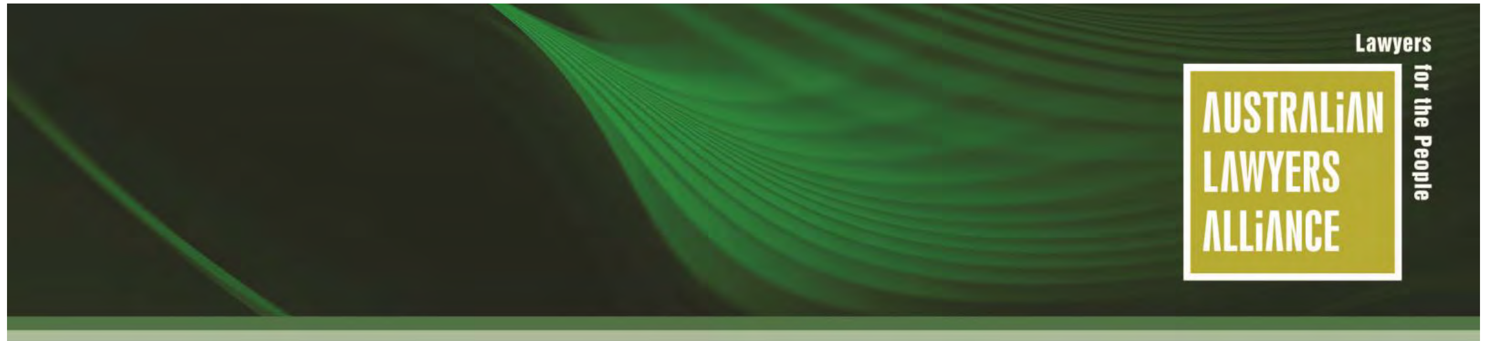

Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry

Submission in response to Policy questions arising from Module 6

22 October 2018

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Protecting and promoting justice, freedom and the rights of the individual

CONTENTS

Who we are 5

Introduction 6

Question 1. Is the current regulatory regime adequate to minimise consumer detriment? If the current regulatory regime is not adequate to achieve that purpose, what should be changed? .. 6

A. Product Design 7

Question 3. Should the requirements of the Life Insurance Code of Practice in relation to updating medical definitions be extended to products other than on-sale products? 7

B. Disclosure 9

Question 4. Is the current disclosure regime for financial products set out in Chapter 7 of the *Corporations Act 2001* (Cth) and Division 4 of Part IV of the *Insurance Contracts Act 1984* (Cth) adequately serving the interests of consumers? If not, why not, and how should it be changed? In answering these questions, address the following matters: 9

4.1 the purpose(s) that the product disclosure regime should serve; 9

4.2 whether the current regime meets that purpose or those purposes; and 9

4.3 how financial services entities could disclose information about financial products in a way that better serves the interests of consumers 9

(Despite the reference to the Insurance Contracts Act 1984 (Cth), this question is not limited in scope to contracts of insurance.) 9

Question 5. Is the standard cover regime in Division 1 of Part V of *the Insurance Contracts Act 1984* (Cth) achieving its purpose? If not, why not, and how should it be changed? 14

Question 6. Is there scope for insurers to make greater use of standardised definitions of key terms in insurance contracts? 15

Question 9. Is banning conflicted remuneration sufficient to ensure that sales representatives do not use inappropriate sales tactics when selling financial products? Are other changes, such as further restrictions on remuneration or incentive structures, necessary? 15

C. Sales 20

Question 11. Is Recommendation 10.2 from the Productivity Commission’s report on “Competition in the Australian Financial System”, published in June 2018, sufficient to address the problems that can arise where financial products are sold under a general advice model (for example, the sale of financial products to consumers for whom those products are not appropriate)? If not, what additional changes are required? Are there some financial products that should only be sold with personal advice? 20

Question 12. Should all financial services entities that maintain an approved product list be required to comply with the obligations contained in FSC Standard No 24: Life Insurance Approved Product List Policy? 20

E. Claims handling 20

Question 18. Should ASIC have jurisdiction in respect of the handling and settlement of insurance claims? 20

Question 19. Should life insurers be prevented from denying claims based on the existence of a pre-existing condition that is unrelated to the condition that is the basis for the claim? 22

Question 20. Should life insurers who seek out medical information for claims handling purposes be required to limit that information to information that is relevant to the claimed condition? 24

Question 21. Should life insurers be prevented from engaging in surveillance of an insured who has a diagnosed mental health condition or who is making a claim based on a mental health condition? If not, are the current regulatory requirements sufficient to ensure that surveillance is only used appropriately and in circumstances where the surveillance will not cause harm to the insured? If the current regulatory requirements are not sufficient, what should be changed? .. 25

F. Insurance in superannuation 27

Question 23. Should universal: 27

23.1 minimum coverage requirements; and/or 27

23.2 key definitions; and/or 27

23.3 key exclusions, ... 27

be prescribed for group life policies offered to MySuper members? 27

Question 24. Should group life insurance policies offered to MySuper members be permitted to use a definition of "total and permanent incapacity" that derogates from the definition of "permanent incapacity" contained in regulation 1.03C of the *Superannuation Industry (Supervision) Regulations 1994* (Cth)? 27

Question 25. Should RSE Licensees be obliged to ensure that their members are defaulted to statistically appropriate rates for insurance required to be offered through the fund under section 68AA(1) of the *Superannuation Industry (Supervision) Act 1993* (Cth)? 27

Question 26. Should RSE Licensees be prohibited from engaging an associated entity as the fund's group life insurer? 31

Question 27. Alternatively, should RSE Licensees who engage an associated entity as the fund's group life insurer be subject to additional requirements to demonstrate that the engagement of the group life insurer is in the best interests of beneficiaries and otherwise satisfies legal and regulatory requirements, including the requirements set out in paragraphs 22 to 24 of Prudential Standard SPS 250, Insurance in Superannuation? 31

Question 28. Are the terms set out in the Insurance in Superannuation Voluntary Code of Practice sufficient to protect the interests of fund members? If not, what additional protections are necessary? 31

G. Scope of the *Insurance Contracts Act 1984* (Cth) 32

Question 29. Is there any reason why unfair contract terms protections should not be applied to insurance contracts in the manner proposed in "Extending Unfair Contract Terms Protections to Insurance Contracts", published by the Australian Government in June 2018? 32

Question 30. Does the duty of utmost good faith in section 13 of the *Insurance Contracts Act 1984* (Cth) apply to the way that an insurer interacts with an external dispute resolution body in relation to a dispute arising under a contract of insurance? Should it? 32

Question 31. Have the 2013 amendments to section 29 of the *Insurance Contracts Act 1984* (Cth) resulted in an "avoidance" regime that is unfairly weighted in favour of insurers? If so, what reform is needed? 33

H. Regulation 33

Question 33. Should the Life Insurance Code of Practice and the General Insurance Code of Practice apply to all insurers in respect of the relevant categories of business? 33

Question 34. Should a failure to comply with the General Insurance Code of Practice or the Life Insurance Code of Practice constitute: 34

34.1 a failure to comply with financial services laws (for the purpose of section 912A of the *Corporations Act 2001* (Cth)); 34.2 a failure to comply with an Act (for example, the *Corporations Act 2001* (Cth) or the *Insurance Contracts Act 1984* (Cth))? 34

I. Compliance and breach reporting 34

Question 36. Is there sufficient external oversight of the adequacy of the compliance systems of financial services entities? Should ASIC and APRA do more to ensure that financial services entities have adequate compliance systems? What should they do? 34

Who we are

The Australian Lawyers Alliance (ALA) is a national association of lawyers, academics and other professionals dedicated to protecting and promoting justice, freedom and the rights of the individual.

