2017 LIFT GROUP WHITEPAPER

"Living the Code - Engendering Trust as a Life Insurance Professional"

November 2017

INSURANCE ▪ COMMERCIAL ▪ BANKING

Contents

Living the Code - Engendering Trust as a Life Insurance Professional

This year will be a milestone for the life insurance industry. More than ever before there is a major disconnect between what the community feels the life insurance industry does and what it actually does: but in 2017 the industry has collaborated to set the record straight. Part of the redress comes in the form of the Life Insurance Code of Practice, which companies adopted this July.

At its latest gathering the LIFT (Life Insurance Future Thinking) Group, sponsored in partnership by ALUCA and TurksLegal, looked at perceptions of the life industry in the media and what the industry could do about them.

It is alarming how much the media's image of the industry is at odds with the reality reflected in key findings of the main government regulator when it looked in detail into the sector.

ASIC's Report 498 "Life insurance claims: An industry review" noted that:

"During the 2015–16 financial years, $8.2 billion dollars in net policy payments were made by life insurers…Our review did not find evidence of cross-industry misconduct across the life insurance sector in relation to life insurance claims payments. 90% of claims are paid in the first instance."

Yet this is far from the image most Australians have, due mainly to the media.

Linking negative media coverage with the insights from the ASIC report and advances made by the recent Life Insurance Code of Practice, the results of this year's LIFT Group discussion seek to throw light on the causes for the industry's poor image and the positive steps the industry can take to address these.

Starting with the fragmented way it collects claims statistics, it could be said that the Australian life industry has done itself no favours. Raw decline figures can be misleading and can result in undeserved negative publicity. Taking the lead from the UK, greater alignment of data may well be the foundation for more objective coverage of the Australian life insurance industry.

The LIFT Group dissects the ways in which the recent Life Insurance Code of Practice can support efforts for the industry to further improve in areas that ASIC feel additional work needs to be done. The Group also wrestles with the vexed issue of trauma definitions.

Drilling down into the issues raised by ASIC and setting out a framework for considering payments that should be made "in the spirit of the policy", the Group considers how the industry can approach the subject of "ex gratia" payments in a way that is both fair and objective and allows flexibility in appropriate cases.

This LIFT paper reflects on the exciting new possibilities presented by social media to showcase the industry's own interesting and authentic stories and concludes how such initiatives, united with the customer centric promises in the Code, could (if the industry harnessed them), be a watershed in changing public perceptions.

Here we present the collective thoughts of industry leaders and professionals at the coalface provoking debate and encouraging stakeholders to take practical steps to continue to build a better Industry that is fairly recognised for the essential role it plays in supporting ordinary Australians when they most need it.

We hope you enjoy and stay tuned for more from the LIFT Group in 2018!

John Myatt
Practice Group Head – Financial Services

About LIFT

An opportunity for tomorrow's leaders to be heard today

In 2016, to mark the tenth anniversary of the ALUCA TurksLegal scholarship, TurksLegal and ALUCA launched the "Life Insurance Future Thinking" (LIFT) Alumni program intended to give the industry leaders of tomorrow an opportunity and a platform to be heard today.

Australia has a mature and sophisticated financial services sector. The ALUCA TurksLegal Scholarship undoubtedly continues to provide an outlet for a rich seam of talented and committed individuals within the industry who have ideas and insights that will help it grow and better serve its customers.

LIFT builds on this tradition by bringing together people at the coal face – the claims specialists, rehabilitation experts, product designers, team leaders – those on the journey to leadership or those who simply have great ideas about how to better the industry to contribute those ideas to encourage change and find new ways forward.

LIFT joins together the winners and runners up of the ALUCA TurksLegal Scholarship since 2007 to connect, discuss and share ideas that will beneficially affect the future of the life insurance industry. This talented group of forward thinking life insurance professionals comes together once a year in person and meets online in our LIFT Online community to discuss and raise solutions to topical industry issues.

The LIFT Roundtable

In 2016 the LIFT (Life Insurance Future Thinking) group got together to offer its collective insights on training and career paths in the industry which resulted in the paper "Toward a Better Industry - Training and Career Paths in Life Insurance". The paper was taken up at a senior level by major insurers and training organisations alike.

