



**ASIC**  
Australian Securities &  
Investments Commission

## EXECUTIVE SUMMARY TO REPORT 633

# Holes in the safety net: A review of TPD insurance claims

October 2019

### About this report

This is the executive summary to Report 633 *Holes in the safety net: A review of TPD insurance claims* (REP 633), which summarises the findings and recommendations from ASIC's thematic review of total and permanent disability (TPD) insurance in Australia.

In particular, the report reviews outcomes for consumers, claims handling practices, the role of data in managing the risk of consumer harm, and our findings on insurers with higher than predicted rates of declined claims.

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- explaining how ASIC interprets the law
- describing the principles underlying ASIC's approach
- giving practical guidance (e.g. describing the steps of a process such as applying for a licence or giving practical examples of how regulated entities may decide to meet their obligations).

**Information sheets:** provide concise guidance on a specific process or compliance issue or an overview of detailed guidance.

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Examples in this report are purely for illustration; they are not exhaustive and are not intended to impose or imply particular rules or requirements.

## Contents

<b>Executive summary</b> .....	<b>4</b>
What we did in this review.....	6
Summary of findings.....	7
Poor consumer outcomes from the ‘activities of daily living’ test.....	7
Frictions in claims handling leading to withdrawn claims.....	9
Consumer harm arising from poor data.....	11
Insurers with higher than predicted declined claim rates.....	13
ASIC’s expectations and action .....	16

## Executive summary

- 1 Total and permanent disability (TPD) insurance is a type of life insurance that pays a lump sum if the consumer becomes totally and permanently disabled under the terms of the insurance policy. Its purpose is to replace future retirement savings lost due to disablement. A TPD benefit can also help with the costs of rehabilitation, debt repayments and future costs of living.
- 2 TPD insurance is widely held—over 13.4 million consumers have TPD cover and almost 90% are insured through their superannuation fund. It plays a crucial role as a safety net in supporting the financial security of Australians. During the 12 months to 31 December 2018, TPD insurance premiums totalled \$3.548 billion and consumers made more than 26,000 claims.
- 3 This report builds on ASIC’s previous review of life insurance in [Report 498](#) *Life insurance claims: An industry review* (REP 498). In REP 498 we identified several concerns about TPD insurance including above-average declined claim rates, high rates of withdrawn claims and poor claims-processing times. We undertook to review TPD claims processes.
- 4 In [REP 498](#) we found that only 65% of notified TPD claims were accepted by insurers, with the balance of claims either declined by the insurer or withdrawn by the consumer. We were concerned that the acceptance rate indicates problems both with the design of TPD policies (with cover being too restrictive under some policies) and with claims handling procedures.
- 5 This report identifies four important industry-wide issues that insurers and superannuation trustees must fix: see Table 1. They are not the only problems associated with TPD insurance. Other issues include the role of rehabilitation providers and the difficulty of comparing TPD definitions particularly in the context of insurance in superannuation (both of which are touched on in this report).
- 6 However, we consider that these four issues in particular create poor consumer outcomes and are connected to our undertaking in [REP 498](#) to review TPD claims processes. We expect insurers and superannuation trustees to address the problems we have identified. ASIC will also take action to address these issues. We have set out ASIC’s expectations and actions in Table 3.
- 7 ASIC will take further action, including enforcement action where appropriate, against insurers and superannuation trustees who fail to properly address our concerns. We will also consider using our product intervention powers to prevent harm to consumers.

**Table 1: Four key industry-wide issues in the TPD market**

Issue	What we found
<b>Poor consumer outcomes from the 'activities of daily living' test</b>	<p>Many insurers selling policies with restrictive cover based on the 'activities of daily living' (ADL) disability test. These policies make some consumers eligible only for a narrow form of TPD cover due to their work status (e.g. non-permanent, casual or part-time employees). This narrow cover pays out only if consumers cannot perform several 'activities of daily living' such as feeding, dressing or washing themselves.</p> <p>We consider that these policies are not designed for, and do not operate to meet the needs of, the broad range of consumers who are funnelled into this type of cover. These policies do not appear to provide cover for all consumers who are unable to work again—they provide cover only to consumers who are so severely disabled that they cannot care for themselves.</p>
<b>Frictions in claims handling leading to withdrawn claims</b>	<p>Approximately 12.5% of TPD claims during the period of our review were withdrawn. We consider that this high withdrawal rate is, at least, partially due to insurers subjecting consumers who are vulnerable (due to life-altering illness or injury) to a claims process that is often unnecessarily challenging and onerous.</p>
<b>Consumer harm arising from poor data</b>	<p>Insurers had significant deficiencies in their ability to record and search for relevant claims data. Without accurate and timely data, insurers cannot identify problems in their products or processes, or determine the changes needed to address problems and improve consumer outcomes. Insurers will need better data to help them meet the design and distribution obligations, which will take effect from April 2021.</p>
<b>Insurers with higher than predicted declined claim rates</b>	<p>Claims with certain characteristics such as the type of underlying condition or occupation of the consumer had higher than predicted declined rates. Our analysis also found that three insurers had higher than predicted declined claim rates: see paragraphs 41–46.</p>

