluded from the extension of Unfair Contracts Terms laws to insurance in the Bill currently before Parliament.<sup>5</sup> This is another gap in protections for consumers of insurance through superannuation – despite super trustees routinely ‘negotiating’ insurance policies for fund members that include unfair terms leading to poor claims outcomes.<sup>6</sup> This loophole must be remedied by the Government.

This conflict of interest is particularly stark when a trustee owns the insurance company that provides insurance to members. For example, AMP Super engages with AMP Life for their insurance contracts in superannuation. This arrangement was last reviewed by AMP Super in 1995, some 25 years ago.<sup>7</sup> There is very limited incentive for AMP to ensure there is a fair and efficient claims handling process when AMP profits from denying or minimising pay-outs. As a result, AMP has some of the worst handling practices of any insurer. AMP takes on average almost 6 months to process group insurance death claims, compared with 1.2 months for most other insurers.<sup>8</sup> This leaves grieving families exposed in situations where they think they are protected with life insurance. It is clear that standards need to be drastically improved for claims handling in superannuation.

We regularly see superannuation funds not acting in the best interests of their individual members. Callers to the Insurance Law Service frequently report stories of superannuation representatives not actively ensuring that they are, for example, up to date with where the insurer is in the group insurance claims process, nor actively engaging with an insurer when there are significant delays.

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<sup>5</sup> See *Financial Sector Reform (Hayne Royal Commission Response – Protecting Consumers (2019 Measures)) Bill 2019: Explanatory Memorandum*, para 1.46.

<sup>6</sup> See Consumer Action Law Centre, Financial Rights Legal Centre, and WEStjustice joint submission to The Treasury, *Extending unfair contract terms to insurance contracts – Exposure draft consultation*, 30 August 2019, pages 4-6, available at: <https://consumeraction.org.au/20190830-treasury-uct/>.

<sup>7</sup> Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry, Final Report, transcript, P-5863

<sup>8</sup> CHOICE 2019, “Please explain: AMP claims handling delays” <https://www.choice.com.au/about-us/media-releases/2019/december/please-explain-amp-claims-handling-delays>

### Case study – Holly’s story

For many years, Holly has held a TPD policy with \$60,000 cover with an Insurer through her Superannuation Fund. In 2007 Holly applied for an additional \$200,000 TPD cover.

In 2010 Holly ceased work because of generalised pain, anxiety and depression. Holly made a claim on her TPD in November 2014. In July 2015 the Insurer wrote to her to say they would pay out the \$60,000 from the original plan but that they would not pay on the second 2007 TPD. The Insurer claimed that Holly did not disclose at that time that she had anxiety and depression.

Holly had been asked in 2007 whether she had:

*“received any medical advice or undergone any medical treatment, investigation or an operation, ... for ...depression or mental disorder (including but not limited to stress, anxiety, chronic tiredness or fatigue, panic attacks, post traumatic stress, behavioural or nervous disorder?)”*

Holly had answered no but she had been on anti-depressants since the death of her child some time prior to 2007. Holly however had never sought to hide this. She had interpreted depression as not being able to cope. She did not put herself in that category as she had been caring for her family and working. She thought she was run down and not getting enough sleep. There is no dispute that this was an innocent misrepresentation (ie not fraudulent).

The Insurer then sought further information from her regarding her entitlement to the additional amount of \$200,000 pending her response. Holly responded within 28 days.

Almost two years after the initial decision the Superannuation Fund wrote to saying

*“the Trustee has still not made a decision on this claim. We are currently obtaining legal advice on the options for the Trustee to continue to pursue this claim on with our insurer.”*

In the end the Insurer accepted that Holly met the definition of TPD (on the terms of the original policy) and has said that had they known about the depression, a mental health exclusion would have been applied. However Holly meets the definition of TPD on the basis of her osteoarthritis alone.

The Insurer has therefore been considering the same issue for over two years and Financial Rights sees no evidence that the Superannuation fund has been advocating sufficiently on Holly’s behalf, if at all.

