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Dear Sir/Madam

SUBMISSION: TO FEDERAL TREASURY Re INSURANCE CLAIMS HANDLING CONSULTATION PAPER

Thank you for the opportunity to comment on *Insurance Claims Handling - Taking action on recommendation 4.8 of the Banking, Superannuation & Financial Services Royal Commission - Consultation paper*.

In our response, we seek to highlight that a regulatory model which nurtures the continued existence of third-party claims advocates that are acting on behalf of claimants – not insurance companies – is a means of addressing the "current issues" detailed on page 5 of the Consultation paper.

We specifically believe our business model and the services we provide very clearly addresses stated concerns by ASIC in its submission to the Royal Commission: "the intrinsic value of an insurance product lies in the ability to make a successful claim when an insured event occurs;" and also the Consultation paper's comment: "As insurance claims are also often made in periods of financial or personal distress for retail clients, poor outcomes during the claims process can have a heightened impact on individuals."

For ease of processing, we have structured our submission as responses to the five "Consultation questions" listed on Page 14 of the Consultation paper.

1. Are there additional issues that have not been identified? If so, are there potential options for addressing them within the proposal?

a. Consumer Claims Advocacy Services

A general observation is that the consultation paper as drafted seems to assume that all persons involved in "handling or settling insurance claims" are employees or third-party representatives of insurance companies.

There seems to be no acknowledgement of the current existence of companies whose sole purpose is to act on behalf of insurance claimants, managing the claims process, to ensure the claimants' financial and health best interests are protected.

The closest we can see to an acknowledgement of the existence of companies such as ours is in the second bullet point of the "Who would be covered" section of the consultation paper on Page 12. However, even this bullet point seems to assume that claims handling services would be acting 'on behalf of the insurer' rather than on behalf of the claimant:

"Certain third-party representatives of insurers that provide a claims handling service on behalf of the insurer. It is likely that third party representatives (which could be identified using a title such as 'claims handling service providers') would need to include service providers such as investigators, loss adjustors, loss assessors, collection agents and claims management services…"

Background on AFRM Claims Advocacy and the services it provides

We are passionate about creating a better outcome for life insurance claimants and raising the level of social responsibility of the industry to a level of trust currently not held.

AFRM Claims Advocacy was formed out of our leading advice business, Australian Financial Risk Management Pty Limited, AFSL 237186, to fulfil a need that was becoming apparent as more and more "non-customers" we're being referred to us because of our reputation for claims management excellence.

We are experts in helping consumers achieve the best possible financial and health outcomes when making a claim on life insurance. We seek to help support their return to wellness while ensuring they receive their entitled financial benefit.

AFRM Claims Advocacy (ACA) was established in October 2017 through a services partnership between Australian Financial Risk Management (AFRM) and Gallagher Bassett (GB) for the sole purpose of independently acting on behalf of policyholders, providing personalised support throughout the claims process to protect emotional and mental health, improve their financial outcomes; while at the same time improving relationships between claimants and insurers, super fund managers and trustees alike.

ACA draws upon the combined 40 years of insurance and claims management experience of AFRM (specialists in risk insurance advice) and Gallagher Bassett (the largest multi-disciplinary third-party claims administrator in Australia). AFRM alone has managed more than 550 claims, achieving in excess of $150m paid out to its customers to help fund their rehabilitation and return to wellness. Many ongoing and long-term income protection claims continually need intervention.

Accordingly, ACA's key driver is to offer consumers a better, more personally engaging and supportive claims management service for people who may otherwise lack adequate advice regarding making a claim on their insurance policy or assistance through the process of making a claim.

Our customers are provided a single point of personal contact to help minimise the emotional and mental stress of the claims process; a Claims Advocate to assist, provide resources and who forms part of a support network throughout the progress of the claim. The Claims Advocate manages all aspects of preparing for the filing of the claim – liaison with medical practitioners, insurance companies, superannuation fund trustees – in short, any relevant stakeholders – and acts on behalf of the consumer throughout the claim's progress.

Our team of Claims Advocates have appropriate nursing, psychology and/or social work training to help coach customers through taking up the rehabilitation option and potentially speeding up their return to wellness. They work with insurers to seek to meet the biological, psychological and social needs of our customers.

