
# Denied

**Levelling the playing field to make insurance fair**

consumer action law centre

February 2018

## ACKNOWLEDGEMENTS

Consumer Action would like to thank the many people who assisted in the production of this report. In particular, we thank the participants of our insurance suitability experts forum held on 4 April 2017 for their valuable contributions.

Thank you to CHOICE and WestJustice for their input into this report.

Our sincere thanks to the people who have shared their experiences as case studies in this report.

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The views expressed in this report are those of Consumer Action and do not necessarily reflect the views of anyone else involved in its preparation.

All effort has been made to de-identify the people and businesses involved in the case studies in this report. All names have been changed, unless otherwise indicated. All case studies have been included with the consent of the people concerned.

To the best of our knowledge, the information in this report is current to 21 December 2017.



Consumer Action Law Centre is a campaign-focused consumer advocacy organisation based in Melbourne, Australia.

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# Executive summary

There is a big 'fairness' problem in insurance.

People often make insurance claims when they are at a low ebb. They can face shocking outcomes and no appropriate recourse under current laws. This report shows how extending the unfair contract terms regime to insurance would provide major benefits for Australians when they are buying or claiming on their insurance.

## 1. What is the status quo?

Insurers have special treatment under the law. Unlike virtually every other industry operating in consumer markets, they are not subject to an unfair contract terms regime.

Current consumer protections in insurance include:

- the duty of utmost good faith for insurers and their customers, which is part of every insurance contract but provides little practical benefit to individuals,
- anti-discrimination laws, which have limited application to insurance,
- restrictions on insurers denying claims based on an insured person's actions,
- limits on insured people's duties to insurers, and
- disclosure obligations on insurers.

This report details consumers' experiences with insurance claims which have had 'unfair' and harsh outcomes. These cases show that the current laws are inadequate in protecting people at some of the most vulnerable times in their lives.

## 2. What would fair insurance laws look like?

Unfair contract terms laws for standard form consumer contracts were introduced in federal law in 2010. These laws prohibit contract terms which would cause a significant imbalance in the parties' rights and obligations, are not reasonably necessary to protect a trader's legitimate business interests, and would cause financial or other detriment to the customer.

Industries such as telecommunications retailers and the big four banks have worked collaboratively to make their contracts, including small business contracts, fairer for their customers.

This report describes how an effective unfair contract terms regime should be modelled for insurance. A robust regime would:

- require all terms to pass the fairness test, with minimal carve outs for elements such as the main subject-matter of the contract,
- drive insurers to proactively avoid detriment, disputes and claim shock for their customers,
- provide accessible and effective remedies,
- apply to all types of consumer and small business insurance contracts, and
- be backed by evidence and regulator guidance.

**"If insurers stick to the same rules as everyone else, it will even the playing field and give Australians a better chance of a fair outcome."**

## 3. The benefits of fair insurance laws

A fair insurance contracts regime would have significant benefits for insurers and the people who buy their products. The advantages of this type of regime include:

- preventing disputes, rather than seeking to rectify them,
- increasing consumer trust and confidence in the insurance industry,
- requiring insurers to play by the same rules,
- improving competition, and
- providing for more efficient regulation.

A fair contracts regime for insurance is overdue. If insurers stick to the same rules as everyone else, it will even the playing field and give Australians a better chance of a fair outcome when they need it most.

# 1. What is the status quo?

## 1.1 A potted history of 'fairness' in insurance

In Australia today, protections for people with insurance are weak and hard to access.

While unfair contract terms are prohibited in virtually all consumer contracts in Australia, insurers enjoy an exemption from these laws. This is because the *Insurance Contracts Act 1984* (Cth) (**Insurance Contracts Act**) states that a person cannot claim relief on the grounds that a contract is harsh, oppressive, unconscionable, unjust, unfair or inequitable under any other Act.[1]

Instead, the law protects people who are buying or claiming on insurance through imposing several key duties on insurers, primarily the duty of utmost good faith, and limited application of anti-discrimination laws (see the discussion at pp 6-16, para 1.2).

**"…insurers have unhealthy and unbalanced relationships with their customers. Insurers unilaterally set the terms of their policies, and can significantly disadvantage their customers"**

This has largely been accepted as the status quo over recent decades. However, it has become clear that these laws are grossly inadequate in protecting people at some of the most vulnerable times in their lives.

The tide began to change in 2013, when a Bill to introduce an unfair contract terms regime for general insurance was introduced to Federal Parliament.[2] The Bill did not pass both chambers before the change of government, and the opportunity to strengthen insurance consumer protections was lost.

However, in recent years, multiple industry scandals have led to broad recognition that the special treatment for insurers must end. In 2016, the CommInsure scandal demonstrated the devastating impacts of outdated policy definitions and harsh exclusions.[3] The Australian Securities and Investments Commission (**ASIC**) has exposed the widespread rip-offs in the add-on insurance market.[4] Insurers have agreed to repay their customers to the tune of more than $66 million for selling worthless add-on insurance to date, with more refunds expected.[5]

[1] *Insurance Contracts Act* section 15.
[2] *Insurance Contracts (Unfair Contract Terms) Amendment Bill 2013 (*Cth).
[3] ABC, 'Money for Nothing', *Four Corners,* 7 March 2016.
[4] ASIC, *REP 470 Buying add-on insurance in car yards: Why it can be hard to say no*, 26 February 2017; REP 471 *The sale of life insurance through car dealers: Taking consumers for a ride*, 29 February 2016; *REP 492 A market that is failing consumers: The sale of add-on insurance through car dealers*, 12 September 2016.
[5] ASIC, 17-189MR *Virginia Surety to refund over $330,000 to add-on insurance customers*, 20 June 2017; 17-268MR *Commonwealth Bank to refund over $10 million for mis-sold consumer credit insurance*, 14 August 2017; 17-258MR *QBE refunds $15.9 million in add-on insurance premiums*, 2 August 2017; 17-446MR *Swann Insurance refunds $39 million in add-on insurance premiums*, 19 December 2017; 17-457MR *Latitude Insurance refunds almost $1.1 million for poor consumer credit insurance sales and claims handling*, 21 December 2017.

What has emerged is that insurers have unhealthy and unbalanced relationships with their customers. Insurers unilaterally set the terms of their policies, and can significantly disadvantage their customers. The imbalance of power and resources, and an acute 'information asymmetry', does little to assure people buying insurance policies that they are getting a fair and balanced deal.

2017 saw increasing support for an unfair contract terms regime for insurance. In March, the Australian Consumer Law (**ACL**) Review recommended that unfair contract terms laws apply to insurance contracts.[6] In August, the Senate Economics References Committee's report on Australia's general insurance industry agreed.[7] The same month, the joint meeting of state, territory and federal Consumer Affairs Ministers confirmed the ACL Review recommendation, directing a regulatory impact assessment of the proposal 'to inform future decision making'.[8]

In December, the Minister for Revenue and Financial Services formally confirmed the Government's intention to extend the unfair contract terms regime to insurance.[9]

In the face of this growing consensus, the question remains: what is the fairness problem facing Australians under our insurance laws?

## 1.2 Consumer protections are not robust

There are big challenges for people trying to assert the rights they have against insurers. The current protections do not necessarily assist in common disputes, and they are not accessible for many people. As noted above, the law seeks to protect people in their dealings with insurers through:

- a duty of utmost good faith (**DUGF**), which applies to both insurers and their customers,[10]
- anti-discrimination laws,[11]
- preventing an insurer from denying a claim because of something the customer did which did not cause or contribute to their loss,[12]
- limits on the customer's disclosure obligations and liability for mis-representation,[13] and
- disclosure obligations on insurers.[14]

### 1.2.1 The duty of utmost good faith

Both insurers and their customers owe each other a duty of utmost good faith (**DUGF**) in all of their dealings with each other—for example, they cannot rely on a term in an insurance contract if to do so would be to fail to act with the utmost good faith.[15] This is an implied term in every insurance contract.

