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ROYAL COMMISSION INTO MISCONDUCT IN THE BANKING, SUPERANNUATION AND FINANCIAL SERVICES INDUSTRY

Consumer Action Law Centre submission

Policy questions arising from Module 6—Insurance

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INTRODUCTION

1. Consumer Action Law Centre (**Consumer Action**) works to advance fairness in consumer markets, particularly for disadvantaged and vulnerable people, through financial counselling, legal advice and representation, policy work and campaigns and training and outreach. We provide financial counselling and legal advice and education to more than 15,000 people each year. Our lawyers have extensive experience in consumer credit, insurance and general consumer law and represent people in disputes with financial service providers and insurers, including in internal and external dispute resolution (**EDR**).

2. Over the past three years, Consumer Action has provided advice and/or representation to 538 people in insurance disputes. This work includes assisting people who have been denied insurance cover, who have bought unsuitable insurance or who have claims disputes with insurers. We most commonly assist with disputes about car insurance, add-on insurance, home insurance and life insurance.

3. Consumer Action provided legal advice and support to Reverend Bruce Grant Stewart, who gave evidence during Module 6 in relation to his experiences dealing with Freedom Insurance.

4. This submission responds to the key policy questions posed by the Commission in Module 6.

SUMMARY OF RECOMMENDATIONS

A. Product design

- The sale of accidental death insurance and accidental injury insurance should be prohibited. The sale of funeral insurance and add-on insurance which provide little benefit and cause consumer detriment should also be prohibited.

- The law should prescribe standard, up-to-date medical definitions for all life insurance policies. This could be achieved by:

    a. extending the unfair contract terms regime to insurance contracts, and specifying that outdated medical definitions are unfair contract terms; and
    b. developing standard medical definitions with independent medical experts and other relevant stakeholders, and keeping these definitions current. For mental illnesses, the definitions should be those contained within the current Diagnostic and Statistical Manual.

B. Disclosure

- The inadequacies of the disclosure regime should be addressed by:

    a. Reforming the law to provide:
        i. a modernised standard cover regime;
        ii. effective Product Design and Distribution Obligations on insurers issuers and distributors;
        iii. improved disclosure on insurance renewal notices; and
        iv. a suitability test for insurance.
    b. Insurers and their distributors improving advertising, marketing and sales practices.

- Standard definitions of key terms in life and general insurance policies should be defined at law and should be developed in consultation with stakeholders, including consumer groups.

C. Sales

- Conflicted remuneration should be banned for general insurance.

- Conflicted remuneration should be banned for life risk insurance.

- The unsolicited sale of financial products should be banned.

- Advice should be regulated on an outcomes basis, considering the types and value of products, and the risks of particular sales channels.

D. Add-on insurance

- The sale of add-on insurance by motor dealers should be prohibited.

- If add-on insurance continues to be sold, this should be done through a deferred sales model in which the customer proactively opts-in to buying the insurance. A consistent model should apply to all add-on products and sales channels, and should have the features identified in our response to question 14.

- If the unsolicited selling of financial products is not prohibited, a deferred sales model should apply to products sold through unsolicited calls and meetings.

- A deferred sales model should be considered for add-on travel insurance and ticket insurance.

- In the alternative to a ban on the sale of add-on insurance in motor dealerships, commissions on add-on insurance sales through motor dealerships should be prohibited. The risk of circumvention of this ban must be taken into account in the legislative drafting and regulatory approach.

E. Claims handling

- Insurance claims handling should be defined as a 'financial service' and subject to the general Australian Financial Services Licence (**AFSL**) holder obligations under section 912A of the *Corporations Act 2001* (Cth) (**Corporations Act**).

- The law should require life insurers to only request information relevant to the claimed condition when assessing a claim.

- The problems with surveillance of claimants with a mental illness should be addressed by:

    a. regulating insurance claims handling as a financial service, to ensure the general obligations of AFSL holders apply;
    b. banning the use of surveillance in relation to claimants for claims in relation to a mental health condition;
    c. introducing uniform laws for surveillance devices and private investigators.

F. Insurance in superannuation

- All MySuper group life insurance policies should include definitions of total and permanent incapacity which match the definition of 'permanent incapacity' in the SIS Regulations, or are more favourable to the policy beneficiaries. This means 'activities of daily living' (**ADL**) definitions should be prohibited in MySuper group life insurance policies.

- When the unfair contract terms regime is extended to insurance contracts, ADL definitions in should be specified as an example of an unfair contract term.

- Insurers, advisers, superannuation fund trustees and others in the life insurance industry should be bound by one single, enhanced LICOP, which should be approved by ASIC.

- The law should:

  a. mandate clearer requirements for insurance suitability on superannuation trustees; and
  b. regulate claims handling under section 912A of the Corporations Act.