This personal assistance is supported by an online technological platform which allows the customer making the claim to also privately monitor every step of the claim's progress - providing the customer comfort in recognising where their claim is at, in term of its progress. This is often important because customers get anxious if they are not able to

quickly access information about the progress of their claim.

Our entire business is centred upon achieving the best possible financial and health outcomes for our customers.

a. Retail insurance market where insurance companies do the claim "pre-assessment"

We also note that another issue not identified in the consultation paper is the fact in the retail insurance market, where advisers are involved; the *pre-assessment* of an insurance claim is done by the insurance company, which represents a conflict of interest. Often the reason this occurs is that advisers are facing downward pressure on revenue and increased cost to serve.

Therefore, the reality is that advisers are increasingly having a reduced time capacity to deal with claims. Additionally, they may not have the experience / capability, given they may deal with one to three claims per year.

Phil Anderson, GM of Policy and Professionalism at Association of Financial Advisers has suggested that only 20 per cent of advisers actively support customers with claims. This therefore leads to the insurer dealing directly with the customer and doing the claim pre-assessment.

The fact that the insurance company does the pre-assessment perhaps contributes to the lack of trust of consumers; a perception of no power parity between consumer and insurer coupled with current outcomes from Royal Commission underscores the need for this process to be more transparent.

Having an independent claim management specialist can achieve this transparency, while also addressing the perception of conflict of interest. It may also reduce the number of instances in which consumers feel they need to seek legal advice to manage their claim. Doing so could be argued to be not in the customer's best interest when legal fees can sometimes erode the ultimate benefit paid by up to 40 per cent, from our personal experience.

b. Superannuation fund trustee market where insurance companies do the claim "pre-assessment"

Further we note that in the superannuation fund trustee market, again the *pre-assessment* of insurance claims is usually performed by the insurer. Again, this is a conflict of interest not specifically identified among the issues detailed within the consultation paper. As per above – most trustees have limited capability and capacity to deal with the claim, so often when they receive a call from a member about a potential claim, they send it to the insurer to do a pre –assessment.

We are aware that, for a selection of trustees, up to 25 per cent of member claims it is not clear if they progress after they receive the form from the insurer. We can only infer that perhaps members don't trust the process and therefore they do not progress with the claim.

c. The need for a precise definition of who is captured and who is excluded from any definition of "handling or settling of an insurance claim"

We agree that the precise definition of who is captured and who is excluded from any definition of "handling or settling of an insurance claim" (as discussed on Page 22 of the consultation paper) needs careful consideration. This is needed to ensure unforeseen burdens are not applied to consumers seeking to make an insurance claim, such as

preventing access to independent third-party advice about their claim.

The fact is that when a consumer is considering making an insurance claim (becoming a claimant) when an illness or injury first arises, they may well refer to one or more trusted advisers with whom they have an existing relationship. This may be their accountant, a friend, or some other service provider they trust (who may or may not be a financial adviser).

The support received in the early stages of making a claim is important for the wellbeing of the claimant.

We would contend that from this point on a claimant needs the support provided by a specialist Claims Advocate, who can help them through the claim management process.

Obviously under current legislation, such Claims Advocates don't need to be licensed.

However, this example underscores the importance of the trusted adviser (the Claims Advocate) having the appropriate training and capabilities to sensitively connect with the claimant. We would contend this capability is far more important than the Claims Advocate holding an Australian Financial Services license.

The persons handling the claim need the appropriate training to be able to best assist people at a vulnerable time in their lives. "Appropriate training" in this context might mean those people well versed in medical and mental health issues rather than someone qualified to hold an Australian Financial Services license.

Assisting vulnerable members is consistent with the Insurance in Super Working Group Code Section 6 and Section 12.

Helping vulnerable members requires capability to deal with a high-risk cohort of customers such as:

- those experiencing financial hardship,
- mental health challenges,
- cultural and/or linguistically challenged, or;
- or of an indigenous background.

Therefore, the emphasis should be on ensuring that those persons handling the claims have the appropriate capabilities to effectively engage with these customers.