[6] *Australian Consumer Law Review: Final Report*, March 2017, Proposal 10, page 6.
[7] Senate Economics References Committee, *Australia's general insurance industry: sapping consumers of the will to compare*, 10 August 2017, Recommendation 11, page 65.
[8] Legislative and Governance Forum on Consumer Affairs, *Joint Communique: Meeting of Ministers for Consumer Affairs—Attachment B: Review of the Australian Consumer Law, 2017 - Proposals considered by Ministers, item 3*. Melbourne, 31 August 2017.
[9] The Hon Kelly O'Dwyer MP, *Media Release: Government responds to Northern Australia Insurance Premiums Taskforce and General Insurance Senate Inquiry*, 18 December 2017.
[10] *Insurance Contracts Act* Part II.
[11] Including the *Disability Discrimination Act 1992* (Cth); *Age Discrimination Act 2004* (Cth).
[12] *Insurance Contracts Act* section 54.
[13] *Insurance Contracts Act* Part IV.
[14] *Corporations Act 2001* (Cth) Part 7.9 Division 2.
[15] *Insurance Contracts Act* section 14.

# “The duty of utmost good faith is about candour, not community expectations of fairness–it doesn’t go to the heart of the power imbalance between insurers and their customers. It does nothing to assure someone that they’re getting a fair deal when they buy an insurance policy.”

## Gerard Brody
## CEO, Consumer Action Law Centre

In 1982, the Australian Law Reform Commission (**ALRC**) recommended a raft of reforms which led to the Insurance Contracts Act. The ALRC stated clearly that the original intention of the duty of utmost good faith was to prevent disputes, and to avoid litigation:

> *[The duty] should provide sufficient inducement to insurers and their advisers to be careful in drafting their policies and to act fairly in relying on their strict terms… such a requirement would not have to be relied on frequently by the courts. It would give rise to less uncertainty than a general power of review.*

There is no statutory definition of the duty, but the Courts have held that the DUGF requires the person buying the policy to make full disclosures, and the insurer to comply with commercial standards of decency and fairness.[16] It does not require one party to prefer the interests of another party to its own interests.[17] A lack of honesty is not necessarily a breach or a prerequisite to a breach of the duty.[18]

### *How the duty of utmost good faith operates*

When we look at how the DUGF works for people buying insurance, considering how it was originally envisaged, the headline is—*it doesn’t*.

The duty can be enforced through the courts or through external dispute resolution (**EDR**) in the Financial Ombudsman Service (**FOS**).[19] Based on our review of recent FOS decisions, often the duty arises in disputes about how an insurer has handled a claim.[20]

Analysis by National Legal Aid has previously found that the DUGF is rarely invoked by people in disputes with their insurance company.[21]

Although very few people argue that an insurer has breached the duty of utmost good faith, Consumer Action has seen many situations where it appears an insurer has not met their duty when handling a claim. It appears to be very difficult for an individual to get a good result without engaging a lawyer.

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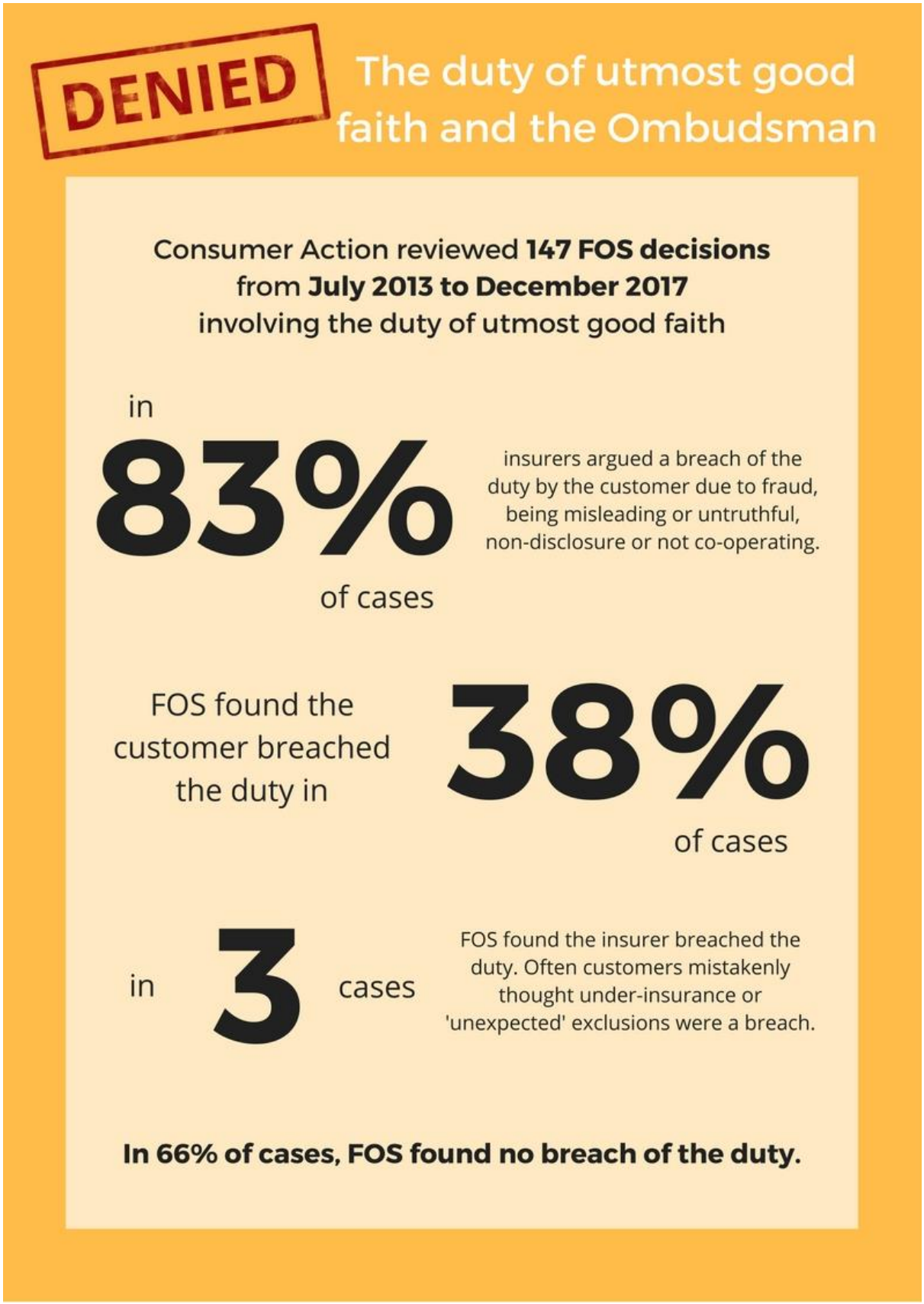
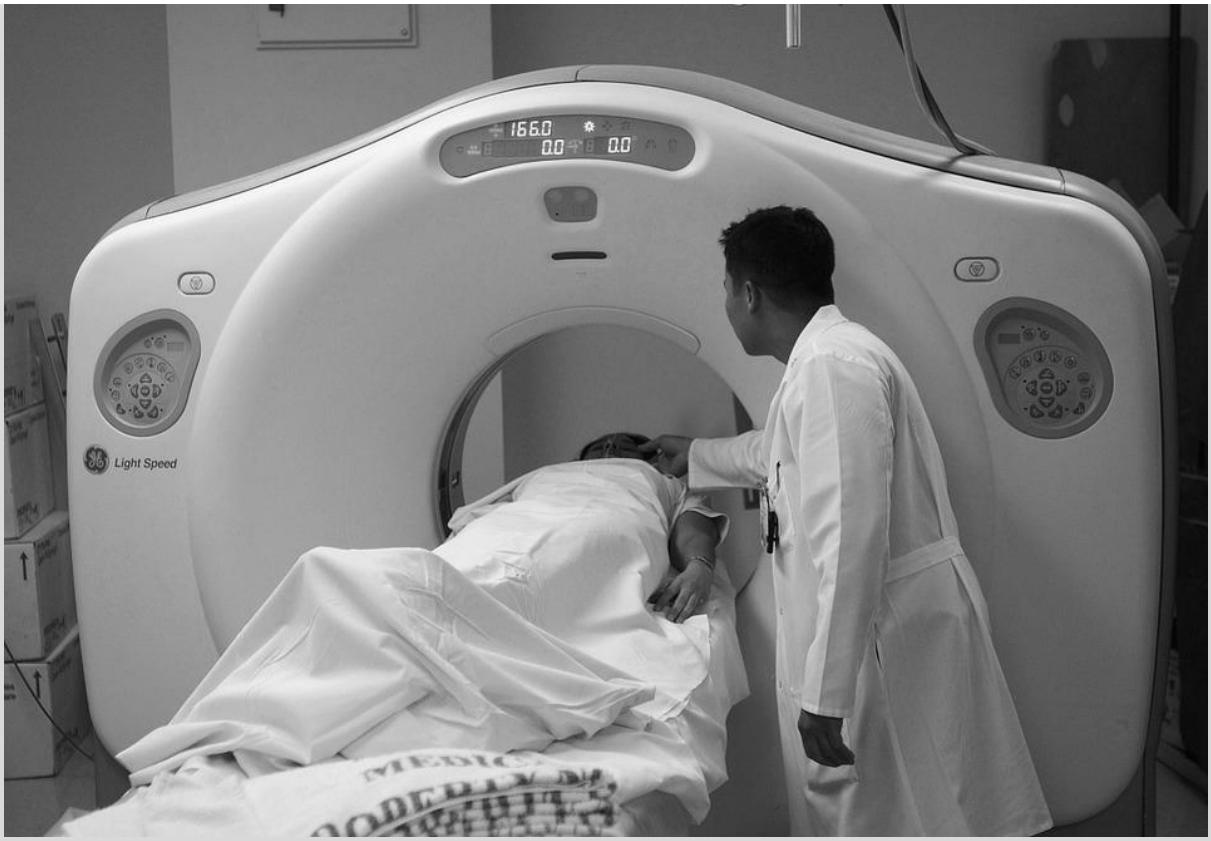
[16] *CGU Insurance Ltd v AMP Financial Planning Pty Ltd* [2007] 235 CLR 1.
[17] *Zurich Australian Insurance Ltd v Metals & Minerals Insurance Pty Ltd* (2009) 240 CLR 391.
[18] *Gutteridge v Cth* [1993] QSC 199.
[19] FOS will be replaced by the Australian Financial Conduct Authority as the EDR body for insurance disputes.
[20] Consumer Action reviewed FOS decisions considering the DUGF between July 2013 and December 2017.
[21] National Legal Aid, *Submission to Senate Economics Legislation Committee Inquiry into the Trade Practices Amendment (Australian Consumer Law) Bill*, 14 August 2009, p 4.