G. Scope of the *Insurance Contracts Act 1984* (Cth)

- The duty of utmost good faith should be strengthened to:

  a. apply to the way that an insurer interacts with an EDR body in relation to a dispute arising under a contract of insurance; and
  b. include penalties for breach.

- Section 29 of the IC Act should be reformed to reflect the position prior to the 2013 reforms, to prevent insurers avoiding claims in ways which do not meet community expectations.

- Section 21 of the IC Act should be replaced by a duty on an insured person to take reasonable care not to make a misrepresentation to an insurer. Other provisions limiting the insured person's duty of disclosure, including those under section 21A, should apply to the new duty.

H. Regulation

- The General Insurance Code of Practice (**GICOP**) and Life Insurance Code of Practice (**LICOP**) should apply to all insurers and others involved in selling insurance and/or handling claims.

- Codes should be required to be enforceable as a term of the consumer contract in order to be registered with ASIC.

- All operating in the insurance business must subscribe to the relevant industry code.

- Systemic breaches of industry codes should be taken into account when a regulator determines breaches of the law.

- Infringement notices should be able to be issued by ASIC in conjunction with other regulatory actions.

- Higher and tiered penalties should apply to infringement notices.

- ASIC should issue guidance on the factors it considers when deciding whether to issue an infringement notice.

I. Compliance and breach reporting

- ASIC should be empowered and resourced to undertake ongoing, targeted compliance audits within financial services entities.
- In addition to the recommendations of the ASIC Enforcement Review Taskforce Report. the following reforms should be made:

    a. the misleading and deceptive conduct and unfair contract terms provisions should be offence and civil penalty provisions;
    b. all ASIC-administered legislation should require the court to consider, when setting a penalty, whether that penalty is sufficient to ensure deterrence and meet community expectations; and
    c. in relation to a relinquishment order for breach of a civil penalty provision, a court should in appropriate circumstances order payment directly to consumers, or funds for the benefit of consumers.

RESPONSE TO POLICY QUESTIONS

Question 1: Is the current regulatory regime adequate to minimise consumer detriment? If the current regulatory regime is not adequate to achieve that purpose, what should be changed?

5. The evidence adduced clearly demonstrates that the current regulatory regime for insurance is not adequate to minimise consumer detriment. There are four fundamental problems with the existing regulatory regime which are particular to insurance.

    a. **Anti-hawking laws have failed to stop inappropriate selling**: As the case studies of ClearView and Freedom Insurance have shown, the anti-hawking provision of the *Corporations Act 2001* (Cth)[1] (**Corporations Act**) has not prevented inappropriate unsolicited sales of insurance—see our response to question 10.

    b. **Unfair contract terms are lawful despite causing consumer detriment**: As the case studies of ClearView, CommInsure, Youi and AAI have shown, the exemption of insurance contracts from the unfair contract terms regime under the *Australian Securities and Investments Commission Act 2001* (Cth)[2] (**ASIC Act**) allows insurance policies to include terms which cause unfair and unexpected claims outcomes—see our response to question 29.

    c. **Inadequately regulated claims handling harms vulnerable people:** As shown by the case studies of TAL, Youi and AAI, and the evidence of the Insurance Council of Australia (**ICA**) and the Financial Services Council (**FSC**), the current regulation of claims handling is ineffective—see our response to questions 18 and 19. Claims handling practices have caused significant harm to claimants, who are often very vulnerable. This has occurred because:

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[1] *Corporations Act 2001* (Cth) s 992A.
[2] *Australian Securities and Investments Commission Act 2001* (Cth) ('*ASIC Act*') pt 2 div 2BA. Equivalent provisions apply to contracts for other products and services under the *Competition and Consumer Act 2010* (Cth) sch 2 ('*Australian Consumer Law*') ch 2 pt 2-3.

i. the exemption of claims handling from regulation as a 'financial service' under section 912A of the Corporations Act[3] means that the Australian Securities and Investments Commission (**ASIC**) cannot address systemic issues such as claims delays or inappropriate surveillance, and

ii. self-regulation of claims handling through industry codes has failed to provide consumers with experiences which meet community expectations and standards.

d. **There is no suitability obligation for insurance:** Unlike in other jurisdictions like the United Kingdom, there is no legal requirement to ensure insurers and insurance brokers sell suitable products—see our response to question 4.

6. Other systemic problems which must be addressed are:

   a. the poor design and sales practices of add-on insurance;
   b. remuneration structures and practices which compel and reward high-pressure selling, particularly of some life insurance and add-on insurance products; and
   c. the complexity of insurance products and the inadequacy of the product disclosure regime as a consumer protection.