On 15th June 2017, the annual LIFT Roundtable event was held at TurksLegal's Sydney offices when the group met to discuss the topic of "Living the Code - Engendering Trust as a Life Insurance Professional. There were a number of LIFT members present from a broad range of organisations:

- Elizabeth McCarthy-Jones – ANZ
- Luke Davies – ANZIIF
- Margaret Dennis – Asteron
- Lara Neate – BT Financial
- Julie-Ann MacCormick – CBA
- Rachel Tritton – CBA
- Vanessa Back – CommInsure
- Eric Liao – CommInsure
- Elizabeth Haddow-Allen – CommInsure
- John O'Leary
- Christine Gan – CommInsure
- Tim Hulme – CommInsure
- Natalie Agnoletto – Health Life Success
- Nick Wendon - Macquarie
- Andrew Prichard – MunichRe
- Stephanie Catalucci – MLC Life Insurance
- Nick Mingo – SwissRe
- Carly VandenAkker – SwissRe
- Darryl Pereira – TurksLegal

Accompanying the LIFT members was an esteemed group of industry leaders handpicked on their knowledge and practical expertise in the area of training and leadership. These included:

- Dr Newman Harris
- Nick Kirwan, Policy Manager, Life Insurance, FSC
- Jim Welsh, Chair, ALUCA
- Alph Edwards, Partner, TurksLegal

The session was facilitated by John Myatt, Head of Financial Services at TurksLegal.

Unravelling the problem

1. Why does the industry have such a bad public image?

The life insurance industry has been on trial in the print media, talk-back radio and television for some time. This June 2016 headline in the on line version of the Sydney Morning Herald is typical.

Parliament to grill life insurers on payouts

Adele Ferguson

Show comments

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The $44 billion life insurance industry – and its regulators – will soon face a powerful parliamentary inquiry that will look into wide ranging issues including whether insurers are engaging in unethical practices to avoid paying claims.

The inquiry, called for by Nationals Senator John Williams, received strong support from all sides of politics on Wednesday afternoon.

'It felt like a pitch fork in my chest'

When James Kessel had a severe heart attack, he thought Comminsure would come good on his policy. He was wrong.

The media portrays the life industry as if it is continuously getting it wrong or worse, as being engaged in "widespread unethical practices". This story and others like it sparked broader parliamentary and regulatory investigations.

In contrast, to the picture of the industry portrayed in the media, careful investigation by ASIC found no evidence of widespread or systematic misbehavior by life insurers.

Unfortunately, in contrast to the pervasive coverage of problematic individual claims in the media, relatively little attention was paid to key positive findings made by the consumer regulator following its investigation of the industry, namely;

- ***"Our review did not find evidence of cross-industry misconduct across the life insurance sector in relation to life insurance claims payments. 90% of claims are paid in the first instance."*** [1]

[1] ASIC Report paragraph 18

- ***"The APRA data available demonstrates that life insurance returns a significant benefit to the community. During the 2015–16 financial years, $8.2 billion dollars in net policy payments were made by life insurers*.***[2]

So, why does the industry currently have a bad image?

Supporting the underdog - an Australian tradition

In many respects the life insurance industry has suffered no more from the way the media operates than other institutions that are perceived as exercising a privileged role in the community, which makes it seem futile to expect fair and unbiased treatment.

Bad news about these institutions sells column inches, ratings and clicks. One negative story reinforces another and produces an atmosphere of crisis which feeds the news cycle. The message that the industry, while not perfect, produces positive outcomes for vast numbers of its customers is un-newsworthy. This makes it hard for the public to hear positive stories about what the industry actually contributes to the community and to get a more balanced picture.

Claims related stories inevitably portray claimants as underdogs battling powerful and better resourced corporations in an uneven fight and stories follow a plotline in which the reporter and media organization intervene on behalf of the underdog, benefiting from the kudos of successfully evening the odds. Once again, there is no room in this scenario for presenting a more balanced picture.

This plotline also serves the interests of claimants and their legal representatives who want to increase the pressure on companies to pay individual claims and whose desire to achieve this outcome is not necessarily served by a measured evaluation of the merits of the claim.

An under-resourced PR machine

The link that currently exists between social media, which amplifies the voices of individual consumers, and the increasingly less well-resourced mainstream media, which sources more of its stories from this pool, exacerbates this problem. It means that if the industry does make a mistake, it is less likely to be resolved by following the company's internal dispute resolution guidelines and relatively more likely to feed this negative news cycle and be resolved in the spotlight of media attention.

The life insurance industry is unlikely to be able to influence any of the forces that currently drive the media, so the acknowledgement that it has to work within the confines of this reality to improve the public perception of what it does needs to be the first step in this journey.

The industry has also not done itself any favours.

