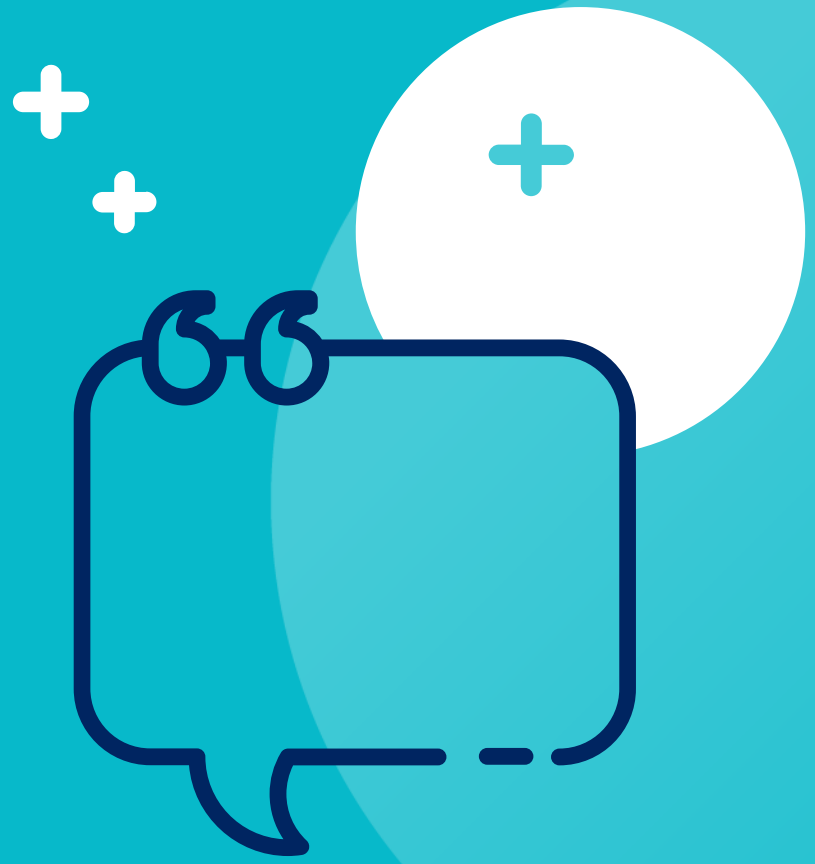

Member forum

Life Insurance

Emma Curtis – Lead Ombudsman, Insurance

Andrew Weinmann – Senior Ombudsman, Life Insurance

Ben Norman – Ombudsman, Superannuation

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Today’s session includes

Setting the scene – the data

Some key themes

Premium increase complaints

Insurance through superannuation

Year at a glance

Between 1 July 2020 to 30 June 2021

Complaints received

70,510
complaints received

12%
decrease in complaints compared to 2019-20

76%
of complaints lodged online

3,562
complaints from small businesses

8,303
complaints related to COVID-19

Products complained about

42,261
Banking and finance

16,912
General insurance

5,249
Superannuation

3,888
Investments and advice

1,623
Life insurance

7.35%
complaints involved financial difficulty

Life insurance complaints

Between 1 July 2020 to 30 June 2021

Complaints received

1,623 complaints received

32% resolved at Registration and Referral stage

Top five life insurance complaints received by product [1]

Product	Total
Income Protection	575
Term Life	290
Total & Permanent Disability	184
Funeral Plans	169
Trauma	115

Top five life insurance complaints received by issue [1]

Issue	Total
Incorrect premiums	213
Denial of claim	212
Delay in claim handling	172
Service quality	141
Misleading product/service information	109

Complaints closed

1,595 complaints closed [2]

Average time to close a complaint
128 days

Stage at which life insurance complaints closed

Stage	Total
At registration	513
At case management	473
Preliminary assessment	225
Decision	280

Average time taken to close life insurance complaints

Time	Total
Closed 0–30 days	10%
Closed 31–60 days	23%
Closed 61–180 days	45%
Closed greater than 180 days	23%

[1] One complaint can have multiple products/issues.
[2] This includes 562 received before 1 July 2020, and 1,033 received from 1 July 2020 to 30 June 2021.

