FSC FINANCIAL SERVICES COUNCIL

Insurance Claims Handling

Taking action on recommendation 4.8 of the Banking, Superannuation & Financial Services Royal Commission

Consultation Paper

9/4/19

FSC FINANCIAL SERVICES COUNCIL

Contents

1. About the Financial Services Council

The FSC is a leading peak body which sets mandatory Standards and develops policy for more than 100 member companies in Australia's largest industry sector, financial services.

Our Full Members represent Australia's retail and wholesale funds management businesses, superannuation funds, life insurers, financial advisory networks and licensed trustee companies. Our Supporting Members represent the professional services firms such as ICT, consulting, accounting, legal, recruitment, actuarial and research houses.

The financial services industry is responsible for investing almost $3 trillion on behalf of more than 14.8 million Australians. The pool of funds under management is larger than Australia's GDP and the capitalisation of the Australian Securities Exchange, and is the fourth largest pool of managed funds in the world.

The FSC does not represent general insurers, therefore our comments in this submission relate to life insurers only.

2. Background

In its policy questions posed to the public after the Insurance Round of Hearings, the Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry (**RC**) asked the following question:

> *"Should the obligations in section 912A of the Corporations Act 2001 (Cth) apply to all aspects of the provision of insurance, including the handling and settlement of insurance claims?"*

In our submission in response to the Interim Report, on 25 October 2018, we stated our position as follow:

> *Yes. The FSC supports the application of section 912A Corporations Act to claims handling staff, in the sense of casting upon them obligations to act in a particular way when managing claims.*
>
> *However, the FSC's view is that the extension of these obligations to claims handlers should be drafted in a manner which ensures that claims handling staff are **not** treated as giving advice under the Corporations Act. That is because persons who provide such services require particular qualifications that the FSC understands to be in excess of that required of claims handlers. If insurers could only recruit persons to perform claims handling functions if they had such qualifications, it would be significantly more difficult and prohibitively costly for them to carry out their business. For example, without analysing the matter in detail at a very high-level, at the least, claims handlers then would be obliged to:*
>
> - *hold a relevant degree;*
> - *pass an exam;*
> - *undertake at least one year of work and training relevant to the provision of financial advice;*
> - *meet continuing professional education requirements; and*
> - *adhere to FASEA's Code of Ethics for Financial Advisers,*
>
> *in accordance with the Corporations Amendment (Professional Standards of Financial Advisers) Act 2017 (Cth).*
>
> *While we believe that education, training, work experience and compliance with ethics are all necessary to undertake the work of handling life insurance claims, we submit that the particular qualifications and professional standards which apply to financial advisers are not appropriate for claims handlers. There is the added complication of course of AFSL licensing and authorisations.*
>
> *Accordingly, section 912A should be applied to claims handlers in a way which ensures that their communications with consumers do not, in the ordinary course, amount to financial product advice, (requiring them to be an AFSL holder, an employee of an AFSL holder, or an authorised representative). We accept that life insurers would need to provide appropriate training to claims handlers to ensure that their conversations with claimants remain factual only and would not amount to recommendations or statements of opinion which are intended to influence claimants to decide about an insurance claim.*

We do think it may be useful for obligations such as some of the more general provisions of Section 912A, modified as we have suggested, to apply to the claims handling process and claims handlers. As mentioned in our earlier comments on the further questions raised in the Interim Report, we feel that a modification of some of the general obligations could with appropriate revision be applied here. For example, in terms of the current drafting of Section 912A, as a matter of general principle, the following obligations are relevant:

- *must do all things necessary to ensure that the financial services covered by the license are provided efficiently, honestly and fairly;*
- *must have in place adequate arrangements for the management of conflicts of interest that may arise wholly, or partially, in relation to activities undertaken by the licensee or a representative of the licensee in the provision of financial services as part of the financial services business of the licensee or the representative;*
- *comply with financial services laws;*
- *ensure that representatives are adequately trained; and are competent to provide the financial services;*
- *have a dispute resolution system in place; and*
- *subject to exceptions for certain APRA-regulated bodies and RSE licensees, a licensee must have adequate risk management systems.*