As companies have always focused on promoting the benefits of their own brand, in the past comparatively few resources have been allocated to explaining the industry's wider social purpose or the benefits it confers on the community.

Data has been hard to come by

As the ASIC Report revealed, there was no relevant body of data that had been collected by the industry, and ASIC noted there was a dearth of consistent statistics that the industry could provide that were relevant to what the regulator wanted to know about overall claims performance.

2 ASIC Report paragraph 118

The life insurance industry has never had to collect this type of industry-wide claims data before, and without this data it is hard to tell any good news stories. In this respect the drive to produce a common body of performance statistics could be beneficial not only to the regulator, but also to the industry itself and give it just the resource it needs to begin to re-dress the balance.

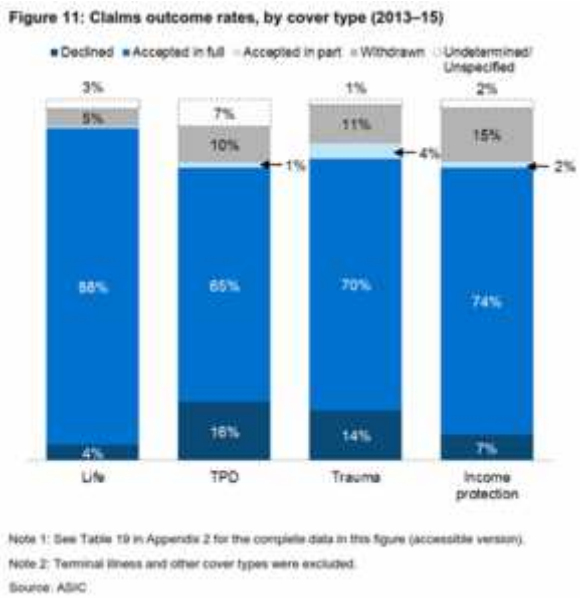
2. The ASIC Report findings – some good, some bad

It would be wrong to suggest that the key findings referred to earlier mean that ASIC does not have any concerns about some things it saw in the data.

The LIFT Group looked at some of the important issues raised in the ASIC Report to offer some insights on whether key data noted by ASIC reflect actual or potential shortcomings or are simply the product of statistical anomalies.

A discrepancy between cover types

Claims Outcomes by cover



Life insurance products were divided into four categories for the purpose of the ASIC Report; life (i.e. cover for death), total and permanent disability (TPD), trauma, and income protection.

The ASIC Report established that across the industry there was a discrepancy between the decline rates in different product categories.

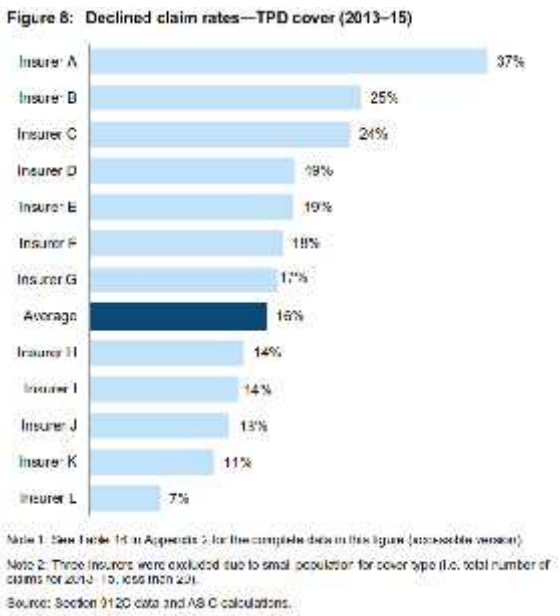
"*Issues of concern*" were identified by ASIC "*in relation to declined claim rates and claims handling procedures associated with:*

(*a) particular types of policies, notably TPD;*

(b) particular insurers for particular policy types

(c) particular causes for consumer disputes".[3]

[3] ASIC Report paragraph 19



Decline rates for TPD products were found to be higher than income protection and trauma with an average decline rate of 16% across the industry.

However, within the TPD product category decline rates for different insurers varied widely from a low of 7% to a high of 27%.

ASIC flagged that it would undertake further targeted surveillance work to establish why particular insurers had higher decline rates than others and "consider regulatory options where these reasons cannot be justified". [4]

The companies concerned were subjected to considerable negative publicity when these statistics were announced and the industry as a whole sustained further collateral damage to its reputation.

