AUSCRIPT
FAST PRECISE SECURE

AUSCRIPT AUSTRALASIA PTY LIMITED
ACN 110 028 825

T: 1800 AUSCRIPT (1800 287 274)
E: clientservices@auscript.com.au
W: www.auscript.com.au

TRANSCRIPT OF PROCEEDINGS

O/N H-919890

THE HONOURABLE K. HAYNE AC QC, Commissioner

**IN THE MATTER OF A ROYAL COMMISSION
INTO MISCONDUCT IN THE BANKING, SUPERANNUATION
AND FINANCIAL SERVICES INDUSTRY**

MELBOURNE

9.00 AM, FRIDAY, 21 SEPTEMBER 2018

Continued from 20.9.18

DAY 59

MS R. ORR QC appears with MR M. COSTELLO as Counsel Assisting with MR M. HOSKING and MS S. ZELEZNIKOW
MR A. BELL SC appears for ICA
MR M. ELLIOTT SC appears for Financial Services Council

THE COMMISSIONER: Ms Orr.

MS ORR: Commissioner, in this final part of this round of hearings, we will draw together some of the themes we've explored in the life insurance and general insurance case studies, and consider the regulation of the insurance industry as a whole. We will do that through two witnesses, the first is Mr Robert Whelan who is the CEO of the Insurance Council of Australia. The Insurance Council of Australia is the peak representative body for the general insurance industry, and is responsible for the General Insurance Code of Practice. The second is Ms Sally Loane, the CEO of the Financial Services Council. The Financial Services Council is the peak representative body for the life insurance industry and is responsible for the Life Insurance Code of Practice.

In addition to Mr Whelan and Ms Loane, the Commission also sought witness statements from the bodies responsible for monitoring compliance with the General Insurance Code of Practice and the Life Insurance Code of Practice. They are the Code Governance Committee and the Life Code Committee. I want to tender those statements, Commissioner. For the Code Governance Committee I tender the witness statement of Lynelle Briggs dated 14 September 2018.

THE COMMISSIONER: That statement becomes exhibit 6.401.

EXHIBIT #6.401 STATEMENT OF LYNELLE BRIGGS DATED 14/09/2018

MS ORR: And for the Life Code Compliance Committee I tender the witness statement of Anne Brown dated 28 August 2018.

THE COMMISSIONER: Becomes exhibit 6.402.

EXHIBIT #6.402 WITNESS STATEMENT OF ANNE BROWN DATED 28/08/2018

MS ORR: Commissioner, I call Mr Robert Whelan.

<ROBERT WILLIAM WHELAN, SWORN [9.02 am]

<EXAMINATION-IN-CHIEF BY MR BELL

THE COMMISSIONER: Thank you very much, Mr Whelan. Do sit down. Yes, Mr Bell.

MR BELL: Mr Whelan is your full name Robert William Whelan?---Yes.

And your business address level 4, 56 Pitt Street Sydney, New South Wales, 2000?---Yes.

And you are an executive director and the chief executive officer of the Insurance Council of Australia?---That's correct.

And you've received, I understand, a summons to appear at this stage of the hearings dealing with Rubric 6-61. Do you have a copy of that summons with you?---I do.

I tender that, Mr Commissioner.

THE COMMISSIONER: Exhibit 6.403, the summons to Mr Whelan.

EXHIBIT #6.403 SUMMONS TO MR WHELAN

MR BELL: And you've prepared a report in relation to Rubric 6-61, I understand?---Yes.

And do you have a copy of that report with you?---I do.

And are the contents of that report true and correct and to the extent that the report expresses opinions, are they opinions you truly hold?---They are.

I tender that as well, Mr Commissioner.

THE COMMISSIONER: Statement of Mr Whelan and its annexures in relation to Rubric 6-61 – statement is dated what date?

MR BELL: I think it's 27 August 2018, Mr Commissioner.

THE COMMISSIONER: Thank you. Becomes exhibit 6.404.

EXHIBIT #6.404 STATEMENT OF MR WHELAN AND ITS ANNEXURES IN RELATION TO RUBRIC 6-61 DATED 27/08/2018

THE COMMISSIONER: Thank you. Yes, Ms Orr.

<CROSS-EXAMINATION BY MS ORR

MS ORR: Mr Whelan, you've been the CEO of the Insurance Council of Australia since March 2010?---That's correct.

And the Insurance Council of Australia, or the ICA, as I will refer to it, is the peak representative body for the general insurance industry?---That's right.

It was established in 1975?---Yes.

And it replaced various state-based associations for general insurers which traced their origins back to 1869?---Yes.

Any company licensed under the Insurance Act to conduct a general insurance business can be a member of the ICA?---Yes.

And at the moment, the ICA has 50 members?---Yes.

And they represent about 92 per cent of all general insurance business in Australia?---That's right.

What are the main functions of the ICA, Mr Whelan?---The main functions are we represent the general insurance industry in a range of areas that go to how the industry is conducted, how the industry is regulated, and the – the types of laws and regulations that affect the industry. We lobby for the industry's interests. We look to build trust in the industry amongst the general community. We also look for ways in which we can improve the consumer outcomes within the industry, and assist the industry in raising its overall standards of service delivered to the customer through our Code of Practice.

Now, you've said that one of the ICAs objectives is to build trust in the industry. Is that right?---That's right.

Now, the ICA is governed by a board?---That's right.

And the members of the board are all representatives of the ICAs members?---Yes.

The board includes Helen Troup who gave evidence on behalf of CommInsure last week?---Yes.

And Gary Dransfield who gave evidence on behalf of Suncorp yesterday?---Yes.

Now, in 2017 the ICA established a consumer liaison forum?---That's right.

And can you tell us what that is?---That consists of representatives from the Insurance Council and representatives from the main consumer lobby groups, and we

meet regularly throughout the year. We have an independent chair that assists us to work through an agenda which is brought to us by the consumer groups. The intent of the forum is to provide a process by which key issues that are of interest and concern to consumers are brought to the Insurance Council through this mechanism where those – those issues are defined and debated and discussed about how the industry may respond to some of those issues, and the out-workings of those – of that forum are reported directly to the board on a regular basis.

Now, does that body, the consumer liaison forum, have access to the ICA board?---It does if it needs to.

And how does it do that?---It can request to present at the board. It can do that through the independent chair or other – other means, but essentially, the management group represents the out-workings of the forum to the board on a regular basis through a reporting mechanism, and that's made transparent to the consumer groups as well.

And what are some of the key issues that that body has brought to the ICAs attention?---Well, there's quite a number, and they're – they're well canvassed across the constituents that they deal with but the sorts of things that have been brought to our attention are things like vulnerable consumers, in particular, and that's a – that's a major issue that we've been contending with over the last year and a half. And things such as unfair contract terms are another issue that gets raised with us. So there's several issues around that type of – that type of thing that they bring to us.

Any other key issues that they've brought to your attention?---Family violence is a particular issue that was raised with us, that they were looking for an input to the Code of Practice to assist with people who have difficulties with family violence and processing their claims, and so on. And disclosure. I think that's another issue that is of concern, needing to improve our methods of informing customers about the contracts that they have.

What are the sorts of issues that people who are victims of family violence experience in their insurance claims?---I think it's a – most of the time it's a confusion about how a particular policy is – is affected when a claim is made. It may be a particular partner may take an interest in a policy, and not inform the other partner of that interest. The claim may be made, the claim may be paid. The other party may not know anything about that particular – that particular claim. So it's a complex area. There's matters of law to – to be able to navigate, as well as privacy issues. To try and put some effect to that, we've brought in specialist lawyer, Ian Enright a legal insurance lawyer who is assisting us to work through some of these issues as well. And it's also being incorporated into the new version of the Code of Practice which is due to be put in practice next year.

What will be incorporated into the new Code of Practice to reflect these difficulties?---So what we will be asking all our member companies that are signatories to the code is to have in their operations a vulnerable consumers teams

trained to be able to respond and identify these sorts of issues when they're working with customers. They will be required within six months of the code being launched to have a policy, a clear and articulated policy about how they will go about dealing with family violence issues within their organisation. And we've got guidance built into the Code of Practice as a way of assisting the companies to be able to build that – that policy to make it a meaningful and useful policy.

Now, the ICAs main source of revenue is from its members. Is that right?---Yes.

And in each of the last five financial years, the income of the ICA from membership fees and levies has been between 8.7 million and $9.6 million?---Yes.

The ICA is responsible for publishing and maintaining the code, the General Insurance Code of Practice. Is that right?---Yes.

And that code was first developed in 1994?---Yes.

Now, could you explain why the code was introduced?---Well, it was accepted at the time by the government that there needed to be some form of self-regulation within the general insurance industry and the government at the time, from – from what I understand, accepted that codes of practice were an appropriate way of doing that, and it evolved pretty much from that point in time on an ongoing basis, through to where it is today.

You tell us in your statement at paragraph 126 that in 1993 the Commonwealth Government announced it was intending to introduce a compulsory Code of Practice for the general and life insurance industries?---Mmm.

And in 1994, following extensive lobbying by general insurers, the Commonwealth Government announced that it would allow the insurance industry to develop a self-regulatory code instead of imposing a statutory code?---Mmm.

That's what occurred?---Yes.

So that lobbying was successful in moving away from the government's idea of a compulsory Code of Practice into a self-regulatory code?---Mmm.

That's correct?---Yes.

All right. Now, was there anything in particular in the early 1990s that prompted a call for a compulsory Code of Practice for the insurance industry?---Look, not that I can – not that I'm aware of.

But the General Insurance Code of Practice was introduced as the industry's favoured alternative to a compulsory code?---Yes.

And there has been some version of the code in force since 1 July 1996?---Yes.

Now, since you became CEO in March 2010, there have been three versions of the code?---Three reviews, yes.

And three – three versions following reviews of the code. Is that right?---There's – I think there's two versions that while I've been here - - -

I see?--- - - - and a third version is in the – in the mix now.

I see. There was one that was in force between May 2010 and June 2012. Is that right?---Yes, there were some amendments to – there was an extraordinary amendment to the existing code due to the disasters that occurred in Queensland - - -

Yes?--- - - - in 2010 and '11.

So we had the version from May 2010 to June 2012, then another version from July 2012 to June 2015?---Mmm.

And the current version, which came into force in July 2015?---Yes.

The ICA is currently in the process of reviewing the code again?---That's right.

And a new version will come into effect next year?---That's right.

And in June this year, the ICA released the final report of its review of the code?---Yes.

And that includes the ICAs recommendations for changes to the code?---It does.

Now, I want to ask you some questions about the code a little later, but first I want to ask you about some of the topics raised in the evidence in the case studies this week?---Right.

Now, the first of those topics is add-on insurance sold through car dealers. And earlier in the week we heard evidence about some of the problems that ASIC identified with the sale of add-on insurance through car dealers?---Yes.

Did you hear that evidence, Mr Whelan?---Yes, I did hear.

Now, ASIC described the problems that it had identified in reports 470, 471, and 492. Are you familiar with those reports?---Some of them, yes.

Some of them?---Yes. I – I've read some of them, yes.

Yes. Have you read each of those reports at some time?---Parts of them, yes.

Okay. We heard evidence about the sale of add-on insurance through car dealers in the case study involving IAG?---Yes.

You heard that evidence?---Yes.

Now, are you familiar with the problems that ASIC has identified with the sale of add-on insurance through the car dealer channel?---I am.

And do you accept that customers are often unaware of the cost of or the cover provided by add-on insurance products sold through car dealers?---Yes.

And that many customers pay for cover that they don't need, or will not be eligible to claim for?---Yes, that's right.

Do you accept that there have been many cases where customers have been pressured to buy add-on insurance products in car dealerships?---Yes, I do.

And told that they were required to buy those products even when they were not?---I'm not sure if they were told that. I can't swear to that, but I am aware that they were pressured into the sale, yes.

And do you accept that compared to the amount of premiums paid on add-on insurance products that are sold through car dealers, the amount paid out on claims is very low?---Yes.

And do you accept that the car dealers who distribute these products earn more in commissions than customers receiving payouts on claims?---Yes.

Is any of that acceptable, Mr Whelan?---No, not at all.

And many insurers have now agreed to remediate customers for add-on insurance sold through car dealers?---Yes.

QBE is going to refund customers around $15 million?---Mmm.

Swann will refund customers around $40 million?---Yes.

And Allianz is going to refund around $45 million?---Yes.

Now, as the CEO of the peak representative body for the general insurance industry, have you reflected on what these issues say about the culture of the general insurance industry?---Most definitely. And when the insurance council was made aware of this through the concerns that ASIC raised with us, it was a concern for the insurance industry because – and the Insurance Council because we saw this as having a very poor effect on the image and perception of the insurance industry amongst the general community. So we embarked, from about 2016 onwards, in a combined effort with ASIC to have a whole of industry approach to this, as you will know. Something in the order of half the – the – the market, the insurers, marketed these products. So it really required a whole of industry approach to deal with it. You would have heard that many companies were reluctant to make the first move to

adjust their products because of the concern about losing competitive advantage. This is a very common issue with these sorts of matters. So the Insurance Council took on a multi-pronged approach to deal with these products because there are multiple issues to be dealt with in these products. It's not only the product structure, the pricing, the loss ratios, but also things like the sales practices and the way in which the consumer is informed about the product, and the way in which the – the consumer pays for the product, etcetera. So there were many issues that needed to be dealt with simultaneously, and the Insurance Council did take on to undertake with members to move them along a path with ASIC to reform these products and improve the consumer outcomes.

So can I ask you again, having reflected on those issues and all of the problems that you've just identified, what they said to you at the Insurance Council about the culture of your industry?---Yes. And I think it – it's informative to think why companies go into these sorts of products. At the end of the day, it was, as you would have heard in previous evidence, is the car dealers were the – seen as the customer as opposed to the end customer, and it was all about gaining a market share of a particular distribution to get access to be able to sell more profitable products through that distribution. So, in essence, it was a competitive strategy to be able to enhance the – the performance of individual companies through that channel. I think that on reflection, as you would have heard from some of the companies involved, they may have well reconsidered that approach, given that the products do have some utility with some customers, limited as it might be, it was used as a mechanism to gain greater market share of broader markets.

Well, I want to put to you that these issues indicated that there's a culture across the industry which prioritises making money over serving the interests of customers. Do you accept that?---Certainly in that case I would have to say yes, that's true.

And they show an industry that's willing to take advantage of customers' lack of understanding of complex financial products to sell them things that they don't want or need. Do you accept that?---Well, certainly in the case of add-on insurance through car yards, that's very true.

Yes. And they also show an industry in which insurers don't adequately take responsibility for intermediaries acting on their behalf. Do you accept that?---There – there is an issue with that, as how those intermediaries were trained and monitored in terms of their sales practices, yes.

And do you accept that insurers were not taking responsibility for intermediaries acting on their behalf?---In that particular channel, I would say yes.

Yes. Now, you said that the ICA has worked with ASIC in coordinating the general insurance industry's response to these issues?---Yes.

In late 2016 ASIC established a working group - - -?---Yes.

- - - with insurers and the ICA, car dealers and consumer groups to address these issues?---Yes.

And that working group met a number of times in early 2017?---Yes, it did.

Now, I will come back to the working group in a moment, but before ASIC established the working group in late 2016, did the ICA do anything to identify or address the issues with the sale of add-on insurance through car dealerships?---Well, we had been clearly warned by ASIC that this was an issue, and so it was raised at various times in the board around how this may impact on the insurance industry's reputation. So it was well known that action had to be taken. So we went down a path within the Insurance Council of looking for the most practical and pragmatic way of dealing with this issue. The first thing that we looked to do was to try and cap commissions. So we looked to a – putting a submission to the ACCC to have a universal cap on commissions from what I think was the highest commissions being paid, around 79 per cent of premium, to 20 per cent.

When did that occur? When did you take that step?---I – I think it was in 2017.

Yes?---But I - - -

So I'm just going to ask you to focus for now on what the ICA did before the establishment of the working group in late 2016, in the period when you've accepted that ASIC had clearly warned the industry of these issues, and it was well known that action had to be taken?---I think all we were doing was building the commitment to actually taking full action across the industry. So all players.

You were building a commitment to taking action?---Yes. And a recognition that the industry needed to act as – as one on this through the working group. Or through a working group.

So you were building a commitment and recognising that the industry needed to act in a unified way. ASIC had released reports 470 and 471 in February of 2016. Is that right?---Yes.

And report 492 was issued in September 2016?---Yes.

But the concerns expressed in those reports weren't new, were they?---No.

They related to conduct that had been going on for years?---That's right.

And the data that ASIC used in those reports related to the 2013 to '15 financial years?---Yes.

And those reports built on earlier work that ASIC had done on the sale of consumer credit insurance through car yards, in report 256?---That's right. Yes.

And report 256 had been released in October 2011?---Yes.

And after that, ASIC repeatedly raised concerns about consumer credit insurance and add-on insurance, both with individual insurers and the insurance industry more broadly. Do you accept that?---Yes.

And the ICA was aware of all of this before the working group in 2016?---Yes.

But the action that the ICA took was to build a commitment to taking action?---That's right.

Should the ICA have done more, Mr Whelan?---There are some limitations of where the ICA can actually act. We have, you know, to be very careful about the Corporations Act and how we may be seen to be collusive, particularly in areas of competition. These products, as I mentioned before, were strategies for enhancing the competitive advantage of individual companies. So we had to tread very carefully about how we went about coalescing the industry to be able to act on this as an entity. And I think we did as much as we could to build that consensus that something needed to be done around this, and to give the companies the time to be able to withdraw or to adjust these products from the marketplace. So working within the limitations of the ICAs legal restraints, I think we did as much as we could.

Well, did the ICA do anything to investigate how its members were selling add-on insurance through car yards?---We were aware how they were selling it. It was – we were informed by ASIC. So we were aware of – we were aware of how it was being done.

But being aware of how it was done, the steps that you took were just to build a consensus about the action that should be taken in the future. Is that right?---A recognition that an action needed to be taken across the industry.

Well, you've told us in your evidence that one of the functions of the ICA is to build trust in the general insurance industry?---That's right.

That's a key purpose of the ICAs work, isn't it?---It is.

So what better way to do that than by taking proactive steps to address the concerns about the way that add-on insurance was being distributed in car yards and harming consumers?---I understand that. But we 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.

The sort of action that I'm talking about, Mr Whelan, I'm not intending to suggest that it's regulatory action. I'm putting to you that it's action that is a critical part of building and maintaining trust in your industry. Do you accept that?---Yes, I do.

And I think by bringing these matters to the board and discussing how we might deal with this, and getting the board to understand the concerns that consumers would have and the way in which this may impact on the industry's reputation was a way of building that commitment to actually changing the way in which these products were marketed in the marketplace.

I see. But in the meantime, consumers continued to suffer detriment as a result of these practices?---Regrettably yes, that's true.

So in early 2017 the ICA participated in the working group that I've mentioned?---Yes.

And what did that working group produce?---It produced a submission to the ACCC to be able to cap commissions, and was starting to evaluate the ways in which the product was marketed and sold in the car yards themselves.

Did the working group also develop principles for product design, distribution and sales?---Yes, it did start to work on those sorts of matters, yes.

Right. And were they formalised? Were there principles produced for product design, distribution and sales?---There were requirements, from memory, that needed to qualify an individual, inform the individual that – whether they were actually suited for that product, that training needed to be enhanced for the distributors who were selling that product, and ultimately, we arrived at the need for, after the ACCC submission failed, to get passed, we arrived at the deferred sales model - - -

Yes?--- - - - as the preferred mechanism for controlling these products.

Can I ask you questions about both of those things, about the deferred sales model and about the submission to the ACCC?---Yes.

So starting with the deferred sales model, can you tell us what that proposal would involve?---So one of the problems with how the product was being sold at the time was it was done in conjunction with the main sale which is the motor vehicle. So in the process of arranging finance, etcetera, people were encouraged to take out these add-on insurance products in the funding of that all the premiums were bundled in the finance for the motor vehicle. So they were sold conjointly with the main – with the main product. And what the deferred sales model does is it says that that can't be done in – any sale of add-on insurance has to be separated from the sale of the main product, and the proposed time of the separation is four days at this point in time. And that that gives the customer the opportunity to consider a proposal to buy add-on insurance and whether it's suitable to their particular needs and make a decision as to whether they would take up the product.

So under the proposed deferred sales model, is the customer given an information sheet - - -?---Yes.

- - - on the first of those four days?---Yes, it's – they're meant to be qualified for the product, and then given an information sheet that informs them of the – the product features and benefits.

And what does it mean to be qualified for the product?---Whether they could actually claim on the product.

I see. So - - -?---We've had that problem before where some people were sold these products that could never actually have claimed.

So there's an assessment to be made of their eligibility to claim under the product?---Yes, the proposal would be that they would be qualified, yes.

And then an information sheet given on the first day?---Yes.

And does that information sheet indicate that – I'm sorry, that add-on insurance is optional. Is that part of the proposal?---It would be. Or it should be.

And then what happens at the end of the four-day period?---They're – it's up to the customer to contact the – the provider of the product, the car dealership, but not – the car dealership is not to contact them. So it goes back to the customer's discretion as to whether they want to take up the offer.

And what kinds of problems do you expect that the deferred sales model will address?---I think, firstly, it reduces the pressure on individual customers who are simply wanting to buy a motor vehicle, in many instances, and it separates away the features of a given product so that people have time, in a calm and collected environment, to be able to assess whether those products actually have any real benefit to them or not.

And do you think that a deferred sales model on its own will be sufficient to address the issues with these sorts of products?---We had the view that the commission cap was also necessary to adjust the pricing of the products as well, because if the commission cap is reduced to what we proposed was 20 per cent, that would reduce the cost of the insurance as well, the price of the insurance.

Now, I will come to the commission cap, but does the deferred sales model address the low value of the products demonstrated by the low ratio of amounts paid to customers in claims compared to amounts paid by customers in premiums?---It should do if the customer is making an informed decision. That's the principle of the deferred sales model. It gives the customer to make a – an informed decision away from a pressure sales environment. So given that the customer makes that decision and makes that determination that the product actually is suitable to them, that they do believe that there's a benefit and that they accept that that price is a fair price for that benefit, then theoretically that should reduce the – the – well, it should increase the sales ratio – the loss ratios on those products because they will be able to claim.

You said that at the end of the four-day period it's up to the customer to contact the car dealer under the proposed deferred sales model. Is that right?---It's my understanding that it should be the customer that makes the determination of whether they want to take up the offer.

Can I just ask that you look at exhibit 9 to your statement, which is ICA.002.001.1653. And this is a letter from the ICA to ASIC on 23 October last year - - -?---Yes.

- - - in relation to consultation paper 294 on the sale of add-on insurance and warranties through car yard intermediaries. Can I take you to 1657 in that document which is a diagrammatic representation of the proposed deferred sales model. And do you see that in this diagrammatic representation we see on day 4, at the end of the deferral period, that the intermediary initiates contact with the customer - - -?---Yes.

- - - to see whether they want to purchase the product?---Yes, I'm sorry. That's correct, yes.

So that is the way the proposal is to work, with contact still coming from the intermediary at the end of the four-day period?---Yes. That's the proposal. It's not necessarily how the deferred model actually would be.

Right. But that's the way the ICA would like - - -?---That's what's being presented.

- - - the deferred sales model to work?---That's how it's being presented, yes.

THE COMMISSIONER: Otherwise there will be a lot of sellers ringing the purchaser of the car four days later saying, "How is the car going"?---That's right, Commissioner, yes.

"While we're talking" - - -?---Yes.

Yes.

MS ORR: But this is the proposal of the ICA?---It is, and that's the consensus, I guess, of the membership involved in this, that that's how it should – should perform. Whether that plays out eventually, that's really it down to how ASIC sees it.

Well, wouldn't it be better for your proposal to be one that had the customer initiating the contact at the end of the four-day period, as you had thought the proposal indicated?---That's right, yes. Well, my view would be yes.

Yes. But that's not the consensus view within the ICA?---Not at this point, no.

I see. All right. Other changes that have been proposed to deal with the add-on insurance issue relate to the monitoring and supervision and training of intermediaries. Is that right?---Yes.

And do you agree that one of the causes of the problems identified by ASIC in relation to add-on insurance was that insurance companies weren't doing enough to monitor and supervise their intermediaries?---Yes.

And what steps has the industry agreed to take to improve the supervision and monitoring by insurers of their intermediaries?---Well, this will be a part of the revised Code of Practice that will require that insurance companies who use intermediaries, who under their AFSL – are authorised under their AFSL that they will be required to comply with the Code of Practice in full. So all the provisions around how a customer is treated are – and the service standards that apply to that, as per the code, will be required of the distributor of the product.

I want to come to those revisions to the code, but over the period that was covered by reports 470, 471 and 492, did the code impose obligations in relation to the supervision and monitoring by insurers of their intermediaries?---I – they were there, but they weren't in force, from what I can see.

And why was that?---I believe the – the companies simply left it to the individual distributors to act as they saw fit.

So the code obligations existed, you say, but were not observed by the industry?---It was open to the industry to be able to apply those provisions if they so chose.

And did they?---I can't speak for all of them. Some may have but given the nature of these sales, I can't say that they were properly monitored.

So you accept that there was noncompliance by significant numbers of insurers with those provisions of the code?---Yes.

And were there any consequences for that noncompliance with the code?---They would be considered breaches if they were identified.

And what would happen upon the identification of those breaches?---They would be required to rectify those breaches.

I want to come to enforcement of the code. I will come back to that topic. But the final report of your review of the current code - - -?---Yes.

- - - that was released in June this year, which deals with your recommendations for the next iteration of the code - - -?---Yes.

- - - contains a recommendation that the code be changed to clarify that all third parties operating under an insurer's AFSL are subject to the standards of the code?---That's correct.

Is that right?---Yes.

And that includes car dealers?---Yes.

And you've also recommended that the code be changed to require insurers to have policies and procedures requiring employees and distributors to conduct sales appropriately and prevent unacceptable sales practices?---That's right.

Is that right?---That's right.

Will the code impose requirements on insurers to monitor distributors and make sure that they are not engaging in inappropriate conduct?---The requirement will be that they do that so that they don't breach those provisions of the code. I think going back to your previous question, it was really up to the insurers to – to make the determination of how they monitored those sales. So the new code wants to make that absolutely clear, that it is the responsibility of the insurers to take responsibility for how their products are sold by operators who distribute their products under their AFSL.

And what makes you think that this time the industry will observe those obligations when they haven't observed them in the previous iterations of the code?---Well, I think this has been a salutary lesson for the industry about how these products have impacted on the industry and the way in which the industry is portrayed in the marketplace. And I think given the understanding that the industry now has and the way in which ASIC has moved on a number of matters, including their enhanced powers, and so on, the industry is under no illusion that they need to undertake a much more rigorous approach to how distributors sell their products.

But it took the events that have been – that I've taken you to, with multiple reports released by ASIC, over many, many years, for that lesson to be understood?---Regrettably, yes.

And what makes you think that the lesson now has been understood?---I think the industry has come under and will come under far more scrutiny as a consequence of these matters, and some of the matters that have been brought in front of the Royal Commission. My hope is that these have a positive impact on how the industry responds to these sorts of issues and how it deals with customers and how the distributors of those products deal with customers.

Because the code has not been able to achieve that purpose, has it, Mr Whelan?---It has in limited respects, but clearly there has been failures, and there's no excuse for these sorts of failures. Customers have had detriment as a consequence of that, so there's no excuse for that. All we can do, as the insurance council, is try and reinforce and then strengthen the provisions that we have to try to build higher levels of service and more accountability within the structure of the industry.

And what does it say to you about the adequacy of self-regulation in the insurance industry?---That it has limitations.

That it has - - -?---That it has limitations but it has always had limitations. And all regulation has limitations. Where we think that it works best as in co-regulation where we can work with black letter law and have the flexibility and capacity to adjust through self-regulation. So the combination of the two would be our view of the most effective way of building increased service levels and standards within an industry.

The black letter law that you work with is very limited, isn't it, Mr Whelan?---It does have limitations, yes.

I mean there's very little black letter law governing the insurance industry. Do you accept that proposition?---Well, there's the Insurance Contracts Act and the Corporations Act.

Yes?---And the ASIC Act. So there's at least three levels of black letter law at least.

Do you accept that compared to other financial products, the black letter law that applies to insurance products is much more limited?---I can't really speak for how it affects other industries. We've always had the view that the industry is a heavily regulated industry with strong oversight from regulatory structures, APRA and ASIC in particular. So I'm not sure I could agree with that – that particular proposition.

Now, in your final report about the next iteration of the code - - -?---Yes.

- - - the ICA has also recommended that the code should be accompanied by best practice product design and distribution guidance?---Yes.

That would apply to add-on insurance sold through car dealers. Is that right?---That's right. That's a specific paragraph that go to add-on insurance through car dealers, yes.

In this guidance that is annexed to the code?---Yes.

Is that right?---That's right.

And that's not going to be included in the code itself?---It – it will be annexed to the code. The reason why we weren't able to incorporate that in the current draft of the code was that we were awaiting on the legislation that was being developed by Treasury for ASICs product and distribution powers. So that had not been finalised when we were drafting – when the final report had been put out and we were drafting this. So we didn't want to, necessarily, have in our code or our draft something that wasn't going to be adequate enough for the – for the law. So we needed to see what the law was going to say.

