FSC FINANCIAL SERVICES COUNCIL

25 October 2018

ROYAL COMMISSION INTO MISCONDUCT IN THE BANKING, SUPERANNUATION AND FINANCIAL SERVICES INDUSTRY: ROUND 6 HEARINGS

The Financial Services Council (**FSC**), as a party to the Round 6 hearing, welcomes the opportunity to make a submission on the policy questions relating to the life insurance industry raised in Counsel Assisting's closing submissions for the hearing.

The policy matters raised in this Round involve a range of difficult and complex issues. We trust the **attached** submissions will be of assistance to the Commission in considering how those issues should be addressed.

We have set out our submission in the following manner:

Part 1 – Overview;
Part 2 –The FSC's Life Insurance Code of Practice (**Code**);
Part 3-The FSC's Response to the Questions.

Please contact us with any questions in relation to this submission on (02) 9299 3022.

Yours sincerely,

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PART 1 - OVERVIEW

Many of the policy matters identified by Counsel Assisting the Commission, with reference to the relevant individual case studies, are directed to whether there should be legislative changes to address issues of the kind identified in those case studies.

There is no question that the behaviours identified through the individual case studies fell far short of community standards and expectations. There is, equally, no question that consumers should have the benefit of readily accessible means of obtaining a remedy when they are confronted with unacceptable behaviour of that kind.

In considering the need for legislative or other change because of these identified misbehaviours, the FSC submits that the following points are important and should be considered by the Commission:

1. Much of the case study behaviour occurred ***before*** the Code was implemented on 30 June 2017. As such, it is not behaviour which necessarily reflects the way in which the life insurance industry is behaving at a time when insurers have been subject to, and consumers have had the benefit of, the obligations and protections under the Code.

2. Since the Code's commencement on 30 June 2017:

    a. The Code has cast a substantial number of key obligations on insurers covering most of the aspects of the life insurance process, from advertising, through to policy negotiation and creation, and claims handling.

    b. The Code is enforceable in the hands of consumers in the following ways:

        i. Consumers can report an alleged Code breach to the Life Code Compliance Committee (**LCCC**) (an independent body established, amongst other things, to monitor and enforce Code compliance).[1]

        ii. Amongst other powers, the LCCC, has power to make determinations in relation to reports of alleged Code breaches which it has investigated and has power to agree fair and reasonable corrective measures with Code subscribers and monitor the implementation of those measures.

        iii. The life insurer FSC members:

            A. are contractually bound to the FSC to comply with the LCCC's determinations and any sanctions. Failure to do so is a breach of the FSC's Standards;

            B. are most likely to comply with the determinations of the LCCC in any event, as the FSC takes the view that the adverse publicity associated with an insurer failing to do that which the LCCC determined would be likely to be extremely harmful to the insurer's brand and reputation in the market. Further, the FSC is likely to treat

[1] Refer to Clause 2.1 of the LCCC Charter: https://www.fsc.org.au/policy/life-insurance/code-of-practice/resources/FINAL%20Life%20CCC%20Charter%20SIGNED.pdf

any failure to so comply as affecting adversely upon industry reputation and as a separate breach of its Standards;[2]

C. In any event, insurers remain amenable to the external dispute resolution jurisdiction of the Financial Ombudsman Service (**FOS**)[3] in respect of a Code breach and further face action in FOS if they failed to comply with the LCCC's requirements. As we explain further in Part B, in arriving at a decision under the "rules" for each of FOS and AFCA,[4] one of the factors each body can have regard to in arriving at a decision is any applicable industry code or guidance as to practice;[5]

c. Consumers have been actively taking advantage of this new system. Naturally it would take some time after its commencement for consumers to become aware of and start to use the system. Notwithstanding that, in little over a year there have been:

i. 23 Code breaches self-reported by subscribers;

ii. 747 referrals of alleged Code breaches (including a bulk referral by Maurice Blackburn) alleging a total of 785 individual breaches;

iii. 2 Code breaches identified through the LCCC's proactive and targeted investigations in compliance in specific areas.[6]

3. The Code has been recognised as having successfully improved the standards of behaviour of insurers since its relatively recent introduction. For example, in ASIC Report 587 *The Sale of Direct Life Insurance,* ASIC indicated that

For many firms, conduct had improved, and the introduction of the Code by the FSC appears to have played a role in improving sales standards, particularly where it sets clear and specific expectations.

For completeness, we do note that ASIC did state however that it

identified ongoing practices that create the risk of poor consumer outcomes[7]

We will discuss measures to address ASIC's concerns below in our comments concerning the next version of the Code (**Version 2**).

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[2] FSC Standard Number 1 – *Code of Ethics and Code of Conduct*
https://www.fsc.org.au/resources/standards/1S%20Code%20of%20Ethics%20and%20Code%20of%20Conduct%20(REVISED%20SEP18).pdf

[3] FOS is to be superseded in November by the Australian Financial Complaints Authority (**AFCA**).

[4] https://www.fos.org.au/custom/files/docs/fos-terms-of-reference-as-of-1-january-2018.pdf
FOS Terms of Reference-paragraph 8.2 (b);
https://www.afca.org.au/custom/files/docs/20180920-afca-rules.pdf
AFCA Rules-Rule A14.2 b)

[5] Noting that there are jurisdictional and compensation limits with EDR. However, these would seem to encompass most claims. For example, in the case of AFCA for an income stream insurance claim, the compensation amount limit per claim is $13,400 per month with the amount claimed by the claimant not to exceed $1 million. All other relevant claims here, except superannuation complaints, have a compensation amount limit per claim of $500,000, with the amount claimed by the complainant not to exceed $1 million. Refer to page 35 of the AFCA rules.

[6] https://www.fos.org.au/custom/files/docs/life-ccc-20172018-annual-review.pdf
LCCC Inaugural Annual Report for 2017-018.

[7] At paragraph 22.

4. Compared with conventional litigation, the process of referring alleged Code breaches to the LCCC does not involve lawyers, is relatively informal, is not the subject of extensive delays due to interlocutory skirmishing and busy court lists, and given these features, easier, quicker and cheaper for consumers to use. In principle, the same analysis applies to FOS /AFCA processes.

5. The Code can and is being improved, to introduce a range of more specific obligations and to cover particular kinds of behaviours that the current version of the Code does not address. This was always the FSC's intention, and the Code was introduced in its current form to ensure that the ongoing process of improvement and expansion did not prevent the Code from being introduced and implemented.

6. It is the intention of the FSC to obtain ASIC Approval of a future iteration of the Code.

7. In deciding whether there is need for regulatory change, and if so, what shape and form it should take, the above matters support the view that:

    a. the Code is an important means by which insurer behaviour is being, and can continue to be, moderated;

    b. the Code is a valuable means by which consumers can have their complaints heard and, where appropriate, real remedies provided to them, in a relatively quick and cheap way;

    c. the behaviours that have been identified during the public hearings are not reflective of insurer behaviour under the Code, and as such, should not be used to draw conclusions about the efficacy of the Code contrary to those set out above;

    d. the Code should continue to be improved, with the Commission's recommendations and views on the nature and extent of any improvements being of significant value to the FSC in this regard;

    e. depending on the particular kind of legislative reform in question, some care needs to be taken in deciding whether it is truly advisable (particularly to the extent they are driven by a desire to provide the consumers with a better ultimate outcome both in relation to policy terms, premium and dispute resolution). While some possible areas of legislative reform identified by Counsel Assisting fall outside this area of concern and are actively supported by the FSC as detailed in these submissions, other possible reforms have the potential to create difficulties. This is because:

        i. legislative reforms providing consumers with conventional causes of action in legal proceedings will only serve to promote the existing costly, time consuming and lawyer-driven litigation path. The merits of giving them more costly and lengthy pathways to a courtroom are questionable. The FSC believes that the Code pathway is valuable and the focus should be on how it can be improved and better brought to the attention of consumers;

        ii. the feedback from the insurance markets that FSC has received indicates that, if legislative reforms have the effect of introducing uncertainty into the position of insurers under policies of insurance with respect to the scope of cover, this will

adversely affect insurers willingness to write cover,(both in terms of whether they will agree to provide cover at all, and if so, on what terms and for what price). The concern is that insurance will be more difficult to obtain, and cost more. The individual insurance members of the FSC will be better placed to provide information to the Commission in relation to this issue. There also is likely to be a flow through effect on the reinsurance market.

iii. Having given this overview, we consider the Code in more detail, and then address the individual questions that have been put.

