LIFE INSURANCE

Competition in the Australian Financial System

MLC Life Insurance submission to Productivity Commission

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MLC Life Insurance welcomes the opportunity to provide a submission to the Productivity Commission's inquiry into the Competition in the Australian Financial System. We applaud the Australian Government's focus in the inquiry Terms of Reference on ways to improve consumer outcomes and support innovation in the financial system. These are worthy objectives and we have responded accordingly in our submission.

We note that the Consultation Paper for the inquiry recognises insurance as being one of five key segments of the financial system but declares anything other than vertically or horizontally integrated insurance to be out of scope. We appeal for this restriction to be relaxed – there are great opportunities for pro consumer change in the life insurance sector that we believe the Commission should examine, and are presently not being examined by any other policy process.

Therefore, and consistent with Term of Reference number four for the Commission to *examine barriers to and enablers of innovation and competition in the system, including policy and regulation*, we have focused in our submission on three areas where we think regulatory reform will improve consumer outcomes and support innovation in the life insurance sector. These are:

- Reforms to health legislation and regulation that prevents life insurers from assisting customers return to health and employment.
- Legislative and regulatory reforms to permit life insurers to move customers from older "legacy" products to current generation products.
- Reviewing financial services regulation to permit the introduction of innovative new forms of financial advice.

More generally, from our vantage point the life insurance sector displays the hallmarks of effective competition, with insurance manufacturers actively competing on price, quality and service. The recent and ongoing phenomenon of bank-owned life insurance disintegration and the introduction of new capital by way of foreign investment heralds a new wave of customer-focused product and service investment in the sector. This is a positive development for consumers.

About MLC Life Insurance

MLC Life Insurance, which traces its origins back to 1886, insures more than 1.5 million lives and is still fulfilling its original goal: "to bring the security and protection of life assurance within the reach of every man, woman and child".

On 3 October 2016 National Australia Bank Limited (NAB) completed its sale of 80% of its interest in MLC Limited (MLC Life Insurance) to the Nippon Life Insurance Company (Nippon Life). This has led to the creation of a specialised life insurance business, MLC Life Insurance, where Nippon Life has a majority 80% holding, while NAB retains 20%.

With a market share of approximately 11%, we are Australia's third largest life insurer. Traditionally our focus has been on the retail market segment where policies are sold via financial advisers, but our involvement in the insurance in superannuation market is growing. Our group insurance inforce premium is approaching $600m, equal to a market share of approximately 8%[1]. We are seeking to grow our presence in this market, particularly in the important industry superannuation fund segment, to which we are bringing new innovation and competition.

[1] NMG Consulting, *Group Channel Risk Distribution Monitor*, June 2017

Regardless of channel, our products play an important role in protecting our customers, their families and businesses against the adverse financial impacts of premature death, illness, injury or disability. In the financial year to 30 June 2017, we paid almost $950m in claims for our customers and their families, in doing so reducing or removing the need for people to rely on government and taxpayer support to manage their financial needs and responsibilities. Over 1,700 customers were supported through occupational rehabilitation and recovery services during the same period, helping them regain ability and normalcy in their lives.

With the strong backing of Nippon Life, MLC Life Insurance is now poised to deliver even better value for its customers. This strategic partnership is enabling us to invest significant capital (in the order of $400 million) to simplify and improve the customer, member, trustee, adviser, banker and employee experience with the aim of ensuring our insurance products are easy, simple to understand and administer. Digital channels and data analytics form a key part of our strategy. We are investing to simplify our back-office systems, including sales, servicing, underwriting and claims, to make it easier and faster for our stakeholders.

Reforms to allow life insurers to assist their customers to return to health and employment

In the Australian healthcare system the right to fund healthcare is reserved for comparably few institutional entities. Outside of private individuals, only state and federal governments, private health insurers and certain other non-government sources such as workers compensation insurers and motor vehicle third-party insurers are permitted to directly pay for health services. Unfortunately, while Life Insurers deal with the consequences of injury and ill health on a daily basis, they are not considered a part of the healthcare funding system and as such are prohibited from paying directly for healthcare services.

MLC Life Insurers contends there is a strong case for these regulatory restrictions to be relaxed in certain circumstances. Via Income Protection and Group Salary Continuance products, life insurers take on risks associated with their customers being unable to work for health reasons, such as in the case of individual injury or illness. The acceptance of this risk means that in the event of an Income Protection or Group Salary Continuance claim due to injury or ill health, life insurers have a strong financial motivation to support their customers to return to health and to paid employment. Not being permitted to directly fund health services constrains a life insurer's ability to achieve this goal and creates a perverse outcome for the customer.

Importantly, MLC Life Insurance does not advocate displacing the existing sources of funding in the healthcare system. Australia's mixed public-private healthcare system is deservedly recognised as one of the world's best, and we support the principal of equity of access based on clinical need that underpins it. Rather, MLC Life Insurance would like to be able to supplement existing funding sources in a very limited range of circumstances with the aim of creating both a benefit for the customer and efficiencies for the insurer. Furthermore, we believe there are clear public policy benefits associated with life insurers being permitted to fund medical treatment in certain circumstances. Each of these points is explained below.