### Key role of superannuation trustees

Insurance is an important feature of the superannuation system and most superannuation funds offer their members life insurance cover in addition to retirement benefits. Trustees of MySuper products are generally required by law to offer members death cover and TPD cover on an opt-out basis. MySuper products are designed for a broad range of consumers including those who are highly disengaged.

While our review was focused on insurers, superannuation trustees play a crucial role in the delivery of life insurance to superannuation fund members, as they must approve the design of the policy, choose an insurer and agree commercial terms, and act as the policy holder for group insurance.

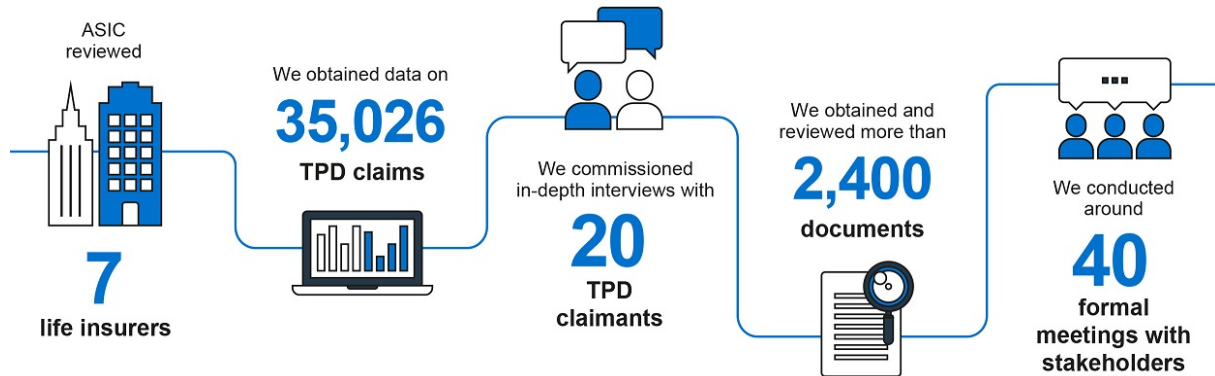
We expect superannuation trustees to act in their members' best interests by providing access to affordable insurance products that are suitably designed for their members. This includes safeguarding their members' superannuation balances from inappropriate erosion.

We also expect superannuation trustees to play a robust role alongside insurers in ensuring a good claims experience for consumers. This role encompasses not just advocating for claims with reasonable prospects of success, but also actively engaging with the consumer's claim journey to make sure processes are simple, timely and transparent. This includes the management of any insurance-related complaints.

## What we did in this review

8 Figure 1 summarises the different elements of our review. For further details of our methodology, see Appendix 1 of this report. The review covered the period from 1 January 2016 to 31 December 2017.

Figure 1: What we did



Note: See Appendix 1 of this report for an accessible version of the information contained in Figure 1. For details of the methodology and limitations of our consumer research, see paragraphs 358–365 in Appendix 1.

- 9 The following insurers were included in our review:
- (a) AIA Australia Limited (AIA);
  - (b) AMP Life Limited (AMP) and The National Mutual Life Association of Australasia Limited—part of the AMP Group of companies;
  - (c) Asteron Life & Superannuation Limited (Asteron)—previously known as Suncorp Life & Superannuation Limited (Suncorp);
  - (d) MetLife Insurance Limited (MetLife);
  - (e) MLC Limited (MLC);
  - (f) TAL Life Limited (TAL); and
  - (g) Westpac Life Insurance Services Limited (Westpac).

Note: On 28 February 2019, the Suncorp Group announced the completion of the sale of its life insurance business to Japanese insurer Dai-ichi Life Holdings, which also owns TAL. See Suncorp Group, [Completion of Australian life business sale](#) (PDF 22 KB), ASX announcement, 28 February 2019.