Source: Financial Rights Legal Centre



### Case study – Lisa’s story

Lisa was diagnosed with stage 4 melanoma. She realised she had benefits in her superannuation, and so made a claim. When she contacted the ILS the claim was with the superannuation fund. It had been 5 months. She had not heard from the superannuation fund. She followed up with them, and was often asked to re-send documents she has already sent in. She received further news from her treating doctors that her prognosis is getting worse. She sought advice from Financial Rights about what were the expected time frames. We explained to her that there are no timeframes currently, that the Life Insurance Code of Practice is implementing a time frame of 6 months for claims like hers with insurers, however, the start of 6 months commences from when the superannuation fund makes the claim with the insurer. It is not clear whether her claim is with the fund or the insurer. No one was talking to her.

Source: [Financial Rights Legal Centre C138474](#)

### Case study – Bianca’s story

Bianca lodged a claim for income protection in late October 2014. In February 2016 when she spoke to the ILS the claim had still not been approved or declined. Bianca put a second claim in around June 2015 and that too hadn’t been decided. She told the ILS by email “I would be extremely happy if the outcomes of my cases were determined. But at least I think it’s fair after 15 months to know how much longer until a decision will be made!!!!!!” All she has been told is that her case was still being reviewed. They’re not asking her for anything. She says the case manager at her superannuation fund has been lovely to her, but they keep saying that they are waiting on the Insurer.

Source: [Financial Rights Legal Centre C132535](#)

### Case study – Heather’s story

Heather’s husband passed away 3 months ago. He was on income protection during his last few months. On his passing, Heather made a claim for his death benefits. She does not understand the delay. The insurer states they are waiting for the superannuation fund, and the superannuation fund says they are waiting for the insurer. She is not sure whether it is due to any issues around the payment of benefits to the nominees or whether they are questioning the claim itself. They keep passing her off to other

departments and she does not get a straight answer. She has a mortgage to pay, and this is distressing. They treated him poorly when he was sick, they kept asking for medical statements even though he was dying and they knew it. She just wants to know how long she has to wait for a decision.

*Source: Financial Rights Legal Centre C138474*

We also see behaviour from superannuation companies that do not align with the expectation that the super fund will act in the best interests of members. There are very few determinations at the Financial Ombudsman Service or the Australian Financial Complaints Authority (if any) based on a superannuation trustee disputing a decision on behalf of a member.

There are also fundamental conflicts of interest embedded in the provision of group insurance itself, i.e. superannuation companies could save money by not engaging enough staff to advocate on behalf of member claims.

Consequently, a superannuation trustee's role in the claims handling process must be captured by either these current reforms or under the reforms mooted in response to Royal Commission Recommendations 3.8, 6.3, 6.4 and 6.5.

### **Insurance Claims Management Services**

Insurance claims management services are for-profit businesses that represent policyholders for a fee, to undertake the administrative work on an insurance claim. Claims management services typically work for a percentage of any cash settlement offered by the insurance company.

The industry is currently not subject to any specific regulation or oversight. Insurance Claims Management Services are not required to hold an Australian Financial Services License nor are they regulated under the *ASIC Act*. They therefore do not have to be members of external dispute resolution scheme like the Australian Financial Complaints Authority. If the policyholder has any problems about the quality of an Insurance Claims Management Service's work or a dispute over their cost, it is difficult and costly to resolve.

Insurance Claims Management Services do not have to have any qualifications, skills or training, don't have to meet any 'fit or proper' person test or satisfy competency standards or any other conduct or disclosure obligations at all. Anyone can call themselves an Insurance Claims Management Service and charge for it. This leaves consumers incredibly vulnerable to the service placing their commercial interests above the policyholder's best interests. The service may not have the resources to undertake all the work they agree to do if they take on too many clients.