Reforms required

7. The key reforms needed to address the inadequacies of the regulatory regime for consumers are to:

   a. prohibit the unsolicited sale of financial products;
   b. extend unfair contract terms laws to insurance contracts;
   c. regulate claims handling as a financial service, in conjunction with additional penalties and ASIC powers;
   d. introduce a suitability test for insurance;
   e. ban conflicted remuneration for all insurance; and
   f. ban the sale of add-on insurance sales through motor dealerships, and introduce an opt-in deferred sales model for any other sales of add-on insurance.

8. While other changes to regulation and industry practice are required to address the significant detriment highlighted in the case studies, in our view the reforms above would have the most significant impact on people who buy or claim on insurance, particularly vulnerable people.

[3] *Corporations Regulations 2001* (Cth) r 7.1.33 provides an exemption under section 766A of the *Corporations Act 2001* (Cth).

A. PRODUCT DESIGN

Question 2: Are there particular products—like accidental death and accidental injury products—which should not be sold?

9. In our view, certain insurance products examined at the hearing should not be sold, because they are poorly designed, provide low benefits and have caused significant consumer detriment. These products are:

    a. accidental death insurance;
    b. accidental injury insurance;
    c. some forms of funeral insurance; and
    d. some forms of add-on insurance.

10. In our view, an insurance product should not be sold if it demonstrates the features outlined below. Accidental death insurance and accidental injury insurance meet these indicators. Many funeral insurance and add-on insurance products which are currently on sale also meet these indicators. We would like to see ASIC consider these factors when using its forthcoming Product Intervention Power.

Features of insurance products which should not be sold

Very low claims ratio

11. Claims ratios are a clear indicator of the 'value' of a product to customers overall. A low claims ratio shows that premiums are high, benefits are low, and/or the product design and consumer engagement are such that few people make a successful claim. For example, accidental death insurance had a claims ratio of just 16.1 per cent across all insurers in 2016–17.[4] Add-on insurance similarly has very low claims ratios. As we noted in our Module 6 case study submission, IAG's add-on insurance sold through motor dealerships had an average claims ratio of 8.3 per cent in the 2009 to 2016 financial years. Protection Plus Insurance (a type of CCI) had a claims ratio of just 2.1 per cent in that period.[5]

High cancellation rate

12. A high product cancellation rate is indicative of customers not understanding the product and/or being subjected to high-pressure sales tactics. This was evident in ASIC's report on the direct sale of life insurance.[6]

Terms which limit successful claims

13. Policies with clauses which significantly limit the chance of a consumer successfully making a claim can be worthless to many customers. For example, while accidental deaths account for 5 per cent of deaths in Australia, the very narrow definition of 'accident' in ClearView's accidental death insurance policy would

[4] ASIC, *The Sale of Direct Life Insurance,* Report No 587 (2018), 9 [35].
[5] Consumer Action Law Centre, Submission on Round 6 Hearings – Case Studies, 1 October 2018, 15 [58].
[6] ASIC, *The Sale of Direct Life Insurance,* Report No 587 (2018), 37 [174]–[177].

likely insure only a small fraction of those deaths.[7] Another example is the onerous servicing conditions in some warranties, such as a requirement to have the car serviced every three months, in order for a successful claim to be made.[8]

No or very limited value

14. Products which provide a small or even negative monetary value clearly lack value for consumers. This includes, for example, funeral insurance with uncapped premiums, GAP insurance where there is no or little gap to be covered, CCI sold to unemployed people, and warranties with individual benefit limits.

Unaffordable

15. Products which target people who cannot afford them should not be sold. Examples seen by the Commission include ClearView's targeting of 'poor' people with its cold-call selling of life insurance products[9] and Freedom selling insurance to Grant Stewart's son, who was on a disability pension and did not need or understand the product.[10] Funeral insurance products with stepped premiums also typically become unaffordable as people age.

Sold using inappropriate channels or techniques

16. The products we have listed above are typically sold using high-pressure sales tactics, such as cold-calling, selling a different product (accidental death insurance) where the original product (life insurance) cannot be sold, and 'adding-on' the product to a primary purchase. This reflects their lack of necessity or value in the eyes of consumers. They are products which are 'sold to' customers rather than 'bought by' customers.

Seller-driven rather than customer-driven

17. In addition to inappropriate sales channels, some products are designed to financially benefit the people who sell them, not the people who buy them. Examples include:

    a. IAG gave evidence that it considered the 'customers' for its add-on insurance products were the motor dealers who were selling the products.[11]
    b. Some products, such as CCI and funeral insurance, replicate cover that many people already have under their life insurance, which may be default insurance in their superannuation.
    c. ClearView, Freedom and other insurers sold accidental death and accidental injury insurance to people to whom they could not sell life insurance. These are products designed to 'fill a gap', where a company could not sell one product due to underwriting requirements. These products are not designed to meet consumer need or demand.