A virtuous circle: the benefits of helping life insurance customers return to health

MLC Life Insurance is a strong supporter of the health benefits of work and already takes an active role in helping our customers return to employment following illness or injury. We note the compelling evidence demonstrating that the longer a customer is away from their work and usual routines of life, the more likely they are to become permanently dislocated, including being unable to work. The evidence shows that if a person is off work for:

- 20 days the chance of ever getting back to work is 70%.
- 45 days the chance of ever getting back to work is 50%.
- 70 days the chance of ever getting back to work is 35%.[2]

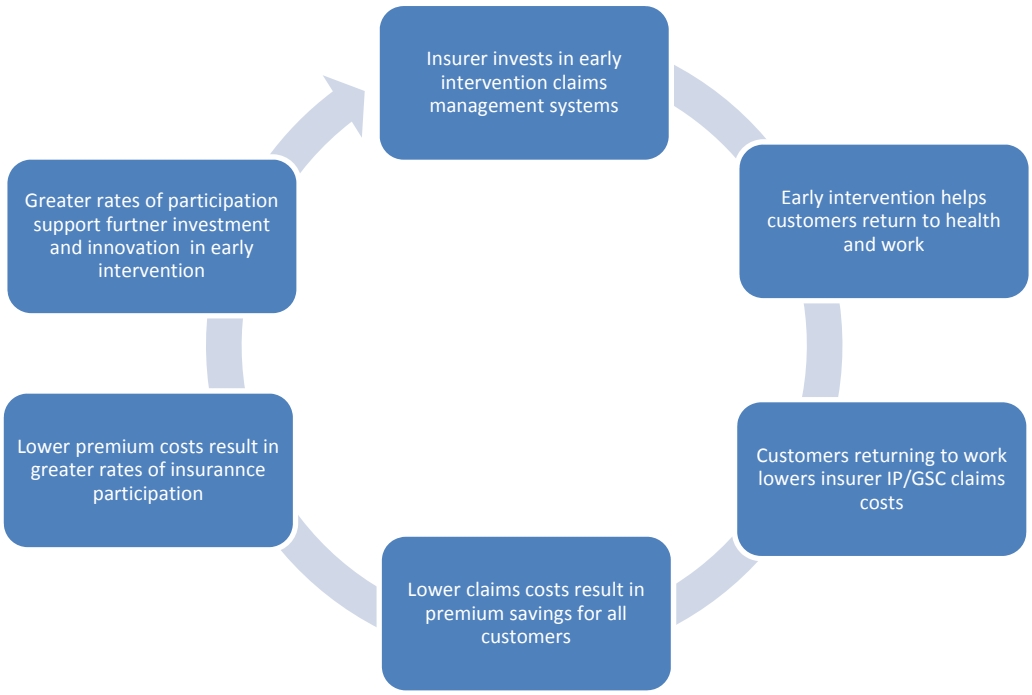
Statistics from other sectors underline the benefits of taking action early. WorkSafe Victoria cites interventions within eight weeks of an injury as leading to a 66% likelihood of returning to work. Where intervention does not occur until after eight 8 weeks, Worksafe Victoria found the likelihood of returning to work decreases significantly, to just 14%.

In response to this evidence, in 2016 MLC Life Insurance proactively shifted our rehabilitation efforts from being a "last resort" in the claims management cycle to provide support delivered prior to our contractual obligations actually commencing. This means that rather than trying to support rehabilitation some months after an injury or health event we now seek to provide up-front support well before the usual 30-90 day waiting period for a, IP or GSC claim is served. Achieving this goal involves working with the customer, their healthcare providers and their employer to deliver an early and improved outcome.

[2] Australasian Faculty of Occupational and Environmental Medicine, *Realising the Health Benefits of Work*, 2011, p. 12,

The result is a more satisfied customer with better future health and employment prospects. Research in the UK has found that employees with access to early intervention services and who utilise them have an average absence period 16.6% shorter compared to those who do not. This translates to a reduction of more than a year (60 weeks) in the average seven-year duration of a long-term absence[3].

From a commercial point of view, the benefits of early intervention claims management processes are obvious – effective early intervention results in decreased overall claims costs. But in achieving this goal we also create system wide efficiencies that directly benefit current and future customers, as depicted in the diagram below:



Presently the restriction on life insurers paying for health services means MLC Life Insurance is limited to paying for non-health services, such as occupational rehabilitation, with the aim of improving a customer's function sufficiently to enable a return to work. Specific services include vocational assessments, work conditioning programmes and job seeking assistance. In order for these services to be relevant and effective, customer must firstly have addressed underlying health issues and making progress on regaining their health. We estimate that on current Income Protection and Group Salary Continuance claims loads approximately 300 MLC Life Insurance customers would benefit each year if we were permitted to pay directly for health services in certain situations.

Presently we have customers on Income Protection and Group Salary Continuance claim whose best chance of returning to full health is via timely access to healthcare, but who for various reasons are unable to access the needed care so placing their chances of returning to health and employment at risk. Common reasons for this include:

- **The customer is awaiting Medicare-funded surgery in a public hospital**. Depending on the surgical speciality, the wait to access a public hospital can be quite long, with surgical waiting times on their own surpassing the optimum return to work timelines set out by authorities such as the *Australasian Faculty of Occupational and Environmental Medicine* (AFOEM). For example the median waiting time

[3] Centre for Economics and Business Research, *The Benefits of Early Intervention and Rehabilitation*, 2015, p. 7

orthopaedic surgery is 67 days, while for ophthalmological procedures the median waiting time is 78 days[4]. Each of these is well outside the optimum return to work window outlined by AFOEM.

