



25 October 2018

## Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry – Insurance Hearings

### Introduction

The Financial Rights Legal Centre welcomes the opportunity to provide written submissions addressing issues raised during the Insurance hearings of the Commission.

The Financial Rights Legal Centre is a community legal centre that specialises in helping consumers understand and enforce their financial rights, especially low income and otherwise marginalised or vulnerable consumers. We provide free and independent financial counselling, legal advice and representation to individuals about a broad range of financial issues. Financial Rights operates the National Debt Helpline, which helps NSW consumers experiencing financial difficulties. We also operate the Insurance Law Service which provides advice nationally to consumers about insurance claims and debts to insurance companies, and the Mob Strong Debt Help services which assist Aboriginal and Torres Strait Islander Peoples with credit, debt and insurance matters. Financial Rights took close to 25,000 calls for advice or assistance during the 2017/2018 financial year.

We provide the following response to the questions arising from module 6.

### Responses to Questions

#### 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?

No, the current regulatory regime is inadequate to minimise consumer detriment.

As outlined in response to the questions below we believe that the following changes are required:

- prohibition of all forms of conflicted remuneration and misaligned incentives should be prohibited
- extension of the Banking Executive Accountability Regime (**BEAR**) regime to insurance companies and strengthened to link accountability to poor consumer outcomes not just prudential matters
- amend Sections 180-184 of the *Corporations Act 2001* to require explicit and mandatory consideration by directors of interests other than shareholders, including amongst others customers.
- remove exemptions in the *Corporations Act 2001* as per section 766A(2)(b) and regulation 7.1.33(1)- (2) of the *Corporations Regulation* for Australian Securities and Investments Commission (**ASIC**) oversight of insurance claims handling

- extend the prohibition on unfair contract terms to general, life and group insurance with a narrow definition of main subject matter;
- prohibit the sale of consumer credit insurance (**CCI**), add-on, funeral insurance, accidental death and accidental injury products;
- extend the proposed Product Intervention Powers to empower ASIC to permanently prohibit classes of products;
- ensure all codes of practice are mandatory, enforceable, apply to all insurers and superannuation trustees and attract effective sanctions via a strong co-regulatory arrangement;
- empower ASIC to respond to emerging issues, prevent them from arising in the first place sanction insurers with strengthened enforcement powers;
- resource ASIC with regulatory technology (**RegTech**) to better monitor the insurance sector;
- introduce an effective standard/minimum cover regime;
- legislate appropriate standard definitions for all key terms and phrases in general and life insurance;
- mandate stronger disclosure requirements including:
  - at renewal, disclosing last year's premium including:
    - the price of the new policy if the consumer renews;
    - any difference between the new price and the old price;
    - the reasons for any change;
    - any substantial change to coverage;
  - at purchase and renewal disclosing the components of a premium;
  - compelling the provision of independent hazard mapping information;
  - compelling the provision of sum calculators at purchase;
  - mandating standard forms of accessing Product Disclosure Statements (**PDSs**) and Key Fact Sheets (**KFSs**) on insurer websites;
  - mandating rules on the presentation of coverage, exclusions definitions in PDSs and KFS;
- ban all outbound direct sales calls;
- if bans are not recommended for add on insurance then mandate their sale only with a deferred sales period;
- prohibition on specific pressure sales tactics and a strengthened Anti-Hawking regime;
- introduction of a suitability requirement to replace the general or no advice model;

- amend section 29 of the *Insurance Contracts Act 1984* to prevent insurers 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;
- limit the ability of life insurers to compel medical information for claims handling to information that is relevant to the claimed condition;
- prevent insurers 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;
- introduce uniform surveillance device laws;
- introduce strengthened uniform private investigator regulations and licensing requirements;
- amend the General Insurance Code of Practice to provide that, when making a decision to cash settle a claim, insurers must act fairly; and ensure that the policyholder is indemnified against the loss insured (as, for example, by being able to complete all necessary repairs);
- prohibit Registrable Superannuation Entities (**RSEs**) from engaging an associated entity as the fund's group life insurer;
- reform the best interests of members requirements to address fundamental conflicts of interest; and
- amend the duty of disclosure under section 21 of the *Insurance Contracts Act 1984* to a duty to take reasonable care not to make a misrepresentation to the insurer.

## A. PRODUCT DESIGN

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

There is already substantial evidence to support a case to prohibit the sale of:

- accidental death and accidental injury products
- some funeral insurance; and
- some CCI and other add-on insurances

ASIC must be empowered to prohibit the sale of these classes of products, where there is:

- limited to value to consumers
- low claims ratios and high cancellation rates
- the use of terms that significantly limit a successful claim
- targeting of vulnerable consumers who cannot afford them
- inappropriate distributions channels or techniques

- demand driven by the seller rather than genuine consumer need.

The products listed above demonstrate all of these qualities.

We note that the current Product Intervention Powers proposed by Government are not broad enough to ensure that the sale of entire categories or classes of products will be permanently prohibited. Interventions are limited to 18 months. By comparison, the UK Financial Conduct Authority (**FCA**) is empowered to make temporary interventions without consultation of up to 12 months, but is able to make permanent rules with consultation with affected parties.

Further the intervention power is currently limited to financial products and credit products regulated under the *Corporations Act 2001* and *National Consumer Credit Protection Act 2009* rather than financial products as defined in the *ASIC Act 2001*. This may have limited impact upon expenses-only funeral insurance, short-term and extended warranties.

ASIC should be able to intervene and prohibit the sale of classes of products on all financial products as defined under the *ASIC Act 2001*, where there is consultation and clear evidence of poor, ongoing consumer outcomes. ASIC should be resourced and empowered to gather granular data on each and every insurance product on sale to identify claims outcomes and ratios through the use of RegTech.

### **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?**

Yes. The Life Insurance Code of Practice (**the Life Code**) includes a clause that promises three-yearly reviews of defined medical events by a 'relevant' medical specialist to ensure the definitions remain current.<sup>1</sup> There are however significant limitations in this approach.

As identified, the Life Code only applies to on-sale policies and therefore leaves significant gaps for those people whose policies are no longer 'on sale'.<sup>2</sup> There is a risk insurers will engage in regulatory arbitrage and simply circumvent passing on upgrades by simply discontinuing the sale of a product and switching to a new product.

The minimum standard medical definitions in the Life Code only apply to the first \$2 million of trauma/critical illness cover issued after 1 July 2017.<sup>3</sup> Those people who have held and paid for life insurance policies for years are those most likely to have definitions that have not kept up with

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<sup>1</sup> clause 3.2

<sup>2</sup> For further information see our joint submission to the FSC's consultation on their draft Minimum Standard Medical Definitions, [http://financialrights.org.au/wp-content/uploads/2016/11/161111\\_FSCDraftMedicalDefinitions\\_Submission\\_FINAL.pdf](http://financialrights.org.au/wp-content/uploads/2016/11/161111_FSCDraftMedicalDefinitions_Submission_FINAL.pdf)

<sup>3</sup> Clause 8.20A

science. Many vulnerable Australians are therefore left to the hapless winds of luck. A mechanism to facilitate the rationalisation of legacy products in the life insurance sector is required.<sup>4</sup>

The existing definitions in the Life Code are also limited in number and do not cover many common illnesses.<sup>5</sup>

The definitions are ambiguous and unclear. The definition of “Cancer – excluding early stage cancers”, for example, does not define “early”. The stage of cancer may also not necessarily be correlated with the severity of the cancer. Many cancers are aggressive and even if discovered early can kill quickly. This is particularly significant given the intention to differentiate between a clinical definition and an insurance definition which “takes into account severity of the condition.”

The definitions were developed in-house at the Financial Services Council (FSC) without reference to independent medical experts – independent of the insurers and therefore their interests. We are not medical experts, just as most consumers are not. Similarly, reviews of medical definitions as stipulated by the Life Code, do not have to be conducted by independent medical specialists. Without the reassurance that the definitions have been drafted, finalised and reviewed by *independent* medical experts neither we nor consumers can have any confidence or trust in the definitions laid out in the Life Code.

## B. DISCLOSURE

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

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

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

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

The current stated purpose of disclosure is to provide information that a person would reasonably require for the purpose of making a decision, as a retail client, whether to acquire the financial

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<sup>4</sup> As recommended in the FSI report and supported by ASIC, para 370 *Report 498 Life insurance claims: An industry review*, October 2016 <http://asic.gov.au/regulatory-resources/find-a-document/reports/rep-498-life-insurance-claims-an-industry-review/>

<sup>5</sup> The Life Code defines three medical events: cancer (excluding early stage cancers); severe heart attack (measured by specific tests) and stroke (resulting in permanent impairment).

product.<sup>6</sup> In other words the information should assist consumers to compare and make informed choices about financial products.<sup>7</sup>

Disclosure should inform consumers of the risks and operation of the product in detail. However what has occurred is that the reliance on disclosure has passed all the risks and consequences of the purchase of increasingly complex financial products on to the consumer on a “buyer beware basis.” This has led to a significant asymmetry in power weighted heavily in the insurer’s favour.

We do not think the current disclosure regime assists consumers to compare and make informed choices about financial products and disclosure documents do not effectively assist people to make the right decisions when acquiring a financial product.

Monash University and Financial Rights recently conducted an experiment which found that Government mandated insurance disclosure doesn’t help people make purchasing decisions.<sup>8</sup> The experiment examined the effectiveness of home contents PDSs and KFSs in assisting consumers to select the best policy that suits their needs. Despite ideal and simplified conditions up to 42% of participants chose the worst offer, despite being given the time and opportunity to review the disclosure information. When able to choose from three policies, 35% chose the worse policy and only 46% found and selected the best policy.

It also found that there was no simple and consistent effect of disclosure - while participants were more likely to forego purchasing an insurance policy when they had only access to the PDS the results did not find a clear pattern of understanding where people were provided more or less disclosure information.