The LIFT Group is doubtful that raw decline rates or even the decline rates within a particular product category would be of particular value to ASIC in identifying potential malpractice in the claims management practices of individual companies.

Unlike comparable countries such as the United Kingdom, where minimum standard definitions make comparisons more likely to be fair, in the Australian context a comparison between companies based on decline rates was not going to be made on a like for like basis.

In other words, companies have portfolios of different claims recognition criteria and differently worded policies, some of which include policies with wordings that raised the benefit bar higher than others. It would be perfectly reasonable to expect a greater number of claims made under the policies with a higher bar to be declined.

Somewhat at odds with the advice that it would take regulatory action where adequate reasons could not be supplied by companies for higher decline rates, the ASIC Report states that;

> "*Some insurers had above average declined claims rates for more than one type of cover. Specifically, nine insurers had higher than average declined claim rates across two or three types of cover, with three insurers having substantially higher rates across two areas.*
>
> *However, some insurers also had above average declined claims rates in one area, and substantially lower than average declined claims rates in other areas. This indicates that high rates may be linked to cover types rather than a systemic issue within the insurer."*[5]

The LIFT Group agreed with this conclusion, which provides a good illustration why raw decline figures can be misleading and can result in undeserved negative publicity when the results are publicized by the media without a proper understanding of what they demonstrate.

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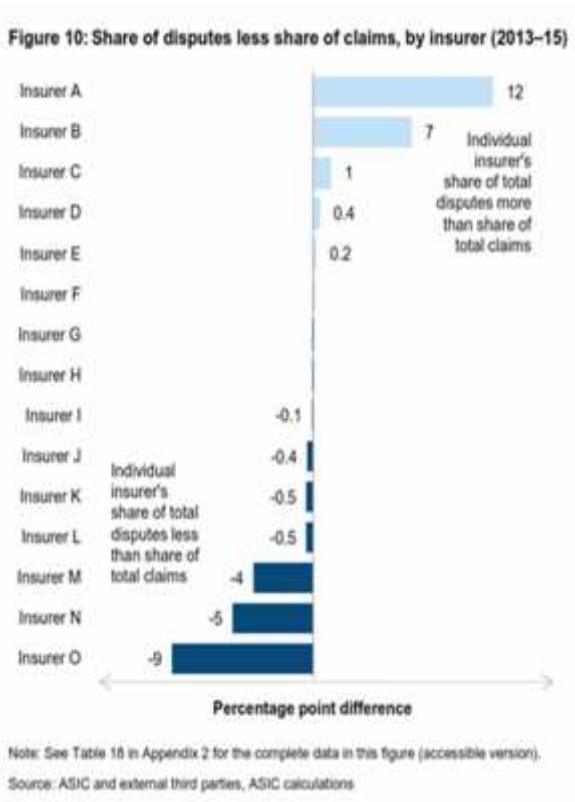
4 ASIC Report Table 2

5 ASIC Report paragraphs 169 -170 The ASIC Report generally acknowledges care needs to be taken when making comparisons (including with statics in other countries) See paragraph 27.

The Lift Group was also not convinced that the statistics around the proportion of disputes a company had as a share of claims was necessarily an indicator of poor practices in the claims department.

Troublesome claims are relatively few

Disputes as a percentage of claims



As the table shows, the number of disputes companies had was, in the great majority of cases, very much what would be expected on the basis of the number of claims it received.

However, to begin with, it is important to realise how small the number of disputes there are compared to the number of claims as a whole.

ASIC found that across the industry, there was a 2% chance of a decision to deny a claim being reviewed through the insurer's Internal Dispute Resolution ("IDR") processes and a 0.9% chance that an External Dispute Resolution (''EDR") body such as the FOS or the SCT would need to become involved.[6]

This finding is consistent with the vast majority of claims being paid in the first place and consumers generally being satisfied with the reasons given by the company for the denial in relation to the claims that were not accepted.

Interestingly, ASIC observed that based on published FOS data, life insurance disputes "*were 1.5 to 6 times less likely than general insurance disputes to be referred to FOS, on a per policyholder basis"* [7] but there are no allegations of systematic misconduct in relation to the general insurance industry currently being pursued by the Australian media.

ASIC was also generally very cautious of the inferences that could be drawn from disputation rates.

