Lawyers for the People

AUSTRALIAN LAWYERS ALLIANCE

DISCUSSION PAPER:

ACCOUNT BALANCE EROSION DUE TO INSURANCE PREMIUMS

Submission to The Insurance in Superannuation Working Group

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Protecting and promoting justice, freedom and the rights of the individual

Lawyers for the People

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Who we are

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

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

The ALA started in 1994 as the Australian Plaintiff Lawyers Association, when a small group of personal injury lawyers decided to pool their knowledge and resources to secure better outcomes for their clients – victims of negligence. While maintaining our plaintiff common law focus, our advocacy has since expanded to criminal and administrative law, in line with our dedication to justice, freedom and rights.

The ALA is represented in every state and territory in Australia. More information about us is available on our website.[1]

[1] www.lawyersalliance.com.au.

Introduction

1. The Australian Lawyers Alliance (ALA) welcomes the opportunity to have input into the issues raised by the discussion paper *Account balance erosion due to insurance premiums*. This submission makes some general comments as well as comments on consultation questions 21 and 27.

2. The ALA agrees with The Insurance in Superannuation Working Group (ISWG) that account balance erosion due to insurance premiums is one of the most important areas where change is required.

3. However, the ALA is concerned that the discussion paper avoids some wider issues such as junk insurance and definitions and largely avoids consideration of the members' perspective or best interests. Discussion of what is in the best interests of members does not extend beyond a sustainable superannuation balance.

4. Also of concern is the fact that the discussion paper does not make a case for consolidation beyond a potential eroding of superannuation. It does not examine the underinsurance gap across the community, nor does it acknowledge that some members choose to have multiple policies.

General comments and background

The slide towards 'junk insurance'

5. The ALA believes that the life insurance industry overreacted to poor financial results arising from a post-GFC 'claims lump'. The reaction included the introduction of much tougher total and permanent disablement (TPD) policy requirements in group default TPD cover.

6. The ALA has called for the application of standard TPD definitions in line with the *Superannuation Industry (Supervision) Act* 1993 (Cth) (SIS Act) and SIS Regulations[2] to ensure that consumers have access to fair coverage.

7. Harsh TPD definitions that deviate from the SIS requirement of permanent incapacity have resulted in some junk insurance products that will not pay out genuine claims.

Unlikely vs unable

8. For example, we have been particularly concerned with the different definitions of 'unlikely' and 'unable'.

9. '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.

10. By contrast, insurers argue that '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 even though they would not be able to obtain work in the competitive labour market.

11. AustralianSuper, with over one million members, was one of the first large funds to change its TPD definition to remove the word 'unlikely'. It now requires claimants to

[2] See the definition of 'Permanent Incapacity' provided for in reg1.03C of the *Superannuation Industry (Supervision) Regulations* (Cth) 1994: 'a member of a superannuation fund or an approved deposit fund is taken to be suffering permanent incapacity if a trustee of the fund is reasonably satisfied that the member's ill-health (whether physical or mental) makes it unlikely that the member will engage in gainful employment for which the member is reasonably qualified by education, training or experience'.

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'.

12. The threshold 'incapable of ever engaging' is much higher than 'unlikely', which is found in the SIS 'Permanent Incapacity' definition. Many seriously incapacitated claimants with no genuine prospect of future employment would find this threshold difficult or impossible to meet.

13. 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'.[3] Surely that test is sufficiently onerous.

Retraining clauses

14. Another example is the introduction by many funds of retraining clauses that would mean that a manual labourer who can never again do physical work due to an orthopaedic injury will not be TPD if, theoretically, he could retrain and work in a call centre, even if no employer would give him such a job in the real world.

Ongoing care

15. Another example is found in the current MTAA Super/MetLife policy which contains the following definition for regular and ongoing care. It means the person:

> 'a. Is under the regular and ongoing care of a medical practitioner who has given a clear prognosis that the Injury or Illness will continue throughout the life of the Covered Person (including after the expiry of the cover and the commencement of retirement) without any prospect of an improvement

[3] *TAL Life Ltd v Shuetrim; MetLife Insurance Ltd v Shuetrim* [2016] NSWCA 68 at [89].

which would lead to a return to work (whether or not for reward) in any capacity; and

b. Is complying with reasonable medical advice and treatment; and

c. Has, in our opinion reached the maximum level of medical improvement possible for that Covered Person based on their Injury or Illness.'

16. This is perhaps the most severe departure from the SIS definition (which determines eligibility by reference to a member's education, training and experience).

17. This is junk insurance. The chances of a claim being admitted are deleteriously low due to the difficulty a claimant will have procuring such unequivocal medical opinion, which effectively requires that a doctor assure against future improvement. Few doctors would provide such a pessimistic message to their patient.

Multiple claim exclusion clauses

18. Some funds prohibit the payment of a TPD benefit if the member is eligible to claim or has received a TPD benefit from another source, despite them having paid premiums. That is plainly at odds with industry's consistent message of underinsurance in Australia and cannot be in keeping with a trustee's fiduciary obligation, or an insurer's obligation of good faith and fair dealing.