- **The customer has exhausted their Medicare-funded services and cannot afford to pay privately for the service**. For example, the Medicare funded "Better Access" mental health program part funds a maximum of ten psychologist services per calendar year. Any additional care must be paid for entirely by the patient, which can serve as a disincentive to care. Even where patients are able to access this service we often see a reticence to access the entitlement as quickly as is clinically optimum.
- **The customer cannot afford to access outpatient health services not covered by Medicare and does not have private health insurance.** Under normal circumstances Medicare does not fund allied health services such as physiotherapy, occupational therapy or remedial massage that are often integral to rehabilitation and return to work care plans[5].

Customers in these circumstances either have no option to obtain the care that would benefit them, or the care is delayed past what is optimum. Regardless of which, the end result is a perverse outcome for the customer, who is less likely to return to full health or employment, for their employer, for their insurer and for the community as a whole. Below are included brief case studies taken from MLC Life Insurance claims records which illustrate the real life impacts associated with the restrictions on life insurers paying for healthcare.

Case Study 1: Preventing the development of chronic pain

Mr B was a self-employed plumber, aged 43, and married with two children age six and 12. While working, he fell off a ladder breaking both feet. He underwent surgery however multiple operations were not successful in providing relief from chronic pain caused by the injury.

MLC Life Insurance identified that Mr B's condition made him a good candidate for a multidisciplinary intervention via a pain clinic. Such an approach could have supported him to manage his pain with a reduced need for reliance on opioid analgesics, and is associated with an improved quality of life and improved likelihood of a returning to work.

Unfortunately Mr B could not afford the pain clinic and MLC Life Insurance is not permitted to fund the treatment. His pain management plan was instead based around heavy doses of opioid analgesics which were only partly effective and brought side-effects. He had trouble sleeping and became depressed and despairing of his future. With the passage of time Mr B has been found to be permanently disabled and assessed as unlikely to ever be able to return to work.

Case Study 2: Treatment for major depression and substance use disorder

Mr P is a 52 year old debt collector who was diagnosed with depression, who became increasing unwell due to a substance addiction. As a consequence of the addiction his business went bankrupt and his health further deteriorated. He ceased work and claimed a benefit from MLC Life Insurance.

To try to turn around his circumstances, MLC Life Insurance engaged with Mr P's doctor to arrange for a review of his case. Mr P was referred to a psychiatrist and a psychologist. While he was motivated to attend he found the cost prohibitive. He reported he needed to wait for a particular month when his MLC Life

[4] Australian Institute of Health and Welfare, *Elective surgery waiting times 2015–16: Australian hospital statistics*, 2015, p. 25

[5] It is possible for Medicare to fund allied health services if the patient has a chronic medical condition and their GP has provided a Chronic Disease Management service, however even in these circumstances access is limited to a maximum of five services per calendar year.

Insurance benefit was not committed to other expenses before he could afford to attend consultations. As a result his treatment was irregular and ineffective.

Despite the fact that Mr P has a mental illness for which treatment is known and effective, a successful outcome appears out of reach for him at this stage. If MLC Life Insurance were able to support Mr P by funding appropriate treatment interventions at the appropriate recommended intervals, there would be a much improved opportunity to facilitate his recovery, long-term health outcomes and prospect of his ultimate return to work.

Case Study 3: Surgery and post-operative rehabilitation for a hip replacement

Mr M is a self-employed tradesman with a role that requires heavy manual labour. He needs a hip replacement and until he receives it he is restricted to using crutches and is in significant pain. As he is unable to afford cost of surgery Mr M is on a public hospital waiting list with an expected 12 month waiting period. Post-operatively he is likely to require as much as six months rehabilitation before he will be capable of resuming his usual labouring duties.

As a sole trader, Mr M's inability to perform his usual duties while awaiting surgery means his business has needed to be closed down. This is likely to impact on his ability to return to work post-operatively and is a source of anxiety for Mr M and his family.

If MLC Life Insurance were able to assist Mr M undergo surgery and rehabilitation in a timely manner we could also assist him with restructuring his business temporarily while he recovers, so as to enable a clear return pathway to employment. Without this option, Mr M remains on claim with a clouded employment future.

Public benefits of life insurers paying for health services

It is not just life insurance customers that stand to gain from reform of rules preventing life insurers from paying for healthcare services. Were life insurers able to provide more effective early intervention that resulted in higher rates of customers returning to their employment there would be a shared public value across the community as a whole. This value would accrue at multiple levels:

- At the individual level employed people are healthier, enjoy better standards of living and experience greater levels of life satisfaction[6].
- At the employer level, employers regain the skills, knowledge and productivity of their employees while avoiding the costs associated with recruiting and training new employees.
- At the government (and taxpayer) level, employed people are also far less likely to be in receipt of welfare support or have unplanned use of the healthcare system[7].
- At the macroeconomic level, an employed person is contributing to economic productivity of the Australian nation.

