FSC FINANCIAL SERVICES COUNCIL

14 February 2011

Mr Damian Byrnes
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Dear Mr Byrnes

DRAFT TAXATION RULING – TR 2010/D9

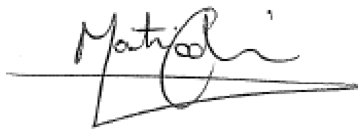
The Financial Services Council (FSC) welcomes the opportunity to comment on the Draft Taxation ruling regarding the deductibility of premiums paid by a complying superannuation fund for an insurance policy providing Total and Permanent Disability (TPD) cover.

The FSC represents Australia's retail and wholesale funds management businesses, superannuation funds, life insurers and financial advisory networks. The Council has 128 members who are responsible for investing $1.7 trillion on behalf of more than 11 million Australians. The pool of funds under management is larger than Australia's GDP and the capitalisation of the Australian Stock Exchange and is the fourth largest pool of managed funds in the world. The Financial Services Council promotes best practice for the financial services industry by setting mandatory Standards for its members and providing Guidance Notes to assist in operational efficiency.

We attach our comments in relation to Draft Taxation Ruling 2010/D9 for your consideration. We would welcome the opportunity to meet with you to further discuss our submission.

If you have any questions regarding the FSC's submission please do not hesitate to contact Pravin Madhanagopal or myself on (02) 9299 3022.

Yours sincerely



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TR 2010/D9 - INCOME TAX: DEDUCTIBILITY UNDER SECTION 295-465(1) OF THE INCOME TAX ASSESSMENT ACT 1997 (THE ACT)

The draft Ruling provides considerable guidance on the manner in which the Commissioner will interpret and apply the terms of Section 295-465(1) of the Act. However, there are a few key areas which remain unclear and on which we seek the Commissioner's expanded interpretation in the Ruling when it issues in its final form.

Policy Terminology

The first matter relates to the alignment of policy terminology with the definition of "disability superannuation benefit".

Paragraphs 28 and 29 of the draft document allow that there need not be an absolute alignment in terminologies. However, in one matter of policy construction we have received a number of questions from trustees – specifically the requirement for two doctors to certify to the trustee that the client is suffering total and permanent disability. In contrast, the insurance policy might be less specific as to medical certification – or may only require the views of one medical practitioner.

It is believed that the intention of paragraphs 28 and 29 is to give comfort that such misalignment does not impact deductibility. However, to remove remaining doubt in the minds of trustees it is strongly recommended that the matter be explicitly covered. Suggested wording for this purpose, which could be added following the current paragraph 29, is –

> *"By way of example, it is not necessary that the policy terms express the need for two medical practitioners to certify total disability. Rather, the Commissioner accepts that, in assessing and admitting liability under these policies, life insurers will apply at least equivalent tests as part of their commercial practices."*

Item 5 Disclosure

The second area of concern is to properly understand the extent to which item 5 can be applied.

It is submitted that, in the construction of Section 295-465 (and its predecessor section 279 of the Income Tax Assessment Act 1936), recourse to actuarial certification is intended as a "last resort" - ie only where each of the alternative options fails. As such, we believe that the Commissioner should be prepared to explore the extent to which item 5 can be given practical application.

Sitting behind this view is the fact that actuarial resources are both scarce and costly. Such costs would necessarily be required to be borne by fund members. Those costs would negatively impact on member benefits – which is contrary to the stated policies of both current and former governments in attempting to provide efficient/low cost superannuation structures. Some support for this may be found in the Explanatory Memorandum (Main Features section) to *Taxation Laws Amendment Act (No.3) 1990* where it was stated –

> *"This Bill will give effect to the proposals announced on 14 February 1990 to ease the operation of the provisions of the Income Tax Assessment Act which require an actuary to certify the amount of particular deductions or exemptions that may be claimed by a complying superannuation fund. "*

Further it is a relevant consideration that, based on sample data, the amount of premiums which are likely to be denied a deduction as a consequence of an actuarial assessment are proportionately small.

When a life company prices a risk policy it effectively adopts a "top down" approach to determine an expectation of claims for each element of the cover provided. This analysis is usually undertaken based on its own claims experience. The work is undertaken by pricing actuaries. However, if the company's own experience is insufficient for one reason or another it is common practice for the pricing actuary to seek inputs and guidance from consulting actuaries who have access to wider industry data.

