Life Insurance Code of Practice

Submission on consultation draft released on 18 August 2021

Australian Financial Complaints Authority

October 2021

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Overview

The Australian Financial Complaints Authority[1] (AFCA) is the independent external dispute resolution scheme for the financial sector.

AFCA welcomes the opportunity to provide feedback on the consultation draft of the Life Insurance Code of Practice released on 18 August 2021 (Draft Code). We continue to support initiatives to strengthen and develop the code.

The Financial Services Council has announced that it plans to submit the code, when revised, to ASIC for approval. We expect the approval process will involve a thorough examination to ensure compliance with new standards set by the legislation for enforceable code provisions and other requirements such as ASIC's Regulatory Guide 183 *Approval of financial services sector codes of conduct* and Regulatory Guide 271 *Internal dispute resolution*.

This submission[2] draws on the experience of AFCA and its predecessor schemes, which have handled financial services complaints for more than 30 years. The submission focusses on issues seen through complaint resolution.

Key points

Disclosure of stepped premiums

We consider that the requirements in the Draft Code for disclosure of stepped premiums are not adequate – either at the point of sale or after sale. We suggest the code should include a mandatory industry standard to ensure effective disclosure of future premium levels.

Timeframes for handling claims

There are broad exceptions to the decision-making timeframes in clauses 5.41 and 5.42. For the wide range of claims within exceptions, the Draft Code does not impose **any** timeframe for making a final decision. Other problems relating to timeframes for claims handling include:

- gaps in timeframes for payments
- departures from requirements in the current code that would lower timeliness standards

We suggest the timeframes should be revised to require – for every claim without exception – prompt action by subscribers to decide claims, inform claimants of decisions and make any payments.

[1] For comprehensive information about AFCA, see our website www.afca.org.au.
[2] This submission has been prepared by the staff of AFCA and does not necessarily represent the views of individual directors of AFCA.

Definition of ‘heart attack’

In the Medical Definitions in clause 9 of the Draft Code, the definition of heart attack is out of date. We suggest the code should include the universal definition of heart attack accepted by doctors.

Updating medical definitions

The Draft Code’s provisions for updating medical definitions are too limited. These provisions should:

- specify standards that reviews of medical definitions and resulting updates must meet
- ensure the standards apply to the broadest possible range of policies.

No application to group life insurance within superannuation

The Draft Code is expressed not to apply to superannuation fund trustees. In July 2021, the Insurance in Superannuation Voluntary Code of Practice developed by the superannuation industry was replaced with guidance notes on claims handling and vulnerable members. This leaves the superannuation industry without coverage by a code of conduct dealing with insurance.

1. Disclosure of stepped premiums

1.1 Changes suggested in AFCA's submission in January 2019

A submission by AFCA in January 2019 commented on the previous draft code released in November 2018 (2018 Draft). That submission noted that we receive many complaints about the clarity of disclosure about premium increases and failure to explain premium increases that may apply year on year. We strongly recommended that the code's requirements around premium disclosure be strengthened. For insurance with stepped premiums, specific suggestions[3] were that the code should ensure:

- before a sale, the consumer is given an estimate – expressed graphically and in numbers – of how much premiums will cost per year over the life of the policy
- the consumer is given an update of this estimate after the sale and with each renewal notice.

Submissions on the 2018 Draft by other organisations also emphasised the desirability of amending the code to address issues about stepped premiums. Examples include the submission by ASIC and the joint submission by consumer organisations.[4]

1.2 Draft Code

We acknowledge that some changes have been made to improve disclosure of premiums for funeral insurance but consider that further changes[5] are desirable in order to improve consumer outcomes. Disclosure of premiums in other kinds of life insurance is also a significant problem. AFCA is particularly concerned about clause 3.5c) of the Draft Code.

Clause 3.5c)

Clause 3.5 only requires information to be given **after** the purchase of a policy. Information about premiums should be provided **before** purchase so a person can make a properly informed choice about long term affordability. Clause 3.4, which provides for disclosure before sales, does not impose any specific requirements for disclosure about how stepped premiums will operate.

Clause 3.5c) merely requires a 'description' of 'how premiums could change'. We anticipate that a subscriber could comply with this provision by simply saying, in the policy document, 'your premium will increase each year with age'. What is

[3] See part 11 of our submission in January 2019 for the full explanation of these suggestions.
[4] See submission by ASIC dated 31 January 2019 and the joint submission by Financial Rights Legal Centre, Financial Counselling Australia and Redfern Legal Centre dated January 2019.
[5] See recommendations in part 1.3 for all life insurance, including funeral insurance.

required is meaningful information about **how much** premiums are likely to increase by, year on year, over the life of the policy.