We estimate that our 1,500 members represent up to 200,000 people each year in Australia. We promote access to justice and equality before the law for all individuals regardless of their wealth, position, gender, age, race or religious belief.

The ALA is represented in every state and territory in Australia. More information about us is available on our website.[1]

[1] www.lawyersalliance.com.au.

Introduction

1. The ALA welcomes the opportunity to have input into the policy questions arising from Module 6, Insurance. This submission addresses the issues raised in those policy questions where applicable. We are available to discuss any of the below in further detail if that would be of assistance.

Question 1. Is the current regulatory regime adequate to minimise consumer detriment? If the current regulatory regime is not adequate to achieve that purpose, what should be changed?

2. The ALA supports Recommendation 3.1 of the Parliamentary Joint Committee on Corporations and Financial Services (PJC).[2] Specifically, the committee recommended that:

   (a) consumer protections for financial and non-financial services are aligned to remove current inconsistencies;

   (b) s15 of the *Insurance Contracts Act 1985* (ICA) be reformed to enable consumer protections to apply to life insurance contracts, with appropriate transitional and other arrangements to accommodate the challenges observed by ASIC to exist.

3. Currently, pursuant to s15 of the ICA, an insurance contract is not subject to the Unfair Contract legislation contained within the Australian Consumer Law (ACL). Accordingly, whilst an insurer may owe a duty of utmost good faith, pursuant to s13 of the ICA, that duty does not in real terms provide a consumer with adequate protection from a contract term that is harsh, oppressive, unconscionable, unjust, unfair or inequitable. The Royal Commission has heard clear and compelling evidence of consumers being provided with such unfair contracts, for example:

   (a) Direct sale insurance policies being sold to vulnerable or disabled persons via high pressure telephone calls (Freedom Insurance and ClearView case studies);

   (b) Life insurance policies with medically obsolete definitions of heart attack or other undefined medical terms which are used to deny claims (CommInsure case study);

[2] Parliamentary Joint Committee on Corporations and Financial Services – Life Insurance Industry, March 2018.

(c) Superannuation fund members who obtain cover via a group life insurance policy paying premiums for insurance they are not in fact covered for (REST case study).

4. To ensure consumers are adequately protected, the ICA ought to be amended to provide protection to consumers from unfair contract terms. Importantly, insurers would still be able to offer insurance which is difficult to claim on. This provision would only be enlivened if the particular provision of the policy operated in an 'unfair' manner.

A. Product Design

Question 3. Should the requirements of the Life Insurance Code of Practice in relation to updating medical definitions be extended to products other than on-sale products?

5. The ALA supports this proposal. Life insurance products are continuous contracts (as opposed to annual renewable) and are therefore commonly held for many decades. Over such time, a policy is likely to become obsolete, with less favourable terms compared to on sale products, even as its premiums are increased to keep pace with on sale policy rates. For example, some TPD and income protection policies sold in the 2000s contained blanket exclusion clauses against mental health related claims before, thankfully, most life insurers moved away from such conditions. There is presently no legal obligation on life insurers to provide policy upgrades or 'riders' to off-market policies.

6. Such upgrades will only occur where the insurer makes a commercial decision to do so, typically due to bad publicity as with the CommInsure heart attack scenario, but also in response to pressure from financial advisers (receiving trailing commissions from the prior sale of the insurer's outdated policy) who would be compelled to advise insured clients of their inferior product if such upgrades did not occur.

7. Of course it is possible for insureds to switch to an on-sale product to obtain the benefits of market improvement however the evidence is that many will not do so due to apathy as lay consumers will rarely know about the specific product upgrades which they could take advantage of by shopping around. This is where financial advisers theoretically assist, however insureds are wary — with good reason — of financial advice, the risk that such

advice will be against their best interests.[3] This risk is exacerbated by financial advisers' history of policy rewriting behaviour (insurance churning) driven by the adviser's desire to secure commissions in perpetuity. Insurance rewriting infamously subjects insureds to a fresh underwriting process and thereby heightens the risk of a claim under a new policy being declined for pre-existing conditions or non-disclosure.

8. The ALA therefore suggests a government regulator such as ASIC be mandated to maintain a regulatory guide on minimum terms for insurers to adhere to, including through upgrades to legacy policies and if they choose not to (e.g. the insurer has chosen to design and offer a low price/inferior product, it must disclose prior to entry into the policy, in clear prominent terms, that the customer's policy terms are not in accordance with recognised minimum industry standards and that upgrades may not be passed on to keep up with such standards.

9. The ALA also refers to and notes its general support for the Recommendation 10.60 of the PJC which recommended that in relation to definitions in life insurance policies, the life insurance industry must:

   (a) regularly update all definitions in policies to align with current medical knowledge and research;
   (b) standardise definitions across all types of polices;
   (c) use clear and simple language in definitions; and
   (d) clearly explain which associated conditions that may arise from the initial condition, including mental ill health, are covered by the insurance policy.

[3] See ASIC report 562 'Financial advice: Vertically integrated institutions and conflicts of interest' dated January 2018 which found that in 75% of the advice files reviewed the advisers did not demonstrate compliance with the duty to act in the best interests of their clients. Further, 10% of the advice reviewed was likely to leave the customer in a significantly worse financial position.

B. Disclosure

Question 4. Is the current disclosure regime for financial products set out in Chapter 7 of the *Corporations Act 2001* (Cth) and Division 4 of Part IV of the *Insurance Contracts Act 1984* (Cth) adequately serving the interests of consumers? If not, why not, and how should it be changed? In answering these questions, address the following matters:

4.1 the purpose(s) that the product disclosure regime should serve;

4.2 whether the current regime meets that purpose or those purposes; and

4.3 how financial services entities could disclose information about financial products in a way that better serves the interests of consumers.

(Despite the reference to the Insurance Contracts Act 1984 (Cth), this question is not limited in scope to contracts of insurance.)

10. Presently, Division 4 of Part IV of the ICA, which obliges an insurer to provide a Key Facts Sheet (KFS) does not apply to life insurance contracts. The ALA calls for life insurance contracts to be deemed 'prescribed contracts' such as to become covered by Part IV of the ICA.

11. The ALA's experience is that particularly in the group insurance sector, consumers are often unable to understand the differences in coverage available. The consequences of not having adequate coverage can mean families are placed in extreme financial hardship in the event of unexpected injury or illness. They then become reliant on government welfare and the public health system if they do not have adequate insurance coverage. This leads to significantly reduced quality of life, with hardship becoming ongoing and self-perpetuating.

12. Over recent years, the quality of TPD definitions in group policies being written have reduced some superannuation funds' offerings to 'junk insurance'. That is, collecting premiums from policy holders while providing little to no genuine prospect of insurance coverage in the event

of serious injury or illness.[4] This was demonstrated in the REST case study wherein a member had premiums deducted from her account for years after her entitlement to claim ceased due a cessation of coverage triggered by a low account balance and the cessation of work. That was despite the fact that her membership statements noted her extant death and TPD cover (albeit with a small print disclaimer). Other examples are as follows:

Capacity: Unlikely vs incapable

13. Australian Super, whose members are underwritten by TAL life Limited, led the industry in changing its TPD definition to remove the word 'unlikely'. It now requires claimants to demonstrate that they are 'incapable of ever engaging in any occupation for which [they are] or may become reasonably suited by education, training or experience'.

