SUBMISSION TO THE PARLIAMENTARY JOINT COMMITTEE ON CORPORATIONS AND FINANCIAL SERVICES INQUIRY INTO THE LIFE INSURANCE INDUSTRY

NOVEMBER 2016

CONTENTS

A. INQUIRY TERMS OF REFERENCE

1. The following matters were referred to the Parliamentary Joint Committee on Corporations and Financial Services for inquiry and report by 30 June 2017:

    a. the need for further reform and improved oversight of the life insurance industry;

    b. assessment of relative benefits and risks to consumers of the different elements of the life insurance market, being direct insurance, group insurance and retail advised insurance;

    c. whether entities are engaging in unethical practices to avoid meeting claims;

    d. the sales practices of life insurers and brokers, including the use of Approved Product Lists;

    e. the effectiveness of internal dispute resolution in life insurance;

    f. the roles of the Australian Securities and Investments Commission and the Australian Prudential Regulation Authority in reform and oversight of the industry; and

    g. any related matters.

B. EXECUTIVE SUMMARY

2. Life insurance helps to secure the financial wellbeing of customers and their families if the customer is struck by illness, injury, becomes disabled or dies.

3. Last year ANZ's insurance business, OnePath Life Limited (OPL) paid $715 million in life insurance claims to support customers and their families at their time of need.

4. For decades the life insurance industry has provided protection to millions of Australians in an environment of confidence and trust. More recently, public scrutiny of some insurer and Trustee practices have reduced trust in the industry.

5. ASIC's recent report into life insurance claims handling found that life insurers pay a majority of claims and there is no evidence of systemic issues such as cross-industry misconduct. Nevertheless, reviews relating to the industry have recommended changes to improve outcomes for customers and confidence in the industry.

6. ANZ believes that actions being taken, or in train, will address the majority of the concerns that have been raised in relation to the life insurance industry. The significant reforms in progress include:

    - To improve quality of advice, Government has introduced to Parliament Life Insurance reforms to change adviser remuneration practices to provide better incentives for good advice and raise adviser professional standards.

These will complement the existing Future of Financial Advice reforms including the best interest duty obligation.

- The life insurance industry has developed the Life Insurance Code of Practice. An industry-led Insurance in Super working group has been formed to expand on the obligations established by the Code, including expanding coverage to superannuation trustees.
- The industry is considering a standard for Approved Products List ("APL") to encourage high standards in life insurance APL practices and provide appropriate competition. ANZ supports a minimum of three providers being offered on APLs.
- Bank owned insurance companies will comply with bank led reforms to increase transparency, including improved whistleblower protections.
- Further Government reforms include providing ASIC with product and distribution intervention powers. ASIC has also recommended regulatory reform to remove limitations to its capacity to take action for systemic conduct or to improve claims handling.

7. ANZ believes there are further reforms that can be made to benefit customers including:

    - Industry moving to standard minimum medical definitions for life insurance cover to allow for greater consistency and enable easy comparison for the benefit of customers.
    - An industry funded insurance claims assistance scheme to help claimants through the claims process from inception to decision. A simple standardised claim form could also be trialled.
    - Allowing life insurers to make targeted payments to aid customer rehabilitation through therapy and medical treatments, improving health outcomes for customers. This is not currently allowed under the Private Health Insurance Act.
    - Setting a time limit (eg six years) on the late notification of claims to reduce the cost of TPD premiums for superannuation fund members.
    - The development of a concise 'key fact statement' for life insurance products to improve consumers' understanding of insurance products.
    - Facilitating product rationalisation so that customers can be moved from legacy products into new insurance products with better features and that reflect development in medical technology.
    - In group insurance, requiring Trustees to consider the age appropriateness of insurance cover to ensure that proper balance is struck between insurance coverage and superannuation balance growth.

8. We believe that ANZ practices and processes, set out below, are resulting in good outcomes for customers:

- We review our insurance offers, including policy definitions, to take into account market and competitor developments, feedback from customers, financial advisers, and changes in medical diagnostic techniques. Favourable changes to insurance terms can be passed on to existing customers subject to any prior underwriting and contractual arrangements, and regulatory requirements.

- ANZ has a continuous training program for claims and underwriting staff in areas such as mental health education and medical knowledge.

- Before a claim is denied the decision is thoroughly reviewed. Customers have access to internal and external dispute resolution (EDR) arrangements. In addition, claim decisions in relation to superannuation business are independently reviewed by the trustee of the superannuation fund who owns the policy.

- ANZ has internal and external audit programs that review claims assessment decisions. This includes specific portfolio audits by our reinsurance partners.

- The OPL Board plays an active role in the approval of product design and the claims philosophy, and oversees claims and complaints management. OnePath has also introduced a Board Claims Review Committee to provide further appropriate, independent, and expeditious review of claims.

- Chief Medical Officers (CMOs) engaged by ANZ are not employees. They have their own practices and function in an advisory capacity only when engaged by ANZ.

- The ANZ Whistleblower Protection Policy allows employees, contactors and consultants to raise issues internally through a Whistleblower Investigations Officer, or using a confidential service operated by Deloitte.

C. ANZ LIFE INSURANCE BUSINESS

OVERVIEW

9. Australians tend to have a base level of life insurance held as part of their superannuation. The majority of this cover is selected by the superannuation trustee in the best interests of members as a whole (not individually tailored). Some people supplement their insurance in superannuation by:

    - Purchasing simple direct insurance on a do it yourself basis (normally under no advice or general advice);

    - Obtaining retail insurance on a comprehensive advice basis (personal advice); or

    - Applying for additional cover within their superannuation fund.