The outcomes of the study raise doubts about the effectiveness of mandated disclosure in nudging consumers towards making rational insurance product choices – even in the most ideal of circumstances.

In reality a PDS is never a plain and simple ‘statement’. Rather, these documents are lengthy and convoluted. The important information, such as the events that are covered and exclusions are buried deep within the PDS. Research we have undertaken observed that finding the PDS or a KFS on an insurer’s website is often no easy task.<sup>9</sup> In many cases, a consumer has to make a determined effort to find it.

Our experience with speaking to consumers on our Insurance Law Service phone line is that people are regularly unaware of what insurance they have purchased, confused about what is covered, and unable to understand their documents when they do in fact read them.

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<sup>6</sup> Corporations Act section 1013D(1)

<sup>7</sup> *Regulatory Guide 168: Disclosure: Product Disclosure Statements (and other disclosure obligations)*

<sup>8</sup> *(In)effective Disclosure: An experimental study of consumers purchasing home contents insurance*  
<https://australiancentre.com.au/publication/ineffectivedisclosure>

<sup>9</sup> Financial Rights Legal Centre, *Overwhelmed: An overview of factors that impact upon insurance disclosure comprehension, comparability and decision making*, September 2018 at <http://financialrights.org.au/publication/>

The lack of effectiveness of PDS's and KFS's in assisting consumers to purchase insurance has also been demonstrated in a study published by the Insurance Council of Australia (ICA) which found that only 2 in 10 people used a PDS.<sup>10</sup>

Despite the lack of effectiveness in assisting consumers to compare and make informed choices about financial products, disclosure does continue to hold some utility. Disclosure can inform the choices of some highly literate and motivated consumers. Disclosure also provides a clear guide as to the limits of their policy when there is a dispute and can guide consumers through the claims process.<sup>11</sup>

In other words, having a document that describes the product is always going to be critically important at claims time but we can no longer expect it to assist consumers to make comparisons or assist them in their purchase decisions.

The most appropriate solution to address the problems of disclosure is to introduce a genuinely effective standard cover featuring a standard definition regime. Professor Malbon has stated that:

*When you look at the fact that sectors like the shipping industry have simplified their own insurances down to a choice between three standard term policies for cargo insurance:- and these people live and breathe insurance risks - it is hard to understand why we expect everyday consumers to figure it all out. It may be time for a serious rethink on disclosure practices. We should consider requiring insurers to offer a standard set of gold, silver and bronze cover across the industry. That way the market can compete on price, and not confound consumers about what is covered and not covered when they make claims under their policy. The government has standardised the terminology for flood cover, it should go further and standardise all terms such as for robbery, fire, earthquakes and so on.<sup>12</sup>*

We support this and strongly believe that an effective standard cover regime as outlined below in answer to Question 5 is essential and will minimise disappointment at claims time. The standard cover regime should include mandated definitions for key terms as outlined below in answer to Question 6.

While accepting the inherent limitations of disclosure, there are important changes that should be introduced to improve the effectiveness of disclosure:

Insurers should be required to provide information (visual or otherwise) as to the components in their premium pricing. This information would communicate to a consumer the risks that apply, and signal potential benefits of changing behaviour to mitigate such risk.

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<sup>10</sup> ICA, *Consumer Research on General Insurance Product Disclosures: Research findings report*, February, 2017, at page 18.

<sup>11</sup> Media Release, Monash University, Financial Rights, Disclosure documents don't help people choose better insurance: ground-breaking research finds, 17 September 2018 <http://financialrights.org.au/disclosure-documents-dont-help-people-choose-better-insurance-ground-breaking-research-finds/>

<sup>12</sup> Media Release, Monash University, Financial Rights, Disclosure documents don't help people choose better insurance: ground-breaking research finds, 17 September 2018 <http://financialrights.org.au/disclosure-documents-dont-help-people-choose-better-insurance-ground-breaking-research-finds/>

Insurers should provide the previous year's premium on the annual renewal notice. The information should include the price of the new policy if the consumer renews; any difference between the new price and the old price; the reasons for any change; and any substantial change to coverage.

#### Case study – David's story

David is a 48 year old man with quadriplegia following a motorbike accident when he was in his early twenties. David has limited use of his arms but describes his hands as being like claws and he is unable to move his fingers. This makes reading difficult, if not impossible, as he is unable to grasp the paper or turn the pages.

He owns a modified van that he bought 10 years ago - the conversion (for a disabled person to drive) cost \$80,000. David explains that, owing to his disability, the modified van is not just transport but vital to his sense of independence and freedom.

Initially David had trouble insuring van with the conversions. He ended up with insurance arranged through a broker intermediary who would insure the van with the modifications. David insured the van for market value, but the modifications for the agreed value of \$80,000. This was important to David because the modifications are specific to his dis/abilities and labour intensive to install, and very expensive and necessary for him to replace the vehicle in the event of loss.

Three years ago he contacted the intermediary to make sure that modifications were insured for agreed value of \$80,000. They said yes. In 2018 the van was destroyed in a house fire.

When David claimed, he was told that some time earlier his policy had been changed to market value for the van *and* market value for the modifications and that the insurer was electing to pay out his claim for \$28,000.

David was informed by the change in the renewal notice, on a page (not the front page) he was unable to read due to his disability. Further, there was nothing to draw his attention to the fact that this had been changed from the previous cover when the change occurred.

*Source: C167682*

Consumers should have mandated access to independent information on natural hazard mapping, modelling, exposure and risk.

Insurers should be required to provide standard paths for accessing PDS's and KFS's on insurer websites and be required to present coverage, exclusions definitions in PDSs and KFS in a more consistent manner to improve comparability.



## 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?

The standard cover regime as currently legislated is not achieving its purpose. Sections 35 and 37 of Division 1 of Part V of the *Insurance Contracts Act 1984* provide for standard cover in certain types of common general insurance but allow insurers to contract out of these provisions so long as they clearly disclose this fact in writing. Insurers have met the letter but not the spirit of the regime. In practice all insurers contract out of the provisions, rendering them pointless and consumers don't know what is standard and what is not.

The standard cover regime was originally enacted to address difficulties caused by lack of information available, the variety of terms and widespread use of unusual terms.<sup>13</sup> The original vision for standard cover was one in which insurers could be free to market policies which offered less than standard cover but if they did would have to draw the insured's attention to that fact.<sup>14</sup> The problem with the implementation of this is that the *Insurance Contracts Act* includes a "get out of gaol" clause stating that the standard cover regime:

*does not have effect where the insurer proves that, before the contract was entered into, the insurer clearly informed the insured in writing (whether by providing the insured with a document containing the provisions, or the relevant provisions, of the proposed contract or otherwise).<sup>15</sup>*

In other words, insurers don't have to "draw the insured's attention" to the fact that they are providing less than standard cover – they just describe the actual cover in the PDS and contract. As noted above very few people use the PDS in their pre-purchase decision making. Further, while many consumers believed they were aware of the terms of their policy, actual tested comprehension levels were low in comparison to confidence levels.<sup>16</sup> In short, insurer's can offer less than standard cover simply by telling their customers in a document few read and even fewer understand.

Insurer advertisements rarely comprehensively capture the nuances of policies, presenting an image of insurance that is at best manipulative and at worst misleading. Consumers are consequently often left frustrated, angry and disappointed when their claims experience fails to live up to expectations.

The standard cover regime must be reformed to institute a more effective regime that ensures that consumers can more easily compare insurance products and decrease the possibility that consumers will end up with an unsuitable product. At a minimum a standard cover regime should include:

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<sup>13</sup> ALRC Report 20, *Insurance Contracts* p.xxvi <http://www.alrc.gov.au/report-20>

<sup>14</sup> As above.

<sup>15</sup> Section 35

<sup>16</sup> Consumer Research on General Insurance Product Disclosures Research findings report, February 2017, [http://www.insurancecouncil.com.au/assets/report/2017\\_02\\_Effective%20Disclosure%20Research%20Report.pdf](http://www.insurancecouncil.com.au/assets/report/2017_02_Effective%20Disclosure%20Research%20Report.pdf)

- minimum standards for a core set of expected coverage below which insurers cannot go below, contract below or alter in any way;
- a complete set of standard definitions for standard risks for all forms of general and life insurance; and
- clearly defined levels of cover (for example, gold, silver, and bronze levels) above the minimum standard cover.

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

Yes. There is currently only one standard definition in general insurance: flood (mandated at law) and three standard definitions with limited application in life insurance: Cancer – excluding specified early stage cancers; Heart attack – with evidence of severe heart muscle damage and Stroke – in the brain resulting in specified permanent impairment (committed to under the Life Code).

In a recent shadow shopping exercise, we found in examining just one definition - fire and explosion – that while there were some superficial similarities there were a large number of variations (subtle or otherwise) that would all become material in a claim and/or dispute.<sup>17</sup> The NSW Emergency Services Levy Insurance Monitor has also found huge variations in key policy features and cover options.<sup>18</sup>

Expecting consumers to be aware of the subtle differences in definitions when comparing products before purchasing, let alone weighing up all of these and factoring them into a purchase decision is laughable. No amount of financial literacy education will ever address the complexities embedded in a market wrought by information overload and a manipulation of the spirit of the standard cover regime.

There is clear evidence of the need for government to intervene and introducing fair and easily understood standard definitions for common concepts in general and life insurance.

We note further concerns with the current life insurance standard medical definitions above in answer to Question 3.

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<sup>17</sup> Financial Rights Legal Centre, *Overwhelmed: An overview of factors that impact upon insurance disclosure comprehension, comparability and decision making*, September 2018 at <http://financialrights.org.au/publication/> In examining 28 insurance policies, one insurer refers to the presence of “mineral spirits”, three refer to the use of “irons”, seven refer to exclusions arising from the use of heaters, five refer to “arcings,” four refer to “grassfires,” twelve refer variously to cigarettes and/or cigars. Most insurance policies exclude the item that has exploded, but not all do so. Most definitions of fire in the KFS and PDS do not refer to the exclusion based on occupancy at the time of the fire despite most if not all products featuring this exclusion, and the exclusion being relevant to a full understanding of fire and explosion coverage.