DENIED
The duty of utmost good faith and the Ombudsman
Consumer Action reviewed 147 FOS decisions from July 2013 to December 2017 involving the duty of utmost good faith
in 83% of cases
insurers argued a breach of the duty by the customer due to fraud, being misleading or untruthful, non-disclosure or not co-operating.
FOS found the customer breached the duty in 38% of cases
in 3 cases
FOS found the insurer breached the duty. Often customers mistakenly thought under-insurance or 'unexpected' exclusions were a breach.
In 66% of cases, FOS found no breach of the duty.




## Paul's story[22]

Paul's partner Suzie had been treated for cancer and was told that she was in remission. A scan showed no evidence of cancer. Paul and Suzie booked a holiday to celebrate. When they bought the insurance, the travel agent did not ask them anything about pre-existing medical conditions. Suzie was then diagnosed with cancer elsewhere, which her specialist doctor said was unexpected and unpredictable.

Suzie made a claim on her travel insurance policy for $5,300 in cancelled flights and other expenses. The insurer declined the claim on the basis that it was exacerbated by a pre-existing medical condition, which was excluded from the policy. Paul says the travel insurer who they bought the policy from did not explain the exclusion.

Suzie passed away several months later. Paul's dispute with the insurer continued for almost a year. The matter resolved when Consumer Action lodged a dispute with FOS on Paul's behalf. This did not occur until about 12 months after the claim was initially declined.

[22] See Karen Collier, 'Insurance companies rejecting thousands of claims each year', *Herald Sun*, 18 February 2017, http://www.heraldsun.com.au/news/insurance-companies-rejecting-thousands-ofclaims-each-year/news-story/230b9a15cdff4b0f96dc7c884f346b8e.

*Note: Stock image above.*

## Ian's story[23]

Ian had to leave work because of depression and anxiety. He saw his doctor five days after leaving his job, then made a disability claim on his Consumer Credit Insurance (**CCI**).

The insurer declined Ian's claim on the grounds that he did not show he was employed 'immediately' before falling sick—the insurer pointed to the short delay between Ian leaving work and seeing his doctor. The insurer also relied on an exclusion for disturbance of the mind due to drugs and/or alcohol, of which there was no evidence.

The insurer eventually paid Ian's claim after Consumer Action contacted the insurer on his behalf. Ian feels 'a lot of these insurance companies hide behind the legal jargon'. He is disappointed that he had to get legal representation to resolve his claim.

[23] See Lucy Cormack, 'Majority of consumers don't read product disclosure statement before buying insurance', *The Sydney Morning Herald*, 1 March 2017, http://www.smh.com.au/business/consumeraffairs/majority-of-consumers-dont-read-product-disclosure-statement-before-buying-insurance-20170228-gumuyz.html.

*Note: Stock image above.*

## Sally's story

Sally bought a 12-year-old car. The finance broker added warranty insurance to the loan without her knowledge. Sally encountered various issues with the car almost immediately. When she made a claim under the insurance policy, the insurer declined the claim saying the policy only covered certain components and the components that failed were not covered.

Sally paid approximately $1,300 for the warranty insurance. Together with interest under the loan, she would have paid approximately $2,300 over the course of the loan.

A review of the policy reveals exclusions for both pre-existing defects and wear and tear. It is difficult to imagine how a mechanical problem in a 12-year-old car would not be either pre-existing or the result of wear and tear.

Also, the covered components are very limited and the claim limits low. Most of the claim limits for covered components are limited to $800. The remaining covered components have a claim benefit limit of $2,000 (that is, less than what she ultimately paid). The insurance policy also has strict servicing requirements.

In both Ian's and Paul's cases, the insurers made offers only after their customers went through long disputes and eventually sought assistance from a lawyer.

It goes without saying that litigation is not an accessible, affordable or quick way for people to pursue their consumer rights. Much of the case law on the DUGF involves sophisticated commercial parties. Non-lawyers do not know the duty exists, let alone how to enforce it.[24] We are unaware of any significant case law involving an individual successfully pursuing an insurer. Litigation outcomes can also have a very limited effect on systemic problems that affect large groups of individuals. In this way it is ineffective and inefficient.

### *Why is the duty of utmost good faith failing?*

The duty of utmost good faith is not achieving its stated aims.

Consumer Action's experience, as well as our reviews of the case law and FOS determinations, have led us to the conclusion that:

- the DUGF does not hold the insurer to account for policy terms which are harsh, oppressive, unconscionable, unjust, unfair or inequitable,
- the DUGF does not require an insurer to draft policy clauses 'fairly',
- the DUGF does not prevent an insurer from selling an insurance policy which is unsuitable, or which the customer does not understand, and
- people are overwhelmingly unaware of the DUGF and, if they are aware of it, it is very unlikely to assist them in common disputes.

The reality of the duty's lack of effectiveness was acknowledged in 2013, when the Parliament granted ASIC the power to take action against an insurer for breach of the DUGF in relation to handling or settlement of claims.[25]

The rationale for granting ASIC this power was that the DUGF presented 'too great an expense for some parties and does not provide long-term solutions to systemic breaches of utmost good faith committed over time'.[26] Despite the sound justification for this reform, the corporate watchdog is yet to pursue any insurer under this power. This highlights several problems with ASIC's DUGF power:

- ASIC's power only extends to post-contractual breaches of the duty, meaning ASIC cannot pursue an insurer for the contents of the policy or the insurer's pre-contractual conduct, such as mis-selling,
- the individual nature of the duty means that it is unclear how a decision in ASIC's favour could have tangible benefits for people buying insurance more broadly, and
- a decision in ASIC's favour would be unlikely to provide anything beyond types of remedies available for an action of unconscionability.[27]

The individual right of customers and ASIC's power are not leading to good results. The question is, could a fair insurance regime revive the duty of utmost good faith? This is discussed further in Chapter 2 (see pp 29, para 2.3.3).

## 1.2.2 Anti-discrimination laws

It is clear that the duty of utmost good faith does not guarantee fairness in insurance contracts. However, anti-discrimination laws could more directly address what may be considered 'unfair' terms. The potential of anti-discrimination laws is limited by the fact that insurers can discriminate if it is considered 'reasonable' under the law.