Complaint information

We have reviewed our complaints data. Our latest figures – for the 2020-2021 financial year - indicate that one in every 16 complaints handled by our life insurance teams involves a complaint about increases to stepped premiums.

Information received through complaints shows that stepped life insurance premiums increase by very large amounts, especially at older ages.

- In a recent case, over ten years, the premium for a $99,000 life insurance benefit was projected to increase from $22,500 to $47,000 per year. If the inflation protection benefit was added, the benefit increased over ten years from $99,000 to $161,000, but the premium rose from $22,500 to $76,500 per year.

- In another case, the premiums for a much younger insured person increased by an average of 16.4% every year, but he was not given any projections when he bought the policy.

Observations on industry practice

We understand that it is not common industry practice to provide information to customers about likely increases in stepped premiums prior to the sale of the insurance, or with annual statements. We consider it is very important for a consumer to have access to this information when deciding whether to buy a life insurance policy. The information should be provided in each case, not only on request. A consumer should not have to be sceptical, suspicious and persevering to obtain the information they need. The information should be provided in a consumer-centric and accessible way, so that an ordinary person with average financial literacy can readily understand how their premiums are likely to change over the lifetime of the policy.

We understand that it used to be common industry practice to provide a table to consumers showing the premium rate at each age, included in or attached to the policy document. We also consider that insurers would have access to the information required to give premium projections as this would be used in designing life insurance policies and in applying premium increases each year.

AFCA is disappointed that the Draft Code does not include suitable standards to address problems that result from ineffective disclosure about future premium amounts. It is concerning that the industry has not proposed an effective response to this problem, despite being aware of the problem for years.

We suggest that the code should include a mandatory industry standard around effective disclosure of future premium levels. This will have benefits for policyholders as it should reduce the effect of 'bill shock' from significant, unexpected and unaffordable premium increases. This can result in policyholders holding unaffordable cover in circumstances where their health situation may mean they cannot find suitable alternative cover.

Noting the limitations of disclosure[6], we suggest that such a standard should consider relevant behavioural research to help ensure that the disclosure to customers is effective. It may be appropriate to undertake testing of the standard in practice to ensure that it is effective and whether it should be enhanced in subsequent iterations of the code.

There are obvious benefits for life insurers too. Reducing the incidence of 'bill shock' should reduce the number of disputes that firms need to deal with through their internal dispute resolution process, and through AFCA. Reducing the number of disputes is likely to reduce both internal and external dispute resolution costs, including time and human resource cost. While many premium related disputes do not proceed through to AFCA case management, once a dispute is lodged with AFCA there are costs incurred for the firm. This furthers the case for the revised code to mandate improved industry standards.

1.3 Recommendation

AFCA considers that the code should require subscribers to provide the customer the following for insurance with stepped premiums:

- before the sale, an estimate – expressed graphically and in numbers – of how much premiums will cost per year over the life of the policy
- an update of this estimate after the sale and with each renewal notice.

We also support ASIC's suggestion[7] that the estimates should include projections of the total cost of the policy if the consumer reaches certain ages such as 60, 70 and 80 and at the end of the policy. The mode of the disclosure should be informed by behavioural research and consumer tested to ensure it is effective.

2. Timeframes for handling claims

AFCA's submission in 2019 drew attention to deficiencies in the timeframe provisions in the 2018 Draft[8] including the exceptions to apply in the broadly defined 'exceptional

[6] See for instance, ASIC's Report 632 *Disclosure: Why it shouldn't be the default*, 14 October 2019.
[7] ASIC's submission on the 2018 Draft dated 31 January 2019, page 9.
[8] See part 12 of AFCA's submission in 2019.

circumstances'. We recommended the timeframes should be reviewed to ensure they operate fairly for consumers, with exceptions and exemptions kept to a minimum.

We consider that the claims handling timeframes in the Draft Code are unsatisfactory. We are concerned that the timeframes provide less consumer protection than the existing code provisions. The main issues are:

- exceptions to decision-making timeframes

  There are broad exceptions to the decision-making timeframes in clauses 5.41 and 5.42. For the wide range of claims within exceptions, the Draft Code does not impose *any* timeframe for making a final decision.