<sup>18</sup> See: Table 6 – Inclusions and exclusions to certain listed events in Emergency Services Levy Insurance Monitor , Standard profile quotations: Mid-term review, April 2018  
[https://www.esinsurancemonitor.nsw.gov.au/sites/default/files/Discussion\\_Paper-Standard\\_Profile\\_Quotations\\_20180420.pdf](https://www.esinsurancemonitor.nsw.gov.au/sites/default/files/Discussion_Paper-Standard_Profile_Quotations_20180420.pdf)

## 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?**

All forms of conflicted remuneration must be prohibited as they are the key driver of the poor conduct and culture identified by the Royal Commission.

The remuneration structures identified by the Royal Commission lead to a series of conflicts of interest. These include product choice conflicts (intermediaries recommending products that do not suit people's needs or they can't afford to maximize their own commission) and insurer choice conflicts (recommending a specific insurer due to higher commission that may not be in the best interest of the consumer). These can increase risks to the consumer, promote low quality products and increase financial hardship in both the short and long term.

We note that the ACCC found that a cap on commissions as proposed by Aioi Nissay Dowa Insurance Company to was unlikely to remove the conflicts of interest or remove the risk of inappropriate sales practices.<sup>19</sup> Nothing short of a total prohibition on conflicted remuneration will remove the risks of poor consumer outcomes.

### **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?**

The reforms brought about by the *Corporations Amendment (Life Insurance Remuneration Arrangements 2017)* involving a three-year phase-down of upfront and ongoing commissions paid to advisers to a cap of 60% and 20% respectively will not remove the fundamental problem of commission based remuneration. Commissions will continue to place advisors in a conflict of interest, incentivising advisors in ways that are more likely to align with the best interests of the advisor rather than the insured.

If the aim is to "better align the interests of life insurers, advisers and consumers by removing any real or perceived misaligned incentives for advisers that could create a conflict of interest and result in consumer detriment"<sup>20</sup> maintaining commissions (albeit at a lower cap of 60% and 20%) does no such thing since the commissions will be reasonably expected to influence the choice of insurance product. The maintained existence of clawback provisions under the amendment also fails to remove the inherent incentive to churn policies, albeit at a later point in time than may

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<sup>19</sup> Applications for authorisation A91556-A91557 lodged by Aioi Nissay Dowa Insurance Company Australia Pty Ltd & Ors in respect of proposal to voluntarily limit the commissions and other payments paid to distributors of add-on insurance products through the motor vehicle dealership channel Date: 9 March 2017 Authorisation numbers: A91556-A91557

<sup>20</sup> Trowbridge page 25

otherwise occur. It is often risky to switch products later in life. Often, a consumer has developed health issues that they may not be aware of (i.e. symptoms of illness and sickness) and/or fail to disclose.

The two key arguments put forward by life insurers for the continued existence of commissions are that:

- underinsurance is a significant issue, it is a grudge purchase and the positive benefits that life insurance provides to individuals and the broader community merits considering how to encourage consumers to take up these products.
- removing insurer payments to advisers would substantially increase the costs to individuals of acquiring insurance.<sup>21</sup>

Ensuring consumers are adequately insured is, as has been argued, a key policy objective. However, maintaining conflicted incentives in the sales of risk products is leading to people owning illusory insurance – insurance that does not cover the objectives of the insured or is not in their best interests. While insurers make much of the level of underinsurance, consumer advice services see a lot of over-insurance such as elderly people who continue to maintain life policies they can ill afford, despite having no dependents, due to a combination of sunk cost bias and insurer customer retention practices.

As for costs, consumers are paying huge amounts on the back end via churn rather than upfront. Consumers are being ripped off. Paying up front may exacerbate the grudge nature of insurance but will force the insurance sector to fundamentally re-think their business model – one that better serves the interests of consumers. Continuing to force or in some way trick consumers into buying something that may or may not be good for them should not be the sales and distribution model.

The cap should reduce to zero and all conflicted remuneration practices in life insurance should be prohibited.

### **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?**

Banning conflicted remuneration is not the only reform required.

Remuneration structures for senior executives that promote poor consumer outcomes must be regulated. The BEAR should be expanded to insurance entities and strengthened to link accountability to poor consumer outcomes not just prudential matters.

Introducing a deferred sales mechanism for add-on sales would be a particularly useful response to pressure selling where a consumer has not sought out an insurance product.

A prohibition on specific pressure sales tactics and a stronger anti-hawking legislation is required.

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<sup>21</sup> as expressed in the Trowbridge Review Final Report of Retail Life Insurance Advice  
<https://www.adviservoice.com.au/wp-content/uploads/2015/03/Final-Report-Review-of-Retail-Life-Insurance-Advice-Final-Copy-CLEAN.pdf>

Pressure selling techniques must be specifically outlawed in the insurance sector including:

- persistent pitches
- keeping consumers 'captive';
- using the cooling off period as a selling point;
- unfairly highlighting the benefits of insurance over cheaper more responsible alternatives;
- masking the cost of loans
- pre-filling forms; and
- sales scripts not allowing customer to say no.

As the evidence presented at the Royal Commission has shown, the anti-hawking provisions of the *Corporations Act 2001* have not prevented inappropriate, unsolicited sales of insurance. While anti-hawking laws do place strict restrictions around the sales of insurance with cold calls, insurers get around these laws via loopholes: they can obtain a customer's consent in some form such as an innocuous ticked box on an unrelated sales document or by making two calls where one is to obtain the consent and the follow up call to make sales. Unsolicited sales in insurance should be banned entirely and all loopholes closed.

**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?**

Yes. We believe that there is more than enough evidence<sup>22</sup> to demonstrate the poor consumer outcomes that have arisen from the outbound sale of insurance products. We do not believe that tinkering at the edges will lead to any systemic change in the industry. Given the evidence of conduct designed to evade and work around anti-hawking rules, we cannot see that any other solution will serve to prevent the sales tactics on display at the Royal Commission and prevent the demonstrated harm to a vulnerable consumers.

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<sup>22</sup> ASIC Report 587 The sale of direct life insurance <https://asic.gov.au/regulatory-resources/find-a-document/reports/rep-587-the-sale-of-direct-life-insurance/>

**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?**

Renaming general advice is not sufficient. Under the current framework the risk is outsourced to consumers to choose appropriate products to suit their needs. This risk should be shouldered more by the entity designing and selling the product.

While insurers generally sell insurance products under a general advice distribution model, in reality many insurers have taken on a no advice model.<sup>23</sup> This means that sales staff promote the product but do not tell the consumer whether or not it is suitable or meets their needs. In some cases this translates into refusal to provide even basic information about the extent of coverage that would in no way constitute “advice” of any kind.<sup>24</sup> Consequently consumers are provided with insufficient or inadequate information to inform their decisions or to engage with the complexities of these products. To add to the complexity, some distribution channels include 3<sup>rd</sup> parties not captured by some of the obligations of Life Code or the General Insurance Code of Practice (**the General Code**).

Under this model the consumer is burdened with the responsibility to purchase a suitable product that is complex, confusing and difficult to compare or assess. No consideration is given by the sales representative or the insurer as to the needs of the consumer.<sup>25</sup> ASIC has made a series of suggestions for improvement with a set of good practice observations including insurers’ training sales staff and developing sales scripts that cover the key topics.<sup>26</sup>

The reasons put forward by the insurance sector for adopting the no advice model have focussed on the cost of complying with the provisions of the *Corporations Act 2001*. However this bottom-line focussed approach is producing poor consumer outcomes industry-wide.

Financial Rights notes that some general insurance brands have, at least in the past, provided General Advice (for example, business insurance products sold by AAMI and GIO) and Personal

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<sup>23</sup> ASIC Report 492 A market that is failing consumers: The sale of add-on insurance through car dealers September 2016 All insurers sold add-on insurance products predominantly through a general advice model as defined under s766B of the Corporations Act 2001 (Corporations Act), although some insurers also used a no advice model where only factual information is provided to the consumer. <http://download.asic.gov.au/media/4042960/rep-492-published-12-september-2016-a.pdf>

<sup>24</sup> See: ASIC Report 416 Insuring your home: Consumers’ experiences buying home insurance, October 2014 <https://download.asic.gov.au/media/2195187/rep416-published-28-october-2014.pdf>

<sup>25</sup> See ASIC Report 492: A Market that is failing Consumers <http://download.asic.gov.au/media/4042960/rep-492-published-12-september-2016-a.pdf>

<sup>26</sup> See ASIC Report 492: A Market that is failing Consumers <http://download.asic.gov.au/media/4042960/rep-492-published-12-september-2016-a.pdf>

Advice (for example Shannons and Apia, the latter providing targeted products to over 50s).<sup>27</sup> In 2011 Suncorp stated that it was:

*one of the few general insurance companies that currently provide personal advice to the retail consumer. The general insurance industry has generally found that the advice provisions of The Corporations Act are too onerous and costly to be successfully implemented. Indeed the provision of personal advice within our business is only viable in the unique operating environment of our niche brands, Shannons and Apia.*

Personal Advice models are obviously viable in a financial sense in some circumstances.

Changing the name of general advice will only deal with one relatively superficial aspect of the problem – that is, the confusion and misunderstanding that consumers have with respect to what general advice means in the context of insurance sales. Such a change may assist clarifying to a consumer that the information provided is in no way meant to convey suitability of a product to individual personal circumstances, but we are unconvinced that merely changing the name will be sufficient.

Just as disclosing a conflict of interest fails to remove it and its impact, disclosing that the consumer is receiving information that is not meant to convey suitability will not address the central issue – that consumers do not understand the products that they are buying, and have difficulty in purchasing a product that genuinely suits their needs.