10. ANZ, including through our subsidiary companies, is one of Australia's leading providers of wealth, insurance and financial advice solutions. OPL and its predecessors have been established for over 130 years. Predecessor businesses

include Mercantile Mutual and, more recently, a joint venture with ING Group (known as ING Australia).

11. OPL offers life insurance through three channels:

    - Fully underwritten and tailored Retail life insurance for customers provided through a financial adviser;
    - Direct life insurance for customers who take up insurance without personal advice; and
    - Group life insurance provided through a superannuation fund or other group plan.

12. In 2015, OPL paid over $715 million in life insurance claims providing support to almost 11,000 customers at their time of need.

13. Life insurance covers events such as total permanent disability (TPD), trauma, terminal illness and income protection. The nature of the payment under the policy will depend on the type of cover; for example, the insurance contract may provide for a lump sum payment, or regular payments.

14. In November 2016, ANZ announced that it is considering the sale of the Wealth Australia division which includes insurance, superannuation and advice businesses. The sale process will continue into 2017.

D. THE NEED FOR REFORM AND IMPROVED OVERSIGHT OF THE LIFE INSURANCE INDUSTRY

15. The life insurance industry is highly regulated. Customers benefit from a range of protections including the duty of utmost good faith, strict disclosure and capital adequacy rules. Where personal advice is given, the financial adviser best interest obligation applies (see Appendix A for a list of existing laws impacting the life insurance industry and a summary of ASIC's powers).

16. ANZ supports a range of reforms now underway or that have recently been announced. These reforms include Government led reforms and industry self-regulation initiatives. We believe these reforms will enhance consumer confidence. They include:

    a. Reforms which govern and set limits on remuneration arrangements for life insurance advisers, commonly known as the Life Insurance Framework reforms ("LIF reforms"). The LIF reforms are designed to address misaligned incentives in life insurance distribution channels, support good outcomes for consumers and better manage conflicts.

    b. Government legislation to raise education standards for financial advisers. ANZ has agreed to contribute seed-funding to assist with the establishment of the independent standards body that will oversee the professional standards framework.

c. The launch by the Financial Services Council ("FSC") of the Life Insurance Code of Practice ("the Code") on 11 October 2016. The Code increases protections for consumers over and above existing law. The FSC is currently working with other peak superannuation associations to extend best practice to superannuation trustees that provide insurance through superannuation.

d. A standard being developed by the FSC relating to Approved Products List for life insurance products. The purpose of the standard is to encourage high standards in approved product list construction practices and encourage competitive access and choice for advisers and their clients in life insurance products.

e. A package of reforms announced by the Australian Bankers' Association (ABA) designed to re-build confidence and trust in the banking industry. The reforms include initiatives relating to sales commissions, expanding the terms of reference of the external dispute resolution schemes, support for ASIC's remediation programs, designing a mandatory last resort compensation scheme covering financial advisers, higher standards of whistleblower protections and an industry register for bank employees.

There are other reforms to insurance that could be considered. ANZ's views on some of these possible reforms are as follows.

STANDARD MINIMUM MEDICAL DEFINITIONS

17. The FSC has developed minimum medical definitions for heart attack, stroke and cancer. Implementation of standard minimum definitions would make it simpler for customers to compare cover consistently across the industry. These definitions would be a minimum level, promoting industry competition in excess of the minimum.

18. The FSC is currently consulting on the draft definitions, including with medical experts. Finalisation of the definitions will require approval from the ACCC.

ANZ VIEW 1: ANZ supports standard minimum medical definitions for life insurance cover to allow for greater consistency and to enable easy comparison for the benefit of customers.

CLAIMS ASSISTANCE SERVICE FOR LIFE INSURANCE AND STANDARD CLAIMS FORMS

19. There is an opportunity for the life insurance and superannuation industries to play a greater role in assisting customers with the claims process. This could be achieved through the establishment of an industry funded Claims Assistance Service for life insurance.

20. We do note that overwhelming majority of claimants with retail life insurance are supported by a financial adviser. We experience significantly less complaints where a financial adviser is involved in the claims process.

21. ANZ endeavours to make the insurance claim process as easy as possible for our customers. However, we appreciate that some customers may have difficulty with the claims process or will have particular requirements when a claim is made. An independent, industry funded service could assist claimants (many of whom do not have an adviser) through the claims process from initiation to decision.

22. The proposed independent Claims Assistance Service for Life Insurance would be funded by the life insurance industry and superannuation trustees. It would not replace existing EDR mechanisms, but sit alongside them.

23. To make the process as low cost as possible to consumers, we suggest that it would be unnecessary for claimants to retain legal advisers at the initial stage of making a claim. Once an assessment is made, claimants should of course be free to take whatever steps are necessary should a claim be refused. Claimants are advised of internal and external dispute processes that are available at no cost.

24. Customers who have retail insurance would be encouraged to continue to engage the services of their adviser when making a claim.

25. The Claims Assistance Service would offer multi-lingual assistance to a claimant at no cost to the member or individual policy holder. Where the claim was in respect of a deceased person, the service would be provided to the beneficiary. In all cases, the service would guide the person requiring assistance through the process.

26. New measures to assist customers could deliver a reduction in disputes and significantly reduce the need for lawyers to be prematurely involved in the insurance claim process. In our view, early legal involvement is often unnecessary and may result in significantly reduced final payments to claimants.

27. In addition to the service, industry can explore ways to better inform claimants about the status of their claims. We believe we can better use new digital technology such as smart phones and the internet to make applying for new cover and lodging claims a simpler and more seamless experience for customers.

28. The industry could create a standardised simple claim form which could be used by the customer, irrespective of the insurer or trustee that they were engaging with. This would make the process more consistent and predictable.

ANZ VIEW 2: ANZ believes that an industry funded service to help customers with the insurance claims process would be valuable. A simple standard claim for could be trialled.