Insurance Claims Management Services can increase the risk of poor outcomes for the policyholders they represent, insurance companies and other policyholders through a fundamental conflict of interest. It is in the financial interests of Insurance Claims Management Services to seek a cash settlement as a resolution rather than getting the insurer to repair or rebuild the damaged property, because of their fee. This may not always be fair as it means the policyholder loses the option for the insurer to do the works with accompanying benefits

including guarantees on the works they do and insurer management of the repair process which can sometimes be complicated. There are also times that the repair costs are uncertain, or where the insurer may have access to cheaper labour and materials, which means a cash settlement may leave the policyholder out of pocket.

According to the Insurance Council of Australia:

*If the process is poorly executed, a claims servicing company may frustrate progress in an effort to gain a greater percentage return, his/her fee. This may happen by delaying responses to the insurance company and/or insisting upon the addition of works not able to be covered by the policy.<sup>9</sup>*

It is also in the interests of Insurance Claims Management Services to unreasonably enlarge or inflate a claim, therefore increasing their own fee. This could work in a policyholder's favour, but is more likely to backfire if they drag out a claim unnecessarily, by arguing for an unrealistic amount.

We note that with the Australian bushfire crisis that we are currently facing, ASIC has released a statement warning consumers away from using "unscrupulous service providers".<sup>10</sup> The statement reads:

*ASIC is also warning consumers and small business owners to watch out for fictitious or unscrupulous tradespeople, repairers or firms offering to assist them with their insurance claim. Mr Hughes added 'These unscrupulous operators typically target homeowners, farmers and small businesses in the aftermath of natural disasters. They may claim to be able to identify damage to your property, sometimes by way of a free inspection. Be wary of anyone who asks for payment up front and who asks you to sign a contract immediately. Don't agree to sign anything which prevents you from dealing directly with your insurer, broker, financial adviser or lawyer. Anybody who is concerned about the conduct of such a person or firm should contact ASIC.'*

As noted above, the Insurance Council of Australia have also released information warning policyholders away from the using what they are calling storm chasers.<sup>11</sup>

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<sup>9</sup> ICA, The scope of works process - What is it?, 2 July 2018

<https://disasters.org.au/news/2018/7/2/building-insurance-and-the-scope-of-works-process-what-is-it-and-why-is-it-necessary>

<sup>10</sup>ASIC, 20-006MR ASIC encourages fair and effective insurance claims handling for people affected by the bushfires – warns against unscrupulous "service providers", 9 January 2020

<https://asic.gov.au/about-asic/news-centre/find-a-media-release/2020-releases/20-006mr-asic-encourages-fair-and-effective-insurance-claims-handling-for-people-affected-by-the-bushfires-warns-against-unscrupulous-service-providers/>

<sup>11</sup> ICA, The scope of works process - What is it?, 2 July 2018

<https://disasters.org.au/news/2018/7/2/building-insurance-and-the-scope-of-works-process-what-is-it-and-why-is-it-necessary>, ICA, Beware the Storm Chasers

<https://disasters.org.au/news/2019/11/19/beware-storm-chasers> and ICA, Victims of \$871 million hail storm being exploited by scammers, January 21, 2019

[http://www.insurancecouncil.com.au/assets/media\\_release/2019/210119%20Victims%20of%20\\$871%20million%20hail%20storm%20being%20exploited%20by%20scammers.pdf](http://www.insurancecouncil.com.au/assets/media_release/2019/210119%20Victims%20of%20$871%20million%20hail%20storm%20being%20exploited%20by%20scammers.pdf)

Financial Rights has released a fact sheet warning policyholders.<sup>12</sup>

We note that Insurance Claims Management Services have not been captured by Item 9, paragraph 911A(2)(ek). This is because they do not fall within the definition of an insurance claims manager since they are defined as a person who carries on a business of handling and settling insurance claims on behalf of one or more insurers: item 4, 761A of the *Corporations Act*.

Not capturing Insurance Claims Management Services is a significant loophole in the ED which will leave vulnerable policyholders at risk during this bushfire crisis and future natural disasters. This runs counter to the Financial Service Royal Commission Recommendation 7.3 which sought to ensure that exceptions and qualifications to generally applicable norms of conduct in legislation governing financial services entities should be eliminated.