We would humbly submit that having an Australian Financial Services license does nothing to ensure a person has these specialist capabilities in order provide the best solutions for these customers at a very emotional and stressful time

2. Are there other approaches that can be taken in designing the legislative amendments that would further improve consumer outcomes (including by reducing compliance costs)?

Adoption of a Consumer Advocacy claims management approach independent of insurance companies is recommended.

This is an approach to insurance claims management that has demonstrably achieved positive outcomes for consumers for decades. It is a claims management model that has at its core an independent third-party professional in claims management who acts on behalf of the claimant guiding them throughout the process, providing expertise and support.

As noted in paragraphs 12 through 14 of ASIC's *REPORT 587 The sale of direct life insurance*, success rates for claims made on direct sales of life insurance is poor by comparison; while 93% of finalised claims across all channels (advised, group and direct) were successful, its only 84% in the direct channel

As stated above, AFRM Claims Advocacy's approach protects the best interests of the consumer – both financial and health – while also maintaining the most positive possible relationships with all stakeholders, including the insurer.

Our parent company, AFRM, has been in business for more the 20 years and we are immensely proud of the fact that its claim success rates exceed industry averages. AFRM has achieved this by ensuring all potential claims are 'triaged' in advance and only valid claims are lodged.

By the term 'triaged' we mean that our Claims Advocates review the full details of the potential claim in advance of its being lodged as a formal claim. We assess the fine print of the policy and the full circumstances surrounding the potential claim. By doing so, we can ensure that only valid claims are lodged.

The benefit for the customer (claimant) is that we can sensitively manage their expectations. Further, the service is more cost effective because we can save the customer time and money.

If we believe the customer (claimant) does not have a viable claim, ACA has the capability to provide expert guidance towards community support services that can help them cope with the claim outcome and/or their health issue. This is known as ACA's Network Support Service.

Another benefit of ensuring that only valid claims are lodged is the efficiencies it creates across the value chain for all stakeholders involved. For example, for insurers, trustees etc., because we are not wasting their time with invalid claims.

This is one of the key consumer benefits provided by a consumer claims advocacy service – third party expertise with a thorough knowledge of policy fine print and an understanding of how to achieve a positive result for the consumer. AFRM currently has 110 active claims and continues to monitor and support customers on long-term claims.

A better outcome for all consumers

We note ASIC's stated Expectations of the life insurance industry; the Actions being undertaken by ASIC and the Recommendations made in *REPORT 587 The sale of direct life insurance*.

We also note the stated intentions of the changes proposed in this Treasury consultation paper.

We humbly submit that consideration be given in any review of existing regulatory frameworks designed with the objective of achieving better outcomes for consumers that consideration be given to the strong evidence of our experience that consumers who have access to a third-party claims advocate achieve positive results in almost every single case.

In fact, adoption of a claims management model that includes a third-party claims advocate acting in the best interests of the consumer could satisfy many of Treasury's and ASIC's objectives. This notion applies not just to direct sales but all sales of life insurance (that is; the adviser and group channels as well).

At a time when public trust in the financial sector is at an all-time low and the need to demonstrate social responsibility at an all-time high, the presence of a third-party consumer advocate could go a long way to help bridge that trust deficit. Insurance companies could demonstrate they are seeking to improve their professionalism and quality assurance mechanisms by including as part of their product offering at the time of sale that access to a third-party consumer advocate will be provided at the time any claim is made. This would also have a positive impact on the direct channel, where currently the cancellation of policies during the cooling off period is quite high; giving the customer increased support (insurance product and Claims Advocate) may deliver these customers greater peace of mind.

The consumer can then be confident that they will have access to a third-party expert who can advise and guide the consumer through the entire claims process – someone who is not conflicted financially and has the appropriate financial and health training to help minimise emotional stress for the consumer and their family throughout the process of making the claim.

A potential way to fund it that does not leave consumers out of pocket

Many retail life insurance policies include benefits to be paid to reimburse costs incurred as a result of the claim after the claim has been admitted, such as a 'Financial Planning Benefit' which reimburses funds up to a set amount to cover the cost of the consumer paying to have a financial plan prepared following the payment of lump sum benefit.