There are other benefits as well: There is substantial evidence demonstrating the link between disablement and lower rates of labour force participation[8]. As Australia grapples how to respond to current and future

[6] Australasian Faculty of Occupational and Environmental Medicine, Realising the Health Benefits of Work, 2011, https://www.racp.edu.au/advocacy/division-faculty-and-chapter-priorities/faculty-of-occupational-environmental-medicine/health-benefits-of-good-work

[7] In fact effective early intervention itself is associated with savings of up to 64% in medical costs, and up to 80% in disability benefits. The cost of rehabilitation is also lower at, up to 56 % lower when administered early. See Theodore, Mayer, Gatchel , "Cost-effectiveness of early versus delayed functional restoration for chronic disabling occupational musculoskeletal disorders", Journal of Occupational Rehabilitation, June 2015, Volume 25, Issue 2, pp. 303–315

[8] Mavromaras, K; Oguzoglu, U; Black, D and Wilkins, R. *Disability and Employment in the Australian*

labour market and skills challenges, we believe there is a strong public benefit to be obtained from insurers being permitted to pay for health services by way of enabling trained and productive working age people to remain in the workforce.

Life insurers should have the same capability as adjacent insurance sectors

MLC Life Insurance notes that insurers in adjacent sectors which play a similar role to life insurance are already permitted to pay for healthcare services. State and federal run workers compensation and transport accident insurance schemes are permitted to pay service providers directly for healthcare, with data for FY15 demonstrating these insurance schemes as spending $10.8 billion directly purchasing health services for their customers[9].

The healthcare services funded by these insurances are comprehensive, with benefits covering not just the immediate outpatient and inpatient medical services needed in response to accident or injury, but also services related to rehabilitation and return to work. Both types of insurances also pay income protection benefits when warranted. Like life insurers, workers compensation and transport accident insurers seek to work with their customer to create a good health outcome that enables them to resume their lives, including their employment.

With such clear parallels between the two sectors there seems no good reason why one sector should be able to support its customers accessing healthcare while the other is restricted from doing so, with customers therefore exposed to lesser quality health and insurance outcomes. It seems a perverse prejudicial outcome for holders of life insurance policies, who are paying for their insurance policies out of pocket (or out of their superannuation accounts), that in the event of disabling injury they should have lesser access to optimum assistance from their insurance policies that are otherwise available for third party or workers compensation insurance schemes.

The same carve outs from health funding policy and regulation that enables workers compensation and transport accident insurers to directly fund health services should be established for life insurers.

Reforms to allow insurers to pay for health services

MLC Life Insurance recommends a set of reforms that would allow life insurers to act as a limited "supplementary funder" of healthcare. We submit that as a supplementary funder life insurers would only function as a provider of "top up" payments when two criteria are met:

1. Where it can be demonstrated that the planned health service is reasonable and necessary to the goal of restoring the customer to health and employment.
2. Where established healthcare funders such as Medicare and private health insurers are constrained from funding the required services due to regulation, timing of the availability of treatment (including health system capacity issues), or, in the case of private health insurance, the customer is not insured.

Importantly the supplementary funding would be a voluntary act on behalf of the life insurer. Life insurance contracts would not specify in any way that the life insurer accepts a liability to make a payment for health services rendered to their customer. Such a contract is not permitted by s126 the *Health Insurance Act 1973.*

Examples of when this funding mechanism could be used include:

Labour Market, Melbourne Institute of Applied Economic and Social Research, 2007

[9] Australian Institute of Health and Welfare, *Health expenditure Australia 2014–15*, 2016, p. 47

- Where a customer requires ongoing psychologist support but has exhausted their Medicare funded *Better Access* entitlements, the life insurer should be permitted to fund the ongoing care to the same extent that Medicare normally would.
- Where a customer with private health insurance requires substantial physiotherapy to return to health and employment, but has used their maximum physiotherapy benefits, the life insurer should be permitted to fund the ongoing care to the same extent that their private health insurer normally would.
- Where a customer and their doctor determines that a major joint replacement is required to progress a customer's return to health and employment, but the length of the public waiting list threatens a successful return to employment, the life insurer should be permitted to fund the procedure or part thereof privately. In this regard, the reforms could stipulate that a waiting time sufficient to exceed the AFOEM determined optimum return to work window would trigger the ability of the life insurer to assist with funding.

Determining reasonable and necessary

In respect of (1) above, MLC Life Insurance recommends *reasonable and necessary* be determined by the requirements of an outcomes focused *return to employment plan*, jointly prepared by the customer, their doctor(s), their employer and their insurer.

The return to employment plan should specify the goal and the steps taken to achieve it, including the commitments of each party. The *return to employment plan* should explicitly require the planners to consider health services funded by established health system funders before calling on health services funded by the life insurer.

The customer's progress to the goal specified on the *return to employment plan* should be closely monitored. Once the goal is achieved the plan can then be iterated with a new goal and further supports, with the process continuing until full or optimal recovery is achieved.

Administrative arrangements

Where a life insurer proposes to pay for a medical procedure where a Medicare benefit is also payable, a MLC Life Insurance suggests the easiest model for customers would see the life insurer pay the full cost of the procedure and recoup the appropriate benefit from Medicare.

Amending laws and regulations to achieve this goal

To put in place the changes recommended by MLC Life Insurance, amendments will be required to the *Health Insurance Act 1973*, the *Private Health Insurance Act 2007*, and the *Private Health Insurance (Health Insurance Business) Rules 2017*. Some key aspects of these are called out below, however we acknowledge a fuller review of legislative restrictions and implications is required.