On 1 February 2019, the RC released its Final Report wherein the Commissioner recommended:

"The handling and settlement of insurance claims, or potential insurance claims, should no longer be excluded from the definition of 'financial service'."[1]

(**Recommendation 4.8**)

In its response to the Final Report, the Government agreed with the Recommendation.[2]

On 1 March 2019, Treasury released its Consultation Paper on the implementation of Recommendation 4.8. As can be seen from our previous position, the FSC wholly supports Recommendation 4.8 and the Government's position. However, issues arise when seeking to implement this recommendation. This response seeks to highlight the key issues for our members. It then provides specific answers to the questions posed in the Consultation Paper. We understand that the next step for Treasury, once it has considered all the submissions to the Consultation Paper, would be to issue an Exposure Draft of the Bill. We look forward to receiving this in due course.

2.1. Key Issues

The key issues we seek to raise with the Consultation Paper are as follows.

---

[1] Recommendation 4.8 of the RC's Final Report.
[2] See: https://treasury.gov.au/publication/p2019-fsrc-response

A. Suggested Method to Implement the Recommendation

The FSC's members do not support implementing Recommendation 4.8 by simply deleting Regulation 7.1.33. This is because it would not have the effect that all aspects of claims handling would be automatically considered a Financial Service. If the Regulation were repealed, some activities that claims handlers undertake would be considered Financial Product Advice[3] (such as discussing the benefits an insured may obtain from making a claim under different insurance policies), some would be considered a Dealing (such as providing assistance to make a death claim as this would reduce the benefit to nil), while others would not amount to the provision of a Financial Service (such as sending forms to customers and receiving information from customers).

We consider that simply deleting Regulation 7.1.33 would lead to an inconsistent application of financial services laws, which would lead to confusion as to when they applied. Instead, a tailored approach should be adopted. We submit that a new Financial Service should be introduced, either in the Corporations Act or the Regulations, being that a person provides a financial service if they

"*handle or settle insurance claims*".

This new financial service should not be treated as the provision of an existing Financial Service. One way of doing this would be to allow Regulation 7.1.33 to continue to operate on its terms, but refine it with a note to state that certain activities are regulated as a Claims Handling Service, rather than Financial Product Advice or a Dealing.

B. Definition of Claims Handling and Settling

a. Scope of new financial service

We consider that Treasury ought to carefully consider the scope of the application of the new Financial Service, so as to ensure it does not apply to people or entities to which it was not intended to apply. We consider that the new Financial Service to "handle or settle insurance claims" should capture financial services providers when they make a decision to pay, decline or settle insurance claims, and capture the process involved in making those decisions. Under this test, simply providing information, an opinion or professional services to the insurer which it uses in the course of assessing, handling or managing a claim would not amount to "handle or settle insurance claims". Adopting this test would mean that providers such as medical practitioners, investigators, rehabilitation providers, occupational therapists, accountants, lawyers, and valuers are not caught within the scope of the new Financial Service. We consider this to be appropriate as the services of such providers is not in the nature of a Financial Service. Rather, they are aiding the financial services provider to make a decision regarding the claim. However, the process of synthesising information or documents against the consumer's policy terms in order to make a decision on the claim would amount to a Financial Service. As a result, we expect that claims managers, case managers and claims consultants would be captured under the new law. To assist Treasury in its understanding of the steps involved in handling and settling claims,

[3] Capitalised terms are terms defined in the Corporations Act.

we have set out in Appendix A those steps. If we were to adopt the test set out above, steps 5 and 8 would amount to the provision of a Financial Service, as possibly would steps 4, 7 and 9 as well.