- gaps in payment timeframes

  Clause 5.54 sets a timeframe for payment of income related claims but it need not be met if the subscriber informs the claimant (within another timeframe) that payment will be late. The Draft Code does not specify any timeframe for payment of other claims.

2.1 Timeframes for deciding claims

The relevant clauses in the Draft Code are:

> 5.41 If your claim is for income-related benefits, unless there are or have been Circumstances Beyond Our Control, we will complete our assessment of your claim within 2 months of:
> a) the Claim Received Date, or
> b) if later, the end of the waiting period your policy specifies.
>
> 5.42 If your claim is for a lump sum benefit, unless there are or have been Circumstances Beyond Our Control, we will complete our assessment of your claim within 6 months of:
> a) the Claim Received Date, or
> b) if later, the end of the waiting period your policy specifies.

Our significant concerns about these clauses are:

- In claims with 'Circumstances Beyond Our Control', there is no provision to ensure the claims are **decided** in a timely way. We are concerned that the processes for handling these claims do not provide adequate consumer protection. Similarly to the 'exceptional circumstances' provisions in the 2018 Draft, the proposed exception for Circumstances Beyond Our Control is very wide and would excuse subscribers from meeting the Code claim handling timeframes in many cases.

- In other claims, if the subscriber issues a 'Procedural Fairness' or 'Show Cause' letter by a stated time, there is no timeframe for **deciding** the claim. This is also not the case under the current code.

2.1.1 Circumstances Beyond Our Control

Where Circumstances Beyond Our Control as defined in clause 9 of the Draft Code exist, or have existed[9], the timeframes specified in clauses 5.41 and 5.42 do not operate.

In this situation, the Draft Code merely imposes obligations to give the claimant **information** under clause 5.50. Further obligations in clause 5.51 requiring a review only apply where the Circumstances Beyond Our Control are considered likely to continue for **more than 12 months** after the Claim Received Date.

In contrast, the current code sets a definite timeframe for decisions in 'Unexpected Circumstances'. Claims are to be decided within 12 months of notification.

2.1.2 Completing the assessment of a claim

A note on page 18 of the Draft Code reads as follows:

> We complete our assessment of your claim by:
> • making a decision on your claim, or
> • issuing a Show Cause or Procedural Fairness letter.

This indicates a subscriber can satisfy clause 5.41 or 5.42 by issuing a Show Cause or Procedural Fairness letter within the timeframe (without deciding a claim). These letters are defined in clause 9:

> Show Cause letter:
> A letter we will send you before we make a decision to vary or avoid your cover, that:
> a) includes copies of any information that may be relevant to our decision,
> b) explains any remedies and the impact our decision may have on your cover under the Life Insurance Policy, and
> c) gives you a chance to explain and provide any further information or documents you would like us to consider.
>
> Procedural Fairness letter:
> A letter we write to you with our preliminary view on your claim and which states you have a chance to respond before we make a decision.

After one of these letters is issued for a claim, there is no provision in the Draft Code requiring the claim to be **decided** within a specified period.

The provisions requiring completion of assessments, rather than decisions, within timeframes would create exceptions that the current code does not provide. Including these exceptions in the code would reduce consumer protection significantly. We are concerned that this represents a significant downgrading of consumer protection in the Draft Code, and a backward step by industry when the new code should raise standards.

[9] The obligations in clause 5.50 and 5.51 seem to only apply where Circumstances Beyond Our Control exist (not also when they have existed).

2.2 Timeframe for payments

> 5.54 For any income-related benefit we owe you, we will:
> a) pay you by the later of the due date or within 5 Business Days of when we have completed all reasonable enquiries, have all the information we reasonably need to assess your claim, and have taken all the steps we need, or
> b) tell you that your payment will be late within 5 Business Days of us finding out.

The Draft Code sets timeframes for paying income related benefits in clause 5.54. For other claims, no payment timeframes are specified.

Where a benefit is 'owed' to a claimant, clause 5.54 gives the subscriber the choice of either:

- (to comply with a)) paying the benefit by the later of –
    - the due date
    - within five business days of the subscriber completing enquiries and information gathering and taking 'all the steps it needs' **or**
- (to comply with b)) informing the claimant, within another timeframe, if the payment will be late.