ALLOW INSURERS TO OFFER REHABILITATION PAYMENTS

29. Licensing and regulatory regimes for life, health and general insurance could be better aligned to ensure products are better designed to meet consumer needs. For example, it may be beneficial to allow life insurers to help fund medical treatment. This currently requires a health insurance licence. To improve the prospect of a return to work, we would like to provide these payments to our customers with a view to reducing the possibility of a disability becoming permanent.

30. We believe that if life insurers had the ability to make targeted payments to aid rehabilitation through therapy and medical treatments it would greatly improve health outcomes for people who are unwell or injured and are covered by a life insurance policy.

ANZ VIEW 3: ANZ recommends the removal all legislative barriers for providing targeted payments for medical and rehabilitation expenses, including any impediments contained in Private Health Insurance Act and the Superannuation Industry (Supervision) Act (SIS Act).

LATE NOTIFED CLAIMS

31. Instances of an excessively long lead time between an incident and a claim being made are commonly known as late notified claims. In recent years insurers have experienced a spike in late notified claims resulting in insurers having to hold significant reserves to cover the liabilities for payment of these claims once notified.

32. ANZ is proposing that a six year time limit on all TPD claims notification be legislated and implemented. The six year period aligns with the time limit in respect of TPD claims which applies for complaints lodged with the Superannuation Complaints Tribunal.

33. Were a time limit to be applied, analysis by our Group Life insurance business suggests that TPD premiums paid by members who hold TPD cover could be reduced by approximately four per cent, all things being equal. This would be a significant amount over the life of a member. Combined with other initiatives proposed it would reduce the extent to which member balances would be eroded by insurance premiums.

ANZ VIEW 4: ANZ supports the implementation of a legislated six year time limit on notification of TPD claims to insurers.

DISCLOSURE

34. The Financial System Inquiry (FSI) final report issued on 7 December 2014 recommended that the Government "remove regulatory impediments to innovative product disclosure and communication with consumers, and improve the way risk and fees are communicated to consumers"[1].

35. In the Government's response it "agreed that regulatory impediments to innovative product disclosure should be removed." "The Government also support[s] the Inquiry's calls for industry-led initiatives to improve disclosure of risk and fees"[2]. The Government proposed to develop legislation to remove any regulatory impediments in 2017.

---

[1] http://fsi.gov.au/publications/final-report/chapter-4/innovative-disclosure/ Recommendation 23.

[2] http://www.treasury.gov.au/~/media/Treasury/Publications%20and%20Media/Publications/2015/Government%20response%20to%20the%20Financial%20System%20Inquiry/Downloads/PDF/Government_response_to_FSI_2015.ashx

36. Lengthy Product Disclosure Statements (PDS) remain a feature of disclosure for life insurance. PDSs can be in excess of 100 pages in length making it difficult for customers to understand the key risks and fees involved. Consumers may choose not to read these documents because the disclosure is not simple or concise.

37. Lengthy disclosures reflect a complex legislative and legal framework in which the industry operates, and the need to ensure all relevant aspects of the contract are stated clearly. ANZ has developed plain English documents but acknowledges the documents are lengthy.

38. This is particularly concerning in the direct life insurance channel where the customer assumes full responsibility for understanding the risk and fees of the product they are purchasing.

39. The introduction of a concise key facts statement that summarises the main features of life insurance cover, including risks and fees, would significantly help consumers to gain a better understanding of the insurance product.

40. This could be supplemented by a streamlined PDS for consumers who wanted greater detail on the product. We maintain our support for the Government's intention, flagged in its response to the Financial System inquiry, to review product disclosure legislation in 2017.

ANZ VIEW 5: ANZ supports the development of a concise key fact statement for life insurance products to improve consumers gaining a better understanding of insurance products.

PRODUCT RATIONALISATION

41. In its response to the Financial System Inquiry (FSI) final report, the Government agreed "to facilitate the rationalisation of legacy products, in light of consumer, constitutional and fiscal issues. It is important that consumers should not be worse off due to any transition to a newer product. Under the existing framework there are possible tax implications of facilitating the transition away from legacy products, which will be explored in the context of the Government's Taxation White Paper process"[3].

42. The ability to migrate customers from legacy products can benefit customers where more innovative products are available and at a cheaper cost. For product providers, legacy products increase administrative cost and complexity, ultimately resulting in higher premiums.

ANZ VIEW 6: ANZ supports the Government's response to the FSI in relation to product rationalisation and looks forward to this initiative being progressed as soon as possible.

[3] http://www.treasury.gov.au/~/media/Treasury/Publications%20and%20Media/Publications/2015/Government%20response%20to%20the%20Financial%20System%20Inquiry/Downloads/PDF/Government_response_to_FSI_2015.ashx Recommendation 43

E. BENEFITS AND RISKS OF DIFFERENT ELEMENTS OF LIFE INSURANCE

43. Consumers can acquire life insurance through three main distribution channels. Each channel places different responsibility on the customer and industry professionals.

Group

44. OnePath offers group life insurance that provides affordable default cover on an opt-out basis to members of superannuation funds under an automatic acceptance limit. This means there is no underwriting or medical examinations required[4] when the life cover is provided up to the automatic acceptance limit. This is achieved through group contracts issued to superannuation fund trustees (for example, retail master trusts, and industry superannuation funds) or to corporations (employers) who take out policies to provide protection for their employees.

45. The provider of group life insurance is usually determined through a competitive tender process. Under this process, insurers respond to requests for proposals from tender managers seeking to secure the most competitive terms, conditions, and price. In purchasing insurance, superannuation trustees must fulfil statutory duties imposed on them under the SIS Act, and trust law generally, which requires the Trustee to act in the best interests of fund members.