## Summary of findings

### Poor consumer outcomes from the ‘activities of daily living’ test

**Finding 1: Claims assessed under the ‘activities of daily living’ test generally result in poor outcomes, with three out of five such claims being declined**

- 10 TPD cover is designed for people who are totally and permanently disabled. However, the meaning of total and permanent disablement varies between the different TPD products distributed by insurers.
- 11 Most consumers who make a claim are assessed under the so-called ‘any occupation’ or ‘own occupation’ tests. Under these tests, consumers making a claim are considered totally and permanently disabled if they are unable to work in ‘any occupation’ or their ‘own occupation’ again. However, some consumers may be paying premiums for TPD cover under a more restrictive policy definition—the ‘activities of daily living’ (ADL) test.
- 12 We found that the declined rate for TPD claims assessed under the ADL test was very high: 60%, or three in five claims, were declined. This was five times higher than the average declined rate for all other TPD claims (12%).
- 13 Although ADL claims represented a relatively small percentage of all TPD claims in our review (4%), based on the 26,150 TPD claims made across all life insurers in 2018 this translates to almost three claims per day being assessed under this restrictive definition.
- 14 The declined rates for TPD claims assessed under the ADL test were concerningly high for some group superannuation policies. The 10 highest ADL declined rates at group policy level ranged from 45% to 87%: see paragraphs 114–118 and Table 6 in this report.
- 15 There is the risk of harm when consumers pay for ADL cover in that:
- (a) they are paying premiums for insurance cover that they are unlikely to be able to successfully claim on and therefore cannot rely on if they are disabled;
  - (b) because most consumers have automatic insurance through their superannuation, they generally pay the same premium regardless of whether, in the event of a claim, they are eligible for ADL-only cover or more general TPD cover; and
  - (c) economically vulnerable consumers are especially disadvantaged as the eligibility criteria often mean that casual, contract or seasonal employees are funnelled into ADL-only cover.

**Finding 2: Eligibility criteria in group insurance cover mean that some consumers are automatically funnelled into low-value ADL cover which may not be worth paying for**

- 16 Consumers who do not meet certain eligibility criteria in group cover are often assessed under the restrictive ADL definition.
- 17 The eligibility criteria in group TPD cover mean that the following consumers are typically funnelled into the narrower ADL definition:
- (a) casual, seasonal or part-time employees who work less than a specified number of hours (e.g. 15 hours per week);
  - (b) people who have been unemployed or on leave without pay for a stated period before the TPD event (often six months, but for some policies 12 months); and/or
  - (c) people in specified occupations that the insurer considers are high risk.
- 18 ASIC is concerned that these types of eligibility criteria unfairly affect more vulnerable consumers, including unskilled workers, people with parental or other caring responsibilities, and workers in certain industries such as retail and hospitality. With the changing nature of the workforce and the growth of the ‘gig economy’, these types of eligibility criteria will capture an increasingly broad range of consumers.
- 19 The risks to consumers who hold these types of group policies are heightened by the low level of engagement that most consumers have with insurance in superannuation. As the Productivity Commission noted in its recent report on superannuation, 24% of superannuation members surveyed did not know whether there was insurance in their fund, and a further 16% knew they paid for insurance but did not know what they were covered for. These consumers are likely to be unaware that their insurance may provide less cover if their employment changes. Consumers are relying on unusable cover when they could potentially purchase more suitable cover.
- Note: See Productivity Commission, [Superannuation: Assessing efficiency and competitiveness](#), inquiry report no. 91, December 2018 (Productivity Commission report), pp. 384–5.
- 20 The fact that 4% of TPD claims are assessed under the ADL test means that at least 4% of the 12 million consumers (480,000) who hold TPD in superannuation are potentially at risk of unusable or inadequate cover.
- 21 The complexity of and lack of comparability across insurance offerings also make it difficult for consumers to compare policies and understand the cover they have. Our findings endorse the need for greater standardisation of terms, especially within superannuation.



**Finding 3: The ADL test is unsuitable for a range of common illnesses and injuries, including mental illness and musculoskeletal disorders**

- 22 The ADL test is suited only to disability caused by the most catastrophic type of injury or illness. When we compared declined claim rates for certain conditions under the narrower ADL definition with rates under the broader general TPD definition, we found that:
- (a) mental health claims were approximately five times more likely to be declined (77% for ADL compared to 15% for the general definition); and
  - (b) musculoskeletal claims were more than five times more likely to be declined (71% for ADL compared to 13% for the general definition).
- 23 The concerning high declined claim rate for consumers with mental illness or musculoskeletal disorders assessed under ADL indicates that this type of restrictive TPD cover is unsuitable for many consumers to whom it is being provided or sold. These medical conditions may be a common cause of disability for certain classes of employees (e.g. manual workers who may be more susceptible to musculoskeletal injuries yet whose employment arrangements mean they are defaulted into ADL-only TPD cover).
- 24 We are aware that one insurer has removed ADL cover from some TPD policies offered within superannuation. This is a step in the right direction.
- 25 Superannuation trustees have a key role to play: they have a legal obligation to offer insurance benefits for fund members (consumers) that are both appropriate and affordable. Considering the needs of different consumer cohorts may require careful balancing by trustees, and some degree of cross-subsidisation is inherent in group insurance as it involves pooling risk. However, we expect insurers and trustees to stop providing ‘junk’ insurance products to consumers. Trustees and insurers must ensure that the products they design and/or distribute are suitable for the consumers to whom they are provided or sold.