PART 2 - THE CODE

It is useful if in the first instance, we outline the operation of the current Code. As we have said above, the positive impact of the Code, albeit that further work is required to be done, has been noted by ASIC. As the Commission is aware, the Code also imposes limitations on the use of surveillance.[8] It is these types of beneficial outcomes for consumers which the FSC hopes to expand upon in the Version 2 of the Code.

Scope of the Code

The Code covers all aspects of an insurer's dealings with their consumers as follows:

- Policy design and disclosure
- Sales practices and advertising
- Buying insurance
- Policy changes and cancellation rights
- Supporting vulnerable consumers
- Making a claim
- Complaints and disputes
- Standards for third parties

Enforceability of the Code

FOS/AFCA

We have discussed this topic above at paragraph 2 of Part 1 of our submission. We confirm that consumers in effect can enforce the Code currently through FOS.[9] Thus, in paragraph 8.2, the FOS Terms of Reference (**TOR**) provide that FOS will do what in its opinion is fair in all the circumstances, having regard to a number of specified factors. One of these factors is applicable industry codes or guidance as to practice.[10] The AFCA Rules in this regard are expressed in similar terms to the TOR.[11] An aggrieved consumer also may report an alleged Code breach to the LCCC. We note that this system of having a "free to consumers" dispute resolution service model is mirrored in other countries and works in an almost identical way to the United Kingdom's Financial Ombudsman Service which can also take account of relevant United Kingdom code breaches in reaching a resolution.[12]

Role of the LCCC

As we have mentioned, compliance with the Code is monitored and enforced through the independent LCCC. The LCCC can receive alleged Code breaches in the following ways:

- Self-reported "significant" breaches from Code subscribers as they occur
- Other self-reported breaches through the LCCC through the Annual Data and Compliance Programme (the first of which, we understand, is in progress)
- Referrals from the FOS/SCT/AFCA following investigations into complaints

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[8] Transcript, 10 September, P-5227, lines 15-20, for example.
[9] The governing legislation and rules for superannuation complaints contains an ability for members to complain about an insurer's and trustee's decision about insured benefits. Refer to the AFCA publication- https://www.afca.org.au/custom/files/docs/afca-transitional-superannuation-guide.pdf
[10] https://www.fos.org.au/custom/files/docs/fos-terms-of-reference-as-of-1-january-2018.pdf
[11] Rule A14.2 b): https://www.afca.org.au/custom/files/docs/20180920-afca-rules.pdf
[12] https://www.financial-ombudsman.org.uk/default.htm

- From anyone at any time, such as consumers or their representatives

The LCCC will agree Code breach rectification with the subscribers including timeframes. If Code breaches are not rectified within the timeframes, LCCC can sanction the subscriber.

Advantages of the Life Code

Codes in general have certain advantages over legislation. In our view, these are as follows-

- Codes can set more aspirational standards which exceed minimum legislated standards or about which the law is silent – for example, maximum time frames for assessing claims.
- Codes are also "agile" relative to the legislative process (including the making of Regulations). Codes can adapt to changing consumer needs and market conditions. Indeed, the current Code review is already well advanced despite the Code having only been in force since 30 June 2017.
- Codes can provide consumers with a free, fast dispute resolution service through EDR channels; such as FOS/SCT/AFCA.

Next steps for the Code

Since its introduction on 30 June 2017, Code subscribers have invested heavily in updating systems, training and revising products and consumer communications to meet the obligations in the Code. Code subscribers are committed to an ongoing process of review and updating of the Code. FSC is currently in the process of updating the Code (to Version 2)[13] which we believe will further improve industry practices and standards. The Code will be regularly reviewed and updated to ensure industry standards support good consumer outcomes.

In this regard, our discussions with ASIC indicate that the Code works best where the obligations on insurers are specific, rather than high level principles. This also is reflected in ASIC Report 587. Further, we have been taking feedback from stakeholders and Version 2 will see significant strengthening of the obligations on insurers at a detailed level in many key areas.

At the time of writing, these provisions for Version 2 are well-progressed in preparation for a formal consultation to commence before the end of the year. At this stage it is anticipated that Version 2 will be released in November 2018 for specific and targeted stakeholder consultation.

As we understand it, no evidence was presented at the hearings of the Commission indicating that the Code is ineffective in its operation. If time permits, it would be useful for the Commission to review the factual matrix of the life insurance case studies and other evidence it holds to compare cases before and after the Code was introduced to test this proposition. Of course, we would be happy to consider any further recommendations the Commission might have for other improvements in the scope and operation of the Code.

In our view, and in our submission, the changes which are contemplated to be expressed in Version 2 and any other relevant improvements, will significantly improve consumer outcomes. We agree with the Commission's general observations that further regulation in an already complex area does not necessarily assist in achieving consumer outcomes. It seems to us to be more appropriate for the current Code and proposed Version 2, to be embedded in the industry and to drive industry change. We are confident this process will significantly improve consumer benefits and consumer outcomes.

[13] The FSC anticipates that a draft of Version 2 will be approved for release as a consultation document within a few weeks of the date of this submission. We will be happy to provide the Commission with a copy at that time if this assists.

QUESTIONS AND FSC RESPONSE

We respond to the specific policy questions which arose from the insurance hearings as follows. Where we have decided not to respond to certain questions, no adverse conclusions should be drawn as to our position on that 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?

   The current regulatory regime is broadly adequate to minimise consumer detriment. Additional legislative changes in progress will further improve the regime, namely:

   • the proposed product design and distribution obligations; and

   • design and distribution obligations and ASIC product intervention powers.

   In our view, a combination of legislative reform as we have outlined in this submission, improvements in the Code and improved self-regulation can deliver real change and sustainably improve consumer outcomes.

   The FSC respectfully supports and endorses the view of the Commissioner in the Interim Report:

   It should be considered recognising there is every chance that adding a new layer of law and regulation would serve only to distract attention from the very simple ideas that must inform the conduct of financial services entities… The more complicated the law, the easier it is to lose sight of them.

   While the evidence led has demonstrated concerning conduct, significant changes are already in train:

   - Tangible benefits of Life Code being referred to by the Commission and ASIC;
   - Further proposed changes to Life Code;
   - Recent implementation of Life Insurance Framework;
   - Proposed strengthening of regulatory framework through the DDO & PIPs Bill;
   - Proposed extension of Unfair Contract Terms regime to insurance;
   - Proposed Increased powers and penalties proposed in the *Treasury Laws Amendment (ASIC Enforcement) Bill 2018* arising from the ASIC Enforcement Review Taskforce report.
   - Industry self-regulation also plays an essential role in minimising consumer detriment, by complimenting and building upon legal obligations. Due to the complexity and relative inaccessibility of the current regulatory regime, Codes provide ability for consumers to better understand their rights when dealing with a financial services provider, navigate the regulatory framework, and have their issues resolved promptly without the need to seek legal redress. Codes also give an industry the opportunity to flexibly and quickly respond to community concerns.

   A combination of legislative reform as we have outlined elsewhere in this submission to introduce the DDO Bill that allows ASIC to use its PIPs, improvements in the Code and improved self-regulation can deliver real change and maximise the potential for appropriate consumer outcomes.

A. PRODUCT DESIGN

2. Are there particular products – like accidental death and accidental injury products – which should not be sold?

Rather than a blanket approach to a product type, the focus should be ensuring products are designed and distributed in a way that provides sufficient value to consumers.

The FSC does not agree that accidental death and accidental injury cover should never be sold. These products can be valuable to certain consumers as an alternative when consumers cannot obtain another, more comprehensive and expensive form of insurance. For example, where a consumer's application for life insurance has been declined because of information which came to light in the underwriting process, the insurer may offer the consumer accidental death cover without any further underwriting being necessary.