We therefore strongly recommend that for-profit Insurance Claims Management Services acting on behalf of a consumer be included in the list under Item 9, paragraph 911A(2)(ek). If it is not we are likely to see an increase in poor outcomes for policyholders with increasing numbers of natural disasters.

### **Insurance fulfilment providers**

Finally we note that, as we read the ED, the Item 9, paragraph 911A(2)(ek) captures services such as smash repairers or builders where they act as an insurance fulfilment provider where they have the authority to reject all or part of the claim. It does not apply if they only have the power to accept a claim.

As it stands, we support this formulation, however we do note that similar issues arise as detailed above with respect to unscrupulous tradespeople, repairers or firms offering to assist policyholders with their insurance claim. These services too should be either captured or regulated in a way to prevent exploitation of vulnerable consumers.

### **Claims handling is not financial advice**

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Items 6 and 7, introduce subsections 766B(7A) and (7B) of the *Corporations Act* so that advice that may reasonably be regarded as a necessary part of handling and settling an insurance claim is excluded from being financial product advice.

This means that claims handlers and settlers do not have to meet financial advice standards such as a best interests duty. However, a person who holds an AFSL covering handling and settling an insurance claim will still be required to comply with the general obligations under s912A of the *Corporations Act*, including to act efficiently, honestly and fairly in relation to the provision of such recommendations or opinions.

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<sup>12</sup> Financial Rights, Should I hire a claims management service to help run my claim?  
<https://insurancelaw.org.au/factsheets/insurance-claims-management-services/>

We also note that the EM provides explicit and appropriate guidance with respect to what will be required of licence holders in handling and settling a claim between paras 1.18 and 1.20 with a series of examples.

We believe that this is useful and support this formulation. We also believe it may be appropriate for ASIC to expand upon these in a regulatory guide.

We provide the following recent case studies of common situations involving issues that have been raised by the Explanatory Memorandum where insureds have not been dealt with in an efficient, honest or fair manner that we believe would fall within the scope for ASIC to act.

Para 1.18 states that licence holders will be required to handle and settle an insurance claim:

*in a manner that ensures adequate support is provided for insureds, in particular for vulnerable consumers.*

The following case involves inadequate support for vulnerable consumers:

#### Case study – Jenny’s story

A pipe burst in Jenny’s kitchen in May last year. Her insurer does not cover the pipe itself bursting but agreed to cover the water damage. Jenny arranged for the pipe to be repaired (approx. \$100). The repairs required to the house due to the water damage have to date still not been completed and the family continues to live in temporary accommodation arranged by her insurer.

Due to accommodation being provided on a short term basis, the family has moved 6 times. Jenny has 2 special needs children and so constantly moving has put a strain on her family.

The insurer has been non-responsive and has not met AFCA’s deadlines to respond. AFCA has not granted the insurer any extensions to respond.

Due to the insurer’s delay, mould developed in the house. Jenny had to throw away mould-affected personal belongings.

Every time they change accommodation, Jenny has to move her kids’ medical equipment. She has a spinal injury, which has been aggravated due to having to pack up and move so many times. Jenny is not supposed to lift weight above 5kg.

Jenny’s insurer previously offered \$1,800 compensation and Jenny considered this too low. She spent a lot of money on the incidental costs associated with moving accommodation and replacing damaged personal belongings (e.g. due to mould, breakages during moves).

*Source: Financial Rights Legal Centre -- S238779*

### Case study – Anna’s story

Anna’s home was burned down in the NSW 2019 bushfires. Anna had a home and contents insurance policy, under which she was entitled to \$20,000 in temporary accommodation costs, in addition to the home or contents sum insured. The insurer offered to arrange temporary accommodation for her. The insurer then proceeded to book accommodation for a period of three-and-a-half weeks, which cost around \$5,000 in total and was deducted from Anna’s temporary accommodation benefit. The insurer did not consult with Anna or inquire about her requirements before booking and paying for the accommodation upfront.