For example;

> "*For some insurers, the number of disputes for claims was substantially higher. For example, for one insurer, a claims-related issue was twice as likely to be dealt with through the insurer's IDR process, compared to the industry average. This could, however, be attributed to greater policyholder awareness of this insurer's IDR process rather than an increased number of concerns.*[8]

6 ASIC Report paragraph 173

7 ASIC Report paragraph 173

8 ASIC Report paragraph 174

Similarly, the possibility of other available inferences from the raw data made it difficult to draw definitive conclusions from the dispute rates attaching to intermediated and un-intermediated policies.

There is a lot of statistical analysis in the ASIC Report, and for the reasons mentioned earlier, the impetus to collect base data should be welcomed by the industry. However, industry participants and regulators need to be cautious with the inferences that can be drawn from it and understand it better.

The LIFT Group believes that better understood and more consistent and reliable data may make considerable inroads towards rebalancing public perceptions of the industry.

3. ASIC's concerns regarding "particular causes" for consumer disputes

How does subjective fairness apply in claims management?

The ASIC Report makes a "Key Finding" that;

> "*Although the considerable majority of claims are paid, we are concerned that in some cases, claims are being declined on technical or contractual grounds that are not in accordance with the 'spirit' or 'intent' of the policy*."[9]

The ASIC report also acknowledges that not every claim made on a life insurer will be payable, observing;

> "*Even though they may not be entitled to payment for a loss not covered by the contract, policyholders can (and do) lodge claims in these circumstances*."[10]

Of course, determining what is and what is not covered by a contract is a core competency of claims managers, who do so by bringing their technical understanding of the policy to bear in the assessment process.

Given this context, ASIC is unlikely to be saying when it talks about "technical" declines that it does not want claims managers to do what they are paid for. But, if so, how should the industry interpret the concerns ASIC is raising and respond to them?

What is at the centre of ASIC's concerns is the issue that "*arises when a policyholder's reasonable expectations about policy coverage do not align with the technical wording in the policy*".[11]

This notion embraces the two limitations claims managers may face when dealing with technical policy issues;

- the fact a succinct written contract cannot be expected to deal with every eventuality that might occur over the life of a long term guaranteed renewable contract; and

- that on some occasions policy documents may not be precise enough to accurately express the issuer's real intent and communicate it accurately to the customer.

These are situations which some companies have endeavored to address by putting in place a structure through which they can give consideration to making a payment outside the policy conditions.

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9 ASIC Report paragraph 22
10 ASIC Report paragraph 15
11 ASIC Report paragraph 22

A structure for fairness

An informal survey of the LIFT Group confirmed ASIC's observation that "ex-gratia (i.e. goodwill) payments were inconsistently applied across the sector[12]". The anecdotal accounts from the Group indicated while some companies had taken formal steps to identify, consider and make decisions about claims that might merit consideration outside the policy conditions, probably most had not.

The LIFT Group acknowledged the difficultly of consistently assessing whether a claimant should be entitled to a payment on imprecise and subjective criteria, such as "fairness" or the 'spirit' or 'intent' of the policy , if it was not actually reflected in the policy conditions. It was also thought to be very problematic to leave decisions of this kind to be shouldered alone by individual claims managers.

Clearly, resorting to such criteria was not necessary where the company had clearly communicated the conditions that attached to the benefit in its policy and disclosure documents and the company could expect the customer to know a benefit was not payable in the factual scenario established by its claims investigation.

However, there was a major benefit to both companies and their customers if internal guidelines about payment outside the policy conditions could be created where the established facts exposed the kind of limitations in the policy wording identified above.

Similarly, in the context of considering a payment outside the policy conditions, there was also an argument for enabling claims managers to tap into wider collective wisdom about how "ex gratia" claims should be handled through a formal consultation or committee structure.

Taking documented steps to identify, consider and potentially resolve claims that the company thought merited consideration of payment outside the terms of the policy would enable companies to directly respond in a concrete way to ASIC's concerns in this area.

As we later moved into a wider discussion of the Life Insurance Code of Practice (the "Code") it became apparent that structures such as this were very much in harmony with the key promises of the Code.

4. Customer expectations vs outdated product definitions

In a slightly different, though related way, ASIC further elaborates its concerns about policy coverage, saying;

> *"If a claim is declined because the condition is not covered by the policy, we think a critical distinction arises between claims for:*
>
> *(a) conditions that could not reasonably be expected to be covered under the policy; and*
>
> *(b) conditions that the policyholder could reasonably expect to be covered."*[13]

The implication being, of course, that ASIC takes the view that when a claim falls into the second category the company should consider paying it anyway. In this respect its remarks on policy coverage dovetail with those about claims being declined on "technical" grounds.