So what you've done instead is create an appendix which contains best practice guidelines?---Yes.

Which won't be enforceable because they're not part of the code?---That's right. They're – that would be voluntary, but we will have the advantage that the final version of the code has not been fully drafted yet. It's not due to go in front of the ICA board until November for review and approval. So we're hoping that any further information that we can incorporate into the code through knowing about the legislation may assist us to bring that into a more forceful structure in the code.

And if you don't know about the legislation by November it will remain as an appendix best practice guideline?---Yes. But the – the point I would make to that is that this is one of the advantages of the code, is that if – if something occurs that fundamentally changes the structure of the industry through legislation or whatever it might be, then the code has the capacity to adjust. So it can reincorporate something like that into the code to keep pace with the – the needs of the marketplace at the time. So that flexibility is one of the key benefits of a self-regulatory system.

But it seems to generally take a number of years for the code to be amended?---There's a three-year timeframe that is locked in for the reviews, but it doesn't preclude the industry from undertaking interim reviews, which we have done, as you will be aware, during the 2011/12 floods.

The natural disaster?---And we made some adjustments and put in some very prescriptive issues around claims handling timeframes and dispute resolution timeframes.

Now, I want to take you to the commission cap - - -?---Yes.

- - - that you've mentioned a couple of times already. An idea that came out of the working group - - -?---Yes.

- - - was to cap commissions payable to car dealers for the sale of add-on insurance?---Yes.

And the ICA coordinated a request by its members to the ACCC to implement a proposal to limit the commissions and other benefits payable to car dealers for insurance product sales?---Yes.

Is that right?---Yes.

And it was proposed that the commissions would be capped at 20 per cent of premiums?---That's right.

And ASIC had found, as you acknowledged earlier, that in the 2013 to 2015 financial years commissions had been as high as 79 per cent of premiums?---Yes.

Now, the ACCC refused to authorise that proposal?---Yes.

But insurers, I think you told us in your statement, have taken steps to reduce commissions voluntarily. Is that right?---Yes, some have.

Some have?---As far as I am aware some have reduced their commissions.

And what proportion, do know, of the - - -?---No, I couldn't – I couldn't give you an estimate of that.

Do you know if it's most or less than that?---I think it might be less than that, but I'm not sure.

Has the ICA been monitoring reductions in commissions payable to car dealers?---No. I'm not familiar with us monitoring that, no.

Has the ICA been monitoring other payments made to car dealers such as volume-based bonuses?---As I understand it, part of the agreement to reduce commissions voluntarily, or whatever, was to also avoid volume-based payments.

Are some insurers still paying volume-based bonuses to car dealers?---Not that I'm aware of.

And do you agree that commissions and volume-based bonuses paid to car dealers were a significant cause of the problems that ASIC identified in its reports?---Yes.

And in particular, do you accept that conflicts of interests that can be created by high rates of commissions and volume-based bonuses?---Yes.

Especially in circumstances where many car dealers operate at a loss or on very small margins?---Yes.

And do you accept that many of the car dealers were, therefore, dependent on revenue from commissions?---Yes.

Do you agree that in those circumstances, high commissions and volume-based payments were particularly likely to create incentives to engage in poor sales practices?---Yes.

Now, Mr Whelan, are you familiar with the conflicted remuneration provisions in the Corporations Act?---I'm not familiar with it but I am aware of it.

Do you know that those provisions came into effect in July 2013?---I wasn't aware of that, no.

Do you know that they prohibit certain monetary and non-monetary benefits from being given to or received by a person who provides financial product advice to retail clients?---I accept that, yes.

Including general advice. Are you aware of that?---I'm not fully aware of that, no, but I accept that.

Now, since those provisions were introduced in 2013, monetary and non-monetary benefits provided in relation to general insurance products have been excluded from their operation. Are you aware of that?---No, but I accept that.

Well, do you accept that a general insurance company can pay as much as it wants in commissions in relation to the sale of general insurance products?---I accept that.

Yes. So given that the general insurance industry has recognised the need to reduce the amount of commissions paid to car dealers in relation to add-on insurance products, would the ICA support a legislated cap on those commissions?---I see no reason why we wouldn't, given that we put the proposal to cap the commissions in the first instance, having it legislated would seem to be a reasonable outcome.

Would the ICA support a legislated ban on those commissions?---I'm not sure banning commissions is the appropriate response. I think there is work that is done that should be remunerated in an appropriate sales environment where the product is properly presented, the customer is properly informed, and the distributor has done the work to make sure that the product has been appropriately sold. So I don't see any reason why that shouldn't generate some kind of remuneration. So banning commissions entirely would – would be, I think, a retrograde step. But the idea of these excessive commissions around 70, nearly 80 per cent of premium are exorbitant, and encourage all the sorts of behaviours that you were mentioning before, Ms Orr.

Well, are the costs of commissions for intermediaries passed on to consumers in higher premiums?---They would have been in the premium, yes.

Yes. And do you think it's necessary for the general insurance industry to pay commissions to intermediaries?---I think it is where the intermediaries have actually added value to the sales process. In the cases that we're talking about with add-on insurance, I would find that very hard to prove that they added any value.

Mr Whelan, why should the entire general insurance industry continue to be exempt from the ban on conflicted remuneration?---Well, I think it has given flexibility to the industry across a wide variety of channels that it operates in, and that means that it gives customers access to products that may not – they may not have had otherwise, and I think those – those channels need to be remunerated. So I – I think maintaining some level of flexibility there is reasonable. But I grant you that, you know, where it reaches those excessive levels like we've seen, that – that is something that's unacceptable.

So why not remove the exemption on the ban from conflicted remuneration insofar as it relies to the general insurance industry?---Well, our – our preference would be

that the industry acts voluntarily to do that themselves and makes the decision themselves rather than have that legislated.

Has the industry made that decision or taken any steps to make that decision?---Well, clearly not in the case of add-on insurance through car yards, no.

Well, in the case of any general insurance products?---I think there is a – a level of market acceptance based on, I guess, market factors, that limit the extent to which commissions are paid in different distribution channels. It is a competitive factor in – in the marketplace. And I think there's a – a general market practice. But legislating that, I think, is a very different matter. And that would be something that would have to be looked at in terms of unintended consequences.

Let me put it this way, Mr Whelan: if the payment of a benefit could reasonably be expected to influence the choice of financial product that's recommended to a person or the financial product advice that's given to the person, why should a product issuer be allowed to continue paying that commission?---Well, they shouldn't be unduly influenced through the commission to choose the product. That's, I guess, my point is that an appropriate distribution model would be that the customer's interests are put as the primary interest, that the product is sold appropriately, that the customer has made an informed decision, and then a commission is paid for the work that has been done to give that product to the individual customer. So I think where you're going is around that – that the – the distribution is incentivised to sell an inadequate product or inappropriate product on the basis of commissions and I think that's – that's not acceptable to do that.

But you understand the concept of conflicted remuneration?---I do.

Where a product issuer is influencing the advice that's given. You understand that?---I do understand that.

And should that be permitted to continue in the general insurance industry?---No, it shouldn't be permitted.

All right. Now, the next topic I want to ask you about, Mr Whelan, is the handling of insurance claims following natural disasters - - -?---Yes.

- - - and severe weather events which was the subject of case studies in recent days involving AAI and Youi?---Yes.

Did you hear that evidence?---I did, yes.

Now, the ICA plays a role in coordinating the insurance industry's response to natural disasters. Is that right?---Yes.

And what role does it play?---So when there is a major event, the Insurance Council determines the extent of that event and applies criterias to whether it will declare a

catastrophe. There are a number of criteria that we use to determine whether we declare a catastrophe. The reason that we do that is that it invokes a taskforce approach across the industry that coordinates the efforts of the individual companies that have a particular footprint in that – in that area, and have a, you know, major claims exposure in that area. And we coordinate the activities of the individual companies. We liaise with the local authorities and the emergency services people to facilitate access for insurance companies to – to the areas, to assist in information transference between the industry and those authorities, local government, state governments, etcetera. And the purpose of it is to facilitate a speedy and effective response to these events.

Now, you tell us that in 2010 and 2011 there were significant issues connected with insurers' responses to Cyclone Yasi and the widespread flooding in Queensland and New South Wales?---Yes.

And what lessons did the industry learn from those events?---Well, quite a number. The size of these events, I would have to say, were extraordinary. They were unprecedented. And so the industry was very stretched to be able to deal with both the size of these events and the geographic areas in which they were spread, and the extent of the damage, which was extraordinary. So a lot of work went into how best to be able to respond to these – these events with federal government as well as state governments, etcetera. So the insurance industry played and the Insurance Council itself played a pivotal role in being able to assist government to find best ways in which the industry could respond through their actions and the industry's actions, coordinate the two. There were significant issues around how communication was made with customers, the extent to which they were kept informed about their claims, the frequency with which they were communicated with, the timeframes that claims were managed in and handled, the extent to which individual claimants were actually able to make a claim, and issues around policy structures, like most particularly flood insurance versus storm damage, which at that point in time was still an issue for the industry.

Now, one of the case studies this week concerned the bushfires at Wye River?---Yes.

Did you hear the evidence given by Mr Dransfield in that case study?---I did hear some of it, yes.

Now, that case study highlighted – one of the things it highlighted was particular terms in home insurance policies issued by AAI?---Yes.

One term that was highlighted allowed AAI to choose to settle a claim for a cash sum equal to the lowest quote that the insurer could obtain for the relevant repairs?---Yes.

Even if that quote was less than the insured could reasonably achieve?---Yes.

Are you familiar with that sort of term?---Yes.

And are you aware that terms of that nature were identified by the government as an example of unfair contract terms in its proposals paper on extending unfair contract terms protections to insurance contracts?---Yes.

And does the ICA support the use of terms such as that by its members?---Well, we don't get involved, necessarily, in how policies are constructed and the terms that the individual companies determine. That's really up to them to make that decision. It's a commercial decision on their part, and that product stands or falls in the marketplace based on that. So that's not an issue that the Insurance Council will take up.

But the Insurance Council has provided a response to the government's proposals paper on extending unfair contract terms protections to insurance contracts, hasn't it?---Yes, it has.

And I just want to explore some aspects of that with you?---Yes.

It might be best to go to the proposals paper first to see what's being proposed?---Yes.

That is RCD.0021.0025.0001. So this is the proposals paper released in June this year by the government?---Yes.

And if we turn to 0005, on the first page we see a summary of the existing position. Can I take you to the third paragraph:

> *In 2010, unfair contract terms laws were introduced which apply to all sectors of the economy and to all businesses operating in those sectors who use standard form contracts in their dealings with consumers. In 2016, these laws were extended to provide protections to small businesses from unfair contract terms. While the UCT laws apply to most financial products and services, they do not currently apply to insurance contracts regulated under the Insurance Contracts Act.*

Now, the Australian Government has decided to extend the unfair contract terms provisions to insurance contracts?---They're in discussion with us on that.

Well, this document contains their proposed model, doesn't it? And so underneath the part that I read to you, we see that the proposal is to – if we go down to the dot points:

> *To amend section 15 of the Insurance Contracts Act, to allow the unfair contract terms law in the ASIC Act to apply to insurance contracts regulated by the Insurance Contracts Act.*

Do you see that?---Yes.

And to:

Tailor those laws to accommodate specific features of insurance contracts.

?---Yes.

Now, one feature of the existing unfair contracts terms regime in the ASIC Act is that it does not apply to terms of a contract that define the main subject matter of the contract. Is that right?---That's correct.

But the main subject matter is not defined?---Yes.

And the proposal – the proposal of the government is that the main subject matter of an insurance contract would also not be subject to the unfair contract terms regime?---Yes.

But the main subject matter would be defined for an insurance contract - - -?---Yes.

- - - as what is being insured?---Yes.

For example, a house, a person, or a motor vehicle?---Yes.

So terms that describe what is being insured would not be subject to the unfair contract terms regime?---Yes.

But other terms of the policy, like the limitations, the condition precedents and policy exclusions would all be subject to the unfair contract term regime?---Yes.

The ICA does not support that approach, does it?---No.

It says that the main subject matter should include any terms that define the risk that is being covered?---Yes.

And that would include any limitations or exclusions under the policy, wouldn't it?---Well, the extent to which that goes to price, yes.

Well, what would be left, Mr Whelan?---Well, quite a number of things would be. The – quite a number of ancillary terms in a contract that may not go to – directly to the price or define the – the nature of the contract or the bargain which the insurers are taking on.

Ancillary terms, you say?---And that would have to be determined because those – any term that didn't necessarily be defined as – as the subject matter of the contract, defining the risk, could be considered ancillary and could be challengeable.

But you accept that the limitations and exclusions under the policy are terms that define the risk that is being covered?---They may do - - -

Yes?--- - - - in the extent, for example, if a policy excludes flood, that will definitely go to the – the – the price of the – the risk.

So I want to say to you again: what other than ancillary matters would be left for the coverage of the unfair contracts terms regime?---Well, all I can say is anything that is outside those terms which go to strike the bargain or the – the nature of the risk being taken on by the insurer.

But they are the important terms, the terms that are capable of being unfair, are they not, Mr Whelan?---Well, I'm not sure they – it's your term to say that they're unfair.

That are capable of being unfair. The sort of terms that the unfair contracts terms regime is designed to address. Do you accept that?---But the – the counterpoint to that is that if you were to challenge those terms that actually do go to what defines the bargain or the risk being taken on by the insurer, you introduce a level of uncertainty in that contract which may be unacceptable to an insurer and definitely unacceptable to the reinsurer that the insurer relies on to be able to take up that risk.

Well - - -?---So I think we need to be very careful – and this is how we responded to the government on this – we need to be very careful about what is acceptable to be challenged in terms of the contract arrangements and what terms are essential to defining the bargain in the contract, and what terms may not be. And those that are not are definitely challengeable.

Well, I want to put to you, in relation to this point about contractual uncertainty, Mr Whelan, for many years there have been provisions allowing courts to declare contracts void if they're entered into, for example, as a result of unconscionable conduct?---Yes.

Why is this any different to that?---Well, you know, unconscionable conduct is, I guess, one matter, but all I'm saying – and – and the response that we have on this particular matter – is that we're not adverse to unfair contract terms being incorporated into insurance contracts, provided that those terms that actually are essential to defining the risk that the insurer is taking on, and are clear to that, are actually protected from being challenged. Otherwise, I'm – I would be concerned that the industry would have to either rewrite or re-price their entire products or withdraw from some markets because the – the ability to – to define the risk was – would not be certain.

THE COMMISSIONER: In what respect is the problem you identify different from the application of unfair contract terms to banking contracts about lending?---Well, yes, reasonable point, but I guess all I can say is that the insurance contract is about defining what the residual risk that an insurer will take up in a given situation for a given event. And if the insurer can't be certain as to the nature of that risk and the extent of that risk, and it's open for challenge at any point in time, then it's very difficult to price that risk. I can't speak for the banking sector, Commissioner.

I'm not asking you to speak for the banking sector at all. But I'm concerned to have you grapple with a more general and basic point. The provision of financial services generally, at least often, perhaps usually, involves the provider of the service forming an assessment of risk. Do you accept that?---Yes.

That is to say, many contracts for provision of financial services are contracts, the terms of which, and a willingness to enter into by providers, will be moulded by assessments of risk?---Yes.

Risk of the counterparty not performing, risk of the counterparty doing something that will enhance the possibility of loss to the provider of the service?---Yes.

What is it that makes the insurance industry stand apart from other forms of financial services when it comes to this particular subject of unfair contract terms? Now, I understand you to say insurance is quintessentially concerned with pricing risk?---Yes.

Is that right?---Yes.

Well, if the law is there are some terms that can be judged to be unfair, what exactly is the problem that that creates in the pricing of risk?---Yes. Okay. Well, all I can say is that we would take the view that there would be particular terms in a contract that are essential for that contract to work and to be acceptable to both parties. And those terms are the ones that go ultimately to how the product is priced. So the insurance contract is all about risk. It's a risk assessment process. So the contract is really all about defining what is essentially that that goes to the risk. And what we argue is pretty much what has been put in place in the European Union and the UK, is to say that there are terms within the contract which should not be challengeable because they actually do define, essentially, the risk that's being undertaken. And to challenge those would introduce this uncertainty. And I think that's – that's all I can say about how the insurance industry approaches this, this matter.

Yes.

MS ORR: Commissioner, could I tender the June 2018 proposals paper on extending unfair contract terms protections to insurance contracts.

THE COMMISSIONER: Treasury proposals paper June '18 extending UCT protection to insurance contracts, RCD.0021.0025.0001, exhibit 6.405.

EXHIBIT #6.405 TREASURY PROPOSALS PAPER JUNE '18 EXTENDING UCT PROTECTION TO INSURANCE CONTRACTS (RCD.0021.0025.0001)

MS ORR: And could we please bring up ICA.002.004.0001. Now, is this document, Mr Whelan, the Insurance Council's response to that proposal?---Yes.

I will tender that document, Commissioner.

THE COMMISSIONER: Letter Insurance Council of Australia to the Treasury, 24 August '18, ICA.002.004.0001, exhibit 6.406.

EXHIBIT #6.406 LETTER INSURANCE COUNCIL OF AUSTRALIA TO THE TREASURY DATED 24/08/2018 (ICA.002.004.0001)

MS ORR: Now, Mr Whelan, the natural disaster case studies that we examined earlier in the week also raised issues in relation to the handling of insurance claims?---Yes.

And ASICs powers under chapter 7 of the Corporations Act don't currently extend to the handling of insurance claims because claims handling is excluded from the definition of financial service?---Yes.

You say in your statement that the ICA is open to considering the need to remove the exception in relation to general insurance?---Yes, we have an open mind on it.

Do you agree that general insurers should be subject to an obligation to do all things necessary to ensure that they handle insurance claims efficiently, honestly and fairly?---Yes.

Now, do you agree that general insurers should be subject to an obligation to ensure that their representatives are adequately trained and are competent to handle insurance claims?---Yes.

Do you agree that general insurers should be required to report significant breaches of those obligations to ASIC?---Yes.

And do you agree that ASIC should have the power to enforce those obligations, including by instituting penalty proceedings where they're breached?---Yes.

All right. Now, could I turn to the General Insurance Code of Practice. We've already touched on a few aspects of the code and the ICAs recommendations for the next iteration of the code that will be introduced next year?---Yes.

One of the recommendations involves adding a new section to the start of the code to state upfront the key commitments of the code, as well as to articulate the spirit, intent, and objectives of the code. Is that right?---Yes.

Was that idea based on a similar section in the Life Insurance Code of Practice?---Yes, to some extent, although we – we had our own view about – about that without necessarily reference to the Life Insurance Code, and there's also something similar in the banking code. So we already had a view that we wanted to

be able to articulate, in a clear and simple way, to customers what it is that the industry is committing to to service their needs.

All right. Can I show you the equivalent part of the Life Insurance Code, which is RCD.0021.0023.0001. This is exhibit 6.176. Now, if we turn to 0004, we see clause 1.4, which tells us that the objectives of the Life Insurance Code are:

> *To commit us to high standards of customer service throughout your relationship with us; to seek continuous improvement within the life insurance industry; to communicate with our customers in plain language where possible; and to increase trust and confidence in the life insurance industry.*

?---Yes.

And in clause 1.5, we see that:

> *The principles that apply to our products and services that are covered by the code are clarity and transparency; fairness and respect; honesty; timeliness; and communications in plain language.*

?---Mmm.

Now, what do you expect the equivalent section of the General Insurance Code will say?---It will certainly canvass those sorts of issues. I mean, the principles of fairness, honesty, openness, transparency, efficiency, they are all things that are embedded in the code, but the – the purpose of the upfront commitments is to say to customers these are the things that the industry will definitely commit to, that will be implemented across its processes to make sure that when they're dealing with you, that they're undertaking all of these principles as they manage their relationship with you. So these sorts of things will be incorporated – we're currently drafting them now – so we're trying to get the best possible way of describing these things without making it too laborious for customers to read.

Will the key commitments extend to the design and distribution of general insurance products?---They could.

Will they?---Well, we haven't finalised them yet but I see no reason why we couldn't be able to put that in.

Now, one proposal that was considered in connection with the recommendation to state key commitments was to include a reference to corporate culture?---Yes.

And the ICA decided not to accept that recommendation?---Yes, because I think it's an extremely difficult thing to define. What I'm happy for us to be able to communicate is the principles and ethics that the industry would abide by and whether that goes to individual corporate culture, that's another matter, but it's essentially how the industry wants to portray itself to – to the customer.

So what are the principles and ethics that you think should inform corporate culture in the insurance industry?---Well, it should be about a customer-centric model, it should be about putting the interests of the customer first, it should be about understanding the customer's needs fundamentally and it should be about designing products, processes and services that actually fulfil those needs to a high level.

And do you think that corporate culture in the industry currently conforms with those principles?---By and large, I think they do.

Do you think there's room for improvement?---Always room for improvement in any system and ours has – certainly has room for improvement.

Did you hear the evidence given by the two witnesses from Allianz earlier this week?---No, I'm sorry, I didn't.

Well, they gave evidence about misleading and deceptive statements that appeared on the travel insurance pages of Allianz's website for up to six years?---Right.

And Mr Winter from Allianz said, in relation to that incident, that it was more important to Allianz to protect the bottom line than to stop misleading its customers?---Well, that's unacceptable.

Well, in light of that, would you agree that there would be value in the code addressing issues related to corporate culture?---Well, I think the – to the extent that you're pointing out where profit precedes customer interests I think that's worth putting that point of view forward, that that shouldn't be the position. As I mentioned before, this should be a customer-centric model where the interests and needs of the customer are paramount in any of the dealings and relationships that the industry has. And I think that is an antithesis to a profit model which puts profit ahead of customer.

Do you accept that the evidence you've heard given in the Royal Commission this week is not demonstrative of a customer-centric model?---Clearly. They were terrible instances, and very distressing for those customers.

Now, five of the ICAs recommendations in relation to changes for the next version of the code relate to disclosure of information about insurance policies?---Yes.

And availability of and access to information, would you agree, is a key assumption that underpins the current product disclosure scheme?---Yes.

And is it fair to say that the ICA believes that the current disclosure regime comprised of product disclosure statements, financial services guides, and key facts sheets is failing consumers?---Yes.

Why?---It was a – a structure that was imposed on the industry some years ago under the Australian financial services amendments that occurred over 12 years ago, I

think, and the structure of it was – and its principle – that the more information you provided, the better informed the customer. It's a fundamentally flawed principle. But the industry has had to comply with that for that period of time. But it's clear to us that that has been inadequate. And we undertook to do research in this area, which you will have seen the number of reports that we did, and the key thing about that, that there was no research before that. And so we understand that one of the principal concerns that the industry has to grapple with is the failure of the customer being able to understand the products that they're buying and the features and benefits of those products and the expectation gap that occurs as a consequence of that when not understanding the product and the product not performing in a particular instance when the customer goes to make a claim is this major cause of concern for the industry and the effect of the industry reputation. So we're looking for ways now, through doing empirical research to find ways of better informing customers to make sure when they need the information, that the information is delivered to them in a useable, effective form so that they can make more informed decisions.

So in 2015 you established something called an effective disclosure taskforce?---That's right.

And that taskforce produced a report called Too Long, Didn't Read?---Yes.

Now, that taskforce considered research into the way that consumers use general insurance disclosure, and I want to take you to just some parts of what the taskforce said about the research at that point in time?---Yes.

Can I take you to exhibit 10 of your statement, ICA.002.0001.1671. I will say the number again in case I said it incorrectly. ICA.002.001.1671. Now, this is the report - - -?---Yes.

- - - that the ICA produced. If I could ask that we have 1691 on the screen. Now, at the top of this page we see the discussion of consumer research and the taskforce said that it:

> *Conducted a literature review into previous research that has attempted to measure the effectiveness of disclosure. The review found no empirical research around how general insurance consumers actually use disclosure documents and the impact of these documents on decision-making. The existing research specific to general insurance, while instructive, is constrained by their reliance on consumers self-reporting, knowledge and use of disclosures. The lack of empirical research has been a significant barrier to the taskforce being able to reach firm conclusions about the effectiveness of disclosure.*

Now, the taskforce went on to consider the research that was available and recommended that further research be undertaken. Is that right?---Yes.

And the ICA has undertaken further research?---Yes.

And in February last year, the ICA published a consumer research report?---Yes.

Can I take you to that document, which is exhibit 11 to your statement, ICA.002.1738 – just before I take you to that document, I'm sorry, can I ask you another question about this document before we move away from it?---Yes.

Could I show you 1694. I'm sorry, 1694. We see towards the bottom of 1694 – ICA.002.001.1671 at 1694. Now, you see a discussion starting towards the bottom of the page of the consumer understanding of general insurance?---Yes.

Could we bring up the following page as well, 1695. And we see that over the page – the taskforce recorded at the top of the page that:

> *Research commissioned by ASIC into consumer understanding of home insurance suggests that consumers generally know very little about home insurance, with many assuming that all policies are the same.*

And then in the second last paragraph on the page:

> *Of concern, field research into customer attitudes conducted by IAG suggests that not understanding insurance seems to be socially acceptable. Interestingly, the research indicates knowledge does not appear to correlate with level of education. Consumers from diverse socioeconomic backgrounds show similar shortcomings in knowledge about insurance. Whilst other equally complex financial concepts, such as interest rates, are generally well understood, knowledge of basic insurance concepts seems to be much poorer. It was put to the taskforce that the banking sector is much more advanced in their financial literacy and customer engagement programs. In contrast, unless a claim needs to be made, insurers have traditionally only had contact when a policy was taken out or renewed. However, there are strong arguments to suggest this strategy is not leading to positive outcomes.*

Now, they were the views expressed in your report Too Long, Didn't Read - - -?---Yes.

- - - in October 2015. And there was then further research conducted by the ICA. And in paragraph 36 of your statement you deal with the five key findings as a result of that research into consumer behaviour when buying insurance?---Yes.

Can I take you to paragraph 36 of your statement. And the five key findings were that:

> *There is no single pathway to purchase, and the use of information in decision-making is highly varied. While most consumers report they have evaluated the details of their policy, most do not access the PDS. While most consumers are*

confident in their understanding, comprehension appears to be poor. Many consumers do not consider the specific risks for which they need to purchase cover as a criterion for decision-making and the accessibility of the PDS can be improved, although there are other opportunities for stronger consumer engagement.

Now, do you think that the insurance industry has a role in increasing Australian's financial literacy in relation to insurance products, Mr Whelan?---Definitely.

Has the ICA taken steps to do that?---Yes. We've developed, some time ago, a program, the principal component of which is a website that we have, called Understand Insurance.

Yes?---And the concept behind that is to provide customers with a customer-friendly, easy to understand guide to all aspects of insurance, right through from defining what type of insurance you want to buy or need - - -

Yes?--- - - - right through to how you might go about making a claim, right through to how you might go about making a complaint. So it canvasses the – the – the entire process in a way that would assist consumers to make decisions about what type of insurance they might want to make.

Are you aware that the most often cited problem with mandated disclosure documents is their length and complexity?---Yes.

Are you aware of research that suggests that retail consumers are not likely to read documents that are more than two to three pages in length?---Yes.

And that studies have shown a decline in decision quality when consumers are provided with information beyond a certain level?---Yes.

And that studies show that decision-making is most effective when consumers are presented with more than five but fewer than 10 attributes for a product choice?---Yes.

Now, what is the ICAs proposal beyond the Understand Insurance program of dealing with these problems?---Well, the entire process of the product disclosure efficiency taskforce is about finding the best possible ways to inform customers, and that research that we've recently concluded shows that people come at these issues and these matters in different ways. Not everybody is the same. So one size doesn't fit all. So we need to find different ways that people can make choices and to access information in a way that suits their particular needs at the time of their particular need. The – the barrier we come up against with insurance, as you've just sort of seen in some of those comments, is that it's a low interest category. People have an optimism bias that these things are not going to happen to them and they take, you know, very little interest in insurance per se. That's understandable. But at the end of the day, it can cause real problems if they think if they just buy an insurance

product it covers everything that they think they could be at risk for. And those sorts of things are the areas that we're trying to find ways of informing customers about what is the risks most likely to affect them, what are the areas that they need to pay attention to, how can they go about getting that information, and what's the best way that the industry can deliver that information that makes a difference to how they make a decision about insurance product. And that's the principles behind which we're working on this idea. When we've been pushed into things by government such as the key facts statement which was required of us just after the 2011/12 floods, we went ahead and did that and the idea of that was a single sheet, you know, minimum amount of information about the policy. People don't use that. Our research showed they didn't use that as well. It's a low interest category. So we need to find mechanisms to stimulate interest, stimulate information, and make sure that that information is transferred effectively.

Now, another of the ICAs recommendations in relation to the next iteration of the code is that certain amendments should be made to meet the requirements for ASIC approval of the code?---Yes.

Is that right?---Yes.

And those changes include clarifying that the code is enforceable through the oversight and sanction powers of the Code Governance Committee?---Yes.

Through FOS taking code breaches into account when determining disputes?---Yes.

And through enabling the Code Governance Committee to report systemic code breaches and serious misconduct to ASIC?---Yes.