Anna moved into the accommodation but quickly became concerned that it was too expensive to continue staying there, given that it was expected to take around a year for her home to be rebuilt and she would need to stay at temporary accommodation for this period. After a few days, she raised her concerns with the insurer about the affordability of the accommodation and asked that the accommodation be cancelled. The insurer informed her that it would not be possible to cancel the accommodation and refund the remaining nights, unless the owner of the accommodation agreed to the refund. The owner ultimately was not willing to provide a refund and the insurer told Anna that it could not do anything further for her in relation to this issue. Anna moved out of the accommodation after two weeks and is now staying at significantly cheaper accommodation.

*Source: Financial Rights Legal Centre - C197979*

Para 1.18 states that licence holders will be required to handle and settle an insurance claim:

*in the least onerous and intrusive way possible, including requesting information, medical examinations, surveillance and undertaking other assessment methods if it is strictly relevant to the claim;*

The following case involves a significantly onerous information request:

### Case study – Jason’s story

Jason is currently on carer’s payments, with a partner and twin daughters with autism. Jason lodged an income protection claim through his Super in 2016. He was injured in 2013 and he had previously claimed on a two year retail income protection first. Jason has provided a lot of documents to his Super IP insurer and they have made three payments in total, ex gratia. However they have just asked Jason for all his Medicare documents dating back to 2005. While excessive, Jason was at first fine to meet this request when his Super IP insurer told him Medicare could give it to him in 30 days, but

then Medicare told him it could take 3 months, maybe over 6 months because of the timeframe they need to go back

It is not clear why the Super IP insurer needs these records going back to 2005. Jason had already made a lot of disclosures about his medical history when he first took out the policy in 2012 where they put him on a 720 day waiting period.

*Source: Financial Rights Legal Centre - C197488*

Para 1.18 states that licence holders will be required to handle and settle an insurance claim:

*fairly and transparently, with information about the handling and settling process, the reason for information requests, and reasons for decisions provided to insureds; and;*

The following case involves an unfair process:

#### **Case study – Katelyn’s story**

Katelyn had a motor vehicle accident in mid-November 2019 and her car was a write-off. Katelyn went to make a claim on her comprehensive car insurance. Katelyn’s insurance expired on the last day of November 2019. Katelyn spoke to her insurer who demanded that she pay premiums for another period before they settle the claim or they would remove the premiums from the payout.

*Source: Financial Rights Legal Centre - C198327*

## **Treatment of unauthorised foreign insurers**

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As we understand item 9, which introduces paragraph 911A(2)(el) and (em) of the *Corporations Act*, unauthorised foreign insurers providing insurance to *retail* clients must have an intermediary that has an AFSL that covers claims handling. Further unauthorised foreign insurers providing insurance to *wholesale* clients do not have to have an AFSL nor do they have to have an intermediary that has an AFSL that covers claims handling.

We believe that the policy basis for an exemption for unauthorised foreign insurers needs to be more thoroughly reconsidered and, ideally, the exemption removed. We note that the last time this was examined in any great detail was during the Potts Review in 2003/2004 which undertook an independent study of unauthorised foreign insurers. This led to the *Financial Sector Legislation Amendment (Discretionary Mutual Funds and Direct Offshore Foreign Insurers) Act 2007* which increased some protections but did not extend prudential regulation to all discretionary insurance-like products as recommend by the HIH Royal Commission.

Despite this, it may be more appropriate to undertake a more thorough review of the exemption of unauthorised foreign insurers via the reforms arising out of the response to Recommendations 7.3 and 7.4 of the Royal Commission Final Report relating to loopholes and exemptions.

Subsequently we support the formulation of the treatment of unauthorised foreign insurers as it currently stands only on the basis that full consideration of the exemption is included in the review and reforms arising from Recommendations 7.3 and 7.4.

## Statement of Claim Settlement Options for retail general insurance

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Item 12, introduces sections 948B to 948D to require claims handlers and settlers to give a Statement of Claim Settlement Options at the time an offer to cash settle all or part of an insurance claim, instead of repairing or replacing the insured item.

This obligation has been limited to general insurance products in the ED.