Should group default life insurance be provided on an opt-in or opt-out basis?

46. There has been considerable discussion about whether life insurance should be delivered to superannuation members under an 'opt-out' or 'opt-in' mechanism. The most recent comprehensive review of life insurance in super that examined this issue was undertaken as part of the Super System Review in 2008 ("Cooper Review").

47. The Review considered in its final report that "the risk of death and permanently disability are not remote." Its recommendation, subsequently legislated with bi-partisan support, was that "life insurance cover and TPD cover (where available, depending on occupational and demographic factors) must be offered on an opt-out basis in MySuper products." It agreed with the view that "the level of default cover should instead be determined by trustees based on adequacy levels and their knowledge of the needs of their members."

48. MySuper products were introduced under the Stronger Super reforms. From 1 October 2013 employers were obliged to make contributions for employees who have not made a choice of fund to a fund that has a MySuper product in order to meet superannuation guarantee requirements. According to APRA's Annual Superannuation Bulletin for June 2015 (reissued 23 August 2016), there were 103 Generic MySuper products with 14.6 million MySuper member accounts with a

[4] It should be noted that if a fund member sought to take out additional cover on top of the standard level offered through the superannuation fund, underwriting or medical exams may apply to the additional component of the cover

significant number of these accounts supporting insurance for death and TPD (noting that some members would opt out of insurance coverage).

49. A further review by the Productivity Commission has now been established to consider the competitiveness and efficiency of the superannuation system. Insurance in superannuation is an aspect of this review which is considering both the value of insurance and its costs.

50. ANZ supports the conclusion of the Cooper Review in relation to insurance (as referenced above) but acknowledge that there are instances where more could be done to ensure that the insurance cover provided to members is appropriate.

The impact of life insurance premiums on superannuation balances

51. A disadvantage with providing default insurance cover to members of a super fund is the likelihood that some members may end up paying premiums for cover that may not be needed. This is of particular concern for the young (20-25) and for older people (60+). These two cohorts are less likely to have financial dependents and significant levels of debt.

52. Using appropriate data about fund members, super funds and insurers could address the issue of inadvertent super balance erosion through the use of 'wave' insurance models. This model alters the cover scale to give, for example, younger members less cover for a reduced premium, with automatic increases as they age, and then reduces again once the member reaches a certain age. We expect the Productivity Commission, focussing on value and costs, will also incorporate some of these considerations in its review given the cost of insurance can have a direct impact on superannuation balance growth.

ANZ VIEW 7: Government should consult with industry in relation to a proposal to require trustees to better consider the age appropriateness of insurance cover for members. This would ensure that insurance coverage and premiums do not unnecessarily impede the growth of superannuation balances. The Productivity Commission's review of the competitiveness and efficiency of the superannuation system is already considering the cost and value of insurance for the benefit of members.

DIRECT

53. OPL also offers Direct Life insurance products. These products are offered primarily to existing ANZ customers. Our Direct life insurance products are stand-alone and are not included within superannuation products.

54. Because these products cater to self-directed customers, there are challenges in ensuring that potential customers are informed about the risks and fees associated with the insurance. We recommend improvements to disclosure to assist customers, including the ability of insurers to effectively communicate the effect of pre-existing condition exclusions to them (see section on Disclosure above).

55. ANZ employees that assist customers to address their life insurance protection needs are remunerated under a 'balanced scorecard' that measures their performance in achieving appropriate financial, customer, risk and culture outcomes. The performance expectations set in the scorecard ensure that

employees are focussed on addressing customer need and that there are no incentives to mis-sell.

RETAIL

56. Retail products are designed for customers seeking comprehensive protection, tailored to a person's health and lifestyle and can extend to the customer's family. This insurance is sold through financial planners. Customers receive the benefit of professional financial advice to help inform their choices.

57. OneCare is our principal product offering in the segment. Customers undergo a comprehensive underwriting process in order to obtain cover. We rely on detailed customer disclosures of health, lifestyle and medical conditions to assess a life, TPD or trauma cover that is appropriate to their circumstances and needs. Most of our Retail insurance options are offered as stand-alone products, but they can also be included with a set of superannuation products.

58. Criticisms associated with retail life insurance have mainly centred on the advice process in relation to the quality of the financial advice given, advisers 'churning' insurance policies to maximise insurance commissions. In doing so, it is questionable whether or not advisers are acting in the best interest of their customers.

59. We strongly believe that current Government and industry self-regulatory reforms will result in better outcomes for retail customers and should address the issues of concern. These reforms, which have been noted, include the Government's professional standards and life insurance remuneration reforms, the current best interest duty under the Future of Financial of Financial Advice reforms, the Life Insurance Code of practice and the ABA's industry reform programme.

F. WHETHER ENTITIES ARE ENGAGED IN UNETHICAL CLAIMS PRACTICES TO AVOID MEETING CLAIMS

60. OPL life has a claims philosophy to ensure that our claims handling processes and decisions are appropriate.

61. We commit to a timely decision and payment, communications to claimants that are sensitive, a clearly-defined risk management and governance frameworks, and assessment of each claim based on its individual merits in line with our policy terms and conditions. The Claims Philosophy is reviewed by OPL's Board of Directors.

GENERAL APPROACH

62. A claim on life or related insurance is generally made when an insured or their beneficiary believes an event covered under their policy has occurred. If a condition of an insured event is met and no exclusion applies, OnePath must meet its obligations under the policy and ensure that the life insurance benefit is paid to the policyholder or their beneficiary. A valid claim is one that meets the policy conditions of an insured event and is not subject to any exclusion under the policy.

63. A claim received by OnePath goes through a Claims Management Process where the claim is assessed. A Claims Consultant is assigned to manage the claim and assist the policy owner and/or beneficiary through the process.