Why does the ICA want ASIC to approve the code?---Well, I think it's – it's a way of giving confidence to the marketplace and to customers that the key regulator of conduct in the industry has agreed that this code is an

effective, useful consumer instrument and it's prepared to accept that and approve it. And I think that's a – a seal of approval, if you like, which will carry weight in the marketplace I think as to the bona fides of the – of the code.

Do you think it will change the behaviour of your members in complying with the code?---Well, it's the instruction of the board that we undertake this, and – and ensure that we can get ASIC approval of the revised code. So they represent the vast majority of the – of the industry, so it's their – their will to – to do that.

One of the things that ASIC looks for before approving an industry code of conduct is whether it's enforceable?---Yes.

You understand that?---Yes.

And that's why to meet that requirement you've recommended amending the code to make it clear that it's enforceable through the oversight and sanction powers of the Code Governance Committee?---Yes.

And the Code Governance Committee was established as a result of the last review of the code?---The Enright review, yes.

In 2014?---Yes.

And it has the power to impose sanctions on insurance companies for breaches of the code - - -?---Yes.

- - - since 1 July 2014?---Yes.

And we see from the statement of Ms Lynelle Briggs, the chairperson of the CGC, that since 1 July 2014 the CGC has determined that there were breaches of the code in 33 cases?---Yes.

And code subscribers have conceded breaches of the code during an investigation in 689 cases?---Yes.

And code subscribers have self-reported a further 31,000-odd breaches of the code?---Yes.

And do you know how many times the CGC has used its powers to impose sanctions on general insurers in response to those breaches?---Yes.

How many?---None.

None?---Yes.

Does that really give you confidence that the oversight and sanctions powers are an effective means of ensuring that the requirements of the code are enforced?---I think, to put context to that, the sanction powers of the CGC are predicated on the fact that those breaches have not been remedied. So the – the sanction powers only kick in if the breaches that have been identified and reported to the CGC are not remedied and resolved or corrected. If that's the case, and they don't correct them, or they don't correct them within the agreed timeframe, then a sanction is applied. Other than that, it's not applied. And the purpose of, I guess, part of the self-regulation is not so much just to sanction, it's to remedy and fix breaches. And that's what they've been able to do, is in their interaction with the individual companies that have breached the code, they are able to get the breach remedied and fixed and that way the customers going forward will be dealt with appropriately. So I think, yes, they haven't had to use the sanction powers because the industry has actually reacted and responded to the breach notification and fixed the problem.

Well, why not have a model, Mr Whelan, that requires the Code Governance Committee not just to ensure that the breach is remedied, but also to impose sanctions for the breach?---That's not part of the code at this point in time.

No. No, I'm asking you why not have that model?---It may be a discussion that the CGC could bring to us as a point where they may feel they would like further powers. It's open to them to do that. And that would be a discussion that we would need to have at the board level.

Well, we see from the statement of Ms Briggs that the number of code breaches has been increasing year on year. Do you accept that?---Yes.

So are the corrective measures, the remedial action, sufficient?---I think it's – it's partly because people are taking the – the code and its breaches much more seriously that there's an increase in compliance philosophy within these companies, and that's driving higher levels of breaches. There's also the fact that we've had natural disasters which tends to drive up breaches. But I also think there has been an increase in the compliance mentality within companies. You would have seen some changes that have occurred – some poor behaviours before that compliance is now much more highlighted in companies. So I think those things have occurred. I'm not necessarily convinced that just bringing in sanctions for the sake of it will necessarily have a major impact on the breaches. I would rather that we remedied the breaches and fixed the breaches rather than just have sanctions.

I'm not talking about bringing in sanctions for the sake of it, Mr Whelan. I'm talking about bringing in sanctions because of the necessity for some denunciation of the conduct of the insurer that has resulted in a breach?---Look, there is an argument – and I grant you that a potential of a sanction can act as a deterrent in the first instance to a breach. So I agree with that and I understand that. That's a point which may be brought forward to us by the CGC as an enhancement of its powers. So I can accept that. And the board would debate that and discuss that.

Well, on the topic of deterrence, Mr Whelan, you heard the evidence of Mr Storey from Youi earlier in the week?---I did, yes.

And I asked Mr Storey what he understood the Code Governance Committee could do in response to a possible breach of the code. And after some hesitation he said:

They could certainly investigate us for that, I would imagine.

And he added that they could:

Request further information and clarification.

And he said that he was not aware of anything further that they could do?---Yes.

Does it concern you that representatives of general insurers aren't even aware that the CGC has sanctions powers?---Well, in that case it does concern me, and – and it's something that we will take up with Youi, but perhaps other companies are more informed and particularly their compliance people are more informed about the potential for sanctions to be applied to them if they breach. Certainly, we know that the major companies are aware of that. I can't speak for Youi. Clearly, that is a lack of understanding within – within that organisation.

Well, what sort of threat does it impose to all general insurers when from the period from 1 July 2014 to now the CGC has not imposed a single sanction for breach of your Code of Practice?---Well, it hasn't worked necessarily on the basis of threat. It has worked necessarily on the basis of information and understanding of where insurers have fallen down and haven't performed. Most of the time those breaches, if you look at where they occur most frequently, they're around timeframes, failure to meet timeframes in both claims handling and decision-making, and in provision of information to the claimant that is appropriate to the particular claim. So it's around timeframes.

And do you accept that those timeframes are very important - - -?---They are.

- - - measures for the protection of claimants?---I agree. But they are things that can be corrected through process change and training, and that's what's being done through the breach notification and the relationship between the CGC and the individual insurer. So those things have been fixed in those instances where the individual companies have breached the code.

The ICA doesn't support making the code enforceable by incorporating its terms into contracts like the banking Code of Practice, does it?---No. No.

Why not?---A couple of reasons. One, we don't see that there is that much advantage to customers through incorporating it into the contract. The current code and the code going forward are essentially a mixture of prescribed requirements such as timeframes around claims and dispute handling, etcetera, but it's also very much around best practice, around guidance, and around principles and ethics, which are very difficult to incorporate into a contract of insurance. So I think those sorts of matters are best dealt with in a code that stands in its – in its own right, and that's how we've approached it. As I understand it, ASIC has an encouragement to that going down that path of incorporating it in the contract but not necessarily is it a strict criteria for them to give approval. They're most concerned about is enforceability of the code and that's where we think we have a robust structure to be able to do that.

So you don't think that what you've described as best practice guidance and principles and ethics should be part of insurance contracts with customers?---They don't translate very well into contractual terms.

Do you know that under the Competition and Consumer Act, a breach of an approved industry Code of Practice is treated as a contravention of that Act?---Yes.

And why couldn't that be an appropriate approach for the General Insurance Code of Practice?---Well, is that not already the case? If they could pursue it on that basis?

On what basis, Mr Whelan?---Sorry, I'm not clear about your question. Perhaps you could repeat it.

So under the Competition and Consumer Act a breach of an approved industry code under that Act - - -?---Yes.

- - - is treated as a contravention of the Act?---Right.

Why couldn't that be an appropriate approach for the General Insurance Code of Practice that a breach of it is a breach of statute?---Sorry, I didn't – I didn't fully understand your question. My concern would be is that is contrary to how we've developed the code. The code is essentially a voluntary code, and that has got a wide coverage as a consequence of it being a voluntary code. And to make it subject to those provisions that you've detailed would, I think, seriously reduce the level of commitment to the code by, you know, by members.

THE COMMISSIONER: The codes with which the Competition and Consumer Act is dealing are themselves voluntary codes, as least as I understand it?---Yes, I think – yes, that may be true, Commissioner. They are also mostly between companies and other companies, as I understand it, not so much between companies and customers.

MS ORR: Well, I just want to understand that answer, Mr Whelan. Are you saying that the general insurance industry is only willing to include meaningful consumer protections in the code if it isn't a breach of statute if it fails to comply with those consumer protections?---Well, I – I would – I would suggest that we have a – a fairly strong enforcement criteria within our existing voluntary code. And I don't see why we would need to bring it into statute.

THE COMMISSIONER: Can I square it up this way: if the promise has value, what's the downside in making breach of the promise a contravention of the Act and open all the remedial consequences that follow for breaching the Act?---It – I guess it would have its implications for the industry, how it moved forward, and whatever consequences that would have, it would be something that we would need to evaluate, if that was the view, that we were presented with. I personally don't think that that would be necessary, but we would have to evaluate it.

And the horns of the dilemma I'm trying to outline for you are these: the promise is either worth something or it's not. If it's worth something, what's the downside in making it enforceable?---Yes, I understand.

Yes.

MS ORR: I have no further questions, Commissioner.

THE COMMISSIONER: Mr Bell.

MR BELL: Yes, I have some re-examination, Commissioner.

<RE-EXAMINATION BY MR BELL [10.46 am]

MR BELL: Mr Whelan, in the context of the questions just being asked, is it the case that consumers, customers, can effectively enforce the code at the moment by making a complaint to FOS?---Yes, they can. The FOS is the dispute resolution system that we subscribe to, external dispute resolution system, and customers can get redress for a dispute or a complaint through that mechanism.

Now, Ms Orr asked you some questions in relation to sanctions which can be imposed by the co-governance committee?---Yes.

And you had an exchange about a distinction between remedies and sanctions?---Yes.

Can I ask you this: does the Insurance Council have any control over or as to whether or not the Code Governance Committee imposes sanctions?---No.

And why is that? Is there some structural reason for that?---We deliberately structured the Code Governance Committee to be separate and independent from the Insurance Council.

All right. And who are the three members of the Code Governance Committee, and – and who do they represent or where do they come from?---There's a consumer representative, usually from consumer law.

And who is that at the moment?---Brenda Staggs.

Is she the same lady who was mentioned in yesterday's case study?---Yes.

Thank you?---And then there's an industry representative, Andy Cornish, who is – cannot be a member of an insurance company.

And when you say he cannot be a member, is that - - -?---Cannot be an employee of an insurance company.

Is that enshrined in the constitutional documents?---Yes. And there's an independent chair.

And that's Ms Briggs?---Ms Lynelle Briggs.

And her background was in?---The public service.

The public service. Thank you. Now, can I go back just to the beginning of the cross-examination. And Ms Orr began by referring to the consumer liaison forum?---Yes.

And you indicated, I think, that it had some ICA representatives but also representatives from the main consumer lobby groups?---Yes.

Could you just identify, if you can, what those consumer lobby groups were?---It's in my – in my statement, I think.

THE COMMISSIONER: If it's in the statement, then you needn't rehearse it all, I don't think.

MR BELL: No. Thank you, Mr Commissioner. And you – there was also mention of an independent chair?---That's right.

Who was that, do you know?---Mr Robert Belleville ex insurance company CEO.

Thank you. Now, you were asked about the – in the context of add-on insurance, it was put to you that there was – the working group was formed at the instigation of ASIC - - -?---Yes.

- - - in late 2016. And that there were meetings in early 2017?---Yes.

And Ms Orr was asking you about what the Insurance Council had done prior to the formation of that working group. Mr Commissioner, could the exhibit 1-158-9 be brought up on the screen? That's – that is ASIC.0900.0001.0372.

THE COMMISSIONER: What's the document, Mr Bell?

MR BELL: It's a letter from ASIC to the Insurance Council but the significance – of 25 May 2017 – but the significance of it, Mr Commissioner, and I may be able to short-circuit this, it refers to a submission put in by the Insurance Council in August 2016 - - -

THE COMMISSIONER: Yes.

MR BELL: - - - well prior to the formation of the working group and which contained a detailed submission by the Insurance Council in respect of add-on insurance and I was – the purpose of that document, which I understood was on the system, and – Ms Orr is – I see. It may not have been uploaded. That's my difficulty.

THE COMMISSIONER: Yes.

MR BELL: But Mr Commissioner, if it's convenient, may I ask the witness – yes, that's it.

THE COMMISSIONER: The wonders of modern science, Dr Bell. Yes.

MR BELL: My note is it is an exhibit, exhibit 1-158-9. Now, when it was made an exhibit, I don't know. But all I'm drawing your attention to, Mr Whelan, is the reference to the ICA submission of 2 August 2016?---Yes.

Do you recall that the ICA put in a detailed submission on add-on insurance prior to the formation of the working group?---I regret, I hadn't recalled it beforehand, but, yes, clearly we did, and I guess it goes to the point that we were active on this matter for some time apart from my attempt to – to say that we were trying to build a consensus across the industry. We did have concrete ideas about what we – what could be done to address these concerns. So it wasn't that we were inactive or incompetent around this. We were seriously concerned about it and we were looking for ways to work to address this issue.

Very well. And you also gave some evidence about the commission caps?---Yes.

Are you able to recall whether the activity by the Insurance Council in relation to seeking ACCC approval, did that involve activity in 2016?---Sorry, I – I'm not sure what you're alluding to.

The application for authorisation under the competition legislation - - -?---Yes.

- - - in relation to the proposal for a cap on commissions for add-on insurance?---Yes.

So that's the topic?---Yes.

Can you recall whether the work that was done leading to that application began prior to the formation of the ASIC working party?---Yes. There was a long lead time into developing that proposal, and that was our first plan of approach to – to address these exorbitant commissions.

What did that lead time involve? What were the practical steps?---Well, we had to, obviously, develop a model that would be acceptable to the ACCC. We needed to engage with the member entities and external advisers about how we could go about doing that and what's the best way to put that structure together, and then formulate a submission.

And did that involve a legal application or lawyers?---Yes, through Gilbert & Tobin, yes.

Thank you. That was ultimately rejected in 2017?---Yes.

But is your evidence that the lead time meant that that work started well prior to the ASIC taskforce?---Well prior to it, yes.

Thank you. Now, you – in relation to unfair contract terms and your exchange with Ms Orr about a carve-out in terms of matters which went to risk - - -?---Yes.

- - - etcetera, you made reference to the relevant European Union approach?---Yes.

Which I think is indicated in the most recent communication by the ICA to the government which Ms Orr took you to and tendered?---Yes.

Is the Insurance Council's preferred position?---Yes.

And is it – are the terms of the European council directive carve-out, are they the terms which are referred to in paragraph 245 of your witness statement, if you just get it – turn up that?---Yes.

That's the European Union approach?---Yes, 19/13/EUC, yes.

Thank you. If you just turn back in your witness statement to paragraph 240?---Yes.

There are references there to various submissions which the ICA has made to government at various levels over a number of years in relation to - - -?---Yes.

- - - this proposal?---Yes.

And you obviously had an exchange with Ms Orr about the merits or otherwise of the formulation?---Yes.

But does one find in these reports a more detailed analysis of the issues?---Yes.

Thank you?---And some of the reasons why we took the initial view that the Insurance Contracts Act provisions and the amendments made to it most recently were more than adequate protections for consumers under that – under that Act, but we were willing to consider how UCT could be applied to the Insurance Contracts Act provided we could be assured of protecting the – the subject matter of the contract.

In your exchange with Ms Orr about that issue, you ventured to suggest that the proposal in the broad form that she was putting to you may be unacceptable to reinsurers?---Yes.

Now, could I ask you this: after the demise of Reinsurance Australia Corporation and GIO Re - - -?---Yes.

- - - are there any current Australian reinsurers in the market or does the Australian insurance industry rely exclusively or overwhelmingly on foreign reinsurers?---On foreign reinsurers.

Thank you. And what implications, if any, in terms of potential impact on premium do you see there could be in the event that there was a loss of certainty in terms going to the commercial risk, if a carve-out of the kind proposed to you by Ms Orr were implemented?---Well, it – it's a calculation of risk, again, and the reinsurers would consider the contracts of Australian insurers to be more risky, more uncertain, and a price would be struck on that which would be no doubt greater than the price it is today. So that uncertainty concern would be priced into the contracts with existing insurers, and that would flow through to increase in premium. Basically, premiums reflect the cost to the industry and one of those major cost inputs is regulation and reinsurance costs.

Thank you. And – yes, thank you. Mr Commissioner, am I right to assume that the exhibits which accompany Mr Whelan's statement will be taken as tendered together with his statement.

THE COMMISSIONER: Yes, it is.

MR BELL: Thank you. I have no further re-examination but I would seek leave to tender and provide to the Commission the 2 August 2016 report to the – or response to ASIC which was referred to in the document that was brought up on the screen. It's not currently an exhibit to Mr Whelan's statement but it is relevant to the question of the timing of the Insurance Council's response. There was a suggestion, I think, it may have been a suggestion that that timing – that that response only really came after the establishment of the workforce. I would seek that leave. It's not electronically on the system but we seek the leave to provide that to the Commission and to tender it, it having been referred to in evidence and referred to in - - -

MS ORR: We think – and we're checking – that it may be an exhibit to a statement given by Mr Saadat in the first round of hearings.

MR BELL: It may well be.

MS ORR: And in that case it won't need to be tendered, Commissioner.

MR BELL: Very well. If it's already in, well and good, and perhaps my colleague – my learned friend can – will draw the Commission's attention to the exhibit number.

THE COMMISSIONER: Take it outside the hearing room. Yes. Thank you, Dr Bell.

MR BELL: I apologise for that. But thank you, Commissioner.

THE COMMISSIONER: Thank you. Yes, thank you, very much, Mr Whelan. You may step down?---Thank you.

<THE WITNESS WITHDREW [11.01 am]

MS ORR: Commissioner, the next witness is Ms Loane from the Financial Services Council. If we could have a brief adjournment just to allow the Financial Services Council's team to come to the bar table.

THE COMMISSIONER: If I come back when, Ms Orr?

MS ORR: Within a few minutes, if possible.

THE COMMISSIONER: If I come back shortly after five past.

MS ORR: Thank you.

ADJOURNED [11.01 am]

RESUMED [11.06 am]

THE COMMISSIONER: Yes, Ms Orr.

MS ORR: Commissioner, the next witness is Ms Sally Loane.

<SALLY ELIZABETH LOANE, SWORN [11.06 am]

<EXAMINATION-IN-CHIEF BY MR ELLIOTT

THE COMMISSIONER: Thank you very much, Ms Loane. Do sit down. Yes.

MR ELLIOTT: Thank you, Mr Commissioner. Ms Loane, what is your full name?---Sally Elizabeth Loane.

And your business address?---44 Market Street, Sydney.

All right. And what position do you hold?---I'm the chief executive officer of the Financial Services Council.

All right. Now, you've been summonsed to attend the Commission today?---Yes, I have.

And in advance of attending today, you have prepared a witness statement in respect of Rubric 6-60?---Yes, I have.

And in preparing that witness statement, have you drawn either on your own information or on information of others within the FSC?---Yes, both.

And is the information contained in that witness statement true to the best of your knowledge and belief?---Yes, it is.

All right. Commissioner, I tender the summons.

THE COMMISSIONER: Exhibit 6.408, the summons to Ms Loane.

EXHIBIT #6.408 SUMMONS TO MS LOANE

MR ELLIOTT: And I tender Ms Loane's witness statement which is dated 30 August 2018, together with exhibit SL-1.

THE COMMISSIONER: The statement of Ms Loane of 30 August '18 together with its exhibits becomes exhibit 6.409.

EXHIBIT #6.409 STATEMENT OF MS LOANE DATED 30/08/2018 AND EXHIBITS

THE COMMISSIONER: Thank you, Mr Elliott. Yes, Ms Orr.

<CROSS-EXAMINATION BY MS ORR [11.08 am]

MS ORR: Ms Loane you've been the CEO of the Financial Services Council since December 2014?---Yes.

And is it fair to say that your background before that position was in media and PR?---Partly, yes. Also, I spent 10 years in the corporate sector.

So you were the director of media and public affairs at Coca-Cola Amatil?---Yes.

And you had 25 years in the media industry?---Correct.

So your background is not one of financial services?---No, it is not.

Now, the Financial Services Council has five different categories of members - - -?---Yes.

- - - including full members?---Correct.

And the full members of the Financial Services Council are all organisations in the trustee company services, managed investment, superannuation, funds management, financial advice, or life insurance industries?---Advice licensees rather than financial advisers. We don't represent individual financial advisers, no.

But the full members come from those industries. Is that correct?---That's correct.

Now, of the different financial service industries represented by the Financial Services Council, would you say that any one is more prominent than another?---What do you mean by prominent?

Well, in the activities that you're responsible for, are the members who belong to the superannuation industry, for example, more prominent than the members who belong to the financial advice or life insurance industries?---We have – the majority of our members come from the – the funds management area.

Okay. Now, could you explain to the Commission what the main purposes of the Financial Services Council are?---Yes. We're a peak industry body representing those five streams across financial services in Australia. We represent around 100 members, approximately 70 of which are what we call full members, and our job, essentially, is to advocate for policy, develop policy. We also develop standards for our members which go to best practice in – in the sector.

Is it fair to say that one of the main activities of the Financial Services Council is to lobby the government in relation to laws that affect the financial services industry?---Yes.

To encourage the government to make those laws more favourable to the industry?---I think – yes, we certainly represent our members. My view is that, you know, at the back of – of that is good public policy as well.

But you accept that your lobbying activity is engaged in to encourage the government to make laws that are more favourable to the industries that you represent?---We represent our members, yes.

Do you accept my proposition, Ms Loane?---More favourable, yes, in part.

Only in part?---Yes, essentially, when we do advocacy activities, it's to represent our members and their – and their views, yes.

Yes. With the objective of making – of ensuring that the laws that the government makes are more favourable to your members?---Yes.

Right. All right. Now, one of your purposes is the promotion of best practice in the financial services industry by setting standards?---Yes.

Is that right? And one of those standards is the Life Insurance Code of Practice?---Yes.

And full members of the Financial Services Council are required to comply with the standards issued by the Financial Services Council?---All standards, yes.

Yes. And that includes the life code?---Only the life insurance members are required to adhere to the life code.

Now, the life code was developed in 2016?---Yes.

Why did the FSC decide to develop the life code in 2016?---The life code was developed after quite a long period. It started – it all started with an ASIC report in 2014 just before I joined. That ASIC review looked into practices in the life insurance sector, particularly around the advice – life insurance advice, and came up with a number of findings that were not favourable to the sector, certainly not favourable for consumer outcomes. The FSC then decided to engage an independent person, an independent expert to do a full review of the life insurance industry. We were joined in that with the association of financial advisers, the AFA, and we engaged Mr John Trowbridge, a former APRA member, and he took several months to come up with a very comprehensive, I guess, view of life insurance. And the reforms that came out of his review or the recommendations, some of them were legislated and at least one of them was the recommendation to have a code of practice for life insurers, and that's what we took on board.

So it was a recommendation in Mr Trowbridge's report that a life code be developed?---Correct.

Yes. Now, why didn't the Financial Services Council develop a code of practice for the life insurance industry before that time?---I really don't know. The – as I said, the code was one of Mr Trowbridge's recommendations. Mr Trowbridge's report came from the ASIC report which identified quite a few issues to do with misaligned incentives for selling life insurance. I can't – I can't say why it wasn't done beforehand.

You know that there had been a General Insurance Code of Practice in place since the 1990s?---Yes.

And why did the Financial Services Council need a review to tell it that it was desirable to implement a code of practice for the life insurance industry?---Well, I

can't – I don't know – I simply don't know the answer to that, no, but that's – that's the procedure that happened.

And should it have been developed earlier in your view, Ms Loane?---I think that's for others to say but - - -

Well, you are the CEO?---Yes, I am now, yes.

- - - of the Financial Services Council. In your view should the life insurance industry have had a code of practice prior to 2016?---Quite possibly, yes.

Quite possibly?---Yes.

You don't think it would have been desirable for a code of practice to be in place for the life insurance much earlier than 2016?---Yes.

You think it would have been desirable?---Yes.

Yes. Okay. Now, I want to come back to the life code, and the insurance and superannuation code a little later but I want to ask you first about some of the topics that have been raised in the case studies that were examined by the Commission last week and a bit earlier this week. The first of those topics is the direct sale of life insurance?---Yes.

Now, last week the Commission heard evidence from representatives of two entities, ClearView and Freedom about the sale of life insurance directly to consumers?---Yes.

Did you hear the evidence given in those case studies?---Yes, I did. Yes.

Are there any observations that you would like to make at the outset on either of those case studies?---I thought the – the practices were – like everybody thought were – were very poor and very disappointing.

The practices were very poor and very disappointing?---Yes. And the effect on the consumers was – was clearly highly detrimental, and to be – to be absolutely regretted.

Are you familiar with ASICs report 587 on the sale of direct life insurance which was released at the end of August?---Yes, I am.

And you know that in that report ASIC looked at the practices of six life insurers and three distributors who sold life insurance directly to consumers?---Yes.

And are you aware that for the purposes of report 587, ASIC reviewed hundreds of outbound sales calls conducted both before and after the life code came into effect?---Yes, I do.

And in ASICs first review of calls which related to calls made between 2010 and 2016, ASIC found that all of the firms included in the review engaged in pressure selling?---Yes.

And ASIC found that the sales calls featured inadequate explanations of future cost and product exclusions, promotional gifts, and tactics to reduce informed decision-making?---Yes.

ASIC also undertook a second review of sales calls which related to calls made in July and August this year after the life code had come into force?---Yes.

And ASIC noted that for many firms conduct had improved and that was likely due in part to the code?---Yes, I read that.

But ASIC nonetheless observed pressure selling tactics used by firms in that period?---Yes.

And it observed firms providing inadequate explanations of exclusions for pre-existing medical conditions?---Yes.

And it observed that firms didn't consistently provide clear explanations of the likely future cost of a person's policy?---Yes.

Do you have any observations on those findings in your capacity of CEO – as CEO of the Financial Services Council, Ms Loane?---Absolutely. That report is – we are going over that with a very fine-tooth comb. We're looking at all the recommendations made in that report. We have in train at the moment the next iteration of the life code. And we will be doing our utmost to include the recommendations which will lead to hopefully those practices not being – not being – not happening again and – and certainly we are – we are looking to put those – some of those examples in our – in the second iteration of our code.

In addition to the review of sales calls, ASIC also considered data provided by the entities, the entities' products, their policies and their procedures, and the sales culture of the entities. Did you see that in the report?---Yes.

And after listening to the calls and considering all of that extra information that it had brought in, ASIC found that outbound sales are more commonly associated with poor sales conduct and increased the risk of poor consumer outcomes?---Yes.

Do you agree with that, Ms Loane?---Yes.

And ASIC also found that from 2012 to 2017, one in five of all policies taken out were cancelled in the cooling-off period?---Yes.

And ASIC considered that that figure might indicate that consumers immediately realised they had made a bad decision, or had been pressured into buying a policy they didn't need?---Yes.

And ASIC found that a quarter of all policies that remained in force beyond the cooling-off period lapsed within 12 months?---Yes.

And that almost half of all policies held beyond the cooling-off period lapsed within three years?---Yes.

Do you have any observations about those findings?---It's not a good outcome, either for the firms or for the consumers.

Well, what does it say about whether consumers were being sold products that they wanted and needed?---It clearly says that those tactics were incorrect and that's certainly something that we're addressing in the second iteration of our code. The first iteration does go into detail on direct sales but we have a lot more to say in the second iteration of the code.

Are you aware that ASIC found that claim outcomes for direct life insurance were also poor relative to life insurance sold through other channels?---Yes.

Having read the report on the direct sale of life insurance, Ms Loane, what is the Financial Services Council's position on whether the direct sale of life insurance should continue?---Look, I think our view is that yes, it's a legitimate product when done correctly. Life insurance, I think, as others have observed, is often a grudge sale and people have to be encouraged to take out life insurance. I think anything that helps people understand life insurance is a reasonable product and it's sold directly to people particularly online to consumers which – that may not sit down with – with an underwriter and go through that process, it – it can be beneficial. But clearly, where there are pressure selling tactics involved and inadequate cooling-off periods, then it's not a good product. I think given some of the things that have been found and given the things that we're now putting into our code, it – it still can be a reasonable and legitimate product.

Does the Financial Services Council have a view on whether direct sales of life insurance should continue to be made via outbound telephone calls?---Not as such. We certainly have a view about cold calling, which is unlawful, and we certainly have a view about pressure selling. By outbound you mean cold calling, do you?

I just mean by outbound sales calls, Ms Loane?---Yes, no, I don't have a fully formed view about that at this stage.

Does the Financial Services Council have a view about that, in light of the ASIC report and in light of the evidence given in the Royal Commission last week?---Well, what I understand is that cold calling is – is – is unlawful. Pressure selling is a very

poor instrument and should not be allowed. I think given the right boundaries and people have accepted conditions, then outbound calling may be legitimate.

It may be legitimate?---Yes, it may be, yes.

But what - - -?---I'm sorry, I can't give you any more on that.

But what needs to be done by the Financial Services Council to ensure that it's legitimate?---Well, that's what we're addressing in our code.

All right. Well, the life code contains provisions in relation to the sale and advertising of life insurance policies, doesn't it?---Yes, it does.

And among other things, those provisions require the entities who are bound by the code to do or refrain from doing certain things when advertising life insurance policies?---Yes, that's correct.

Do you accept that?---Yes.

And to have clearly documented sales rules to prevent pressure selling?---Yes.

And to have a clearly documented framework in place to monitor compliance with sales rules?---Yes.

But those obligations only apply to life insurers who are bound by the code?---Yes.

They don't apply to entities like Freedom which sell life insurance policies on behalf of life insurers?---Not in the first edition in the code but they will be – they will be in the second edition of the code.

