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

Round 6 Hearing – Insurance

RESPONSE TO COUNSEL ASSISTING'S CLOSING SUBMISSIONS: PART A

Introduction

1. CommInsure (on behalf of The Colonial Mutual Life Assurance Society Limited (**CMLA**) and Commonwealth Bank of Australia (**CBA**)) accepts Counsel Assisting's summary of the evidence concerning the third case study, which dealt with CommInsure's handling of claims made under life insurance policies that provided trauma cover, save for one matter identified in paragraph 4 below. CommInsure submits that the following additional matters clarify and provide context for the issues under consideration in this case study.

Additional matters concerning an insured's claim in respect of a heart attack

2. The Commission has examined CommInsure's handling of a claim made by an insured (the **First Insured**) who had suffered a heart attack in early 2014.

3. CommInsure initially declined the First Insured's claim on the basis that the definition of "heart attack" under the CommInsure policy was not met. CommInsure treated the event suffered by the First Insured as having met the policy definition of coronary artery angioplasty[1], and on that basis paid the First Insured the amount of cover applicable to that condition, rather than the higher amount that would have been payable in the case of a heart attack as defined under the policy.

4. In describing CommInsure's handling of the First Insured's claim, Counsel Assisting noted that CommInsure had declined the claim in circumstances where the First Insured's "level of troponin only rose to 1.9 micrograms per litre", which was below the policy definition requirement of above 2.0 micrograms per litre[2]. Presumably, the 1.9 micrograms troponin result was referred to because that reading barely fell short of the policy requirement of 2.0. While CommInsure accepts (as set out below) that the First Insured's claim and subsequent complaint were not handled correctly in a number of respects, it is not the case that the First Insured almost met the extant

[1]Statement of Helen Troup dated 28 August 2018 in response to Rubric 6-27 (Heart Attack case study), HT-7 at p1.

[2] T6471.8-10.

policy definition of heart attack so far as (amongst other things) troponin levels were concerned. In assessing whether the definition of heart attack had been met, CommInsure's Medical Officer relied upon the peak troponin reading obtained during the course of the First Insured's myocardial infarction, being 0.69 micrograms per litre[3]. As explained by Ms Troup during the course of her evidence[4], consistently with the contemporaneous documents[5], the reading of 1.9 micrograms per litre referred to by Counsel Assisting was obtained following (and probably attributable to ischemia associated with) the angioplasty procedure which the First Insured underwent after the infarction to treat that infarction. It was not a reading obtained in the course of measuring the impact of the spontaneous acute infarction suffered by the First Insured. Accordingly, it is clear that CommInsure did not deny the First Insured's claim because the "insured's level of troponin only rose to 1.9 micrograms per litre".

5. Upon the First Insured taking up his complaint with the Financial Ombudsman Service (**FOS**), CBA's Group Customer Relations' Customer Resolutions Manager (**CRM**) sought to challenge FOS's jurisdiction to determine the complaint on the basis that he believed that a request for CommInsure to pay a claim outside of policy terms was a matter for CommInsure to determine in its discretion[6]. The CRM's view likely reflects, as Ms Troup explained during the course of giving her evidence, the challenge, from a commercial perspective, for an insurer if it was not able to conduct its business on the assumption that the application of a policy turns on the terms of the contract between insurer and insured[7]. Having regard to that explanation, it was not unreasonable for CommInsure to have raised a question of whether that was an appropriate issue for FOS to determine.

6. FOS decided that it did have jurisdiction to determine the complaint lodged by the First Insured. Thereafter, CommInsure twice maintained its challenge to FOS's jurisdiction[8]. Ms Troup explained that this occurred because FOS's initial rejection of the jurisdiction argument was notified to CommInsure at a time when the relevant CRM handling the complaint was on leave and CommInsure failed to log the FOS

[3] Statement of Helen Troup dated 28 August 2018, HT-8.

[4] T5560.38-47.

[5] Statement of Helen Troup dated 28 August 2018, HT-26 at p2.

[6] Statement of Helen Troup dated 28 August 2018, HT-27.

[7] T5563.12-14.