The general and no advice models also ensure that insurers play no role in educating consumers about the role of insurance. This hands-off approach has exacerbated the lack of financial literacy.

Just as there is a suitability requirement applied in consumer credit (albeit one that is limited to ‘not unsuitable’) there should be some equivalent requirement placed on insurers to ensure that consumers are obtaining insurance products that suit their needs.

The introduction of design and distribution obligations may go somewhat towards ensuring that consumers do not obtain insurance that has a target market to which they do not belong, but this too does not go far enough.

It requires mandated personal and general advice for certain products whose sale has been identified to be leading to poor consumer outcomes. It requires simplifying the confusopolopoly found in the sale of insurance. It requires standard cover that insurers are unable to adjust downwards. It requires the introduction of standard definitions to ensure a shared understanding of basic product features. It requires strictly enforced knock-out questions in all sales formats to ensure consumers outside of a target market are unable to purchase a product that they could not claim on or would find it difficult to claim on. It requires providing consumers with independently maintained tools (natural disaster mapping, home and contents calculators etc.) to evaluate their risk. It requires the removal of unfair contract terms. It also requires insurers to be prevented from selling unsuitable products and to be held accountable if they do.

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<sup>27</sup> Suncorp Submission to the draft Future of Financial Advice (FOFA) legislation, September 2011  
[https://futureofadvice.treasury.gov.au/content/consultation/corporations\\_amend/submissions/Suncorp.pdf](https://futureofadvice.treasury.gov.au/content/consultation/corporations_amend/submissions/Suncorp.pdf)

Given appropriate powers, ASIC could classify products on a spectrum using objective consumer outcome based indicators, to determine whether they should be subject to more generally applicable provisions, should only be sold via personal advice, or should be banned outright.

**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?**

No comment.

## **D. ADD-ON INSURANCE**

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

Yes. There is an overwhelming amount of evidence to demonstrating significant consumer harm and very little benefit arising from the sale of add-on insurance through the motor dealer arm.

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

If a prohibition the sale of all add-on insurances by motor dealers and other distributors is not recommended by the Royal Commission, then in the alternative, a mandated deferral period for the sale of all add-on products by all distributors (including motor dealers for both new and used vehicles) should be introduced.

The principles for a deferred sales model should be as follows:

- the decision to purchase and finance a vehicle must be distinct from the decision to purchase and/or finance an add-on insurance product;
- the deferral period should commence once the vehicle has been purchased, financed *and* delivered to the consumer and the consumer communication has been provided. In other words the deferred sales period should begin on delivery of the car with no room for a consumer to believe loan approval is dependent on the purchase of the add-on;
- the consumer must instigate the contact to take up the purchase of at the end of the sales period, not the sales representative or insurer;
- the customer should have useful product information regarding an add-on insurance product and engage with it before the deferral period starts;
- the customer should know the total, discrete cost of add-on insurance before the deferral period starts;
- a deferral period of at least four days is required but we believe there is considerable merit in introducing a 30 day deferral period to allow a consumer to fully assess their financial situation before purchasing add-on insurance



- insurers should not offer ‘bridging’ cover during the deferral period, as it would not address the small risk involved in the lack of coverage during the deferral period, could perpetuate high-pressure selling and could distort consumer decision-making
- innovative, interactive consumer communication techniques should be mandated and supervised to ensure greater consumer understanding and purchase of suitable add-on insurance products. To ensure this we support a standardised model that is
  - active/interactive and not passive (that is simply providing a piece of paper); and
  - includes a series of ‘filter’ or ‘knock out’ questions, before the purchase of the product.
- enhanced supervision obligations with specific requirements must be introduced as a part of the deferred sales model.

We note that the ICA have proposed amending the General Code to include a non-mandatory accompanying best practice product design and distribution guidance, which would apply to add-on insurance sold through motor dealer intermediaries.

We do not think that this in any way enough to address the fundamental issues with add-on insurance and that regulation is required to intervene in this failing market.

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

Yes. Deferred sales processes should be considered for all forms of add-on insurance distributed by all third parties not just motor dealers. Outside of the common add-on products sold by motor dealers,<sup>28</sup> there are a range of insurances that are added-on at the time of purchasing another product or service. These include:

- ticket insurance when purchasing a ticket to a concert or event;
- travel insurance when purchasing a flight;
- contents insurance when renting a storage unit;
- consumer credit insurance for estate mortgage.

While a deferred sales process may not neatly fit in some circumstances consideration needs to be given to interventions to empower the consumer in these transactions.

We are not aware of any specific regulatory monitoring of any of these add-on insurances but we would expect that the claims ratios on these products would be particularly low.

In addition any unsolicited sale of an insurance product (if not prohibited as we recommend) should be subject to a deferred sales process – particularly in life insurance.

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<sup>28</sup> Including consumer credit insurance (CCI); Guaranteed Asset Protection (GAP) insurance; Tyre and Rim; Mechanical Breakdown Insurance; Windscreen; Extended warranties including discretionary risk products and dealer-issued warranties (not a general insurance product)

**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?**

Yes. The harm in CCI is driven by a poor product being distributed by the fervent sales of motor-dealer who earns more money from the sale of CCI than the profit on the car itself – driving poor sales conduct. The commissions lead to increased premiums, which are passed onto consumers making it an even poorer value product. The model is fundamentally broken, either the product is banned or, at minimum, the sales channel in its entirety.

It applies equally to other areas where the spotlight has yet to shine so brightly – add-on sales in banks, retail outlets, travel agents, event operators etc. While these other distributors have yet to have their models as closely scrutinised by regulators, we expect similar poor outcomes to be present.

## **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: see further information below in answer to Question 18.

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

Yes.

Handling insurance claims is specifically excluded from the definition of a financial service<sup>29</sup>. This means that insurers are specifically excluded from having (a) to do all things necessary to ensure that it provides financial services efficiently, honestly and fairly; (b) to have in place adequate arrangements for the management of conflicts of interest that may arise in the provision of financial services; and (c) to take reasonable steps to ensure that its representatives comply with the financial services laws.

While the Duty of Utmost Good Faith continues to apply to claims handling the nature of the duty is such that it is on an individual, case by case basis and cannot be applied widely or in a systemic manner. ASIC is therefore restricted to taking on case after case to address claims handling issues.

Claims handling makes up a large part proportion of the advice and casework by solicitors on the Insurance Law Service.

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<sup>29</sup> in the *Corporations Act* as per s766A(2)(b) and reg 7.1.33(1)- (2) of the *Corporations Regulations*

As we understand it the ICA has an open mind to the removal of the carve-out. The FSC does not, asserting that a claims operator might provide “personal advice”<sup>30</sup>. We do not agree with this view. Insurers use “no advice” models in sales and as such should effectively be able to monitor and comply with relevant financial services laws in claims handling, including referring consumer to appropriate advice when advice is needed.

We note that the only real regulation of claims handling arises with the two self-regulatory insurance Codes of Practice.<sup>31</sup> These have been self-evidently ineffective at protecting consumers despite both Codes committing insurers to honesty and fairness but these Codes do not cover the entire distribution channel. Code monitoring bodies do not have the resources or remedies available to effectively monitor and impose penalties when insurers fail on a systemic basis to deal with clients honestly, fairly and deal with conflicts of interest.

We support the introduction of strengthened powers proposed by the ASIC Enforcement Taskforce and supported by the government including civil penalties for a breach of section 912A obligations, a relinquishment power to prevent unjust enrichment with a breach and new civil penalties and increased criminal penalties for breach.<sup>32</sup> We also support other proposals arising from the ASIC Enforcement Taskforce including a directions power.

### **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?**

Yes. Pre-existing conditions that are unrelated to the claimed condition arise predominantly in the non-disclosure space, where a consumer is asked a question about their existing or prior health condition. The insurer can then refuse a claim, even if it is unrelated to the claimed condition.

Allowing insurers to exclude claims related to unrelated pre-existing conditions may have significantly contributed to the “fishing expedition” culture we see in life insurance and general insurance claims. We argued in the original Life Code consultations for the inclusion of a commitment to restrict open ended authorities entitling insurers to obtain personal health records spanning decades for the purposes of scouring for any reference to ache, pain or symptom which might result in a claim being declined.

Prohibiting insurers from undertaking such exercises may improve the claims experience of some consumers who are declined benefits unfairly or subject to excessive claims handling time frames. The problem is compounded by: consumers not being aware they have been diagnosed or forgetting; adequacy or inadequacy of medical profession notetaking; and poor sales conduct, including by advisors giving their opinion on how to answer which is not documented;

Fundamentally, it comes down to a matter of fairness.

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<sup>30</sup> Transcript of proceedings, In The Matter Of A Royal Commission Into Misconduct In The Banking, Superannuation And Financial Services Industry, 21 September 2018 , Evidence of Sally Loane, P6641

<sup>31</sup> : Life Code, Section 8; General Code, Section 7

<sup>32</sup> See The Hon Josh Frydenberg MP, Media release: Strengthening penalties for white collar crime, 21 October 2018 <http://jaf.ministers.treasury.gov.au/media-release/033-2018/>

### Case study –Sarah’s story

Sarah was injured in a motor vehicle accident and suffered from a physical injury which then resulted in a psychological claim. She had income protection and claimed. She was paid for 3 years when the insurer without notice ceased paying. They advised her she had failed to disclose a mental health condition. The condition referred to a reference of a consultation with her GP relating to symptoms arising from side effects from hormone medication and not a clinical diagnosis of any mental health condition.

*Source: CLSIS 114461*

## **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?**

Yes. From our experience working with clients on the Insurance Law Service we regularly see insurers undertake fishing expeditions through medical records to look for any material that may be used against a claimant. Not only do they overwhelm the claimant with paperwork, they are a key frustration mechanism used to delay the claims process including it being a reason for “unexpected circumstances” under the Life Code.