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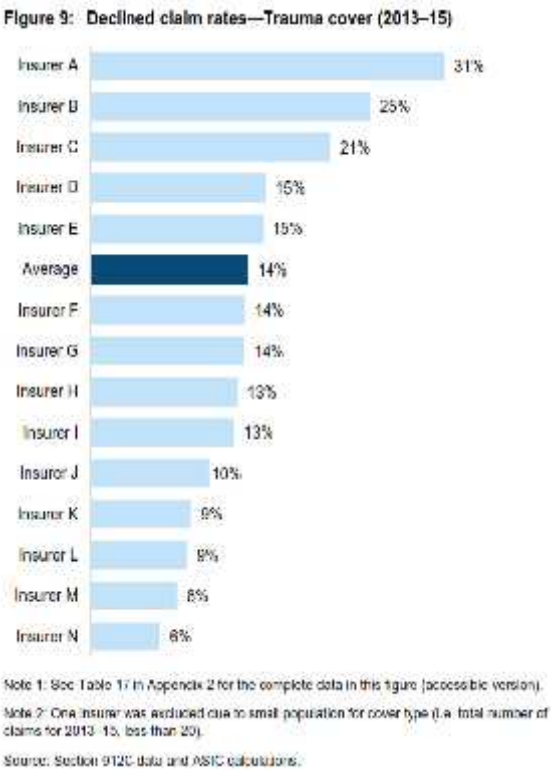
12 ASIC Report paragraph 23

13 ASIC Report paragraph 16

Though the question of how well the industry is meeting customer expectations has a wider ambit, one of the most dramatic scenarios to recently play out in the media has been criticism of the industry over the continued use of "out dated' medical definitions in trauma policies.



Trauma is the product category with the second highest declinature rate on average (14%) with a range of variation in decline rates between companies similar to that for TPD.

As previously discussed, there are inherent difficulties in trying to draw inferences from raw decline data.

In this instance the conclusion drawn by ASIC is not to do with claims practices but that the decline rate is connected with the coverage issues flowing from the complex definitions that are used in these products.

ASIC's major concerns are in respect of the wide variety of definitions in use in the Australian market and that "*while some variations are subtle, others are significant, which is likely to cause confusion and may not allow for simple comparisons by consumers*." [14]

The LIFT Group thought that customer expectations certainly played an important role in creating appropriate products, but it was difficult to see how they should be part of the claims assessment process, other than when a company might be considering paying outside the policy conditions.

Hence the concerns that ASIC raised in relation to medical definitions and policy coverage really ought to be seen mainly as ones that should be addressed by product design and consumer education, rather than claims management The LIFT Group looked at the analysis of various definitions appearing in the market and broadly agreed with ASIC's comments.

[14] ASIC Report Table 2.

Table 4: Review of policy definitions—Summary of observations

Definition	Observations from our review of the definition
Heart attack	The policies used a variety of definitions that included various diagnostic tests to determine the severity of the heart attack. Some policies included troponin as a diagnostic test. While all policies allowed for secondary tests, some policies stated that the insurer would consider appropriate and medically recognised tests if technological advancements had superseded the test set out in the policy. One insurer had a share of heart attack definition disputes that was six times its share of claims. Two other insurers also had higher than proportionate heart attack disputes based on their share of claims.
Severe rheumatoid arthritis	10 of the 11 policies prescribed the type of medical specialist who could diagnose the condition. The policy definitions required the diagnosis of severe rheumatoid arthritis to meet the criteria for the onset of the conditions, symptoms and other criteria (e.g. morning stiffness and rheumatoid nodules). Two definitions referred to the 'failure' of treatment regimes.
Multiple sclerosis	The policies referred to both the type of medical specialist who could diagnose the condition and the diagnostic criteria.
Stroke	The definitions referred to onset timeframes, the type of medical specialist who was required to confirm the diagnosis and a series of diagnostic tests.
Cancer	Cancer is a complex condition and therefore there is great complexity in the definition of specific cancers and cancer generally. Insurers require the cancer to be characterised with 'uncontrolled' or 'unlimited growth' and 'spread of malignant cells' and the 'invasion' of tissue. The definitions include various medical and/or histological classifications. One insurer had a level of cancer definition disputes that was four times its share of claims. Another insurer had a level of cancer definition disputes that was almost three times its share of claims.