[8] T6471.39-42.

decision on its case management system[9]. Ms Troup accepted that whilst this was a mistake in complaints handling processes[10], it was conduct that occurred on a mistaken footing (the mistake being the failure to register that FOS had adversely determined the jurisdictional argument). CommInsure's conduct at that time revealed a single failure in its complaint management process rather than a disregard for FOS's decision on jurisdiction.

7. In relation to the withholding of the medical opinion obtained by CommInsure as to whether the First Insured's claim met the revised definition of heart attack, it was Ms Troup's evidence that such conduct was misguided and that this was not a decision she would have made[11]. In response to a letter dated 14 February 2017 from FOS[12], CommInsure determined that an internal audit of events would be performed because CommInsure's more senior decision makers were very concerned with the way the First Insured's complaint had been handled[13]. Through its internal audit process, CommInsure self-identified (amongst other things) that the decision to redact the medical opinion was poor and it recognised the need for process improvements to avoid such conduct occurring in the future, including through appropriate escalation of decisions and inclusion of CommInsure management in key decisions[14]. This does not, of course, excuse the original poor decision made in the course of dealing with FOS. But it does demonstrate recognition, and action, by more senior members of CommInsure in response to that initial failing.

Additional matters concerning an insured's claim in respect of breast cancer

8. The Commission also considered the manner in which CommInsure dealt with a claim and complaint by an insured (the **Second Insured**) who was diagnosed with breast cancer.

9. In that case, CommInsure had declined the Second Insured's claim because it held the view (maintained by its Medical Officer) that "*radical breast surgery*" in its policy definition denoted a mastectomy. Ms Troup acknowledged that, in failing:

[9] T5565.15-32.

[10] T5565.36.

[11] T5571.1-4.

[12] Exhibit 6.142.

[13] T5576.5-6.

[14] T5577 - 5578.

(a) properly to review the differences in medical opinion as to whether the insured had undertaken radical breast surgery; and

(b) to escalate the claim for review by a broader cross-section of CommInsure management,

CommInsure did not act with utmost good faith toward the Second Insured in the way it handled her claim[15].

10. CommInsure accepts that the handling of this claim and complaint, fell below community standards and expectations, but it does not accept that it amounted to misconduct under the Commission's terms of reference. However, Ms Troup's acceptance that CommInsure did not act with utmost good faith should not necessarily lead to a finding to that effect. The question whether acts or omissions by an insurer constitute a failure to act with utmost good faith towards an insured raises matters of law as well as fact. Whether the evidence before the Commission was sufficient to found, in law, a failure by CommInsure to act with utmost good faith towards the Second Insured is not a straightforward question, as explained at paragraphs 31 and following below.

Additional matters concerning CommInsure's updating of its definition of heart attack

11. As Counsel Assisting has noted, CommInsure has now retrospectively applied its revised heart attack definition to 2012[16]. In so doing, CommInsure reviewed all claims lodged during the relevant period (that is, from October 2012 until the introduction of the revised definition in March 2016) and paid approximately $4.3 million dollars to 33 claimants who met the revised policy definition[17].

12. Further, CommInsure has caused a number of reviews to be performed of its handling of life insurance claims to determine whether claims have been incorrectly declined or whether there was a poor customer experience[18]. The reviews did not find any systemic issues in CommInsure's claims handling or in declining claims. The reviews recommended, and CommInsure has implemented, several changes in order to

[15] T5646.9-37.

[16] T6474.15-17.

[17] Statement of Helen Troup dated 7 September 2018 in response to Rubric 6-17 at [53] – [55].

[18] T5635.

enhance its claims handling processes[19]. CommInsure has a product management policy that requires all of its products to go through annual review and additionally now reviews its medical definitions every 3 years at a minimum[20].

Allegations of misconduct in relation to handling of the First Insured's claim

Allegation concerning misleading of FOS

13. CommInsure accepts that, in redacting the medical opinion it provided to FOS and stating that it declined to obtain or provide an opinion as to whether the First Insured met the revised policy definition at a time when CommInsure in fact held such an opinion, it misled FOS. CommInsure accepts that those actions constitute misconduct. CommInsure has implemented the recommendations outlined in its internal audit report to ensure such misconduct is not repeated.