Insureds often do not understand what they need to provide to prove their claim. Doctors and health professionals are not funded or resources to respond to multiple requests and can be overwhelmed in responding in order to sift through records.

Improvements in the approach are required including:

- the language used by insurers in requesting information from doctors and claimants should be precise, clear and informative as to what and why information is being requested;
- the costs of obtaining that information should be transparent and clear;
- the importance and timeliness of the requests need to be communicated to the relevant parties; and
- where an insured or their medical practitioner disputes the information requests an easy, clear and quick process to narrow the information in issue must be available.

**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?**

Yes, with some very limited qualifications.

Surveillance and the awareness that one is being surveyed can exacerbate some mental illnesses through increased paranoia, increased stress levels. It is unclear what surveillance can reveal with respect to mental illness. Mental illness is by its very nature a hidden affliction. Any evidence captured can be interpreted and misinterpreted in ways that cannot in most cases establish clear intent. If a claimant is captured socialising when they, for example, have stated that they cannot leave the house due to anxiety, is this evidence that they have misrepresented their illness or is it evidence that they are actively working to resolve their problems with say exposure therapy? There are also others ways to confirm suspicions and gather information – through interviews with third parties for example.

Current surveillance regulatory requirements are insufficient and must be changed.

We note that there have been significant drops in surveillance usage since the introduction of the Life Code as detailed by Senior Counsel<sup>33</sup>, but there remains significant continued usage in mental health claims.

#### *Current regulatory requirements of surveillance*

Surveillance device laws theoretically provide a level of protection against the unwarranted, intrusive or inappropriate surveillance of Australians, including insurance claimants. While laws are in place in each state and territory to regulate the use of surveillance devices, their complexity, inconsistency and failure to keep up with technological progress provide irregular protection and little comfort to parties subject to intrusive surveillance.<sup>34</sup> The level of consumer protection is therefore highly contingent upon where the surveillance occurs.<sup>35</sup>

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<sup>33</sup> Royal Commission 14.9.18R2 P-5787-9 <https://financialservices.royalcommission.gov.au/public-hearings/Documents/transcripts-2018/transcript-14-September-2018.pdf>

<sup>34</sup> Financial Rights details this complexity in Table 1: State surveillance legislation coverage, page 67 Guilty Until Proven Innocent: Insurance Investigations in Australia <http://financialrights.org.au/wp-content/uploads/2016/03/Guilty-until-proven-innocent.pdf>

<sup>35</sup> For example, mobile phones can be deemed a tracking device for the purpose of the Act in NSW but not necessarily in Victoria. In Victoria, surveillance of a person in their own backyard is not an offence but in NSW optical surveillance is an offence only when it has involved installation, use or maintenance of the device that required entry onto a premises or interference with an object such as a car. With respect to listening devices, some states provide an exception if the surveillance has the consent of all parties to a conversation (NSW, ACT, Tas, WA), others if one party provides consent (Qld, Vic, NSW). Some jurisdictions provide for a public interest exception (NT, WA).

The Life Code launched in October 2016 included in its first version launch commitments with respect to interviews and surveillance.<sup>36</sup> Notably the Life Code commits life insurers to restrict surveillance of policyholders in certain circumstances where there is evidence from an independent medical examiner that it is negatively impacting your recovery.<sup>37</sup>

This however requires the insured to take action once surveillance has taken place and after it has begun to impact upon the insured in a negative manner. In other words the insured needs to realise that they are under surveillance and then take active steps to either seek an independent medical opinion to detail the negative impact of the surveillance or contact the insurer and request that the insurer engage their own “independent medical examiner” to undertake an examination in order to discontinue the surveillance. This is therefore highly ineffective at preventing harm in the first place from surveillance.

Financial Rights notes that the FSC announced as part of the launch of the Life Code that the next iteration of the code will “seek to increase obligations on insurers when interacting with consumers suffering mental health issues”.<sup>38</sup> However, we note from our review of the Life Code 2.0 provided in evidence that no further changes are contemplated to the surveillance section or accommodation for those suffering a mental health condition.<sup>39</sup>

In our experience new regulatory measures often produce immediate responses that are not necessarily sustained over time. For the surveillance sections, the obligation to continue monitoring falls to the Life Code Compliance Committee (LCCC) monitoring activities and insurers self-reporting.

There are also significant short-coming in the law as it applies to investigators: the significant variability and inconsistency across Australia with respect to private investigator licence schemes<sup>40</sup> and codes of conduct. Licencing of private investigators is a state matter and is minimal.<sup>41</sup>

#### *What should be changed*

Firstly, the Life Code and the General Code must include specific commitments relating to surveillance and investigations, particularly with respect to the surveillance of those with mental health problems. These codes should prohibit the surveillance of any insured suffering from a mental health problem and be sufficiently empowered to monitor and sanction for breach.

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<sup>36</sup> Clause 8.11 and 8.12

<sup>37</sup> Clause 8.12 (f)

<sup>38</sup> 11 October, 2016 Media Release Life Insurance Code Of Practice, <https://www.fsc.org.au/entity/annotation/fe078546-30a7-e611-80c9-00155d252c17>

<sup>39</sup> Exhibit 6.409.25 - FSC.0006.0001.0306 - Exhibit SL-1 Tab 25 - Tab 9 - Draft 8 of Life Code 2.PDF <https://financialservices.royalcommission.gov.au/public-hearings/Documents/exhibits-2018/21-september/EXHIBIT-6.409.25.pdf>

<sup>40</sup> All states and territories except ACT have licensing regimes in place: see Table 2 State Investigator Legislation page 70-2 Guilty Until Proven Innocent: Insurance Investigations in Australia <http://financialrights.org.au/wp-content/uploads/2016/03/Guilty-until-proven-innocent.pdf>

<sup>41</sup> As above.

Surveillance device laws should be uniform across Australia, a recommendation of the Australia Law Reform Commission (ARLC)<sup>42</sup>. Such legislation should: provide stricter protections for members of the public; provide greater certainty to consumers and businesses; be technologically neutral to ensure that all (known and developing) forms of surveillance be captured; and should remove “participant monitoring” exceptions (found in Qld, Vic, and NT), that is outlaw the recording by one party to a private conversation or activity without the consent of other parties.

There also needs to be fundamental reform applied to the private investigation industry. In line with the ALRC’s recommendation<sup>43</sup> the Federal Governments through the Council of Australian Governments should develop and implement uniform private investigator regulations. As a part of this there should be a uniform enforceable code of conduct.

## **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)?**

Yes but whether such an amendment will be sufficient to combat the use of clauses that allow insurers to have unfettered discretion in their policies to determine what is “reasonable” cash settlement, choose which quote, refuse to repair, or replace like for like is not guaranteed.

We deal with cash settlement disputes at the Insurance Law Service on a daily basis. There are times consumers want to be cash settled but are refused and other times when consumers don’t want to be cash settled and are. Many disputes end up in external dispute resolution being reviewed in respect of the fairness of imposing the policy conditions. Consumers find obtaining quotes to compete with insurers’ estimates time consuming, cumbersome or in some cases, impossible as some repairers refuse to compete with insurers or require payment. The Australian Financial Complaints Authority (AFCA) must be better empowered to obtain independent quotes from reputable sources.

Confusion often arises where there are claims with mixed causes of loss (insured and uninsured), or where an insurer states they are unable to guarantee repair work. The General Code should be amended to provide clearer rights of consumers who are vulnerable or facing particular circumstances and what is fair in all the circumstances.

More importantly though two key reforms are required – insurance claims handling should be brought under section 912A of the *Corporations Act 2001* and be required to act fairly in cash settlements and the exemption of the insurance sector from the unfair contracts regime must be removed to appropriately deal with policy terms such as found in the AAMI home building policy examined by the Royal Commission.

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<sup>42</sup>In its 2008 Report on Privacy Law and Practice

<sup>43</sup>As above

In addition to this, insurers should apply a Total Loss Protocol in the case of natural disasters. Where a customer has suffered a total loss in relation to a contents claim, unless exceptions apply, insurers should not require the insured to complete a list of their contents and provide evidence. The agreed sum should be paid. Exceptions may include situations where there is a reasonable basis for suspicion of fraud, or where there is a reasonable basis for forming a belief that the actual loss is less than the agreed sum.

We note that the ICA have come some way to supporting such a proposal in the Final Report of the General Insurance Code of Practice Review recommending that the General Code should require claims to be treated with sensitivity and claimants provided with support, assisted to determine the amount of their claim and not be required to provide proof of ownership or an inventory assessment where it is clear that the loss exceeds the sum insured or any sub-limit within it.<sup>44</sup>

This does not go far enough in our view, as it still requires the consumer to itemise their entire household contents, albeit with some support.

## 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?**

### 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)?

Yes universal minimum coverage requirements, key definitions, and key exclusions should be prescribed for group life policies offered to *all* superannuation members not just MySuper members. This is consistent with our call for standard definitions and standard cover to be introduced in general and life insurance.

In particular the development of consistent standard definitions for common terms such as “total and permanent incapacity” (TPD), “pre-existing conditions” medical definitions and other terms is essential.

The definition of TPD in superannuation has significantly deviated from the *Superannuation Industry (Supervision) Regulations 1994 (SIS Act)* requirements of permanent incapacity. This has resulted in

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<sup>44</sup> ICA, Final Report, Review of the General Insurance Code of Practice, June 2018



harsh outcomes for consumers with many insurance products not paying out consistently, causing confusion and anguish as they are left with the luck of the draw with respect to the terms they were defaulted to or what the superannuation trustee re-negotiated with the insurer.