14. This is very much intentional: The threshold "incapable of ever engaging" is higher than 'unlikely', which is found in the *Superannuation Industry (Supervision) Act 1993 Act* (SIS Act) and Regulations.[5]

15. Further, the standard of work that is considered appropriate is lower than that provided for in the SIS definition. Ultimately this means that claimants can have claims rejected, even if it is unlikely that they will ever engage in employment similar to that which they were performing before the accident.

16. The NSW Court of Appeal has considered the 'unlikely' TPD test and found that 'A real chance that a person will return to relevant work, even if it is less than 50%, will preclude an Insured Person being unlikely ever to return to relevant work.' Surely that test is sufficiently

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[4] See for example: http://www.abc.net.au/news/2018-06-03/sunsuper-insurance-members-sue-qld/9825324; https://www.afr.com/personal-finance/superannuation-and-smsfs/rest-industry-super-withheld-paraplegic-womans-disability-insurance-20160520-goztiy; https://www.smh.com.au/business/banking-and-finance/cba-fought-employee-with-ms-20160401-gnvwo9.html; http://www.abc.net.au/news/2017-07-11/amp-accused-of-dragging-out-disability-insurance-claims/8698278; https://www.afr.com/business/insurance/prepare-for-life-insurance-horror-show-20180909-h154l4

[5] See the definition of 'Permanent Incapacity' provided for in reg 1.03C of the *Superannuation Industry (Supervision) Regulations* (Cth) 1994: "a member of a superannuation fund or an approved deposit fund is taken to be suffering permanent incapacity if a trustee of the fund is reasonably satisfied that the member's ill-health (whether physical or mental) makes it unlikely that the member will engage in gainful employment for which the member is reasonably qualified by education, training or experience."

onerous.[6]

17. It is pleasing to see that some funds, such as CBUS, have resisted pressure from insurers to depart from the SIS 'Permanent Incapacity' test, retaining the 'unlikely' definition. The fact that such definitions are being retained by some confirms the viability for doing so across all insurers.

Ongoing care

18. The current MTAA/Metlife policy contains the following definition for regular and ongoing care. It means the person:

    (a) 'Is under the regular and ongoing care of a medical practitioner who has given a clear prognosis that the Injury or Illness will continue throughout the life of the Covered Person (including after the expiry of the cover and the commencement of retirement) without any prospect of an improvement which would lead to a return to work (whether or not for reward) in any capacity; and
    (b) Is complying with reasonable medical advice and treatment; and
    (c) Has, in our opinion reached the maximum level of medical improvement possible for that Covered Person based on their Injury or Illness.'

19. This is perhaps the most severe departure from the SIS definition (which determines eligibility by reference to a member's pre-morbid education, training and experience).

20. This is a gross deviation from any community expectation of a reasonable TPD definition. The chances of a claim being admitted are deleteriously low due to the difficulty a claimant will have procuring such unequivocal medical opinion, which effectively requires that a doctor assure against future improvement. Few doctors would provide such a pessimistic message to their patient.

21. The definition also expressly enables the insurer to decline claims where a claimant may be able to do some unpaid work. Compare that to the definition of gainful employment in the

[6] *TAL Life Ltd v Shuetrim; MetLife Insurance Ltd v Shuetrim* [2016] NSWCA 68 at [89].

SIS Regulations: *'employed or self-employed for gain or reward in any business, trade, profession, vocation, calling, occupation or employment'*.

Multiple claim exclusion clauses

22. Some funds prohibit the payment of a TPD benefit if the member is eligible to claim or has received a TPD benefit from another source, despite them having paid premiums. That is even the case where a member holds cover with the same insurer elsewhere.

23. See for example the AMP Flexible Super policy exclusion as follows:

> *12 AMP Flexible Super Employee Essential Protection*
>
> *12.5 Employee eligibility*
>
> *An employee Member of an Employer Plan is eligible for Employee Essential Protection if:*
>
> *…*
>
> *(h) the employee does not have existing insurance cover within AMP Flexible Super;*
>
> *(i) the employee has not previously been paid a total and permanent disablement benefit from AMP Flexible Super, or another superannuation or insurance plan.*

24. The effect of this clause is such that AMP can, at the time of claim, retrospectively deem a member ineligible for insurance, despite accepting premiums under two policies for any number of years whilst knowing (or at least having the ability to know) that the member is ineligible for the second benefit.

25. This shows that the AMP trustee and insurer specifically engineered its policy to facilitate 'fees for no service' by allowing the insurer to collect premiums for a benefit that would never be payable in respect of large numbers of members.[7]

26. A further example is the following exclusion clause contained in an NGS Super/CommInsure policy:

[7] This issue was raised by the ABC in 2018: http://www.abc.net.au/7.30/banking-royal-commission-to-look-at-superannuation/10063336

'Excluded Member Means a Member to whom any of the following applies:

(a) A terminal illness, total and permanent disablement, trauma or similar benefit has been paid or is payable or can be claimed in respect of the Member under any insurance policy, whether that policy be owned by the Member or another person (including the Fund or another superannuation scheme);

(b) the Member has received, or is eligible to receive, a benefit, or has had a claim for a benefit admitted, from:

i. the Fund; or
ii. another superannuation scheme;

on the basis the fund or scheme has found the Member to suffer from 'permanent incapacity' or a 'terminal medical condition' under the Superannuation Industry (Supervision) legislation or any legislation which replaces it; or

(c) the Member has or was eligible to have cover under any group life policy issued to the Fund and the Member:

i. opted out of being covered; or
ii. cancelled the cover; or
iii. ceased being a member of the Fund.'

27. The ATO stated that as at 30 June 2018 approximately 39% of workers held more than one super account.[8] As such, this CommInsure policy effectively excludes TPD claims by almost half of its members despite taking non-refundable premiums from them.

28. We have seen clauses similar to these in other policies currently on sale in the group life market affecting millions of superannuation fund members who are unlikely to have an informed appreciation for the low quality insurance they are paying for.

29. The ALA further advocates for specific matters to be communicated to superannuation fund insureds in the KFS to mitigate against the risk of members not realising and doing something

[8] https://www.ato.gov.au/About-ATO/Research-and-statistics/In-detail/Super-statistics/Super-accounts-data/Super-accounts-data-overview/

about their sub-standard insurance terms. Specifically, the KFS should contextualise the price and product offerings as follows:

(a) Price: The premium cost should be compared to equivalent cover available in an independent benchmarked retail product for insured of the same demographic as the member;

(b) Product: A rating of definitions should be developed with tiering total and permanent disablement (TPD) definition classes to ensure a like for like comparison. For example, definitions that are consistent with the SIS superannuation early release provisions could be a Tier 1 policy and the use of 'unable' definitions is a Tier 2, a retraining clause is a Tier 3, pre-existing exclusion clause being Tier 4, an Activities of Daily Living (ADL) test being Tier 5, and so on. A member could then clearly see where their TPD cover sits within that comparison.

30. This should be done consistently across the industry.

Question 5. Is the standard cover regime in Division 1 of Part V of *the Insurance Contracts Act 1984* (Cth) achieving its purpose? If not, why not, and how should it be changed?

31. By incorporating life insurance definitions into the 'prescribed contracts' they would enjoy the consumer protections provided by Part IV of the ICA. An insurer could then only deviate from the standard definition if it clearly informed a consumer of the fact that the policy is below the standard that is set by law as required by s35(2) ICA. That is in a prominent, clear, concise and effective manner.