[24] Based on the experiences of Consumer Action and Financial Rights Legal Centre's Insurance Law Service.
[25] The *Insurance Contracts Amendment Act 2013* (Cth) inserted section 14A into the Insurance Contracts Act.
[26] *Insurance Contracts Act Amendment Act 2013* (Cth), Explanatory Memorandum, para 1.6.
[27] Under Part 2 Division 2 of the *ASIC Act*.

Insurers can legally discriminate against people on various grounds, for example, disability or age.[28] This discrimination is part of the underwriting process. The insurers' limited exemption from discrimination laws enables them to:

- refuse to provide insurance,
- price the insurance the way they want to, and/or
- provide insurance on certain terms, for example, by excluding coverage of pre-existing medical conditions.

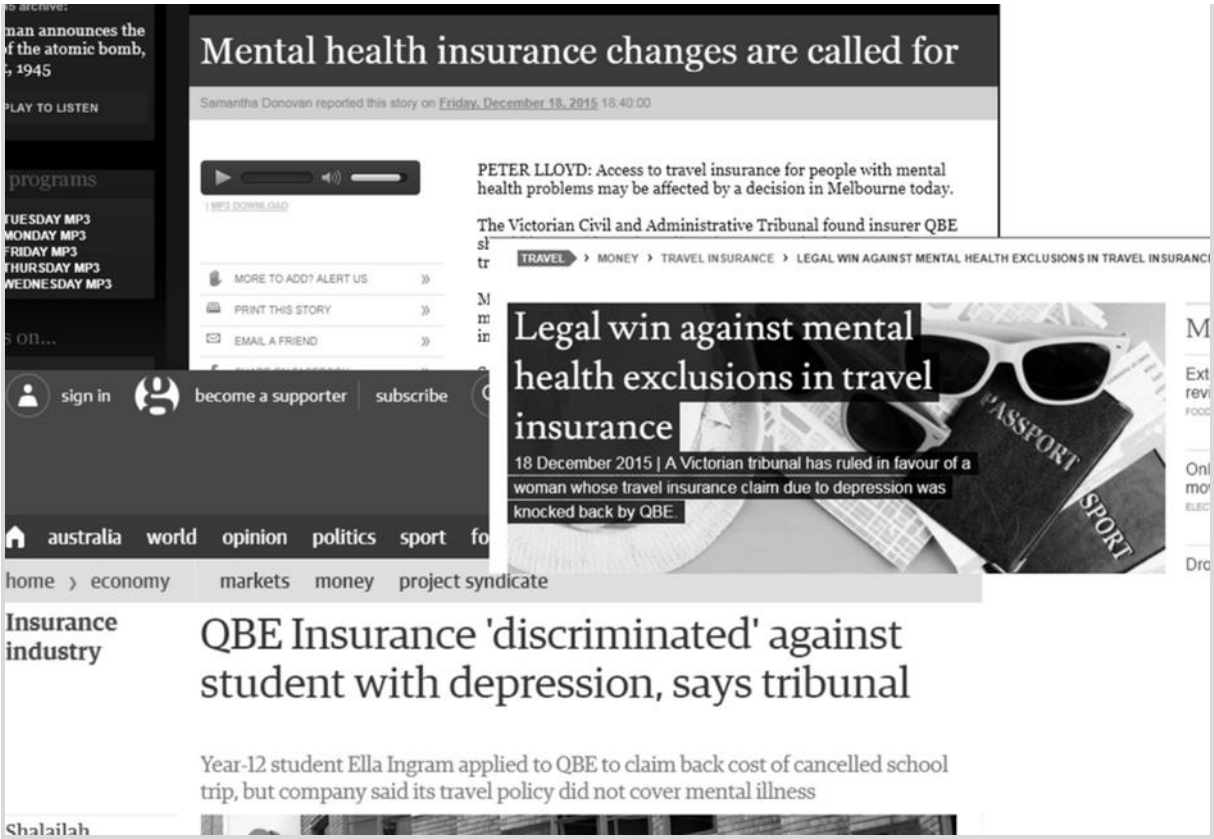
However, to *legally* discriminate, an insurer must show that:

- the discrimination is based upon actuarial or statistical data on which it is reasonable to rely, and is reasonable having regard to that data and other relevant factors, or
- where no such data is available and it cannot reasonably be obtained, the discrimination is reasonable having regard to any other relevant factors.[29]

Under disability discrimination laws, discrimination is also lawful if 'avoiding the discrimination would impose an unjustifiable hardship on the discriminator'.[30]

Despite the clear requirements that must be met for insurers to discriminate lawfully, it is often unclear to people why they are being discriminated against, or even that the insurer is discriminating against them at all. It can be difficult for people to dispute decisions, especially because free legal advice can often be difficult to obtain. In some cases, insurers have failed to show that they have discriminated against someone 'lawfully'. It seems this lack of justification may be a systemic problem.

[28] See *Disability Discrimination Act 1992* (Cth) section 46; *Age Discrimination Act 2004* (Cth) section 37.
[29] See *Disability Discrimination Act 1992* (Cth) section 46; *Age Discrimination Act 2004* (Cth) section 37(3).
[30] *Disability Discrimination Act 1992* (Cth) section 29A. Section 11 of that Act lists the factors to be taken into account in determining whether there would be 'unjustifiable hardship'.




**Blanket mental illness exclusions**

## Ella Ingram[31]

Ella Ingram booked an overseas school trip, then had to cancel it several months later when she was diagnosed with depression.

Ella claimed the costs of cancelling her trip from QBE, her travel insurer. QBE declined her claim on the basis of a blanket exclusion of mental illness.

The Victorian Civil and Administrative Tribunal (**VCAT**) found QBE had discriminated against Ella under the *Equal Opportunity Act 2010* (Vic), which includes equivalent 'unjustifiable hardship' and lawful discrimination provisions to federal discrimination laws. QBE did not show it would suffer unjustifiable hardship without the exclusion, and did not have the data to justify it.

Ella was entitled to over $4,000 for economic loss and $15,000 for hurt and humiliation, and the fear QBE's decision caused her about future discrimination. However, VCAT did not make an unlawful discrimination declaration, meaning the decision did not have broader implications.

## FOS determination 428120[32]

An Australian man went on a trip to Canada. While he was there, he experienced an acute psychotic episode. It was the first time this had happened to him. He went to hospital and was diagnosed with

[31] *Ingram v QBE Insurance (Australia) Limited* [2015] VCAT 1936 (18 December 2015).
[32] FOS Determination 428120, 31 March 2017.

bipolar disorder. He had to return to Australia with his parents, and claimed on his travel insurance for the costs of his medical treatment, cancelling the trip and returning to Australia.

The insurer denied his claim under its blanket exclusion of claims arising from or related to 'depression, anxiety, stress, mental or nervous conditions'. The man disputed this and took his complaint to FOS.

FOS found that the blanket mental illness exclusion was discriminatory. The insurer would not suffer unjustifiable hardship without the exclusion. Similarly to Ella Ingram's case, the insurer could not show any data or other relevant factors to justify the blanket exclusion.

The man was entitled to more than $8,800 in cancellation fees and medical and other expenses. He was also awarded $1,500 for non-financial loss because the insurer's denial of the claim was 'unreasonable and caused an unusual degree of inconvenience and pressure'.

The FOS decision is a red flag for insurers. It is possible that other insurers' blanket mental illness exclusions are unlawfully discriminatory.

Some insurers have not had mental illness exclusions in their travel insurance policies for some time. Others are taking steps to remove these exclusions.[33]

The move away from unjustified mental health exclusions in travel insurance policies is a promising trajectory for the industry. However, removing some highly problematic, discriminatory terms from travel insurance policies is a relatively small step within the broader market. It shows the limits of anti-discrimination laws as a consumer protection. Anti-discrimination laws are not the answer to the broader problem of unfairness.

### 1.2.3 No denial of claims for unrelated actions

The Insurance Contracts Act prevents insurers from denying someone's claim because of something the customer did after they entered the contract, if their actions were unrelated to the loss in question.[34]

However, it is difficult for non-lawyers to find out about this consumer protection.[35] Some policies include clauses which suggest that this protection does not exist. For example, a policy may require the customer to make a claim within a set period of time after the insured event, or to pay the excess before the insurer will pay out the benefit. Additionally, raising this protection in a claims dispute can be complex depending on the surrounding facts.