We are currently engaging with insurers, proposing that they include in their retail life insurance policies a specific benefit to reimburse the cost of the third-party claims advocacy service. The Claims Advocate manages the claim on the consumer's behalf and works with medical practitioners and industry specialists to develop and implement a return to wellness program for the consumer to support the rehabilitation process during the claim process. The benefit would be paid to the customer.

If the Federal Government and its agencies were to consider imposing a regulatory requirement to ensure consumers of direct life insurance products have access to third-party claims advocacy, then requiring policies to have such a benefit would help ensure better claims outcomes for consumers.

Such a mechanism would ensure that the consumer's best financial interests and best health interests are not only being protected but promoted in the very way the policy is structured.

Industry stakeholders see merit in a third-party consumer advocacy model

Despite ACA only being in business since late 2017, industry stakeholders are seeing merit in the service that a company like ours provides. This includes third-party financial advisors, insurance companies and superannuation fund trustees.

To date, we have had more than 100 financial advisers indicate an intention to use our service to manage all life insurance claims on behalf of their customers.

We have also had productive meetings with insurance companies and superannuation fund trustees who recognise how engaging a third-party consumer claims advocate to act on behalf of their customers and fund members in the event of the need to file a claim can assist in improving consumer/member perceptions of those organisations at this time of unprecedented public distrust of companies operating in the financial services sector.

Insurer, AIA Australia, has also advocated for the establishment of an industry funded

"Independent Claims Assistance Service" in its 2016 Submission to the Parliamentary Joint Committee on Corporations and Financial Services Inquiry into the Life Insurance Industry [See page 18].

AIA Australia argued that the purpose of this Independent Claims Assistance Service should be to "assist members with inquiries about claims processes, lodging claims, and claims decisions."

The AIA submission also states: "Though we envisage this service will be open to all potential claimants, it may be particularly useful for those insured via direct channels, as they do not have the advocacy services provided by superannuation trustees, or financial advisers, to assist them in the same manner as the other channels."

Such an approach is also not inconsistent with public statements by consumer advocacy groups seeking reform to claims handling processes to ensure better outcomes for consumers, such as the Public Interest Advocacy Centre, the Consumer Action Law Centre and the Financial Rights Legal Centre.

3. Are there any obligations, besides the existing AFS licencing obligations, that would provide further useful consumer protections in respect claims handling activities and so should also apply to them?

We refer to our comments made in Section "d" of our response to Consultation question 1, on Page 4 of this submission, which refers to vulnerable customers and persons handling claims needing to have the appropriate training and capabilities which would not be guaranteed by a person simply holding an Australian Financial Services license.

Perhaps a person with this appropriate training may fall under the scope of the second bullet point, on Page 13, of the Consultation paper:

> *"Whether a new category of person could be created that is entitled to engage in specified financial services in a representative capacity without being an authorised representative."*

4. How could the activity of handling or settling an insurance claim (in relation to both life and general insurance products) be defined as a financial service for the purposes of the Corporations Act?

We have no submission to make in response to this question.

5. What penalties should apply to insurers breaching the general obligations of s912A in the specific instance of insurance claims handling? Should the penalties attaching to insurance claims handling, be the same that attach to other financial services?

We have no submission to make in response to this question.

Conclusion

We sincerely believe the adoption of a model across the life insurance sector, whether regulated or self-imposed, in which all claimants are provided access to an third-party advocate to help them through the claims process would provide a means to satisfy a number of the Federal Government's stated desired outcomes, including improving consumer outcomes and providing the industry with a means to demonstrate it is meeting all regulatory requirements in terms of providing financial services efficiently, honestly and fairly and also having adequate arrangements in place to avoid conflicts of interest.

We thank you for taking the time to read this letter and would be happy to share our knowledge and experience in third-party insurance claims advocacy with your office; or any other stakeholder you may nominate; to help ensure better outcomes for consumers.

Sincerely,

Nicholas Hatherly

Managing Director

Australian Financial Risk Management Pty Ltd

Bruno Muraca

CEO

AFRM Claims Advocacy