We note that the *Treasury Laws Amendment (Design and Distribution Obligations and Product Intervention Power) Bill 2018 (Cth)* (**DDO Bill**) has been introduced into the House of Representatives. It has been referred to the Senate Economics Legislation Committee with submissions due to that Committee by 18 October. The FSC previously made submissions on the Bill to Treasury and has made a submission to the Committee. Currently, the DDO Bill is drafted so that the DDO Bill commences 24 months after the DDO Bill receives Royal Assent.

In our view, the new DDO and PIPs provisions will significantly reduce the occasions on which products are distributed to consumers who will receive little or no benefit from them.

The intent of the DDO Bill is to ensure that financial products are only marketed and distributed to the appropriate market to improve consumer outcomes. The regime is complex but in summary it does this by introducing the following rules:

- Issuers must have in place a documented "Target Market Determination" (**TMD**) before marketing/distributing their products;
- Issuers must develop review protocols to ensure that their products are only marketed and distributed in accordance with the TMD;
- if products are marketed and distributed outside the TMD, the issuer is obliged to remove the product from the market until the issue is rectified;
- Distributors are prohibited from distributing a product unless a current TMD is in place;
- Offerors and distributors must take reasonable steps so that distribution is consistent with the most recent TMD;
- Distributors must maintain records of distribution information (being numbers of complaints and distribution information specified by offerors) and information relating to their obligations under the DDO regime.
- Distributors must provide to offerors numbers of complaints about the product and distribution information relating to the product that offerors have specified;
- Distributors must notify a product's offeror, and an offeror must notify ASIC, of a significant dealing in a product that is not consistent with the product's TMD;
- ASIC will have power to enforce the DDO, including the ability to request necessary information; issue stop orders; and, make necessary exemptions and modifications to the regime;
- A person who suffers loss or damage because of a contravention of the design and distribution obligations may recover that loss by civil action

A contravention of an obligation in the new DDO regime is both a civil penalty provision and an offence. Putting to one side the criminal liability focus, a person who suffers loss or damage because of a relevant contravention of the DDO regime may recover that loss or damage by civil action. The relevant contraventions relate to:

- failing to review the target market as required and associated obligations;
- distributing a product without a TMD; and,
- failing to take reasonable steps to comply with a target market determination.

The DDO Bill also introduces product intervention powers (**PIPs**). These permit ASIC to make a range of orders prohibiting specified conduct in relation to products regulated under the Act and the Credit Act. The intervention power allows ASIC to proactively reduce the risk of consumers suffering significant detriment from financial and credit products, available for acquisition after the **commencement** of the PIPs. Civil and criminal penalties apply to contraventions of the new regime.

The Explanatory Memorandum to the Bill indicates that

> *2.24… the Government proposes to make regulations that would apply the PIP regime to a number of products that are not currently regulated under Chapter 7 of the Corporations Act to ensure competitive neutrality by enabling ASIC to intervene in respect of functionally similar products irrespective of the legal basis on which the provider offers those products.*
>
> *…*
>
> *2.25 This would give ASIC the ability to proactively address consumer detriment in relation to these products.*[14]

Version 2 of the Code will also require life insurers to identify for certain products, including those where claims are paid only when because of an accident:

- the target market; and
- the needs of consumers the product addresses.

Life insurers are then only able under Version 2 of the Code to not knowingly promote the product to consumers who are outside the target market. We anticipate that this obligation is likely to take effect sooner that the DDO Bill.

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?

A significant actuarial issue in managing legacy products is the direct connection between policy definitions and policy pricing. In particular, premiums for such legacy products have been determined having regard to a number of factors including the then prevailing policy definitions of insured events at that time. Indeed, the construction of a policy at any point in time take into account a number of connected pricing and risk management factors including target customer market, premium rates, policy definitions, underwriting approach and claims management philosophy. For example, a unilateral adjustment to medical definitions may lead to an expected increase in claims beyond the original pricing expectation. This in turn may require a commensurate

[14] Paragraphs 2,24 and 2.25 of the Explanatory Memorandum.

increase in premium rates and product pricing for those policyholders. These are important considerations in managing legacy product arrangements.

The Royal Commission should note that applying new medical definitions to existing policyholders generally tends to result in insurers bearing greater risk and paying more claims. It is therefore legitimate to ask if life insurers should be permitted to increase premiums commensurate with the greater risk. Presently, legislative restrictions (and other impacts such as taxation) prevent insurers implementing solutions to this problem, such as rationalising products or allowing the charging of higher premiums for improving definitions. Life insurers, the Financial Services Council, the Financial Services Inquiry, ASIC and APRA have each recommended that required legislative changes be made to facilitate rationalisation of legacy products.

An exception to this would be in cases where the medical definition has ceased to be a claimable event. In this case, the challenge for insurers is to update the definition in a way that maintains both the cover and the premium at the levels initially intended. If premiums increase, this would be to the detriment of many consumers who might no longer be able to afford their policy, nor able to replace it if their health had deteriorated since the original purchase.

There may also be issues in retaining reinsurance cover if there were in effect updated definitions introduced to cover these products. We would need to undertake in conjunction with our insurance and reinsurance members detailed consultation. Our preliminary view is that we do not believe this can be achieved by insurers in practice.

B. DISCLOSURE [15]

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;

The purpose that the product disclosure regime should serve is to assist consumers to make an informed decision in relation to the acquisition of a financial product, and as part of that, clearly set out the key features of the product (such as what is covered, what is not covered, and any applicable exclusion which may apply).

In our view, it would be appropriate for there to be detailed consultation of this topic. In short, the current disclosure regime does not adequately serve the purpose of aiding consumers to simply understand the product. The reality is that most consumers of financial products do not peruse in detail and do not understand much of the language used in Product Disclosure Statement (PDS) disclosure. This can be the case, even if the PDS is drafted in a "plain English" style. The disclosure regime should serve to help consumers make informed buying decisions to that they take out cover that they understand and is well suited for their needs.

[15] Our comments in this section are restricted to **life insurance products**. We note that in respect of fees and costs disclosure generally this remains under review with the industry waiting on ASIC's response to the independent expert McShane review of August 2018. However, the FSC consistently has advocated for disclosure in the is regard which is practicable and user-friendly, i.e., such disclosure must be "fit for purpose".

The current disclosure regime as outlined in the question does not adequately serve the interests of consumers. The reality is that most consumers of financial products do not read the PDS in detail and do not understand much of the language used in PDS disclosure. This can be the case even if the PDS is drafted in a "plain English" style.

The current disclosure regime is detailed and comprehensive, but the outcome is that the disclosures are not easily understood by consumers. Monash university research proved that providing a PDS reduced correct decision making by consumers in respect of insurance products. The best outcome was achieved with a short Key Facts Sheet; the worst outcome was with both PDS and a Key Facts Sheet together. [16]

In our view, it would be appropriate for there to be detailed consultation of this topic taking into account consumer research to test for the regime that would be most effective.

One possibility might be to make disclosure simpler, specific and ongoing to help improve consumer understanding. The purpose should be to match the disclosure regime to the aspects of the contract that are central to the decision-making process (rather than to disclose every aspect) and direct the reader to where further information can be found if needed. Improvements supporting more consumer friendly disclosure might include:

- The most important product information should be set out in a short *Key Facts Sheet*. This should refer to where the full PDS can be found if needed. A *Key Facts Sheet* would also aid ongoing disclosure as it could be easily sent to a consumer on a yearly basis and would be more likely to be read than the PDS.
- The PDS should be available to everyone (for example, on-line) but not required to be provided pre-sale. PDSs should be shortened, thereby increasing the likelihood of a consumer reading the material and should be simplified, with the intent of increasing consumer understanding. To achieve this, life insurers should be able to incorporate more current PDS components by reference rather than in their complete form. The legislation currently prevents some aspects being "incorporated by reference" in a PDS – for example, privacy provisions. Accordingly, the amount of detail and information required to be disclosed generally is well beyond what most consumers would want or need to know to make a rational and informed buying decision.
- A PDS received by a consumer should be matched precisely to the features of the product purchased. Presently a life insurance PDS contains details on the full range of insurances available to the consumer, but in a scenario where a consumer has purchased a single insurance component such as term life policy only, a PDS would be simpler without information relating to disability and critical illness insurance.
- Disclosure should also be ongoing. A *Key Facts Statement* (or other similar information) could be sent to the consumer on a yearly basis to remind them of their policy coverage and the options available.