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[7] Exhibit 6.66.8, *Freedom Protection Plan Product Training* (July 2017).
[8] Consumer Action Law Centre, *Donating Your Money to a Warranty Company* (August 2015), 15–16 <https://consumeraction.org.au/wp-content/uploads/2015/08/DonatingYourMoneyToAWarrantyCompany.pdf>.
[9] Transcript, Gregory Martin, 10 September 2018, 5315–6.
[10] Transcript, Grant Stewart, 11 September 2018, 5405–18.
[11] Transcript, Benjamin Bessell, 18 Sep, 6098.

Recommendation

18. The sale of accidental death insurance and accidental injury insurance should be prohibited. The sale of funeral insurance and add-on insurance which provide little benefit and cause consumer detriment should also be prohibited.

Question 3: Should the requirements of the Life Insurance Code of Practice in relation to updating medical definitions be extended to products other than on-sale products?

19. The minimum standard medical definitions under the LICOP are an improvement on the position prior to 1 July 2017. However, the definitions are an incomplete and inadequate response to the significant detriment caused by outdated medical definitions in life insurance policies. This is because the LICOP definitions:

    - apply to the first $2 million of trauma and critical illness cover only;
    - do not apply to income protection or total and permanent disability (**TPD**) policies;[12]
    - cover cancer, heart attack and stroke only, not other common illnesses;[13] and
    - are developed in consultation with 'relevant' medical specialists, who do not have to be independent.[14]

20. The LICOP definitions themselves should not be deemed an acceptable minimum standard. For example. the LICOP definition of 'cancer' does not cover:

    'Carcinoma in situ except carcinoma in situ of the breast where a total mastectomy with full removal of the breast has been undertaken and was considered by treating doctors to be the appropriate and necessary treatment.'[15]

    This definition could still allow an insurer to decline a claim for breast cancer, in similar circumstances to the CommInsure case study examined by the Commission in Module 6.

21. The CommInsure case studies involving outdated heart attack and cancer definitions showed that outdated medical definitions have caused people to have their claims declined in perverse and unfair ways, when they are at their most vulnerable. These outcomes fall far below community standards and expectations, and show that industry self-regulation is not working. Medical definitions should be kept up to date with accepted, current medical option. Law reform is the appropriate response to a widespread problem which has significant impact on vulnerable people's lives.

Recommendations

22. The law should prescribe standard, up-to-date medical definitions for all life insurance policies. This could be achieved by:

[12] Financial Services Council, *Life Insurance Code of Practice* ('*LICOP*') Appendix cl 8.20A.
[13] *LICOP* Appendix, 30–32.
[14] *LICOP* cl 3.2.
[15] *LICOP* Appendix, 30.

a. extending the unfair contract terms regime to insurance contracts, and specifying that outdated medical definitions are unfair contract terms; and
b. developing standard medical definitions with independent medical experts and other relevant stakeholders, and keeping these definitions current. For mental illnesses, the definitions should be those within the current Diagnostic and Statistical Manual.

B. DISCLOSURE

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

4.1 the purpose(s) that the product disclosure regime should serve;
4.2 whether the current regime meets that purpose or those purposes; and
4.3 how financial services entities could disclose information about financial products in a way that better serves the interests of consumers.

(Despite the reference to the Insurance Contracts Act 1984 (Cth), this question is not limited in scope to contracts of insurance.)

23. The objective of the current financial product disclosure regime is to provide information that 'a person would reasonably require for the purpose of making a decision, as a retail client, whether to acquire the financial product'.[16] The purpose of a Product Disclosure Statement (**PDS**) in particular is to 'help consumers compare and make informed choices about financial products'.[17]

24. The disclosure regime often means little more than a financial services entity providing a PDS of many of dozens of pages to the customer. This type of disclosure is increasingly being recognised as an outdated and ineffective form of consumer protection—it assumes that people make rational decisions on all the available information, and does not acknowledge the realities of human behavioural biases.[18] It is now well-established that insurance disclosure, through PDSs and Key Fact Sheets, is ineffective.[19]

25. As the cases studies of Allianz, AAI and CommInsure showed, the problem is not the disclosure regime alone. It is also advertising—an effective and engaging form of product disclosure—which can mislead people as to the key features of products. In addition, sales scripts and practices, such as those seen in the ClearView and Freedom case studies, can also mislead people and inhibit them from deciding whether

[16] *Corporations Act 2001* (Cth) s 1013D(1).
[17] ASIC, *Regulatory Guide 168*, 28 October 2011, r 168.37.
[18] See for example ASIC, *Submission: Senate Economics References Committee Inquiry into Australia's general insurance industry*, March 2017, 12.
[19] See for example Justin Malbon and Harmen Oppewal, *(in)Effective Disclosure: An experimental study of consumers purchasing home insurance* (2018) <https://australiancentre.com.au/wp-content/uploads/2018/09/InEffectiveDisclosure-final.pdf>; Senate Economics References Committee, *Australia's general insurance industry: sapping consumers of the will to compare* (2017); Insurance Council of Australia, 'Consumer Research on General Insurance Product Disclosures' (Research findings report, February 2017) <http://www.insurancecouncil.com.au/assets/report/2017_02_Effective%20Disclosure%20Research%20Report.pdf>.

a product would be suitable for them. The disparity between sales pitch and reality further undermines the disclosure regime.