**Frictions in claims handling leading to withdrawn claims**

**Finding 4: Insurers do not have sufficient understanding of the reasons for withdrawn claims**

- 26 Withdrawn claims are an important indicator of potential consumer harm. Consumers suffer harm if claims handling processes contain frictions which result in consumers withdrawing potentially valid claims. The way in which a claim is withdrawn, and the timing of the withdrawal, may indicate where there are frictions in the claims handling process. Withdrawn claim rates may also mask real declined claim rates.

- 27 Insurers were generally poor at capturing reasons for withdrawn claims. We found that for over 50% of withdrawn claims, the reason given by the insurer was lack of response by the consumer to a request for information. This lack of response could be driven by factors which, if identified, could be properly addressed.
- 28 The second most common reason recorded was the consumer withdrawing for reasons other than eligibility or return to work (31%). Insurers did not record the actual reason for these active withdrawals.
- 29 While we acknowledge that it is not always possible for an insurer (or superannuation trustee) to know the reasons for withdrawn claims, we expect insurers to improve their understanding of these reasons. When a consumer begins a claim via a trustee for insurance held in superannuation, a superannuation trustee has obligations to pursue insurance claims for members. Therefore, we expect trustees to improve their own understanding of the reasons for withdrawn claims.

**Finding 5: Insurers' claims handling practices create frictions that contribute to consumers withdrawing claims**

- 30 Our consumer research found that consumers had limited time, ability, focus and/or funds to manage a TPD claim because they:
- (a) were typically impaired or in pain due to a life-altering illness or injury;
  - (b) were often dealing with numerous other issues connected with their illness or injury—medical appointments, overdue bills and debt collectors, or separate legal processes (e.g. WorkCover, claims against their employer, and public liability insurance claims); and
  - (c) had limited or no income to live on.
- 31 Information obtained from insurers together with our consumer research identified numerous frictions for consumers in the claim assessment process, including the following:
- (a) *Poor insurer communication practices*—The way in which insurers' claims staff communicated with consumers had a significant effect on consumer experience; empathetic and proactive communication is key to good claims-handling practice.
  - (b) *Multiple requests for further medical assessments*—These requests often seemed unreasonable or unnecessary and were a concern reiterated throughout our consumer research.
  - (c) *Potentially threatening behaviour, including surveillance of claimants and questionable allegations of fraud*—Seven out of 20 consumers we interviewed in our consumer research were subject to physical surveillance and reported experiencing additional stress. This was not drawn from a representative sample of claims (details of the

methodology used are contained in Appendix 1 of this report). Yet our data analysis showed that where physical surveillance was used more broadly, the insurer ultimately admitted the claim in over 60% of cases.

- (d) *Excessive delay*—Delay in receiving a claims decision was an issue for many of the consumers who participated in our consumer research. ‘Unexpected circumstances’ allow insurers to extend the promised timeframe in the Life Insurance Code of Practice (Life Code) for a TPD claims decision from six months to 12 months.
- (e) *‘Fishing’ for non-disclosure*—The Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry (Royal Commission) raised concerns about insurers seeking to avoid claims by relying on a legal technicality rather than supporting the consumer through the claims process.
- (f) *Ongoing costs of the claims process*—The claim assessment process, including being asked to attend multiple medical appointments, can be ‘time consuming, costly and painful’.
- (g) *Changes to claims staff*—Several consumers emphasised the difficulties they encountered when the staff managing their claim changed. We found that several insurers in our review had a claims staff turnover rate near or above 25% for one of the two years of our review.

32 Our consumer research and data analysis showed that these practices and the frictions they created contributed to the withdrawal of 4,365 claims during the period of our review—approximately one out of eight claims reported.

### Consumer harm arising from poor data

#### Finding 6: Insurers did not have adequate data to effectively manage the risk of consumer harm

33 Good data is key for the effective and proactive management of the risk of consumer harm. To effectively manage consumer harm, insurers need data that is timely, accurate, adequate and complete and that uses consistent definitions. Without timely and insightful data, insurers cannot proactively identify and address, in a targeted manner:

- (a) the value of products to consumers and whether the products are meeting consumer needs;
- (b) key friction points in the TPD claims handling process;
- (c) claims handling staff whose conduct may give rise to a higher likelihood of consumer harm;
- (d) claims handling practices leading to consumer harm; and
- (e) harm caused to consumers at either a granular or consolidated level.

