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9 September 2016

Commissioners Chester and MacRae
Efficiency and Competitiveness of the Superannuation System Study
Productivity Commission
Locked Bag 2, Collins St East
Melbourne VIC 8003, Australia

Dear Commissioners

We welcome the opportunity to provide a submission in response to the Draft Report of the Productivity Commission's Study of the Efficiency and Competitiveness of the Superannuation System.

Having regard to the Draft Report, this submission will seek to respond to the issues raised regarding insurance, and particularly those issues considered in section 6.4. While the Report raises many important questions that relate to the economic circumstances and dignity in retirement of working Australians, we have contained our comments to our specific expertise in Superannuation Insurance products.

Please do not hesitate to contact me and my colleagues if we can further assist with the Commission's important work.

Yours sincerely,

Greg Tucker
CEO
MAURICE BLACKBURN

SUBMISSION TO THE PRODUCTIVITY COMMISSION STUDY OF THE EFFICIENCY AND COMPETITIVENESS OF THE SUPERANNUATION SYSTEM

September 2016

Introduction

Maurice Blackburn Pty Ltd is a plaintiff law firm with 32 permanent offices and 29 visiting offices throughout all mainland States and Territories. The firm specialises in personal injuries, medical negligence, employment and industrial law, dust diseases, superannuation (particularly total and permanent disability claims), negligent financial and other advice, and consumer and commercial class actions.

Maurice Blackburn employs over 1000 staff, including approximately 330 lawyers who provide advice and assistance to thousands of clients each year. The advice services are often provided free of charge as it is firm policy in many areas to give the first consultation for free. The firm also has a substantial social justice practice.

Our Superannuation business

Maurice Blackburn assists more Australians every year in making TPD and other insurance claims under their Superannuation policy than any other law firm.

Through the hundreds of clients we assist, we see the best of intentions and the best of performance from Superannuation Funds and their insurers. We unfortunately also see the worst of culture and behaviours that have real and profound consequences for their members and our clients at a time they can least cope with such difficulty.

Many of these poor experiences have been reflected by media coverage of the wider life insurance industry. Most recently, this has included unethical behaviour by certain Insurers such as disputing claims using out-of-date medical definitions, and delay tactics to avoid claims.

Default TPD in superannuation is a critically important resource for superannuation fund members. It is the means by which a disabled member can top up the shortfall in their superannuation retirement savings caused by the premature end to their career. We know the personal story behind each of the claims we assist with each year, and the difference the financial assistance makes in difficult personal and family circumstances.

As the Draft Report articulates, this resource is of great importance given the underinsurance problem in Australia, and the potential cost to the taxpayer. The KPMG study cited in the Report found that:

> *"the typical person targeted in the analysis required cover of $570 000, that 19 per cent of families did not have cover, and that underinsurance levels varied significantly by age group, gender and geographical location. Australians in the 18–29 age bracket were the most underinsured for this cover".*

A further study cited in the Report, undertaken for ASFA, stated that "the median underinsurance gap (in dollar terms) was 36 per cent for (basic) life, 58 per cent for (income replacement) life, 86 per cent for TPD, and 84 per cent for income protection cover" and that the "underinsurance gap is large, but would be much larger if cover was not provided through superannuation funds".

Questions of Efficiency

The Draft Report considers the bundling of insurance relevant to questions of whether our Super system is efficient.

As such, the Report asks
- do funds offer insurance products that meet members' needs? and
- are the costs of insurance being minimized given the type and level of cover?

The analysis, including quantitative analysis, proposed as the next step of the Study is sound. However it is also critical that specific aspects of Insurer behavior are considered as context to these questions of efficiency.