26. Disclosure of commissions is intended to alert a consumer to the potential for an adviser, broker or other person selling a product to be conflicted because of how they are being remuneration. However, research in the UK has shown this to have the opposite effective. One study found that consumers interpreted commission disclosure as mortgage brokers being more honest.[20]

27. For a disclosure regime to be effective, it should aim for tangible outcomes—that is, consumers understand financial products and only buy the products which they need, and which are best suited to them. An example of this would include questions in the sales process which clearly identify where insurance may be *unsuitable* for someone, such as CCI if a person is unemployed. However, the complex nature of financial products, particularly insurance, means that a disclosure approach has significant limitations.

28. The most effective changes that could be made to achieve the objective of better consumer understanding and choice of financial products are:

    Law reform

    a. A modernised standard cover regime for insurance, to provide a minimum standard that meets community expectations (see the response to question 5 below). For complex products such as insurance, standardised products are needed to improve the effectiveness of disclosure.
    b. An effective 'product safety' regime. An example of this is the proposed Product Design and Distribution Obligation which will require some financial product issuers, including insurers, to design products for an identified target market and distribute products to those markets. This reform shifts the onus for product knowledge and selection towards the insurer, which is better placed to understand whether a product suits a particular category of customer.[21]
    c. A requirement to include on insurance renewal notices the components of the premium and the prior year's, as recommended by the Senate Economics References Committee.[22] Disclosure of the prior year's premium has been shown to be effective in prompting people to 'shop around'.[23]
    d. A suitability test for insurance, which could form part of an effective Product Design and Distribution Obligation regime, and would consider claims ratios, eligibility targets and compliance

[20] James Lacko and Janis Pappalardo, *The effect of mortgage broker compensation disclosures on consumers and competition: A controlled experiment,* Federal Trade Commission Bureau of Economics Staff Report (February 2004) <https://www.ftc.gov/reports/effect-mortgage-broker-compensation-disclosures-consumers-competition-controlled-experiment>; cited in Financial Services Authority, *Consumer Research 69: Financial Capability: A Behavioural Economics Perspective* (July 2008) <https://www.ftc.gov/reports/effect-mortgage-broker-compensation-disclosures-consumers-competition-controlled-experiment>.

[21] c.f. Joint consumer submission, *Senate Economics Inquiry into Treasury Laws Amendment (Design and Distribution Obligations and Product Intervention Powers) Bill 2018* < https://policy.consumeraction.org.au/2018/10/16/senate-inquiry-pip-dado-bill/>

[22] Senate Economics References Committee, *Australia's general insurance industry: sapping consumers of the will to compare*, August 2017, ix (rec 3 [3.76] rec 4 [3.77]).

[23] Financial Conduct Authority, *FCA to require insurance firms to publish details of last year's premium* (Press Release, 3 December 2015) <https://www.fca.org.uk/news/press-releases/fca-require-insurance-firms-publish-details-last-year%E2%80%99s-premium> .

performance of insurance products. This could be formulated with consideration of the UK's individual suitability test.[24]

Industry best practice

e. Accurate advertising, which informs people of key features of products.
f. Transparent sales processes which improve and assess consumers' understanding of products.

Recommendations

29. The inadequacies of the disclosure regime should be addressed by:

    a. Reforming the law to provide:
        i. a modernised standard cover regime;
        ii. effective Product Design and Distribution Obligations on insurers issuers and distributors;
        iii. improved disclosure on insurance renewal notices; and
        iv. a suitability test for insurance.
    b. Insurers and their distributors improving advertising, marketing and sales practices.

Question 5: Is the standard cover regime in Division 1 of Part V of the *Insurance Contracts Act 1984* (Cth) achieving its purpose? If not, why not, and how should it be changed?

30. The standard cover regime for insurance is clearly not meeting its objectives. The 1982 Australian Law Reform Commission (**ALRC**) inquiry into insurance contracts recommended standard cover as a benchmark for insurance. The ALRC stated:

> 'Policies contain numerous terms which affect in unexpected ways the cover offered… **The insured's ignorance remains undisturbed until he makes a claim.** Standard cover should be prescribed in certain fields of insurance… **The control of policy terms is not a matter which can be left to self-regulation.**
>
> …
> An insurer should be free to market policies which offer less than the standard cover. If it chooses to do so, **it should have to draw the insured's attention to that fact and to the nature of the relevant diminution in cover**. If it fails to do so, the contractual terms should be overridden to the extent to which they provide cover which is less than the standard.'[25]