64. OnePath treats each claim on its own merits and the individual circumstances of the particular claim. A Claims Consultant must take a holistic view of the claim taking into account information about medical, financial, employment or vocational aspects of the claim and how this relates to the insurer's obligations under the policy.

65. All claims decisions must be based on evidence. The gathering of this evidence is one of the most critical tasks of a Claims Management Process. In most cases, gathering evidence is straightforward and a timely decision can be made. In more complex cases, for example related to some types of TPD or trauma claims, additional medical, financial and vocational evidence may be needed.

66. As with any type of insurance, not all claims will be successful. Claims may be denied if the event does not meet the definition contained in the policy or for reasons such as fraud, non-disclosure or misrepresentation.

67. When managing our more complex claims, the Claims Consultant assigned to manage the claim will keep all parties to the claim updated on the progress and next steps. Where claims are denied, customers wishing to dispute the claim decision have access to dispute resolution processes (see Section E) and, for policies owned via superannuation, review by the Trustee.

68. The following points summarise ANZ practice in relation to recent issues raised in the media about claims management.

INDEPENDENCE OF THE CMO FROM THE INSURANCE BUSINESS

69. Within ANZ, the term CMO is given to a number of consulting medical practitioners who support the claims management and underwriting operations. CMOs engaged by OPL are not employees of OPL or ANZ. They have their own practices and function only in an advisory capacity. CMOs are remunerated as external consultants and are separated from our claims handling area to ensure that their opinions are not subject to influence or pressure.

70. CMOs assist claims assessors with the assessment and management of insurance claims. OnePath uses the expertise of CMOs to understand the claimant's medical conditions and associated treatment regimes.

71. Our CMOs do not have the final decision about whether a claim is approved. This sits with the claims assessor. Decisions are reviewed by senior or technical claims staff, management, and in- some cases, a full Claims Review Forum comprised of senior management of OnePath.

72. In the group insurance environment, the superannuation fund trustee must also independently review claims made by members of their Group superannuation plans. The trustee has a legal duty to pursue its insurer where, in their view, the claim has a reasonable chance of success.

PROTECTIONS AGAINST 'CHERRY PICKING' OF MEDICAL ADVICE

73. As part of the claim assessment process it is not uncommon to encounter conflicting and or differing medical opinions. These can range from initial diagnosis, future treatment and prognosis for recovery.

74. As an insurer, OPL does not seek to influence a treating doctor's or specialist's diagnoses. When presented with a conflict, the claims manager can seek an assessment via an Independent Medical Examination (IME). These assessments are completed by a specialist in the field of medicine relevant to the claimant's condition. IMEs are provided with all relevant medical evidence to allow them to make an informed assessment.

POLICY TERMS AND HEALTH RELATED DEFINITIONS

75. Concerns have been raised about policy definitions and the assessment of claims. The following section outlines aspects of OPL processes for updating policies and our approach to some definition-related issues reported in recent media.

76. OPL seeks to make its policy terms and definitions, and other relevant information as clear as possible given the nature of the insurance products.

GENERAL APPROACH TO UPDATING DEFINITIONS

77. There are important features of insurance that need to be taken into account in providing services.

78. Medical diagnosis and treatment continually improve, leading to great benefits for patients but creating challenges for insurance underwriting and product development.

79. Life insurance operates under a guaranteed renewal basis. An insurer is unable to alter adversely the terms and conditions of the policy offered to the customer even if in the future the customer's health deteriorates or diseases can be detected at an earlier stage.

80. The level of payment under some policies is designed to reflect the expected level of financial impact on the policyholder and their medical condition. This results in more complex decision-making in many cases. For example, a *carcinoma in situ* (i.e. a group of abnormal cells that have not spread into adjacent tissue) under a trauma policy may trigger a partial payment while stage two cancer would trigger a full payment, as this form of cancer is of a more severe nature of illness.

81. The benefits and costs to a consumer of a particular contract will depend on the events covered and exclusions (such as self-inflicted acts or pre-existing medical conditions) and how the cover is placed. The cover may be fully medically and financially underwritten or have limited or no underwriting. In the case of Group insurance, there may be default basic cover or cover available under automatic acceptance (that is, without having to provide evidence of health).

82. For retail life products, we conduct periodic reviews where each of the terms and conditions within the insurance policy are examined by our product, claim and underwriting teams, pricing actuary, CMO and reinsurer.

83. Decisions to make changes to our definitions, terms and conditions take into account market and competitor developments; feedback from customers, financial advisers; and changes in medical diagnostic techniques.

84. The assessments made for retail life products are also used in designing or modifying Direct Life insurance products.

85. For group life insurance, our product team meets trustee clients or their management representatives to review the terms of their individual policies. These reviews will take into account competitor offers and pricing, Trustee requirements, as well as market developments.

TERMINAL ILLNESS

86. OPL assesses terminal illness claims against the policy definition relating to the respective policy the customer holds. In most instances, we seek confirmation from two medical practitioners that the insured's life expectancy is less than 12 months. One medical practitioner will be a specialist in the field of medicine related to the insured's claimed condition.

87. Should we be presented with evidence of medical trials or organ transplants we would further investigate the likelihood and impact that these interventions will have on the life expectancy of the particular claimant. Many of these medical trials or organ transplant situations are unique to each claimant, so we would assess each claim on its merits taking into account individual circumstances.

TOTAL PERMANENT DISABILITY

88. There is a broad range of TPD definitions available in the market. However, generally a minimum threshold contained within all TPD definitions is that insured's disability must be "total and permanent" and the claimant must be unlikely, unable, or incapable of ever returning to work. This inability may relate to either their 'own' occupation or to 'any' occupation for which the person claiming is suited to perform based on their specific past education, training or experience.