Not only do we consider that the test set out above addresses the issues that came to light in the RC hearings, we also consider it makes commercial sense. If all third parties that provided an opinion or a professional service (such as legal, medical, health, occupational, valuational, accounting or other professional services) were captured by the new law, an unintended consequence that could result would be many of these providers withdrawing from the industry to avoid being deemed to be providing a Financial Service.

b. Treatment of Superannuation Trustees

The FSC and its members consider that the new definition of "handle or settle insurance claims" would not capture superannuation trustees unless they are acting as the insurer's delegate. We say this for the following reasons:

- Trustees are already subject to onerous fiduciary and statutory obligations under the *Superannuation Industry (Supervision) Act 1993 (Cth*) (**SIS Act**). These laws hold trustees to a higher standard than the duty of utmost good faith owed to policy holders by insurers, and already provide significant protection to members in relation to the trustees' role in claims handling. For example, section 52(2) of the SIS Act imposes statutory covenants on trustees:
  - s52(2)(a) to act honestly in all matters concerning the entity;
  - s52(2)(c) to perform the trustee's duties and exercise the trustee's powers in the best interests of the beneficiaries;
  - s52(2)(d)(i) where there is a conflict between the duty of the trustee to the beneficiary, and the duty of the trustee to any other person or the interests of the trustee itself, to give priority to the duty to the beneficiary over the duties to and interests of other persons;
  - s52(2)(e) to act fairly in dealing with classes of beneficiaries within the entity; and
  - s52(2)(f) to act fairly in dealing with beneficiaries within a class.

  Breach of these covenants would be an offence and have civil consequences for trustees and their directors once the *Treasury Laws Amendment (Improving Accountability and Member Outcomes in Superannuation Measures No. 1) Bill 2019* becomes law.

- Trust law imposes fiduciary duties on trustees (including to act in the best interest of beneficiaries of the fund, to act honestly and in good faith, and to avoid conflicts of interest). These fiduciary obligations are supported by a comprehensive body of case law which (as the Consultation Paper points out) requires the trustee to do all that is reasonable to pursue insurance claims with reasonable prospects of success for beneficiaries. These cases detail the actions expected of trustees complying with their duties and signify a well-trodden and well-developed path of protection for members where the role of the trustee is already well understood;

- Trustees may use service providers (like the fund's administrator) to undertake some of the tasks involved in handling insurance claims relating to the fund. The trustee remains liable to the members of the fund for the actions of their service providers and so the same high standards would apply to protect members whether the claims handling activities of the trustee are by the trustee personally or by one of the trustee's service providers.

Therefore, we submit that there would be little additional member benefit to include the services of trustees in the financial service to "handle or settle insurance claims". Adding additional regulatory requirements adds cost which ultimately is likely to be borne by the members of the fund. The underlying insurer though would be caught by the new financial service.

2.2. Responses to Specific Questions

We respond to the specific questions posed in the Consultation Paper below.

No.	Questions from CP	Response
1	Are there additional issues that have not been identified? If so, are there potential options for addressing them within the proposal?	An appropriate transition period should be given. Many of our members will have to obtain an Australian Financial Services Licence (**AFSL**) or a variation to their existing AFSL, and will need to determine whether their existing Responsible Managers have the requisite experience and qualifications to support the new authorisation, or whether they need to appoint new Responsible Managers. We are concerned about ASIC's capacity to grant new AFSLs or variations to AFSLs to potentially large quantities of service providers in short time frames. We therefore submit that 18 months is an appropriate period. This 18 month period assumes that ASIC guidance on the new Financial Service will be released within 6 months. When Treasury issues its Exposure Draft on the Bill, we would expect it to draft a Regulatory Impact Statement which considers: • increased compliance costs following the change in laws; and • a potential obligation to increase capital requirements due to Operational Risk requirements. Treasury should consider whether or not additional training requirements specifically on claims handling for financial advisers is required.
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)?	See comments in Section 2.1 A and B. As to whether or not people falling under the definition of the new Financial Service could be representatives or authorised representatives of life insurers as AFSL holders, this could be problematic because s912C of the Corporations Act allows an authorised representative to represent more than one AFSL holders only in limited circumstances (such as, where each AFSL holder has consented, and where each AFSL holder is a related body corporate of the other). This is an unrealistic requirement when applied to third-party service providers such as medical and vocational specialists.