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

[16] https://australiancentre.com.au/publication/ineffectivedisclosure/

In a practical sense, the level of detail required in a PDS means that the consumer can neither digest nor understand the features of the product that are most relevant nor undertake an effective comparison of products in arriving at a purchase decision.

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.) [17]

As we have indicated previously, despite the scope of the question, we have confined our responses to life insurance disclosure. This is because it is far beyond the permitted length of this submission to detail all of the relevant issues with disclosure and in particular fees and costs disclosure. This is also in a state of flux at the moment and accordingly there may be little benefit in reciting the various issues which have arisen in relation to disclosure for other kinds of financial products. As we have said, however, we would be happy to engage with the Commission separately on this aspect.

In relation to life insurance contract disclosure, we do note that some jurisdictions such as the United Kingdom have disclosure regimes focussed on providing Key Facts Documents of limited size, covering the key elements of the contract likely to influence the decision about whether to buy.

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?

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

Standardisation does have an important role to play. The FSC supports this in principle as evidenced by the "foundation" medical definitions for trauma and critical illness cover in the Code. Unless a case could be made to the contrary in a specific instance, definitions should be set as minimum standards to allow competition and for life insurers to offer additional cover.

However, there would need to be a significant amount of work involved and a clear scope and careful consideration of the impacts. Care is also needed not to stifle consumer choice through limiting the types of policy and features available. There also may be competition law issues which would need to be considered.

There also would need to be a consideration of issues on a "whole of legislation" basis and in particular, the interaction with superannuation provisions dealing with insured benefits. This goes not only to the insured benefits which can be covered by superannuation but also when benefits satisfy a superannuation condition of release, enabling benefits to be paid to an insured member.

C. SALES

7. Should monetary and non-monetary benefits given in relation to general insurance products remain exempt from the ban on conflicted remuneration in Division 4 of Part 7.7A of the Corporations Act 2001 (Cth)? If so, why?

[17] In relation to non-life insurance products, as mentioned, the FSC consistently has advocated for fair and appropriate disclosure which consumers can understand and compare comparable products. Current Schedule 10 of the Act and RG 97 do not achieve this outcome. Due to content restraints we have not outlined the long history of our and industry dealings with ASIC in this regard. We would be happy to do so separately if the Commission thought this useful.

8. Should monetary benefits given in relation to life risk insurance products remain exempt from the ban on conflicted remuneration in Division 4 of Part 7.7A of the *Corporations Act 2001 (Cth)*? Why shouldn't the cap on such benefits continue to reduce to zero?

Preliminary Comments

By way of preliminary comment, we note as follows:

- The life insurance financial advice sector is undergoing significant reform:
  - The best interests duty applies to life insurance financial advice.
  - Insurers are reporting to ASIC on lapses for individual advisers.
  - Increasing education and professional development requirements are being implemented through FASEA.
  - Implementation of LIF from 1 January 2018, reaching end state 60%/20% by 1 January 2021.
  - A further review of the effectiveness of the LIF reforms from 2021.

In addition, we are making separate submissions in relation to grandfathered commissions and other payments.

Reform in addition to what is already in train may materially impact on financial adviser numbers and the supply of life insurance financial advice – this would not be a good consumer outcome given the need for financial advice.

The advice process can be set out as follows:

- The advice process involves the financial adviser understanding their client's objectives, financial situation and needs, and then determining which insurer and insurance policy is appropriate for the client.
- The underwriting process involves the financial adviser assisting their client to complete a lengthy policy application (including fully explaining the client's duty of disclosure) and then help their client navigate through the full underwriting process, which can entail obtaining extensive medical information over a number of weeks or months. Often this will involve the financial adviser having a number of further discussions with both their client and the life insurer.

LIF Reforms

We note that the *Corporations Amendment (Life Insurance Remuneration Arrangements) Act 2017 (Cth)* came into effect on 1 January 2018. However, in November 2015, when it announced this package of reforms, the Government stated that ASIC would review the impact of LIF in 2018 (**ASIC Review**). If this review determined that there had not been significant improvement in better aligning the interests of financial firms and consumers, the Government indicated it would mandate that advisers would only be able to receive level commissions (that is, commissions at the same amount each year, with no higher commission paid at the commencement of the policy)[18]. The 2018 ASIC review was premised on the LIF Reforms commencing on 1 July 2016. Given the reforms commenced 18 months later, the Government re-set the date for the ASIC review to 2021.[19]

[18] See Government press release of 6 November 2015: http://kmo.ministers.treasury.gov.au/media-release/024-2015/; and 9 February 2017: http://kmo.ministers.treasury.gov.au/media-release/007-2017/
[19] To consider the Government's press release, please see: http://kmo.ministers.treasury.gov.au/media-release/007-2017/

In our view, the setting of the maximum upfront commission and maximum ongoing commissions, together with the clawback requirements will work together to significantly reduce any financial incentive financial advisers may have to replace products, that is, recommending a client replace a life insurance policy with another, when to do so would not benefit the client, but benefits the adviser in that the adviser receives an upfront commission. If an adviser were to replace a client's policy after 1 January 2018 in the first two years of the client holding the life insurance policy, the adviser would receive an upfront commission of a lesser amount (between 60 – 80% depending upon the year, which is down from 120%[20]); however the adviser would be forced under the LIF Reforms to repay all or 60% of those commissions.

Further, we submit that the Commission should not recommend that the ASIC Review be brought forward. This is because as the legislated cap of 60% upfront commissions commences from 1 January 2020, at least one year's policy replacement data from life insurers ought to be considered once the actual maximum upfront commission rate is in force. This will enable ASIC to undertake a comprehensive review and make meaningful recommendations to Government. We do suggest however that the appropriate due date for the ASIC Review could be as early as 31 January 2021, enabling ASIC one month to consider the data from the previous 12 months.

The FSC expects that, once the full extent of the commission caps as set out in the LIF Reforms come into force on 1 January 2020, there will be very little incentive for advisers to replace policies. In fact, the FSC expects that much of this incentive has already been removed with the implementation of the 80%: 20% caps as from 1 January 2018.

In parallel, ASIC has investigated those financial advisers in the industry who have a high percentage of lapses and has banned or suspended those advisers where its investigations have found that the adviser did not act in their client's best interests.

The FSC accepts the premise and intent behind the conflicted remuneration provisions. However, we submit that life insurance policies, by their very nature, ought to be treated differently from other products.

We believe that consumers should be able to access financial products through any means they wish to. It is therefore important that Australians who prefer to obtain life insurance through an adviser can afford to do so and that the advice helps those consumers *generally achieve more appropriate levels of cover, a better quality policy and the benefit of thorough medical underwriting at the time the advice is given.*[21]

As we have explained in our Preliminary Comments, life insurance advice involves advisers undertaking a significant amount of work to establish a policy by helping the consumer through a lengthy application and underwriting process, and then on an ongoing basis. The process can be set out as follows:

- The advice process involves the financial adviser understanding their client's objectives, financial situation and needs, and then determining which insurer and insurance policy is appropriate for the client.
- The underwriting process involves the financial adviser assisting their client to complete a lengthy policy application (including fully explaining the client's duty of disclosure) and then help their client navigate through the full underwriting process, which can entail obtaining extensive

[20] See Review of Retail Life Insurance Advice, John Trowbridge, Final Report, 26 March 2015, page 5
[21] See Review of Retail Life Insurance Advice, John Trowbridge, Final Report, 26 March 2015, page 2

medical information over a number of weeks or months. Often this will involve the financial adviser having a number of further discussions with both their client and the life insurer.
- Providing on-going advice as the consumer experiences life events which change their need for life insurance – for example, changes in work patterns, earnings or borrowing (say, after moving home), starting a family or relationship changes.
- Helping consumers arrange a will or nominate beneficiaries.
- Advisers can also play an important role in the claims process.