89. The threshold for "total and permanent" disability is high. Depending on a claimant's illness, injury or condition, it can take quite a long time before a final diagnosis can be made or assessment of the claim can be completed.

90. It is important to note that as an insurer we are contractually obliged to determine claims against the definitions contained in the policy held by the claimant or by their superannuation fund or their employer.

91. In almost all cases, the definitions contained within insurance contracts will differ from those associated with other arrangements such as permanent retirement benefits, disability support pension or workers' compensation. Claimants may incorrectly assume that if they satisfy the conditions for a benefit under another arrangement that this will necessarily mean that they satisfy definitions under an insurance contract.

TRAUMA COVER

92. Payments under a trauma insurance policy are generally intended to allow the insured to repay debt, meet the costs of lifestyle changes and to cover medical expenses not otherwise covered. Trauma insurance can be complex because of the nature of the payment and the medical and customer circumstances.

93. Advances in medical diagnosis and treatment affect how trauma insurance events are defined and many other aspects of the insurer's business. In responding to these advances, OnePath seeks to ensure that we meet our contractual obligations to existing customers, and that our products remain commercially viable and attractive to new customers. Some factors that influence an insurer's ability to respond quickly to advances in medical diagnostic techniques are:

    - For existing customers, where the actual change in the diagnostic treatment creates a broadening of their coverage, the insurer needs to assess and investigate how these changes can be passed on to customers given the policy contractual obligations.

    - Significant changes in rates of diagnosis or treatment. Rates used in the original design and pricing of insurance may no longer be valid.

94. Customers will reasonably expect the insurer's medical definitions to evolve to reflect medical advances.

95. Medical related definitions are necessarily technical in nature but nevertheless should be expressed as clearly as possible.

96. The definition of a heart attack under a trauma policy has been the subject of recent media reporting. In 2012, an updated definition of a heart attack was released by world cardiology bodies ("Third universal definition of myocardial infarction").

97. Prior to the 2012 change, there was a single definition of a heart attack in the OnePath trauma insurance product. In response to this change, OPL introduced a new partial payment event called "Heart Attack – minor" and renamed the existing heart attack definition to "Heart Attack – major", reflecting the severity of the attack for its OneCare product. The OPL definitions include multiple factors based on advice from relevant specialists and are consistent with the 2012 definition. They are available in the OneCare PDS.

98. For Severe Rheumatoid Arthritis, OPL has updated its definition following CMO advice in 2013 that the existing definition was no longer appropriate. OnePath worked with the CMO to create a new definition that reflected the severity of the condition and took into consideration contemporary diagnostic techniques. This definition is available in the OneCare PDS.

MENTAL HEALTH

99. OPL has policies that include life insurance payments for mental health conditions in the event of Death, TPD and Temporary Disablement (Income Protection and Group Salary Continuance).

100. Mental health-related claims can be particularly complex and specific to an individual. Claimants can be experiencing a wide range of symptoms and require individual treatment plans. Reflecting this, we assess each claim on its individual merits to achieve the most appropriate outcome.

101. We seek to treat our customers with sensitivity and respect with the understanding our customers may be medically, financially or emotionally vulnerable. For Temporary Disablement (Income Protection & Group Salary Continuance) claims, our priority is to ensure our customers return to work in the same or alternative employment. Based on research, we consider that this is the outcome most likely to result in a recovery to good mental and physical health.

102. Concerns have been raised that insurers' approach to mental health conditions was to 'deny insurance coverage' for customers based on a broad range of factors 'that might foreshadow future mental health problems' - such as 'perfectionism, working excessive hours, having financial problems, being new in business and being older than 50'. OnePath does not take such an approach in our underwriting or assessment of mental health-related conditions.

103. OPL seeks to make suitable life insurance cover available to respond to customer needs. Where a policy is underwritten, factors such as the customer's medical history, occupation and financial history will need to be considered.

104. OPL CMOs provide advice on training and underwriting and claims in these areas. Underwriting is based on actuarial analysis of claims data, advices from medical practitioners, medical research and information from our reinsurers.

105. All customer-facing staff, such as underwriting and claims staff, complete annual Mental Health Awareness training as required under membership of the FSC.

CLAIMS ASSURANCE

106. In April 2016 ASIC requested OPL to undertake an independent review of its claims handling systems, product design processes and risk based review of denied or withdrawn claims.

107. OnePath Life adopted an engagement model encompassing a mix of legal and professional services firms to ensure the right level of expertise and experience was applied to specific areas of the review. The three service providers were Allens, Turkslegal and KPMG

108. KPMG and Turkslegal have completed their review and issued their final reports on 18 October 2016.

109. Allens concluded that: "The review did not identify any claim that had been inappropriately denied. There were no material issues identified in the claims handling system or the design and implementation of OPL's product design processes and KPMG has issued an unqualified assurance opinion."

110. Turkslegal concluded that: "No claims were inappropriately declined" and "The OPL claims team was seen to be operating to a high standard and exceeded legal obligations, particularly with respect to procedural fairness."

111. KPMG issued an unqualified reasonable assurance report that concluded that: "Controls were suitably designed to achieve the control objectives set out in the Company's Claims and Product Controls Document as at 31 July 2016" and "The controls were implemented as designed as at 31 July 2016"

112. For the review of claims, OPL has also introduced a Board Claims Review Committee which is a sub-committee of the Board and comprises two independent non-executive directors as well as the Executive responsible for Insurance.

113. Given these members are subject to their overall directors' duties as outlined in the Corporations Act, we believe this will give the most appropriate, independent, and expeditious review of any disputed claims which may arise.