The SIS Act defines ‘permanent incapacity’ as where:

*a trustee of the fund is reasonably satisfied that the member's ill-health (whether physical or mental) makes it unlikely that the member will engage in gainful employment for which the member is reasonably qualified by education, training or experience.*<sup>45</sup>

Some superannuation trustees (such as Australian Super) has replaced the word ‘unlikely’ with “incapable of ever engaging” – with the consequence that many people experiencing lengthy claims periods. Other examples of dodgy definitions have included:

- retraining clauses that would mean that manual labourers unable to do physical work due to injury will not meet the TPD threshold if they could retrain and work in, says a call centre, even if the labourer has no realistic chance of ever obtaining such a job;
- regular and ongoing care clauses that require medical opinions, that effectively require the doctor to assure against future improvement;
- exclusions based on “at work clauses,” where insurers deem that the member was not working sufficient hours or was working on a restricted basis, by reference to an ‘at work’ or ‘active employment’ test in the relevant policy leaving them to harder to meet “Activities of Daily Living’ tests.

The presence of fundamental conflicts of interest in group life insurance (as detailed below under Questions 26 and 27) promotes the creation of these variations.

Standardising definitions will assist in ensuring that the insurance products developed or negotiated by superannuation trustees do not become junk products as trustees and insurers amend definitions, introduce more exceptions and trade away member rights.

**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)?**

No comment.

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<sup>45</sup> Regulation 1.03C

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

**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?**

Yes, however all RSE Licensees – not simply those who engage an associated entity – should be subject to additional requirements to demonstrate that the engagement of a group life insurer and is in the best interests of beneficiaries and otherwise satisfy legal and regulatory requirements, including the requirements set out in paragraphs 22 to 24 of Prudential Standard SPS 250, Insurance in Superannuation.

Superannuation funds have substantial negotiating power and owe statutory<sup>46</sup> and common law obligations to act in the best interest of fund members. This however has not been sufficient to protect consumer interests.

Despite a best interests duty, superannuation trustees have a series of fundamental conflicts of duty. It is unclear whether a retail superannuation trustees can act both in the best interests of members and the best interests of their shareholders. It is also unclear whether any superannuation trustees can act in the best interest of their membership as a whole and individual members at the same time.

We regularly see superannuation funds not acting in the best interests of their individual members all the time. Callers to the Insurance Law Service frequently report stories of superannuation representatives not actively ensuring that they are, for example, up to date with where the insurer is in the group insurance claims process, nor actively engaging with an insurer when there are significant delays. We also see behaviour from superannuation companies that do not align with the expectation that the super fund go into bat for their member. There are very few determinations at FOS (if any) based on a superannuation trustee disputing a decision on behalf of a member.

There are also fundamental conflicts of interest embedded in the provision of group insurance itself, i.e. superannuation companies could save money by not engaging enough staff to advocate on behalf of member claims.

Trustees also regularly benefit in negotiating for cheaper group insurance by lowering the levels of coverage and accepting unfair contract terms as outlined above. Superannuation trustees would argue that this is in the best interests of their members by preserving higher levels of retirement income. But it significantly lowers the ability of member beneficiaries making a successful claim on a product that they pay for.

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<sup>46</sup> Section 52 of the *Superannuation Industry (Supervision) Act 1993*

Superannuation trustees have made these conflicts of interest worse by instituting profit-sharing arrangements between superannuation trustees and insurers. ASIC reported to the PJC Life Insurance Inquiry that in a review of insurance and superannuation they had:

*issued notices to, approximately, 47 trustees ... we're looking in the region of about seven or eight that may have some form of arrangements that are called different things in different circumstances—essentially, it's profit sharing, premium sharing or some form of other arrangement between the insurer and the super fund. ... There's clearly a recognition by [Insurance in Super Working Group] that the arrangements haven't been as clear and tight as would be desirable and that it would be much better to come up with a cross-industry standard that says they ought to be applied only in a way that ultimately benefits members<sup>47</sup>*

It was expected that the Insurance in Superannuation Working Group would address this in a Code of Practice. They did not.

The Senate Life Insurance Inquiry found a litany of further conflicts of interest and less than transparent arrangements between superannuation trustees and insurers:

*"Firstly, there appears to be the potential for performance related pay, commissions, and fees to create incentives to upsell products that are not in the customers best interests.*

*Secondly...direct insurance occurs without the provision of financial advice. Consequently, some of the consumer protections associated with personal advice do not apply because there is no 'personal advice' from an adviser.*

*Thirdly, because direct insurance does not contain an intermediary in the form of an adviser, consumers may have an expectation that direct life insurance would be free from hidden fees, commissions and performance related pay."<sup>48</sup>*

And further:

*Other payments from life insurers to trustees and from trustees to life insurers are shown in Figure 5.2 for situations when a consumer becomes a member of a superannuation fund by choice. This appears to occur regardless of whether the customer sought personal financial advice.*

*It is unclear what the nature of these other payments are, how much they are, whether they are one-off or ongoing, to what extent they are deducted from a consumers super contributions and life insurance premiums, and whether there are any consumer protections in place...<sup>49</sup>*

Finally the Committee found that:

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<sup>47</sup> Fitzpatrick, PJC Committee [http://parlinfo.aph.gov.au/parlInfo/download/committees/commjnt/896c9d2f-2646-4e8e-bb18-19ceee3972e3/toc\\_pdf/Parliamentary%20Joint%20Committee%20on%20Corporations%20and%20Financial%20Services%202017%2009%2008%205514%20Official.pdf;fileType=application%2Fpdf#search=%22committees/commjnt/896c9d2f-2646-4e8e-bb18-19ceee3972e3/0000%22](http://parlinfo.aph.gov.au/parlInfo/download/committees/commjnt/896c9d2f-2646-4e8e-bb18-19ceee3972e3/toc_pdf/Parliamentary%20Joint%20Committee%20on%20Corporations%20and%20Financial%20Services%202017%2009%2008%205514%20Official.pdf;fileType=application%2Fpdf#search=%22committees/commjnt/896c9d2f-2646-4e8e-bb18-19ceee3972e3/0000%22)

<sup>48</sup> Para 5.17-5.19 page 69  
[https://www.aph.gov.au/~/\\_media/Committees/corporations\\_ctte/LifeInsurance/report.pdf?la=en](https://www.aph.gov.au/~/_media/Committees/corporations_ctte/LifeInsurance/report.pdf?la=en)

<sup>49</sup> Para 5.26-5.27 page 69  
[https://www.aph.gov.au/~/\\_media/Committees/corporations\\_ctte/LifeInsurance/report.pdf?la=en](https://www.aph.gov.au/~/_media/Committees/corporations_ctte/LifeInsurance/report.pdf?la=en)

*Evidence to the committee, particularly from ASIC, indicates that a plethora of hidden payments including commissions, fees, performance-related payments, soft dollar benefits, and non-financial benefits exist within the various structures of the life insurance industry.<sup>50</sup> ...*

*The committee also notes that payments made from life insurers to trustees remain unregulated by conflicted remuneration provisions and can include payments arising from profit sharing arrangements that exist between trustees and life insurers in the provision of default insurance funded by superannuation guarantee contributions. The committee also notes that there is no transparency around other payments that may exist between life insurers and trustees including soft dollar benefits. The committee believes that given the compulsory nature of superannuation and the automatic provision of insurance, transparency around the exact nature of the value of these arrangements is critical for confidence in the superannuation system.<sup>51</sup>*

The Committee recommended that

*ASIC conduct a systematic review and risk assessment of all payments and benefits flowing between participants in each sector of the life insurance industry—direct, group, and retail—and inform the government of any regulatory gaps; and the government consider further regulation of payments between life insurance industry participants following the ASIC review.<sup>52</sup>*

The above conflicts of interest and non-transparency that exists in the nexus between superannuation trustees, the insurance sector and beneficiary members is such that it is clear that the current regulatory environment is not producing good consumer outcomes and must be reformed.

For these reasons we also do not believe insurance in the superannuation should be exempt from the unfair contract provisions currently being consulted by Treasury in relation to question 29 below..

## **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?**

No, the Insurance in Superannuation Voluntary Code of Practice is not sufficient to protect the interests of fund members.

The Insurance in Superannuation Voluntary Code is non-binding on superannuation trustees, unenforceable, does not create a governance body to investigate breaches and has not been approved by ASIC to ensure that it meets the requirements as laid out in RG183. Superannuation trustees also make no commitment to prevent erosion of people's account balances beyond what is required under the law. These must be addressed. Other improvements required include:

- cessation periods for accounts with low contributions must be introduced;

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<sup>50</sup> Para 5.85

<sup>51</sup> Para 5.107

<sup>52</sup> Para 5.105

- premium caps in line with the draft code released for public consultation in 2017 should be committed to by superannuation trustees with a time-bound public commitment to review these caps to ensure they are set at appropriate levels for a basic default products;
- insurance terms used should be standardised including common eligibility and exemption definitions for TPD;
- claims handling commitments need to be improved including committing to acting in the interests of the individual member;
- any cover that is reduced in order to reduce premiums should still meet minimum standards, be worthwhile, suitable and appropriate;
- the definition of ‘exceptional cases’ should be rewritten to tighten up the timeframe in which a review may be exceeded.

## 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?**

Removing the exemption of unfair contract term protections in the *Insurance Contracts Act 1984* is well overdue.

We strongly support the grand majority of proposals put forward by Treasury<sup>53</sup>. The proposed model is largely balanced, fair and will achieve its stated intentions. The key elements we support are:

- amending Section 15 of the *Insurance Contracts Act 1984*;
- narrowly defining Main Subject Matter as proposed; and
- defining the insurer’s legitimate interest as when the term reasonably reflects the underwriting risk accepted by the insurer in relation to the contract and it does not disproportionately or unreasonably disadvantage the insured.

There are a small number of elements we wish to see amended.

The first is that the exclusion from review of the quantum of excess payable should only be allowed to the extent that the terms are transparent, upfront and clear.