- 34 Our review found that, to varying degrees, all seven insurers failed to meet our criteria for ‘good data’ during 2016 and 2017, for the reasons set out in Table 2.

**Table 2: Findings on insurers’ data resources**

<b>Insurers’ responses to our data requests were slow</b>	No insurer could provide a complete response to our data request by the due date (a reasonable time in which to respond). Full responses from some insurers were still outstanding five months after we requested claims data under statutory notice.
<b>Crucial data was not readily available in searchable formats</b>	All insurers needed to conduct manual reviews to extract relevant data, including reviewing paper files.
<b>Some requested data was not available at all</b>	Some insurers could not tell us how many claims they had assessed under an ADL definition. Most insurers could not provide accurate data on something as fundamental as whether a consumer had withdrawn a claim because they had returned to work.
<b>All insurers’ responses contained errors</b>	Some insurers resubmitted errors to ASIC after we had informed them of the errors in our initial feedback.
<b>There were no standard definitions for key data</b>	This lack of consistency was particularly problematic for claims notification and lodgement. For example, insurers used a range of practices to record when a claim ‘begins’. This issue has been improved through work undertaken with the Australian Prudential Regulation Authority (APRA)—the ASIC-APRA life claims data collection work.
<b>Insurers did not have access to comprehensive data about insurance in superannuation claims</b>	For some insurance in superannuation claims, insurers became involved in a claim after the superannuation trustee passed details of a claim and the consumer on to them. Insurers usually did not have information about what occurred before the claim was passed on to them—including the amount of time since the consumer first notified the trustee of the claim, which is fundamental to understanding how a consumer has been pursuing a claim.

- 35 No insurer had a holistic, up-to-date picture of the potential consumer harm arising from TPD claims handling and outcomes. They could only get this information from reactive, post-event quality assurance reviews, audits or analysis—by which time conduct risk and consumer harm had already crystallised.

**Finding 7: Despite some improvements, insurers must invest more time, resources and funds to strengthen data resources to effectively reduce the risk of consumer harm**

- 36 Insurers are already improving their data capability largely to meet the requirements of APRA and ASIC’s data collection initiatives. However, insurers must do more to address the issues we have identified. We expect boards and owners of all insurers to ensure there is sufficient investment in the business to appropriately manage the risk posed by inadequate data resources. This will require additional investment and the active engagement

of boards and senior management. We also expect superannuation trustees to ensure that they receive adequate data from insurers to manage the risk of harm to their members (consumers).

- 37 Recent and anticipated changes to life insurer ownership create an opportunity for these issues to be resolved. We are aware of at least one new owner investing in data and systems since buying a life company from an Australian bank, and we encourage other owners to do the same.

### Insurers with higher than predicted declined claim rates

**Finding 8: Different factors, such as the TPD definition, the consumer's age and the underlying TPD condition, have significantly different likelihoods of a claim being declined—unfairly affecting some consumers**

- 38 We analysed the data we collected and used statistical modelling to identify factors that were statistically significant in relation to the likelihood of a claim being declined. Based on the results, ASIC is concerned that consumers with these characteristics may be receiving unfair treatment.
- 39 In addition to the significant variations between claims assessed under different TPD definitions, we made the following findings across the seven insurers:
- (a) There was a significant difference between the declined rates for disease-related claims and for claims for other conditions. Mental illness-related claims had the highest declined rate at 16.9% closely followed by injury or fracture conditions at 16.1%. TPD claims for disease-related conditions had a lower declined rate of 9.7%. While there may be legitimate reasons for this difference, we expect insurers to ensure that their claims handling procedures are not operating unfairly for consumers with mental health, injury or fracture conditions.
  - (b) The rate of declined claims decreased as the age of the consumer increased. This could be expected, as it is more difficult for an insurer to determine that a younger person will never be able to work again, than to determine the same for an older person. However, two insurers—MLC and TAL—had a noticeably lower rate of declined claims for younger consumers. We will be working with the other insurers to understand this difference.
  - (c) The age of the policy at the claim event date (the number of days since the policy began, to the date of the TPD claim) is significant. Generally, the longer a policy is in force, the lower the declined claim rate.
  - (d) The length of any delay in claim reporting is significant. Claims that were reported more than 1,000 days after the claim event were declined at a higher rate—around 17.4% compared to 12.4% for other claims. We will be working with insurers, particularly where the insurer on risk

for a claim is no longer the current insurer for the relevant superannuation fund, to understand this difference.