31. Despite the ALRC's recommendation, the IC Act as passed allowed an insurer to offer less than standard cover if they also provide the policy wording.[26] There is no requirement for an insurer to draw a consumer's attention to the fact that its policy falls below standard cover. As Consumer Action stated to the 2017

[24] Financial Conduct Authority (UK), *Insurance Conduct of Business Sourcebook,* Release 32 (2018), ch 5 < https://www.handbook.fca.org.uk/handbook/ICOBS/5.pdf>; Gail Pearson, 'There are a few gaping holes in the proposals to beef up ASIC' *The Conversation* (Online), 16 December 2016 <https://theconversation.com/there-are-a-few-gaping-holes-in-the-proposals-to-beef-up-asic-70408>.
[25] Australian Law Report Commission, *Insurance Contracts*, Report No 20 (1982), xxxviii [69]–[70].
[26] Section 35 of the Statute Law (Miscellaneous Provisions) Bill (No 1) 1985 (Cth) clarified that an insurer can notify an insured by providing a copy of the policy document itself.

Senate Economics References Committee Inquiry into Australia's general insurance industry: 'It is fair to say that standard cover is not a reality. We have no minimum standard for insurance and no benchmarks for comparison.'[27]

32. This bears out in the conduct of insurance disputes. Consumer Action reviewed Financial Ombudsman Service (**FOS**) decisions between 1 July 2013 and 30 June 2018. This review found that, of the thousands of FOS domestic insurance determinations since July 2013:

    - standard cover was considered in just 30 determinations;
    - standard cover was found to apply in 43 per cent of those cases; and
    - the insurer had not provided a PDS in 92 per cent of cases where standard cover applied—that is, the insurer's failure to provide a PDS is the overwhelming reason standard cover applied.

33. The experience of consumers at EDR indicates that:

    a. standard cover is rarely raised by consumers in disputes with insurers; and
    b. when standard cover is raised, it appears to provide little recourse for consumers.

34. We understand that the Government plans to review disclosure in insurance, including standard cover. In our view, the options and issues which should be considered are:

    a. Updating the features of the existing standard cover regime[28] to meet modern community standards and expectations. It is unlikely that a regime developed without significant consumer input in the early 1980s is fit for purpose today.
    b. Making standard cover a mandatory minimum standard for insurance policies.
    c. Developing a 'rating' system which rates products against the standard cover benchmark.

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

35. Insurance policies should use standard definitions of key terms, to clarify what consumers can expect from their policies and avoid 'claims shock'. ASIC told the Senate Economics References Committee 2017 Inquiry into Australia's general insurance industry that:

    '[W]here there are differences in definitions, it is not always possible for consumers to appreciate the nuances that those differences can create and, if you do have a different definition, what the implications of that are from a coverage perspective.'[29]

36. The wording and coverage of insurance policies vary hugely. This makes the task of comparing policies and making an informed choice virtually impossible. In August 2017, the Senate Economics References Committee Inquiry into Australia's general insurance industry reported that the complexities and

[27] Senate Economics References Committee, *Australia's general insurance industry: sapping consumers of the will to compare* (2017), 37 [3.54].
[28] *Insurance Contracts Regulations 2017* (Cth), pt 3 div 1.
[29] Michael Sadaat, ASIC, cited in Senate Economics References Committee, *Australia's general insurance industry: sapping consumers of the will to compare* (2017), 38, [3.60].

variations in home and motor vehicle insurance were 'sapping consumers of the will to compare'.[30] The varied definitions of key terms is a significant part of this failure in the market. Examples of this include:

a. There are different definitions of 'actions of the sea' under home insurance policies, which exclude loss or damage caused by 'actions of the sea' to a greater or lesser extent.[31]
b. There are different definitions of the 'reasonable cost' for which insurers will cash settle a home building claim.[32]
c. The standard definitions of heart attack, cancer and stroke under the LICOP only apply to some policies which are currently 'on sale'. Those standard definitions do not apply to the very large number of existing policies (see further our response to question 3).

37. The importance of definitions in insurance policies became very clear in 2011, when major flooding in Queensland saw some people's claims denied because the definition of 'flood' in their policy did not include riverine flooding.[33] The Government responded by legislating a standard definition of 'flood' in home, strata and some small business insurance contracts, which includes riverine flooding.[34]

38. The Senate Economics References Committee Inquiry recommended the government work closely with industry and consumer groups to establish standard definitions of other key terms in general insurance policies.[35] In our view, this should extend to life insurance policies, as the same problems and principles apply across many types of insurance policies.

Recommendation

39. Standard definitions of key terms in life and general insurance policies should be defined at law and should be developed in consultation with stakeholders, including consumer groups.