So the next edition of the code will extend to distributors of life insurance?---Correct.

Now, are you aware that Mr Martin, the chief actuary and risk officer of ClearView, expressed the view that it was difficult to understand how direct life insurers could reconcile financial viability and legal compliance?---Yes, I heard him say that, yes.

Do you have any observations about that, Ms Loane?---I would certainly take his views into consideration. ClearView are a member of ours and we would always listen to – to what our members say about their products and the way they're being sold, yes.

And Mr Orton, the chief operating officer of Freedom Insurance, said that it was possible to sell direct life insurance in outbound sales in a way that was financially viable and legal compliant but this would involve changes to the model. Do you recall that evidence?---Yes, now that you've reminded me, yes.

Now, despite industry participants holding those views the FSC doesn't support restricting the outbound sale of direct life insurance by telephone?---I – I would like to just reflect on that. We will certainly take all of the evidence that has come before this Royal Commission and what our members tell us about those particular products into consideration. I'm sorry, I don't have – I can't give you any further information on outbound calls.

Well, I want to move to asking you about the handling of insurance claims, Ms Loane. Both the CommInsure and the TAL case studies that we examined last week raised issues on that topic. Did you hear the evidence in those case studies?---Yes, I did.

Now, in relation to the TAL case study, Ms van Eeden, TALs head of claims, accepted that the way in which TAL dealt with one of the three claims that her evidence covered was not efficient, honest or fair. Do you recall that evidence?---Yes.

But life insurers are not currently subject to an obligation to do all things necessary to ensure that they handle insurance claims efficiently, honestly or fairly, are they?---You mean by law?

Yes?---They're subject to the – the utmost – the law that prescribes doing the utmost duty, yes.

Are you referring to the provision in the Insurance Contracts Act which requires insurers - - -?---I believe so.

- - - to act toward insured people with the utmost good faith?---Yes, I believe so.

But they are not subject to any legal obligation to do all things necessary to ensure that they handle insurance claims efficiently, honestly and fairly, are they?---No. They're subject to a carve-out under that – I think it's the ASIC Act.

That's right. That's right?---Yes. Yes.

Well, chapter 7 of the Corporations Act doesn't extend to the handling of insurance claims because claims handling is excluded from the definition of a financial service?---That's correct, yes.

Now, in your statement you refer to the Financial Service Council's views on that carve-out?---Yes.

And you say that:

> *The FSC does not support the removal of the exception or otherwise support the extension of ASICs powers in relation to the handling and settlement of insurance claims.*

?---Yes.

Why not, Ms Loane?---My understanding of the carve-out as it is – as it stands is that often claims – claims operators, assessors, have to give some advice to people who call about their claims, and if they strayed into an area that could be perceived as personal advice, then they would not be able to give that advice. It could be that they're reminding people that you can't claim twice on an income protection policy, for example, and I think the idea is that they did – they shouldn't be in the same category as a financial adviser, and I think that's the reason for the carve-out. I think the reason that we're saying that this should stay is that in our code, and certainly in the second iteration of the code, we have a lot of provisions on how to behave, very quite granular prescriptions on commitments on claims assessors and claims handlers. We would like to see if that code is producing those better outcomes. The code is quite new. Also, APRA is doing quite a large data collection project on claims handling. And I think that comes out next year. And I think that would be useful again for informing our view. It's not necessarily set in stone, but at this point I think we're saying, clearly, claims handling needs to improve. What's the best way to do it, is turning claims handlers into financial advisers that may not be the best way. Financial advisers are subject to a new regime for a great deal of training, university degrees, professional bodies, etcetera. So I think at the moment we're saying let's try and get the behaviours, let's try and get all sorts of things fixed. Let's see if the code can do that and have a look at what the APRA data tells us about claims handling.

But in the meantime consumers need to wait and potentially suffer detriment while you're assessing how this is working?---No, well, the code is in force, and - - -

But my point is about a statutory obligation to act in this way?---Yes, I know. Yes. I know the point you're making, yes.

And the Financial Services Council's position is that the statutory position should remain unchanged?---As - - -

Claims handling should continue to not be subject to an obligation to act efficiently, honestly and fairly?---Yes. At this point, yes.

Does the FSC consider that life insurers should be subject to a statutory obligation to ensure that their representatives are adequately trained and are competent to handle insurance claims?---Sorry, could you repeat that?

Does the FSC consider that life insurers should be subject to a statutory obligation to ensure that their representatives are adequately trained and competent to handle insurance claims. You understand that this is a statutory obligation that applies in respect of the provision of other financial products?---Yes. I think you're asking me the same thing about claims handlers.

No, I'm - - -?---Statutory - - -

Well, I'm asking you about the – the consequences of the carve-out at the moment are numerous because it takes the provision of – it takes claims handling outside of a regime that imposes multiple obligations?---Yes.

Do you understand that?---Yes, I do, yes.

And one of those obligations is the obligation to ensure that your representatives are adequately trained and are competent to provide a particular service. And what I'm asking you is whether there is any reason why it should not be the case that there's a statutory obligation to ensure that representatives of life insurers are adequately trained and competent to handle insurance claims?---Well, I think what – what we would say is that we absolutely agree that insurers and claims handlers should be adequately trained, and competent. Absolutely.

So do you oppose the imposition of a statutory obligation to that effect?---Yes, we – we maintain the carve-out for – for claims assessors at this point.

Why, though? Let's leave the carve-out to one side. If a statutory obligation could be imposed on life insurers – let's not worry too much about the fact that this situation arises because of a carve-out from the definition of financial services – leaving that to one side, is there any reason why there should not be a freestanding statutory obligation on life insurers to ensure that their representatives are adequately trained and competent to handle insurance claims?---I really – I'm – I'm just not sure of – of – of what you're asking me. What we say about claims assessors is that we are giving a great deal more granularity around commitments to service, training, etcetera, in – in the code. We would like to see the code play out. We would like to see – to see if that's working, as it has – is starting to work in – in some areas. And I think we would like to see how APRA comes to its conclusions about claims handling in its research document.

Does the FSC consider that life insurers should not be required to report significant breaches of these sorts of obligations to ASIC?---I – I – the claims handling to ASIC?

These sorts of obligations that I've been putting to you, is it your position that there should be no obligation on life insurers to report breaches of those sorts of obligations to ASIC?---The obligations around complaints around claims?

The obligations that you resist, Ms Loane?---Yes, the ones about claims, yes.

Yes. All right?---Yes, that's still – that's still our position.

The FSC doesn't consider it problematic that ASIC doesn't have the power to enforce breaches of any obligation to act efficiently, honestly and fairly in relation to claims handling?---I can only repeat - - -

I see?--- - - - we are still – we would like to see the code work. I think if claims assessors became financial advisers, it would mean a great deal more, I suppose, training to put them in a different category. They would then be subject to FASEA and perhaps all the obligations that financial advisers are subject to. It may be, using a term, a sledge hammer to crack a nut. We're - - -

Are you worried about obligations like the best interest duty?---No, not at all. We – we are trying to get as good a result as we possibly can with the code and if that doesn't deliver results then clearly we will – will – we will consider.

The TAL case study that we examined last week also raised issues in relation to the scope and operation of section 29 of the Insurance Contracts Act. Are you familiar with that provision, Ms Loane?---Could you remind me, please?

Well, section 29 provides that an insurer may, in some circumstances, avoid a contract if an insured has not complied with their duty of disclosure or has made a misrepresentation to the insurer. Are you familiar with that?---Broadly.

I can have it brought up on the screen if it assists you?---No, I – I understand that you have to disclose any pre-existing conditions, yes.

And do you understand that an insurer can avoid a contract if an insured has not complied with the duty of disclosure or has made a misrepresentation?---I – I understand that broadly, yes.

Okay. Now, did you hear the evidence given in the TAL case study?---Yes.

And in short compass, Ms van Eeden gave evidence about TALs general processes and its processes in relation to three particular policyholders in connection with section 29 of the Insurance Contracts Act?---Yes.

And in two of those cases TAL relied upon section 29 to avoid a contract of insurance on the basis of a non-disclosure or a misrepresentation of a health issue - - -?---Yes.

- - - which was unconnected to the condition in respect of which the claim was made?---I do remember that, yes, yes.

Now, one of those cases just predated the amendments to the scope of section 29 that were made in 2013 and the other post-dated those amendments. Are you familiar with those amendments, Ms Loane?---No, I'm not.

The amending Act introduced a number of significant amendments, including to the scope and operation of section 29(3). Now, if I can explain that to you. Before the amendments, section 29(3) provided that if the insurer would not have been prepared to enter into a contract of life insurance with the insured 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. Do you understand that?---Yes.

And since the amendments, the section has provided that an insurer may avoid a contract within three years if an insured's failure was not fraudulent or their misrepresentation was not made fraudulently?---Yes.

Now, the effect of the amendment is that if the insurer would not have entered into a contract of insurance on the same terms - - -?---Yes.

- - - had it known of the relevant facts, the insurer can now avoid the contract of insurance?---Yes.

Now, the amendment expanded the circumstances in which an insurer could rely on section 29(3) because it's now easier 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?---Mmm.

Now, we know from an exhibit to your statement that the FSC played a leading role in consultations with Treasury, both sides of Parliament, and consumer representatives to advocate for the passage of that amending Act. Are you aware of that, Ms Loane?---Not to the detail, no, I'm sorry.

Well, we see that from exhibit 10 to your statement which is a document entitled FY13: The Year in Review. Have you read that document that you annexed to your statement, Ms Loane?---Yes. Yes, I have.

That is FSC.0006.0001.1001. If we turn to 1006, we see under the heading Insurance Contracts Act, partway down the page, the passage that I've just read to you. Do you see that?---Yes, I do.

So the FSC supported the changes to section 29(3)?---Yes.

Why?---I think – look, I'm – I'm sorry, I'm not - - -

You don't know?---Well, I – I certainly have people on my – that work for me who do this day in day out who can inform me of the detail of this.

Well, I want to ask you but you may not be able to answer, Ms Loane, whether you think that section 29(3) now strikes the right balance between the interest of the insurer and the interest of the insured person?---I think what we've said here is that:

> *The amendments contained in the bill include measures to improve efficiency and certainty for insurers and achieve that appropriate balance.*

So yes, I would agree with that. That's what we said.

So based on that sentence, you answer my question that you do think that section 29(3) now strikes the right balance between the interests of insurers and insured people?---Look, I'm sorry, I don't have the up-to-date detail of when we said that and what we think now.

And you don't have a current position on that yourself?---Not myself, no. I don't know the detail of that but I – I can certainly provide that detail to you.

Okay. You've exhibited to your statement a document that you've referred to as a list of the key items which are being considered by the FSC as part of the second iteration of the life code?---Yes.

Do you recall that?---Yes, I do.

Can we go to that document which is exhibit 24, FSC.0006.0001.0302. And we see a number of items are listed under the heading Agreed Scope. So these are matters that are agreed that will be included in the next iteration of the life code. Is that right?---Yes, that's right.

And under that heading at item 7 we see:

> *For general consent at claim, requests to be targeted to the cause of the claim (ie, no fishing).*

?---Yes, I see that.

Do you understand what that refers to, Ms Loane?---No, I don't, I'm sorry.

You don't know what that refers to?---No, I don't. This was put together by a member of my staff who is – his entire job is to deal with the code. I'm sorry, I don't – I don't have that but we could certainly get you that detail.

But Ms Loane, you are the CEO - - -?---Yes.

- - - of the Financial Services Council who is responsible for the development of the code - - -?---Yes.

- - - and you've been put forward by the Financial Services Council to give evidence on these topics?---We actually - - -

MR ELLIOTT: I object to that.

THE COMMISSIONER: Just a moment.

MR ELLIOTT: We did put forward two witnesses, Commissioner, a Mr Kidson who is responsible for the code, and Ms Loane. And as I understand it, that was not

considered desirable and we were asked to identify one person to give evidence on all topics.

MS ORR: But we asked whether the CEO was capable of handling all of the items in the Rubric that was sent to the Financial Services Council. And as a result of that question, we were provided with a statement - - -?---Yes. That's right.

- - - covering all of those matters by you and annexing this document to your statement?---Yes.

But are you unable to explain this document that you've annexed to your statement?---I'm unable to explain the detail of number 7. And I apologise for that. As – as I said, I'm CEO. I have a lot of people on my staff and I have one particular expert whose day-to-day job it is to put together the code. That's what he works on every day. I've been trying to spend every minute with him to understand the detail of his work and I'm sorry that I have neglected – not understood this particular detail but we can certainly get you that information.

Well, I want to put to you, but I expect you will be unable to answer, that this item has been included in recognition of the fact that provisions like section 29 can result in substantial unfairness unless some restrictions are imposed on its operation?---I – I couldn't answer – give you the detail of that, I'm sorry.

All right. Now, another broader issue arising from the TAL case study related to the scope and ongoing applicability of the duty of disclosure. Are you aware of that?---Could you remind me of that particular case? I did watch it.

The TAL case study. Do you recall that - - -?---Yes.

- - - one of the topics that was the subject of evidence was the duty of disclosure by an insured person?---Yes.

Are you aware of the insured's duty of disclosure contained in section 21 of the Insurance Contracts Act?---I'm aware broadly that you need to disclose any pre-existing condition, yes. That's – that's the extent of my knowledge.

Well, section 21 requires an insured person to disclose to the insurer a number of matters before the contract of insurance is entered into, including every matter that is known to the insured that the insured knows to be a matter relevant to the decision of the insurer whether to accept the risk?---Yes.

Now, are you familiar with the provisions of the Insurance Contracts Act relating to misrepresentations by an insured person?---Broadly, not in detail.

Are you aware that since 2013 the UK has taken quite a different approach to non-disclosure and misrepresentations?---No, I'm not aware of that.

Well, in 2012, the UK Parliament passed legislation which substantially amended consumers' duty of disclosure in consumer insurance contracts. Are you aware of that?---No, I'm not.

The UK Parliament replaced the pre-existing duty of disclosure or representations – duty not to make misrepresentations – with a duty to take reasonable care not to make a misrepresentation to the insurer. Do you understand that? I just want to put that proposition to you that the UK replaced provisions such as those we have with a duty to take reasonable care not to make a misrepresentation to the insurer?---Yes, I think – I think I understand.

Do you understand that? Does the FSC have any views on whether it would be desirable to introduce a similar change to the duty of disclosure in Australia?---I don't have a view on that, no, I'm sorry.

And you're unaware of whether the FSC - - -?---I'm unaware.

Has a view on that?---But I could certainly find out from Mr Kirwan.

Now, I want to ask you some questions about life insurance and mental health?---Yes.

The TAL case study also raised questions about the way in which life insurers handle claims for mental health issues?---Yes.

And the way in which some life insurers interpret particular circumstances as indicating a pre-existing mental health condition?---Yes.

Does the life code currently address issues associated with mental health in life insurance claims?---Not this particular code. Not the first one, no.

Now, the FSC has been doing work in connection with mental health issues and life insurance for some years?---Yes.

Is that right?---Yes.

And extensive consultation had taken place prior to the introduction of the first version of the code?---I think the first version of the code was done without a lot of extensive consultation with the life – the mental health community. I think our view at the time was that we wanted to get the code out quite quickly, and more complex areas would be – would be attended to in the second version of the code, and that has certainly been the case. We've had a great deal of engagement with the mental health stakeholder community in the time, certainly the last couple of years, and we do have a great deal more granularity around mental health in the next version of the code.

Well, we see from the document on the screen that one of the things that's going to happen, according to this document with the next iteration of the code, is examples of good mental health questions in underwriting. Do you see that as item 4?---Yes, I do. Yes. Yes.

Now, if we turn to the second page of this document – perhaps if we could bring the second and the third pages on to the screen together. We see – and I'm sorry, before we leave that page, you will need to see the heading that applies to these two pages. If we could just go back to the first page, we've got two categories of items in this document?---Yes.

Agreed scope, which is 1 to 17?---Yes.

And still for consideration - - -?---Correct.

- - - which is what follows?---Yes.

Now, if we can go back to the second and third page, we see that one of the things that's still for consideration is item 14, which is that insurers are to:

> *... ensure that applications for insurance that reveal a mental health condition or symptoms of a mental health condition are not automatically declined.*

?---Yes.

That is still for consideration?---I'm not sure where we're up to there. I know this document was – was written some time ago. Some of the still for consideration may have shifted into the being done bucket. Again this is – with a timeframe - - -

You're unable to say, Ms Loane? Are you able to say whether any of the aspects of paragraph 14 which relates to the treatment of mental health in connection with life insurance claims are matters that the FSC has now decided should be dealt with in the new iteration of the code?---I believe that's correct, yes.

I'm sorry, I don't understand that answer. I'm asking you whether any of those matters have been decided to be now matters that should be dealt with in the code rather than matters that, as this document demonstrates, are still under consideration?---Yes, that's what I said, yes. Yes.

I'm sorry, I'm clearly not making myself clear. I'm asking you - - -?---Yes.

- - - to identify whether any of the matters listed in paragraph 14 are matters that will now be included in the code, given that the document describes them as matters that are still under consideration for inclusion in the code?---Yes, there's eight points to 14. I can't say for absolute certainty that they will be in the next iteration, but as that's still being formed as we speak, I would be – it would be highly likely, in my view.

I see?---That those points would be included.

I want to move to asking you some questions, Ms Loane, about the relationship between the life insurance industry and the financial advice industry?---Yes.

The FSC represents both the life insurance industry and entities in the financial advice industry?---The advice licensees - - -

Yes?--- - - - companies, yes.

And it's the peak representative body for the life insurance industry?---The FSC is, yes.

And it's one of several bodies that represent financial advice entities – licence holders, they're also represented, some of them, by other organisations. Is that right?---I don't know about that.

All right. Now, the financial advice industry was examined in the second round of the Commission's hearings in April this year, and at the beginning of this round of hearings we touched on the relationship between the two industries. We heard that in the last five years the life insurance industry has paid around $6 billion in commissions to financial advisers?---Yes.

And we heard about a number of other types of payments that the life insurance industry makes to financial advisers, including sponsorship payments?---Yes.

Did you hear the evidence that Mr Whelan gave earlier, Ms Loane?---Yes.

His evidence was that in relation to add-on insurance sold through car dealers, insurers saw car dealers as the customer, not the end customer. Did you hear that evidence?---Yes, I did, yes.

And is that the way life insurers see financial advisers?---I'm not – I'm not sure about that. I couldn't say yes or no. It's possible but you would probably have to ask an insurer.

Ms Loane, the life insurance industry pays vast sums of money to financial advisers, doesn't it?---I don't know the – the number. I do know that they have been capped in – in legislation.

Would you agree that when the industry pays – the life insurance industry pays commissions to financial advisers, it expects something in return?---A good product, good advice, yes.

What is all the money for, Ms Loane? What is the approximately $6 billion paid by the life insurance industry in commissions to financial advisers for?---I really

couldn't say with certainty. These are – these are to do with commissions that are paid to advisers - - -

Yes?--- - - - for, essentially – for essentially selling their products. This was subject of the ASIC report that triggered the Trowbridge inquiry and led to legislation which capped those high upfront commissions.

Well, the whole point of paying commissions to financial advisers is to influence the advice that they give, isn't it?---To – it would certainly mean that they are paying commissions for their products to be sold, yes.

And the cost of the commissions is borne ultimately by the consumer, in the form of increased premiums. Do you accept that?---I don't know. I couldn't say.

You know that financial advisers have a duty to act in the best interests of their customers when providing financial advice?---Yes, I do.

And do you agree that by providing benefits to financial advisers to influence the advice that they give, life insurance companies create a conflict of interest for financial advisers?---That has definitely happened and that was the subject of the ASIC review that triggered the Trowbridge report, yes.

Well, are you familiar with the FOFA reforms that came into effect in - - -?---Yes.

- - - July 2013. Are you familiar with the ban on conflicted remuneration introduced by those reforms?---Yes.

Did the FSC support the FOFA reforms when they were introduced?---It was before my time. I believe so. Life insurance - - -

You're unable to say?---I believe so. I'm unable to say.

When it was introduced, the ban on conflicted remuneration didn't apply to life risk insurance products, other than group life policy for members of superannuation entities or life policies for members of default superannuation funds. Are you aware of that?---Yes.

And what was the FSCs position on that exemption. Did it support it?---I believe so.

Does it still support it?---We initiated the Trowbridge report which led to the commissions being reduced. So I'm not sure that – that we would – I think the position has changed.

Are you familiar with the life insurance framework reforms, Ms Loane?---Yes, we are.

And as a result of those reforms from 1 January this year a cap has been imposed on the amount that can be paid in upfront and trailing commissions to financial advisers in relation to life insurance products?---Yes.

And that cap is currently 80 per cent of the first year's premium?---That's correct.

And next year it will be 70 per cent?---That's as I understand it, yes.

And from January 2020 it will be 60 per cent?---Yes.

Should it stop there, Ms Loane?---I think we will think about that when the time comes. This was the life insurance reforms came out of the Trowbridge report which, as I said, the FSC and the AFA initiated. The government initiated that legislation which essentially reduced the high upfront commissions for sales of life insurance products through advisers. There is a review that ASIC is going to do – I think next year – which will be useful in – in us getting some more information on whether that has addressed some of those misaligned incentives.

Ms Loane, I want to ask you finally on that topic why shouldn't commissions for life insurance products be phased out entirely?---I think that is a – that is a view that various people have had, including in the FSC. I think the reason that life insurance was carved out initially from FOFA went to that tenet that life insurance is something that people have to be persuaded to buy, therefore, people needed to be incentivised to sell it. But certainly, we would like to see the effect of the legislation and the APRA review and make decisions then.

I want to return to the life code, Ms Loane. You say in your statement that the FSC doesn't plan to submit the current version of the life code for approval by ASIC?---Not the one that's in the market now, no.

But it's ultimately the FSCs intention for the life code to be approved by ASIC?---Correct.

And will it submit the next version for approval?---It's very possible. We haven't really made up our minds about that yet. We – we're having monthly meetings with ASIC to make sure that we are adhering to the regulations which lead to approval by ASIC and it's very much our intention.

You know that one of the matters that ASIC looks for when deciding whether to approve an industry code is whether it's enforceable?---Yes, that's correct.

Is the life code enforceable?---We believe so.

How?---Through the Life Code Compliance Committee.

And what does the Life Code Compliance Committee do to enforce the life code?---The – the Life Code Compliance Committee is an independent three-person

body that is administered by – by FOS. Again, that came out of the Trowbridge review as a recommendation that we have a life code and that it be supported by an independent compliance body, and it – it is able to enforce actions on insurers who breach the life code.

In your statement you say at paragraph 16.2:

> *Breaches of the life code will be taken into account in both internal and external dispute resolution process.*

?---Yes.

Continuing:

> *In this way, the life code is enforceable.*

?---Yes.

What does it mean to take into account a breach of the code?---The life code compliance committee asks our life insurers who have signed a contract with the Life Code Compliance Committee to go through the – the terms of the code and show the Life Code Compliance Committee how they are adhering to those clauses, and they also do need to inform the Life Code Compliance Committee of breaches through – or complaints through their internal processes. And the Life Code Compliance Committee can then enforce any breaches of the code on to the insurers. And there is a mechanism whereby the consumer is also given the contact number for FOS, and they can then take up a complaint with FOS as well.

Well, can I take you to the relevant part of the life code, Ms Loane, which is RCD.0021.0023.0001. And if we turn to 0027 and 0028. 0027 and 0028. We see that section 13 of the code deals with monitoring, enforcement and sanctions?---Yes.

And we see from clause 13.4 that the code requires subscribers to report significant breaches of the code to the committee?---Yes.

And the committee has the power under clause 13.8C to investigate alleged breaches?---Yes.

And under 13.8(e):

> *To agree corrective measures with a life insurer.*

?---Yes.

And under 13.8(f):

> *To monitor the implementation of agreed corrective measures.*

?---Yes.

Continuing:

And if the insurer fails to rectify a breach or agree on corrective measures under 13.10 the committee can impose a sanction.

?---Yes.

And the sanctions include:

...requiring rectification of the breach, giving a warning, requiring an audit, requiring corrective advertising, and publishing noncompliance on the website.

?---Yes.

Has the committee imposed sanctions on any subscribers to the code?---I have – no, it hasn't. I've – that's the information that we've got from the life code - - -

It hasn't, has it?---No, it hasn't.

And you say in your statement that when the life code was drafted, it wasn't contemplated that it would be incorporated into contracts with consumers?---Yes. Could I just explain the reason that no sanctions have been applied. The Life Code Compliance Committee hasn't actually reported on its first year yet. So they – they just haven't made those determinations yet.

But you've read the statement from the representative of - - -?---Yes.

- - - the life code committee - - -?---Yes.

- - - which shows us that no sanctions have been applied?---They – correct, they haven't reported yet.

Well, no, it tells us that no sanctions have been applied. Have you read that statement, Ms Loane?---Yes. Yes.

All right. Now, I asked you about your statement – in your statement that when the life code was drafted it wasn't contemplated that it would be incorporated into contracts - - -?---Yes.

- - - with consumers. Does the FSC oppose the requirements of the code being incorporated into contracts with consumers?---We have not fully formed our view on that. Certainly, the first edition of the life code wasn't put together with contractual obligations in mind. And as I say, the second, at this stage, has not been either. It's not that it's a firm no, it's just that it hasn't been contemplated at this point.

You say in your statement that the obligations in the code are aspirational?---Yes.

And not easily translated into law?---Yes.

What do you mean by aspirational, Ms Loane?---I think what we mean by aspirational is that we give a lot of – a great deal of detail about behaviour, how we will treat you, a lot of timeframes that are very specific around claims, etcetera. And they're sort of service agreements which are, I guess, if you translate them, are very aspirational.

Can I - - -?---We want – we want them to be adhered to 100 per cent of the time but sometimes there may be circumstances where they cannot be.

I just want to understand. Are you saying that the timeframes imposed under the code for the handling of claims and for communications with customers are aspirational?---No, they're very much in the code. That may not be the best example of the use of the word aspirational.

It's the example you gave in your statement, isn't it?---Yes, it is. It may not be the best example with hindsight. I think what we're trying to say there is if we do breach – if our members do breach those timesframes then that is a hard – that is a hard breach of the code and it would be – it would be reported to the Life Code Compliance Committee, even if it was a day late, as being a breach of the code. It's probably not the best example. I think perhaps where we talk about aspirational, it's more around behaviours, we will treat you with empathy and respect and compassion at claims time, etcetera.

They're aspirational, that the claimant will be treated with empathy and respect?---They are – no, we're putting them in the code. They must be adhered to.

But are they examples of things that you regard as aspirational?---They're things that we believe must be adhered to.

What use is aspirational statements to consumers in a document like this, Ms Loane?---Well, I think it's – it's very useful to have the – the code written in plain English with a lot of points and granularity so people can understand it. I – I take – I take your point about the word "aspirational". It may not be the best use of the word.

Do you know, Ms Loane, that under the Competition and Consumer Act, as I said to Mr Whelan, a breach of an approved industry Code of Practice is treated as a contravention of the Act?---I heard you say that to Mr Whelan but I have no further knowledge about that.

Well, can I ask you, in relation to the life insurance industry, why that wouldn't be an appropriate approach for the life code?---I'm sorry, I just don't – I haven't given that any consideration at this point.

All right. I have no further questions, Commissioner.

THE COMMISSIONER: Thank you, Ms Orr. Yes, Mr Elliott.

MR ELLIOTT: Your Honour, Mr Commissioner, just a few things very briefly.

<RE-EXAMINATION BY MR ELLIOTT [12.10 pm]

MR ELLIOTT: Ms Loane you referred to a Mr Kirwan in your evidence?---Yes. Yes.

Who is he?---Nick Kirwan is a senior policy manager at the FSC for life insurance.

Does he have a function in relation to the improvements being made to the life code?---Yes. Mr Kirwan was hired specifically to – to do all of our work on the life code. That is his – that is his full-time job.

And what is your understanding of his training and experience in that field?---He's had something like 30 years in life insurance with a regulator in the UK.

All right. And were you responsible for hiring him for that purpose?---Yes, I was.

All right. You were asked some questions about the LCCC?---Yes.

The life compliance code. And whether to your knowledge any sanctions had been imposed?---Yes.

To your knowledge, how long has the committee been in existence for?---I think it's just over a year. Perhaps even shorter than that. I do know that they haven't yet reported their first report, if you like.

To your knowledge, have consumers made – submitted complaints to the committee?---I don't know at this point, no. I don't know.

Yes. Thank you, Mr Commissioner.

THE COMMISSIONER: Thank you, Mr Elliott.

MR ELLIOTT: May the witness be excused?

THE COMMISSIONER: Ms Loane, thank you for coming. You are excused from further attendance?---Thank you.

<THE WITNESS WITHDREW [12.12 pm]

THE COMMISSIONER: Yes, Ms Orr.

MS ORR: Now, Commissioner, during these hearings we've tendered a number of witness statements provided to the Commission by life insurers and general insurers concerning the way that insurance products are designed and sold and the way that claims are handled. And at various points in the last two weeks we've summarised the information and data set out in those statements. In the past few days, the Commission has received further witness statements from some of those insurers. Some of these further statements were provided by the insurers to correct errors in the information that they provided to the Commission.