### 1.2.4 Customer's limited duties regarding statements and disclosure

Insurance customers have legal duties to make certain disclosures to insurers and to not make misrepresentations.[36] Positively, these duties are limited in a way that benefits customers. For example:

- A person does not need to disclose things that an insurer ought to know in the ordinary course of business as an insurer,[37]
- A person also does not breach any duty regarding representations if they make a statement which is untrue 'but was made on the basis of a belief that the person held, being a belief that a reasonable person in the circumstances would have held',[38]

[33] See Andy Swales, 'A new mindset', *insuranceNEWS*, August/September 2017, pp 66-68.
[34] *Insurance Contracts Act* section 54.
[35] There is no prominent mention of the section 54 protection on the Insurance Council of Australia's 'Understand Insurance' website or ASIC's 'Money Smart' website,
[36] *Insurance Contracts Act* Part IV.
[37] *Insurance Contracts Act* section 21(2).
[38] *Insurance Contracts Act* s 26(1).

- If a person mistakenly made a mis-representation in response to an ambiguous question, and a reasonable person would have understood the question the same way, they will not have made a misrepresentation.[39]
- Insurers must ask people specific questions that are relevant to the decision whether or not to accept the risk in relation to the inception of 'eligible contracts of insurance.[40] If an insurer fails to do so, they are taken to have waived compliance with the duty of disclosure.[41]

However, it can be very difficult for an individual whose claim is declined on the basis of non-disclosure or misrepresentation to argue these exceptions without a lawyer, because the provisions are complex and difficult for individuals to access.

### 1.2.5 Insurers' disclosure obligations

Insurers must tell their customers certain things about their policies before they buy them, primarily in the Product Disclosure Statement (**PDS**).[42] This is intended to ensure that people understand the insurance that they buy. There is now widespread acknowledgement that this type of mandatory disclosure is an outdated consumer protection. As ASIC stated in its submission to the 2014 Financial System Inquiry:

> *Economic research in behavioural economics, as well as the experience of regulating retail financial markets, indicates that investors and consumers are prone to behavioural biases that mean decision making is often not instrumentally rational. This undermines the effectiveness of disclosure as a regulatory tool. Importantly, these behavioural biases are significant and systematic, rather than random and trivial.*[43]

In 2017, the Insurance Council of Australia published independent research which found that people are not relying on mandated disclosure. It reported that approximately 80% of people do not read the PDS before buying insurance.[44] The current disclosure requirements cannot be described as an effective consumer protection.

## 1.3 Insurance terms can have unfair outcomes

For large swathes of insurance customers, the existing consumer protections provide no relief if they find themselves vulnerable and stuck in a gruelling claims dispute.

As we have seen, the duty of utmost good faith in practice does little more than require insurers to handle claims in accordance with commercial standards of decency and fairness (see page 7, para 1.2.1). Anti-discrimination laws have limited effectiveness and are not relevant to all types of insurance and disputes.

This problem for people buying insurance is obvious when a claim results in what could be called an *unfair* outcome, but not an *unlawful* outcome.

### 1.3.1 Insurers can apply policies unfairly

The phenomenon of 'claims shock' often happens because an insurer reads and applies a policy term in a way that is unexpected and harsh for their customers.

[39] *Insurance Contracts Act* s 23.
[40] *Insurance Contracts Act* section 21A(3) and (4).
[41] *Insurance Contracts Act* section 21A(2).
[42] *Corporations Act 2001* (Cth) Part 7.9 Division 2.
[43] ASIC, *Financial System Inquiry: Submission by the Australian Securities and Investments Commission*, April 2014, para 40.
[44] Insurance Council of Australia, *Consumer Research on General Insurance Product Disclosures: Research findings report*, February 2017, page 18.

## Jan's story

Jan's car was stolen when it was parked on the street near her house. She reported the theft to police. Police eventually arrested the man who stole her car and recovered the car, which was damaged.

Jan made a claim on her car insurance. The insurer declined the claim on the basis that the policy did not cover drivers under 30 years of age, and the man who stole the car was under 30 years old. The insurer also said that Jan had not co-operated with the claims process, despite the fact that she had reported the theft to police.

Jan sought help from WestJustice community legal centre, who lodged a dispute with FOS on her behalf. FOS made a recommendation in Jan's favour, which the insurer accepted. FOS said the insurer had to settle the claim in accordance with the policy terms and conditions. If the insurer cash settled, it had to pay interest from the date it denied the claim until the payment date of the claim. The insurer also had to pay $750 in non-financial loss compensation.

## Henry's story

Henry was living with his parents while he saved to buy a house. His friend John was having trouble at his share house, so he came to live with Henry's parents at the family home temporarily.

Early one morning, Henry reversed out of the driveway and accidentally collided with John's car. He made an insurance claim online immediately, and included his address and that of John (that is, the same address). The insurer appeared to accept the claim, offering to cover the repairs to John's car. Over two months later, after the repairs were completed, the insurer decided to decline the claim because they said Mr John was 'normally living with' Henry. John unwittingly signed up to a legal retainer with a law firm, which is now pursuing Henry.

This is very stressful for Henry and has had a significant impact on his friendship with John. This happened at a particularly stressful time in Henry's life. He had recently purchased a house and was, and is still, worried he will lose the home. The cumulative stress led Henry to seek medical treatment following a mental health breakdown.

Jan and Henry's experiences show that the way insurers apply policy terms can have perverse, unfair outcomes which are not intuitive. Yet shocking results like these are sometimes lawful under current insurance laws. If there is doubt about the lawfulness of a claims decision, it is complicated and stressful for a person at their lowest ebb to challenge it.

### 1.3.2 Insurers have policy terms which are unbalanced and unnecessary

Some insurance policies include terms which do not appear to reasonably balance the interests of insurers and their customers. For example:

> **Home Building Insurance[45]**
>
> **How to pay your excess**
>
> When you make a claim we will choose whether to deduct the applicable excesses from the amount we pay you or direct you to pay the excesses to us or to the appointed repairer or supplier. We may require you to pay the excesses in full before we pay your claim or provide any benefits under your policy. The fact we have asked for payment of your excess does not of itself mean that your claim has or will be accepted by us either in whole or in part.

In our view, this clause and similar clauses are unfair because:

- Requiring the customer to pay an excess before the claim is paid causes a significant imbalance between the individual and the insurer. Someone in financial distress, whose home or car has been damaged or completely destroyed, may not be able to afford to pay the excess. They may then assume that they cannot claim the benefit they are entitled to.
- This requirement is not necessary to protect an insurer's legitimate business interests. The insurer could instead deduct the excess from the benefit paid or, if the insurer pays to rebuild or repair the home, they could bill the individual and/or allow the excess to be paid in instalments.
- This clause is also misleading, and may not comply with the law and the General Insurance Code of Practice. Under the Insurance Contracts Act, an insurer cannot deny a claim based on what the insured person does after the contract is entered into, unless the person's actions cause or contribute to the loss.[46] The Code of Practice also entitles people to apply for financial hardship when they make claims.[47]

### 1.3.3 Insurers have superior knowledge and bargaining power

Some people experience unfair claims outcomes because insurers by nature have much better commercial knowledge and bargaining power than their customers. Home building insurance policy terms which allow an insurer to pay the customer a cash amount, rather than rebuild or repair the home, are a stark example of this. For example:

> **Home building insurance[48]**
>
> **How we settle building claims**
>
> If we agree to pay a claim for loss, theft or damage to the building, we will decide if we will:
>
> - repair damage to the building;
> - rebuild the building;
> - *pay you what it would cost us to repair or rebuild the building;*
> - pay you the building sum insured shown on your certificate of insurance;

[45] AAMI Home Building Insurance Product Disclosure Statement, dated 1 October 2013, page 44, https://www.aami.com.au/aami/documents/personal/home/pds-building.pdf.
[46] *Insurance Contracts Act* section 54.
[47] Insurance Council of Australia, *General Insurance Code of Practice*, '8. Financial Hardship'.
[48] AAMI Home Building Insurance Product Disclosure Statement, dated 1 October 2013, page 45, https://www.aami.com.au/aami/documents/personal/home/pds-building.pdf .