- Section 20A of the *Health Insurance Act 1973* would need to be amended to permit life insurance customers to assign their Medicare benefit to their life insurer.
- The *Private Health Insurance Act 2007* specifies payment for health services as being *health insurance business*, prohibiting life insurers from making such payments. However Section 121 of the *Private Health Insurance Act 2007* goes on to exclude certain types of payments from the definition of *health insurance business*, raising the possibility of the addition of a new exclusion based around payments for health services associated with a *return to employment plan* as outlined above. The requirements of the *return to employment plan* could be fully expressed in the *Private Health Insurance (Health Insurance Business) Rules 2017*.

Legislative and regulatory reforms to permit life insurers to move customers from older products to current generation products

Life insurers and their customers struggle with the complexity brought by the proliferation of prior generation "legacy" products that are still in force but have features or terms inconsistent with current generation products. The rationalisation of life insurance products would improve consumer outcomes, support product innovation, boost insurer productivity and efficiency, and add competitiveness to the life insurance market.

What is product rationalisation?

Product rationalisation in life insurance typically involves the closure of a product for all customers on that product and the simultaneous transfer of each customer to a replacement product. In doing so the contractual terms and conditions applicable to the original product are extinguished for the insurer and the transferring customers, and the new product terms and conditions brought into force.

Benefits of product rationalisation

Life insurance products are generally sold as "guaranteed renewable", meaning that once the policy is issued the policy cannot be cancelled[10] or changed[11] as long as the customer meets their statuary obligations and continues to pay the premium. This is mostly a very positive feature for the customer, but an unintended consequence is that products can remain in force decades after they have been removed from sale or replaced, creating entire classes of legacy products that are out of step with current generation of products.

While customers on legacy life insurance products may be satisfied with their product, they may unknowingly be incurring financial and/or opportunity costs by not being on a newer product. This is because as a general rule current generation products are better suited to the needs and wants of contemporary customers, with new features or innovations that suit present times. Additionally, the management of legacy products brings with it complexity and costs that may lead to poor customer experience while adding to the insurers administrative cost base, a burden that is ultimately borne by the customer.

These same impacts are felt by the insurer. Insurers find it difficult and costly to efficiently administer the often times small groups of legacy products on their books due to multiple factors:

- Legacy products are often administered on past generation systems which do not meet contemporary standards, may not interface well with other business systems and which are hard and expensive to maintain.
- Transferring legacy products to modern business administration systems may be expensive and operationally riskier than leaving them on the old system.
- As employees move roles or leave the business, detailed knowledge of legacy products is hard to sustain. Knowledge of legacy products may exist in document form only, rather than in the lived experience of employees.
- Changes in the regulatory environment may leave some products stranded or dependent on the policy holder to take some sort of action.

[10] Policies cannot be cancelled until their natural expiry date. Life insurance policies typically have expiry dates as at age anytime between 65-75 years (or longer), depending on the type of insurance.

[11] Changes cannot be made to the contract except under limited circumstances allowed under the *Life Insurance Act 1995* (Cth). Changes that are allowed are pricing changes and changes that enhance the terms of the contract, to the advantage of the customer, that do not result in a price increase.

- As the number of legacy products on issue diminishes, it becomes problematic and expensive to manage the preparation and fulfilment of customer communications.
- The lack of a product rationalisation framework for life insurance also creates a significant barrier to product innovation in life insurance. This is because life insurers don't want to be left with small portfolios of policies from innovation initiatives, for the reasons listed above.

Rationalising legacy products would address these issues and produce benefits across the value chain:

- customers would be moved on to a newer products that would on average leave them better off, while enjoying a better experience by way of contemporary product features and support
- decreased levels of insurer administrative complexity would lead to simpler business processes, resulting lower costs for insurers
- a rationalisation mechanism would encourage innovation by insurers by lowering barriers to trialling products in the market
- lower costs would ultimately reduce pressure on premiums, supporting life insurance participation rates and the many benefits this produces for customers, policy beneficiaries and governments.

Approaches to life insurance product rationalisation

MLC Life Insurance acknowledges there are steps insurers can already take to unlock some of the benefits associated with product rationalisation. For example, presently we are taking the initiative to design and implement a new Product Administration System and other technology platforms that will improve the customer experience and create administrative efficiencies. These actions are consistent with the Australian Prudential Regulatory Authority's view that the solution to the legacy products issue should be at least partly based on insurer's being proactive in updating their systems[12].

However regardless of this sort of insurer led activity, achieving the full benefits of product rationalisation will require legislative and regulatory change as well. Presently product rationalisation is hampered by a range of legal, consumer and tax issues that inhibit an insurer's ability to update legacy products. Essentially this renders any current attempt to rationalise life insurance legacy products and other related products as too difficult and expensive.

The approach to product rationalisation supported by MLC Life Insurance was developed by an FSC Product Rationalisation Working Group in 2015 and is based on amendments the *Insurance Contracts Act 1984* (Cth) to allow life insurers to unilaterally amend policy terms under certain circumstances.

While granting such powers to insurers may initially appear confronting, it is important to understand that before being able to amend policy terms insurers would be required apply a consumer interest test that would ensure the change is in the interests of the majority of affected policyholders. The consumer interest test would have a number of key features:

- The consumer interest test would be applied at the collective level to enable the maximum number of consumers and other stakeholders to benefit, driving overall industry efficiency.
- The consumer interest test would be overseen and approved by APRA.