Others were provided in response to a request by the Commission for further information about particular topics. And we want to tender those statements, Commissioner. The first is a supplementary statement from Westpac in relation to the sale of life insurance policies and specifically the commissions paid in relation to those policies. In our opening statement last Monday, we referred to information provided by Westpac in the statement of Michael Wright, dated 23 August. Late last week, Westpac informed the Commission that some of the data provided in Mr Wright's statement was incorrect. A supplementary statement was provided by Westpac correcting that information. I will tender the supplementary witness statement of Michael Wright dated 21 September 2018.

THE COMMISSIONER: Exhibit 6.410.

EXHIBIT #6.410 SUPPLEMENTARY WITNESS STATEMENT OF MICHAEL WRIGHT DATED 21/09/2018

MS ORR: We received another supplementary statement from Westpac in relation to the handling of life insurance claims. In our statement about the handling of life insurance claims last Wednesday, we referred to information provided by Westpac in the statement of Susan Houghton, dated 28 August. And that information formed part of the basis for the charts tendered in connection with that statement. And earlier this week, Westpac told the Commission that some of the data provided in that statement was incorrect. A supplementary statement was provided on Wednesday correcting that information. I tender the supplementary witness statement of Susan Houghton dated 19 September 2018.

THE COMMISSIONER: That becomes exhibit 6.411.

EXHIBIT #6.411 SUPPLEMENTARY WITNESS STATEMENT OF SUSAN HOUGHTON DATED 19/09/2018

MS ORR: We also received a supplementary statement from Allianz in relation to the handling of general insurance claims. In the introduction to the general insurance part of the hearings on Monday, we referred to information provided by Allianz in the statement of David Krawitz dated 30 August 2018. That information formed part of the basis for the charts tendered in connection with that statement. Yesterday, Allianz told the Commission that some of the data provided in that statement was incorrect. A supplementary statement was provided by Allianz yesterday correcting that information. I tender the supplementary witness statement of David Krawitz, dated 20 September 2018.

THE COMMISSIONER: Exhibit 6.412.

EXHIBIT #6.412 SUPPLEMENTARY WITNESS STATEMENT OF DAVID KRAWITZ DATED 20/09/2018

MS ORR: I turn to the further request for information from the Commission. On Monday, we made some observations about the monetary benefits provided by general insurers to Australian financial services licence holders or authorised representatives of AFSL holders in circumstances where an employee or authorised representative of that entity might be expected to provide personal financial advice in relation to general insurance products. These products were limited to motor vehicle insurance, home and contents insurance, and travel insurance, and we observed that in the period from 1 July 2013 to 30 June this year, Allianz had told the Commission that it had paid more than $240 million in commissions to those entities. IAG, more than $500 million in commissions to those entities. And QBE, more than $800 million in commissions to those entities.

Earlier this week we sought further statements from the general insurers that we referred to on Monday requesting that they also provide information about the monetary benefits they provided to entities that distributed motor vehicle insurance, home and contents insurance, and travel insurance products issued by that insurer in circumstances where either general advice or no advice was provided. And the witness statements that we received from the general insurers showed that each of them paid the following monetary benefits to distribution entities in the five-year period that we asked about. Westpac paid more than $270 million, CBA, including CommInsure, paid more than $290 million, AAI paid more than $350 million, QBE paid more than $740 million, IAG paid more than $1.27 billion, and Allianz and AWP paid more than $1.28 billion.

That amounts to a total of more than $4.2 billion in monetary benefits to distribution entities in connection with the sale of general insurance products issued by these insurers in about five years. We note that some of the entities told us that there is overlap between these benefits and the commissions we referred to earlier in relation to sales where personal advice is provided, as some AFSL holders who provide

personal advice about general insurance products might also be expected to sell, promote, or provide general advice about those products.

Commissioner, I tender the further witness statements that set out the information I've referred to. In relation to AAI, I tender the witness statement of Andrew Mair, dated 19 September 2018.

THE COMMISSIONER: Exhibit 6.413.

EXHIBIT #6.413 STATEMENT OF ANDREW MAIR DATED 19/09/2018

MS ORR: In relation to Allianz, I tender the witness statement of Michael Winter, dated 19 September 2018.

THE COMMISSIONER: Exhibit 6.414.

EXHIBIT #6.414 STATEMENT OF MICHAEL WINTER DATED 19/09/2018

MS ORR: In relation to IAG, I tender the witness statement of Mark Milliner dated 19 September 2018.

THE COMMISSIONER: Exhibit 6.415.

EXHIBIT #6.415 STATEMENT OF MARK MILLINER DATED 19/09/2018

MS ORR: In relation to CBA, I tender the witness statement of Miles Sowden, dated 19 September 2018.

THE COMMISSIONER: Exhibit 6.416.

EXHIBIT #6.416 STATEMENT OF MILES SOWDEN DATED 19/09/2018

MS ORR: And the witness statement of Gareth Russell, dated 20 September 2018.

THE COMMISSIONER: Exhibit 6.417.

EXHIBIT #6.417 STATEMENT OF GARETH RUSSELL DATED 20/09/2018

MS ORR: In relation to QBE, I tender the witness statement of Christopher Killourhy dated 19 September 2018.

THE COMMISSIONER: Exhibit 6.418.

EXHIBIT #6.418 STATEMENT OF CHRISTOPHER KILLOURHY DATED 19/09/2018

MS ORR: In relation to ANZ I tender the witness statement of David Roberts, dated 19 September 2018.

THE COMMISSIONER: Exhibit 6.419.

EXHIBIT #6.419 STATEMENT OF DAVID ROBERTS DATED 19/09/2018

MS ORR: In relation to Westpac, I tender the witness statement of Susan Houghton dated 19 September 2018.

THE COMMISSIONER: Exhibit 6.420.

EXHIBIT #6.420 STATEMENT OF SUSAN HOUGHTON DATED 19/09/2018

MS ORR: And in relation to Youi, I tender the witness statement of Bert Bakker, dated 19 September 2018.

THE COMMISSIONER: Exhibit 6.421.

EXHIBIT #6.421 STATEMENT OF BERT BAKKER DATED 19/09/2018

MS ORR: Commissioner, we're now in a position to commence our closing address for this round of hearings, but perhaps it would be desirable to have a brief break to allow the Financial Services Counsel to leave the bar table.

THE COMMISSIONER: Yes. So if I come back at, what, 25 past?

MS ORR: Yes, thank you, Commissioner.

THE COMMISSIONER: Yes.

ADJOURNED **[12.20 pm]**

RESUMED **[12.25 pm]**

THE COMMISSIONER: Ms Orr.

MS ORR: Commissioner, over the past two weeks we have heard evidence of misconduct and of conduct that falls below community standards and expectations in relation to life insurance and general insurance. In this closing address, we will deal with each of the case studies that has been the subject of evidence in turn with the exception of the final two case studies relating to the regulation of the insurance industry. For each of these case studies, we will identify the findings that we regard as being open on the evidence. Next week, we will publish a document containing the questions that arise from the case studies and the other evidence tendered in these hearings. We plan to publish that document next Friday, 28 September.

The first case study examined in these hearings involved ClearView Life Assurance Limited, which I will refer to as ClearView, in relation to the direct sale of life insurance. The Commission heard evidence from Mr Gregory Martin, the chief actuary and chief risk officer of ClearView Wealth Limited. Prior to 2011, ClearView operated as a captive insurer selling life insurance products to customers of the corporate group of which it formed part, most recently, Bupa. By 2013, ClearView had expanded into a more substantial and professional direct life insurance business, in the words of Mr Martin, and was selling policies to non-Bupa sourced customers.

At that time, ClearView established a sales centre in Parramatta. In 2014, ClearView expanded its direct life insurance operations by investing in an outsourced Melbourne-based sales centre called Your Insure. ClearView closed this business in late 2015. In late 2015 to ’16 ClearView made changes to its business to target a more preferred mix of customers, which Mr Martin accepted essentially equated to more affluent customers. By mid-2016, ClearView planned to revise its operating model by moving from a high-volume, low value model involving emotional sales pitches and above market pricing, to a lower volume, higher value model in which products were to be sold with both an emotional and rational pitch at market price.

Mr Martin accepted that for the period that ClearView was operating under the former model, the life insurance products that it sold in its outbound telephone sales were more expensive and of lower value than the products they were selling to more affluent people through other channels. ClearView ceased direct sales of life insurance in mid-2017 for reasons that we will come to. For the period that ClearView was directly selling life insurance, ClearView sold a range of life insurance products through outbound telephone sales, including life cover, trauma cover, funeral cover, and accidental death cover. ClearView continues to sell a number of similar products through its retail channel.

One of the products that was sold by ClearView's direct life insurance business and which continues to be sold through its retail channel is accidental death cover. Accidental death policies pay out upon a person's death where that death is due to an accident. ClearView's practice in its adviser sales channel has been to always offer an accidental death policy to a customer whose application for life cover has been declined for medical reasons. Mr Martin said that he was aware of ASICs view that accidental death policies offer a very limited benefit to consumers. Mr Martin accepted that the number of claims made under ClearView accidental death policies was low compared to the number of policies sold. He also accepted that the claims ratio for accidental death policies was lower than for other products. The ratio of claims paid out to premiums collected over the last five years was 26 per cent, and in 2014 the ratio was 1 per cent.

In response to a question about whether ClearView would continue to sell such products in light of ASICs views, Mr Martin said that ClearView had not yet reached a position on this but that if ASIC and society would like ClearView to stop offering the product, it would do so. The Commission heard that in April 2016 ASIC raised concerns with ClearView about unsolicited telephone sales in breach of the requirements of the Corporations Act. ASICs concerns related to whether ClearView's sales were properly characterised as solicited or unsolicited sales and if the latter, whether they met the requirements in section 992A(3) of the Corporations Act, which is frequently referred to as the anti-hawking provision.

By early May 2017, ClearView estimated that it had breached the anti-hawking provision, a criminal offence provision, somewhere between 300,000 and 303,000 times. Mr Martin accepted that by February 2017, there were concerns within the ClearView direct business, both about breaches of the anti-hawking provisions, and about the way that those breaches were being escalated and responded to within the organisation. The breaches were not being treated as material matters that required escalation and consideration. In the course of engaging with ASIC about the anti-hawking issues, in March 2017 ASIC also raised concerns with ClearView about pressure selling and mis-selling conduct.

After reviewing the transcripts of 42 sales calls from the second half of 2015, ASIC formed the view that ClearView's sales practices may be unfair or manipulative and may pressure consumers to purchase a policy. Mr Martin accepted that these calls involved highly problematic sales practices and that some involved misleading and deceptive conduct and unconscionable conduct. The problematic sales practices recognised by ASIC and Mr Martin included, but were not limited to, misrepresentations about what customers were committing to purchase, misrepresentations or omissions about payment arrangements, including by not explaining to customers precisely when their first premium would be due, and failing to quote prices aligned with the frequency with which premiums would be deducted so as to underemphasise the extent of the customer's financial liability.

There were also other forms of misrepresentation, including that a customer's premiums would never go up with age, despite ClearView retaining the right to

unilaterally vary premiums and about the terms or application of the policies. Sales agents also continued to attempt to sell policies despite a customer indicating that they wished to read over ClearView's documentation or consult with a partner or friend. Mr Martin accepted that this was done because ClearView direct did not want to give people time to reflect upon their purchase because they might then decide that they did not want or need the product.

The problematic sales practices also included sales agents collecting customers' personal information, including bank details, before customers had confirmed their agreement to proceed with the purchase. Mr Martin accepted that the issues identified in the 42 calls were representative of what he termed almost endemic compliance issues within ClearView direct for a number of years. ClearView continued to struggle with such issues in 2016 and '17 during its engagement with ASIC. As at February 2017, one quarter of all monitored calls by ClearView sales agents involved a breach. Mr Martin agreed that this was totally unacceptable.

Mr Martin accepted that there were at least three causes of the systemic compliance issues. The first was ClearView's remuneration structure. Mr Martin accepted that ClearView's commission structure was a contributor to inappropriate behaviour as it incentivised aggressive sales tactics with the aim of making as many sales as possible at whatever cost. The second was a culture within ClearView direct that tolerated aggressive sales tactics at the cost of compliance. This was apparent in ClearView's training practices. Mr Martin accepted that sales agents were trained to engage in unfair sales practices including through aggressive objection handling approaches. The overarching theme was a sell at all costs approach which Mr Martin accepted was reflective of ClearView direct's broader culture.

The prioritisation of sales over compliance was also evident in communications relating to at least one proposed incentives program which the head of direct sales considered was necessary to stimulate the team and revive the cultural pulse and which he proposed badging as a training and education trip in order to circumvent the conflicted remuneration provisions. The third cause of the systemic compliance issues accepted by Mr Martin was large scale deficiencies in ClearView direct's quality assurance and compliance program. As just one example, of the 42 calls provided to ASIC only 10 had been previously reviewed by ClearView's quality assurance team and only a small number of those had failed that process. Mr Martin accepted that when the legal team subsequently reviewed those calls, they had taken a different view.

More broadly, Mr Martin accepted that there was insufficient division between ClearView's sales team and its quality assurance function, and that there was a lack of specific legal and compliance experience, particularly in the direct business. The Commission heard that ClearView and ASIC had negotiated terms by which ASICs investigation into the anti-hawking and mis-selling issues would be resolved. These terms required ClearView to undertake a remediation program in respect of over 32,000 policies sold between 2014 and mid-2017. Most customers are required to

opt into the program, and only a small number of customers will be entitled to a full refund of premiums paid.

ClearView also agreed to inform ASIC if it decided to recommence selling through the direct channel. ClearView said that it had no present intention of doing so. Mr Martin said it was difficult to understand how an insurer could sell life insurance in outbound sales calls in a way that was both financially viable and legally compliant. He told the Commission that ASIC had not indicated whether it would take any further action in respect of ClearView's 300,000-odd breaches of the anti-hawking provisions, or the unconscionable conduct or the misleading or deceptive conduct engaged in by its sales agents.

On the evidence, it is open to find that ClearView engaged in misconduct in the following respects, each of which was accepted by Mr Martin: first, ClearView breached the prohibition on the hawking of financial products contained in section 992A of the Corporations Act between 300,000 and 303,000 times between early 2014 and mid-2017. Second, in the calls in which ClearView representatives mis-sold insurance policies between 2013 and 2016, ClearView breached the prohibition on unconscionable conduct contained in sections 12CA and 12CB of the ASIC Act by pressuring individuals to purchase policies, breached the prohibition on misleading or deceptive conduct contained in section 12DA of the ASIC Act by misrepresenting matters such as whether customers were committing to purchase an insurance policy and the terms of those policies and breached its duty to act towards its policyholders with utmost good faith as required by section 13 of the Insurance Contracts Act.

Third, ClearView contravened the obligation contained in section 912A(1)(a) of the Corporations Act to do all things necessary to ensure that the financial services covered by its Australian financial services licence were provided efficiently, honestly and fairly. ClearView's systemic failures in its sales processes meant that policyholders were frequently being sold policies in circumstances where ClearView was not behaving honestly or fairly. Fourth, ClearView failed to ensure that its representatives were adequately trained to provide the financial services covered by its financial services licence, in contravention of section 912A(1)(f) of the Corporations Act.

ClearView sales agents were encouraged to sell aggressively, to sign up customers immediately, and to use other inappropriate methods of obtaining sales. Fifth, ClearView failed to take reasonable steps to ensure that its representatives complied with the financial services laws, in contravention of section 912A(1)(ca) of the Corporations Act. Amongst other things, ClearView had inadequate training, quality assurance and compliance processes to ensure that its representatives complied with financial services laws. Sixth, ClearView failed to have in place adequate arrangements for the management of the conflict of interest that it created between the interests of its employees and the interests of its customers in contravention of section 912A(1)(aa) of the Corporations Act.

The remuneration and incentive structures that ClearView had in place encouraged its sales agents to make as many sales as possible, frequently to the detriment of customers' best interests. On the evidence, it is also open to find that ClearView may have engaged in conduct that fell below community standards and expectations. First, ClearView failed to take speedy and effective action to address substantial compliance issues when they became apparent. As we've mentioned, Mr Martin's evidence was that the compliance issues that were identified in the 42 calls provided to ASIC were almost endemic within ClearView direct sales processes for a number of years.

Second, ClearView failed to take meaningful steps to address defects in its quality assurance processes after becoming aware that they were ineffective because agents who had not been flagged for review felt some sort of immunity. Despite ClearView having decided to move towards monitoring 100 per cent of sales calls, it did not execute that decision because it was moving towards a decision to shut down the business. The upshot of this was that ClearView appears to have permitted its sales agents to continue to engage in problematic sales practices for about a year in circumstances where it had concerns about the effectiveness of its compliance system.

On the evidence, it's open to find that the misconduct and the conduct that fell below community standards and expectations may be attributed to ClearView's culture and governance practices, its risk management practices and its remuneration practices. In relation to culture and governance practices, the evidence given by Mr Martin indicates that there were substantial and insurmountable cultural problems within ClearView direct. As we've indicated, Mr Martin's evidence was that there was a culture within ClearView Direct that tolerated aggressive sales tactics at the cost of compliance, and that the management of ClearView Direct did not treat compliance issues, such as the breaches of the anti-hawking provisions, as matters that required consideration and escalation.

In relation to risk management practices, the evidence indicated that the quality assurance program within ClearView Direct was seriously inadequate, as its staff lacked qualifications, experience, supervision, and resources. In relation to remuneration practices, Mr Martin accepted that the remuneration and incentive structures that ClearView Direct had in place encouraged sales agents to make as many sales as possible, sometimes at the expense of customers' best interests.

The second case study concerned Freedom Insurance Group, a company which markets and distributes a range of life insurance products directly to consumers by telephone. The Commission heard evidence from Mr Craig Orton, Freedom's chief operating officer. The Commission also heard evidence from Mr Bruce Stewart whose son was sold an insurance policy by Freedom in June 2016. At 3 pm on the day before Mr Orton was to give evidence, Freedom notified the Commission of substantial changes to its business model. Freedom told the Commission that it intended to cease selling all insurance products, except funeral insurance and loan protection cover, through outbound sales calls.

While Mr Orton accepted that this was a significant change to Freedom's business model, Freedom was not able to produce any documents which directly recorded these decisions. Mr Stewart told the Commission that his son was born with Down syndrome. While Mr Stewart's son has a degree of independence, he has difficulties with understanding whether a product is expensive or cheap and whether he has enough money to make purchases. As a result, Mr Stewart and his wife assist their son to manage his finances. In 2016, when Mr Stewart's son was sold insurance by Freedom, his only source of income was the disability support pension.

Mr Stewart learnt that his son had taken out insurance after his son received a letter from Freedom. The letter said that Mr Stewart's son had taken out a Freedom protection plan which comprised three types of cover: funeral cover, accidental death cover, and accidental injury cover. The letter said that premiums for the funeral cover would not be due for 12 months, but that premiums for the accidental death and accidental injury cover would be due 12 days later. Mr Stewart told the Commission that he was flummoxed by the letter. He did not understand how or why his son had been signed up, so he asked his son what had happened.

Mr Stewart's son remembered speaking to someone on the phone and providing that person with his debit card details but could not explain why he had done so. Mr Stewart did not think that his son understood that he had provided those details in order to purchase an insurance policy. The following day, Mr Stewart telephoned Freedom and attempted to cancel the insurance on his son's behalf. Mr Stewart was not able to do so. Instead, a Freedom representative told Mr Stewart that they would listen to a recording of the call in which Mr Stewart's son was sold the insurance, and then call Mr Stewart back. The representative also told Mr Stewart that the sales agent who sold the insurance to his son probably did not know that his son had a disability.

Mr Stewart did not receive a call back from Freedom or a response to an email that he sent to Freedom's head of operations lodging a formal complaint. Two days later, he telephoned Freedom again. During this second phone call to Freedom, Mr Stewart and his son were transferred to Freedom's retention team. The retention agent tried to explain the potential benefits of the insurance for Mr Stewart's son, and emphasised multiple times that the policy was free for the first 12 months. The retention agent also said that there was no reason for Freedom to have known that Mr Stewart's son had a disability.

However, the retention agent ultimately agreed to cancel the plan. Mr Stewart's son was asked to confirm that he wished to terminate the policy. Mr Stewart's son had great difficulty articulating those words. After the phone call, the retention agent engaged in an instant messenger conversation with another Freedom employee in which disparaging remarks were made about Mr Stewart and his son. Mr Orton accepted that this conduct was totally inappropriate. During the call in which the plan was cancelled, Mr Stewart asked Freedom to provide him with copies of the recordings of the calls in which his son had been sold the insurance. Mr Stewart did not receive those recordings until August this year.

Excerpts of two of those calls were played in the course of Mr Stewart's evidence. In the first call which lasted for just over two minutes, a Freedom sales agent asked Mr Stewart's son whether his mother was at home, and discontinued the call when he determined that she was not. In the second call, which took place two days later and which lasted for 18 and a half minutes, the same sales agent sold the policies to Mr Stewart's son. Mr Stewart told the Commission that having listened to that call, he did not think that his son had any understanding of what he was signing up for. Mr Orton accepted that the sales agent's actions were inappropriate and that the sales agent should have known that Mr Stewart's son was not capable of understanding what was occurring in the call.

Mr Orton said that the sales agent who sold the policies had engaged in deeply troubling conduct. The way in which Freedom treated Mr Stewart's son was only one example of a broader pattern of inappropriate dealings with vulnerable customers. In its submission to the Commission, Freedom acknowledged that it had engaged in misconduct and conduct that fell below community standards and expectations in respect of its treatment of at least six other vulnerable customers. These instances related to conduct both before and after the introduction of Freedom's vulnerable customer training in February 2017. The most recent complaint was received by Freedom in late April this year.

The week before Mr Orton gave evidence, Freedom filed a breach report with ASIC which related in part to the complaints that Freedom had received in relation to its treatment of vulnerable customers. Freedom told ASIC that when taken together, the conduct of its sales agents in connection with those sales may have breached several aspects of section 912A of the Corporations Act. We asked about the causes of these problems, Mr Orton referred to insufficient quality assurance coverage for calls made by Freedom Insurance representatives. The breach report filed by ASIC also linked Freedom's remuneration structures with its mis-selling to vulnerable customers.

Before turning to the remuneration and quality assurance structures, we will say something about Freedom's sale of accidental death and accidental injury products, which as you've heard were sold to Mr Stewart's son. As we've indicated, on the day before Mr Orton gave evidence, Freedom told the Commission that it had ceased the outbound sale of those products. The products will still be sold by Freedom's website and will still be offered to customers if they request them. In his statement, Mr Orton had suggested that accidental death cover, combined with an accidental injury rider provides a relatively low cost alternative insurance benefit to full life cover.

In his oral evidence, Mr Orton conceded that these types of cover are not a true alternative to life cover because the circumstances in which a person can make a claim on these policies are much more limited than under a life insurance policy. Despite this, Freedom engaged in downgrading sales practices in relation to accidental death policies by offering these policies to customers who failed to qualify for life cover. Freedom also offered accidental death policies to policyholders who attempted to cancel their existing life insurance policy. Mr Orton accepted that

neither of those practices should occur. Mr Orton also conceded that Freedom's sales processes for accidental death policies were deficient because the sales scripts failed to notify customers of the narrow definition of accident or the key exclusions from the policies.

Mr Orton accepted that as a result, policyholders could be confused about what their policies covered. Until it stopped outbound sales of the product, Freedom sold significant numbers of accidental death policies, around 20,000 policies in each of 2016 and '17. Despite this, Freedom has consistently received a very small number of claims, no more than 22 in any of the last three years. As to Freedom's remuneration and incentive structures, the Commission heard that between 2013 and '15, Freedom used a standard volume-based Commission structure. In about 2015, Freedom began introducing variants to this model. Amongst other things Freedom introduced requirements that sales agents cover their seat cost and the cost of their leads before they would be eligible to earn commission.

Mr Orton conceded that this increased the possibility that sales agents would engage in aggressive sales tactics. More broadly, Mr Orton recognised that Freedom's commission structure over recent years had created a situation in which sales agents had been incentivised to aggressively pursue sales. In the breach notice that it provided to ASIC on 7 September 2018, Freedom notified ASIC that its remuneration arrangements between 1 January this year and May this year may have breached section 963E of the Corporations Act in respect of the variable component of sales agent remuneration. In the same breach notification, Mr Orton informed ASIC that from 1 October, no commission-based incentives will be made available to Freedom's sales teams.

Mr Orton told the Commission that this was because of concerns that commissions may inappropriately influence the conduct of sales agents. In Mr Orton's words "any commission payable to a sales agent has the potential to be conflicted". Mr Orton also gave evidence about various incentive programs including non-monetary incentive programs which had been run by Freedom in recent years. A number of these incentive programs were based solely on sales made by a sales agent without any qualifying quality assurance requirement. Mr Orton accepted that these incentive programs, particularly the higher value incentive programs, encouraged conflicted conduct by sales agents and that this risk was heightened where no quality assurance qualifications were placed upon participation.

In its recent breach notice to ASIC, Freedom also told ASIC that it considered that certain incentive programs run between January and April this year constituted conflicted remuneration in breach of section 963E of the Corporations Act. Turning to Freedom's quality assurance and disciplinary processes, Mr Orton told the Commission that Freedom's quality assurance monitoring processes had been inadequate. The evidence also indicated that Freedom's call marking guidelines were insufficiently robust. For example, at the time Mr Stewart's son was sold his insurance, a sales call would not be marked as a fail if the sales agent provided many categories of misleading, deceptive, false or incomplete information.

Many similar deficiencies persisted in the call marking guidelines until July this year. Mr Orton conceded that the marking guidelines should have been strengthened at an earlier point in time. The Commission also heard evidence about Freedom's ineffective disciplinary practices, including the actions taken in respect of the sales agent who sold the policy to Mr Stewart's son. That sales agent had received an initial written warning in January 2016, and a final written warning in February 2016. In the following months, additional concerns were raised about the sales agent's practices. For the most part, those warnings and concerns were not referred to in the fortnightly feedback that Freedom provided to the sales agent.

Rather, the sales agent's supervisor continued to encourage him to "aim big" and sell more policies. Mr Orton conceded that the disciplinary processes in place at this time did not adequately respond to sales agents who engaged in misconduct and that there were broad problems in the feedback loop used by Freedom Insurance. Finally we turn to Freedom's retention strategies. In its submission to the Commission, Freedom acknowledged approximately 27 instances of retention-related conduct that fell below community standards and expectations. The vast majority of instances related to complaints received since the start of February this year.

Mr Orton accepted that Freedom's retention processes had been "too strong" and that Freedom had at times made it "too difficult" to cancel policies. Information provided by Freedom to ASIC indicated that over a 12 month period Freedom had received an average of 72 cancellation requests a day, and that policyholders had only succeeded in cancelling their policies in 28.5 per cent of calls they made to Freedom. The Commission also heard about various retention marketing campaigns run by Freedom, including as recently as July. The retention campaigns were directed to dissuading policyholders from cancelling their policies or getting them to reinstate cancelled policies.

Mr Orton conceded that these campaigns were designed to make it as difficult as possible to cancel policies and to win policyholders back after they had cancelled. Mr Orton said that the campaign should not have been initiated and that Freedom would stop campaigns of this nature. Now, Commissioner, I was to turn to the available findings of misconduct in relation to Freedom, but I see the time. So perhaps after the lunch break.

THE COMMISSIONER: Come back at 2 pm?

MS ORR: Thank you, Commissioner.

THE COMMISSIONER: Yes. We will come back at 2 pm.

ADJOURNED **[12.59 pm]**

RESUMED **[2.00 pm]**

THE COMMISSIONER: Yes, Ms Orr.

MS ORR: Commissioner, we turn to the available findings in relation to Freedom Insurance. On the evidence, it's open to find that Freedom may have engaged in misconduct in the following ways: first, by selling insurance to Mr Stewart's son in circumstances where the sales agent knew or ought to have known that Mr Stewart's son did not understand what he was agreeing to, Freedom may have engaged in unconscionable conduct within the meaning of section 12CA or 12CB of the ASIC Act. Second, in respect of the other four instances of misconduct relating to the sale of insurance policies to vulnerable consumers which were the subject of Freedom's recent breach notification to ASIC, Freedom may also have engaged in unconscionable conduct within the meaning of sections 12CA and 12CB of the ASIC Act.

Third, as accepted by Freedom in its breach notification, the conduct of Freedom sales agents demonstrated in connection with the five vulnerable consumers may have constituted a breach of sections 912A(1)(a), (1)(ca) and (1)(f) of the Corporations Act. Fourth, Freedom failed until July this year to appropriately frame its call marking guidelines to ensure that serious misconduct, including legislative breaches, constituted a quality assurance fail. By failing to have in place an adequate process to deter legislative breaches in the sales process, Freedom failed to take reasonable steps to ensure that its representatives complied with financial services laws for the purposes of section 912A(1)(ca) of the Corporations Act or to have in place adequate risk management systems in contravention of section 912A(1)(h) of the Act.

Fifth, in accordance with the acknowledgement contained in Freedom's breach notice, Freedom may have breached section 963E of the Corporations Act in respect of the variable component of its sales agent remuneration. Freedom also failed to have in place adequate arrangements for the management of conflicts of interest that arose between its employees and its policyholders in this regard in breach of section 912A(1)(aa) of the Corporations Act. Sixth, and also in accordance with the acknowledgement made by Freedom to ASIC, Freedom may have breached section 963 of the Corporations Act in respect of the non-monetary benefits that it provided to its representatives between January and April this year.