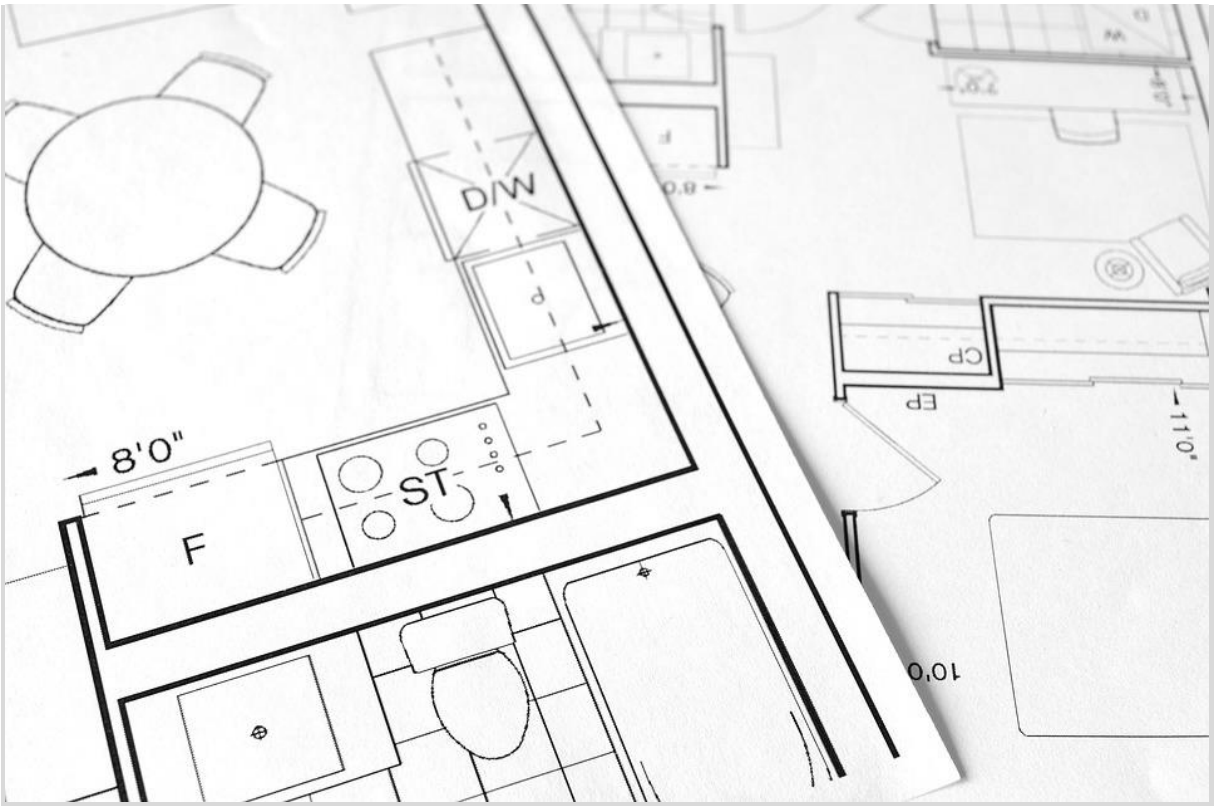
Note: This does not apply if you have selected the Complete Replacement Cover® option.

- *give you a voucher, store credit or stored value card for the amount it would cost us to repair or rebuild an item*... [Emphasis added]

This clause allows the insurer to pay someone what it would cost the insurer—not their customer—to repair or rebuild the property.

Typically, under these clauses, people are offered cash payments when they have no way of knowing whether the amount will be inadequate to repair or rebuild their home. This is a serious risk when someone can be offered the amount it would cost the insurer to repair or rebuild the home, with their bulk-buying power. This may bear little resemblance to the cost for a regular individual to repair or rebuild their home.

People often report feeling pressured into accepting the cash settlement offer to avoid a protracted dispute with the insurer.




## Shirley's story

Shirley's home and contents were destroyed by fire. She was very stressed when the insurer offered to cash settle. She did not know how much it would cost to rebuild her home and did not feel she had the skills to navigate the process of demolishing and rebuilding her home. This added stress to an already difficult time in her life. This is a typical example of the insurer-customer power imbalance, and a key part of the fairness problem.

## 1.3.4 Insurers can place onerous requirements on their customers

Some insurance policies can require the insured person to provide extensive details when they make a claim. For example:

> **Motor vehicle insurance[49]**
>
> **Uninsured motorist's extension**
>
> We will cover your vehicle for loss or damage arising from an accident caused by the driver of an uninsured vehicle up to a maximum amount of $5,000 for any one incident including the cost of protection, removal and towing.
>
> You may only claim under this extension if you:
>
> - did not contribute to the cause of the accident;
> - can provide us with the *name and contact details of the person responsible for the accident*; and
> - can provide the *registration number of the other vehicle*. [Emphasis added]

For an insurer, this type of clause could be characterised as an additional benefit, where the insurer steps in to pursue an uninsured at-fault driver rather than the insured person litigating themselves. However, for an individual, the requirements to make a claim can have harsh and inconsistent outcomes.

[49] Allianz Car insurance PDS, 25 May 2017, page 24.

## Ruby’s story

Ruby was hit by a car while riding her motorcycle. The car driver fled the scene.

Ruby’s insurance policy said the insurer would pay up to $3,000 for damage to the bike if the insurer thought the accident was caused by an uninsured driver or rider.

The insurer declined Ruby’s claim because she did not have the details of the other driver. Consumer Action assisted Ruby to lodge a dispute through FOS. Only then did the insurer agree to pay Ruby’s claim.

The types of experiences in this section have highlighted some of the ways that insurance policy terms can quite lawfully lead to unfair outcomes for people attempting to claim on their insurance.

# 2. What would fair insurance laws look like?

We have seen the inadequacy of the current legal framework when insurance policies operate unfairly, and the impact this has on people's lives. People buy insurance to protect themselves for when things go wrong, only to have their claims denied.

While the problems seem complex, the solution is obvious—we need unfair contract terms laws for insurance.

## 2.1 What are unfair contract terms laws?

Unfair contract terms laws were introduced in 2010 as part of the ACL reforms.[50] These laws were recommended by the Productivity Commission in its 2008 review of consumer laws, following the introduction of an unfair contract terms regime under Victorian consumer laws.[51] Virtually all standard form consumer contracts, offered on a 'take it or leave it' basis, are covered.[52]

Under Australia's current unfair contract terms laws, a term is unfair if it ticks three boxes:

1. It would cause a significant imbalance in the parties' rights and obligations
2. It is not reasonably necessary to protect the legitimate business interests of the advantaged party (the trader), and
3. It would cause financial or other detriment to the individual if it were applied or relied on.[53]

Unfair contract terms laws require businesses to ensure that their contracts are:

- reasonably necessary to protect their legitimate interests, and
- 'transparent', that is, in plain language, legible, clear and readily available to affected parties.[54]

Businesses do not have to weigh up all of their contract terms against this test. Three parts of the contract are carved out from the regime:

1. subject matter,
2. upfront price, and
3. terms which are required or expressly permitted under law.[55]

An individual can seek a declaration from a tribunal or court that a contract term is unfair.[56] If a declaration is made, the unfair term is void for anyone who would suffer the same detriment. If the contract can continue without the term, it will do so. If a business continues to rely on a term declared unfair and void, a court or tribunal can grant an injunction, order compensation or make another appropriate order. No civil penalties currently apply to businesses.

In 2016, the unfair contract terms regime was extended to cover small businesses as if they were individual consumers.[57] This acknowledged the vulnerabilities of small businesses dealing with large businesses, but also the effectiveness of the unfair contract terms regime in addressing this relationship imbalance.

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[50] The provisions for financial services and products are in the *Australian Securities and Investments Commission Act 2001* (Cth) (**ASIC Act**), Part 2 Division 2 Subdivision BA. These provisions mirror Chapter 2 Part 2-3 of the ACL.
[51] Productivity Commission, *Review of Australia's Consumer Policy Framework: Productivity Commission Inquiry Report*, No 45, 30 April 2008, Recommendation 7.1, Volume 1, page 69.
[52] *ASIC Act* section 12BK/ACL s 27 list the factors to be taken into account when determining if a contract is a standard form contract.
[53] *ACL* section 24(1)/ASIC Act section 12BG(1).
[54] *ACL* section 24(3)/ASIC Act section 12BG(3).
[55] *ACL* section 26(1)/ASIC Act section 12BI(1).
[56] *ACL* s 250/ASIC Act section 12GND.
[57] Under the *Treasury Legislation Amendment (Small Business and Unfair Contract Terms) Act 2015* (Cth).