At the time of its focus on this issue, the FSC Product Rationalisation Working Group noted the structural benefits of addressing legacy products would include:

  - 38 of 79 legacy IT systems could be closed

[12] APRA, submission to Parliamentary Joint Committee on Corporations and Financial Services inquiry into the life insurance industry, November 2016, pp 24-25

- 286 life products and 77 managed investment schemes could be closed
- $22.6 billion in funds under management could be transferred to contemporary products.

FSC members forecast that through these changes they could achieve $94 million in cost reductions over the near term through a staged rationalisation program, which would result in a more efficient and sustainable industry.

Below is a case study that outlines how product rationalisation could work in practice.

Case study: legacy life insurance bond products

Insurance bonds provide customers with tax advantages if held for more than 10 years and additional investments do not exceed the previous year addition.

Insurance bond products tend to have variations regarding pricing and investment options and thus must be managed separately even if there is only one customer left. Over time these products may become unsustainable and because life insurance companies have neither the power to transfer customers to another product offering or to terminate the product, they either need to absorb losses (thus reduce spend on customer-valued activities) or pass on the costs to customers through increased prices.

If life insurers had the ability to transfer customers to another product with similar features this would provide benefits to customers, life insurers and the industry.

Potential solution:

The life insurance company compares its most contemporary insurance bond product against its legacy insurance bond products. It finds the contemporary product has lower premiums and a broader range of investment options than legacy products.

If the insurer had the ability to move customers to this contemporary product and chose to do so the customer gets the life insurance equivalent of a get a "free upgrade" to a more product with better features at a lower cost.

For the insurer the likely outcome is a decreased margin at the individual customer level. However this loss would be offset by gains through reduced operating costs and increased customer satisfaction, plus benefits associated with reduced compliance and business complexity.

Regulator and policy maker support for rationalisation

While the life insurance industry is clearly an advocate for the legislative reform to permit rationalisation of legacy products, there is also support for the concept at a regulator and policy maker level as well. This support has been clear for some time but the most recent expressions of support have been:

- **The Financial System Inquiry**. Recommendation 43 of the 02014 Final Report of the Financial System Inquiry (FSI) called for the Australian Government to *Introduce a mechanism to facilitate the rationalisation of legacy products in the life insurance and managed investments sectors.* In the recommendation the FSI recognised that legacy products increase costs to life insurers while also preventing consumers from accessing better features in newer products[13].
- **Australian Prudential Regulatory Authority.** APRA's 2016 submission to the Parliamentary Joint Committee on Corporations and Financial Services inquiry into the life insurance industry recognises that life insurance product portfolios are becoming more complex and expensive to administer over time. In APRA's view this is contributing to increased operational risk to insurers and consumer

[13] The Treasury, *Financial System Inquiry Final Report*, November 2014 p. 274

outcomes that are poorer than they would otherwise be. As a result APRA recommends the introduction of a mechanism to facilitate product rationalisation[14].

- **Australian Securities and Investment Commission.** In its 2016 submission to the Parliamentary Joint Committee on Corporations and Financial Services inquiry into the life insurance industry ASIC notes " key areas of reform we have identified…critical to improving consumer outcomes and industry practice". It includes mechanisms to facilitate the rationalisation of legacy products in the life insurance in its list of identified reforms.

[14] APRA, submission to Parliamentary Joint Committee on Corporations and Financial Services inquiry into the life insurance industry, November 2016, pp 24-25

Reviewing financial services regulation to permit the introduction of innovative new forms of financial advice

The benefits to consumers of working with a financial adviser are compelling. Australian research conducted on behalf of the Financial Services Council by KPMG Econtech in 2011 clearly demonstrates that Australians who engage an adviser generally save an extra $1,590 a year, after advice costs, and are almost $100,000 better off at retirement when compared to a similar individual without a financial adviser[15]. It also found levels of underinsurance amongst people with a financial adviser were lower when compared to those without an adviser, with advised people more likely to hold insurance, by at least a multiple of four, for each type of insurance covered in the analysis[16].

Apart from the financial benefits, financial advice clients also benefit from the assistance advisers provide navigating some of the complexities that can be found in the financial services sector. For example while life insurers try and generally succeed in making their business processes as easy for customers as possible, advisers continue to help their clients through each stage in the life insurance process, be it understanding their needs, finding the right product, navigating the underwriting process or meeting their obligations at time of claim. There is little doubt the experience and expert knowledge financial advisers possess leave them well positioned to assist their clients through the insurance life cycle.

Despite these many benefits the rate of consumer uptake of financial advice remains stubbornly low. There are a variety reasons posited for this, including consumer mistrust of advisers and the institutions that sit behind them, the financial expense of engaging an adviser and the time cost associated with finding and working with an adviser. Also at play may be a sense that the time honoured, face to face consultation approach taken by financial advisers no longer meets the needs of modern consumers, who increasingly seek to engage online.

As a strong advocate of the benefits of financial advice, MLC Life Insurance believes that at least part of the solution to growing the usage of financial advice may lie in expanding the use of new models of advice in the Australian market. In particular we see potential for the greater use of so-called “robo-advice”, which refers to financial advice delivered online. By lowering costs robo-advice would improve accessibility to financial advice for people on lower or fixed incomes. We also see the possibility of hybrid models of advice where aspects of the advisory process are delivered by robo-advice, while other components rest on more traditional interactions.