Again, it may follow from this that Freedom failed to have in place adequate arrangements for the management of conflicts of interest that arose between its employees and its policyholders in breach of section 912A(1)(aa) of the Corporations Act. Seventh, and finally, Freedom acknowledged certain breaches of the anti-hawking provisions in the Corporations Act to both the Commission and to ASIC. On the evidence, it's also open to make the following findings of conduct that fell below community standards and expectations. First, Freedom acknowledged 29 instances of conduct that fell below community standards and expectations in respect of its retention and cancellation practices.

Second, more generally, Freedom employs extremely heavy-handed retention strategies which result in policyholders finding it very difficult to cancel policies that they no longer want or need. The community would not expect that an insurance company would make it so difficult to cancel a policy in those circumstances. Third, in its submission to the Commission, Freedom acknowledged three additional instances of conduct that fell below community standards and expectations relating to its treatment of vulnerable customers which were not picked up in its breach notification to ASIC.

Fourth, Freedom's disciplinary procedures were inadequate to address problematic conduct by its sales agents. By way of example, Freedom encouraged the sales agent who sold the policy to Mr Stewart's son to sell aggressively, even in circumstances where there were serious compliance concerns in relation to the agent. The community would expect an organisation like Freedom to have and to apply robust disciplinary practices. Fifth, Freedom failed to appropriately recognise and respond to the harm suffered by Mr Stewart's son.

This was demonstrated in a number of respects, including by Freedom's failure to call Mr Stewart back when it had promised to do so, Freedom's failure to ensure Mr Stewart received the call recordings in a timely manner, and the belittling tone of Freedom's internal communications about Mr Stewart and his son. On the evidence, it's open to find that the misconduct and conduct that fell below community standards and expectations, can be attributed to Freedom's culture and governance practices and its remuneration practices. As Mr Orton accepted, Freedom's remuneration and incentive structure encouraged highly aggressive and inappropriate sales practices.

THE COMMISSIONER: Just one other aspect of the community response to events, I think the community might have been particularly struck by the phone call where the agent insisted upon the son uttering the words, "I want to terminate the policy." It was a particularly affecting record. Yes.

MS ORR: Freedom's quality assurance and disciplinary processes were insufficient to deter and detect these inappropriate sales practices. These difficulties were compounded by Freedom's failure to provide any training to its staff about dealing with vulnerable consumers until February 2017. Commissioner, the third case study concerned CommInsure's handling of claims made under life insurance policies that provided trauma cover. It examined the way that CommInsure handled two particular claims, one involving an insured person who had had a heart attack, and the other involving an insured person who had breast cancer, as well as a number of issues relating to the definition of heart attack in CommInsure's policies.

The Commission heard evidence from Ms Helen Troup, the executive general manager of CommInsure. In the first specific case that was examined, the insured took out a life insurance policy in 2000. That policy included cover for heart attacks as defined in the policy. The insured suffered a heart attack in January 2014 and made a claim under the policy later that month. The medical definitions in the

insured's policy were updated from time to time. However, at the time the insured suffered his heart attack, CommInsure had not made any substantive changes to the definition of heart attack since July 2005.

In accordance with the medical opinion of one of CommInsure's medical officers, Dr Carless, CommInsure denied the insured's claim for a full trauma benefit on the basis of heart attack because he did not meet the relevant policy definition.

Amongst other things the policy definition required elevation in levels of troponin above two micrograms per litre but the insured's levels of troponin only rose to 1.9 micrograms per litre. The insured made a complaint to CommInsure in June 2014 but CommInsure did not change its decision. In March 2016, the ABCs Four Corners program and Fairfax Media reported on concerns about CommInsure's life insurance business. Among other things, the reporting raised concerns that the definition of heart attack in CommInsure's trauma policies was out of date and did not reflect developments in medical science. As a result of these reports, CommInsure decided to bring forward a planned update to its heart attack definition to March 2016.

It decided to backdate the application of the updated definition to 11 May 2014. Shortly after these media reports, the insured made a complaint to FOS about his claim with CommInsure. At that time, a representative of CBA told the insured that the updated heart attack definition did not apply to his claim which was made in January 2014 because the updated definition only applied from 11 May 2014. Despite this, the representative asked the insured for information to allow his claim to be assessed against the updated definition. Ms Troup acknowledged that this communication was likely to confuse the first insured and raise his hopes about the potential outcome of his claim.

At about this time, CBA asked Dr Carless to provide a further medical opinion about the claim, assessing the claim against both the previous 2013 definition and the new 2016 definition of heart attack. Dr Carless again concluded that the insured did not meet the 2013 definition but said that he did satisfy the 2016 definition. On the basis of this opinion, CBA told FOS that it was still CommInsure's position that the insured did not meet the 2013 definition and that it was the 2013 definition that applied to his claim. CBA also challenged FOSs jurisdiction to deal with the dispute on the basis that the dispute related to a matter of commercial judgment for CommInsure.

In the words used by Ms Troup, FOS appropriately rejected CommInsure's challenge to its jurisdiction. Despite FOS having considered and rejected the jurisdictional argument at this time, CBA continued to maintain that the dispute was outside FOSs jurisdiction and twice challenged that jurisdiction again. Ms Troup acknowledged that this should not have happened and that CBA should have accepted FOSs determination as to its jurisdiction. Having rejected CBAs challenge to the jurisdiction, FOS asked CBA to provide the medical opinion on which it relied to say that the insured did not meet the 2013 definition, and asked CBA to obtain and provide a medical opinion about whether the insured met the 2016 definition.

In the covering email, CBA said that it declined FOSs request to obtain or provide a medical report to assess whether the applicant would satisfy the upgraded definition. Ms Troup accepted that it was misleading for CBA to convey to FOS that it did not already have a medical opinion about whether the insured met the 2016 definition. Ms Troup acknowledged that CBA acted inconsistently with FOSs terms of reference and ASIC regulatory guide 139 in refusing to provide this information to FOS. In July 2016, FOS wrote to CBA requesting further information, including information about the decision to backdate the 2016 definition to May 2014.

CBA did not provide information about this decision to FOS because it did not consider it relevant to the dispute. Ms Troup acknowledged that the failure to respond to FOSs request was a breach of FOSs terms of reference and was not open or transparent. In August 2016, more than three months after FOSs first request, CBA provided Dr Carless' opinion to FOS in unredacted form. FOS ultimately made a recommendation in favour of the insured. CBA rejected that recommendation but settled the matter with the insured on an ex gratia basis. Ms Troup acknowledged that CommInsure's handling of the dispute contributed to the delay in resolving the dispute with the insured, and affected CBAs relationship with FOS.

In the second specific case that was examined, the Commission heard that the insured took out a life insurance policy in 1996. In March 2016, the insured was diagnosed with breast cancer and underwent two surgeries to have the cancer removed. Following this, in August 2016, she made a claim. At the time the insured made her claim, the definition of "cancer" that applied to her policy had not been updated since November 1998. One of the exclusions from that definition was carcinoma in situ unless leading to radical breast surgery.

In August 2016, CommInsure denied the insured's claim on the basis that she had a carcinoma in situ and her treatment did not involve radical breast surgery. CommInsure formed the view that the treatment did not constitute radical breast surgery because she had not undergone a mastectomy. CommInsure did not explain this in the letter it sent to the insured and Ms Troup acknowledged that the letter did not provide the insured with an adequate explanation as to why her claim had been declined. The term "radical breast surgery" was not defined anywhere in the insured's policy.

Similarly, the policy did not specify that a mastectomy was required to meet the definition of radical breast surgery. Ms Troup accepted that the lack of definition of radical breast surgery in the policy resulted in confusion for the insured. The insured and her husband told CommInsure they were not happy with its decision to decline the claim and in February 2017 they provided CommInsure with further information from the insured's GP and surgeon. Both medical practitioners said that the treatment the insured had for her breast cancer constituted radical breast surgery.

Despite the views of these two medical practitioners, CommInsure maintained its decision to decline the claim, again on the basis that the insured did not have a

mastectomy. Ms Troup accepted that CommInsure's decision to decline the claim was unacceptable in circumstances where CommInsure was relying on a definition of cancer that at that time was about 18 years old, imposed limitations on that definition that were not expressed in the policy documents, and did not account for the way in which the insured had been treated by her doctors and the opinion expressed by those doctors.

Ms Troup also acknowledged that CommInsure had breached its duty to act towards the insured with the utmost good faith by denying her claim in those circumstances. The insured made a complaint to FOS in April 2017. Ms Troup accepted that CBAs engagement with FOS in relation to the complaint fell below what the community would expect of it. Specifically, CBA chose not to respond to FOSs request for information, or to seek an extension of time to respond to that request. Ultimately, FOS made a recommendation in favour of the insured.

The insured and CommInsure accepted the recommendation and CommInsure paid the insured $169,305, plus interest of just under $5000. Ms Troup acknowledged that FOS made the right decision and that CommInsure's handling of the claim caused distress to the insured. Ms Troup also gave evidence about certain decisions that CommInsure made in relation to the heart attack definition, including decisions about whether to update the definition and about the date from which the updated definition would be applied. Ms Troup told the Commission that between July 2005 and March 2016 CommInsure had considered updating its heart attack definition but decided not to.

Ms Troup accepted that from at least early 2012 CommInsure knew that its definition of heart attack, first, did not reflect the universal definition of heart attack which, among other things, required reference to whether the insured person's cardiac biomarkers were elevated above the 99th percentile of a normal reference population rather than above some absolute level. Second, depending on the laboratory equipment used, might have required troponin levels 20 times higher than those required under the universal definition of heart attack, and third, could discriminate against CommInsure's female customers as it was harder for women to reach the troponin level specified in the definition.

Ms Troup also told the Commission that in 2012, CommInsure's chief medical officer had expressed the view that he would personally move to the universal definition of heart attack. Ms Troup accepted that CommInsure should have updated its definition of heart attack in 2012 to reflect the universal definition. Ms Troup acknowledged that the decision by CommInsure not to update the definition of heart attack in 2012 fell below community standards and expectations. In 2013, CommInsure amended the name of its heart attack definition so that it was headed:

> *Heart attack of a specified severity.*

Ms Troup accepted that prior to that change, people reading the policy would have assumed that the policy was intended to apply to all heart attacks. By May 2014 a

number of other insurers had updated their heart attack definitions to reflect the universal definition. Ms Troup acknowledged that CommInsure's failure to update its definition in May 2014 was a commercial misjudgement that had adverse consequences for its policyholders. Ms Troup accepted that this misjudgement was at least in part the result of CommInsure focusing on commercial considerations at the expense of the interests of its consumers, or the potential reputational risks to CommInsure. Ms Troup accepted that the decision not to update the definition in 2014 also fell below community standards and expectations.

As we've mentioned, when CommInsure decided to update the heart attack definition in March 2016, it decided to backdate the application of the definition to 11 May 2014. Ms Troup told the Commission that this decision was based upon the date of the last relevant product disclosure statement. Ms Troup acknowledged that another reason for choosing this date was that it was in the middle of the period in which CommInsure's competitors had updated their definitions. After receiving a letter from ASIC in March 2017, CommInsure decided to backdate the definition of heart attack even further to October 2012.

Ms Troup acknowledged that October 2012 was a more appropriate date to which to backdate the definition, and that CommInsure should have settled on that date at the point that it decided that backdating was necessary. Ms Troup also gave evidence about the way that CommInsure advertised its trauma policies between December 2012 and March 2016. In connection with its investigation into CommInsure in 2016, ASIC raised concerns with CommInsure about its advertising of trauma policies. ASIC raised concerns that certain web pages and brochures made available by CBA were misleading or deceptive.

In essence, ASICs concern was that the material was not sufficiently qualified or limited to convey the specific criteria that consumers would need to meet to satisfy the heart attack definition. Ms Troup gave evidence about two web pages and two brochures made available by CommInsure concerning its trauma policies. She accepted that a person reading each of the documents would have been likely to believe that CommInsure's trauma policy covered all heart attacks which was not the case. Ms Troup accepted that the documents were misleading. CommInsure had not made this acknowledgement prior to the Commission's hearings.

ASIC did not take any enforcement action against CommInsure for these misleading advertisements. Rather, ASIC and CommInsure reached an agreement under which CommInsure would make a voluntary community benefit payment of $300,000 and would commission a compliance review of its advertising sign-off processes and procedures. In relation to the insured who suffered a heart attack, on the evidence it is open to find that CBAs conduct in withholding part of Dr Carless' medical opinion from FOS during the dispute with the insured, and saying that it declined to obtain or provide such an opinion, may amount to misconduct.

Ms Troup acknowledged that this conduct misled FOS. She also conceded that CBA had failed to be open and transparent in its dealings with FOS, and that it had acted

inconsistently with ASIC regulatory guide 139 and FOSs terms of reference in this respect. It is also open to find that CBA may have engaged in misconduct by contravening clause 7.2 of FOSs terms of reference when it declined to provide information requested by FOS about its decision to backdate its updated heart attack definition to May 2014. Ms Troup conceded that this contravened FOSs terms of reference and was not open or transparent.

In relation to the web pages and brochures, on the evidence, it's open to find that CommInsure engaged in misconduct in the following ways: CommInsure may have breached its statutory obligation under section 12DA of the ASIC Act by engaging in misleading and deceptive conduct in relation to its advertising and promotional material for trauma policies, specifically in relation to cover for heart attacks. And CommInsure may also have breached its statutory obligation under section 12DB of the ASIC Act by making false and misleading representations in that promotional material.

In relation to the insured who suffered from breast cancer, on the evidence, it is open to find that CommInsure's handling of this claim may amount to misconduct. Specifically, that CommInsure may have breached its statutory obligation under section 13 of the Insurance Contracts Act to act towards the insured with the utmost good faith. On the evidence, it's also open to make the following findings of conduct by CommInsure that fell below community standards and expectations. First, in relation to the heart attack definition in its trauma policies, as Ms Troup acknowledged, CommInsure's failure to update the definition in 2012 fell below community standards and expectations.

As Ms Troup also acknowledged, CommInsure's failure to update the definition in 2014 was also a decision that fell below community standards and expectations. And CommInsure's decision in March 2016 to backdate the updated heart attack definition to May 2014 instead of October 2012, also fell below community standards and expectations. Second, in relation to the insured who suffered from breast cancer, CommInsure's failure to respond to FOS within the required time or request an extension of time in connection with the dispute was conduct that fell below community standards and expectations.

The evidence supports a finding that the conduct of CommInsure that fell below community standards and expectations specifically the decisions not to update the heart attack definition in 2012 and 2014, and the decision to backdate the definition to May 2014 instead of October 2012, were attributable, at least in part, to CommInsure not adequately taking into account the interests of its customers in making those decisions, and instead being motivated by commercial considerations. Ms Troup acknowledged this to be the case. One of the matters referred to in the Commission's terms of reference is the effectiveness of mechanisms for redress. In both of the specific cases considered in this case study, there were aspects of CBAs dealings with FOS that were concerning.

In the case of the first insured, who suffered from the heart attack, Ms Troup accepted that CBA misled FOS, made inappropriate challenges to its jurisdiction, and failed to provide information requested by FOS in breach of FOSs terms of reference. In the case of the second insured who suffered from breast cancer, CBA failed to respond to FOS within the required time without providing an explanation or requesting an extension of time. Both of these specific cases indicate a troubling lack of respect on the part of CBA for FOS, and the external dispute resolution process more broadly. It is a requirement of section 912A of the Corporations Act that CBA be a member of an external dispute resolution scheme approved by ASIC.

As this case study and others in this round of hearings demonstrated, external dispute resolution schemes like FOS are an important mechanism for redress for consumers in their dealings with insurance companies. When insurance companies fail to be open, transparent, and responsive in their dealings with FOS, it undermines the effectiveness of external dispute resolution mechanisms as an effective mechanism for redress.

THE COMMISSIONER: Well, there's a series of particular questions emerging from the CommInsure case, which together yield a question capable of more general statement about whether departure from steps required by FOS terms of reference is itself simply conduct falling short of community standards, or whether, if it were established, would constitute a form of misconduct, at least in the form of breach of contract. It occurs to me that there is at least some textual footing in the terms of reference, as they stood, as amended at 1 January '15, for the notion that the terms of reference bind the financial services provider. I have in mind particularly 1.3(a):

These terms of reference are binding upon financial services providers.

And presumably, the mechanism or the legal mechanism is contract. Perhaps contract in light of statutory obligation, but ultimately, I think, contract. Now, financial services providers in their submissions can no doubt tell me how and why that is or is not the case.

MS ORR: Thank you, Commissioner. Commissioner, could we turn to the fourth case study, which concerned TALs claims handling practices. The Commission heard evidence from Ms Loraine van Eeden, the general manager of claims. Ms van Eeden made three statements to the Commission dealing with the experiences of three people who had made claims on TAL income protection policies. Only two of the statements were tendered as the person to whom the third statement related did not wish to have their circumstances examined by the Commission.

We turn first to the case of the first insured who applied for an income protection policy from TAL in February 2009. In the online application form that she completed, she was asked whether she had or ever had had depression, anxiety, panic attacks, stress, psychosis, schizophrenia, bipolar disorder, attempted suicide, chronic fatigue, postnatal depression, or any other mental or nervous disorder. She answered no. TAL offered the insured income protection cover which she accepted. In May

2010, the first insured made a claim under her policy for stress-induced depression and anxiety which was tied to circumstances at her workplace.

Along with her claim form, the first insured provided TAL with a letter from her GP explaining that she had a generalised anxiety disorder that prevented her from working, and indicating that the first insured's condition was a new onset illness. Pursuant to an authority provided by the first insured, TAL began bringing in the first insured's medical records and records about a related workers' compensation claim. When asked about TALs approach to investigations at that time, Ms van Eeden accepted that until 2013, it was TALs practice to bring in extensive medical information about a claimant for the purpose of determining whether their policy could be avoided on the basis of non-disclosure.

Ms van Eeden accepted that this practice was not acceptable. In 2016 TAL introduced a formal guideline relating to investigations. Under this guideline TAL authorised case managers to undertake a general review, even where there were no inconsistencies identified between the underwriting disclosures and the claim information, to ensure there was no adverse non-disclosure. Ms van Eeden conceded that these reviews amounted to fishing expeditions by case managers, and that TAL had engaged in a fishing expedition in relation to the first insured's claim. Based on the information obtained by the case manager, the case manager formed the view that the first insured may have failed to disclose a pre-existing history of work-related stress when applying for her policy, and answered the mental health question inaccurately.

Ms van Eeden did not agree with this assessment. Despite the first insured's attempts to address TALs concerns, TAL relied on section 29(3) of the Insurance Contracts Act to avoid the first insured's policy on the basis that she had breached her duty of disclosure and made a misrepresentation. The first insured applied to TAL for internal review of the decision. In November 2010, TALs IDR team confirmed the initial decision. Upon reviewing the letter that TALs IDR team sent to the first insured, Ms van Eeden agreed that the IDR team did not seriously engage with the first insured's request for internal review and that the letter merely reiterated the claim team's decision.

In February 2011, the first insured lodged a complaint with FOS about the avoidance of her policy. As part of this process, the first insured provided extensive medical material to TAL. Ms van Eeden accepted that this material provided a comprehensive response to the allegations being put by TAL against the first insured. However, despite this, TAL continued to defend the FOS dispute. On 5 October 2012, more than two years after the first insured made her claim to TAL, FOS delivered a recommendation in favour of the first insured, finding that TAL was not entitled to avoid her policy. TAL rejected the recommendation.

Ms van Eeden conceded that this decision was inappropriate. FOS later delivered a determination in favour of the first insured, directing TAL to reinstate the policy and to pay benefits to the first insured with interest. Following this, TAL did a number

of things which were inconsistent with the spirit of the determination, including requesting that the first insured repay premiums that TAL had previously refunded in order for her claim to be assessed as well as failing to promptly assess all aspects of the first insured's claim, and failing to pay interest in the correct sum and for the full period. Ms van Eeden agreed - - -

THE COMMISSIONER: That's more than spirit.

MS ORR: Yes.

THE COMMISSIONER: That's letter.

MS ORR: That's so. Spirit and terms, I should say, Commissioner.

THE COMMISSIONER: Yes.

MS ORR: Ms van Eeden agreed that TAL should have moved more quickly to put the first insured in the position she would have been in had TAL assessed her claim correctly three years earlier. In November 2013, about eight months after the FOS determination, TAL began to conduct surveillance on the first insured. The surveillance lasted for at least four months and included desktop surveillance and physical surveillance. Ms van Eeden accepted that the material reported to TAL was very personal and highly intrusive of the first insured's privacy, and that more generally, the surveillance authorised by TAL in this case was deeply inappropriate.

In December 2013 while the surveillance was ongoing, TAL asked the first insured to complete a daily activity diary, commencing from 4 November 2013. Ms van Eeden accepted that this was another attempt by TAL to disprove the first insured's entitlement to benefits. Despite the first insured having provided TAL with medical evidence that the daily diary was exacerbating her state of anxiety and likely having a negative impact on her health, TAL continued to insist on completion of the diary. Ms van Eeden accepted that this resulted in harm to the first insured and accepted that some of the case manager's communications with the first insured about the diary amounted to bullying.

Ms van Eeden also accepted that the case manager made a misrepresentation to the first insured by telling her that completion of the diary was a term of the policy. The first insured made a further complaint to FOS about TALs insistence upon the daily diary. In its submissions to FOS, TAL said that it was standard practice in the industry to require the completion of a diary. Ms van Eeden accepted that it was not, but was unable to say why TAL had misrepresented the position to FOS. In March 2014 while the second FOS dispute was ongoing, TAL informed the first insured that it had determined that she no longer met the definition of total disablement, and that it would cease paying benefits to her and she would be required to repay $69,000 in benefits that she had been paid to date.

In support of its decision, TAL relied upon section 56(1) of the Insurance Contracts Act which applies to fraudulent claims. Ms van Eeden accepted that the first insured's claim had not been made fraudulently, and that the communication of these matters would have caused considerable distress to the first insured. Ms van Eeden also agreed that by this time, the case manager managing the first insured's case had no regard for the first insured's well-being and was on a mission to stop her from receiving benefits under the insurance policy.

In April 2014 TAL declined an invitation from FOS to participate in a conciliation conference with a view to resolving the first insured's claim. In November 2014 FOS delivered its recommendation in the second dispute. FOS found that the first insured had not made a fraudulent claim, that it was not fair and reasonable to require her to complete the diary and that she remained entitled to benefits. TAL challenged the recommendation insofar as it related to the diary. The matter proceeded to a determination where FOS again found in favour of the first insured.

After the determination, TAL again failed to calculate the payment of interest correctly and since the determination, TAL has continued to engage in heavy-handed tactics in relation to the first insured's claim and has continued to make various systems errors and administrative errors in respect of her case. Overall, Ms van Eeden accepted that TALs conduct was a deeply troubling response to a legitimate mental health claim, that it involved a series of wrong decisions, and very troubling breaches of the first insured's privacy. Ms van Eeden accepted that the poor conduct extended over a significant number of years and involved numerous TAL employees. She also accepted that TAL did not impose disciplinary consequences on two of the case managers who had handled the first insured's file.

The second insured took out a TAL income protection policy in October 2013. At the time that she obtained the policy, she was asked whether she had ever had or received medical advice or treatment for a significant number of health conditions, including depression, anxiety, panic attacks, or any other mental or nervous condition. She answered no. In mid-December 2013, the second insured was diagnosed with cervical cancer. She made a claim on her policy in January 2014. From January to May TAL paid the claim. And throughout this period, TAL brought in and reviewed information about the second insured's medical history.

TAL ostensibly did so because the second insured's claim was made in close proximity to the risk commencement date. However, Ms van Eeden accepted that this was another general review or fishing expedition conducted by the case manager. This was reinforced by the fact that the medical information brought in was not confined to information relevant to the claimed condition. TAL did not inform the second insured that it was conducting these investigations. At the end of June 2014, without giving the second insured prior notice, TAL avoided her contract of insurance on the basis that she had failed to disclose a prior history of depression.

Ms van Eeden accepted that at this time, TAL generally did not give policyholders an opportunity to provide information prior to their policy being avoided for non-

disclosure, and that this was a systemic deficiency within TAL. TAL first communicated this decision to the second insured by phone. After listening to a recording of the call, Ms van Eeden acknowledged that TAL had not informed the second insured of its decision in an appropriate way, there had been a lack of empathy and lack of sensitivity towards the second insured's situation. The situation was compounded by the second insured's case manager having left her with the impression that she might need to pay back the benefits that she had received from TAL under the policy, and overall, the way in which the phone call was handled fell below community standards and expectations.

TAL subsequently sent a letter to the second insured confirming that her policy would be avoided. TAL asserted in that letter that the second insured had breached her duty of good faith under section 13 of the Insurance Contracts Act. Ms van Eeden acknowledged that this assertion was itself a breach by TAL of its duty of utmost good faith. Ms van Eeden also acknowledged that until recently, if TAL declined a claim for non-disclosure, its communications to the policyholder would generally allege that the policyholder had breached their duty of good faith. Ms van Eeden conceded that there would have been many cases of innocent non-disclosure in which this allegation was made, and which would have been very unfair to the policyholder.

The letter to the second insured also emphasised that TAL retained its right to recover the payments it had made to the policyholder. Until about 2017, it had been TALs practice to reserve its right to repayment of benefits where it voided a policy for non-disclosure. The second insured also challenged TALs decision in FOS. While the FOS dispute was ongoing, TAL undertook further investigations into the second insured's disclosures. Ms van Eeden accepted that TAL did so to try and find a basis for avoidance which was directly related to the claimed condition. TAL sought a second retrospective underwriting opinion in relation to some symptoms experienced by the second insured prior to entering into the policy, which may have been indicative of cervical cancer.

The underwriter advised that if those symptoms had been disclosed, the insured's application for a policy would have been refused on that basis, potentially providing TAL with an alternative basis for avoiding the contract of insurance. Upon receiving the opinion, TALs general manager of claims expressed some concern about TAL trying to make retrospective decisions when the facts at the time were different. In April 2015, TAL and the second insured attended a FOS conciliation conference. Despite having known of the proposed additional basis for avoidance for at least two weeks, TAL only notified the insured of the additional basis on the day before the conciliation conference. Ms van Eeden did not know whether this was a strategic decision by TAL, but accepted that it was part of a broader pattern of delay in TALs dealings with FOS in this matter. Following the conciliation conference, TAL and the second insured settled the dispute by TAL waiving its right to recover the $25,000 paid to the second insured and paying her a further $25,000.

We turn to the case of the third insured in respect of whom a statement was not tendered. Because no statement was tendered, the cross-examination in this part of the case study focused upon a number of acknowledgements made by TAL in the untendered statement. First, TALs claims decision committee had determined to avoid the third insured's policy, but before that decision was communicated to the third insured, the case manager added some additional grounds for avoidance, namely an alleged non-disclosure of a mental health condition. This additional information was derived from the contents of an underwriting opinion obtained by the case manager which was inconsistent with the committee's decision.

TAL then communicated that revised information to the third insured. Ms van Eeden accepted that the case manager should not have communicated the content of the underwriting decision, rather than the decision of the committee, to the third insured, and that this fell below what the community would expect. Ms van Eeden attributed this to a lack of oversight of, and rigour in, the case manager's decision-making process. Second, following TALs decision to avoid the third insured's policy, the third insured applied for internal review of that decision. Following the internal review, the file was returned to the original case manager. That case manager undertook a review of the file that extended beyond the recommendation made by TALs IDR team.

Ms van Eeden accepted that the case manager's failure to conduct a review in accordance with the IDR team's recommendation fell below what the community would expect. Ms van Eeden also told the Commission that TAL is currently revising its processes to ensure that claims are no longer remitted from its IDR team back to the original case manager, to improve independence in the decision-making process. Third, Ms van Eeden acknowledged that in light of both of those matters, TALs decision to defend the third insured's matter in FOS fell below community standards and expectations.

Fourth, similarly to the case of the first insured, Ms van Eeden accepted that TAL knew about, but did nothing to stop, the inappropriate approach that had been applied to the third insured's claim. Fifth, similarly to the case of the second insured, Ms van Eeden accepted that TAL should have handled the insured's claim with greater sensitivity and empathy. The Commission heard that as a result of the issues raised in these case studies, Ms van Eeden will review all mental health claims that TAL declined for non-disclosure between 2013 and 2016 to ensure that appropriate processes were followed in each case. It is open to find that TAL engaged in misconduct in a number of respects.

First, in relation to the first insured, TAL acknowledged that it had breached its duty of utmost good faith towards the insured, breached professional standards, and engaged in conduct that was misleading. In making these admissions, TAL referred to numerous types of inappropriate conduct, including the engagement of and inappropriate utilisation of, and instructions to, external investigators; the excessive use of surveillance; bullying tactics and offensive communications; misrepresentation of policy terms; and misuse of the daily activities diary.