3	Are there any obligations, besides the existing AFS licencing obligations, that would provide further useful consumer protections in respect of claims handling activities and so should also apply to them?	To the extent that any guidance or regulation is made to outline how claims handlers should meet their obligations under the new law, that guidance/regulation should be cognisant of (and not inconsistent with) the standards set out in the FSC's Life Insurance Code of Practice (**Code**).
4	How could the activity of handling or settling an insurance claim (in relation to life insurance products only) be defined as a financial service for the purposes of the Corporations Act?	See comments in Section 2.1 B. The new Financial Service of "handle or settle insurance claims" should be limited to decisions made prior to the commencement of the External Dispute Resolution (**EDR**) process. At that point the matter is handled by legal representatives of the insurer and, as such, the activity is no longer fairly characterised as claims handling.
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?	Penalties should be proportionate to the activity being undertaken in the course of claims handling and settlement. Standards applied to claims handling should be contextual and cognisant of the training and education necessary to perform claims handling and settlement. We do not consider that the suspension or cancellation of an AFSL is an appropriate penalty for a claims handling breach, as this would mean an insurer could not handle the claims of the rest of its clients, which is its primary role. Penalties in relation to the claims handling service should be applied at the AFSL level, and not to representatives (such as individual claims handling employees).
6	Should it apply only to insurance claims made by retail clients?	Yes, we consider that the carve out should only apply to "retail clients" as that term is defined in the Corporations Act.

APPENDIX A: Steps involved in handling and settling a life insurance claim:

1. An insured person or beneficiary (in the case of Life Claims) contacts the insurer or trustee (in the case of group cover) to indicate an intention to lodge a claim under their policy.

2. Initial enquiries are made with the insured person by a representative of the trustee or insurer to ascertain the cover held by the insured person and the claim they intend to make, and to explain the claims process and information that will be required in order to assess the claim.

3. The insured person or beneficiary/representative completes the required claim requirements. This will typically include medical and employment information, as well as psycho-social factors. In the case of group cover, this process may also be conducted through or with the assistance of the trustee.

4. A claims manager contacts the insured person to explain:
   a. the claims manager's role;
   b. the initial claim requirements;
   c. why certain information is being requested from the insured person; and
   d. where relevant, the waiting period to be met before any payment can be made.

5. The claims manager assesses the claim by reference to the cover type (such as income protection, trauma, total and permanent disablement) and applicable policy definition.

6. The claims manager keeps the insured person/beneficiary/representative appraised of the status of the claims process in accordance with the requirements of the Code.

7. Depending on the cover and claim type, the claims manager may need to obtain medical, employment or financial evidence from third parties. This can include assessment by an independent medical expert, and functional assessment performed by either a medical or vocational expert or rehabilitation expert. The claims manager may also seek guidance from employed Medical Specialists. The claims manager may request information from investigators and forensic accountants in order to better understand the claim. In limited circumstances, and in accordance with the Code, the insurer may also retain a third-party provider to conduct surveillance on the insured person to explore perceived inconsistencies.

8. For lump sum benefits, such as TPD or trauma, once the claims manager determines that the insured person satisfies the policy definition, the insured benefit is paid to the insured person or the trustee. In the case of Life Claims, the claims manager may also have to consult with the beneficiary or their representative.

9. For ongoing benefits, such as income protection benefits, the claims manager may need to continue to monitor the insured person's medical, employment and/or financial position. The claims manager may also need to arrange for the insured person to be medically assessed.

10. The assessment of ongoing claims may also involve third party providers such as rehabilitation specialists, vocational providers, and allied health professionals, typically with a view to helping the insured person return to work.

11. Where a claim is declined, or the insured person expresses dissatisfaction with the claims process, the insurer will commence its internal dispute resolution (**IDR**) process, which may involve its complaints team, or another independent party.

12. If such a claim referred to in step 11 cannot be resolved through the IDR process, it may proceed to EDR.