If one assumes that premiums increase when life insurers pay commissions to advisers, in effect the upfront and ongoing commissions structure enables consumers to avoid paying adviser service fees (**ASF**) and instead pay a slightly higher premium over the life of the policy. This enables the consumer to afford the advice. If this argument is accepted, it might be thought that ASFs should not replace commissions, and instead they be paid over the life of the policy in equal amounts added to the premium each year. However, the adviser would not be rewarded at the commencement of the policy for the effort the adviser undertakes which is concentrated at the time of application for the policy.

Thus, the risk is that, if the caps on benefits/commissions are reduced to zero, people seeking advice would be required to pay for it up-front directly, rather than spreading the cost over the life of their policy. This would restrict access to advice on life insurance for low to middle income households, arguably, who are amongst those that need life insurance the most.

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?

The FSC supports the LIF Reforms backed by an ASIC review in 2021 to inform the next steps thereafter. Apart from extending the ban on conflicted remuneration to financial product advice provided on life insurance products, it also extended it to direct sales channels (that is, where personal advice is not provided) by a ban on certain benefits given in relation to information given on, or dealing in, a life insurance product. These new laws only came into effect from 1 January 2018.

Further, the Code bans members from adopting pressure selling tactics. Version 2 will more fully address issues regarding mis-selling in chapter 4. The FSC expects the industry to respond positively to this higher bar and for standards in this area to lift once Version 2 is implemented, i.e., there will be prescribed, listed matters which members will need to satisfy. In ASIC Report 587 *The Sale of Direct Life Insurance*, ASIC indicated that in its view, the Code has been most effective when it has detailed provisions, rather than high level principles.

10. Should the direct sale of insurance via outbound telephone calls be banned? If not, is the current regulatory regime governing the direct sale of insurance via outbound telephone calls adequate to avoid consumer detriment? If the current regulatory regime is inadequate, what should be changed?

We do not support an outright ban on outbound calling. However, we believe that the anti-hawking provisions could be strengthened such that, where the life insurer or its distributor has no customer relationship with the person, a call should only be made if the caller is satisfied that the person has given their consent.

FSC would welcome a consultation process on outbound calling with a view to assessing any refinements which may be appropriate.

Further protection will be introduced by the DDO and PIP regime.

This, supported by detailed provisions in Version 2 aimed at preventing pressure selling, will give consumers the new protections they clearly need. has no customer relationship with the person, a call should only be made if the caller is satisfied that the person has given their consent.

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?

The legislative distinction between general and personal advice needs to be addressed. This has been an issue raised over many years and in various quarters, including the Financial System Inquiry. We support the Productivity Commission's recommendation which involves renaming general advice so that it is not construed as advice (as opposed to product information). Consultation should be undertaken as to the renaming of general advice.

The fundamental issue, is what is included and what is excluded from the scope of personal advice. Complex financial products need to remain available for people with complex financial needs. This may be too drastic a step to take and cause market disruption and dislocation to achieve a minimal outcome.

It would be preferable in our view for Version 2 and the DDO and PIPs legislation to deal with such issues organically. Further regulation of an already highly-regulated area seems to us to add an overlay of further complexity and cost for potentially minimal consumer benefit. The necessary consumer benefit can be achieved by implementation of these measures and structures.

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* (**Standard 24**)?

Standard 24 only applies to "AFSL Members" of the FSC. This term is defined to mean a member of the FSC who holds an Australian Financial Services Licence (**AFSL**) under which the member is authorised to provide personal advice in relation to life insurance products to retail clients. It mandates that AFSL Members must have at least three or more life insurance providers on their Life Insurance Approved Product Lists (**APLs**). This Standard is mandatory for all advice licensees who are members of the FSC. The FSC encourages advice licensees that are not members to adopt the standard. The FSC does not disagree with a proposition under which the terms of the Standard should apply to all advice licensees who provide advice on life insurance products to retail clients.

The minimum number of life insurance providers that must be on an AFSL Member's Life Insurance APL reflects the fact that there are currently in the order of 22 insurance providers in the market. However, in our view, it is not appropriate to apply Standard 24 in its current form to other kinds of APLs as there may be greater or lesser providers in the market. For example, there are hundreds of fund managers offering fund management services in the Australian market. We therefore would expect the minimum number referable to Fund Manager APLs would be far greater than three.

Standard 24 also obliges AFSL Members to disclose to clients that they have an APL and how many life insurance providers are on their APL. The FSC supports extending this obligation to all advice licensees who provide advice on life insurance products to retail clients.

D. ADD-ON INSURANCE

13. Should the sale of add-on insurance by motor dealers be prohibited?

No. The FSC supports a Deferred Sales Model introduced by ASIC in consultation with providers of such add-on insurance. By separating the sale of the insurance from the sale of a motor vehicle and the way it is financed, the consumer is required to make a decision on taking the add on insurance in isolation. For example, this means that the cost of the insurance has to be shown in isolation, and not as part of an "overall cost for the car, the loan and all the insurances" presented as a single figure without a breakdown of the individual components. In this way, the consumer will be much better informed about the cost, features and benefits of the add-on insurance.

Further, the proposed DDO and PIPs legislation may be used where appropriate.

14. Alternatively, should add-on insurance only be sold via a deferred sales model? If so, what should be the features of that model?

Yes, where the insurance is a secondary or tertiary purchase to a non-insurance primary purchase, as for CCI through a 4-day deferral. The FSC does not consider that the sale of add-on insurance by motor dealers or other third parties should be prohibited. It submits, instead, that it is more appropriate to enforce a deferred sales model for add-on insurance sold through third parties through industry self-regulation.

The FSC's position in Version 2 of the Code aligns closely in this regard to the Australian Banking Association's (**ABA**) new Banking Code of Practice[22] (**Banking Code**) which provides that:

- where members offer consumer credit insurance (**CCI**) for credit cards and personal loans through branches or over the telephone, the member will not offer the CCI product to the consumer until four days have elapsed from the application for the credit product; and
- with respect to digital applications for credit cards and loans, members will only inform consumers of the availability of CCI after the consumer has completed the loan application.

The Insurance Council of Australia (**ICA**) has also expressed its in principle support of the introduction of a deferred sales model for sales of add-on insurance products through the motor dealer channel.[23]

Additionally, we do think that potential provisions governing qualifications and expertise of the third party selling the product should be considered quite carefully. In this regard, it would be useful for there to be further consultation and consideration of these issues.

In our view a number of these issues will be addressed by Version 2, if it applies, and by the DDO and PIPs Bill.

15. Would a deferred sales model also be appropriate for any other forms of insurance? If so, which forms?

[22] Reference is to the Banking Code of Practice which will commence on 1 July 2019

[23] See ICA's Final Report Review of General Insurance Code of Practice, June 2018, which can be found here: http://codeofpracticereview.com.au/assets/Final%20Report/250618_ICA%20Code%20Review_Final%20Report.pdf

FSC believes that the deferred sales model is likely to be appropriate where all of the following characteristics of the product apply:

- The product is a secondary, or tertiary sale to the primary non-insurance product[24] being purchased; and
- Where the sale is not following an initial enquiry made by the consumer; and
- Where the product can be taken out immediately, for example, without the need for an extensive underwriting process which introduces a similar period of reflection for the potential consumer.

We do not support mandating the adoption of a deferred sales model for other kinds of insurance sold through third parties. Rather, we consider that the implementation of the DDO Bill will reduce mis-selling of life insurance products generally as insurers will need to carefully turn their minds to the appropriate type of consumer for the product, and the way these consumers are targeted in developing each product's TMD. Obligations cast upon distributors of products and the oversight of the product manufacturer set out in the Bill, together with Version 2, will also be of assistance.

16. If the ban on conflicted remuneration is not extended to apply to general insurance products, should the payment of commissions for the sale of add-on insurance by motor dealers be limited or prohibited?

E. CLAIMS HANDLING

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

Yes. The FSC supports the application of section 912A Corporations Act to claims handling staff, in the sense of casting upon them obligations to act in a particular way when managing claims.