G. THE SALES PRACTICES OF LIFE INSURERS AND BROKERS, INCLUDING THE USE OF APPROVED PRODUCT LISTS

114. ANZ employees who assist customers to address their life insurance protection needs are remunerated under a 'balanced scorecard'. The scorecard measures their performance in achieving appropriate financial, customer, risk and culture outcomes. The performance expectations set in the scorecard ensure that employees are focussed on addressing customer need and do not create an incentive to mis-sell.

115. Other controls that we have in place to mitigate against the risk of mis-selling of direct insurance products are detailed under the heading of 'Direct' above.

116. The Future of Financial Advice reforms amended the Corporations Act to establish a best interest duty for advisers that give personal advice to retail clients. The obligations include the duty for advisers to act in the best interests of clients, ensure the advice they provide is appropriate, advise clients of advice limitations (i.e. if it is incomplete or inaccurate), conduct reasonable investigations into financial products that might meet the needs of a client and to prioritise the client's interest.

117. In addition to these protections, APLs relating to ANZ Financial Planning and our aligned dealer groups have sufficient representation of insurers so that a number of products are available for review when our advisers are considering the product that is in the best interest of the client. ANZ Financial Planning has four providers on its APL, one of which is OPL. Our aligned dealer groups have nine providers on their APL, which also includes OPL.

H. INTERNAL DISPUTE RESOLUTION IN LIFE INSURANCE

DISPUTE RESOLUTION

118. For Retail and Direct insurance customers, our dispute resolution process provides access to internal complaint resolution, the ANZ Customer Advocate and external dispute resolution through the Financial Ombudsman Service (FOS) or the Superannuation Complaints Tribunal (SCT).

119. The Customer Advocate operates at arms-length from ANZ's businesses, reporting directly to the Group Executive accountable for Retail and Commercial Banking in Australia. ANZ is bound by the Customer Advocate's findings in all cases while the customer is not. A customer who is not satisfied with a review by the Customer Advocate is able to take their matter further for review through an external dispute scheme, such as FOS or the SCT.

120. Complaints in relation to the decision and conduct of Trustees of superannuation funds are dealt with by the SCT under the Superannuation (Resolution of Complaints) Act.

121. For Group insurance, our contracts contain specific dispute resolution and claims review committee provisions. All claims are reviewed by a technical claims consultant. They are also subject to Trustee review.

122. We have procedures to ensure all enquiries and complaints are properly considered in accordance with ASIC Regulatory Guide 165, *Licensing: Internal and external dispute resolution*. All decisions are communicated to customers in writing. If a decision is made to decline a claim, correspondence will set out the basis for the decision and inform the customer of the internal and external avenues available to them for review.

123. ANZ has internal and external audit programs that review claims assessment decisions. This includes specific portfolio audits by our reinsurance partners. As noted above, the OnePath Board of Directors oversees the complaints and claims which arise within OnePath.

124. ANZ notes that the Government is looking at options, such as a low cost tribunal, to assist consumers that have financial service complaints. The current Ramsay review of external dispute resolution schemes will help inform the shape of this tribunal[5].

125. The House of Representatives Standing Committee on Economics in *its Review of the Four Major Banks (First Report)* tabled on 24 November 2016 has also recommended such a tribunal be established.

PROTECTION OF WHISTLEBLOWERS

126. The ANZ Whistleblower Protection Policy is designed to ensure that all employees can raise concerns regarding actual or suspected contravention of our ethical and legal standards without fear of repercussions. ANZ ensures employees and contractors who disclose reportable conduct are not victimised or disadvantaged.

127. The Policy allows employees, contractors and consultants to raise issues internally through a Whistleblower Investigations Officer, or using a confidential phone, email and web-based service operated by Deloitte. If a whistleblower has concerns about

5 http://www.smh.com.au/federal-politics/political-news/malcolm-turnbull-confirms-federal-government-will-create-new-banking-tribunal-20161006-grwvu5.html

the resolution of the matter, an escalation avenue to the Chairman of the Audit Committee is also available.

128. The ABA is currently considering enhancements to whistleblower protections as part of its industry reform program. As part of this process the ABA commissioned research from Promontory Australasia that found Australian banks have comprehensive whistleblower programs that generally meet global best practice. There are areas for improvement, including making protections for whistleblowers more consistent between banks. The ABA used this analysis in developing the draft principles on how banks can strengthen their existing programs[6].

I. THE ROLES OF ASIC AND APRA IN REFORM AND OVERSIGHT OF THE INDUSTRY

129. ANZ's experience is that best practice regulatory oversight is more likely to occur when regulators work cooperatively with industry participants to achieve positive outcomes that support consumer protection and industry sustainability.

ASIC AND APRA REFORMS

130. On 20 April 2016 the Government announced further reforms to strengthen ASIC. Government commitments of relevance to the life insurance industry include:

- An announcement of a $127.2 million reform package to strengthen ASIC, including an industry funding model for ASIC to commence in the second half of 2017, and an additional funding of $57 million for surveillance and enforcement on an ongoing basis.
- Implementation of a product intervention power to enable ASIC to respond to market problems in a flexible, timely, effective, and targeted way and product distribution obligations for industry to foster a more customer focussed culture.

131. Arising from its October 2016 Report 498*, Life Insurance Claims: An industry review*, ASIC has recommended regulatory reform to remove limitations to its capacity to take action for systemic conduct or to seek broad improvements to current practices in relation to claims handling. This includes establishing, with APRA, a new public reporting requirement for life insurance industry claims data and claims outcomes and recommending the consumer dispute resolution framework for claims handling be strengthened.

ASIC has also indicated that it would conduct targeted reviews on areas of concern including individual insurers with high decline and dispute rates, as well as a new major review of life insurance sold directly to consumers without personal advice.