Solicitors on the Insurance Law Service regularly see insurances with multiple excesses that are unclear, complex and have complicated structures. The excess payable is not usually one single

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<sup>53</sup> Treasury, *Extending Unfair Contract Terms Protections to Insurance Contracts* Proposals Paper, June 2018  
[https://static.treasury.gov.au/uploads/sites/1/2018/06/t284394\\_UCT\\_Insurance\\_Contracts\\_Proposals\\_Paper\\_Aug.pdf](https://static.treasury.gov.au/uploads/sites/1/2018/06/t284394_UCT_Insurance_Contracts_Proposals_Paper_Aug.pdf)

excess. The excess payable is regularly made up of multiple, complex excesses at different rates, so that it is not clear what the quantum of excess actually is upfront.

Further the “basic excess” may be highlighted upfront but additional excesses are rarely if ever highlighted. Emphasising the “basic excess” over all applicable and potential excesses is misleading. There is very little transparency with additional excesses, largely invisible to consumers. A customer must search for them and know to click on a number of links and know to read further documents to find out the full information and potential excess quantum.

The circumstances in which an excess is payable are also not straightforward and are structured in complicated ways so that it is not clear upfront when an excess will be paid. To understand the way the excesses work, the customer must go digging in the PDS (or other documents).<sup>54</sup>

The second amendment we wish to see regards the remedy for a contract term found to be unfair. The remedy should be that the insurer cannot rely on the term rather than voiding. Voiding an unfair contract term can lead to unfair outcomes where the voiding undermines the effect of a contract in part or in whole. Insurance contracts are made up of a complex array of conditions, exceptions, inclusions, exclusions and definitions. Voiding a term may unintentionally lead to the contractual house of cards falling, causing the insured to not receive the benefit of the contract.

Finally the proposal must be amended to ensure that group insurance be subject to unfair contract terms protections on the basis of well-documented conflicts of interest and not meeting their best interest duty.

**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?**

We do not hold a view whether the duty of utmost good faith extends to AFCA or not but do believe that it should. If interpreted broadly, it may well extend, however, in practice we do not think that a breach of the duty - extending to interactions with an EDR body or otherwise - has any significant consequence as currently formulated under the *Insurance Contracts Act 1984*.

While damages are available for a breach of the duty of utmost good faith under the *Insurance Contracts Act 1984*, it would require significant, costly and impractical legal action to address the issues which most claimants are unlikely to and rarely if ever pursue. AFCA currently has under its Rules an ability to award damages to a consumer, and we would support a widening of the use of that award where a financial firm has in the course of their conduct in a complaint unnecessarily delayed, withheld evidence or misrepresented positions. Whether that mechanism is the extension of duty of utmost good faith needed or otherwise, we would support that objective.

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<sup>54</sup> Financial Rights provides a number of examples relating to excess in our submission to the current review at pages 20-30 [http://financialrights.org.au/wp-content/uploads/2018/08/180824\\_ExtendingUnfairContractTerms\\_Submission\\_FINAL.pdf](http://financialrights.org.au/wp-content/uploads/2018/08/180824_ExtendingUnfairContractTerms_Submission_FINAL.pdf)

**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?**

Yes.

Under the original subsection if the insurer would not have been prepared to enter into a contract of life insurance with a customer on any terms if the duty of disclosure had been complied with, or the misrepresentation had not been made, then an insurer could avoid the contract within three years after the contract was entered into.

In many cases the insurer would have entered into the contract with a tailored exclusion or charged an additional premium. In such cases the claimant could still successfully claim on an unrelated condition albeit potentially with the additional premium deducted.

The amendments have harshly impacted upon the insured and in our view is not the correct balance.

If the insurer would not have entered into a contract of insurance on the same terms and it knew of the relevant facts, the insurer can now avoid the contract of insurance. The insurer simply has to show that a contract of insurance would not have been entered into on the *same terms*, rather than showing that a contract of insurance wouldn't have been entered into on *any terms*.

The net result of the changes is that people now have illusory cover and insurers can exclude claims despite having suffered no disadvantage.

At a minimum the 2013 amendments need to be rescinded and the original words restored.

Insurers should be compelled to improve processes and information at the time of disclosure to reduce the chance of misstatement, and not be incentivised to rely on a “get out of claim/gaol” free card after the insurance is incepted. This causes serious detriment to the consumer and entitles the insurer to engage in its own moral hazard.

**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 onus under Section 21 of the *Insurance Contracts Act 1984* is on an insured to disclose to an insurer matters that are relevant to the contract of insurance, for some classes of insurance s21A places an onus on the insurer to ask specific questions. The duties imposed serve the purpose of upholding the principle of “utmost good faith” between the insurer and the insured.

In reality, however, this legislation serves to favour insurers and to allow them to find reasons to avoid contracts, often those of desperate or disadvantaged people, in order to maximise profits. Financial Rights has long been concerned about insurers having readily accessible databases to check common risks such as car accident claims history which they access at claims time but not at

inception, with the consequence that consumers are paying for illusory insurance – that is insurance they could never have claimed on.

When the Joint Law Commission and Scottish Law Commission review into UK insurance law examined the equivalent duty<sup>55</sup> the commission found that the law operated harshly and was inappropriate for modern consumer insurance. The four problems they identified were that:

- the duty operated as a trap for consumers
- insureds were denied even when acting honestly and reasonably
- the ability of the insurer to refuse a claim was overly severe and
- mistakes were treated harshly.<sup>56</sup>

The same criticisms can be levelled at the application of Section 21.

The UK replaced their clause with the duty of the consumer to take reasonable care not to make a misrepresentation to the insurer.<sup>57</sup>

When making a determination as to whether or not a consumer has taken reasonable care not to make a misrepresentation to an insurer, factors relating to the insurer's actions, the type of insurance contract and other circumstances are taken into account.<sup>58</sup> While the insured person still has a responsibility to take reasonable care not to make a misrepresentation in response to the insurer's question, the insurer also has a responsibility to ask clear, specific and comprehensive questions. There is a distinction made between misrepresentations made by consumers that are "deliberate or reckless", and those that are "careless", with outcomes significantly less detrimental to consumers for those misrepresentations deemed "careless". The onus is placed on the insurer to prove that a misrepresentation is deliberate or reckless, and where the insurer cannot prove this, a misrepresentation is deemed to be careless.

This approach is more reasonable and appropriate and should be used as the basis to replace section 21

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<sup>55</sup> *Marine Insurance Act 1906* s. 18(1) (UK) "the assured must disclose to the insurer, before the contract is concluded, every material circumstance which is known to the assured"

<sup>56</sup> Law Commission, "Consumer Insurance Law: Pre-Contract Disclosure and Misrepresentation", Law Commission website, accessed online <https://www.lawcom.gov.uk/project/consumer-insurance-law-pre-contract-disclosure-and-misrepresentation/>.

<sup>57</sup> Section 2 of the *Consumer Insurance (Disclosure and Representations) Act 2012* (UK)

<sup>58</sup> *Ibid.* s.3.



## 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?

Yes, the Life Code and the General Code should apply to all insurers. The coverage of the codes needs to be broadened to ensure consumers do not fall into existing gaps in consumer protections due to machinations of industry structures and politics.

The current Life Code only applies to:

*registered life insurance companies issuing Life Insurance Policies that are covered under membership of the FSC; and any other industry participant, including a non-FSC member, which adopts the Code by entering into a formal agreement with the FSC and the Life CCC to be bound by the Code.*

It does not apply to superannuation fund trustees, financial advisers or other life insurance industry participants such as third party distributors under their own Australian Financial Service (AFS) licence. This leaves significant gaps in coverage of the Life Code. We note that group insurance makes up the grand majority of life insurance consumers – with 13.3 million lives covered by group insurance out of a total of 15.9 million covered (or 83%).<sup>59</sup> For the majority of Australians this is the only way they can obtain life insurance cover and the only self-regulatory code protections available to these consumers are under the Voluntary Insurance in Superannuation Code of Practice and these are particularly weak, as outlined above. The Life Code 2.0 seeks to include FSC superannuation members. This will not cover the whole industry and the FSC has deviated in their proposed “Chapter 2” from the Insurance in Superannuation Working Group wording, which may set an alarming precedent even if they are not substantial amendments. The risk is that there will be an inconsistent approach across the industry in future iterations.

The current General Code only applies to members of the ICA and other entities as approved by the ICA. The commitments made under the General Code do not and, in the proposed next iteration of the Code, will not extend to those insurance distributors that operate under their own AFS licence. This was considered during the ICA’s recent review of the Code and the ICA took the view that:

*those distributors that operate under their own AFSL are subject to ample regulation, through the law as well as self-regulation, without requiring duplication in the Code. Potential breaches of licence conditions can be reported to ASIC.*

We do not agree with this position. The National Insurance Brokers Association (NIBA) Code may refer to the General Code but the Banking Code of Practice and the Customer Owned Banking Association (COBA) Code do not. There is also little currently in place to compel the NIBA Code to continue to refer to the General Code.

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<sup>59</sup> APRA, Response to Submissions, Life insurance - public reporting of claims information - update on progress, 24 May 2018

It should be the case that all entities that sell general or life insurance are subject to the General and Life Codes.

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

**34.1 a failure to comply with financial services laws (for the purpose of section 912A of the *Corporations Act 2001* (Cth));**

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

A failure to comply with the General or Life Code should lead to serious consequences including enforceable sanctions, civil penalties and administrative action. We do not hold any specific views on which approach is more appropriate, simply that action is required to ensure that insurers are held to account for breaches of the Code and are incentivised to meet their commitments in a way that is stronger than the voluntary nature of commitments under current self-regulatory arrangements.

Codes are not strictly enforceable upon insurers and there are very few consequences for a breach of the Codes.