2021 – it’s a wrap

Changes at AFCA

New Lead Ombudsmen and Senior Ombudsmen

Law reform

Post FSRC – DDO, claims handling, disclosure obligation, UCT, DSM, hawking, breach reporting, RG 271

Business as usual – the new normal

COVID

Industry sustainability and IDII

Key learnings

- Engage with us early!
- Have you done everything you can to resolve the dispute?
- If you can’t resolve the dispute - have you given us all relevant documents

Funeral expense policies

- AFCA continues to see a high number of cases where consumers – in particular, First Nations Australians – believe they have been misled into buying funeral plans
- Funeral plans were in the top 5 life insurance products complained about in 2020-21
- In the last 15 months, AFCA received 260 funeral plan complaints
- More than half of them were from people who identified themselves as Aboriginal or Torres Strait Islander peoples
- AFCA has awarded over $700,000 in refunds and compensation as a result

> Case Study:

- Door to door sales of an Aboriginal funeral fund product
- Brief verbal explanation of the funeral fund, with fortnightly payments from Centrelink
- Plan cancelled in 2019 for non-payment of premiums
- AFCA panel found the sale was unsolicited and mislead a person who was vulnerable
- Firm was ordered to refund premiums paid, with interest

Systemic Issues – Year at a glance

AFCA Annual Review financial year 2020–21

Identified **1086** potential systemic issues

Referred **147** systemic issue investigations to financial firms

Reported **55** definite systemic issues to regulators

Resolved **59** definite systemic issues with financial firms

Reported **36** possible serious contraventions to regulators.

Identified and investigated systemic issues resulting in the remediation of **357,959** consumers.

Ensured more than **$31 million** in refunds were made to consumers.

Systemic Issues in Life Insurance

AFCA Annual Review financial year 2020–21

Identified **43** potential systemic issues

Referred **17** systemic issue investigations to financial firms

Reported **19*** definite systemic issue to regulators

Resolved **10** definite systemic issues to regulators

Incorrect premium increases on trauma insurance policies and **delays in claim handling on TPD and income protection policies** were the top complaint themes linked to Definite Serious Contravention reports to regulators

Claims delays and denials for income protection, TPD and term policies formed the basis of the most referrals for investigation

*The reported number is higher than the referred to firms to account for dual reporting of the same systemic issue to more than one regulator such as both ASIC and OAIC.

Case Study – Life Insurance

Systemic Issue – Misleading Conduct

We investigated possible misleading conduct regarding increases in insurance premiums after the age of 70.

- our initial enquires related to whether the firm's disclosures about insurance premium increases after the age of 70 were adequate
- investigations found that the policy was designed so that premiums were capped at age 70, but a system issue meant this did not occur in practice

Following the investigation the firm confirmed that it was implementing:

- system changes to resolve the issue
- a remediation program for affected policy holders, with total refunds for current policyholders estimated to be over $20,000 and affected former policy holders yet to be determined

Fairness Jurisdiction Project

We have finalised our project

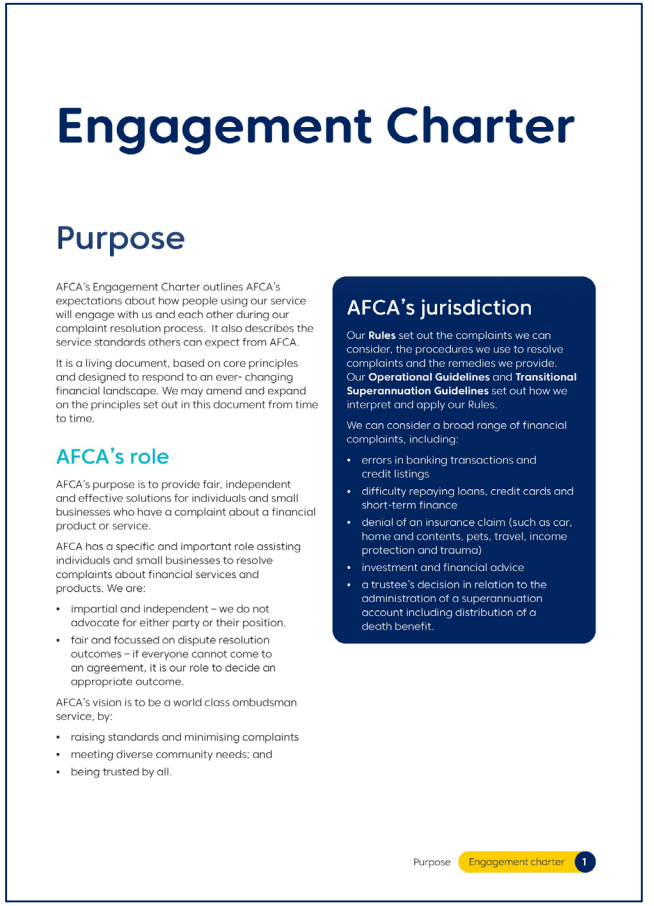
- Our aim was to create a framework for how we operate in our fairness jurisdiction, making decisions and providing dispute resolution in a fair, independent and consistent way.
- We have:
  - described and benchmarked our fairness jurisdiction both domestically and internationally
  - built a framework to assist AFCA staff to consistently apply the fairness jurisdiction in our complaint handling
  - articulated how the parties should engage with each other and AFCA to ensure a fair process
  - explained our approach to delivering fair outcomes; and
  - designed systems to calculate and capture fair outcomes once achieved.
- We thank all of our stakeholders who we engaged with during 2019 to 2021 for their thoughtful feedback which helped shape our work and considerations.