AFCA considers that clause 5.54 should be altered in order to operate as an effective timeframe provision. Although it specifies a payment timeframe, a subscriber can satisfy the provision by simply providing information - without making a payment. A secondary issue is the unclear wording used in clause 5.54, such as 'have taken all the steps we need'.

2.3 Other timeframes

Specific deficiencies in proposed timeframe provisions are outlined in parts 2.1 and 2.2 above. In addition, AFCA is concerned about other provisions reducing timeliness standards in claims handling. For example:

- Clause 5.43 of the Draft Code extends the timeframe for informing claimants of decisions on their claims. Section 8.15 of the current code sets a timeframe of ten business days. Although clause 5.43 sets a five-business day timeframe for informing a claimant of a decision, if this information is not provided in writing, the provision allows a further ten business days to confirm the decision in writing. By using the broader opening wording 'have taken all steps to finalise our decision', clause 5.43 also allows its timeframe to start running at a later point than section 8.15.

- Clause 5.48 states that, if a claim is closed or declined and later reopened, the full timeframes apply to the reopened claim from a new Claim Received Date.

2.4 Recommendation

AFCA considers that all claims handling timeframes in the Draft Code should be revised to ensure they operate effectively and fairly for consumers. The revised timeframes should require – for every claim without exception – prompt action by subscribers to decide claims, inform claimants of decisions and make any payments.

3. Definition of 'heart attack'

Clause 5.57 of the Draft Code requires a heart attack claim to be assessed against two definitions so that the definition most favourable to the consumer can be applied. The definitions are:

- the applicable definition in the PDS or policy document
- if different, the current definition in the 'Medical Definitions' section of the code.

The Medical Definitions in clause 9 of the Draft Code include a definition of 'heart attack with severe heart muscle damage'. This is the outdated definition used in the current code. It is not the universal definition of heart attack accepted by doctors.

Many insurers have updated their definition of heart attack to align with the definition used by doctors. That is now good industry practice.

By retaining the old definition, the Draft Code sanctions outdated industry practice. An AFCA determination[10] describes this problem in detail.

AFCA recommends that the revised version of the code should include the universal definition of heart attack accepted by doctors.

4. Updating medical definitions

AFCA's submission in January 2019 recommended measures to ensure medical definitions are easy to understand and keep up to date with community expectations and diagnostic practice. The Draft Code does not introduce these measures, however.

Key concerns about the provisions in the Draft Code headed 'Updating Medical Definitions' – clauses 2.4 to 2.8 – are as follows.

[10] This and other determinations by AFCA are published on our website under 'Search published decisions'.

4.1 Clauses 2.4 and 2.5 do not apply to all policies

The review and update requirements should apply as broadly as possible. Clauses 2.4 and 2.5 are drafted in limited terms so that they only apply to 'policies available to new customers'.

4.2 Standards for reviews and updates are not specified in sufficient detail

Clause 2.4 requires certain definitions to be reviewed at three-year intervals 'with help from relevant medical specialists' but does not set any further requirements to satisfy in reviews of definitions. There is a commitment in clause 2.5 to make updates 'if needed'.

AFCA maintains that the code should specify standards that reviews of medical definitions and resulting updates must meet. The code should, at a minimum, ensure that reviews are thorough and updates are implemented effectively.

4.3 The exclusion in clause 2.8 creates a gap

Clause 2.8 limits the application of clauses 2.5 to 2.7. It appears that the review obligations in clause 2.4 would apply in respect of group policies but there would be no obligations imposed by clause 2.5 for updates resulting from reviews of definitions in those policies.

5. No application to group life insurance within superannuation

The Draft Code is expressed not to apply to superannuation fund trustees unless they have adopted it.

The Insurance in Superannuation Voluntary Code of Practice (ISVCP) was developed by the superannuation industry and commenced on 1 July 2018. It was adopted by most APRA-regulated superannuation funds, either in whole or in part. In July 2021, the ISVCP was replaced with guidance notes on claims handling and vulnerable members. This leaves the superannuation industry without broad coverage by a code of conduct dealing with insurance.

We suggest that the Draft Code provide coverage for superannuation fund trustees.

Note

We have identified various drafting issues in the Draft Code but have not commented on all of them in this submission. Examples of provisions affected are:

- clauses 2.6 and 2.7 (indexation provisions located in a section headed 'Updating Medical Definitions')

- clause 1.6 (referring to ‘key promises in the next section’).

When the Draft Code is amended to address feedback obtained in the present consultation, we suggest all the drafting should be fully reviewed.