How robo-advice works

Robo-advice is simple in concept. The client enters a range of personal information into an algorithm based engine, including financial information, and answers questions on topics relevant to the robo-advice category, for example risk tolerance or investment class preferences for an investment orientated service. Based on this information the computer algorithms underpinning the robo-advice engine generate a set of outcomes.

There are limitations on what robo-advice engine can do. Robo-advice interfaces tend to have a specific focus linked to the goal of the service so are generally restricted in the information they acquire. This means they may miss important details that could be relevant to client decision making, and cannot take into account the client’s overall financial circumstances and needs. At present levels of technology robo-advice engines are not able to be responsive to the information provided by the client in the same way a human adviser can be, so will not ask or respond to the client’s goals and objectives or clarify any possibly incorrect

[15] KPMG Econotech, *Value Proposition of Financial Advisory Networks – Update and Extension*, 2011, p. 10
[16] Ibid p12-13

information entered. There also may not be an opportunity for the client to ask questions relating to the advice provided.

Unless and until these limitations can be overcome by technological improvement human advisers will continue to play a key role in providing advice. In fact human advisers may integrate robo-advice into their own business processes, for example by using such systems to gather client information and assessing it so as to produce a shortlist of products that appear to meet the client's needs, but with a human adviser playing the key role of interpreting these results so as to match the client with the one product that best suits the client.

Alternatively specialised financial advisers, such as advisers that focus on life insurance, could use robo-advisers to expand their advice range. The adviser could remain focused on their speciality area while drawing on a robo-advice engine to add value for their client by advising on adjacent markets.

Another possibility is that existing financial advisers may be able to draw on robo-advice to expand their business by using the services to access markets that are uneconomic under current market settings. For example the introduction of lowered commissions for the sale of life insurance products under the Life Insurance Framework regulations that will apply from 1 January 2018 may make it uneconomic for financial advisers to take on clients seeking a single product solution with a low sum insured. If robo-advice can reduce the costs of addressing this market for advisers they may benefit from its introduction into their business, while also addressing equity issues that currently existing in the broader market.

For financial advisers and their clients alike, robo-advice also brings important risk management and compliance benefits. It does this in three ways:

- Consistency in advice – robo-advice treats clients with similar characteristics in a similar way.
- Reduced risk of conflicted advice – robo-advice is less likely to be motivated by human self-interest, with conflicts able to be "designed out" of the system. This would work alongside existing measures and further reduce the already low risk of clients being provided with conflicted advice.
- Higher standard of advice documentation –all inputs and responses from both the client and the robo-advice service provider are captured in the system in a consistent manner. This would also create additional benefits by ensuring there is a complete and standardised audit trail, should it be required.

The state of the current robo-advice market

There are a small number of robo-advice businesses that have commenced in the Australian market in the last five years. For the most part these are investment focused advice businesses that use robo-advice engines to help investors optimise their investment, for example by advising on an investment portfolio, investing the money and automatically rebalancing it in reaction to market developments.

There are no insurance robo-advice services presently active in the Australian market, however there are some active overseas. An example from the United States is the general insurance start-up *Lemonade*, which uses artificial intelligence (AI) in its customer joining and account creation process and again at claims time. In some circumstances *Lemonade's* AI systems can complete these processes with no human input at all: earlier this year the claims AI processed and paid a claim in three seconds. The stated goal of *Lemonade's* management is to eventually automatically process 90 precent of claims within a day[17].

[17] Accenture Insurance, *Where are insurance robo-advisors deployed today?*, 2017, http://insuranceblog.accenture.com/where-are-insurance-robo-advisors-deployed-today, accessed 03/10/2017

In the realm of life insurance, there are presently no life insurance robo-advice platforms in Australia or indeed globally. However the first steps towards this are already well underway, with advanced "insurtech" algorithmic engines being deployed to assist and automate aspects of the life insurance customer experience. Locally MLC Life Insurance is a part of this movement. For example we are presently deploying the *UnderwriteMe* underwriting rules and quote engine, which uses an advanced robo-underwriting and algorithmic pricing system to bring new levels of simplicity, flexibility and speed to underwriting, improving a process that has historically been difficult for customers and advisers to negotiate.

Overseas insurers are pursuing life insurance advice focused engines that will be capable of providing the sort of personalised advice client require[18]. Given the speed of technological improvement and the appetite amongst consumers for robo-advice in adjacent markets, it is highly likely that such services will emerge in the future. It is therefore incumbent for policy makers and regulators to start to consider how to facilitate and manage their emergence.

Regulatory considerations

While we are positive about the trajectory of robo-advice in life insurance and its deployment in Australia, we are alert to the potential difficulties robo-advice providers may have in complying with Australia's financial services regulatory regime.

In particular navigating the fine difference between general and personal advice and meeting the statutorily defined best interest duty may be challenging for providers. Depending on the objective of the robo-advice engine, the outcome could be simple factual information that helps clients make decisions, or it could be general advice or personal advice.

Any financial services market participant needs to understand the fine lines separating information, general and personal advice. The latter two outcomes require an Australian Financial Service Licence (AFSL) and in the case of personal advice providers need to understand and meet certain statutory obligations, including the best interests duty.

For service providers trying to provide a useful service to consumers it is easy to stray from one type of information or advice to another. Recently MLC Life Insurance developed its *Lifeview* tool intended to make it easier for members of superannuation funds affiliated with us to manage any life insurance they have as part of their membership. *Lifeview* includes two calculators to help guide members in their decisions. The first calculator asks the customer to input information about their circumstances and based on this suggests the type and amount of cover that might be meet their needs. The second calculator separately quotes how much a given amount of insurance might cost.