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[30] Senate Economics References Committee, *Australia's general insurance industry: sapping consumers of the will to compare* (2017).
[31] CHOICE, cited in Senate Economics References Committee, *Australia's general insurance industry: sapping consumers of the will to compare* (2017), 38, [3.62].
[32] See for example AAMI, *Home Building Supplementary Product Disclosure Statement* (19 January 2018) <https://www.aami.com.au/aami/documents/personal/home/spds-building-05-03-2018.pdf>; *RACV, Home Insurance: Product Disclosure Statement and Policy Booklet* (29 September 2017), 71 <https://www.racv.com.au/content/dam/racv/documents/insurance/racv-home-insurance/RACV_Home_PDS_G018333_0618.pdf>; Allianz, *Home Insurance Product Disclosure Statement* (31 May 2017), 6 <https://www.einsure.com.au/wb/public/openCurrentPolicyDocument/POL1085DIR/$FILE/POL1085DIR.pdf>.
[33] See Treasury, *Reforming Flood Insurance: Clearing the Waters* (2011), 3–4.
[34] *Insurance Contracts Regulations 2017* (Cth) r 34.
[35] Senate Economics References Committee, *Australia's general insurance industry: sapping consumers of the will to compare* (2017), ix (rec 6 [3.79]).

C. SALES

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

40. In our view, conflicted remuneration is a root cause of many problems exposed at the Commission, and it should be banned. A blanket ban would simplify the law, reduce the risk of regulatory arbitrage and close the loopholes which have been created through industry lobbying.

41. General insurance should be subjected to the conflicted remuneration ban. The current exemption is not supported by the realities faced by consumers. For example, reverse competition in the add-on insurance market in motor dealerships (see our response to section D below) has caused widespread harm to hundreds of thousands of people. The pressure-selling of insurance, including various types of general insurance, through bank branches is another practice that is clearly not consumer-centric and is driven by conflicted remuneration. Both examples are clear cases for removing the exemption.

Recommendation

42. Conflicted remuneration should be banned for general insurance.

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

43. As noted in question 7, a ban on conflicted remuneration would go a significant way towards preventing the poor sales practices and consumer harm exposed at the Commission. The poor selling practices of ClearView and Freedom were predominantly driven by conflicted remuneration including commissions and incentives.

44. While there has been law reform to restrict commissions in life insurance,[36] this has not completely stopped problems caused by conflicts. The restrictions involved a reduction in upfront commissions from July 2016, and a cap on ongoing commissions at 20 per cent. The reform also allowed for clawback of commissions in certain circumstances and a ban on other forms of conflicted remuneration. We refer to the Parliamentary Joint Committee on Corporations and Financial Services (**PJC**) report on the Life Insurance Industry published in March 2018, which found, despite these reforms there was still 'a plethora of hidden payments including commissions, fees, performance-related payments, soft dollar benefits, and non-financial benefits' in the life insurance industry.[37] The report found that these money flows exist to varying degrees across retail, direct and group insurance.

45. While the PJC report recommended greater transparency associated with the fees, including fees which insurers pay advisers for training (referred to as a 're-badging exercise'), we consider that a better response would be a complete ban on conflicted remuneration. This is particularly so given the avoidance strategies

[36] *Corporations Amendment (Life Insurance Arrangements) Act 2017* (Cth).
[37] PJC, *Life Insurance Industry* (2018), 85 [5.85].

engaged in by industry, which means that participants are not capable of managing the conflicts of interests that arise. These payments should therefore be removed entirely.

Recommendation

46. Conflicted remuneration should be banned for life risk insurance.

Question 9: Is banning conflicted remuneration sufficient to ensure that sales representatives do not use inappropriate sales tactics when selling financial products? Are other changes, such as further restrictions on remuneration or incentive structures, necessary?

47. While a ban on conflicted remuneration of sales representatives is critical to prevent inappropriate sales tactics, it is not on its own enough. To tackle the endemic problem of inappropriate selling of financial products, the following changes must also take place:

    a. The conflicted remuneration ban must apply not only to frontline sales staff but to *all* staff, up to and including executive level staff. The objective of this change should be to shift the embedded sales culture of financial services businesses to a culture of customer service and trust (see further our response to question 38).
    b. Unsolicited sales should be banned entirely. Unsolicited sales cause significant consumer harm and do not deliver any benefits to consumers which would justify the practice continuing (See further our response to question 10).
    c. An opt-in deferred sales model should be introduced for all add-on insurance sales (see further our response to question 10).
    d. Financial services entities should set targets and KPIs which recognise and reward customer service and satisfaction rather than pure profit (see further our response to question 38 below).