Medical definitions and legacy issues

ASIC acknowledged the difficulty of legacy issues and the problems that derive from the fact retail life insurance is a long term guaranteed renewal product.[15] Medical definitions are also generally complex and incorporate scientific terms that make it difficult for companies to describe what they are covering in a way that is both medically accurate and user friendly to customers.

The onus is therefore on the product issuer to educate customers about what is covered in a trauma policy and not to permit a situation to arise where customer expectations get ahead of what the product is actually providing.

The UK market probably handles this issue much better than we do as companies have more standard consumer tested definitions and market their product more on the basis of brand and service rather than unique policy terms.

The life industry in Australia needs to look at definitions regularly with guidance from experts who are in touch with current advances in medical practice. It also needs to use customer friendly language in trauma definitions.

However, ASIC also sees the need for the industry to do the work to make products appropriate to customers and manage their expectations, so the product does not appear to over promise and under deliver.

[15] ASIC Report Table 2 Item 3 Policy Definitions

The work going forward in these areas is where ASIC sees legitimate customer expectations being addressed[16], coupled with the introduction of structures that allow fairness to be applied to claims that merit payment outside the strict policy conditions –these measures will meet most of ASIC's concerns.

As the ASIC Report points out;

> "Poor and/or inconsistent management of these relatively small numbers of claims can lead to very poor outcomes for consumers and significant reputational damage for insurers. This issue highlights the importance of and the need for the industry to improve what it does going forward…"[17]

5. Living the Code

Fortunately, the work that ASIC considers necessary in relation to policy definitions expressly forms part of the customer promises now contained in the Code[18].

In general, ASIC takes the view that its recommendations are supported by the Code. [19]

This observation deserves a bit of further exploration, as the Code makes at least seven references to the idea of fairness, but none of them are in the part of the Code that deals with claims. This reasonably prompts the question "Does the Code promote 'fairness as an element of the insurer's claim's philosophy?"

The Lift Group had no hesitation in answering this question in the affirmative, referring to the first of the Key Code promises that companies;

> ***"… will be honest, fair, respectful, transparent, timely, and where possible we will use plain language in our communications with you."[20]***

The LIFT Group's discussion suggests that the Key Code promises should be seen as informing all of the company's other behaviors. Consequently, the Group felt "fairness" must be a concept that is reflected in the way a company goes about the claims assessment process, so that in the long run it underpins all actions in relation to claims.

Organisations that intend to "live the Code'' will already be considering the wider obligations implicit in the Key Code promises for themselves and be deciding how they can best address the issues that ASIC has raised in the light of those promises.

The LIFT Group sees major opportunities to structurally reinforce fairness, in a way that meets ASIC's concerns, as part of the agenda of "living the Code".

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16 ASIC Report Table 2 Item 3 Policy Definitions - Further Work
17 ASIC report paragraph 24
18 Code Sections 3.1 and 3.2.
19 ASIC report paragraph 53
20 FSC Life Insurance Code of Practice Key Code Promise No 1.

Towards a solution

The main goal of the LIFT roundtable is to explore more deeply the important issues that affect the industry, in the knowledge that if others become engaged and they also take up the discussion, companies will each find their own best solution.

The Group was not in the comfortable position of being able to furnish detailed answers to the issues we chose to debate. The next section of this paper merely points the way to potential solutions that occurred to members of the Group which we thought might be of value to share. The ideas discussed are not intended to be either a complete or an exhaustive list.

Hopefully, this paper will provide a stimulus for further discussion.

Addressing the industry's bad public image – No Quick Fixes…

The industry has no control over the media or the news cycle. It will encounter significant difficulties in seeking more balanced coverage of what it does and of the benefits it brings to the community because the media will generally see the industry simply doing its job as not being newsworthy.

There are consequently a limited range of opportunities to turn this situation around, and no "quick fixes".

One of the opportunities the industry has is identified in the ASIC report, and comes from improving the management of the admittedly small numbers of claims that "lead to very poor outcomes for consumers and significant reputational damage for insurers". [21] We will elaborate on the ways that companies might consider approaching that task in a bit more detail further on.

The other opportunities rely upon collective action by the industry to work together. The decision to create a Code of Practice shows that where there is a common interest and a desire to effect change, this can be done.

A proper base of comparable claims statistics gives the industry a basis for good news stories and, if nothing else, establishes transparency and accountability.

The image of the industry in the UK has benefited from this kind of accountability, having gathered and published its claims data since 2008. This improvement in its public perception has occurred despite the fact that, taken at face value, some of its statistics paint a picture that is much less attractive to customers than currently exists in Australia.