There are six specific aspects of behavior that Maurice Blackburn wishes to highlight as the Commission proceeds to this analysis stage. They are:

i. The creation of junk insurance through unreasonable thresholds and definitions, and deliberately undermining products where a member has multiple policies
ii. The treatment of legacy claims as an indicator of all claims going forward and not a temporary increase in claim numbers.
iii. An unwillingness to recognize the right of members to access legal representation in a claim.
iv. Barriers created through unreasonable delays in processing claims and barriers created in the application process
v. A move towards periodic payments rather than lump sum TPD payment requiring claimants to undergo numerous medical and other checks over a period of years
vi. The introduction of a 'statute of limitations' for making claims that is for a period less than that provided by Statute of limitations law throughout Australia and inconsistent with S54 of the Insurance Contracts Act

All of these behaviours undermine efficiency by creating a product that members cannot effectively access.

The creation of junk insurance

Over recent years, some Insurers have effectively created "junk insurance" through new, unreasonable thresholds, eligibility rules and definitions, and creating redundancy where a member has multiple policies despite continuing to receive premiums for the product.

The Superannuation Industry (Supervision) Act allows for early release of funds in a members' retirement saving account in limited circumstances including 'Permanent Incapacity', which is defined as:

> *if a trustee of the fund is reasonably satisfied that the member's ill health (whether physical or mental) makes it unlikely that the member will engage in gainful employment for which the member is reasonably qualified by education, training or experience.*

Any TPD insurance definition must be 'consistent' with that condition of release, however the industry interprets that to mean it cannot be less onerous, and has, in recent years provided TPD definitions that depart substantially from this 'Permanent Incapacity' requirement.

Any comparison of products should consider whether there is departure from the SIS Act and whether the definition is onerous.

We have been particularly concerned with the change of definition from “unlikely” to “unable”.

“Unlikely” has been interpreted by Australian Courts to require a consideration of “the real world”, namely market conditions, in assessing whether the person is unlikely to return to work given their injuries or illness.

By contrast, “unable” is a medical assessment without consideration of the “real world”. For instance, it is possible to argue that even a quadriplegic is theoretically capable of work and may not satisfy an “unable’ definition”. As a consequence, the insurance effectively becomes junk insurance.

In 2014, a major fund with over a million members changed its TPD definition to remove the word “unlikely”. It now requires claimants to demonstrate that they are “incapable of ever engaging in any occupation for which [they are] or may become reasonably suited by education, training or experience”.

The industry generally considers that the threshold “incapable of ever engaging” is much higher than “unlikely” as found in the regulations, hence their policy change to limit their liability to pay claims. Further, the standard of work that is considered appropriate is lower than that provided for in the Regulations. Ultimately this means that claimants can have claims rejected, even if it is unlikely that they will engage in employment similar to that which they were performing before the accident.

The NSW Court of Appeal recently considered the “unlikely” TPD test and found that “a real chance that a person will return to relevant work, even if it is less than 50%, will preclude an Insured Person being unlikely ever to return to relevant work.” We advocate that such a test is sufficiently onerous.

It is pleasing to see that some other major funds have resisted pressure from insurers to depart from the ‘Permanent Incapacity’ test and have kept the “unlikely” definition. The fact that such definitions are being retained by some confirms the viability for doing so across all insurers.

It has also come to our attention that one Fund and Insurer has chosen to incorporate a new form of exclusion clause where if they have another insurance policy – whether that be a retail policy or through a second superannuation fund. Of course, Australians being members of multiple funds is commonplace.

The full Clause is

> *Excluded Member Means a Member to whom any of the following applies:*
> *(a) a terminal illness, total and permanent disablement, trauma or similar benefit has been paid or is payable or can be claimed in respect of the Member under any insurance policy, whether that policy be owned by the Member or another person (including the Fund or another superannuation scheme);*
> *(b) the Member has received, or is eligible to receive, a benefit, or has had a claim for a benefit admitted, from:*
> *(i) the Fund; or*
> *(ii) another superannuation scheme;*
> *on the basis the fund or scheme has found the Member to suffer from ‘permanent incapacity’ or a ‘terminal medical condition’ under the Superannuation Industry (Supervision) legislation or any legislation which replaces it; or*
> *(c) the Member had or was eligible to have cover under any group life policy issued to the Fund and the Member:*

(i) opted out of being covered; or
(ii) cancelled the cover; or
(iii) ceased being a member of the Fund.