Currently the General and Life Codes are not a part of the contract with a consumer and explicitly rejects any additional legal rights between the consumer and the insurer.<sup>60</sup>

In its recent review of the General Code the ICA have maintained their stance against enforceability:

*ICA maintains its position that the Code should make it clear that it is enforceable through the CGC's oversight and powers of sanction, as well as through the EDR process. The current FOS Terms of Reference state that FOS can take into account industry codes when determining disputes, and it is expected that the AFCA Terms of Reference will provide for the same enforcement. It is the ICA's view that Code enforceability does not require incorporation of the Code in the customer contract.*

We do not agree.

With respect to the CGC, the CGC's oversight and sanctions powers are incredibly limited. CGC can only impose a sanction if the CGC considers the insurer to have merely *failed to correct* a Code breach.<sup>61</sup> Even at this stage the range of sanctions are incredibly limited.<sup>62</sup>

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<sup>60</sup> General Code clause 1.5, Life Code 1.3

<sup>61</sup> Clause 13.11 and 13.13

<sup>62</sup> Clause 13.15 ....(a) a requirement that particular rectification steps be taken by us within a specified timeframe; (b) a requirement that a compliance audit be undertaken; (c) corrective advertising; and/or (d) publication of our non-compliance.

With respect to the ombudsman point, yes the Financial Ombudsman Service (and presumably AFCA) can take into account industry codes when determining disputes but they merely have regard to applicable industry Codes or guidance - they are not strictly enforceable prima facie. Where AFCA does not have jurisdiction such as a claim is over its compensation cap the Codes need to be enforceable in court.

The ICA has relied on the fact that ASIC RG183 is merely a guidance and not a direction. RG 183.27 for example states:

*In most cases, subscribers will incorporate their agreement to abide by a code by contracting directly with the independent person or body that has the power to administer and enforce that code. In some cases, subscribers will also incorporate their agreement in individual contracts with consumers (e.g. written directly into the terms and conditions of a particular product). **We strongly encourage code owners to consider this approach.***

And further at RG183.70

*These sanctions **might** include: (a) formal warnings; (b) public naming of the non-complying organisations; (c) corrective advertising orders; (d) fines; (e) suspension or expulsion from the industry association; and/or (f) suspension or termination of subscription to the code*

Strong encouragement and “might include” are rather weak in the circumstances where an industry has refused to do any such thing for decades. At a minimum RG183 needs to be updated to ensure that all sanctions are available and that subscribers incorporate the Code in their contracts.

The ICA and FSC are thoroughly conflicted in their dual roles as administrators of self-regulatory codes and industry lobbying bodies seeking less regulation.

The ICA in its evidence demonstrated this conflicted role clearly:

*[W]e have limitations in the actions that we can take. We are a member-based company. It's - it's voluntary. And for us to enforce upon members to withdraw from a market or change a product is really outside the powers that we have. We're not a regulator.<sup>63</sup>*

The FSC also gave evidence that the Life Code is aspirational<sup>64</sup> and evidence was produced to demonstrate that no sanction had ever been applied under either Code.

Our preference is that the codes become enforceable through a co-regulatory scheme with ASIC. This would ensure that:

- every general insurer, life insurer and superannuation trustee is subject to a mandatory code affording all insurance consumers appropriate protections,
- the codes are made a part of the contract with a consumer,

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<sup>63</sup> Transcript of proceedings, In The Matter Of A Royal Commission Into Misconduct In The Banking, Superannuation And Financial Services Industry, 21 September 2018 , Evidence of Rob Whelan, P6400.

<sup>64</sup> Transcript of proceedings, In The Matter Of A Royal Commission Into Misconduct In The Banking, Superannuation And Financial Services Industry, 21 September 2018 , Evidence of Sally Loane, P6453.

- the codes are monitored and enforced by unconflicted, independent code governance or compliance committees with fully guaranteed resources to conduct their work;
- the code governance or compliance committees are empowered with the full toolbox of sanctions to be imposed for any breach at any time where appropriate
- full transparency is instituted with the naming of every subscriber breach,
- overseen by ASIC who would be empowered to initiate action with respect to:
  - any and all code breaches;
  - systemic breaches of the Code;
  - failures to address any breaches;
- and ensure that all codes are regularly reviewed and fully address consumer concerns.

**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?**

Regulators should have sufficient tools available to them to efficiently penalise breaches of the law. These penalties should not be capable of regulatory arbitrage or be seen as “the cost of business” by financial firms. If the regulator in finding conduct that is a breach of the law, should have the capability to effectively penalise an entity.

## **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?**

No, external oversight of the adequacy of the compliance systems of financial services entities should be increased with additional resourced provided to ASIC and APRA to utilise RegTech to do so.

It is critically important that regulators are empowered to keep tabs on insurer compliance with the codes and the law. ASIC needs be resourced and empowered to use or RegTech to provide the tools they need to monitor insurers in an ongoing manner.

As a rule, financial services providers across the board should be providing more data to regulators via RegTech systems to enhance regulatory monitoring.

APRA and ASIC have initiated a program to work with industry to collect and publish comprehensive and reliable life insurance claims information. The aim is to improve the

accountability and performance of life insurers.<sup>65</sup> ASIC and APRA plan to report on this data publicly at the aggregate industry level as well as individual insurer level.

The same should be initiated for general insurance claims information. However both programs should be expanded to ensure that they are capturing data arising out of all compliance requirements including code of practice requirements and breaches information, pricing information, underwriting, claims handling data, sales and quotes, marketing and advertising compliance.

The information gathered by regulators should be used to provide information to empower consumers and promote competitive markets. For example, as above claims data could be used to provide claims ratios for consumers at point of sale.

The information gathered via RegTech should also empower ASIC to evaluate existing and proposed public policies and evaluating affordability and availability of financial services and products and competition issues.

ASICs move to embed supervisors within financial services entities should be expanded to beyond the five identified and, they should be empowered to conduct spot checks and audits.

**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**

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

Yes. The insurance sector has, with impunity, placed greater emphasis on resourcing their technology and systems where a profit can be drawn (such as utilising telematics and big data technologies for underwriting purposes), rather than complying with laws, regulations and codes. There are seemingly currently no consequences for the industry dragging their heels on maintaining their compliance systems. They have therefore made a straightforward cost benefit analysis that has resulted in them not maintaining these systems.

Currently AFS licence holders need to monitor and report on their compliance, including reporting relevant breaches to ASIC<sup>66</sup>. AFS licence holders are expected to keep records of monitoring and reporting, including records of reports on compliance and breach notifications.

Insurers should be compelled by law to design, maintain and resource compliance systems at threat of losing their license, as well as fines based on a formula applied to their annual turnover.

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<sup>65</sup> following recommendations in ASIC Report 498 *Life insurance claims: An industry review*

<sup>66</sup> Section 912D

**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?**

Laws and regulators have a central role in shaping culture.

Governance practices, remuneration structure and the incentives they create drive insurer culture. These are borne of laws defining the duties of directors and remuneration structures.

The culture within an organisation and its subsequent conduct arises from a sum of the people within an organisation – the board, management, middle management, front line, sales. People will act in their own best interests and will act in ways they are incentivised to act. The most basic incentive is a financial one.

If people (both executives and employees) within an organisation are incentivised via remuneration structures (variable incentives, commissions or bonus payments) to increase sales and/or profit then the culture will form around this aim. Conduct is then directed at placing sales and profit above the customer's best interests first, no matter how much lip service an organisation pays to customers in a value statement.

Rewards related to performance against specific sales or profit measures or targets are the most common through the sector. Even in a performance management structure that measures performance against a number of weighted elements used to determine an overall performance including sales, customer satisfaction and/ or the extent of compliance with policies, procedures, or behavioural standard, companies continue to reward sales targets.

Reform is required to ensure self-interested financial benefit to the individuals and corporation is counter-balanced with clear incentives and directives to promote individual and corporate responsibility towards consumer's best interests and a broader social responsibility. These reforms must be directed at every level of the financial services sector from the board and senior executive level to middle management and front line sale staff.

Firstly directors must be explicitly directed to take other stakeholder interests into account so as to adequately manage these risks. The UK has taken this step and has included mandatory consideration by directors of certain interests other than shareholders, including, amongst others employees, customers, suppliers, and the environment.<sup>67</sup> Australia has yet to take this step.

The *Corporations Act 2001* is therefore, in our view, out of step with community expectations with respect to the expected behaviour of directors and corporations, and as such sections 180-184 of the Act should be updated to explicitly ensure directors take into account the stakeholder interests other than shareholders, particularly their customers.

Remuneration structures for senior executives that promote poor consumer outcomes must also be regulated. The BEAR should be expanded to insurance entities and strengthened to link accountability to poor consumer outcomes not just prudential matters.

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<sup>67</sup> Section 172 of the *Companies Act 2006 (UK)*

All forms of conflicted remuneration for insurance sales all intermediaries and employees must be prohibited.

**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?**

Yes.

Recommendation 20 states that

*Approved codes should be binding on and enforceable against subscribers by contractual arrangements with a code monitoring body.*

Codes need to be enforceable as a term of the contract with consumers.

Recommendation 36 states that:

*Imprisonment should be removed as a possible sanction for strict and absolute liability offences.*

This sends the wrong message. Section 190 of the *Corporations Act 2001* currently bears imprisonment as a possible sanction for strict and absolute liability offences and even though the Attorney General’s Department guide stipulates these offenses should not be punishable by imprisonment, removing this penalty altogether might undermine ASIC’s prosecution of these offenses.

Recommendation 45 states:

*Infringement notices should be set at 12 penalty units for individuals and 60 penalty units for corporations for any new infringement notice provisions*

All new infringement notice provisions in the *Corporations Act 2001* should utilise the ration currently in use under the *National Consumer Credit Protection Act 2009*, being one-fortieth of the maximum penalty that a court could impose for civil penalty provisions.

Misleading and deceptive conduct and unfair contract terms should be civil penalty provisions.

ASIC administered legislation should require courts to have to consider community standards and deterrence principles when setting a penalty.