Allegation concerning contravention of clause 7.2 of the FOS Terms of Reference

14. The Commission examined CommInsure's conduct in declining to provide to FOS an explanation as to why CommInsure had decided to apply its revised heart attack definition retrospectively to May 2014.

15. CommInsure accepts that clause 7.2 of FOS's Terms of Reference obliged it to provide to FOS any information that FOS considered necessary and that the exceptions to that obligation (contained in subclauses 7.2(a) – (c)) did not apply in the circumstances of this case.

16. CommInsure accepts that the First Insured's complaint raised a number of novel issues for FOS to consider. That was because the First Insured's claim had been declined on the basis of an out of date medical definition. Having regard to the issues that resulted from the out of date medical definition, FOS took the step of requesting information concerning the deliberations of CommInsure as to the medical definition that ought to apply under its policy. CommInsure accepts that it should have responded to that request promptly and within time to facilitate resolution of the First Insured's complaint. The failure to do so contravened clause 7.2 of FOS's Terms of Reference and CommInsure accepts that this constitutes misconduct.

[19] T5637.39-40.

[20] Statement of Helen Troup dated 7 September 2018 at [51] – [52].

Allegations of misconduct in relation to documents concerning the heart attack definition in CommInsure's trauma policies

17. Ms Troup was asked a series of questions in relation to two web pages and two brochures that referred to CommInsure's cover for heart attack. The two web pages and two brochures were published prior to the updating of the heart attack definition[21].

18. Ms Troup accepted that those documents were misleading[22].

19. Ms Troup also gave evidence concerning the seriousness with which CommInsure treated its engagement with the regulator and as to how it viewed the consequences it faced as a result of publication of the documents. Ms Troup was asked directly whether CommInsure felt it had been punished or brought to book in connection with the documents under consideration. Ms Troup's evidence was that CommInsure did feel that had occurred[23]. It was CommInsure's understanding that its community benefit payment of $300,000 to a consumer law group did represent a punishment[24]. Further, CommInsure engaged with the regulator in the context of ensuring that, if any customer had been misled, the effects of the conduct had been or would be corrected by reason of the retrospective application of an ample definition of heart attack coupled with review of claims that had been declined under the outdated definition[25].

Alleged breach of s12DA of the ASIC Act

20. CommInsure accepts that, in respect of the four documents considered during the hearing, it breached s12DA of the *Australian Securities and Investments Commission Act 2001* (Cth) (**ASIC Act**) by publishing them without any prominent qualification that only heart attacks of a specified severity were covered. CommInsure accepts that conduct contravened s12DA of the ASIC Act and, therefore, constituted misconduct.

21. CommInsure has remedied that misconduct by the amendment and retrospective application of its heart attack definition, by payments to persons who would otherwise have been adversely affected by the application of the outdated heart attack definition

[21] Commencing at T5617.45.

[22] T5621.14–15; T5622.8-13; T5623.26; T5624.41.

[23] T5633.32-33.

[24] T5633.7-9.

[25] T5632.46ff.

since October 2012, by its revised approach to the review of medical definitions in its trauma policies and by making a community benefit payment.

Alleged breach of section 12DB of the ASIC Act

22. Counsel Assisting also submit that it is open to find that CommInsure may have breached s12DB of the ASIC Act by making false or misleading representations in the same publications.

23. CommInsure accepts that the publication of the webpages and brochures may have been in contravention of s12DB of the ASIC Act, which is a penalty provision.

24. To the extent that the issue of adequacy of penalty is relevant, the factors to be considered were recently set out by Moshinsky J and include:

    (a) the extent of the contravening conduct and the circumstances in which it took place;

    (b) whether the conduct was systematic or deliberate;

    (c) whether the contravention arose out of the conduct of senior management or at a lower level;

    (d) whether the contravenor has a corporate culture conducive to compliance with the regulator;

    (e) whether similar conduct has occurred in the past; and

    (f) other factors, including whether the contravenor has communicated with and provided financial redress to consumers who may be affected by the contravention [26].

25. In determining the pecuniary penalty to be applied, a court also takes into account whether reparation has been made as a mitigatory consideration[27].