We note, however, that the original consultation for the development of the exposure draft simply raised the potential to provide for a “statement of advice” and did not limit this to general insurance.

We strongly recommend that this obligation be extended to life insurance products.

### General Insurance

The reasons that a Statement of Claim Settlement Options being provided in general insurance claims are well established:

- Cash settlements offered to consumers are too low: Cash settlements are being offered by insurers for the amount that the insurer could engage a builder to repair the property not the amount that a consumer is able to engage a builder undertake repairs to a property. There is no recognition of the commercial bargaining power advantage of the insurer for cash settlement amounts being paid by insurers.
- Consumers underestimate the impact increased demand, for builder and other trade services subsequent to a natural disaster, has on the prices quoted and charged as well as the difficulties in engaging qualified repairers quickly after a natural disaster;
- Consumers are asking for cash settlements without understanding critical issues such as that the repairs will not have the same insurer guarantees concerning the quality of the repairs;
- Consumers can lose the benefit of lifetime repair guarantees offered by insurers when they agree to a cash settlement;
- There is a perception in the community that insurers are using cash settlements as a means of getting rid of more difficult complaints when there is a dispute over the scope of works;



- Cash settlements are a problem where the consumer has a mortgage on the property. Where there is a mortgage on the property, the mortgagee is entitled to receive the insurance payout and then approve any repairs done on the property;
- Consumers find an insurers' IDR process difficult to deal with and will consider cash settlements purely so that they do not have to continue what they view as the battle with their insurer;
- Consumers find it difficult to project manage complex repair projects following a cash settlement or underestimate the time and complexity and do not take into consideration the cost of hiring a building manager; and
- Consumers do not always obtain their own quotes before accepting cash settlements. The problem with this is that they have no conception of whether the amount being offered by the insurer is appropriate.

Problems with cash settlement practices have been well documented in the TAL and AAI case studies in Module 6 during the Financial Services Royal Commission as well as the ACCC Northern Australia Insurance Inquiry.

## Life Insurance

Similar problems to those described above can also occur in the life insurance context.

The issue of cash settlements in income protection arises when people are offered a choice between monthly payments and a lump sum payment.

Income protection insurance is generally designed to provide cover for part of one's income, (usually up to 75%), to help during a period of recovery that prevents a person from working. There are however many policies that provide the option of receiving a lump sum payout in certain situations. The Insurance Law Service at Financial Rights regularly receives calls enquiring about this situation. The following are from the last few weeks:

### Case study – Paul's story

Paul has IP and TPD policy through his superannuation. Paul contacted the Insurance Law Service to find out if he can obtain a lump sum payment as he can't survive on monthly payments. Paul had previously spoken to his insurer who told him to get legal advice and that it's not possible to get a lump sum.

*Source: Financial Rights Legal Centre -- S237726*

### Case study – Stephan's story

Stephan is currently receiving monthly income protection. Stephan wants to know if he can get a lump sum payment instead of his monthly payments. Stephan first claimed 8

years ago when he stopped working due to depression. Stephan is very anxious about upsetting his insurer if he asks for a lump sum.

*Source: Financial Rights Legal Centre - - S237967*

The choice to receive a regular monthly payment or a lump-sum payout (“commuted value”) has significant implications, and its usefulness depends on the insured’s personal circumstances at the time. There are a number of issues people need to keep in mind when deciding to take out a lump sum payment or choose to continue with a regular payment. Some insurers when they agree to pay as a lump sum will pay a reduced amount than if they had continued with monthly payments.

Commuting a policy may preclude an insured from receiving any further benefit or income from the policy which may not work well if the illness or disability requires regular payments for treatment. It can also have significant tax implications and can affect any government payments that the individual receives, such as an entitlement to a health care concession.

#### **Case study – Alice’s story**

Alice suffered from a disability rendering her incapacitated for work. Alice was entitled to did claim on her Salary Continuance which entitled her to approximately 75% of her pre-disability income. Alice was financially dependent on the income stream derived from the insurance payment to meet her income expenses of mortgage, electricity, water and living expenses and was also entitled to Family Tax benefits.