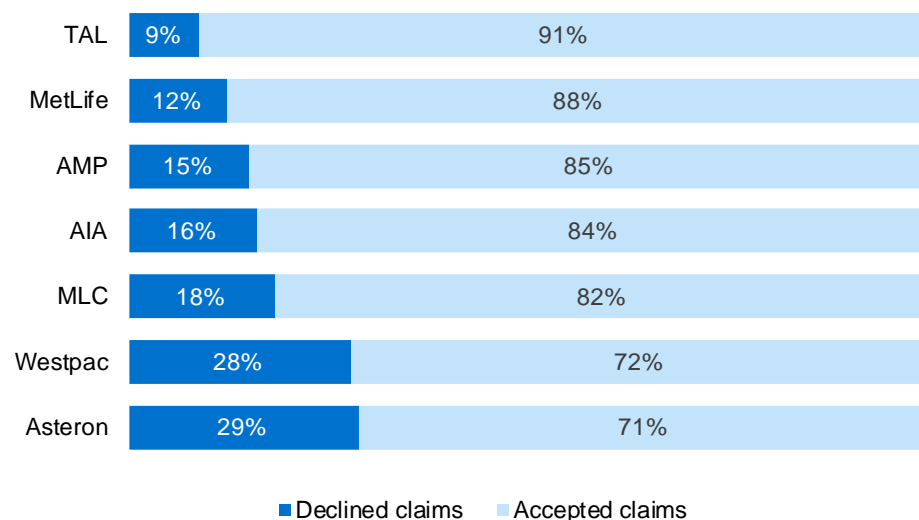
- (e) There was only a slight difference between the declined rates for claims on group policies (13.6%) and for retail policies (14.5%).

40 We expect all insurers to review their claims handling practices in light of this analysis to ensure they are not treating groups of consumers unfairly.

### Finding 9: TPD declined claim rates varied significantly between individual insurers

41 As Figure 2 shows, TPD declined claim rates varied significantly among insurers, from TAL with a declined rate of 9% to Westpac and Asteron with declined rates of 28% and 29% respectively.

**Figure 2: Declined claim rates for TPD cover, by insurer (2016–17)**



Source: ASIC data collection

Note 1: Some of the difference in declined claim rates between insurers can be explained by the relative mix of each insurer's policy portfolio and distribution channel including:

- distribution channels: the declined claim rates vary for group (13.6%), retail (14.5%) and direct (22.6%) (see Table 20 in this report); and
- policies open for sale and closed to sale (i.e. legacy products).

Note 2: See Table 24 in Appendix 2 of this report for the underlying data (accessible version).

42 We collected data about more than 35,000 TPD claims to improve our understanding of these declined rates. The granularity of our data collection allowed us to conduct industry-wide analysis that, to our knowledge, has not been undertaken in the Australian life insurance market before. By assessing the individual characteristics of each claim, we were able to predict the declined claim rate for each insurer based on the features of its claims and then identify factors that contributed to any variance from the predicted rate.