32. It is submitted that the standard definition of superannuation TPD cover should be based on the current permanent incapacity definition contained in Regulation 1.03C of the SIS Regulations. In that respect, the Parliament has for decades now had in place a fair definition of permanent incapacity which strikes a balance between the needs of those who cannot work due to ill health and the public interest to ensure funds are preserved for the purposes of superannuation and only released in exceptional circumstances.

33. It is further submitted that s37 if the ICA should be amended to require the insurer to give disclosure of the 'unusual terms' to the beneficiary (or life insured) as well as to the named

insured. In that regard, s37 currently only requires such disclosure be given to the named insured which for example would include a super fund trustee but not the covered members.

Question 6. Is there scope for insurers to make greater use of standardised definitions of key terms in insurance contracts?

34. This is addressed in response to questions 4 and 5 above.

Question 9. Is banning conflicted remuneration sufficient to ensure that sales representatives do not use inappropriate sales tactics when selling financial products? Are other changes, such as further restrictions on remuneration or incentive structures, necessary?

35. The 2012 Future of Financial Advice (FOFA) reform package banned conflicted remuneration structures including commissions and volume based payments, however that ban was limited to the distribution of and advice about a range of retail investment products — it excluded commissions in respect to the sale of 'life risk insurance products' outside superannuation. That exception enabled advisors to continue to receive commissions from insurers for recommending their products. Those commissions were often up to 120% of the premium a client was to pay for their policy in the first year.

36. A 2014 ASIC investigation identified a strong correlation between high upfront commissions and poor consumer outcomes, with 37% of the advice it reviewed failing to comply with the law in force at the time the advice was given.[9] The likelihood of advice breaching legislative standards was dramatically increased where the advisor received an upfront commission from the insurer: 45% of upfront commission advice failed ASIC's tests, whereas only 7% of non-upfront commission advice failed.

37. It was not until the introduction of the *Corporations Amendment (Life Insurance Remuneration Arrangements) Act 2017* (Life Insurance Remuneration Act) that life insurance commission caps were legislated as follows (from 2020):

[9] ASIC *Review of Retail Life Insurance Advice*, October 2014.

- 60% of the premium in the first year of the policy; and
- a maximum trailing commission of 20% of the premium in all subsequent years.

38. These reforms also require amounts to be repaid if the policy is cancelled within the first two years of the policy (clawback).

39. While the ALA welcomed these reforms which will go some way to curtailing insurance churning practices (where advisers unnecessarily rewrite their customer's policies in order to earn commissions), they do not sufficiently address the problem of vertical integration which has driven much of the rewriting conduct.

40. This has long been, and remains, a known root cause of poor advice outcomes, with a 2009 Parliamentary inquiry observing: 'A significant conflict of interest for financial advisers occurs when they are remunerated by product manufacturers for a client acting on a recommendation to invest in their financial product'.[10]

41. Such incentives are not limited to commissions and may be associated with an employee's targets and other performance indicators outside the scope of the *Life Insurance Remuneration Act*.

42. ASIC has described the vertically integrated advice model as being inherently conflicted, and lacking in customer transparency. For example ASIC's submission of December 2014 to the Scrutiny of Financial Advice Inquiry noted:

> 'The inherent conflict of interest created by vertical integration may not be readily apparent to clients, particularly if the product manufacturer and advice parts of the business operate under separate licences and business names. Roy Morgan Research found that 55% of surveyed consumers receiving financial advice from an entity owned by a large financial institution, but operating under a different brand name, considered it to be independent—in contrast, only 14% of consumers considered financial planners working under the brand of the same financial institution to be independent. This was also an issue identified by the Financial

[10] "Inquiry into financial products and services in Australia" by the Parliamentary Joint Committee on Corporations and Financial Services 2009

System Inquiry, which recommended that advisers be required to disclose ownership structures of the advice firm to consumers.'

43. Vertically integrated sales models have had devastating results for their life insureds, who are subjected to new disclosure obligations each time they buy a new policy. That increases the risk of having their eventual disability or death claim declined by the insurer due to non-disclosure. This has given rise to much litigation in recent years,[11] the most notable case being *Commonwealth Financial Planning Ltd v Couper*[12] (Couper). In Couper, the late Mr Stevens was advised by a Commonwealth Bank of Australia advisor to cancel his existing Westpac life insurance policy and replace it with a vertically integrated CommInsure product, which he did. The subsequent claim made by his Estate for his life insurance benefit was declined, and the policy avoided on the basis of non-disclosure under s29 of the ICA. The Court of Appeal found that the financial advisor was negligent and engaged in misleading and deceptive conduct. The Court noted that while the Statement of Advice did disclose the risk of avoidance for non-disclosure, it failed to disclose the 'three year rule', namely that:

    - because his Westpac policy had been on foot for more than three years, it could not be avoided by the insurer except by proving fraud; and
    - the CommInsure policy could be avoided for 'innocent non-disclosure' within the first three years from inception, and was therefore an inferior product.

44. The three year rule was, in the adviser's words '*news to me*'.

45. Although ASIC has been working with industry to open up advisers approved product list (APL) to non-affiliated products, ASIC's research confirms that even where APLs are broadened, the majority of customers are still likely to be directed into in-house products.

46. ASIC's data is consistent with Roy Morgan research found that over a three year period, these dealer groups allocated an average of over 70% of their sales to their own products.[13]

[11] See also *Swansson v Harrison & Ors* [2014] VSC 118.

[12] [2013] NSWCA 444.

[13] http://www.roymorgan.com/findings/6262-superannuation-political-football-but-new-report-shows-what-members-think-201505270222

47. Because the big vertically integrated players have such vast distribution channels to sell their 'in-house' products they do not rely on other advice firms to do it for them. That means they are disinclined to take the lead on product design, which leads to inappropriate or defective products being paid for by the client, and often results in the insurer denying liability because of those defects.

48. It is often less than clear to consumers that the distributor is linked to the product manufacturer. The distributor and the manufacturer will often have different names and branding, offering no hint to consumers that a link exists. Further, due to the complexity of financial services, consumers are less capable of comparing products and determining which one best meets their unique needs.

49. Controversies have exposed stark examples of this, such as CommInsure's retail Trauma policies, which contained medically obsolete heart attack and severe rheumatoid arthritis definitions. Despite knowing the definitional flaws, CommInsure relied upon them to decline claims. It took a media expose to prompt CommInsure to update its obsolete clauses and even then they did not adequately backdate policies, as revealed in the evidence of Helen Troupe at the Royal Commission[14].

50. While some banks have divested their wealth management and insurance divisions or are in the process of doing so, others remain committed to the 'one stop shop' wealth management model (e.g. Westpac, AMP). Hence the hazards associated with such a model remain a significant concern in need of reform. To address this, the ALA supports Recommendation 6.45 of the PJC. Specifically: that the life insurance industry should have, as a matter of urgency, a balance of affiliated and non-affiliated products on their approved product lists, and if affiliated products are recommended, the affiliation should be disclosed, and the customer should be given a comparison with non-affiliated products.

51. It is submitted that in view of the poor industry track record of self-regulation, the measures proposed by 6.45 need to be enshrined as a legal requirement through legislation or regulation.

[14] http://www.moneymanagement.com.au/news/financial-planning/comminsure-upgrades-heart-attack-definitions

52. These measures would provide prescriptive requirements to support compliance with the best interest test established by FOFA. These measures are also directed towards achieving the recommendation of John Trowbridge that APLs be reformed to 'ensure competitive access and choice for all advisers and their clients'.

53. The ALA also supports Recommendation 10.3 from the Productivity Commission's report on 'Competition in the Australian Financial System' for greater transparency of products on APL lists. In addition to the recommended reporting requirement that the proportion of products recommended that are off-APL, it is submitted that regulations for minimum quotas for the recommendation of non-affiliated products should be considered as it is important that advisers don't passively hold non-affiliated products on their APL's without actually considering and recommending them.