26. Further, although s12DB is a strict liability provision, the intent of the contravenor is relevant to the determination of the scale of pecuniary penalty that ought to be

[26] See: A*ustralian Securities and Investments Commission v Superannuation Warehouse Australia Pty Ltd* [2015] FCA 1167 and see *Australian Competition and Consumer Commission v Telstra Corporation Limited* [2018] FCA 571 at [60]ff

[27] See: *Australian Competition and Consumer Commission v Optus Internet Pty Ltd* [2018] FCA 777 at [24].

imposed – where there is an intention to deceive, the penalty ought to be proportionate to that intention[28].

27. A question raised during the hearing was whether the community benefit payment of $300,000 might not have been an adequate "penalty" for the publications.

28. Applying the considerations set out in paragraph 24 above, in light of all the circumstances surrounding the documents under consideration in this case:

    (a) there is nothing to suggest that the documents were intended to mislead;

    (b) the documents do not, of themselves, point to any attempt to mislead at a senior management level, or omission at a senior management level;

    (c) CommInsure co-operated with ASIC in its investigation of the matter, including by:

        (i) agreeing to apply a revised heart attack definition retrospectively from 2012; and

        (ii) resolving the matter with ASIC in a timely fashion;

    (d) persons who may have been misled by the documents were compensated by reason of CommInsure's payment of approximately $4.3 million to persons who did not meet the outdated definition of heart attack;

    (e) independent compliance reviews were undertaken and recommendations implemented by CommInsure; and

    (f) these outcomes were achieved without ASIC incurring the significant cost associated with litigation.

29. These matters point to the likelihood that a court proceeding for a pecuniary penalty would not have achieved a substantially better outcome in response to the offending conduct than was obtained by ASIC by agreement with CommInsure.

30. For these reasons, CommInsure submits that, on the evidence before the Commission, it should be accepted that it has responded appropriately, and has been punished accordingly, in answer to the concerns ASIC raised with it in relation to the publications.

Allegations of misconduct in relation to CommInsure's handling of the Second Insured's claim

31. CommInsure accepts that in failing to give adequate consideration to differences in medical opinions concerning the nature of the surgery undertaken by the Second Insured and failing to escalate her claim for review, its conduct fell below community standards and expectations.

32. However, to establish a breach of the duty of utmost good faith requires a demonstration that CommInsure engaged in conduct that was capricious or unreasonable[29]. The touchstone of the duty is to act, consistently with commercial standards of fairness and decency, with due regard to the interests of the insured[30]. The essential element of the duty is honesty[31].

33. There is no evidence that CommInsure acted less than honestly, or capriciously or unreasonably toward the Second Insured. The documents before the Commission and Ms Troup's evidence do not support such a finding. Rather, the evidence suggests that CommInsure acted honestly and upon the opinion of its Medical Officer, who took the view (which was not, on its face, unreasonable) that "radical surgery" for breast cancer meant a mastectomy. When the original determination of CommInsure was challenged, CommInsure caused its Medical Officer to reconsider the position having regard to further and other information provided by the Second Insured. In so doing, CommInsure acted consistently with the duty of utmost good faith.

34. Consequently, CommInsure does not accept that it engaged in misconduct in relation to the Second Insured's claim.

35. CommInsure has acted to remedy those aspects of its handling of the Second Insured's claim that fell short of community standards and expectations. In particular, CommInsure paid the Second Insured's claim plus interest in 2017, recognised that the claim ought to have been met earlier and has apologised for the shortcomings in the way in which the Second Insured's claim was handled[32].

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[29] *Tal Life Ltd v Shuetrim* (2016) 91 NSWLR 439 at [49].

[30] *CGU Insurance Limited v AMP Financial Planning Pty Ltd* (2007) 235 CLR 1 at [15] per Gleeson CJ and Crennan J.

[31] *CIC Insurance Ltd v Barwon Region Water Authority* [1999] 1 VR 683 at [42], citing *Kelly v New Zealand Insurance Co Ltd* (1996) 9 ANZ Ins Cas para 61-317.

[32] T5650.25-31 and T5652.40-46.