However, the FSC's view is that the extension of these obligations to claims handlers should be drafted in a manner which ensures that claims handling staff are **not** treated as giving advice under the Corporations Act. That is because persons who provide such services require particular qualifications that the FSC understands to be in excess of that required of claims handlers. If insurers could only recruit persons to perform claims handling functions if they had such qualifications, it would be significantly more difficult and prohibitively costly for them to carry out their business. For example, without analysing the matter in detail at a very high-level, at the least, claims handlers then would be obliged to:

- hold a relevant degree;
- pass an exam;
- undertake at least one year of work and training relevant to the provision of financial advice;
- meet continuing professional education requirements; and
- adhere to FASEA's Code of Ethics for Financial Advisers,

in accordance with the *Corporations Amendment (Professional Standards of Financial Advisers) Act 2017 (Cth).*

While we believe that education, training, work experience and compliance with ethics are all necessary to undertake the work of handling life insurance claims, we submit that the particular qualifications and professional standards which apply to financial advisers are not appropriate for claims handlers. There is the added complication of course of AFSL licensing and authorisations.

[24] excluding any superannuation benefits

Accordingly, section 912A should be applied to claims handlers in a way which ensures that their communications with consumers do not, in the ordinary course, amount to financial product advice, (requiring them to be an AFSL holder, an employee of an AFSL holder, or an authorised representative). We accept that life insurers would need to provide appropriate training to claims handlers to ensure that their conversations with claimants remain factual only and would not amount to recommendations or statements of opinion which are intended to influence claimants to decide about an insurance claim.

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

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

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

Yes. From an enforcement and regulatory perspective this is advantageous but ASIC should not be able to intervene in individual cases on a case by case basis. ASIC jurisdiction should be limited to matters arising under section 912A and ASIC looking into systemic issues including in relation to the claims decisions, processes, training and claims correspondence.

From a consumer perspective, where the goal is to provide a reasonably quick and cheap avenue of complaint (and financial result) for the consumer, the FSC considers that External Dispute Resolution (**EDR**) through FOS, SCT or AFCA together with the Code and LCCC provides a good solution.

Life insurance

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?

Where this question is in reference to “pre-existing exclusion causes” which may be included in a policy, life insurers cannot rely on the clause to deny claims on the basis of a condition that is not related to the condition that is the subject of the claim, in accordance with section 47 of the ICA.

It appears however that this policy question relates to the avoidance of a life insurance policy at the time of a claim for the non-disclosure of an unrelated medical condition.

Where this applies in practice is where a person fails to disclose a pre-existing condition in their application for insurance, and the matter only comes to light at the time the consumer makes a claim on their policy.

Section 29 of the Insurance Contract Act (ICA) contains the remedies for non-disclosure. Specifically, when non-disclosure is identified, insurers may avoid a contract under s29(2) or (3), or alter it pursuant to s29(4) or s29(6). On occasion an insurer has a choice, because of the difference that the non-disclosure would have made to the terms offered, between avoiding the cover or amending it.

Presently, in such circumstances, insurers have discretion to choose between the remedies. If this discretion is exercised to avoid the policy, then no amount is payable, irrespective of the matter that was not disclosed. It should be noted that life insurers are proposing to voluntarily restrict their rights under s29 ICA, under the draft, revised version of the Life Insurance Code of Practice (Version 2). Version 2 will allow insurers to investigate the full history of conditions the consumer is claiming for, but only allow investigating other conditions to check the consumer's original disclosures if there are reasonable grounds for doing so and explain those grounds if asked. This prevents a life insurer "fishing" for reasons to decline a claim.

It also requires insurers to restore the consumer to be no better or worse off in cases of non-disclosure discovered at the point of claim, other than in cases of fraud. This means that if an insurer discovers an unrelated condition that, if known at application, would have resulted in that unrelated condition being excluded, restoring the consumer to the same position would mean the unrelated condition that is excluded would not stand in the way of the claimed condition resulting in a valid claim.

Other than in cases of fraud, only in cases where an undisclosed, unrelated condition would have prevented the life insurer from offering any cover at all (or a benefit that can be unbundled, if applicable) if the condition had been disclosed should the policy be avoided and the claim declined. Restoring the consumer to the same position would also mean refunding the consumer's premiums.

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?

Version 2 will allow insurers to investigate the full history of conditions the consumer is claiming for, but only allow investigating other conditions to check the consumer's original disclosures if there are reasonable grounds for doing so and explain those grounds if asked.

Additionally, FSC is currently consulting with the Royal Australian College of General Practitioners (**RACGP**) on this issue. Both parties have agreed as follows:

- GP's clinical notes are written for clinical purposes (rather than for insurance)
- A report is always preferable to clinical notes.

If these discussions conclude as FSC expects, a GP's clinical notes would only be requested by insurers if the consumer has given a separate consent, and if the GP is unable to provide the report within 4 weeks, or if the report is clearly incomplete or incorrect.

With the exception of critical illness benefits, life insurance products do not generally make payment for medical conditions. Rather they provide for payment in the event of becoming disabled, terminal illness and death. Accordingly, the evidence relevant to such claim is broader than solely that relating to the medical condition(s) causing, for instance, the disability.

A TPD claim assessment, for example, is not an assessment of whether a particular condition in itself has been diagnosed. Rather, it is a broader consideration of the claimant's functional capacity for employment with reference to their medical condition, prognosis, treatment options, education, training and experience, employability and labour market. Clinical records are used to understand a

claimant's medical history, and their broader circumstances, in that context and are a key reason insurers are able to assess and admit the majority of claims in a timely manner.

Limiting life insurer access to information relevant only to the claimed condition would have a detrimental impact on life insurers and consumers. Essentially insurers would no longer be able to properly assess their liability under the contract.

An insurer should only be able to obtain evidence relevant to its liability under the contract and consumers are protected from insurers seeking to access any information not relevant to this liability by two mechanisms:

- The duty of utmost good faith prevents an insurer from obtaining material that is not relevant to its liability.
- The Code sets practical guidelines on how insurers access consumer health information.

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?

FSC believes that surveillance is an area where the Code has been effective in ensuring that surveillance is used appropriately. The Code specifically states that any surveillance must stop where there is evidence that it is adversely affecting a claimant's mental health, noting that much of the conduct discussed in the Royal Commission hearings pre-dates the Code. Regrettably, there are rare instances where claimants attempt to commit fraud. Surveillance can be important in detecting fraud which, if undetected, increases costs for other policyholders.

Life insurer's products effectively provide for two limbs to support a claim for income protection or TPD:

- that the insured is ill or injured (physically or mentally); and
- is unable to work.

Surveillance is not used for diagnostic purposes. It is used primarily to establish whether someone is working, or is able to do so. Generally, our life insurance members have indicated that surveillance is not used for a diagnostic purpose such as establishing whether a person has a mental illness. Rather it is used to detect and prevent payment of claims which are fraudulent.

Under the Code, surveillance must only be used appropriately and in circumstances where the surveillance will not cause harm to the insured.

As we have said, currently the Code does address these issues at least in part, if not fully. We submit that through the Code, the life insurance industry has gone further than many other comparable industries (including workers compensation, public liability and CTP) in restricting the use of surveillance. Our members report that since the introduction of the Code that they have looked to use surveillance as a last resort and have invested in other areas to manage claims. For example, by employing health professionals with mental health experience as part of their claims teams.

General insurance

22. Should the General Insurance Code of Practice be amended to provide that, when making a decision to cash settle a claim, insurers must:

22.1 act fairly; and

22.2 ensure that the policyholder is indemnified against the loss insured (as, for example, by being able to complete all necessary repairs)?

F. INSURANCE IN SUPERANNUATION

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?

Yes, there should be minimum coverage requirements. The current MySuper arrangements already largely address the aim of standardisation for minimum coverage requirements, definitions and exclusions for members within the same superannuation fund, but consideration could be given to extending these.

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)*?

Currently, MySuper products offer a standard, default level of death and Total and Permanent Disability (TPD) insurance for members of the superannuation fund covered by the product. Members of MySuper products are able to increase or decrease their insurance cover (if offered by the trustee) without having to leave the MySuper product.