54. It has been encouraging to see the growing number of self-described 'independent' advisors who have voluntarily opted to unshackle themselves from their insurance paymasters by moving to full fee-for-service models. While this innovative approach may decrease their profits in the short term, it will distinguish them from their conflicted peers, thus helping them gain market share in the longer term as vigilant consumers seek greater integrity and transparency.

55. As positive as this development is, it is difficult to envisage the big Banks' financial advice arms ever embracing anything like a truly 'independent' structure. Their business models are far too entrenched towards the sale of their own in-house products.

56. With such variety in the directions taken by difference industry players, we will likely see an ever greater gulf in the quality of advice available, the fundamental distinction being between those who are interested in providing personally tailored advice, and those who are going through the motions in order to sell a particular product.

C. Sales

Question 11. Is Recommendation 10.2 from the Productivity Commission's report on "Competition in the Australian Financial System", published in June 2018, sufficient to address the problems that can arise where financial products are sold under a general advice model (for example, the sale of financial products to consumers for whom those products are not appropriate)? If not, what additional changes are required? Are there some financial products that should only be sold with personal advice?

57. The ALA agrees with the Productivity Commission's recommendation 10.2 and suggests the inherently misleading term general should be renamed to make it clear to insurers that the product is not tailored to their personal needs, circumstances or objectives and may be unsuitable.

Question 12. Should all financial services entities that maintain an approved product list be required to comply with the obligations contained in FSC Standard No 24: Life Insurance Approved Product List Policy?

58. The ALA does not consider the FSC Standard No 24: Life Insurance Approved Product List Policy to be an adequate response to the problems identified in response to question 9 above noting it is non-binding, centres around 'best practice principles' rather than hard requirements and imposes no real consequences to non-adherent members. This is another reason for our recommendations set out in response to question nine above concerning advice practices and use of APLs across both investment and insurance products.

E. Claims handling

Question 18. Should ASIC have jurisdiction in respect of the handling and settlement of insurance claims?

59. The ALA has long advocated for all insurers to be required, as a licencing condition, to commit and adhere to a binding and enforceable Code of Practice that has been ratified by ASIC (including through compliance with ASIC's 'RG 183 Approval of financial services sector

codes of conduct'). ASIC should have an active role in monitoring an independent code administrator with the power to impose sanctions for breaches of the code. The ALA otherwise supports Recommendations 18–22 of the ASIC Enforcement Review Taskforce Report of December 2017 concerning Industry codes in the financial sector.

60. The FSC's Life Insurance Code of Practice and the Insurance in Superannuation Code do not meet these important requirements and also fall short of providing adequate consumer protections, for example the Life Insurance Code of Practice:

    (a) allows for insurers to use blanket authorities[15] which enables information trawling from any third party rather than targeting authorities to the entity and information relevant to the claim;
    (b) allows insurers to require claimants to undergo multiple medical examinations with experts of the same discipline every six months which enables 'doctor shopping' by insurers over the course of a claim.[16] This practice has been particularly common in respect to income protection claims which run over a number of years where the insurer wants to 'have a go' at the claimant on an intermittent basis despite having medical evidence supporting the claim. See for example the case study examined by the ABC's 2016 story wherein the claimant, Mr Fernando, who suffered from Major Depression and Adjustment Disorder, was compelled by his income protection insurer Westpac Life Insurance Limited to submit to the examination of numerous different psychiatrists over 3 years until a third psychiatrist's opinion deviated from the preponderance of supportive evidence and was used by the insurer to cease stopped payments;[17]
    (c) imposes no time limit for the assessment or payment of an ongoing income protection benefit (the 'soft' time limit only applied in respect to the initial income protection payment);[18]

[15] Clause 8.6.

[16] Clause 8.10.

[17] Radio National's Background Briefing: "Insurance industry stuck in 'dark ages', say mental health advocates", 27 November 2016 (http://www.abc.net.au/radionational/programs/backgroundbriefing/2016-11-27/8054972).

[18] Clause 8.16.

(d) enables an insurer to circumvent any claim assessment time limit by invoking the excessively broad 'Unexpected Circumstances' clause. That broad codicil is prone to misuse and the ALA is aware of insurers invoking it on the basis requesting Medicare, tax or Centrelink information, which are all routine (or expected) steps in any claim assessment process;

(e) allows an insurer to withhold relevant information from a claimant where it considers 'the release of the information may be prejudicial', which is blatantly inconsistent with insurers' long established 'procedural fairness' obligations[19] and their duty of utmost good faith.

61. It is noted that since its commencement in July 2017, the Life Code Compliance Committee (LCCC) who administers the Life Insurance Code of Practice has received 747 notices of alleged breaches but a mere 23 self-reported breaches as at September 2018 which strongly suggests a lack of adequate self-evaluation by insurers as to their own code compliance standards.[20]

62. On these bases, and those noted by the PJC, the ALA supports the PJC's Recommendation 4.58 that ASIC be given the power to undertake enforcement action (halting misconduct, remedies and sanctions) in relation to systemic or systematic breaches of codes of practice in the financial services sector, including in the life insurance sector.

<u>**Life insurance**</u>

Question 19. Should life insurers be prevented from denying claims based on the existence of a pre-existing condition that is unrelated to the condition that is the basis for the claim?

63. Yes. Too often we see policies avoided on the basis of alleged non-disclosure/misrepresentation following trawling by insurers of a claimant's medical history, and often on the basis of a reference to depression or anxiety that resolved before the policy commenced. Under s.29(3) of the ICA in order to avoid a policy *ab initio* (and thereby deny any claim) an insurer need only prove that it would not have entered into *the* policy on the

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[19] *Sayseng v Kellogg Superannuation Pty Ltd & Anor* [2003] NSWSC 945 per Bryson J at [82].

[20] https://www.fos.org.au/custom/files/docs/life-ccc-20172018-annual-review.pdf

same terms, even where:

(a) the non-disclosure/misrepresentation was innocent (non-fraudulent);

(b) but for the non-disclosure/misrepresentation the life insurer would have accepted the risk and provided a policy (albeit on different terms such a premium loading or exclusion) that would respond to the claim actually made.

64. The current regime is disproportionately and unfairly tilted in favour of the insurer — it permits the insurer to take a sledgehammer to the policy where a scalpel is appropriate. That is, the remedy in the context of innocent non-disclosure/misrepresentation should be relative to the prejudice suffered by the insurer, if any, due to a non-disclosure/misrepresentation. That approach would be consistent with the more sophisticated and proportionate remedies found in s28 and s54 of the ICA. The extent of the prejudice should be objectively determined against the practices of other reasonable insurers and not merely based on the protagonist insurer's own underwriting practice/opinion.[21] If, through that process, an insurer can prove that it would not have accepted the risk on terms that would have responded to the claim actually made, it ought to be permitted then, and only then, to decline that claim.

65. Further, the current limitation that an avoidance in the context of innocent non-disclosure/misrepresentation must be done within three years from policy inception is an inadequate and illogical protection. That is because, if anything, an insured acting fraudulently would surely be *more* likely to make a claim within the first three years and does not in any way reflect the prejudice actually suffered by the insurer, leading to disproportionately harsh outcomes for non-fraudulent insureds.