It is unclear whether this particular clause is specific to the fund/insurer or more widespread across the sector.

The most recent APRA Superannuation Statistics Bulletin states there are 30m Superannuation accounts. There are approximately 15m Australians of working age. The ATO stated in 2015 that 45% of working Australians have multiple Superannuation accounts.

As such, the particular insurer has deliberately chosen to exploit this multiple policy dynamic – this is neither efficient nor fair.

Multiple fund membership and therefore more than one insurance policy positively supports the problem of underinsurance and contributes to alleviate pressure on the Social Security system.

Legacy claims

Our experience is that TPD claim services in geographic markets have developed at different rates at different times. For instance, the Sydney market developed many years before Perth.

Our experience is that a key characteristic of regional markets has been for a large number of older, "legacy" claims to come forward after Fund members are made aware of their right and the existence of their insurance policy. Once these legacy claims are processed, demand for services normalizes to a significantly lesser amount.

We are concerned that Insurers are treating these legacy claims as a lead indicator, whereas they should be treated as a one of demand for services – or, at the least, a lag indicator.

Obviously such treatment inflates the cost and does not reflect the contemporary likelihood of claims coming forward.

Insurers will have the datasets to confirm this processing of legacy claims and normalization of claims by each regional market.

The right to representation

While a majority of Funds respect the right of their members to engage legal representation, there is still a minority of Funds that are aggressive and hostile towards lawyers playing any role in a claim. Such culture undermines the effective resolution of the claim and discourages others from making claims.

As we understand it, the vast majority of claims are made without legal representation despite the fact that those insurers employ teams of lawyers to oversee the processing of claims being made.

Funds have regular, ongoing communication with their members. If their members choose not to engage directly on their claim and instead access specialist advice, it is disingenuous and intellectually dishonest to seek to blame others for that choice being made. Members usually engage lawyers because they feel unable, physically and mentally, to handle an insurance fight on their own.

Barriers and hurdles created

We have consistent experiences with some Insurers and Funds having unreasonable delays in processing claims and creating barriers in the application process.

A recent media article by Adele Ferguson explained the journey of one of our clients:

> *…Take for instance, Eric McQueen, whose life started to unravel in September 2011 when he was medically retired from the Queensland Police Service with post-traumatic stress disorder. A series of shocking and violent incidents, encountered while on the job, had taken their toll physically and emotionally.*
>
> *After he "retired" from the police force, his mental health continued to deteriorate, leaving his wife Kate to pick up the pieces and become his full-time carer, while raising their two young sons. "Being there to help your husband off a ledge is draining but I love him to bits and I made a decision to be around him 24/7," she said.*
>
> *The family's money troubles mean that Eric can't see a psychiatrist regularly. They have been pinning their hopes on an insurance claim for total and permanent disability (TPD).*
>
> *The McQueens are just one of many Australian families locked in gruelling disputes with life insurance companies over policies paid for through superannuation.*
>
> *Eric, like millions of Australians, had TPD coverage through his super – in his case, through Queensland-based Sunsuper, a $35 billion fund into which he had contributed since he was 14. Sunsuper's life insurance contract is with insurance giant AIA.*
>
> *A second fund, QSuper, accepted his TPD claim and paid him out immediately. But Sunsuper refused.*
>
> *"Sunsuper has been despicable," Kate says. "When I first tried to put the claim in they said he wasn't covered, when he was." She then contacted Maurice Blackburn. "We have been battling ever since."*
>
> *In sharp contrast, QSuper were brilliant, she says. "They did independent reviews, looked at psychiatrist reports and did various assessments then paid it out straight away."*
>
> *But the medical bills kept mounting, adding to the financial strains facing the family. "I had to sell everything to keep food on the table. We came close to having to sell the house," she says.*
>
> *The McQueens' situation raises some interesting questions about what is going on in the sector and how we can fix it. Sunsuper dragged its heels, QSuper didn't. Are the trustees to blame? The life insurer? The quality of the policy? Or are there too many gaps in a system that allows trustees and life insurers to put claimants last?*
>
> *We know some super funds get rebates when claims are kept below a certain level. This can be lucrative and help bolster returns. Unquestionably it is a massive conflict of interest.*