As a part of the Stronger Super reforms in 2013, disability definitions must be consistent with corresponding definitions relating to conditions of release in the SIS Regulations.

It is important trustees retain the ability to assess the needs of their members and to tailor group policies accordingly.

In a practical sense, it is often contended that the current definition of "permanent incapacity", despite it being grounded in objective considerations, is applied by an insurer on a subjective basis. This leads to uncertainty and inconsistency. In our view, the fairer position would be for insurers to provide alternative definitions to replace the current definition of permanent incapacity.

Unless the definition of "permanent incapacity" is improved, insurers should be permitted to use alternative definitions that provide more consistent outcomes. Currently, the regulations require that an insured benefit is capable of being released where the insured definition is satisfied.

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)*?

The FSC believes this is appropriate, but notes that if this obligation is placed on RSE licensees they will be required to obtain and provide insurers with greater detail about their membership than currently is done. RSE licensees (or their administrators) may not currently be equipped to provide the level of detail that will be required to change the defaulting process. This means there may be

further upgrades to administrative systems required necessarily incurring greater costs for the trustee which may be passed on to members through increased fees or premiums.

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

No, we do not believe such a prohibition is appropriate. Without undertaking a detailed examination of the general law and various provisions under the *Superannuation Industry (Supervision) Act 1993* and *Regulations* 1994, it seems to us that there are sufficient protections to ensure trustees who engage such an associated entity in the result are acting in the best interests of the members of the RSE. In our experience, such an engagement only occurs after detailed analysis and market testing by the administrator is submitted to the trustee. Please also refer to our response to question 27.

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*?

We cannot of course give an absolute assurance but we would anticipate that trustees who engage in associated entity do in fact retain all records which demonstrate the matters to which the question refers. Nevertheless, we can see some merit in "hard-wiring" such an obligation in either the Regulations or in APRA Prudential Standards.

In particular, arrangements governing the actions RSE Licensees must take to ensure sufficient and appropriate monitoring of the relationship between the RSE Licensee and an associated entity insurer should be strengthened. Strengthened standards will help avoid any degradation of the relationship such that the RSE Licensee fails to meet its best interest's obligations. The strengthening could occur by way of greater prescription in paragraph 24 of SPS 250. Key standards that should be prescribed include:

- The controlling entity to establish an overarching associated entity policy that sets the minimum requirements for managing commercial arrangements, documentation standards, performance monitoring and conflict identification and management.
- An RSE Licensee and an associated entity insurer should develop service standards setting out the expected level of performance.
- For medium to high value group insurance policies, any premium re-rate should be reviewed by an independent consultant to ensure premiums are fair and reasonable for members.
- The RSE Licensee and an associated entity insurer should develop a relationship governance model that supports regular meetings of key and senior representatives of the RSE and insurer. It should also establish working groups covering key matters such as governance, product, claims and operations.
- The RSE Licensee and an associated entity insurer should develop an aligned claims philosophy.
- The insurer should operate a dedicated relationship management team to support as associated RSE Licensees in all matters.
- The RSE Licensee and an associated entity insurer should develop a joint business plan outlining insurance strategy and initiatives

- Where the insurer is an associated entity the arrangements should not be exclusive, with the RSE Licensees retaining the ability to contract with more than one insurer.
- The association between the RSE Licensees and the insurer should be disclosed to superannuation members.

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?

The Voluntary Code of Conduct will provide significant protection to members of the funds who adopt the Code.

However, the Voluntary Code will need to be updated to align with changing regulatory requirements. For example, if the Protecting Your Super package is passed, additional provisions will be needed to protect members – for instance by ensuring appropriate communications where the trustee is required by law to cancel a member's cover.

As we have indicated, the substantive provisions of the Superannuation Voluntary Code of Practice will be replicated as Chapter 2 of Version 2. The current intention is that this Chapter will be binding on the FSC's superannuation trustee members.

G. SCOPE OF THE INSURANCE CONTRACTS ACT 1984 (CTH)

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?

The FSC accepts that unfair contract terms could be appropriately applied to life insurance contracts. However, we would be concerned to ensure that a measure designed to benefit consumers does not in fact cause significant consumer detriment.

The FSC has provided a submission in response to the unfair contract terms model outlined in Treasury's Proposal Paper *Extending Unfair Contract Terms Protections to Insurance Contracts* (**Proposal Paper)**. An overview of that submission is as follows:

- The existing unfair contract laws (UCT) should be incorporated into the Insurance Contracts Act (**ICA**) with the appropriate carve outs for life insurance to ensure there are no adverse unintended consequences for consumers.
- For life policies, as defined by the Life Insurance Act 1995 (Cth) (**Life Act**), which are which are long term contracts, it should be made clear that a term which provides a life company with the ability to unilaterally increase premiums will not be considered unfair in any circumstances where the increase is related to the management of the insurer's risk and is consistent with the requirements of the Life Act.
- The new UCT provisions in the ICA should be applied to new contracts only. Life insurers should be given a reasonable period to amend their contracts before the new regime commences.
- The 'main subject matter' of an insurance contract should be defined broadly to include terms that have, or have the effect of, defining the scope of cover.
- Clarification should be provided that the 'upfront price' will include the premium and the waiting period, as well as additional premiums, fees or charges that are payable by the policyholder, regardless of the stage in the policy's life, and that these will not be subject to review.
- A contract should be considered as standard form even if the consumer or small business can choose from various options of policy coverage.

- The definition of 'consumer contract' and 'small business contract' should include contracts that are expressed to be for the benefit of an individual or small business, but who are not a party to the contract, with the exception that contracts of insurance entered into with wholesale clients should be excluded in recognition of their robust bargaining power which protects their members' interests.
- The existing UCT test for determining whether a term is unfair should be applied, without any additional specificity in relation to underwriting risk which would unduly focus on only one of a number of risks to insurers' legitimate interests.
- Examples specific to insurance ought to be added to the list of examples of the kinds of terms that may be unfair. However, this should be provided through regulation and following appropriate consultation.
- Where a term is found to be unfair, as an alternative to the term being declared void, a court should be able to make other orders if it deems that more appropriate.
- ASIC should be given the power to exempt or declare that a life insurance product or a term of a life insurance product is not subject to the UCT regime or that it is not subject to the UCT regime in particular circumstances.

If the majority of the proposals above are not made, uncertainty may result which may result in higher premiums and less choice including the following:

- Products may be priced to allow for the fact that the life insurers cannot increase premiums. This could see products priced at considerably higher levels from the outset.
- Life insurers may also seek to mitigate risk by limiting the maximum duration of cover, meaning that consumers would need to reapply for a new contract when their cover expires, and their health may have changed.
- Reinsurance premiums may also increase to match the static risk exposure of life companies.

A further consequence could come in the form of a brake on innovation in meeting new customer needs as society and the market evolve. When new products are brought to market, almost by definition, there can be no existing claims experience on which to be confident about setting premium rates appropriately. Once again, if insurers cannot be confident of re-pricing a product if needed, an overly cautious approach might result in a new product being unaffordable for its intended target market.

To ensure simplification and avoid confusion for consumers and insurers alike, the relevant unfair contract terms should be incorporated into the ICA to ensure that there is a uniform piece of legislation covering insurance contracts and to ensure that the laws are not contradictory.

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?

While the duty of utmost good faith does not expressly apply in relation to an insurer's interaction with an EDR body, it does apply in relation to the way that the insurer acts towards the insured in respect of any matter arising under or in relation to the contract of insurance, including in our view, throughout the EDR process.

In addition, the insurer must ensure that it complies with the terms of reference of the EDR body, which in the case of AFCA, are the Complaint Resolution Scheme Rules.

Given this, it seems to us that extending the duty to apply directly from an insurer to the EDR is unnecessary.

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?

Before 28 June 2014, the only remedy available to life insurers for misrepresentation was avoidance. The 2013 amendments introduced a new remedy for insurers to amend the contact, as an alternative to avoiding it. Version 2 will impose a new obligation on insurers such that, other than in cases of fraud, to use that remedy wherever it is available in law, to put the consumer into the same position as if the error or omission in the consumer's disclosure had not occurred.