Alice was in regular contact with her insurer but found that the insurer’s representative generally appeared “uninterested” in her case; was inconsistent with information as to the dates of her payments and would sound irritated and be short with her.

The benefit was payable as a monthly payment. Prior to the end of June the following year the insurer’s representative advised Alice that based on her medical certificate of her practitioner her claim would be “paid out until the end and then the claim closed.” That amount was close to \$20,000.

The representative did not tell Alice to obtain any financial advice in respect of what the consequences of her income, equivalent to 18 months, being paid as a lump sum prior to the end of the financial year would be.

Alice was sent a PAYG statement after the end of the financial year reflecting her income for the previous year. She attended at her accountant’s office to prepare her tax return and became aware that her income would be assessed as the equivalent of receiving 18 months of income, as opposed to 12. This was going to have serious consequences for her tax and Centrelink payments.

Alice contacted the insurer who advised her to repay the amount to allow an amendment. Alice told the insurer representative that the money had been spent prepaying her living expenses.

Alice was then advised words to the effect “if you repay the amount, by getting a loan the PAYG could be amended”.

Alice took steps to obtain a loan to repay the superannuation payment, and obtained a loan for that purpose.

Alice contacted the insurer and was advised words to the effect “as the repayment would occur outside of the financial year, the PAYG statement could not be altered”.

Alice contacted the ATO and was advised that the superannuation provider was able to amend the PAYG statement.

Alice pursued a dispute through the Financial Ombudsman Service (FOS) and the Superannuation Complaints Tribunal (SCT).

When it was apparent that the statement could not be amended, Alice had to proceed with the filing of the tax return or face the risk that her Centrelink Family Tax Benefits would cease.

Alice ended up with a liability to the ATO and to Centrelink.

*Source: Financial Rights Legal Centre - - C99939*

We note section 8.18 of the Life Insurance Code of Practice which states:

*If we accept your claim and it includes a lump sum payment, we will suggest you seek financial advice to help manage your claim payment. For an income-related claim, if we offer to pay you a lump sum instead of ongoing payments in order to finalise your claim, we will suggest that you seek financial and legal advice before accepting our offer.*

The Life Code does not capture the whole of the industry, for example those who distribute under their own AFSL, and we understand the life insurers are seeking to restrict this to claims over \$50,000 in the next iteration of the Code.

We also note that exempting life insurance from the design of the statement of claims option notice introduces an exemption that has not been publicly discussed or transparently considered. This is counter to the approach recommended by the Financial Services Royal Commission under recommendations 7.3 and 7.4 regarding exemptions and loopholes.

Consumers need clear and useful information from their life insurer when choosing between monthly payments or a lump sum settlement. It is critical that similarly poor consumer outcomes

are prevented in the life insurance sector by including them within the scope of the Statement of Claim Settlement Options.

## Statement of Claim Settlement Options required to be given

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Item 10, subsection 940C(1) requires that the Statement of Claim Settlement Options must be given to an insured when the offer to settle all or part of the claim using a cash payment is made. The statement can be provided in printed or electronic form.

While our experience is that most insureds will take some time to consider their options, there is a slim risk that some people may decide over the phone to take a cash settlement with a statement sent to the insured to their email without being opened or read. This is likely to occur - but not exclusively - following a natural disasters where people can be experiencing stress, anxiety and trauma,

Rather than introducing a deferment period we believe that there needs to be some ability to amend the decision so that if an insured accepts a cash settlement early and then works out something is missing or incorrect, the insured can return to the insurer and have it amended, similar to what currently occurs with a Scope of Works.