From a customer experience point of view it would be logical to combine both calculators so a customer is able to determine both the quantum of insurance required and the cost of the insurance. Unfortunately providing both in the one place would be considered as providing advice, which exceeds the terms of MLC Life Insurance's AFSL. Apart from the diminished customer experience, separating the sum insured calculation from the quotation calculation risks consumers missing out on all the information required to make an informed decision.

Personalised robo advice and the challenge of the best interest duty

When giving personalised financial advice, a financial adviser needs to satisfy the best interest duty expressed in Division 2 of Part 7.7A of the *Corporations Act 2001* (Cth). This applies regardless of the mode of advice, meaning any future robo-adviser would need to meet the requirement just like a human adviser does.

[18] Life Insurance International, Life insurance 2026: Rise of the robo-advisers, 2016, https://www.linkedin.com/pulse/life-insurance-2026-rise-robo-advisers-ronan-mccaughey/ , accessed 03/10/2017

Division 2 of Part 7.7A of the *Corporations Act 2001* requires advice providers when providing personal advice to clients to:

- act in the best interests of their clients
- provide appropriate advice
- warn the client if advice is based on incomplete or inaccurate information
- prioritise the client's interests.

To assist financial advisers in meeting these obligations, the *Corporations Act* section 961B(2) contains so called "safe harbour" provisions. Section 961B(2) states advisers meet their obligation when the adviser has:

a) identified the objectives, financial situation and needs of the client that were disclosed to the provider by the client through instructions;

b) identified:

   (i) the subject matter of the advice that has been sought by the client (whether explicitly or implicitly); and

   (ii) the objectives, financial situation and needs of the client that would reasonably be considered as relevant to advice sought on that subject matter (the client's relevant circumstances);

c) where it was reasonably apparent that information relating to the client's relevant circumstances was incomplete or inaccurate, made reasonable inquiries to obtain complete and accurate information;

d) assessed whether the provider has the expertise required to provide the client advice on the subject matter sought and, if not, declined to provide the advice;

e) if, in considering the subject matter of the advice sought, it would be reasonable to consider recommending a financial product:

   (i) conducted a reasonable investigation into the financial products that might achieve those of the objectives and meet those of the needs of the client that would reasonably be considered as relevant to advice on that subject matter; and

   (ii) assessed the information gathered in the investigation;

f) based all judgements in advising the client on the client's relevant circumstances;

g) taken any other step that, at the time the advice is provided, would reasonably be regarded as being in the best interests of the client, given the client's relevant circumstances.

In order to promote the development and deployment of innovative personal robo-advice engines MLC Life Insurance recommends the safe harbour provisions be reviewed to ensure they are applicable to the robo-advice service model. While most of the provisions appear reasonable and applicable to a robo-adviser, all are expressly designed with a human adviser in mind and at least two appear problematic to meet from a robo-advice perspective, including (c) and (g).

However rather than rewriting the section 961B(2), or developing new and separate provisions specific to robo-advice, the best course may be for there to be the promulgation of guidance making clear how 961B(2) can be implemented in practice by robo-advisers. One possible approach is outlined in the example below.

Example: making reasonable inquiries to obtain complete and accurate information
Safe harbour provision c of section 961B(2) of the *Corporations Act* requires an adviser to make reasonable inquiries to obtain complete and accurate information where it is reasonably apparent that information relating to the client's relevant circumstances is incomplete or inaccurate.

For a human adviser, meeting this requirement draws on their experience and their judgement of their client to know when they might be faced with such a scenario and need to make further inquiries. These human qualities are hard to recreate in robo-adviser so meeting the obligation would need to be delivered differently.

One solution may be for a robo-advice service to partly reverse the onus. Clients considering using a robo-adviser could first be screened to ensure they meet a base level of financial literacy. If the client meets the required level of sophistication, they are warned on the consequences of inaccurate information being provided and must actively accept the responsibility in order to proceed. If the client does not meet the required level of sophistication they may be streamed towards a traditional advice pathway, or offered general advice only.

A more technological solution might be for the robo-advice service provider to be authorised by the client to directly retrieve information from trusted sources so as to pre-populate a client questionnaire. Or alternatively the robo-adviser could draw on the sort of improved data access recommended by the Productivity Commission in its *Data Availability and Use inquiry* to certify client provided information electronically in real time.

The impact of regulation the development of the Australian robo-advice market

While individually regulation is often well intended and makes sense, in totality regulation can produce an unintended effect of hampering market development and consumer advancement. It can do this by impeding innovation and acting as a barrier to entry by new market participants, in the process blocking consumer access to the benefits of each, .

MLC Life Insurance's concern is that as robo-advice technology matures globally and lowers the costs of financial advice, including with development of life insurance robo-advice engines, Australian financial services regulation may slow or stop Australian consumers from being able to access these benefits. This could occur because local providers are deterred from undertaking the capital investment required to develop robo-advice or overseas providers prefer to expand into less complicated markets.

Ensuring the Australian financial services regulatory system is able to facilitate robo-advice is therefore of vital importance and we recommend that current regulations are reviewed with this outcome in mind. Future introductions of new regulation or changes to existing regulation should also be done with an eye to how it may impact on this emerging technology.