DENIED

# Unfair contract terms

**Unfair contract terms laws** require businesses to ensure their contracts are:

- reasonably necessary to protect their legitimate business interests, and
- 'transparent' - plain language, legible, clear, readily available

**Under Australia's unfair contract terms laws, a term is unfair if:**

- It would cause a significant imbalance in the parties' rights and obligations
- It is not reasonably necessary to protect the legitimate business interests of the advantaged party (the trader), and
- It would cause financial or other detriment to the individual if it were applied or relied on

## Insurers are exempt from these laws

## 2.2 Impact of unfair contract terms laws

The introduction of the unfair contract terms laws was an opportunity for improvements in consumer markets, particularly telecommunications and airlines.

As the Productivity Commission stated when recommending an unfair contract terms regime:

> … in those countries and jurisdictions that have introduced new regulations [prohibiting unfair contract terms], there is little evidence of significant compliance costs or other burdens for business (and therefore consumers). In fact, some businesses in Australia have supported such regulation, and many are used to complying with provisions against unfairness in industry codes.'[58]

When the national laws were introduced, the Australian Competition and Consumer Commission (**ACCC**) took a cooperative approach to compliance, rather than moving immediately to enforcement. In March 2013, the ACCC reported on its industry review of unfair contract terms.[59] The review examined contracts in the airline, telecommunications, fitness, vehicle rental and travel agent industries, and some common online trader contracts.

During its review, the ACCC worked cooperatively with businesses to identify and remove or change unfair terms, and to address the issues identified.[60] The ACCC said of this work and its broader significance:

> *The ACCC directly engaged with businesses to address fairness concerns and to restore balance to a number of important provisions in those contracts…*
>
> *Clear, simple consumer contracts can build a foundation for positive relationships. Transparent contract terms can be a tool for communicating 'headline' consumer information and helping consumers to understand the key aspects of the agreement.*
>
> *Good contract terms offer an opportunity for businesses to deal up front with areas of consumer dissatisfaction and dispute, thereby reducing complaints. Businesses working to align contracts with the ACL unfair contract terms provisions will in many cases be addressing these broader concerns.*

The Australian Communications Consumer Action Network (**ACCAN**) also commissioned research which found 'widespread' non-compliance with ACL 'substantive fairness requirements', particularly among smaller players in the telecommunications industry. ACCAN noted that many of the problem provisions identified were modified following positive consultations between telcos, the ACCC and ACCAN.[61]

[58] Productivity Commission, 2008, Volume 1, pages 34-35.
[59] ACCC, *Unfair contract terms: Industry review outcomes*, March 2013.
[60] ACCC, March 2013, p 1.
[61] Dr Jeannie Marie Paterson and Jonathan Gadir, ACCAN, *Executive Summary and Update: Telco "Fine Print" Project*, December 2013.

**"Removing unfair terms from contracts is not something new or scary. When introduced to the telco sector, the reform provided a good opportunity for telcos and consumer advocates to have a mature debate about what was fair to put in a standard contract."**

**Xavier O'Halloran, CHOICE**

More recently, the big four banks agreed to remove unfair terms from their small business loan contracts. Some of these were extremely onerous on their customers. The changes included:

- removing clauses that absolved the banks from responsibility for conduct, statements or representations to borrowers outside the written contract,
- limiting indemnification clauses, for example, by removing clauses which required customers to cover losses due to the fraud, negligence or wilful misconduct by the bank,
- removing clauses allowing banks to call in a default for an unspecified negative change in the circumstances of the customer, and
- restricting the banks' ability to vary contracts to specific circumstances, and where variation would cause a customer to want to exit the contract, providing 30 to 90 days for the customer to do so.

The banks co-operated with ASIC and the Australian Small Business and Family Enterprise Ombudsman to achieve these significant changes.[62]

The unfair contract terms laws are a consumer protection based co-operative prevention of consumer harm and disputes. Where the laws have applied, they have not resulted in lengthy litigation but improved certainty for business and people through reviews and updates of contractual terms to improve fairness. Unfair contract term prohibitions represent a modern and well-informed understanding of what an effective consumer protection looks like.

[62] ASIC, 17-278MR *Big four banks change loan contracts to eliminate unfair terms*, 24 August 2017.

## 2.3 Legislating for fair insurance contracts


A fair contracts regime for insurance would substantially mirror the existing regime under the ASIC Act for other financial products.[63] There are some key principles that should be adopted to ensure that fair insurance laws have the intended effect and balance the interests of businesses and their customers.

### 2.3.1 All insurance contract terms pass the fairness test

Fair insurance laws would operate to make insurance contracts fair from the outset, to avoid consumer detriment and disputes. This would mean that, when insurers draft their contracts, they apply the fairness test to key terms, and determine that those terms are necessary to protect their own legitimate business interests.

In line with the existing unfair contract terms regime, all of the terms in an insurance contract should meet the fairness test, with the reasonable exception of the main subject matter, upfront price and terms expressly permitted by law.

#### *'Subject-matter' as defined under insurance law*

Under the Insurance Contracts Act, the 'subject-matter' of an insurance contract is the thing being insured, such as 'property'[64] or a 'road motor vehicle'.[65] It could also be a person or group of people.[66] Importantly, the subject-matter of an insurance contract is distinct from the insured event and risk (or cause of loss) under the contract.[67]

As noted in Chapter 1 of this report, in 2013 the Insurance Contracts (Unfair Contract Terms) Amendment Bill 2013 (Cth) (**the 2013 Bill**) was introduced into Federal Parliament. The 2013 Bill did not define 'main subject-matter'. However, the Explanatory Memorandum to the Bill stated that it could include:

> *'... the decision to purchase a particular type of general insurance or to encompass a term that is necessary to give effect to the supply of the insurance or without which the supply of insurance would not occur'.*[68]

The Explanatory Memorandum emphasised that the Insurance Contracts Act definition of subject-matter 'should not determine the meaning of' main subject-matter under the unfair contract terms regime.[69]

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[63] *ASIC Act* Part 2 Division 2 Subdivision BA.
[64] *Insurance Contracts Act* sections 17, 44, 49.
[65] *Insurance Contracts Act* section 65.
[66] Such as workers under a workers' compensation policy: *Wallaby Grip Ltd v QBE Insurance (Australia) Ltd* [2010] HCA 9, para 29.
[67] *Wallaby Grip Ltd v QBE Insurance (Australia) Ltd* [2010] HCA 9 at para 29 per French CJ, Gummow, Hayne, Heydon, Kiefel JJ citing Professor Malcolm Clarke.
[68] *Insurance Contracts Amendment (Unfair Contract Terms) Bill 2013: Explanatory Memorandum*, para 1.64.
[69] *Insurance Contracts Amendment (Unfair Contract Terms) Bill 2013: Explanatory Memorandum*, para 1.65.

The important point here is that the scope of the 'main subject-matter' exemption would be a vital characteristic of a fair insurance regime. A broad definition could effectively carve out many key contractual terms, even though they do not define the thing being insured. Insurers would not have to review these terms for fairness, and people could not seek a remedy in relation to these terms. A very broad 'main subject-matter' definition could therefore render an unfair contract terms regime close to meaningless.

Under the 2013 Bill for example, there could be a very broad reading of 'a term that is necessary to give effect to the supply of the insurance or without which the supply of insurance would not occur'. It may refer to any term which excludes or limits what is covered, as this would be relevant to the underwriting risk for the insurer. For example, it may include a clause in a home building insurance policy which excludes cover for damage caused by flood, or it may include exclusions for pre-existing conditions or mental illness in a travel insurance policy. This is despite the fact that these are events or risks, not the subject-matter, under an insurance contract.

**The question for an insurer when drafting a policy clause would be—is this reasonably required to protect our legitimate business interests? The answer would be clear through the underwriting process.**

The underlying subject-matter of an insurance contract can and should be distinguished from terms that go to what events and risks are insured. A clear distinction will simply mean that the substantive elements of an insurance contract, such as the conditions, exclusions, excess and benefits, will need to meet the fairness test, and reflect the insurer's underwriting risk.