66. Importantly, s31 of ICA gives a court a discretion to disregard avoidance in circumstances where it would be harsh or unfair to allow avoidance, however:

(a) that only applies to avoidances for fraudulent non-disclosure/misrepresentations and there is therefore a critical lacuna in the law whereby equivalent protections are denied to innocent insurance applicants; and

[21] Consistent with the test in s.29(7) of the ICA.

that power does not vest in the Australian Financial Complaints Authority (AFCA) as it is not a court.

67. Reform is clearly needed in this area and in addition to the above points the ALA supports the PJC's Recommendation 10.21 that insurers make an explicit commitments that:

    (a) where a pre-existing condition is to be used by an insurer as the basis for denying a claim or avoiding a contract a direct medical connection between the prognosis of a pre-existing diagnosed condition and the claim must be established; and
    (b) the statistical and actuarial evidence and any other material used to establish a pre-existing condition, as well as a written summary of the evidence in simple and plain language, be provided by the life insurer to the consumer/policyholder on request.

Question 20. Should life insurers who seek out medical information for claims handling purposes be required to limit that information to information that is relevant to the claimed condition?

68. The ALA accepts that it is reasonable for an insurer to seek medical information to determine whether there has been a non-disclosure/misrepresentation which prejudiced it in the underwriting process. That is because in order to determine the extent of prejudice suffered by an insurer, if any, due to a non-disclosure or misrepresentation, it must know what information it should have had at the time of underwriting.

69. However only precise and targeted authorities should be used, and insurers should only be entitled to obtain records dating back a reasonable period of time, which the ALA submits should be no more than five years prior to policy inception.

Question 21. Should life insurers be prevented from engaging in surveillance of an insured who has a diagnosed mental health condition or who is making a claim based on a mental health condition? If not, are the current regulatory requirements sufficient to ensure that surveillance is only used appropriately and in circumstances where the surveillance will not cause harm to the insured? If the current regulatory requirements are not sufficient, what should be changed?

70. Reform needed in this area due to the specific and complex range of difficulties encountered by claimants suffering from psychological illness.

71. The ALA notes and supports the PJC Recommendation 10.101 that after consultation with relevant medical professionals independent of the life insurance industry and mental health advocacy groups, the Financial Services Council establish a mandatory and enforceable Code of Practice for its members, or a dedicated part of its existing Code of Practice, specifically in relation to mental health life insurance claims and related issues.

72. On the specific issue of surveillance, the ALA notes the limited utility of surveillance in such claims as well as the elevated risk of claimants' conditions being aggravated by surveillance activities.[22] That was demonstrated by the TAL Life Limited case study in the Royal Commission which demonstrated the obvious lack of good faith by not only seeking evidence from a surveillance operative, but insisting on its delivery, which counterproductively led to the exacerbation of the claimant's illness.

73. The ALA endorses the pertinent remarks of Robb J concerning surveillance of psychological claimants in *Wheeler v FSS Trustee Corporation as trustee for the First State Superannuation Scheme*: [23]

> 'I will not attempt to be exhaustive, but the medical evidence suggests that both PTSD and major depressive disorder are insidious mental injuries, which can be extremely detrimental to the sufferer's ability to hold down regular employment, whether full-

[22] See for example https://www.smh.com.au/national/nsw/life-insurance-claims-often-more-stressful-than-original-injury-20151112-gkwzib.html; https://www.smh.com.au/business/banking-and-finance/doorknock-insurers-must-be-stopped-20160311-gngy5x.html; http://www.abc.net.au/news/2016-03-17/insurance-investigators-accused-of-bullying-and-intimidation/7255262; http://www.abc.net.au/radionational/programs/backgroundbriefing/2016-11-27/8054972

[23] [2016] NSWSC 534 at [273].

time or part-time; but the symptoms of the disorders are not permanently and consistently manifested. The psychological injuries may have the effect that the sufferer becomes too unreliable, too disorganised, too unsociable, and too lethargic, to be realistically employable, among other disabilities. However, when a person is suffering from these psychological disorders, what you see is not necessarily what you get. The sufferer may, at various times and periods, appear reasonably normal, and capable of engaging in many forms of employment. The presence of the psychological disorders is not necessarily inconsistent with periods of happiness and sociability. Indeed, treating psychiatrists and psychologists are most likely to advise sufferers to do their best to get out into the real world and try to live a normal life, as a remedial exercise. In short, the ordinary person cannot safely look at evidence of the occasional day to day activities of a person suffering from PTSD and major depressive disorder, and conclude that the person is not suffering from disabilities that may make the person practically unemployable, because the person is able from time to time to engage in the sort of activities of which healthy people are capable of doing.'

74. It is submitted that the following reforms are appropriate:

(a) Insurers proposing to conduct surveillance on a claimant with any non-physical medical condition be required to submit an *ex parte* application for approval to an independent body such as AFCA who would be mandated to consider and determine any such applications before surveillance is commenced;

(b) The test for approving the application be that the independent body is satisfied based on evidence preferred by the insurer that:

   i. there is a reasonable basis for believing that the claimant has given inconsistent information to it in respect to the claim in issue which is not based on an unconfirmed suspicion which the insurer hopes to later confirm through the surveillance activity;

   ii. there is medical opinion from an appropriately qualified expert witness or otherwise that there is no danger that the proposed surveillance activity, conducted lawfully, will cause harm to the claimant.

75. These measures could be enshrined in the AFCA rule and/or a mandatory code of practice that is compliant with ASIC's 'RG 183 Approval of financial services sector codes of conduct'.

F. Insurance in superannuation

Question 23. Should universal:

23.1 minimum coverage requirements; and/or

23.2 key definitions; and/or

23.3 key exclusions,

be prescribed for group life policies offered to MySuper members?

76. Yes for the reasons discussed in response to questions four and five above concerning the standardisation and enhanced disclosure of life insurance definitions through expansive reform to the Standard Cover and Key Facts Sheets sections of the ICA.

Question 24. Should group life insurance policies offered to MySuper members be permitted to use a definition of "total and permanent incapacity" that derogates from the definition of "permanent incapacity" contained in regulation 1.03C of the *Superannuation Industry (Supervision) Regulations 1994* (Cth)?

77. This issue is addressing in the above response to question five.

Question 25. Should RSE Licensees be obliged to ensure that their members are defaulted to statistically appropriate rates for insurance required to be offered through the fund under section 68AA(1) of the *Superannuation Industry (Supervision) Act 1993* (Cth)?

78. The ALA is of the firm view that automatic death and TPD insurance cover in MySuper is an overwhelmingly successful means of mitigating Australian households' serious

underinsurance gap. It has been and remains an invaluable resource for disabled workers and their dependents who often have no other means of managing medical retirement besides resorting to Centrelink.[24]

79. However in reaction to the post GFC 'claims spike' which caused unbudgeted pay outs[25] a concerning number of rushed group life insurance policy renegotiations derogated the quality and value of members' default arrangements as the insurers attempted to recover losses. This resulted in the widespread use of oppressive policy conditions discussed in response to question four above. Additionally, insurers increased their disputation of existing claims under legacy policies. These factors were ultimately counterproductive as they led to community concerns as to the sustainability and value of the default arrangements, thereby contributing to the push for the Royal Commission.

80. The ALA accepts that it is inevitable that in a group underwriting arrangement, where cover is not bespoke to each individual member, some will get better value from the arrangement than others. However trustees and insurers must do more to understand their membership's circumstances and needs and ensure that all members get some value for their premiums.