Consistent, comprehensive data to compare apples with apples

Australian statistics are less easy to assemble and compare because of individual differences between companies in the way they are recorded and due to the design of the products themselves. It is difficult to identify a minimum set of benefit criteria in the Australian market in key product areas. This, of itself, may undermine consumer confidence in the industry's products.

With ongoing regulatory attention being paid to these issues, the industry has a strong incentive to work towards better means of synthesising data and creating a more robust base to compare claims portfolio information, including by standardizing minimum policy terms and definitions across companies.

[21] ASIC report paragraph 24

Building a positive online brand

Social media presents a lot of opportunities for the industry if it has interesting authentic stories to tell and provides a platform for telling them when or before the mainstream media will.

The industry needs more positive information to be disseminated to change the negative perceptions in the community. We need to gather the good news stories and present them in a way that resonates with ordinary members of the public.

In the UK the life insurance industry used real life stories to show how insurance changed people's lives, picking families living on social welfare and providing them with the benefits they would have had if they had been covered by an income protection policy.

The program, "7 Families" followed the families over the course of a year and engaged viewers in the real life struggles they faced, incidentally illustrating the value of insurance and the positive changes it could make. Details of the program can be found at http://7families.co.uk. This initiative proved to be a huge success in changing attitudes in the UK and something similar should be considered in Australia.

Engaging with the Community

The Group also talked about some other ways the industry could engage with the community.

Positive messages can be spread in the community through the way the industry interacts with graduates and recruits talent as it explains the industry's mission to help people rebuild their lives. [22]

Engaging with Health Professionals

Another group the industry can positively influence is the constituency represented by health care professionals who may be become involved in claims. Ultimately, companies and health care professionals are work to a common goal– for the patient/ insured to recover full health, including the fulfilment that comes with work and career.

This is a natural meeting point to work together to get the best outcome for patients. Through interactions of this nature the industry can take its positive message regarding the health benefits of good work and rehabilitation forward and make health care professionals aware of the resources available through the industry.

This could be achieved in a simple and low cost way, by using social media and via active involvement presenting at medical conferences and meetings.

And finally, Living the Code…

Sadly, in the current climate the industry gets no credit for the enormous improvements it has made over the recent past in the way it manages claims.

The LIFT Group felt there had been a long-standing but now increased focus on ethics and integrity as a consequence of these improvements which has been ignored or neglected in the barrage of bad publicity the industry has received. The industry works to an ethical and socially useful agenda, which has been backed by a significant investment in additional resources that benefit customers.

[22] See LIFT Group Whitepaper 2016 "Toward a Better Industry- Training and Career Paths in Life Insurance"

One participant observed anecdotally that there are 10 times more people working in rehabilitation in the industry now than there were even 5 years ago. Claims teams were trying to go above and beyond to help people.

Despite this a small number of claims outcomes had been poor for customers and ASIC observed that they had caused and significant reputational damage for the industry. [23]

ASIC has pointed to a need for the industry to take on board customer expectations, which the LIFT Group sees as being substantially addressed through the work the industry has promised to do in response to the Code in relation to product development and marketing. We consider the industry's Code promises in these areas will ensure products are appropriate to customers and that it will manage their expectations, so products do not appear to over promise and under deliver.[24]

ASIC has also raised concerns about claims being declined on technical or contractual grounds that are not in accordance with the 'spirit' or 'intent' of the policy. At least, superficially, this appears to call into question the key technical element of the claims manager's role and seek to replace it with a n ill-defined extra-contractual obligation of fairness.

As we explained earlier in this paper, this is not what we believe ASIC is seeking and that the objective it wants from the industry is consistent with a company's legal obligation to assess a claim against the contractual conditions of the policy.

However, companies need to understand that

- there are a small number of claims it will assess which a succinct written contract cannot be expected to precisely deal with; and

- that on some occasions policy documents may not be precise enough to accurately express the issuer's real intent and communicate it accurately to the customer.[25]

As we noted earlier, these are situations which some companies have endeavored to address by putting in place a structure through which they can give consideration to making a payment outside the policy conditions.

Identifying and putting formal structures in place to assist claims managers approach these claims with fairness will help the industry address ASIC's concerns about the small number of claims that have resulted in poor consumer outcomes and caused reputational damage for the industry.

Better dealing with these claims in a more effective way will also be a step forward for the industry in "Living the Code".

[23] ASIC report paragraph 24
[24] See page 15 of this paper for more detail.
[25] See page 12 of this paper for more detail