Fairness Jurisdiction Project

AFCA Engagement Charter

- We recently launched the AFCA Engagement Charter
- The Engagement Charter shares AFCA's values and outlines the behaviour we expect from financial firms, complainants and AFCA employees when resolving disputes
- It is a living document that makes the roles, responsibilities and expectations of each party more explicit so that our stakeholders have a shared understanding of good conduct

See more
www.afca.org.au/engagement-charter



Engagement Charter

Purpose

AFCA's Engagement Charter outlines AFCA's expectations about how people using our service will engage with us and each other during our complaint resolution process. It also describes the service standards others can expect from AFCA.

It is a living document, based on core principles and designed to respond to an ever- changing financial landscape. We may amend and expand on the principles set out in this document from time to time.

AFCA's role

AFCA's purpose is to provide fair, independent and effective solutions for individuals and small businesses who have a complaint about a financial product or service.

AFCA has a specific and important role assisting individuals and small businesses to resolve complaints about financial services and products. We are:

- impartial and independent – we do not advocate for either party or their position.
- fair and focussed on dispute resolution outcomes – if everyone cannot come to an agreement, it is our role to decide an appropriate outcome.

AFCA's vision is to be a world class ombudsman service, by:

- raising standards and minimising complaints
- meeting diverse community needs; and
- being trusted by all.

AFCA's jurisdiction

Our **Rules** set out the complaints we can consider, the procedures we use to resolve complaints and the remedies we provide. Our **Operational Guidelines** and **Transitional Superannuation Guidelines** set out how we interpret and apply our Rules.

We can consider a broad range of financial complaints, including:

- errors in banking transactions and credit listings
- difficulty repaying loans, credit cards and short-term finance
- denial of an insurance claim (such as car, home and contents, pets, travel, income protection and trauma)
- investment and financial advice
- a trustee's decision in relation to the administration of a superannuation account including distribution of a death benefit.

Purpose Engagement charter 1

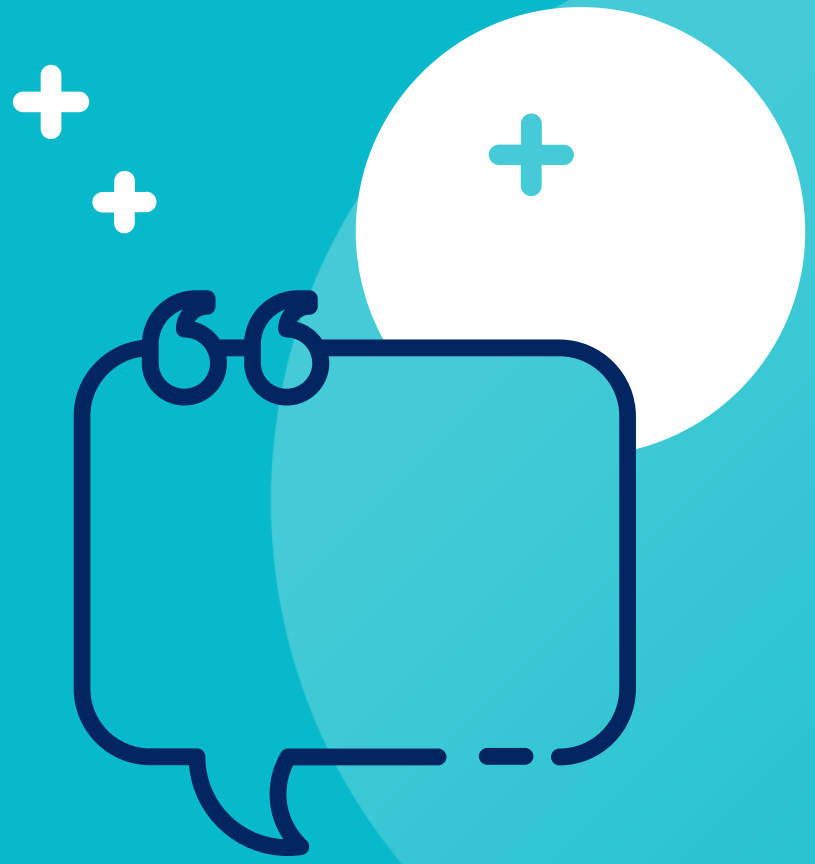
Fairness Jurisdiction Project

Approach to Terms of Settlement

- We recently completed the final element of the fairness framework
- Ensuring that the parties capture and document fair outcomes when complaints are resolved is an important aspect of our fairness jurisdiction
- ASIC also requires us to report when terms of settlement are unfair or inappropriate
- AFCA's revised Approach to Terms of Settlement has been published and includes information about how to prepare terms of settlement and how terms of settlement can affect a further or current complaint with AFCA
- We are taking feedback until 8 December 2021