The cost of the top layer of cover in TPD would generally be referable to the "any occupation" risk. The next layers might be "own occupation" and/or "loss of limbs or sight". Those added risks are costed according to their expected addition to claims expense – ie the incremental, rather than stand-alone, cost. In the pricing analysis it might well be concluded that the particular additional risk definition will have only a small additional claims risk. Accordingly, the contribution to product pricing would also be small. The key point to recognise is that life companies engage qualified actuaries to undertake product pricing based on incremental risk analyses.

There is also potentially a pricing differential between bundled and unbundled policies which offer the same set of risk covers. Suffice it to say that, all else being equal, bundled policies are potentially less costly because in bundled policies all risks are being spread across the population of policyholders. In contrast, in unbundled arrangements clients can select from a menu of risk options – which can result in a risk population which is skewed against the insurer. Further, there are additional systems, underwriting, marketing and administrative costs associated with offering unbundled policies. These additional costs need to be loaded into the pricing model.

High levels of competition within the industry and price sensitivity by consumers have both contributed to an increasing trend towards bundled policy offerings. Bundling in this sense also combines different risk classes. Combined death/TPD policies are not uncommon.

The purpose of the above four paragraphs was to establish a background for the argument that, even in a bundled policy environment, the issuing life company -

- has the clear capability to provide a price dissection for the purposes of s.295-465(1);
- is best placed to do so; and
- employs actuarial resources in its process.

The following comments are provided with the view to illustrating that the scope of item 5 in s.295-465(1) need not be read as narrowly as is inferred in the consultation draft TR 2010/D9.

Item 5 of the table in s.295-465(1) uses the words "specified in the policy". These four words contain two requirements, namely –

- that there be some form of disclosure (the specification); and
- that that disclosure appear in a particular document (the policy).

The specification is required to be "the part of a premium that is … wholly for the liability to provide benefits referred to in section".

It is submitted that the legislation does not require that each element insured under the policy be separately priced – although that would certainly be one form of disclosure. Support for this view is again provided in the wording of the Explanatory Memorandum (Clause 27 Notes) to *Taxation Laws* Amendment Act (No.3) 1990 where it was stated -

> *"Where the whole or part of the premium referable to death or disability cover is specifically identified in the policy (e.g. an unbundled policy) the fund is entitled to a deduction equal to the amount identified (paragraph (c)) also without need for an actuary's certificate."*

A narrow interpretation of this sentence would be to require the policy to be unbundled. This appears to be the view adopted by the Commissioner in the draft ruling. However, it is submitted that the choice of "e.g." rather than "i.e." in the above Explanatory Memorandum extract was intended to demonstrate that other policy types (potentially including bundled arrangements) would not automatically fall outside the intended scope of the provision.

Assuming that issuing life companies are prepared to make the disclosure, it would seem that a statement "in the policy" which disclosed "the part of a premium that is … wholly for the liability to provide benefits referred to in section" would remove the need for a trustee policyholder to seek independent actuarial advice in the matter of premium deductibility.

This then raises the questions of what form or forms of disclosure are acceptable – ie need it be a dollar based disclosure or, and this is the preferred option, would it be sufficient for the company to attest that a given percentage of premium is referable to s.295-460 risks. The preference for percentage based disclosures reflects the fact that superannuation trustees generally offer insurances to their members via single/master policies. So the annual dollar premium expense arising in relation to that policy cannot be determined in advance as it will be impacted, among other things, by new members being added to the policy during a year and other members ceasing cover. However, the deductible percentages of premium dollars will be constant.

Finally, and perhaps most importantly, the matter which needs consensus is the interpretation of the words "in the policy".

Read narrowly, the policy is a document which sets out terms of contract between the insurer and the policy owner. Importantly, the document does not contain pricing data. Therefore it seems clear that the intention is that those words be read more broadly as to do otherwise would be to deny any application to item 5.

For a policy issued to an individual a policy schedule may be provided after the cover has been effected. The schedule contains specific data referable to the insured and is "joined" to the policy frequently both literally (stapled) and in the more traditional legal sense. In a bundled arrangement there would normally be no pricing dissection of the separate risks – however, there would seem to be no reason for a deductibility statement not to be incorporated in the policy schedule.