Allegation of available findings of conduct falling below community standards and expectations in relation to the heart attack definition in trauma policies

Failure to update the heart attack definition in a timely fashion

36. CommInsure accepts that by failing to update its heart attack definition in 2012 and in 2014 to accord with the medical definition that was accepted at that time, CommInsure failed to meet community standards and expectations.

Decision in March 2016 to backdate the updated heart attack definition to May 2014

37. Ms Troup accepted that, based on everything known today, CommInsure ought to have backdated the revised definition of heart attack to 2012 at the time that it updated the definition in 2016[33].

38. That, however, is a different matter to accepting that the decision made in 2016 fell below community standards and expectations.

39. As disclosed by the minutes of meeting of CommInsure's Board[34], in making its decision to backdate the revised definition to 2014, the Board took into account a number of factors, including:

    (a) an explanation by Dr Phillips, CommInsure's Head of Life Product and Strategy, Life Product and Distribution, that while the clinical definition of heart attack changed in 2012, this was not immediately adopted in medical treatment;

    (b) that many competitors had updated their definition by May 2014, which was a date that was in the middle of the range of dates upon which competitors had updated their definition;

    (c) that as CommInsure had updated its product disclosure statement on 11 May 2014, it was reasonable to adopt that date as the start date for the revised definition; and

    (d) the financial impact of backdating the definition to May 2014, as described by the Appointed Actuary, noting that some risk attended the estimated impact.

[33] T5593.16-18.

[34] Exhibit 6.149 at p.15ff.

40. These factors were reasonable matters to take into account in determining the date to which the revised definition ought to be retrospectively applied.

41. Further, the decision by CommInsure to backdate its insurance definition was unique in the sense that ordinarily when an insurer updates an insurance definition, it applies to claims received from the time it is adopted but not retrospectively. At the time of making its decision, the Board had accepted that there was no single right perspective or view in determining the date from which the revised definition would apply[35], which was a reasonable position to hold.

42. It is submitted that, in the circumstances, the decision made by CommInsure, although subsequently shown to differ to that which CommInsure now accepts as appropriate, was one made in good faith on a reasonable basis and, as such, did not fall below community standards and expectations.

Allegation of available findings of conduct falling below community standards and expectations in relation to the handling of the Second Insured's claim

43. CommInsure accepts that it did not meet the required timeframes in relation to this complaint. This failure constituted conduct falling short of community standards and expectations.

Characterisation of a departure generally from the FOS Terms of Reference

44. The Commissioner has raised a more general question as to whether a departure from steps required by the FOS Terms of Reference is, of itself, by reason of breach of contract or otherwise, misconduct or conduct falling below community standards and expectations.

45. CommInsure's view is that a Member's failure to comply with FOS's Terms of Reference may be properly characterised as a breach of that Member's contractual obligation to FOS. That is because, pursuant to clause 3.7 of FOS's Constitution, Members of FOS agree to be bound by the Terms of Reference. CommInsure accepts that a breach by a Member of its contractual obligation to FOS may, depending on the circumstances, amount to misconduct or conduct falling below community standards and expectations.

[35] Exhibit 6.150.

The two FOS complaints are not representative of CommInsure's engagement with FOS more generally

46. CommInsure recognises that engagement with FOS and compliance with FOS's Terms of Reference is fundamentally important to the provision of its services. The two FOS complaints considered in this Round are not representative of CommInsure's approach to engagement with FOS and compliance with its Terms of Reference.

47. The conduct of the CRMs who dealt with FOS in connection with the First Insured's claim is not representative of CommInsure's conduct as a whole – that much is readily apparent from both Ms Troup's candid recognition of the inappropriate nature of that engagement and, equally importantly, from CommInsure's own conduct in undertaking an internal audit and implementing changes in recognition of management's concerns. In particular, the approach taken by senior management suggests that, although the individuals engaging with FOS in connection with the First Insured's claim made serious errors of judgment in handling the complaint, those errors should not be taken as an indication of a systemic failing in CommInsure's engagement with FOS, nor as indicative of a systemic failure to comply with FOS's Terms of Reference.

28 September 2018