We note that this principle currently exists in a form under the General Insurance Code of Practice in relation to quick claim finalisations following a declared catastrophe. Paragraph 9.3 commits general insurers to the following:

*If you have a property claim resulting from a Catastrophe and we have finalised your claim within one month after the Catastrophe event causing your loss, you can request a review of your claim if you think the assessment of your loss was not complete or accurate, even though you may have signed a release. We will give you 12 months from the date of finalisation of your claim to ask for a review of your claim.*

*We will inform you about:*

- (a) this entitlement when we finalise your claim; and*
- (b) our Complaints process.*

We also believe that the provision of a statement of claim settlement options should be monitored by ASIC to examine the effectiveness and success or otherwise of the statement. We recommend that ASIC collect data from insurers and survey consumers on different aspects of the statement including but not limited to:

- rates of take-up for cash settlements;
- rates of reading, comprehension and influence on decisions; and
- length of time for a decision to be made.

## Contents of a Statement of Claim Settlement Options

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As we understand it, Treasury do not expect to create any regulations between now and the implementation of the legislation. We are also led to believe that ASIC may develop guidance on the development of contents for a Statement of Claim Settlement Options but that this is some time away - likely third and fourth quarter 2020.

We note that under the new General Insurance Code of Practice developed by the Insurance Council of Australia, general insurers have committed to providing:

*information to help you understand how they work and how decisions are made on cash settlements.*

This commitment is limited to home building policies. It is our further understanding that the ICA will be developing this information sheet during 2020. We commend the ICA for taking these steps.

It is our recommendation though that ASIC develop a guidance for the development of Statement of Claim Settlement Options and that they consult widely with industry and consumer representatives to ensure that all relevant issues are raised.

It is our view that the ASIC guidance for the contents of the Statement of Claim Settlement Options for general insurers should address the following issues:

- Insurers have a commercial bargaining power advantage to be able to engage builders to repair properties at lower rates – rates far lower than a consumer is able to obtain from a builder. Cash settlements subsequently reflect this lower amount;
- After a natural disaster there is increased demand for building and other trade services. This both increases the prices quoted and charged as well as leads to delays and difficulties in engaging qualified repairers quickly;
- Repairs obtained by the consumer with their cash settlement will not have the same insurer guarantees regarding quality, cost or timeliness of any works or repairs;
- Consumers can lose the benefit of lifetime repair guarantees offered by insurers when they agree to a cash settlement;
- Consumers should seek advice from their mortgage lender about any implications of accepting a cash settlement for their mortgage including the fact that the mortgagee is entitled to receive the insurance payout and then approve any repairs done on the property;
- Project managing repairs or a rebuild is complex and difficult, and hiring a building manager could be a big additional expense; and
- Consumers should obtain their own quotes before accepting cash settlements in order to figure out whether the amount being offered by the insurer is appropriate.

Many of the above align with the ACCC's views in its Northern Australia Insurance Inquiry, which has recommended the provision of a one-page document written in plain English setting out matters the consumer should consider to help them make an informed decision, including:

- if a cash settlement is accepted, the insurer would no longer be required to manage or guarantee the quality, cost or timeliness of any works the consumer decides to carry out;
- the consumer should seek advice from their mortgage lender (if applicable) about any implications of accepting a cash settlement for their mortgage;
- the insurer may be able to obtain lower repairing/rebuilding quotes than the consumer is able to achieve; and
- the consumer should obtain independent quotes for repairing/rebuilding their property before making their decision.<sup>13</sup>

With respect to life insurance, the Statement of Claim Settlement Options should advise the insured to seek legal and financial advice and address the following issues:

- the significant impact a lump sum can have upon a consumer's tax liabilities;
- the impact upon any government pensions, payments or housing eligibility;
- a lump sum may not be suitable if the consumer's illness or disability requires regular payments for treatment.

Any Statements of Claim Settlement Options must be consumer tested before being finalised.

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<sup>13</sup> Page 27 ACCC, *Northern Australia Insurance Inquiry Second Update Report*, <https://www.accc.gov.au/system/files/Northern%20Australia%20Insurance%20Inquiry%20Second%20Update%20Report.pdf>

## Concluding Remarks

Thank you again for the opportunity to comment. If you have any questions or concerns regarding this submission please do not hesitate to contact Financial Rights on (02) 9212 4216.

Kind Regards,



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CHOICE