A product's Policy Disclosure Statement (PDS) is a pre-policy marketing document that must be provided before entering into the policy. As a document required under the Corporations Act it is relied upon by the consumer and the issuer is legally obligated to stand behind the statements contained in it. In practical terms it becomes joined to the policy in that statements within the PDS must by law be accurate when the policy is accepted. To that end, if a PDS disclosed a deductible premium percentage it could be argued that there has been appropriate disclosure "in the policy".

In a wholesale environment the disclosures and documents are more commonly via quotation documents and exchanges of letters while the policy conditions (including pricing) are being settled. Again, these documents would seem to be appropriate disclosure points for the purposes falling within the definition of "in the policy".

The industry is requesting that, in the interests of ensuring certainty and simplicity and also of limiting the cost burden on superannuants, the Commissioner be prepared to adopt a wide interpretation of the expression "in the policy" in the final ruling. We recommend that the definition should include at least the following:

- Policy schedules;
- PDS;
- Quotation documentation and associated correspondence;
- "Welcoming" documentation; and
- Letters issued specifically to trustee policyholders for the purposes of s.292-465.

TPD Definitions

Against the background of the above proposition that a life office should be capable of providing relevant disclosures for the purposes of item 5 of s.295-465, the following discussion focuses on specific TPD policy definitions and the manner in which life offices would generally view deductibility for the purposes of those disclosures. The industry considers that agreeing these treatments is an integral part of ensuring that the system is made workable and not subject to uncertainty, market imbalances or challenges in the future.

1. Day One TPD

An example of this term is as follows:

> *"Following the date of disablement, the insured member has been continuously absent from employment or his or her previous duties in the case of the self-employed, or, in the case of the unemployed, been continuously unable to accept employment, as a result of suffering from any of the following: cardiomyopathy, primary pulmonary hypertension, major head trauma, motor neurone disease, multiple sclerosis, muscular dystrophy, paraplegia, quadriplegia, hemiplegia, diplegia, tetraplegia, dementia and Alzheimer's disease, Parkinson's disease, blindness, loss of speech, loss of hearing, chronic lung disease or severe rheumatoid arthritis".*

It is submitted that the portion of the premium covered by this definition would be considered deductible on the basis that the individual is unlikely to be employed again in any capacity if the member suffers the serious ailments listed.

2. Activities of Daily Working

An example of this clause is:

> "The *insured member*, as a result of illness or injury which occurred after cover has commenced is permanently unable to perform at least two of the five *everyday working activities* without the physical assistance of another person, despite the use of appropriate assistive aids and that permanent inability has lasted for a continuous period of six months or more following the *date of disablement*; and where:

- *everyday working activities* means Mobility, Communicating, Vision, Lifting and Manual Dexterity and:

- *unable to perform Mobility* means :
  a) the insured member cannot walk more than 200m on a level surface without stopping due to breathlessness or severe discomfort; and/or
  b) the insured member cannot bend, kneel or squat to pick something up from the floor and straighten up again after bending, kneeling or squatting; nor can the insured member get in and out of a standard sedan car.

- *unable to perform Communicating* means:
  a) the insured member cannot speak in their first language so that they are understood in a quiet room; nor can the insured member hear (with or without a hearing aid or other aid) an instruction given in a normal voice in their first language in a quiet room; and/or
  b) the insured member cannot understand a simple message in their first language, and relay that message to another person.

- *unable to perform Vision* means the insured member cannot, with or without glasses or contact lenses read ordinary newsprint, nor can they pass the standard eyesight test for a car license.

- *unable to perform Lifting* means the insured member cannot lift, carry or move objects weighing 5kg using either or both hands.

- *unable to perform Manual Dexterity* means the insured member cannot use either or both hands or fingers to manipulate small objects with precision (such as picking up a coin or fastening shoelaces or buttons, using cutlery, or using a pen or keyboard to write a short note)."

It is submitted that a claimant who is unable to perform everyday working activities is unlikely to be employed in any capacity, and therefore the portion of the premium attributable to this benefit should be treated as being deductible.

3. Cognitive Loss/Need for Continuous Supervision

An example of this type of clause is as follows:

> *"The Insured Person through illness or injury is suffering from the permanent deterioration or loss of intellectual capacity and has provided proof to the insurer's satisfaction that they are required to be under continuous care and supervision by another adult person for six consecutive months and this care is likely to be on a permanent to be on a permanent daily basis and on-going."*

It is submitted that the premium attributable to this benefit should also be deductible on the basis that a claimant who needs to be supervised permanently is unlikely to be able to work in any job for which they are qualified by education, training or experience.