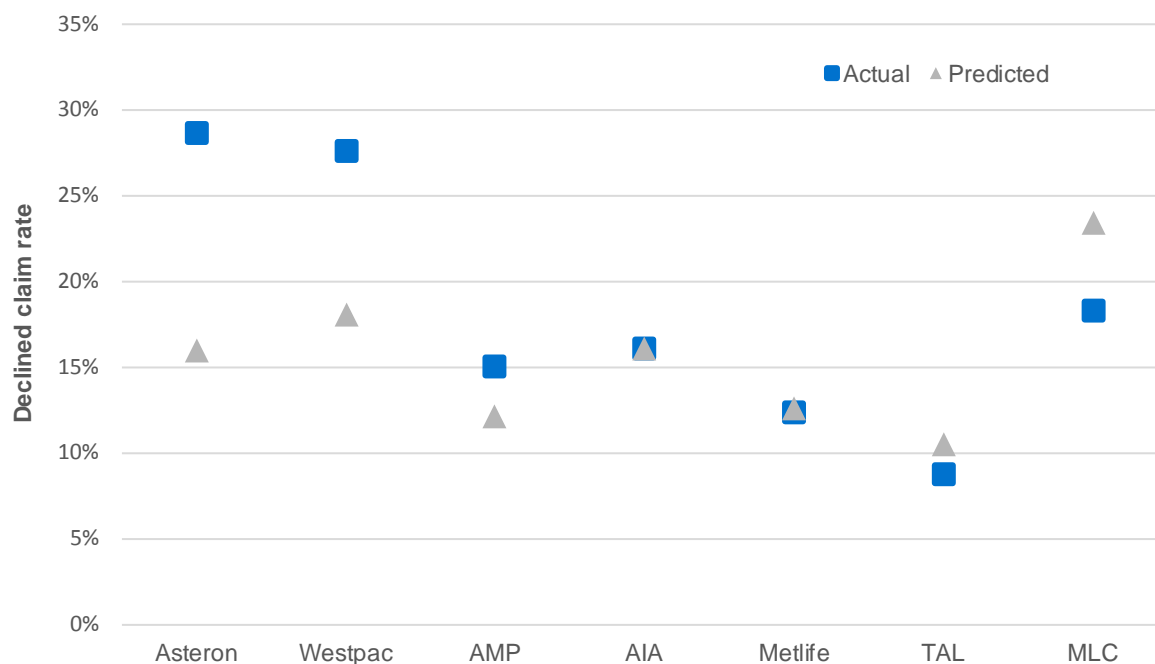
- 43 The data we collected allowed us to analyse the following 10 factors:
- (a) the type of definition the claims were assessed under (i.e. ADL, ‘any occupation’ and ‘own occupation’);
  - (b) the age of the consumer making the claim;
  - (c) the primary medical condition giving rise to the claim;
  - (d) whether the claim was formally underwritten and tailored in some way to the consumer;
  - (e) the type of policy the claim was made on (i.e. a group policy, a retail policy or a direct policy);
  - (f) the gender of the consumer making the claim;
  - (g) the amount the consumer was insured for under the policy;
  - (h) the delay between the date the claim was made and the date that the consumer became aware of the primary condition;
  - (i) the length of time the policy had been in effect; and
  - (j) whether the consumer had a white-collar or blue-collar occupation.

- 44 The methodology, analysis and statistical results were reviewed and confirmed as appropriate by Finity Consulting, an actuarial consultancy firm. The limitations of our methodology, analysis and conclusions are set out in Appendix 1 of this report.

**Finding 10: AMP, Asteron and Westpac had higher than predicted declined rates for claims with certain characteristics**

- 45 As illustrated by Figure 3, our analysis showed that for claims where a decision had been made, AMP, Asteron and Westpac had declined claim rates higher than our analysis predicted. The declined claim rate for Asteron was almost double what our analysis predicted.

**Figure 3: Actual declined rates compared to ASIC-predicted declined rates for claims that went to a final decision, by insurer (2016–17)**



Source: ASIC data collection

Note: See Table 25 in Appendix 2 of this report for the underlying data shown in this figure (accessible version).

- 46 We may undertake targeted surveillance work to examine the reasons for the substantially higher declined claim rates and consider appropriate regulatory action if required.

## ASIC's expectations and action

- 47 Table 3 summarises our expectations of insurers and superannuation trustees based on the findings of our review, along with the action we will be taking.



**Table 3: ASIC's expectations**

Problem	What we expect of insurers and superannuation trustees	What ASIC will do
<p><b>Poor consumer outcomes from the ADL test and other restrictive definitions</b></p> <p>(see Section B)</p>	<p>We expect all insurers and superannuation trustees (not just those included in this review) to:</p> <ul style="list-style-type: none"> <li>• review all TPD policies that include ADL or other restrictive definitions (e.g. 'loss of limbs') to:               <ul style="list-style-type: none"> <li>– consider removing definitions in group policies that are so restrictive as to make the policy unlikely to benefit the consumers to whom the policy is sold or provided, or appropriately redesign the product; and</li> <li>– develop measures to assess the value of the product offered or provided to consumers;</li> </ul> </li> <li>• improve data collection on outcomes for different types of TPD cover, including ADL or other restrictive definitions; and</li> <li>• improve communications with consumers about the type of TPD cover they will be eligible for under various circumstances.</li> </ul> <p>We expect trustees to consider our findings when negotiating future group insurance arrangements with insurers. Trustees must be confident that the definition used for TPD in group insurance arrangements is consistent with their duty to act in the best interests of fund members (consumers).</p> <p>We expect insurers to have addressed our expectations by 31 March 2020.</p>	<p>ASIC will conduct further work during 2020 and 2021 to assess the suitability of ADL and other restrictive definitions in TPD policies and the benefit to consumers of the policies that contain these definitions. This work will be informed by additional data about restrictive definitions that we expect industry to collect, particularly about claim outcomes, underlying claim conditions and loss ratios for products where the ADL definition is used.</p> <p>ASIC will ask certain insurers selected at our discretion to report to us on the changes made to their retail and direct product offerings, using our compulsory notice powers under financial services laws if necessary. We will consider reporting publicly on the appropriateness of the changes made by insurers during 2020 and 2021.</p> <p>We will also consider information that insurers report to us about their analysis of each policy containing an ADL definition, the changes made to the TPD policy (removal or redesign of the definition, including eligibility) and the specific measures in place to assess consumer value. We will consider using our product intervention powers to regulate the sale of policies where we are satisfied that there is a reasonable likelihood of consumer harm or detriment.</p> <p>We will conduct targeted surveillance of insurers, particularly for products that had the highest rate of declined claims for various definition types. We will take enforcement action if appropriate.</p>