81. The REST case study in the Royal Commission hearings highlighted the hazards of managing information across thousands of members all with specific individual rights under a group life insurance policy. In that case the Trustee, insurer and participating employer (McDonalds) failed to have proper systems in place to determine members' employment status and other circumstances directly material to each member's eligibility for cover. Consequently, valuable cover ceased entirely unbeknownst to members whose account balance fell below a threshold and whose employment ceased. However since the introduction of s68AA, which makes default TPD cover mandatory in MySuper products, rather than cover ceasing entirely due to employment triggers, the quality of the TPD cover provided cascades down to the point of being almost impossible to satisfy. For example,

[24] The ALA's submission to the Productivity Commission's 'Superannuation: Assessing Efficiency and Competitiveness' detailed our concerns as to unintended consequences of auto-consolidation of super accounts and opt-out cover for members aged 25 and under is here: https://www.pc.gov.au/__data/assets/pdf_file/0003/221493/sub065-superannuation-assessment.pdf

[25] Life insurance industry overview General insurance industry overview: www.apra.gov.au/Insight/Documents/14-Insight-Issue-2.pdf

under current arrangements, many members' death or TPD cover will exclude a claim arising from a condition that existed prior to the commencement of cover (Limited Cover), or only assess the member under a highly onerous Activities of Daily Living (ADL) definition. That commonly occurs where the insurer deems that the member was not working sufficient hours or was working on a restricted basis, determined by reference to an 'at work' or 'active employment' test in the relevant policy.

82. A member does not usually find out about the application of the inferior coverage until their claim is declined, despite paying the same premium as optimally insured members. That is because neither funds nor insurers know which group members will be deemed to have inferior conditions until after a claim is lodged. That is clearly inadequate:

    (a) Firstly, those members with Limited Cover or ADL cover should be paying a much lower premium to reflect the vast inferiority of their coverage. By charging the standard premium funds and insurers are improperly eroding their account balances and that cannot be consistent with s52(7)(c) of the SIS Act which states that a trustee must 'only offer or acquire insurance of a particular kind, or at a particular level, if the cost of the insurance does not inappropriately erode the retirement income of beneficiaries'.
    (b) Secondly, members with such inferior cover ought to have certainty regarding the insurance cover they hold to enable them to determine whether such cover is adequate and if not to seek additional or alternative cover.

83. Blanket underwriting, whereby the same coverage is provided to all members regardless of their personal circumstances, is not the problem per se — It is too costly to individually underwrite millions of policy holders. However, 'at work' or 'active employment' definitions vary widely from one policy to another, and are often technical or counter-intuitive to the terms' natural English meaning. It is therefore submitted that minimum standards should be developed to provide for full cover as long as members meet minimum work attendance. Work attendance information is readily knowable for trustees for example by obtaining such data from the participating employer or by deducing it from their earnings based on the default employer contributions received. With such data members could have certainty as to their cover type and not be 'blind-sided' with a denial based on Limited Cover or ADL when

they are permanently disabled from suitable work and in need of their insurance payment.

84. It is also concerning that group life insurers often have no idea which individuals they are covering despite receiving premiums, let alone their age and other important individual details (noting insurers often receive only a list of member numbers and dates of birth). Greater visibility and communication between trustees, insurers and employers is needed. Trustees need to do a better job of monitoring these matters and ensuring members are matched to appropriate levels of quality cover suited to their demographic profile. This is no doubt a complex challenge which will require significant investment in technology. The linking of superannuation accounts to tax file numbers can assist and that advantage should be capitalised.

85. The ALA observes, parenthetically, that one significant advantage many industry funds have in addressing the above challenges is that they are specialised to a particular class of employees (e.g. construction workers (CBUS), healthcare workers (HESTA) transport and delivery workers (TWUSuper)). Hence that the pool of beneficiaries share characteristics around which targeted cover may be designed. This advantage is lost where funds' membership bases become large and generalised. That problem would likely be exacerbated by the introduction of the Productivity Commission's 'best in show'[26] proposal which would drastically broaden and vary the membership base of the top performing funds.

86. On the basis of the above, the ALA believes that a statutory requirement under s68AA of the SIS Act would be an appropriate means of enacting a clear obligation on Trustees to ensure that their members are defaulted to statistically appropriate rates for insurance required to be offered through the fund. This should be followed by the development of clear minimum standards through a regulatory guide.

[26] Draft Report 'Superannuation: Assessing Efficiency and Competitiveness' 29 May 2018 (https://www.pc.gov.au/inquiries/current/superannuation/assessment/draft)

Question 26. Should RSE Licensees be prohibited from engaging an associated entity as the fund's group life insurer?

87. Yes, due to the inherent risks associated with large volume vertical integration as seen in the numerous cases studies involving retail superannuation trustees who almost without exception insure their members with its affiliated company at rates that represent poor value compared to equivalent cover offered by, for example, industry funds. Such cover often contains draconian exclusion clauses, for example the AMP Flexible Super policy multiple claim exclusion clause discussed in response to question four above. Indeed, there are few if any examples of a fund trustee owned by a major bank or AMP engaging a non-affiliated insurer.

Question 27. Alternatively, should RSE Licensees who engage an associated entity as the fund's group life insurer be subject to additional requirements to demonstrate that the engagement of the group life insurer is in the best interests of beneficiaries and otherwise satisfies legal and regulatory requirements, including the requirements set out in paragraphs 22 to 24 of Prudential Standard SPS 250, Insurance in Superannuation?

88. Good practice for any trustee ought to involve a competitive tender at least every 3–5 years to ensure the best deal for its members. If mass scale vertical integration between trustees and insurers is to be tolerated, the highest standards of accountability and transparency ought to be required and monitored by the appropriate regulators. Regulatory guidance should be developed to set minimum standards for these tender processes.

Question 28. Are the terms set out in the Insurance in Superannuation Voluntary Code of Practice sufficient to protect the interests of fund members? If not, what additional protections are necessary?

89. No. The numerous flaws in the Insurance in Superannuation Voluntary Code of Practice (Super Code) are fundamental (and often at odds with the recommendations of the ASIC Enforcement Review Taskforce Report). The most obvious being that:

    - it is voluntary;

- where trustees do decide to sign up, they have the discretion to 'opt out' of any specific aspects of the Super Code;
- it has no code administrator to enforce it and relies upon self-reported breaches;
- it has no ASIC approval or oversight;
- it has an excessively long transition period for compliance (2021);
- it imposes no higher claims assessment standards than those set out in the deficient Life Insurance Code of Practice which it notionally binds participating trustees to;
- it is not compliant with *ASIC Regulatory Guide 183: Approval of Financial Services Sector Codes of Conduct*.

90. The ALA supports the various recommendations made by the PJC concerning the Insurance in Superannuation Voluntary Code of Practice as well as its reasoning for those recommendations.

G. Scope of the *Insurance Contracts Act 1984* (Cth)

Question 29. Is there any reason why unfair contract terms protections should not be applied to insurance contracts in the manner proposed in "Extending Unfair Contract Terms Protections to Insurance Contracts", published by the Australian Government in June 2018?

91. The ALA refers to the submissions made concerning Unfair Contracts in insurance in response to question one above.

Question 30. Does the duty of utmost good faith in section 13 of the *Insurance Contracts Act 1984* (Cth) apply to the way that an insurer interacts with an external dispute resolution body in relation to a dispute arising under a contract of insurance? Should it?

92. The ALA sees no good reason why the duty of utmost good faith should not continue upon lodgement of an external dispute resolution (EDR) complaint, or indeed court proceedings (so long as the relevant policy remains in force). That should be confirmed in statute. Moreover, given the industry's record of misconduct, it is submitted that serious consideration should be given to require financial service providers to operate in accordance with the Model Litigant Rules.