Limited cover

19. Another example is that many members' death or TPD cover will exclude a claim arising from a condition that existed prior to the commencement of cover, or only assess the member under an Activities of Daily Living (ADL) definition. That may occur where the insurer deems that the member was not working sufficient hours or was working on a restricted basis, by reference to an 'at work' or 'active employment' test in the relevant policy.

20. A member does not usually find out about the application of the exclusion until their claim is declined on that basis. Moreover, despite reduced coverage such limited cover does not attract a lower premium. That is because neither funds nor insurers know which group members will be deemed to have limited cover until after a claim is lodged.

21. That is clearly inadequate:

    (a) Firstly, those members with coverage that excludes pre-existing conditions or who are only covered for ADL should be paying a much lower premium to reflect the vast inferiority of their coverage. By charging the standard premium funds and insurers are improperly eroding their account balances and that cannot be consistent with s52(7)(c) of the SIS Act which states that a trustee must 'only offer or acquire insurance of a particular kind, or at a particular level, if the cost of the insurance does not inappropriately erode the retirement income of beneficiaries'.

    (b) Secondly, members with such inferior cover ought to have certainty regarding the insurance cover they hold to enable them to determine whether such cover is adequate and if not to seek additional or alternative cover.

22. Blanket underwriting, whereby the same coverage is provided to all members regardless of their personal circumstances, is not the problem per se. It is too costly to individually underwrite millions of policy holders. However, 'at work' or 'active employment' definitions vary widely from one policy to another, and minimum standards should be developed to provide for full cover as long as members meet minimum work attendance.

The implications for members and for the industry

23. These inadequate products will result in the denial of claims by genuinely incapacitated members who would have been entitled to a TPD benefit under a traditional definition, which will in turn attract media attention and heightened public scrutiny of the feasibility of default insurance in superannuation.

24. Some funds have claimed that their definitional changes are merely intended to clarify the TPD definition. However, these changes have not been accompanied by any 'no-disadvantage' guarantee to members.

25. The fact is that these changes can only have been introduced by the industry to rein in future TPD claim pay outs and maximise insurers' profits. However, the evidence does not support that such an approach is necessary. Recent Australian Prudential Regulation Authority (APRA) statistics, which largely relate to claims made under the less stringent definitions, confirm that the group life insurers are enjoying healthy profits.[4] The ALA suspects that insurers are seeking to claw back the losses from the 2013 'claims lump', unfairly penalising holders of new policies and rendering some default insurance offerings virtually meaningless.

26. It is pleasing to see that some funds, such as CBUS, have resisted a departure from the SIS 'Permanent Incapacity' definition, by retaining the 'unlikely' definition. The fact that such definitions are being retained by some funds supports the viability of doing so across all funds.

[4] Net profit after tax for the 12 months to the September 2016 quarter was $2.6 billion: Australian Prudential Regulation Authority, *Quarterly Life Insurance Performance Statistics, September 2016* (15 November 2016) 5.

The prejudice members may suffer by auto-consolidation or auto-cessation

27. It is not good public policy to automatically consolidate into a fund that provides life or TPD insurance that is:

    (a) inferior in its terms, such as those with the sub-standard terms discussed above; or

    (b) less adequate in its quantum to the cover being relinquished.

28. The same principle applies to any automatic cessation of insurance in an inactive fund: that is, if auto-cancellation leaves the member with an inferior or less adequate cover than their prevailing fund, they are being inappropriately disadvantaged.

21. What flexibility is needed to cater for different demographics e.g. members who have casual employment patterns?

29. There are many circumstances in which contributions inactivity or low contributions activity occurs, such as: illness, pregnancy, extended leave, overseas work, seasonal work, underemployment and unemployment.

30. In order to balance superannuation contributions allocated to saving for retirement versus automatic insurance benefits, the ISWG needs to obtain numbers for each group described above and conduct appropriate actuarial modelling to make out any standardisation argument.

27. What else should the protocols [between insurers for the treatment of claims against multiple income protection policies] consider?

31. For the reasons discussed above, any auto-consolidation or auto-cessation must be subject to a No Disadvantage Test. That will necessarily require a rating and comparison of definitions, and a system to ensure that a member being consolidated does not end up being more underinsured.

32. There obviously also needs to be robust practices in place to notify members of proposed auto-consolidation or auto-cessation, with practical information as to the risks of losing cover, and to allow them to opt-out of any such automated event.

33. Further to discussion above under the heading 'Limited Cover', full cover should be granted where either of the following has occurred:

    (a) A certain qualifying period of unrestricted employment has passed; or

    (b) A member's compulsory super guarantee contributions made to the Fund by the employer is above a threshold set by the fund/insurer.

34. Neither of the above are burdensome administratively as funds obviously have that data on their members' contribution periods and amounts ready to hand. Using that data, funds and their insurers could determine the scope of cover for each member, and clearly disclose same to them in their periodical membership statements. It is submitted that the above approach is workable and reasonable: if after a qualifying period of employment a pre-existing condition has not caused a member to cease work, or within that qualifying period they are working sufficient hours to attract a certain level of super guarantee contributions, then any such pre-existing condition's effect on risk is much diminished and the insurer ought to recognise that.