4. Whole Person Impairment

An example of this clause is as follows:

> "has suffered, solely because of *Illness* or *Injury*:
>
> (i) at least 25% impairment of Whole Person Impairment;
> (ii) is not working in any occupation; and
> (iii) is disabled to such an extent as to render them unlikely to ever again work in any occupation for which they are reasonably suited by education, training or experience.
>
> The assessment of Whole Person Impairment will be undertaken by an appropriately qualified specialist Medical Practitioner and will be based on the Insured Person attaining maximum medical recovery.
>
> Whole Person Impairment means the Insured Person suffers 25% Whole Person Impairment based on the latest edition of the American Medical Association publication 'Guides to the Evaluation of Permanent Impairment', or an equivalent guide approved by us. The 'Guides to the Evaluation of Permanent Impairment' covers every body system and provides a standardised approach to determine impairment assessment using patient history, physical examination and clinical tests"

This definition is less common, and it is submitted that the premium attributable to this benefit should also be deductible on the basis that a claimant meets the 25% threshold is unlikely to be employed in any capacity

5. Terminal Illness

This benefit is sometimes paid under death and sometimes paid under TPD cover. A terminal illness benefit is paid where the terminal illness definition is satisfied, but the amount of the benefit paid is the higher of the death or TPD cover if the member had both cover.

"means an insured member or spouse member suffers from an illness which:

A. a medical practitioner specialising in the insured member's or spouse member's illness, certifies in writing will despite reasonable medical treatment lead to the insured member's or spouse member's death within 12 months of the date of the certification; and

B. we are satisfied, on medical or other evidence, will despite reasonable medical treatment lead to the insured member's or spouse member's death within 12 months of the date of the certification referred to in paragraph A)."

This premium should be treated on a basis consistent with other terminal illness benefits irrespective of the fact that it is treated as a TPD benefit for the purposes of the policy.

6. Loss of Limbs and Sight clauses

These benefits are payable even though the claimant may still have the capacity to engage in employment for which the claimant is reasonably qualified by education training or experience. For example an accountant who loses a leg in an accident may qualify for a benefit under the policy even though he/she is may return to work after the accident. The trustee of the superannuation fund may not be able to release this benefit as the claimant does not meet the Conditions of Release.

However, these disability benefits are ancillary to the basic disability benefit offered by the policy and the portion of the premium attributable to these benefits is miniscule (certainly less than 0.5%). The incidence of payments under these ancillary benefits is also extremely infrequent.

It is submitted that it should acceptable be for each company to determine its actual non-deductible percentage.

Actuarial Certificates

In the interests of containing the costs of actuarial certificates (in circumstances where they might still be required) it is suggested that the above descriptions of TPD definitions and the resultant tax treatments should be included in the ruling and that actuaries should be allowed to adopt these same deductibility views as expressed for the life industry.

That said, it is submitted that where the only "apportionable" risk in a policy related to Loss of Limbs and Sight benefits a requirement to obtain an actuarial certificate is an unnecessary compliance burden. The certificate would most likely show the portion of the premium attributable to ancillary benefits as zero or an extremely small percentage. It is therefore submitted that the draft ruling should allow trustees a de minimis exemption from the requirement to provide an actuarial certificate where the portion of the premium attributable to ancillary benefit is close to zero.

We suggest that the ATO be requested to accept as administrative practice that there is no need to treat a TPD premium as non-deductible where the trustee has relied on the de minimis exemption from seeking an actuarial certificate.

As a further concession to containing costs associated with these certificates it is submitted that the Commissioner should accept, as a matter of administrative practice, that if an actuarial certificate is obtained and the underlying policy remains unchanged then the trustee may continue to rely on that certification for up to 5 years. For this to be given practical effect the actuary's certificate would need to be expressed as a percentage of premiums paid. Where a certificate nominates a specific deductible dollar premium, the deductible percentage calculated by dividing that premium by the actual premium paid would be used in non-certificate years.

We also raise the uncertainty surrounding the interaction of the Tax Agents Services Regime with the provision of the actuarial certificates.