Question 31. Have the 2013 amendments to section 29 of the *Insurance Contracts Act 1984* (Cth) resulted in an "avoidance" regime that is unfairly weighted in favour of insurers? If so, what reform is needed?

93. Yes, for the reasons discussed in response to question 19 above.

H. Regulation

Question 33. Should the Life Insurance Code of Practice and the General Insurance Code of Practice apply to all insurers in respect of the relevant categories of business?

94. Yes, codes should be a requirement of a financial services license and not a voluntary option for insurers. The ALA supports the following comments of ASIC:

> 'At present, there are significant weaknesses in the Code, including in its monitoring and enforcement arrangements, that limit its potential effectiveness. Industry codes work best if they have full coverage across the industry. One way to achieve this is to make Code membership mandatory. ASIC cannot mandate a code or force industry sectors to submit a code for approval.'[27]

95. Please also refer to the responses to question 18 above.

[27] ASIC Report 591: Insurance in superannuation, September 2018.

Question 34. Should a failure to comply with the General Insurance Code of Practice or the Life Insurance Code of Practice constitute:

> **34.1 a failure to comply with financial services laws (for the purpose of section 912A of the *Corporations Act 2001* (Cth));**
> **34.2 a failure to comply with an Act (for example, the *Corporations Act 2001* (Cth) or the *Insurance Contracts Act 1984* (Cth))?**

96. Yes, there should be legal consequences for code breached beyond any sanctions of an appointed code administrator who may impose for example a requirement for the insurer to publish its breach. If codes are to be effective and credible regulatory instruments insurers should be contractually and statutorily bound by their provisions.

I. Compliance and breach reporting

Question 36. Is there sufficient external oversight of the adequacy of the compliance systems of financial services entities? Should ASIC and APRA do more to ensure that financial services entities have adequate compliance systems? What should they do?

Claims data monitoring and reporting

97. The ALA considers the role of the regulators concerning the monitoring and reporting of the industry's statistical claims and other data to be essential in providing accountability and encouraging consumer focused competition. It is for this reason that the ALA has welcomed ASIC's investigations resulting in Report 498 'Life insurance claims: An industry review' of 12 October 2016 which published life insurers' claim assessment/denial data, albeit on a de-identified basis. APRA and ASIC are in advances stages of finalising this project with a plan to publish insurer specific data from 2019.

98. The ALA notes the objectives of the public reporting of claims information process, as spelled out in the 24 May 2018 update on progress at section 1.2:[28]

- To improve accountability and performance of life insurers in relation to claims; and
- To facilitate an informed public discussion about the performance of the life insurance industry.

These objectives will be achieved through publication of credible, reliable and comparable data. (p7)

99. The ALA submits that the publication of industry data should include the following (which are not presently proposed in the regulators' proposals):
    a) Statistics on the number or percentage of claims denied across the following categories for denial:[29]
        - the claim is outside of the policy terms and the claim entitlement is not met;
        - the claim is declined due to an exclusion clause for example there is a pre-existing condition;
        - the policyholder is found to have made a fraudulent non-disclosure;
        - the policyholder made an innocent non-disclosure in the first three years; or
        - an allegation of a fraudulent claim.
    b) A breakdown of instances where either surveillance was conducted or an expert witness report was obtained/relied upon by the insurer together with a reference to the general nature of the condition involved (e.g. orthopaedic, chronic illness, mental health etc.).
    c) A breakdown of the reasons for delay in claim assessment, delineating between:
        - Delay caused by dispute; or
        - Delay caused by insurer inertia; or
        - Delay caused by outstanding requirements of the insurer.

[28] APRA and ASIC, Response to Submissions. Life insurance – public reporting of claims information – update on progress, 24 May 2018

[29] As proffered by in the submission of the Financial Rights Legal Centre, August 2017: https://www.apra.gov.au/sites/default/files/Financial-Right-Legal-Centre-Submission.pdf

d) A breakdown of how many of the undetermined claims reported at the end of one reporting cycle are still undetermined at the end of the next — so what percentage of the undetermined claims are 'newly undetermined'.
e) Claim quantum statistics (noting that the degree to which an insurer is likely to dispute a claim is related to the size of the potential payout) by comparing 'declined' claims by 'the dollar range of the payout', across product types.
f) The publication of industry data grouped by re-insurer who often have a major financial interest in a claim outcome.
g) The publication of superannuation fund data noting that the publication of insurer data, without reference to the super funds they underwrite, will mean little to a substantial portion of the public.

100. The ALA endorses APRA's proposal to determine under s57 of the APRA Act that all data collected under the Reporting Standard be non-confidential. We consider that de-identification of funds/insurers would also have a stifling effect on competition within the insurance sector through a diminished incentive for insurers to demonstrate themselves to be the 'best in show'.

<u>Use of 'independent reports' and self-administered compensation schemes</u>

101. The ALA is aware of the widespread practice by financial services companies including insurers of commissioning independent investigations by third parties such as large legal or accounting/auditing firms and then submitting those reports to regulators as 'independent'. It is submitted that the regulators must do more to monitor investigations of this type and ensure their integrity due to the significant risk that such reports lack real independence and result in a real or perceived 'whitewash' of the true extend of the matters being investigated.

102. This matter was explored in the AMP evidence in the Royal Commission's financial advice hearings wherein a report characterised as 'independent' was submitted to ASIC after 25 drafts passed between Clayton Utz and to AMP wherein significant changes were made at AMP's request.

103. The ALA remains concerned by the lack of transparency in such a process generally and notes for example the fact that two reviews commissioned by CommInsure from DLA Piper and Ernst & Young in 2017 were not released to the public on the ground of confidentiality and privilege[30] despite the fact that CommInsure 'cherry picked' parts of those reports to clear itself of any systemic wrongdoing in its investigation into its claims handling practices.[31]

104. Such reports are often material ASIC's decision as to the action to take against a financial services firm, and where it is determined that an Enforceable Undertakings is appropriate, they are material to the terms negotiated including the parameters of any remediation scheme[32]. That was a stark concern in the negotiation and implementation of the Macquarie Equities Limited (MEL) remediation program. In that example, serious compliance deficiencies identified in 2011 finally catalysed an Enforceable Undertaking in January 2013[33] which required MEL to initiate a so called 'independent' investigation and obtain a report from KPMG before finally writing to customers inviting them to participate in a review in early 2014. By that time, many customers' time limits for court proceedings had expired and MEL did not agree to any waiver of such limits.

105. Clearly, the lack of transparency and scrutiny, coupled with the excessive delay common to such investigations and remediation schemes is inadequate. Until the public can have confidence in the integrity of the 'independent report' process which must include all such reports being made public, it cannot have confidence in the regulatory response to misconduct, or the legitimacy of any remediation scheme.

[30] See for example https://www.afr.com/business/banking-and-finance/financial-services/comminsure-to-keep-independent-reviews-private-20170301-guo54v

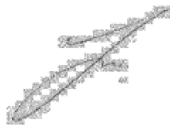
[31] https://www.commbank.com.au/guidance/newsroom/comminsure-releases-deloitte-report-into-claims-handling-201702.html

[32] See for example the https://asic.gov.au/about-asic/news-centre/find-a-media-release/2015-releases/15-022mr-macquarie-equities-limited-enforceable-undertaking-and-next-steps/

[33] https://download.asic.gov.au/media/1301089/027955255.pdf

106. ASIC simply needs to do a better job of managing such matters by intervening in their compliance systems at the front end but also by efficiently managing the timely response to compliance failures without any risk of the issues being down played or 'whitewashed'. It should be given all necessary powers and resources to do so.

Yours sincerely,



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