---

[6] http://www.betterbanking.net.au/faster-industry-repair/whistle-blowers/ . Promontory did not conduct a formal assessment of practices in international or Australian banks, so the conclusions in this report should be interpreted against those limitations.

APPENDIX A: REGULATORY FRAMEWORK SUMMARY

THE INSURANCE CONTRACTS ACT 1984 (ICA)

132. The ICA regulates contracts of insurance and contains a number of safeguards including a statutory duty of utmost good faith. The duty applies to the insurer, the insured, as well as third party beneficiaries under a contract. While the requirements of the duty may vary in different circumstances, it is generally accepted that the duty requires the insurer to act consistently with commercial standards of decency and fairness, with due regard to the interests of the insured. As an example, the duty will have implications for claims handling practices and processes, such as handling claims without undue delay and with a level of sensitivity and respect.

133. Further, the ICA provides that if a party's reliance upon a section of an insurance contract would be a breach of the duty to act with the utmost good faith, that party cannot rely upon that section. Such a provision would apply to the reliance upon inaccurate or out of date definitions in an insurance contract.

134. The ICA also includes a duty on the part of the insured to disclose all matters relevant to the decision of the insurer to provide insurance. Failure to fully disclose could mean that a claim is not paid.

THE LIFE INSURANCE ACT 1995 (LIA)

135. The LIA regulates the conduct of life insurance business through a system of registration. In Australia, life insurers must be registered under the LIA administered by APRA.

136. Life insurers are subject to prudential supervision by APRA and must comply with applicable prudential standards that deal with matters such as minimum capital requirements, reinsurance management, risk management, outsourcing and governance.

SUPERANNUATION INDUSTRY (SUPERVISION) ACT 1993 (SIS)

137. The SIS Act is the primary legislation governing superannuation entities. Under SIS, trustees of superannuation funds are required to ensure that their duties and powers are performed and exercised in the best interests of beneficiaries of the superannuation fund. The SIS Act also contains specific covenants around insurance in superannuation.

138. Most life, income protection and TPD insurance cover, though not trauma cover, are offered inside superannuation. Since insurance is provided to members of the superannuation fund, superannuation trustees are therefore subject to SIS requirements and APRA Prudential Standards impacting superannuation business.

APRA PRUDENTIAL STANDARDS

139. There are 13 APRA Superannuation Prudential Standards, including a standard on "Insurance in Superannuation" that requires superannuation trustees to have in place an insurance management framework to manage making insured benefits available to beneficiaries.

140. Insurers operating in the superannuation space have similar requirements including Prudential Practice Guide LPG270. LPG270 outlines prudent practices in relation to group insurance arrangements. The main area of focus is life insurance, TPD insurance and income protection insurance provided to a registrable superannuation entity (RSE) licensee, for offering to beneficiaries.

141. LPG270 also discusses the implications for insurers of Prudential Standard SPS 250 Insurance in Superannuation. SPS 250 sets out APRA's requirements for RSE licensees in relation to making insured benefits available to beneficiaries. APRA has also issued guidance for RSE licensees in Prudential Practice Guide SPG 250 Insurance in Superannuation. RSE licensees retain primary responsibility for complying with SPS 250 and other relevant legal requirements, notwithstanding the guidance provided to insurers in LPG270.

CORPORATIONS ACT 2001 (ACT)

142. The Corporations Act contains uniform licensing, disclosure and conduct requirements for the financial services industry. In setting up Australia's conduct and disclosure regime, the report to the Wallis inquiry in 1997 states that financial markets cannot work well unless participants act with integrity, to ensure mutual trust, and unless there is adequate disclosure to facilitate informed judgements.

143. In essence, the Corporations Act impacts the life insurance industry by:

- Setting out product disclosure and ongoing disclosure requirements for providers to help inform consumers about their product;
- Providing a range of consumer protections (refer ANZ SOFA submission of January 2015); and
- Putting in place the life insurance remuneration reforms (noted previously) in relation to financial advice on life insurance.

AUSTRALIAN SECURITIES AND INVESTMENTS COMMISSION ACT 2001 (ASIC ACT)

144. The ASIC Act includes the following consumer protections:

- Prohibiting a person from engaging in conduct which is unconscionable. As well as the general prohibition, there is a particular prohibition relating to contracts for the provision of financial products or the supply of financial services;
- Prohibiting a person from engaging in misleading and deceptive conduct; and
- Prohibiting a person from making a false or misleading representation. The relevant section lists various false representations that are banned, including making a false representation concerning the existence, exclusion or effect of any condition of the contract.

145. Noting the Government reforms enhancing ASIC powers, ASIC has the following powers under the Act:

- Compelling an Australian Financial Services licence holder (AFSL) to produce documents (for example, correspondence with clients);
- Compelling an AFSL holder to answer questions in writing.
- Examining under oath current or past employees of an AFSL holder;
- Interviewing an AFSL holder's clients;
- Taking action against an insurer where it has breached the duty of utmost good faith; and
- Cancelling or suspending licences, imposing licence conditions, taking action personally against directors and officers, and banning AFSL holders and their advisers from the industry where a breach of the financial services laws has occurred.

146. Breaches under the ASIC Act may result in a financial institution being subject to pecuniary penalties, injunctive relief, fines, payment of damages, punitive and non-punitive orders, adverse publicity notices, public warning notices, and other orders as courts see fit.

BREACH REPORTING

147. AFSL holders and APRA regulated entities are obliged to report certain matters to ASIC or APRA, including:
    - Where they or one of their authorised representatives significantly breach the financial services laws; and
    - Breaches of their financial obligations or capital requirements under the LIA.

148. The LIA allows APRA to take enforcement action on behalf of policyholders who have been adversely impacted. Where there is a major prudential compliance failure and perceived threat to policyholders, APRA also has powers to suspend the board and management and take control of the insurer.