Second, in relation to the second insured, TAL accepted it may have breached its duty of utmost good faith by telling her, when it avoided her contract of insurance, that she had breached her duty of utmost good faith. At most, the second insured had innocently failed to disclose certain information about her medical history. Third, TAL acknowledged that until early 2017, its standard practice was to tell policyholders whose contracts were being avoided under section 29 of the Insurance Contracts Act that they had breached their duty of good faith. In those circumstances, and given the admission made in respect of the second insured, it's open to find that TAL systemically breached its duty of good faith when communicating with policyholders whose policies had been avoided for non-disclosure.

Ms van Eeden accepted that there were many cases of innocent non-disclosure in which TAL would have made this allegation in circumstances that were very unfair to the policyholder. Fourth, it's open to the Commissioner to find that at least until 2013, TAL systemically breached its duty of good faith to policyholders in its approach to investigations. Ms van Eeden accepted that until that time, TAL would go out and call for every kind of report from policyholders' medical practitioners, and would seek out medical information that extended well beyond the claimed condition. Ms van Eeden accepted that the purpose of doing this was to determine whether TAL might be entitled to avoid a policy on the basis of non-disclosure.

On the evidence, it's open to find that TAL may have engaged in conduct that fell below community standards and expectations in a number of respects. First, TAL failed to ensure that it had adequate systems to train its case managers and to oversee the actions of its case managers. In the case of the first and third insureds, this resulted in a number of inappropriate decisions being made and a failure by TAL to correct those decisions in a timely manner or at all. Second, at least until 2016, TAL failed to have in place robust systems to avoid potential conflicts of interest. As demonstrated by the case of the first insured, TAL permitted a case manager to sit on the claims decision committee when the committee was reviewing the case manager's recommendation.

As demonstrated by the case of the third insured, TAL remitted claims to case managers after TALs IDR team had essentially indicated that the case manager had taken the wrong approach. The community would expect that an insurer would have more robust systems to avoid potential conflicts. Third, and relatedly, as was apparent in the case of the first insured, TAL failed to have adequate systems in place to ensure that its internal dispute resolution team conducted a robust analysis of declined claims in a way that was independent of the claims team.

Fourth, TAL failed to engage with FOS in a cooperative and frank way. Amongst other things, TAL provided misleading information to FOS, delayed providing relevant information, refused to participate in a conciliation conference with the first insured, and failed to comply with FOSs decisions in a timely manner or, in some respects, until pushed by FOS to do so. The community would expect better.

THE COMMISSIONER: Well, and, again, there's this question of - - -

MS ORR: Misconduct.

THE COMMISSIONER: Is that a breach of contract.

MS ORR: Yes. And, therefore, misconduct.

THE COMMISSIONER: Yes.

MS ORR: Fifth, as we saw in the case of the second and third insureds, until mid-2017 TAL failed to accord procedural fairness to policyholders prior to avoiding their policies. The community would expect that if TAL was considering avoiding a person's policy, it would offer them the opportunity to make submissions to TAL and those submissions would then be the subject of serious considerations. Sixth, as acknowledged by TAL, several aspects of the way that TAL communicated with the first, second and third insured fell below community standards and expectations. In relation to the first insured, TAL accepted that it communicated in a way that was inappropriate, bullying, threatening, and misleading.

In respect of each of the three insureds, TAL failed to communicate in a sensitive and empathetic way, that recognised the difficult circumstances they were facing. Amongst other things, this was evidenced by TAL leaving the second insured with the impression that she might be required to repay the benefits that she had obtained under the policy. Finally, TAL failed to have adequate systems in place to avoid serious administrative errors, such as erroneous notifications of policy cancellation for non-payment of premiums. As acknowledged in respect of the first insured, these types of errors were likely to cause significant distress to claimants.

It is open to find that one cause of the misconduct and conduct that fell below community standards and expectations was the minimal training and oversight of TAL case managers. Ms van Eeden accepted that at the time when the three claims were made, 2010, 2014 and 2015, there was minimal oversight within TAL of its senior case managers. Further, Ms van Eeden told the Commission that there were no structured ongoing training programs in relation to TALs claims handling processes and procedures, and no mandatory induction training for new TAL employees. Ms van Eeden acknowledged that this was a serious flaw in TALs systems.

Another potential cause was the internal culture of TAL at the time that the claims were made. Ms van Eeden said that she was unable to speak to TALs general culture during that period as she was not employed by TAL at the time. However, Ms van Eeden accepted that there were multiple employees of TAL involved in extremely poor conduct across the three files over different periods of time. These included people at all levels of the business, from the claims team, the internal dispute resolution team, and the external dispute resolution team. Ms van Eeden accepted

that the fact that there was so many problems with so many people involved over such a lengthy period of time was telling in terms of TALs culture.

Another potential cause of the misconduct and conduct that fell below community standards was a systemic lack of independence in TALs decision-making processes. Ms van Eeden accepted that the internal dispute resolution team, and the external dispute resolution team, were insufficiently independent of the business at the time that the three claims were handled. Finally, when asked about TALs key performance indicators, and whether they were drivers of poor claims handling conduct, Ms van Eeden said that they were not and said that case managers did not have a KPI connected with the non-payment of claims.

Ms van Eeden accepted that TAL had, and has, KPIs connected to claims' closure, but she said that these related to finalising claims within a particular timeframe. Despite this, when shown a breakdown of TALs KPIs for team managers in 2015, Ms van Eeden accepted that 50 per cent of TALs scorecard for team managers depended on profit targets. In relation to the effectiveness of mechanisms for redress, we make similar observations about TAL to the observations we made about CBA. The individual cases considered in this case study indicated a culture within TAL that had inadequate respect for FOS.

THE COMMISSIONER: Particularly in the first case study, there's a further set of issues which I think is difficult to articulate sufficiently accurately, but I was struck by the evidence given in that first case study – I think in the form of the last treating doctor's opinion, which said, in effect – and I need to go back and read it and be very careful about whether I'm accurately recording it – but my impression was the doctor was saying his patient was worse because of the way in which the insurer had treated her. Now, that's a 12 inch brush description of a much more subtle medical report, I think, and I need to go back and read it, but to the extent to which it's accurate, it presents a set of issues – or may present a set of issues of, well, does that matter. Obviously, it does to the patient.

But is it something which in any sense the insurer is somehow to be held accountable. Now, within my terms of reference, that becomes is there misconduct or conduct falling short. I would have thought that to the extent to which an insurer's actions make the medical condition of the insured worse, the community may form a view, if that's all is known, reasonably quickly. But whether it's a form of misconduct may turn, may it not, on whether the steps taken were sufficiently well based in contractual rights, powers, privileges. And my impression, subject to what TAL later have to tell me, is that there seemed to be, perhaps, some question about whether all of the steps taken in that first case would find a sufficient or sufficiently firm base in contractual powers, privileges, rights, etcetera. Now, I don't know.

Now, that's far too general, far too imprecise. But I think TAL should be aware of the fact that there is a set of issues which I think emerges, which I have not articulated properly, about what would follow if there were available evidence which

suggested that their conduct had caused, in this case, diagnosable and diagnosed psychiatric injury to the insured.

MS ORR: I think, Commissioner, you are referring to the psychiatric report of Dr Dinnen, which we tendered into evidence, and our recollection of that report is that it recorded that the psychiatric condition of the insured had been the subject of significant deterioration over a particular period, that there was increased paranoia and anxiety and stress, and that the insured spoke of her insurer – her experiences with the insurer, in connection with the presentation of those symptoms. And I think our position would be that that psychiatric evidence is demonstrative of the breach of the utmost duty of good faith in section 13 of the Insurance Contracts Act which we say emerges from the evidence as one of the forms of misconduct.

THE COMMISSIONER: Yes. I see. I understand that. And utmost good faith might also be particularly relevant to making unjustifiable or unjustified allegations of fraud.

MS ORR: Yes. Absolutely.

THE COMMISSIONER: Allegations of fraud are not likely to be bandied about. Yes.

MS ORR: Now, Commissioner, we're about to move to another case study. Would you be open to a brief break before we did so?

THE COMMISSIONER: If you're not careful, Ms Orr, it will be a very long break. But if I come back at, say, 10 past 3. Is that - - -

MS ORR: Thank you, Commissioner.

THE COMMISSIONER: Right. 10 past 3 it is.

ADJOURNED **[3.05 pm]**

RESUMED **[3.10 pm]**

THE COMMISSIONER: Mr Costello.

MR COSTELLO: Commissioner, the first group life case study concerned the conduct of the Retail Employees Superannuation Trust or REST in relation to life insurance, TPD and income protection policies offered to REST members. The Commission heard evidence from Lachlan Ross, project specialist in the REST operations team. REST has about two million members. Between 1.4 and 1.5 million of those members have group life insurance with REST. Since 2004, AIA

has been RESTs group life insurer. AIA will receive annual premiums of between 750 million and $800 million from REST this year. Mr Ross told the Commission that insurance cover was very valuable to RESTs membership.

Turning first to RESTs prescribed minimum balance clause, until December 2017 the default policies offered to RESTs members contained a prescribed minimum balance clause that operated in conjunction with a prescribed employment status clause. In tandem, these clauses meant that if a member's balance fell below a certain amount, $3000 for TPD insurance and $1200 for life insurance, and a member was not working or did not receive contributions from their employer, the member would lose the default life and TPD cover after 71 days. During the five-year period from 2013 to 2018, the operation of the minimum balance requirement led to REST denying the claims of 11 members and the TPD claims of 36 members.

As to RESTs internal processes for dealing with cessation of cover, as soon as REST became aware that a member had ceased working and had a balance below the minimum threshold, it would cease charging premiums to that member. However, in the event that REST was not notified that a member had ceased working, it would continue to deduct premiums from the member's account regardless of whether the account had a balance below the minimum threshold. In addition, REST frequently communicated with members in a way that did not accurately reflect the terms of the group life policy. REST disclosed 52 separate miscommunication incidents affecting more than 48,500 members.

Mr Ross accepted that the operation of the minimum balance and prescribed employment status clauses made it complicated to communicate with members about their level of cover and that this was one of the reasons that REST removed the minimum balance clause in December of last year. The Commission heard evidence about how these clauses operated in two specific cases. In the first, a REST member became totally and permanently disabled five days after his cover lapsed. Until a claim was made, REST had not been aware that the member had previously ceased work, and REST continued to deduct insurance premiums at the time of the member's injury. The member's TPD claim was denied but REST refunded the premiums paid by the member after the date his employment ceased.

In the second case, a woman had joined REST in 2005 and was rendered paraplegic in May 2012 after falling from the fifth floor of a building. After the member was injured, she received her 2012 REST annual statement. The statement informed the member that she had TPD coverage of $108,000. The statement did not mention the $3000 minimum balance requirement. Mr Ross gave evidence that this information possibly should have been included in RESTs annual statements. In January 2014, with the assistance of her lawyers, the member submitted a TPD claim to REST. It took REST six months to provide the claim to AIA. Mr Ross gave evidence that this took too long and that the delay of this length would now be unusual. After being notified of the claim, AIA had to follow up REST for further information on a number of occasions.

In November 2014, AIA accepted the member's claim and transferred $108,000 to REST. In December 2014, REST emailed AIA requesting that AIA review its decision and refunded the full payment. Mr Ross said that this communication was made because REST had realised that it had made an administrative mistake in relation to the member's last employment date and had failed to enter that date into its systems. Mr Ross considered that it was appropriate for RESTs administrator to have acted in that way, despite RESTs obligation to do everything that is reasonable to pursue an insurance claim for the benefit of a beneficiary if the claim has a reasonable prospect of success.

After the member commenced litigation in the Supreme Court of New South Wales, AIA settled the claim. Mr Ross said that he did not believe that REST failed to act in the best interests of this member but that with hindsight he wished REST could have done more to get the benefit paid to the member sooner. Turning next to the evidence about the operation of RESTs TPD clause, Mr Ross told the Commission that TPD is the most complex type of insurance offered in group life policies. RESTs definition of totally and permanently disabled has three disjunctive limbs. The first limb has two elements. A person must be absent from work for a period of three consecutive months and be so disabled that they are unlikely to engage in any occupation for which they are reasonably suited through education, training or experience.

The second element of the first limb is very similar to the definition of permanent incapacity in regulation 1.03C of the Superannuation Industry (Supervision) Regulations 1994. The second limb of RESTs definition will be met if the member has suffered significant injuries, for example, loss of two hands or two feet. The third limb of the definition requires that the member will be unable to perform at least two activities of daily living, being dressing, bathing, toileting, mobility or feeding without assistance. Mr Ross accepted that it was possible for a member to satisfy the first limb of RESTs definition but not the second or third limbs.

However REST will only assess a member's eligibility against the first limb if the member satisfies REST that they have been in gainful employment in the 13 months before the incident. RESTs policy defines gainful employment as being employed for gain or reward in any business, trade, profession or employment for at least 10 hours her week. If a member does not meet the gainful employment requirement REST will assess their eligibility for TPD benefits under the second and third limb of the policy definition but not the first limb. In the last five years, REST has declined the death or TPD claims of 224 of its members based on the operation of its prescribed employment status requirements, including the gainful employment requirement.

REST also provides default income protection cover to its members. Mr Ross considered that this form of insurance cover was particularly valuable to RESTs membership. A member may not claim the income protection benefit if that member is unemployed. Despite this, absent explicit notification that a member has ceased working, Mr Ross was not aware of any systems that REST had in place to detect

and stop the deduction of income premiums for unemployed members. Mr Ross accepted that this meant that those members would be paying a premium for a policy on which they could not claim but did not accept that income protection insurance would be junk insurance in those circumstances.

In the last five years, REST declined 37 income protection claims due to the requirement for the claimant to be employed. Turning to the Insurance in Superannuation Code of Practice, Mr Ross said that REST had expressed its intention to comply with the Insurance in Superannuation Code of Practice by the end of 2029. Clause 5.17 of the code relates to communications with members and requires an entity to provide a member with an annual statement that includes information about the type of cover the member holds, how much they are insured for, their current premium, an explanation for any changes in their premium, and the policy standard exclusions and rules for automatic cessation of cover.

The code also requires entities who receive a completed claim form to either provide the claim form to the insurer or tell the member they are not eligible to claim within five business days. Mr Ross was not aware whether REST currently satisfies the five-day requirement. On the evidence, it is open to the Commissioner to find that REST may have engaged in misconduct in the following respects: first, RESTs conduct in continuing to deduct insurance premiums when a person is no longer covered by insurance may constitute a failure to perform the trustee's duties and exercise the trustee's powers in the best interests of the beneficiaries as required by section 52C of the Superannuation Industry (Supervision) Act.

Second, RESTs conduct in relation to the member who became paraplegic may have demonstrated a failure to do everything that is reasonable to pursue an insurance claim for the benefit of a beneficiary if the claim has a reasonable prospect of success. Such conduct would be a contravention of section 52, subsection (7)(d) of the Superannuation Industry (Supervision) Act. On the evidence, it is open to the Commissioner to find that REST may have engaged in conduct falling below community standards and expectations in the following respects: first, by failing to communicate with members about key exclusions such as the prescribed minimum balance exclusion in annual statements. Once the code comes into effect, this conduct would constitute a breach of clause 5.17 of the code.

Second, by continuing to deduct premiums from members, such as the paraplegic member, when they were not covered by the policy. Once the code comes into effect, trustees will be required to notify members no later than six months after receipt of the member's last eligible contribution and to include various requests and warnings in that communication. Third, by deducting income protection premiums from unemployed members who were unable to claim on their policies, and fourth, by failing to have sufficient systems in place to detect when a member was unemployed and, therefore, at risk of losing cover. The community would expect that a superannuation fund's systems would be capable of detecting when a member is in this position even absent notification from the member.

That conduct can be attributed to the inadequacies of RESTs systems, including a lack of systems to detect changes in members' circumstances that materially affect their insurance cover. It may also be attributable to systems which have an overreliance on hardcopy claim forms and which carry with them a greater risk of human processing errors. Commissioner, after the conclusion of Mr Ross' evidence additional statements prepared on RESTs behalf were tendered. One of those statements was from Mr Paul Howard. Yesterday afternoon, REST provided a further statement of Mr Howard that supplements paragraphs 5(a) and 13 of his earlier statement by providing additional information not known to Mr Howard at the date of his initial statement.

That additional information includes that was yesterday REST filed a breach report with ASIC in which REST stated that it considered that it had inadvertently breached various provisions including section 101, subsection (1)(c) of the Superannuation Industry (Supervision) Act which requires trustees to provide reasons for a decision in response to a complaint about the proposed payment of a death benefit. REST said that it had done so 184 times since 15 March 2017. It follows from that evidence that it is also open to you, Commissioner, to find that REST has engaged in misconduct by breaching sections 29E(1)(a) and 101(1)(c) of the Superannuation Industry (Supervision) Act and section 912A(1)(b) and (c) of the Corporations Act.

Those breaches are also attributable to RESTs systems, specifically to its template letter for conveying decisions in response to complaints about the proposed payment of death benefits. Commissioner, I tender the statement of Paul Howard, dated 20 September 2018 with document ID WIT.0001.0171.0001.

THE COMMISSIONER: That document becomes exhibit 6.422.

EXHIBIT #6.422 STATEMENT OF PAUL HOWARD DATED 20/09/2018 (WIT.0001.0171.0001)

MR COSTELLO: Thank you, Commissioner. Aspects of the group life arrangements of AMP were also considered in this hearing block. The case study concerned two RSE licensees, AMP Superannuation Limited and NM Superannuation Proprietary Limited. Both entities sit within the AMP Group. The Commission heard evidence from Mr Paul Sainsbury, group executive, wealth solutions and customer for AMP Group. AMP Life Limited, a wholly owned subsidiary of AMP Limited is the group life insurer for most members of the trustee's funds. It is also the administrator of all of AMP Superannuation Limited's funds and some of NM Superannuation's funds. Mr Sainsbury could not say precisely how long this arrangement had been in place, but agreed that it had certainly been for a very long time.

Mr Sainsbury's evidence was that tenders do not occur for the provision of group life insurance to the members of the trustee's funds which we take to mean its public

offer funds. Mr Sainsbury was taken to prudential standard SPS 250, insurance and superannuation, one requirement of which is that the trustee be able to satisfy itself and demonstrate to APRA that the engagement of the insurer is conducted at arm's length, and is in the best interests of beneficiaries. Mr Sainsbury did not accept that a conflict arose by AMP Life acting as the group life insurer and also undertaking the prudential tasks connected with the assessment of the group life arrangements.

Mr Sainsbury's evidence was that there was sufficient separation of roles within AMP Life to satisfy the requirements of SPS 250. The Commission heard evidence that members who were part of their employer superannuation plan with AMP were charged default insurance rates when they ceased employment and were delinked from their employer's account. Those members were known as delinked employees. The evidence before the Commission was that delinked employees were defaulted to a standard insurance rate. Mr Sainsbury's evidence was that delinked employees were defaulted to this rate because AMP did not have a full understanding of the health of those members.

Mr Sainsbury described the standard rate as being different to an actual smoker rate although he accepted that for group life policies there were only two rates, the standard rate and the non-smoker rate. Mr Sainsbury accepted that the only criteria applicable to a member being moved from the standard rate to the non-smoker rate was the submission by the member of a non-smoker declaration. Mr Sainsbury also accepted that the nuanced differences between the rates would be difficult for a member to understand. The Commission heard evidence of a case where a delinked employee who did not smoke was informed by his financial adviser that he had been classified as a smoker. The member was unaware that he was classified as a smoker. It was not stated on his annual statement.

At the time of the discovery, the member was charged $2600 in premiums per month. The premiums reduced to $1600 per month on the member's reclassification as a non-smoker. To that point in time, the member had been charged almost $77,000 in additional premiums. AMP declined to refund the member on the basis that its records showed that the member was issued with the non-smoker declaration at the time of his delinking, and that it had clearly explained what would happen to his insurance once he left his employer. That was the sole occasion where the matter was drawn squarely to the member's attention.

An AMP document described AMPs failure to include the smoker status in his annual statements as unethical. Mr Sainsbury did not agree with that statement. Mr Sainsbury's evidence was that the member received a welcome letter on delinking, and was given an opportunity at that stage to elect non-smoking rates. The member subsequently lodged a complaint with the Superannuation Complaints Tribunal. AMPs position remained that it had acted appropriately and should not be required to refund the additional premiums. The tribunal held that AMP had not acted fairly and reasonably in refusing to refund the customer.

Mr Sainsbury accepted that it would have been better if the annual statements disclosed the smoker status, particularly in circumstances where there was a very significant differential in the premium. After this incident in 2013, AMP member statements commenced including this information. Mr Sainsbury said that he was familiar with ASIC report 529 entitled Member Experience of Superannuation, in which ASIC expressed the view that only 14.5 per cent of adults were daily smokers and that in these circumstances it was statistically appropriate to assume that a person is not a smoker in the absence of other information about that member or the group of members. Mr Sainsbury was not aware of the trustees taking any step to implement that view.

The Commission also heard evidence that in April 2018, AMP Life identified that life insurance premiums were continuing to be deducted from deceased members' accounts and that after payment of a death benefit, refunds were not being processed to a deceased member's account. AMP investigated this issue following evidence given by the Commonwealth Bank of Australia at the Commission's second round of hearings concerning fees being charged to deceased wealth customers. On 26 June 2018, AMP notified ASIC and APRA that it had breached section 912A subsection (1)(c) of the Corporations Act and sections 29VC and 52(2)(b) of the Superannuation Industry (Supervision) Act because insurance premiums charged after the member's death were either not refunded or the refunded amount was incorrect.

That breach notification identified 3124 members with a total of $922,902 in premium refunds owing. AMP said that it determined the matter was reportable under section 912D of the Corporations Act and section 29JA of the Superannuation Industry (Supervision) Act on 12 June 2018. As at 5 September 2018, AMP had identified that 4645 customers were affected by the issue with $1 .3 million in premium refunds owing. There was evidence before the Commission that the issue of continuing to deduct life insurance premiums from deceased members' accounts had been raised within AMP in at least 2015. Mr Sainsbury's view was that this issue was different to the matter reported to APRA and ASIC under section 912D in 2018. That was because the breach notification issued in 2018 included the fact that not only were the premiums being charged but they were also not being refunded.

However, Mr Sainsbury conceded that life insurance premiums were being incorrectly deducted from deceased members' accounts in 2016, and that fact was not reported to ASIC or APRA, and still has not been reported as at 17 September 2018. Mr Sainsbury accepted that AMP had no continuing entitlement to charge premiums for life insurance to a member who was deceased. The Commission also heard evidence that a member of AMPs Superannuation Limited MySuper product who was diagnosed with a very serious illness was not provided with insurance. Section 68AA of the Superannuation Industry (Supervision) Act requires trustees who offer MySuper products to ensure that the fund provides, relevantly, a permanent incapacity benefit to each MySuper member on an opt-out basis.

The member was a delinked employee and lost his insurance coverage when he ceased employment with his then employer. The member had also been paying fees

to a financial adviser who had not drawn the member's attention to the fact that there was no insurance connected with the group life superannuation account. The member's wife wrote to Craig Mellor the then CEO of AMP who referred the matter to AMPs customer advocate. Mr Sainsbury accepted that the member held the MySuper product at the time the member's wife had written to Mr Mellor. Mr Sainsbury was aware of the duty imposed on trustees under section 68AA to provide permanent incapacity benefits to each MySuper member of the fund, except where, as he said, the trustee determines that the cover is not appropriate.

Mr Sainsbury's evidence was that it had been determined that it was not appropriate to provide insurance to this member because when he was delinked, a welcome call had been made to him that talked about him not having insurance cover in place, and on that basis he was deemed to have opted out. The member was then in a category of members who were not offered insurance as part of the transition to MySuper. The AMP customer advocate did not agree with the view that the member should not have been provided with insurance. Mr Sainsbury's evidence was that the trustee disagrees with the customer advocate's view and considers the decision to be appropriate, and that AMP does not consider its conduct to be a breach. An ex gratia payment was ultimately made to the member.

The member's complaint caused AMP to undertake an investigation into whether this issue affected other members. The evidence before the Commission was that AMP Super issued a possible breach notification to APRA and ASIC about this issue on 4 June of this year. APRA rejected that letter and invited a formal breach notification from AMP Super. That notification was provided on 10 August 2018, which said that AMP was in the process of satisfying itself that the non-provision of insurance to 1600 MySuper members was appropriate. Mr Sainsbury told the Commission that it would take another month or two until AMP Super would reach a view on this matter.

On the evidence, it is open to the Commissioner to find that AMP may have engaged in misconduct in the following ways: first, by authorising the deduction of premiums from members' accounts where those premiums are calculated on a statistically inappropriate basis. That conduct may amount to a breach of sections 52(2)(b) and (c) of the Superannuation Industry (Supervision) Act. Second, by continuing to deduct insurance premiums from deceased members' accounts since at least 2016, the trustees may have breached section 912A subsection (1)(c) of the Corporations Act and sections 29VC and 52(2)(b) of the Superannuation Industry (Supervision) Act. Third, by failing to notify APRA and ASIC of the continued deduction - - -

THE COMMISSIONER: Whether or not it's a breach of those provisions, it's more basic than that, isn't it, Mr Costello? By what right is it deducted? How do you deduct a premium for life insurance on a life that's dead.

MR COSTELLO: Expired. And Mr Sainsbury in evidence accepted the fact that there was no basis by which the deduction could occur. Third - - -

THE COMMISSIONER: It's ordinarily thought necessary to show some entitlement to take money. Yes, go on.

MR COSTELLO: Third, by failing to notify APRA and ASIC of the continued deduction of premiums from deceased member accounts since at least 2016, except to the extent notified on 26 June 2018, the trustees may have breached their obligations under section 912D, subsection (1B) of the Corporations Act and section 29JA, subsection (1) of the Superannuation Industry (Supervision) Act. Fourth, by failing to ensure that there were adequate systems in place to cease deducting premiums from deceased members' accounts, the trustees may have breached section 912A, subsection (1)(a) of the Corporations Act, and section 52, subsections (2)(b) and (c) of the Superannuation Industry (Supervision) Act.

Fifth by not ensuring that at least one of the MySuper members was provided with permanent incapacity benefits on an opt-out basis AMP Superannuation Limited may have breached section 68AA, subsection (1)(a) of the Superannuation Industry (Supervision) Act. Further, on the evidence, it is open to the Commission to find that AMP may have engaged in conduct falling below community standards and expectations in the following respects. First, by not adequately ensuring that members were aware they had been defaulted to an insurance rate that assumed the member smoked in circumstances where it was unlikely that the member smoked.

Second, by refusing to refund premiums incorrectly charged to the member who was charged the smoker rate in circumstances where that member was not a smoker. Third, by failing to stop the deduction of premiums from deceased members' accounts in a timely way; and fourth, by refusing to provide insurance cover to members who hold a MySuper product. It is open to the Commissioner to find that the cause - - -

THE COMMISSIONER: Well, no, just go back. Failed to stop in a timely way is a singular event, isn't it? There's no opportunity for reasonable time to elapse.

MR COSTELLO: Notification of the fact.

THE COMMISSIONER: Notification of death.

MR COSTELLO: Yes.

THE COMMISSIONER: Payment stops. Not a case of stops some reasonable time thereafter. It stops, I would have thought.

MR COSTELLO: We would accept that, Commissioner.

THE COMMISSIONER: I will be told I'm looking at these things far too simply. Well, if I am, I need to be told I am.

MR COSTELLO: There's no dispute from Counsel Assisting as to that proposition.

THE COMMISSIONER: That's the real worry, Mr Costello.

MR COSTELLO: Commissioner, as to the causes of the misconduct, it is open to find that the causes of the misconduct and the conduct falling below community standards and expectations included AMPs culture and systems which failed to promote the best interests of members in various ways, including by failing to ensure that members were provided with default insurance cover on a statistically appropriate basis, and failing to prevent the continued deduction of premiums from deceased members' accounts. Commissioner, Ms Orr will now close on the Allianz case study.

THE COMMISSIONER: Yes. Ms Orr.

MS ORR: Commissioner, the Allianz case study concerned misleading and deceptive content that appeared on the travel insurance pages of Allianz's website between 2012 and 2018 as well as issues relating to Allianz's compliance processes, governance, and culture more generally. The Commission heard evidence from Mr Michael Winter, the chief general manager of retail distribution and Ms Lori Callahan, the chief risk officer. Allianz Australia Insurance Limited issues general insurance products including travel insurance products. It distributes those products through a number of channels including through its own website and through an underwriting agency, AWP Australia Proprietary Limited. AWP also distributes travel insurance products issued by Allianz through a number of channels, including its own website and through the websites of third parties, such as airlines or travel businesses, which Allianz refers to as partners.

Allianz is responsible for determining the travel insurance content on its own website and for checking that the travel insurance content of its own website and the websites of AWP and AWPs partners comply with the law. Allianz is also responsible for checking that the content of the purchase paths used by customers who buy Allianz travel insurance products from those websites comply with the law. In 2015, Allianz decided to update the look and feel of its website. At that time, Allianz had a process for approving new website content called the document compliance sign-off process.

That process was used to review the new content that was added to the website but was not used to review the updated website as a whole before it was made accessible to the public on 10 December 2015. Mr Winter described this as a failure in the approach. Shortly before the updated website was made accessible to the public, an Allianz corporate solicitor identified issues with the updated website, including an absence of certain legally required disclaimers. Despite this, the website was launched. Over the coming weeks, the solicitor identified further issues with the content on the website, including misleading and deceptive statements. Despite these issues, Allianz did not take down the website.