A fair insurance regime should retain the existing definition of 'subject-matter' under insurance law. This will simply ensure that insurers have a legitimate basis for most policy terms, including for example, the conditions and exclusions. The question for an insurer when drafting a policy clause would be—is this reasonably required to protect our legitimate business interests? The answer would be clear through the underwriting process.

### *Legitimate business interests are clear*

Under an effective unfair contract terms regime, ASIC would provide clear guidance on 'what is a legitimate business interest'.[70]

Insurance is predicated on assessments of risk. The regime would recognise this as a central feature of insurance products and markets. Under the proposed 2013 model, an insurer's legitimate business interests included underwriting risks.[71] That meant a term would be reasonably necessary to protect an insurer's legitimate business interests if it reasonably reflected the underwriting risk for the insurer under that contract. A term would only be unfair if the insurer could not justify it by reference to evidence of the underwriting risk.

[70] This was also envisaged under the 2013 Bill—see Explanatory Memorandum, page 4.
[71] *Insurance Contracts Amendment (Unfair Contract Terms) Bill 2013* section 14—inserting new section 14C(5).

### 2.3.2 Insurers proactively avoid consumer detriment, disputes and claims shock

Fair insurance laws will be an 'early intervention' or a prevention, rather than just a cure.

As seen in other industries (see pages 25-26, para 2.2), these laws will prompt insurers to remove terms in existing contracts which do not pass the fairness test. While some insurance policies may already pass the unfair contract terms test, others, such as the examples discussed above, may not.

The laws will require insurers to clarify what their own legitimate interests are and to ensure that their policies reflect these interests. They will also need to make sure the terms of their policies are clear and comprehensible to their customers.

This requirement for pro-active review and justification of contracts should reduce 'claim shock', where insurance customers see their claims outcome as grossly unfair because they were unaware of the effect of a policy term. In many cases of claim shock, the reason for the term is unclear to the individual. An unfair contract terms regime will make insurance contracts and claims decisions less opaque for customers and should reduce disputes.

### 2.3.3 Remedies are accessible and effective

The existing unfair contract terms regime is a particularly effective consumer protection because it can achieve systemic change when a contract is found to have an unfair term. This can and should be replicated for insurance contracts.

Firstly, people would be empowered to protect their own rights by seeking to have a policy term declared void due to unfairness. Once that term has been declared void, other people would be protected from the same term in future.

Secondly, ASIC would be able to seek to have terms declared void, recognising that an unfair term in a standard form contract is a systemic problem, and that many people cannot pursue their own disputes through litigation.

If a term was declared unfair, the insurer may have breached their duty of utmost good faith. This way the duty of utmost good faith could be revived to have the pre-contractual effect that the ALRC envisaged more than three decades ago (see page 7, para 1.2.1).

### 2.3.4 Application to all insurance contracts

A fair insurance regime would apply across the board. This means all insurance for individuals and small businesses would be in line with the existing current unfair contract terms laws (see page 23, para 2.1).

**"A fair insurance regime would apply across the board"**

It would cover both life and general insurance contracts. The unfair contract terms regime proposed for insurance in 2013 was restricted to general insurance contracts only. However, recent life insurance scandals show the need for an intervention in the relationship of life insurers and their customers.

There is currently a gross imbalance in the power held by life insurers and their prospective or existing customers. A customer's life can literally depend on a fair deal from the insurer. Without any effective onus on life insurers to issue fair contracts with the insured, there is a deep chasm between community expectations and the reality of life insurance contracts (see page 5, para 1.1).

It is becoming increasingly important that life insurance contracts are fair, as insurers pour their efforts into selling life insurance without the benefit of individualised financial advice (known as 'direct life insurance' or insurance sold under a no advice model). ASIC reported in 2016 that people who buy life insurance directly

from insurers are more likely to have their claims denied than people who have purchased through an advisor or have a group insurance policy (most commonly through superannuation).[72]

### 2.3.5 Backed by evidence and guidance

An unfair contract terms regime for insurance could be implemented through amendments to the Insurance Contracts Act (as proposed in 2013) and/or the ASIC Act.

If insurance contracts were brought under the ASIC Act, the broad exclusion of people who have bought insurance from seeking relief under other Acts would need to be modified.[73] There is benefit in applying the ASIC Act regime to insurance—so there is one regime and judicial interpretation of unfair contract term laws will not diverge based on the particular regime. However, the regime may sit under the Insurance Contracts Act, if consistency with existing approaches under the Insurance Contract Act is preferred.

If adopted under the Insurance Contracts Act, the regime would need to substantively replicate the existing unfair contract terms provisions under the ACL/ASIC Act. This would deal with the risk noted above—that the jurisprudence under each regime developed consistently. As the laws developed, it would ensure the rights of insurance customers and the rights of people who are customers in every other consumer market are aligned.

Irrespective of where the regime sits, this law reform must be supported by regulatory and other efforts, including:

- the use of a behavioural economics lens of consumer behaviour when drafting the laws, to ensure that the laws operate effectively as a consumer protection,
- ASIC guidance for industry on policy drafting, what constitutes main subject-matter, legitimate business interests and other significant aspects of the regime, and
- collaboration between industry, ASIC and consumer representatives to identify and rectify unfair terms in insurance contracts.

[72] ASIC, *REP 498: Life insurance claims: An industry review*, October 2016, para 28. ASIC's review of direct life insurance is ongoing.
[73] Under section 15 of the *Insurance Contracts Act*.

# 3. The benefits of fair insurance laws

A fair insurance regime in Australia would provide significant benefits to individuals and the insurance industry.

## 3.1 Prevention rather than cure

Unfair contract terms laws incentivise businesses to pro-actively prevent detriment to their own customers and avoid disputes. The Productivity Commission pointed to unfair contract terms laws as a way to establish 'better incentives for fairer contracts that assign risks efficiently between consumers and suppliers'.[74]

This early-intervention approach is much more effective and efficient than laws which require individuals, with limited resources and knowledge, to assert their rights via litigation against well-resourced businesses, with their many lawyers. It stands in stark contrast to the duty of utmost good faith, which is enforced through litigation and is failing the people who thought they would be protected when things went wrong (see pages 9-11, para 1.2.1).

**"This early-intervention approach is much more effective and efficient…"**

On the balance of evidence, it is clear that insurers currently have unhealthy relationships with their customers. Disputes are at an all-time high.[75] We need a preventative health measure to curb the widespread consumer harm and disputes.

[74] Productivity Commission, 2008, Volume 1, page 60.

[75] The most recent data shows that general insurance internal disputes were up 32% on the prior year: General Insurance Code of Practice Code Governance Committee, *General Insurance Code of Practice: Industry Data Report 2015-16*, March 2017. External disputes were up 28% for general insurers and down 7% for life insurers: FOS, *Annual Review 2016-17*.

## 3.2 Increased trust and confidence

A prohibition on unfair contract terms in insurance policies will mean people have more predictable experiences with insurers, and face fewer traps and pitfalls. People are also less likely to have a nasty shock when they make an insurance claim, at the time when they are at their most vulnerable. This is where insurers can legitimately build trust and confidence with the people buying their products—a win-win.

## 3.3 Insurers compete under the same rules

The insurance industry's carve out from the unfair contract terms regime has resulted in an uneven playing field. The fairest or most suitable insurance policy is not necessarily the cheapest—in fact, it often is not. Because competition in the insurance market is heavily driven by marketing offers, brand recognition and price, rather than product value, a fairness test should improve product value and competition in the market, as it has in other consumer markets.

## 3.4 More efficient regulation

Unfair contract terms laws are efficient for business, individuals and regulators. For individuals and business, the anticipated reduction in disputes would be a clear benefit. The Productivity Commission's 2008 report also stated that a key benefit of an unfair contract terms regime would be 'more timely and cost-effective redress for those suffering detriments related to the use of [unfair] terms'.[76]

In addition to this, ASIC would have uniform powers across all financial services to enforce the unfair contract terms prohibition. This would enable systemic redress for products that fall short of the fairness test.

[76] Productivity Commission, 2008, Volume 1, page 60.

Consumer Action Law Centre

Our vision: a **just marketplace** where
**people have power** and **business plays fair**

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