That said, reform is needed to section 29. These amendments to the ICA introduced a new remedy for insurers in cases of non-disclosure or misrepresentation. Section 29(6) of the ICA enables insurers to be able to vary the policy (or benefit due to unbundling as prescribed under section 27A of the ICA), instead of avoiding it under section 29(2) or 29(3). Section 29(6) is not available to in relation to a policy (or benefit) that provides for cover upon the death of the insured.

Currently, if there is a non-disclosure or misrepresentation and the effect is that the insurer would not have offered the policy (or benefit due to unbundling) on the same terms, if the non-disclosure or misrepresentation is discovered in the first three years from the policy inception date, then the insurer has the legal right to cancel the policy (or benefit). This is regardless of whether an insurer would still have issued a policy (or benefit), for example, with an exclusion. Section 29 currently leaves this choice with insurers who would still have issued a policy (or benefit), for example, with an exclusion. Section 29 currently leaves this choice with insurers. As we understand it, the current form of drafting does not correctly or appropriately reflect the original intention as outlined below in the paragraphs, relating to suggested changes.

While the change to the Code is appropriate to remedy the current deficiency in section 29 of the ICA, the most appropriate course is to amend section 29 itself, to ensure that a policy (or benefit due to unbundling) can only be avoided if the insurer would not have issued the policy (or benefit) had the appropriate disclosures been made.

Simple changes can be made to the ICA to achieve the desired end state.

Section 29(3) wording needs to change to "the policy on any terms" (rather than "the policy") so that only in cases where the insurer would not have offered the policy on any terms (or the specific benefit on any terms after unbundling) due to the non-disclosure or misrepresentation, will they be allowed to avoid the policy (or benefit). This would mean that if the insurer would have offered the policy (or benefit) under different terms (that is, with an exclusion) then they cannot avoid the policy (or benefit) for non-disclosure or misrepresentation other than in cases of fraud. The only remedy available to the insurer would be using section 29(6) to apply an exclusion to the policy (or benefit).

Section 29(6) and 29(10) also should be amended so that the variation remedy can apply to death benefits within the first three years of the policy, to match the three-year time period specified in section 29(3).

Section 29(7) also requires some additional thought because it is currently difficult to prove should the matter proceed to Court or EDR.

If these changes are made, an insurer could never legally avoid a policy (or benefit) if they would have offered the policy (or benefit) on different terms had the appropriate disclosures been made during the application process.

32. Does the duty of disclosure in section 21 of the *Insurance Contracts Act 1984 (Cth)* continue to serve an important purpose? If so, what is that purpose? Would the purpose be better served by a duty to take reasonable care not to make a misrepresentation to an insurer, as has been introduced in the United Kingdom by section 2 of the Consumer Insurance (Disclosure and Representations) Act 2012 (UK)?

The purpose of the duty of disclosure is to allow the insurer to make a fair assessment and pricing of the risk. The duty of disclosure is to ensure fairness between the parties and protect the rights of both the insured and the insurer by insisting upon appropriate disclosure. Without this, life insurance might become unsustainable.

There are material differences between the UK model and Australian Law (including common law). This includes, among other things, the meaning of innocent non-disclosure in each jurisdiction.

If a review of the duty of disclosure is undertaken, this would require consultation with all relevant stakeholders before such a radical change in law were proposed. In our view, we would need to ensure that such a change would provide consumer benefit, as distinct from detriment by repricing future risk at both the insurer and reinsurer level.

H. REGULATION

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?

In the case of the Life Code, it already applies to all "active" life insurers and all Australian licenced reinsurers except one.

Although outside FSC's power, it would welcome a reform that required all participants to subscribe, including off-shore reinsurers that provide reinsurance into Australia without being licenced here.

Additionally, Version 2 will bind FSC Superannuation Trustee members to a new Chapter in the Code for RSE Licensees.

Again, although outside FSC's power, it would welcome a reform that required all participants to subscribe.

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)*);

No. Standards set by the Code are above the minimum life insurer duties and obligations set in law. It would be unfair if a failure to comply with the Code triggered a penalty that was intended to apply to a lower standard. If this were the case, the Code would need to be significantly watered down to avoid penalties being disproportionate to breaches of the Code – which, for example, could be missing a communication deadline by as little as one day.

The ABA Code avoids this by introducing a number of timeframes in a way that do not create code breaches if they are missed. For example, at paragraphs 200 to 206 in complaints handling, the

timeframes are either absent (for example paragraphs 201 & 203) or positioned in a way that do not result in ABA Code breaches if missed – merely the requirement for an explanation that can be made after the deadline has passed (paragraphs 205 & 206). Contrast this with 9.13 of the current FSC Code in complaints handling, where an explanation for a delay is required before the deadline expires. This means that the missed deadline would always be a Code breach.

We believe the current arrangements in the Code for LCCC supervision and the consumer's ability to take a matter to EDR is appropriate and practicable without lessening the strength of the Code.

34.2 a failure to comply with an Act (for example, the *Corporations Act 2001 (Cth)* or the *Insurance Contracts Act 1984 (Cth)*)?

Please refer to our comments above.

35. What is the purpose of infringement notices? Would that purpose be better achieved by increasing the applicable number of penalty units in section 12GXC of the *Australian Securities and Investments Commission Act 2001 (Cth)*? Should there be infringement notices of tiered severity?

Our understanding is that these are to notify a financial services provider where ASIC finds evidence, for example, of:

- unconscionable conduct
- false or misleading representations
- 'bait' advertising
- harassment or coercion in connection with the supply of credit or financial services
- pyramid selling
- sending unsolicited credit or debit cards
- failure to respond to a substantiation notice, and
- giving false or misleading information in response to a substantiation notice.

We note that in 2017 the ASIC Enforcement Review Taskforce recommended a number of significant changes to the various provisions imposing penalties for corporate and financial sector misconduct. The Government has accepted these proposals following evidence earlier in the year led at the Commission. The Treasury has issued and Exposure Draft of proposed legislation. [25]At this stage, our preference would be for that legislation to progress through the Parliament and then the matter re-examined.

I. COMPLIANCE AND BREACH REPORTING

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?

37. Should there be greater consequences for financial services entities that fail to design, maintain and resource their compliance systems in a way that ensures they are effective in:

37.1 preventing breaches of financial services laws and other regulatory obligations; and

[25] *Treasury Laws Amendment (ASIC Enforcement) Bill* 2018

https://treasury.gov.au/consultation/c2018-t328482/

Regardless of the design and resourcing of a compliance system, it is not possible to entirely prevent breaches of financial services laws and other regulatory obligations. The occurrence of a breach should not automatically mean an entity has failed to properly design, maintain or resource their compliance system.

Consequences should recognise this fact and be proportionate. For example, the consequence for an isolated compliance failure should be relatively low, with greater consequences applying when entities are found to have systemically failed to adequately assess their compliance systems; adequately respond to findings from any assessments; or to adequately invest in compliance systems.

Greater consequences should apply to breaches having greater consequences on consumers (past or present).

37.2 ensuring that any breaches that do occur are remedied in a timely fashion?

Greater consequences should apply to breaches with greater consequences on consumers (past or present) that are not remedied in a timely fashion.

Remediation is relatively new and ASIC should assist entities to provide timely and effective remediation by providing guidance on key aspects of administration. For example, ASIC in addition to its current guidance, could address issues such as how entities set look back periods, the basis of compensation, minimal remediation amounts, un-contactable consumers and non-financial loss payments. Doing so would provide a standard against which entities can be held to account.

38. When a financial services entity identifies that it has a culture that does not adequately value compliance, what should it do? What role, if any, can financial services laws and regulators play in shaping the culture of financial services entities? What role should they play?

39. Are there any recommendations in the *ASIC Enforcement Review Taskforce Report*, published by the Australian Government in December 2017, that should be supplemented or modified?

By way of response to each of these questions at 38 & 39, we simply note that the FSC has indicated that, given evidence led at the Commission, it now supports the Government's and Treasury proposal in relation to increased penalties outlined in the ASIC Enforcement Review Taskforce Report and the Treasury materials referred to in response to question 35.