See more

www.afca.org.au/about-afca/publications/approach-terms-of-settlement



Premium increase complaints

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Premium increase complaints are common

- AFCA gets a lot of complaints about premium increases

- Two main drivers
  - stepped premium increases
  - premium re-rates

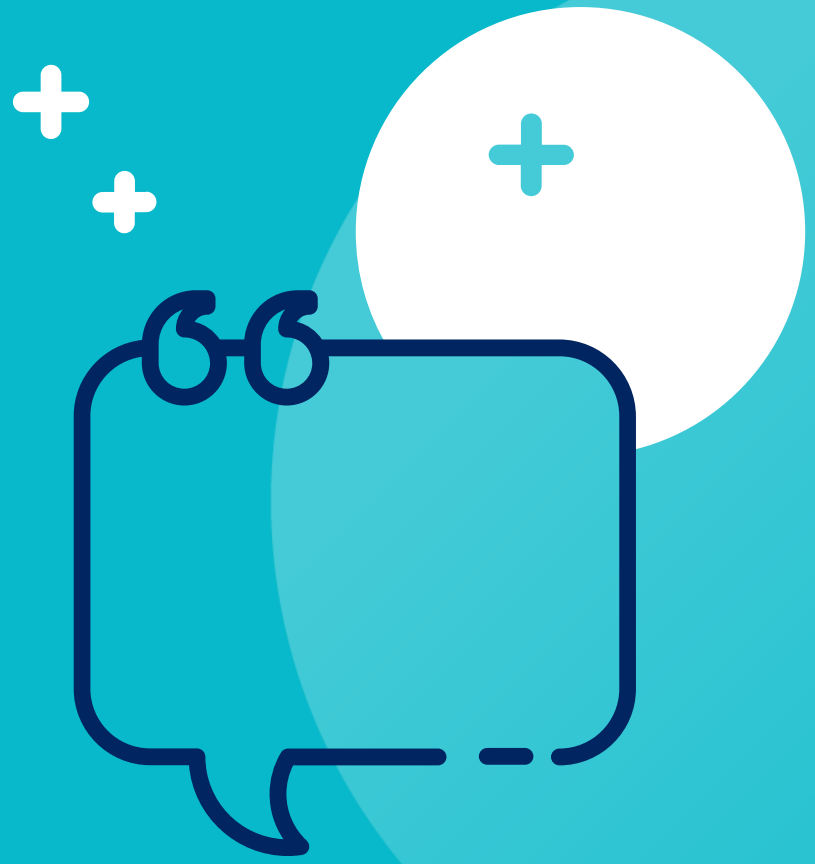
- Stepped premium increases
  - One in every 16 complaints to AFCA involves a misunderstanding or complaint about stepped premiums
  - Many customers don't understand how fast stepped premiums can increase
  - in many cases insurers give no information at all about it, or not enough
  - Improvements in industry practice are necessary
  - AFCA has made submissions to the Life Code review saying that information about the rate of increase needs to be given at point of sale and on renewal

Case study – stepped premium increases

- Complainant bought a stepped premium policy over the phone
- He asked what the cover would cost
- Insurer said 'it does go up each year, very slightly, based on your age and the benefit amount'
- Complainant pressed for information about the cost of cover, but was only given the same general and vague information about a 'slight' increase each year
- None of the documents sent to the complainant by the insurer showed the rate of increase
- No premium projection was provided
- Stepped premium increases were in fact not 'slight', but quite steep
- Disputes about premiums led to two complaints. The first was determined in the complainant's favour, and the second was on the verge of being determined when the parties reached an agreement
- Similar to a previous FOS determination 486847 – where FOS found insurer could not increase stepped premiums by more than it indicated when it sold the policy