In January 2016, Allianz decided to undertake a review of the website content. The corporate solicitor put together a proposal for an external law firm to review the website content by mid-February 2016 at a cost of 25 to 30 thousand dollars. Mr

Winter declined to approve this expense. As a result, the corporate solicitor spent two days a week working on the matter until the review was done. Mr Winter conceded that his decision not to approve this expense was not the right decision, and conceded that this was reflective of a lack of prioritisation within Allianz of fixing the issue. The review ultimately took about 10 months to complete.

Because of the limited resources available, the corporate solicitor prioritised the review of the home, motor, life and business insurance content. By April 2016, the review had identified a number of misleading and deceptive statements in relation to the home, motor, life and boat insurance pages of the website. These included 14 such statements in relation to home insurance, four in relation to car insurance, three in relation to life insurance, and one in relation to boat insurance. Mr Winter accepted that these statements may have misled consumers and were contrary to financial services laws. In May 2016 Allianz decided not to report the incorrect and misleading content to ASIC.

Mr Winter was present at the meeting of the committee that made that decision but could not recall whether the committee considered the number or frequency of similar previous breaches, as required by section 912D of the Corporations Act. He conceded that the decision not to report the matter to ASIC was the wrong decision. He also conceded that there were clear problems known to the committee at the time of this meeting with the way the DCSO process was operating and being applied within Allianz. It took until November 2016 for Allianz to complete the review of the travel insurance content and prepare an issues list and proposed rectification plan.

Mr Winter told the Commission that the review took so long because Allianz had failed to allocate the appropriate resources and priority to the issue. The issues list identified numerous misleading and deceptive statements about travel insurance products on Allianz's website. Having compiled the issues list, Allianz provided it to AWP for review. Mr Winter conceded that this was an unnecessary step and told the Commission that Allianz could have just fixed the issues itself. AWP did not return the issues list to Allianz with its comments until May 2018, some 18 months later. Mr Winter said that the issues list had been the topic of discussion at 14 meetings between Allianz and AWP, between July 2017 and May 2018, and conceded that Allianz had been aware of the failure to rectify these issues. He accepted that Allianz had not treated the matter as urgent.

During the period between December 2015 and May 2018, the misleading and deceptive statements identified in the issues list remained on the website. During that period, Allianz did not report the matter to ASIC, or even consider taking down the relevant parts of the website. Mr Winter conceded that neither Allianz nor AWP acted with any sense of urgency to fix the issue, or appreciated the seriousness of the issue, and that every day the website was accessible to the public, Allianz was contravening financial services laws. Mr Winter accepted that in this instance, it was more important to Allianz to protect the bottom line than to stop misleading its customers.

The Commission heard that at this point, given the amount of time that had passed, Allianz decided to engage an external law firm to conduct another review of the web pages and purchase paths. That review identified 39 incorrect or misleading statements on the travel insurance pages of the website, and found that many of those statements had been on the website since 2012. In June this year, Allianz reported the matter to ASIC. On 12 June, Allianz told ASIC that the misleading and deceptive content had been on the website since December 2015. Although Allianz found out on 21 June 2018 that some of the misleading and deceptive statements had been on the website since July 2012, it did not inform ASIC of this fact until 7 September in response to a compulsory notice issued by ASIC.

Allianz took down the travel insurance pages of its website on 6 June 2018 and disabled the direct purchase path on 12 June 2018. Although Allianz was aware by 14 June that there were also misleading and deceptive content in the purchase path for its partner websites, Mr Winter decided not to take down the purchase paths for those websites. During the period from December 2015 to June 2018 Allianz issued more than two million travel insurance policies. Mr Winter was not able to say how many Allianz customers were affected by the misleading and deceptive content on Allianz's website.

Ms Callahan gave evidence about issues relating to Allianz's compliance processes, governance and culture, both in connection with the misleading and deceptive content on the website, and more generally. We will return to her evidence in addressing the open findings about the causes of the misconduct and conduct falling below community standards and expectations that are available in this case study.

One of the matters about which Ms Callahan gave evidence was Allianz's breach reporting systems. In May this year, Allianz introduced a new breach review committee. Allianz also began reviewing all open compliance incidents and reassessing them to determine whether they were reportable to ASIC. As a result of that process, in 2018 Allianz has reported seven significant breaches to ASIC. Ms Callahan said that apart from one year where Allianz had reported four significant breaches, in other years Allianz reported either no or one breach to ASIC. Ms Callahan said that Allianz has now identified that it needs to look at all historical breaches to determine whether Allianz had an obligation to report them to ASIC.

This is because the corporate compliance department at Allianz could not assure itself that the section 912D reportability requirements had been applied to all prior breaches. Ms Callahan said that this task was underway but she was not able to assist the Commission in identifying the number of historical breaches that are to be assessed. We turn to the available findings of misconduct in relation to Allianz. First, it is open to find that Allianz may have engaged in conduct that was misleading or deceptive and therefore amounted to misconduct in respect of each of the 39 representations in relation to travel insurance, described in the table in paragraph 86 of the statement of Michael Winter, dated 24 August 2018; each of the 14 representations in relation to home insurance described in the table in the annexure to that statement; each of the four representations in relation to motor vehicle insurance

described in that annexure; each of the three representations in relation to life insurance described in that annexure; and the representation in relation to boat insurance described in that annexure.

Second, it's open to find that Allianz may have contravened its obligation in section 912D of the Corporations Act and, therefore, engaged in misconduct by failing to report any of this misleading and deceptive conduct to ASIC as a significant breach within 10 business days by failing to take into account each of the matters set out in section 912D(1)(b) of the Corporations Act when deciding in May 2016 not to report the misleading and deceptive conduct to ASIC as a significant breach; by failing to report at least three of the other matters identified in the compliance update, dated July 2018, which is exhibit 6.299 to ASIC as significant breaches within 10 business days; and until the introduction of the breach review committee in May 2018, failing to have in place an adequate system to assess whether compliance incidents should be reported to ASIC as significant breaches.

Third, it is also open to find that Allianz may have engaged in misconduct by failing to comply with the requirement set out in prudential standard CPS 220 that Allianz have a designated compliance function that assists senior management in effectively managing compliance risks and is adequately staffed by appropriately trained and competent persons who have sufficient authority to perform their role effectively. Ms Callahan acknowledged that Allianz had not complied with this requirement. It is open to find that Allianz engaged in conduct that fell below community standards and expectations in the following ways: first, by not taking steps to remove the relevant pages of its website from public view while it investigated the extent of the misleading representations and determined how to fix them.

Second, by not being frank and open in its dealings with ASIC after it reported the misleading and deceptive travel insurance content to ASIC as a significant breach. In particular, by failing to inform ASIC of all of the similar breaches that had been identified, and having told ASIC on 12 June that the misleading and deceptive representations had first appeared on the website in December 2015, and having learned on 21 June that, in fact, many of the representations had first appeared in July 2012, failing to take any steps to correct its earlier representation until it provided a response to a compulsory notice on 7 September.

Third, by seeking to manipulate the content of an independent report commissioned by Allianz for the purpose of satisfying the requirements of CPS220 and which Allianz intended to provide to APRA. Ms Callahan conceded that based on her review of the email correspondence, it appeared that Allianz was attempting to manipulate the content of EYs independent report to try and get one of the ratings to change. It is open to find that this misconduct and conduct falling below community standards and expectations is attributable to at least four matters. The first is that for many years, Allianz had inadequate processes for monitoring the content of its own website and the websites of other companies that distributed its products.

Ms Callahan accepted that for many years, Allianz had inadequate processes in this respect. Both Ms Callahan and Mr Winter accepted that these issues contributed to the misleading and deceptive content remaining on the travel insurance pages of the website. Both Mr Winter and Ms Callahan accepted that issues with Allianz's DCSO process were identified in 2015. Despite this, in 2018, Allianz continued to have problems with its DCSO process. This was evidenced by another compliance breach identified in May this year which related to hyperlinks on a number of financial institution partner websites that were linked to the incorrect product disclosure statement.

An internal audit report prepared in August this year considered the DCSO process and found that the execution of the DCSO process is ineffective in ensuring adherence with legislative and internal requirements. Ms Callahan agreed with the findings of the report. The second matter is that for many years Allianz has had inadequate processes for monitoring and closing compliance incidents once they have been identified. Ms Callahan accepted that one of the causes of the misleading and deceptive content remaining on the travel insurance pages of the website was that there was insufficient oversight of the incident by corporate compliance.

A report to Allianz's risk committee in September 2016 recorded that remediation of the incident was substantially complete, and that all material errors on the website had been corrected, even though at that time the review of the travel insurance content on the website was still ongoing. Ms Callahan accepted that for many years Allianz's processes for identifying and monitoring compliance incidents were not sufficient to deliver the compliance results that one would want. An internal audit report from September 2015 found that significant improvement was required in measuring, monitoring and reporting within Allianz, and that there was no standard process to monitor and confirm that remedial actions had been implemented prior to closing reported incidents.

Despite the critical findings made in the report, the issue was listed as a low priority. Ms Callahan accepted that the audit report indicated that at the time Allianz was not taking its compliance obligations seriously, particularly in relation to the remedial action necessary after a compliance incident had been identified. Monitoring and supervision remains an issue at Allianz. An internal audit report prepared in August found that the compliance plans for laws, legislation and regulations impacting product and related processes are out of date and compliance monitoring is not taking place. Ms Callahan agreed with this finding. She said that Allianz was only at the start of addressing it.

The third matter is that until July this year, Allianz had inadequate oversight of AWP. Ms Callahan accepted that this was one of the causes of the misleading and deceptive content remaining on the travel insurance pages of the website. She observed that in 2016, an internal audit identified that Allianz's monitoring and control of its underwriting agencies was not sufficient. Although steps were taken in 2017 to address those issues across other underwriting agencies, those steps did not

include AWP. Allianz's monitoring of AWP did not improve until Allianz and AWP entered into a new underwriting agreement in July this year.

Ms Callahan accepted that under the previous underwriting agreement with AWP Allianz's oversight of AWP was inadequate. She accepted that while that underwriting agreement was in place, there were issues with AWPs compliance with its legal obligations. She accepted that AWP regarded compliance as a lower priority than other aspects of its business and that AWPs conduct created a risk that Allianz would breach its own legal obligations. Ms Callahan said that Allianz's systems for monitoring and supervising third party distributors was a broader problem which went beyond AWP. She admitted that as well as underwriting agencies, Allianz also had problems supervising car dealers and the financial institutions selling Allianz products.

Ms Callahan gave evidence that Allianz was currently investing more in its compliance systems to improve its supervision and monitoring of third parties, but she admitted that she has not provided final sign-off as to whether the manual controls put in place are effective. The fourth matter is that Allianz's culture is one that does not consider risk and compliance as a priority, and which adopts a defensive attitude when challenged about its practices. Ms Callahan accepted that one of the causes of the misleading and deceptive content remaining on the travel insurance pages of the website was that Allianz had an insufficient appreciation of the consequences for customers of this information being on the website. She also said that this incident was an example of an instance where Allianz's management had not considered compliance to be a priority.

Ms Callahan said that prior to her time as chief risk officer, Allianz had focused on technical or legal compliance, rather than encouraging a culture that really looked to improve Allianz's processes. She accepted that in the past, Allianz had not devoted adequate resources to compliance. Ms Callahan gave evidence that Allianz only reached the point at which it was fully resourced for its compliance function, one week before she gave evidence. Ms Callahan also gave evidence about the way that Allianz reacted to external reports from Ernst & Young and Deloitte about the adequacy of its risk and compliance arrangements.

The Commission heard that Allianz commissioned EY to prepare two reports, a risk report and a compliance report. Allianz commissioned the risk report for the purpose of complying with CPS220 and providing the report to APRA. After receiving draft copies of both reports, Allianz provided extensive feedback to EY in an attempt to improve the ratings given by EY in the reports. Ms Callahan accepted that this was not appropriate and that Allianz was trying to influence and alter the content of a report that it was required to produce under CPS220. EY changed the ratings in the compliance report but did not change the ratings in the risk report.

In June 2018, Ms Callahan commissioned Deloitte to prepare a report addressing the compliance incidents that Allianz had recently reported to ASIC. On receiving a highly critical draft report, Ms Callahan's reaction was to ask Deloitte to retract the

report. She agreed that this was not her finest moment and that this matter would be relevant to the risk governance written assessment that Allianz is currently preparing for submission to APRA in November. Commissioner, we want to turn to the next case study, which involves IAG. Mr Costello will address you on that case study.

THE COMMISSIONER: Yes.

MR COSTELLO: Commissioner, this case study concerned the add-on insurance products of Swann Insurance Australia Proprietary Limited, a subsidiary of Insurance Australia Group Limited which I will refer to as IAG. The Commission heard evidence from Mr Benjamin Bessell, the executive general manager, business distribution and group executive within the Australia division at IAG. Mr Bessell described the relationship between IAG and Swann as a devolved business model where Swann was effectively a standalone business. However, the person with ultimate responsibility for Swann was the head of the IAG division in which Swann sat, and since 2013 the CEO of IAG had been a director of Swann.

From 2008 to 2018, Swann sold comprehensive motor insurance and eight add-on insurance products, some of which were variations on or replacements of other products. Swann sold these products through its authorised representatives which included car and motorcycle dealers. In this 10 year period, Swann sold approximately 846,000 policies through car dealerships, received approximately $1.07 billion in premiums, and paid out about 10 per cent of that amount in claims under its add-on insurance policies. At its peak, Swann had approximately 3000 authorised representatives selling its products throughout Australia. Add-on insurance was a very significant part of Swann's business. In the financial year ending 2014, auto dealers delivered 71 per cent of Swann's gross written premiums.

Swann sold three types of consumer credit insurance: loan protection insurance, walk away insurance, and protection plus insurance. Swann also sold guaranteed asset protection or gap insurance, purchase price protection insurance which was similar to gap insurance, mechanical breakdown insurance and tyre and rim insurance. Swann's add-on insurance products were added on to the purchase of a car or motorcycle which generally occurred at the dealership. Mr Bessell acknowledged that add-on insurance products were sold to customers rather than being bought by customers and that in many circumstances the customer's decision about whether or not to buy an add-on insurance product came after a customer had chosen the vehicle and agreed the terms for finance.

Swann generally engaged its authorised representatives through authorised representative agreements. Under those agreements, representatives were authorised to provide general advice but not personal advice, and to deal in financial products. The agreements required the authorised representatives to, among other things, comply with applicable laws and policies, and any reasonable requirements or directions given by Swann. The agreements also provided Swann with the right to inspect the authorised representative's place of business and to conduct audits. Mr Bessell was not aware whether these clauses had been invoked but said that Swann

regularly obtained information about and visited the premises of its authorised representatives.

Under the agreements, representatives were remunerated exclusively by commission with different rates of commission attaching to different products. The agreements usually provided for more than one commission rate for gap insurance, the commission increased when the customer was sold a higher level of cover. Swann also entered into incentive scheme agreements with some authorised representatives. Mr Bessell's evidence was that these agreements were offered to dealers who Swann thought could grow the business. These agreements were not uncommon in the market and were also used to ensure that Swann remained competitive.

The amounts paid under the incentive scheme agreements were paid in addition to the amounts paid under the authorised representative agreement. Payments under the incentive scheme agreements were calculated based on the gross written premiums for the financial year, and a factor called group product mix, which was calculated by reference to the mix of different add-on products sold. The rationale behind the group product mix factor was to incentivise dealers to sell a variety of add-on products to a single customer. Under the incentive scheme agreements, authorised representatives could also be paid a performance bonus commission and a product mix bonus which was based on the gross written premiums of consumer credit insurance and tyre and rim insurance, because tyre and rim insurance was more difficult to sell.

Mr Bessell told the Commission that the potential breach by Swann of section 145 of the National Credit Code referred to in IAGs submission to the Commission of 29 June 2018 was likely to have been caused by the product mix bonus offered to some authorised representatives. Another way in which Swann incentivised sales was through the Swann ignition incentives program. That program had been running since 2004 and was designed to incentivise employees of authorised representatives by providing them with points when they sold add-on insurance products. One point was equal to $1. The points were redeemable online and could be exchanged for particular products.

At least between 2014 and 2016 Swann also ran short-term bonus programs called super-charged ignition which allowed employees to accrue more points when they sold a bundle of three or four products in the same transaction. Mr Bessell said that Swann was not the only market participant which provided incentives to employees of car dealers. Mr Bessell accepted that the point of Swann's remuneration and incentive arrangements was to incentivise sales. He accepted that on occasion these incentive programs incentivised inappropriate sales practices and that Swann's authorised representatives sold products that were not appropriate to some customers.

Mr Bessell accepted that Swann was heavily reliant on its dealers to maintain market share. A risk report from October 2014 recorded that Swann considered that one of its risks was competitor attacks to its dealer market resulting in reduced market share. One control identified to protect against this risk was the commission and

incentive arrangements between Swann and its authorised representatives. That risk report did not record any explicit consideration of Swann's customers. Mr Bessell agreed that this was at least partly because Swann viewed the dealers as its customers. Mr Bessell was aware that at all relevant times Swann was obliged to have in place adequate arrangements for the management of conflicts of interest that may arise from the sale of its products.

The arrangements that Swann had in place for that purpose were a training program and an electronic questionnaire for authorised representatives, along with the ability for employees to notify Swann of issues through a compliance mail box. Between March 2013 and January 2017, Swann maintained a light touch approach to the monitoring of authorised representatives, due in part to the prioritisation of scarce resources. Mr Bessell acknowledged that as at January 2017 Swann had not responded to the changing level of risk that had arisen from the increased scrutiny of add-on products. At that time, Swann had no oversight of any issues that may be occurring because Swann's authorised representatives were not actively recording potential breaches.

In addition, Swann did not undertake any monitoring to ensure that refresher training was completed, nor conduct any face-to-face audits. Swann's electronic questionnaire was limited in the detail that it captured. Mr Bessell accepted that at least between 2013 and January 2017 Swann did not have in place adequate risk management systems, particularly in the light of the failure to authorise – for authorised representatives to actively report breaches. Mr Bessell agreed that if he were running the business today he would not be comfortable with the level of oversight that had been in place as at January 2017. He agreed that this level of oversight would not have been considered appropriate in any year since 2013.

Turning to IAGs engagement with ASIC, Mr Bessell accepted that IAG had been aware since late 2013 that ASIC had concerns with add-on insurance products and that IAG had understood since 2015 that ASICs concerns related to product design and sales practices. However, Swann did not take any proactive steps to investigate the products or sales techniques that were of concern. By June 2015 IAG had begun engaging with ASIC through the Insurance Council of Australia. Mr Bessell accepted that at the time, the industry had generally acknowledged that commission structures were either inappropriate or not financially competitive for product providers, but that no one was prepared to move first by reducing commissions.

Mr Bessell said that in December 2018 Swann became aware that ASIC considered the sale of Swann's products through motor dealers may be contravening regulatory requirements. Despite this, in May 2016, Swann's primary concern about product design risks was still profit related and there was no consideration of whether the design of Swann's products adversely affected consumers. In addition, Swann continued with its remuneration incentive programs until at least June 2016. Mr Bessell accepted that Swann's maintenance of its market share would not have been possible had it unilaterally decreased commissions.

By June 2016, IAG was aware that it had limited oversight of car dealers' sales practices in relation to add-on insurance and it had not reviewed Swann's add-on insurance products to assess whether they provided sufficient benefit to customers. Mr Bessell attributed Swann's failure to take any proactive steps to investigate issues within its business to Swann's preference for an industry-wide approach to ASICs concerns. Mr Bessell agreed that there had been nothing swapping Swann from participating in an industry-wide approach while also reviewing its business to ascertain whether there were any problems. From August 2016, IAG commenced negotiations with ASIC in relation to Swann's add-on insurance products.

On 19 December 2017 ASIC announced that IAG would enter a remediation program. As at the date of Mr Bessell's statement, it was estimated that just over 64,000 customers would be remediated $37.1 million. Mr Bessell told the Commission that Swann was about halfway through the remediation program, and expected to complete the program by 31 January 2019. Swann ceased distributing its products through car dealers in August 2016 and through motorcycle dealers in October 2017. Swann no longer sells add-on insurance products but continues to sell comprehensive motorcycle insurance. In December 2017, Swann developed product design principles applicable to its products. Mr Bessell's evidence was that if Swann's add-on insurance products were sold today, they would not meet the standards of these principles.

Turning to questions about the value of add-on insurance more generally, Mr Bessell accepted that consumers were sold products that were of questionable or little value to them, and that the products could have been better explained by the dealers. Mr Bessell agreed that the number and complexity of the products presented to the consumer and the various options within the products made it difficult for consumers to have a proper

understanding of the products. Mr Bessell acknowledged that there were two important features of the regulatory regime which facilitated the sale of add-on insurance. First, the point of sale exception in the National Consumer Credit Protection Regulations relevant to consumer credit insurance products, and second, the ability for Australian financial service licensees to authorise representatives to provide general advice. Mr Bessell acknowledged that some industry participants considered it inappropriate for authorised representatives to determine whether an add-on insurance policy was suitable for the customer in circumstances where authorised representatives were authorised to provide general advice only.

When asked about the proposal that add-on insurance should be only sold via a deferred sales model, Mr Bessell said that he would support such an approach. On the evidence, it is open to the Commissioner to find that Swann may have engaged in misconduct in the following ways: first, in circumstances where Swann undertook no meaningful review of its products to determine whether they provided any value to customers, continued to authorise the sale of those products after becoming aware that ASIC held concerns about their product design and sales practices, established and maintained arrangements that incentivised dealers to sell as many add-on

products to consumers as possible regardless of the suitability or value to consumers, and failed to establish systems to oversee and monitor the sales practices of its authorised representatives.

Swann may have breached section 912A, subsection (1)(a) of the Corporations Act by failing to do all things necessary to ensure that the financial services covered by its licence were provided efficiently, honestly and fairly. Second, by failing to establish systems to oversee and monitor the sales practices of Swann's authorised representatives, Swann may have breached section 912A, subsection (1)(ca) of the Corporations Act by failing to take reasonable steps to ensure that its representatives complied with financial services law. Third, by failing to have in place adequate arrangements for the management of any conflicts of interest that arose through incentivising sales of the add-on insurance products, Swann may have breached section 912A, subsection (1)(aa) of the Corporations Act.

Fourth, Swann may have breached section 145 of the National Credit Code by authorising payments to 34 authorised representatives that may have exceeded the 20 per cent cap on commissions imposed under that section. On the evidence, it is also open to the Commissioner to find that Swann may have engaged in conduct that fell below community standards and expectations in the following ways: first, by failing to take meaningful steps to ensure that its authorised representatives only sold add-on insurance products in circumstances where the product would be of value to the customer. Second, by designing and implementing remuneration and incentive systems that promoted conflicts of interest and unfair sales practices.

Third, by failing to promote sales practices that focused on delivering value to consumers and that met customer needs and expectations. Fourth, by failing to investigate the appropriateness of its add-on insurance products or the sales practices of its authorised representatives in a timely manner. Fifth, by failing to redesign the add-on insurance products and the remuneration and incentive arrangements after first becoming aware of ASICs concerns in late 2013. It is open to the Commissioner to find that this misconduct and conduct falling below community standards and expectations can be attributed to the remuneration and incentive arrangements Swann put in place for its authorised representatives.

Those arrangements were, by design, focused solely on sales volume. The arrangements did not incentivise or promote appropriate sales. Indeed, they encouraged the inappropriate conduct that has led to the remediation program. Further, it is open to the Commissioner to find that Swann's misconduct and conduct falling below community standards and expectations is attributable to Swann's culture in at least two respects. First, that culture placed the pursuit of profit and the maintenance of market share above the interest of its customers by designing its remuneration and incentive programs in a way that promoted inappropriate sales.

Second, Swann's culture prioritised the interests of motor dealers over the interests of consumers. Mr Bessell acknowledged that Swann viewed the motor dealers, not the ultimate customer, as its customers. In its initial submission to the Commission,

IAG acknowledged that Swann's focus on motor dealers was a significant contributor to the conduct that was now the subject of the remediation program. It is also open to the Commission to find that a further cause was Swann's governance practices which did not properly supervise or audit the activities of its authorised representatives.

And, finally, it is open to the Commissioner to find that the conduct can be attributed to IAGs governance practices which due to the devolved business model failed to appropriately supervise and monitor the operations of its wholly owned subsidiary, Swann. Commissioner, Ms Orr will now say something about the natural disaster case studies.

THE COMMISSIONER: Yes.

MS ORR: Commissioner, the remaining case studies that we wish to deal with in closing concerned the conduct of two insurers, Youi and AAI, in responding to claims made under home insurance policies following natural disasters and severe weather events. These case studies involved evidence from three consumers about the handling of their claims. The evidence was factually complex and we formed the view that it would be beneficial to provide our closing submissions on these case studies in writing. Could I tender those submissions, Commissioner. The document ID is RCD.0027.0001.0001.

THE COMMISSIONER: Written closing submissions about natural disaster case studies, RCD.0027.0001.0001, exhibit 6.243.

EXHIBIT #6.243 WRITTEN CLOSING SUBMISSIONS ABOUT NATURAL DISASTER CASE STUDIES (RCD.0027.0001.0001)

MS ORR: And Commissioner, as I indicated at the outset, we intend to publish a further document containing the questions that arise from the case studies and the other evidence tendered in the hearings for submissions more broadly. And as I indicated, we will publish that on Friday next week. Our submissions in relation to the natural disaster case studies, we understand, will be made available on the website by 6 pm tonight.

THE COMMISSIONER: Yes. That, I think, is that, is it not, Ms Orr?

MS ORR: Yes. But for the timelines that you wish to fix, Commissioner, for responses, both to the closing submissions that we have delivered today and which we will deliver on the website this evening, and in relation to the questions that we will publish next Friday.

THE COMMISSIONER: Well, as to case study submissions, the position will be substantially as it was in past rounds. That is to say, those who are the immediate

parties to particular case studies may make submissions in writing not exceeding 20 pages. And they may do that by no later than 4 pm on Monday, 1 October. I fix Monday, 1 October, in light of the fact that Friday, 28 September is a public holiday in this state, though not elsewhere, I think. Those submissions should be submitted to the solicitor assisting the Commission in the usual way. And at the risk of repeating something that I've said, I think more than once before, it's my expectation that the documents referred to in the submissions about case studies would be restricted to those documents that have been tendered in the course of hearings.

If for some reason a party sought to refer to a document that was not tendered, that party would need to apply to tender the document, would need to provide written submissions as to why the document was not tendered during the course of the hearing. And if the application were made and granted and the document was then tendered, it would be marked as an exhibit and be published in the ordinary way. Now, you've indicated, Ms Orr, that by midday on that holiday Friday, 28 September, you intend there should be published a document setting out the more general questions that arise from the case studies, and the other evidence that has been heard.

Any person who wants to provide submissions about those questions, the general questions, will have until midday on Friday, 26 October – Friday, 26 October, midday, to do that, and as in relation to the fifth round of hearings, I would say that the submissions are not to exceed 50 pages, but that is the outer limit. The submissions are to be as concise as they can reasonably be made. We all know the aphorism about writing a long letter because I didn't have time to write a short letter, well, that applies to these submissions. And those submissions should be lodged with the Commission through the Commission's website. That, I think, is that, is it not, Ms Orr?

MS ORR: Yes, Commissioner.

THE COMMISSIONER: Thank you. Well, we will adjourn the Commission until 19 November next in Sydney.

MATTER ADJOURNED at 4.30 pm UNTIL MONDAY, 19 NOVEMBER 2018

Index of Witness Events

Index of Exhibits and MFIs

EXHIBIT #6.412 SUPPLEMENTARY WITNESS STATEMENT OF DAVID KRAWITZ DATED 20/09/2018	P-6457
EXHIBIT #6.413 STATEMENT OF ANDREW MAIR DATED 19/09/2018	P-6458
EXHIBIT #6.414 STATEMENT OF MICHAEL WINTER DATED 19/09/2018	P-6458
EXHIBIT #6.415 STATEMENT OF MARK MILLINER DATED 19/09/2018	P-6458
EXHIBIT #6.416 STATEMENT OF MILES SOWDEN DATED 19/09/2018	P-6458
EXHIBIT #6.417 STATEMENT OF GARETH RUSSELL DATED 20/09/2018	P-6458
EXHIBIT #6.418 STATEMENT OF CHRISTOPHER KILLOURHY DATED 19/09/2018	P-6459
EXHIBIT #6.419 STATEMENT OF DAVID ROBERTS DATED 19/09/2018	P-6459
EXHIBIT #6.420 STATEMENT OF SUSAN HOUGHTON DATED 19/09/2018	P-6459
EXHIBIT #6.421 STATEMENT OF BERT BAKKER DATED 19/09/2018	P-6459
EXHIBIT #6.422 STATEMENT OF PAUL HOWARD DATED 20/09/2018 (WIT.0001.0171.0001)	P-6489
EXHIBIT #6.243 WRITTEN CLOSING SUBMISSIONS ABOUT NATURAL DISASTER CASE STUDIES (RCD.0027.0001.0001)	P-6505