Perhaps Sunsuper should take a leaf out of the QSuper trustee notebook on how to advocate for members, quickly and with respect.

Late on Friday, Fairfax Media was told that the McQueens' claim would be paid by the insurer, AIA…

(The article was published in Fairfax publications on Saturday, August 6th 2016)

These forms of unnecessary delay are one example of creating a barrier and a deterrent to members accessing their policies. Another example is to create an onerous application process – for instance, one private superannuation fund has a 42 page application form.

Unlike workers compensation where insurers are required by law to decide claims speedily (usually within one month), there is *no legislated time limit* imposed on Superannuation insurers. Consequently delays of 12-18 months before making a *decision* are commonplace.

We can provide the Commission with hundreds of case examples.

Periodic Payments

Insurers are moving away from a single lump sum payment to instalment payments, typically over a period of 5 years. Claimants are then required to prove annually they remain unable to return to work in accordance with the definition. This results in claimants being required to undergo numerous medical and other checks over a period of years, despite the fact – given their guidelines – the condition or injury is always permanent or irreversible (eg a loss of limb).

More generally, this is likely to increase legal conflict, escalate administrative costs and is unfair to claimants with conditions that have no prospect of improvement. There is diminished financial utility in payments over time rather than a one off larger lump sum (eg paying off a mortgage). Presently TPD lump sums are tax free and do not impact on Centrelink benefits. It is unclear whether the change to instalment payments alters their tax and Centrelink status.

Statute of Limitations

As mentioned above a 5 year time limit appears in breach of S54 of the Insurance Contracts Act which prevents the insurer from declining a claim on grounds of delay save to the extent that it is prejudiced. The statute of limitations for contractual disputes in all Australian jurisdictions is at least 6 years. In our experience Super Fund members fail to claim in a timely way because they are dealing with significant dislocation and distress in their working, social and family lives because of unexpected serious illness or injury. The other principal cause is because they are ignorant of their rights.

Time for a Code of Practice

Maurice Blackburn, amongst others, believe there is a need for an enforceable Code of Practice to be developed to regulate the conduct of the insurance and superannuation industries. The above examples clearly indicate that a self-regulated code will be insufficient, and will represent a wasted opportunity to effect genuine change in the industry.

This proposed Code should ensure that these industries operate in an ethical and fair manner. It should be developed through an open and transparent process, involving genuine consultation with both community representatives and industry groups.

The Code should ensure that the objectives of the SIS Act and the Insurance Contracts Act 1984 (Cth) are met. ASIC's Regulatory Guide 165 regarding time limits for internal dispute resolution should also be reflected in the Code. Consistent with the above concerns, the definition of Permanent Incapacity should reflect that found in the Superannuation Insurance (Supervision) Regulations 1994 (Cth), extracted above.

The Code should regulate conduct of insurance companies and regulators in assessing claims. It should agree to the fair and reasonable exchange of documentation relied upon in assessing claims. It should include hard time frames. Claims should be assessed in a timely manner and avoid excessive delays. Any delays in assessing claims due to their complexity should be agreed between the parties. Any claim that is not assessed within a reasonable period of time after an internal complaint is lodged should be assessed in line with ASIC Regulatory Guide 165.

In conclusion, an efficient system would be characterized by clients being able to access insurance policies they have paid for, their rights will be respected, there will be consistency and fairness, and delays would be reasonable and based on agreed expectations. We strongly encourage the Commission to consider these aspects of an efficient system.