Premium re-rates – case study

- AFCA understands the problems with losses in IP, and is aware of APRA's concerns and intervention in the market.
- AFCA has a limited jurisdiction in cases about premiums, and will exclude complaints which are outside our jurisdiction.
- AFCA has circulated a draft Approach document for complainants and insurers on premium increase complainants for consultation; we are considering the feedback and will publish the Approach document soon.
- Case Study
  - customer lodged complaint saying premium increase was higher than expected and wanted the insurer to justify it
  - no allegation of misleading conduct
  - Insurer lodged jurisdictional objection, with stat dec by Head of Pricing explaining there had been a re-rate, on actuarial advice, because it was necessary to maintain a sustainable product, and that the re-rate was applied to all customers
  - Insurer also provided policy document and all relevant communications
  - AFCA ruled the dispute outside of its jurisdiction



Insurance through superannuation

Income Protection & Covid-19

Ben Norman - Ombudsman

Income Protection in Superannuation

- We receive more TPD complaints than IP complaints in AFCA's superannuation stream
  - Only about eight funds provide default IP cover
  - However, IP complaints are a growing percentage of our work

- AFCA received 695 IP complaints (in superannuation) from 1 January 2021 to 30 September 2021 compared with 826 TPD complaints for same period (approximately 84% IP claims as a ratio against TPD claims)
  - In the prior year, AFCA received 901 IP complaints compared with 1111 TPD complaints (approximately 81% IP claims as a ratio against TPD claims).

- We see recurring issues in dispute (offsets, definitions of salary and disability, calculations of pre-disability income and application of business expenses)
- We are also seeing emerging issues in relation to Covid – including whether JobKeeper is income for the purposes of calculating pre-disability income
  - No determinations on this issue yet

Case study – under the regular care of a medical practitioner (766228 & 776311)

- Complainant made a claim for IP benefits under cover held through superannuation. Claim based on mental health related matters (including significant anxiety-based symptoms)
- The complainant met with his GP on 3 March 2020, who recommended the complainant meet with his counsellor for the next two months and if no improvement then appointment with psychiatrist in third month
- The complainant did not meet with his counsellor again until 29 June 2020 and then again on 13 July 2020
- Some initial benefits paid for earlier periods when complainant had been regularly meeting with his counsellor; however, insurer ceased paying benefits on the basis the complainant failed to comply with the policy requirement of:

  …under the ongoing and appropriate care of a medical practitioner, including complying with the regular advice and treatment given by that medical practitioner except to the extent that the insured member has declined to follow that advice or treatment on reasonable grounds
- Insurer declined on basis of the gap between seeing GP and counsellor – non-compliance with the treatment plan
- The trustee agreed with the insurer's decision to not pay any further IP benefits

Case study - continued

- AFCA found that the insurer's decision to cease paying benefits completely was not fair and reasonable and set aside the insurer's decision; AFCA substituted a decision that the insurer should pay benefits for the June 2020 and July 2020 monthly periods
- AFCA also found that the trustee's decision to agree with the insurer was not fair and reasonable and set aside the trustee's decision
- The Ombudsman noted that:
  - Complainant had *reasonable grounds* not to follow treatment immediately due to stage 3 lockdowns in Metropolitan Melbourne during the period 30 March 2020 – 11 May 2020
  - Complainant had reconnected with his counsellor in the first month after restrictions eased (June 2020)
  - Access to telehealth was not widely available during the first Covid restrictions for the entire community and complainant had some additional barriers (unstable housing and issues with access to a mobile phone), and
  - Complainant was living with anxiety symptoms when Covid-19 became prevalent in Australia, and it was not unreasonable to consider the complainant may have been anxious about face-to-face appointments, in the event his counsellor offered face-to-face appointments

Case study - continued

- From the determination:

  The insurer has said that it is quite reasonable to expect that a person who is claiming... IP benefits would be under the ongoing treatment of a medical practitioner. I agree with this position and do consider that in normal circumstances this may be the case... However, the world was anything but normal in March 2020 due to the COVID-19 pandemic.

  With the benefit of hindsight, it is easy to feel a degree of calm about how matters unfolded in March 2020; however, at the time it was deeply unsettling, and I imagine this must have been especially the case for the complainant who was living with anxiety...To my mind, this gap in following the treatment plan is reasonable considering the COVID-19 pandemic

- Key take-away: consider the impact (if any) that COVID has on whether a complainant has reasonable grounds not to follow medical treatment including:
  - Access and availability of health services (including telehealth)
  - The impact of the pandemic on those already living with mental health issues (does more flexibility need to be shown than normal?)
  - Whether treatment plans made pre-COVID are still suitable during COVID, and therefore whether the failure to comply with treatment plans amounts to failure to follow reasonable care
  - Not to judge people too harshly who may have ceased engagement with medical professionals and insurers during COVID

Thank you

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