Problem	What we expect of insurers and superannuation trustees	What ASIC will do
<p><b>Frictions in claims handling leading to withdrawn claims</b></p> <p>(see Section C)</p>	<p>We expect all insurers and superannuation trustees to work constructively towards a consistent set of binding standards for life insurance that covers both insurers and trustees and contains robust standards for all third-party providers. The next iteration of the Life Code and the Insurance in Superannuation Code should incorporate additional or enhanced obligations including for proactive communication with consumers during their claim, appropriate use of desktop surveillance, and documented guidelines on training and competency requirements for claims handling staff.</p> <p>We expect insurers and, where relevant, trustees to take immediate steps to implement our recommended changes to claims handling practices, reinsurer arrangements and claims staff remuneration scorecards.</p> <p>We expect insurers to have addressed our expectations by 31 March 2020.</p>	<p>ASIC will consider changes to claims handling practices made by insurers and superannuation trustees in response to this review and monitor consumer outcomes including withdrawn claim rates. If we remain concerned about claims handling practices and withdrawn claims, we will use our current and proposed powers, including under the <i>Corporations Act 2001</i> (Corporations Act), to intervene.</p> <p>We will ask certain insurers selected at our discretion to report to us on the changes made to their claims handling practices, using our compulsory notice powers under financial services laws if necessary. We will consider reporting publicly on the appropriateness of the changes made by insurers during 2020 and 2021.</p> <p>We have previously highlighted publicly the need for trustees to improve their processes around claims handling. This report provides more insight into areas for improvement and we expect trustees to review their processes with the benefit of this report by 31 March 2020. We will be engaging with trustees to review what progress has been made.</p>
<p><b>Consumer harm arising from poor data</b></p> <p>(see Section D)</p>	<p>We expect all insurers to:</p> <ul style="list-style-type: none"> <li>• invest in data resources and improve the quality of their data;</li> <li>• develop plans and timeframes for further developing their data capabilities to capture, store and retrieve data and information that is necessary to adequately manage conduct risk and consumer harm;</li> <li>• collect more data including on withdrawn claims, product value, consumer satisfaction, claim assessment practices, and involvement of third parties such as legal representatives;</li> <li>• collect data that enables analysis of each individual policy offered (including where there are multiple covers in one policy), not merely data aggregated at an insurer level; and</li> <li>• continue to work with APRA and ASIC on the industry-wide collection of life insurance claims data.</li> </ul>	<p>ASIC will recommend to Government strengthening the regulatory framework for data resources and the management of conduct risk. Our ability to intervene on issues of data resources and conduct risk management is limited by the exemptions in s912A(4) and 912A(5) of the Corporations Act. We recommend that these exemptions be removed.</p> <p>We will work with APRA, insurers and stakeholders to improve insurers' data resources. This will include using the types of data fields identified in Table 14 in this report as the basis for confirming the data capabilities that insurers need to have in order to capture, store and retrieve data and information that is necessary to adequately manage conduct risk and consumer harm.</p> <p>We will continue to work with APRA to improve the public reporting regime for claims data and outcomes including considering expanding its existing scope beyond claims into underwriting and other non-claims areas.</p>

Problem	What we expect of insurers and superannuation trustees	What ASIC will do
<p><b>Insurers with higher than predicted declined claim rates</b></p> <p>(see Section E)</p>	<p>We expect all insurers to review their claims handling practices in light of our analysis to ensure they are not treating certain groups of consumers unfairly. They should also review a statistically significant sample of declined claims between 1 January 2016 and 31 December with the claims characteristics set out in Table 23 in this report.</p> <p>Insurers should complete these reviews by no later than 31 March 2020.</p>	<p>ASIC may ask certain insurers selected at our discretion to report to us on the outcomes of their reviews, using our compulsory notice powers if necessary. We may also examine any steps taken by insurers to address the findings of their reviews. We will consider reporting publicly on insurers' response to these expectations.</p> <p>We may undertake targeted surveillance work to examine the reasons for substantially higher declined claims rates.</p>