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

48. There is a clear case for banning unsolicited sales of not only insurance but all financial products.

49. ASIC recently reported on the significant harm caused by direct sales of life insurance, finding high cancellation rates and high claim decline rates.[38] ASIC has signalled its intention to restrict outbound sales calls for life insurance.[39]

50. The ClearView and Freedom case studies at the Commission showed the significant harm caused by unsolicited sales of insurance, including:

    a. **Sales to vulnerable people**: The case study of Grant Stewart, whose son has a disability and was cold-called and sold insurance by Freedom, showed the stark reality of unsolicited selling. Cold-calling is a particularly harsh practice when it involves vulnerable people who may not understand

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[38] ASIC, *The Sale of Direct Life Insurance,* Report No 587 (2018).
[39] ASIC, *The Sale of Direct Life Insurance,* Report No 587 (2018), 17 [78].

the products or feel able to say no to the seller. Many people targeted by cold-calls have no need for the products being sold. While Freedom identified that it inappropriately sold insurance to four vulnerable people other than Grant Stewart's son, it is likely that a much larger group of people have been harmed by the direct selling of life insurance by ClearView, Freedom, TAL and other insurers.

b. **Targeting people who could not afford it**: ClearView targeted people on disability pensions and others with lower financial means for cold-call sales of insurance. This increases the risk of unsuitable sales and cancellations due to non-payment of premiums.
c. **Poorly-designed, low-value products**: Insurance products sold via cold-calling, particularly accidental death and accidental injury insurance, are not valuable products. This is evidenced by their very low claims rates and ratios (see our response to question 2);
d. **Insurers not complying with unsolicited selling laws**: ClearView, which had significant cold-calling operations within its business, may have breached the existing anti-hawking provision—a law integral to its business operations—more than 300,000 times.[40]

51. Section 922A(3) of the Corporations Act allows unsolicited selling if the seller meets certain requirements. For ClearView, and presumably other insurers, the watered-down anti-hawking requirement has seen unsolicited selling take place within structures and systems which do not ensure compliance with the law. This type of non-compliance is an inevitable risk of any laws which are relatively complex and contain loopholes which may enable businesses to go further with their practices than the 'spirit' of the law dictates. The anti-hawking provision is an example of laws being complicated by industry lobbying. Laws such as these, which have been heavily influenced by industry interests rather than implementation of evidence-based policy solutions, are ineffective at protecting people from harm.

52. In addition to the problems exposed at the Commission, Consumer Action has seen people suffer severe financial harm as a result of the finance sold with products which are sold through cold-calling and unsolicited meetings. These products include timeshare schemes and products sold door-to-door, such as solar panels sold with unregulated credit. We also regularly hear complaints about unsolicited sales of consumer leases, particularly among Aboriginal and Torres Strait Islander communities. We do not see unsolicited sales deliver benefits to consumers. Generally, the products sold are expensive and poor value. Frequently, they are sold to people who cannot afford them.

Recommendation

53. The unsolicited sale of financial products should be banned.

[40] Transcript, Senior Counsel Assisting, 21 September 2018, 6463.

Question 11: Is Recommendation 10.2 from the Productivity Commission's report on "Competition in the Australian Financial System", published in June 2018, sufficient to address the problems that can arise where financial products are sold under a general advice model (for example, the sale of financial products to consumers for whom those products are not appropriate)? If not, what additional changes are required? Are there some financial products that should only be sold with personal advice?

54. In our view, renaming 'general advice' is not a sufficient response to the problems and confusion arising from the sale of financial products under general advice models.

55. While there are significant problems with insurance products that are sold under general advice, consumers are overwhelmingly unaware of which advice model sellers are operating under. To focus on the name of 'general advice' and on better informing consumers of the advice regime falls into the same trap of the disclosure regime (see our response to question 4). That is, largely futile efforts are being directed at improving consumer understanding, rather than improving seller conduct and product safety.

56. The advice regime could instead benefit from a more practical, outcomes-based approach to regulation. This would look at factors such as the types of products, the sales environment and representative and indicators of the value of the particular product, or lack thereof (see for example the features outlined in our response to question 2),

Recommendation

57. Advice should be regulated on an outcomes basis, considering the types and value of products, and the risks of particular sales channels.

Question 12: Should all financial services entities that maintain an approved product list be required to comply with the obligations contained in FSC Standard No 24: Life Insurance Approved Product List Policy?

58. All entities with Approved Product Lists (**APL**s) should comply with the FSC's Standard. There is no reason that some sellers of life insurance products should operate to a lesser standard than others. However, we reiterate our view that self-regulation should clarify and enhance how insurers will comply with the law. It should not be a substitute for actual regulation. Any critical improvements to the obligations of insurers, advisers, superannuation funds and others selling insurance should be enshrined in law.

59. We further note and support the recommendation of the PJC that the industry transition to open approved product lists, as well as its recommendation that appropriate regulators investigate whether the use of APLs in the industry breach any competition laws.[41]

[41] PJC, *Life Insurance Industry* (2018), 100-1 [6.45], [6.48].

D. ADD-ON INSURANCE

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

60. The sale of add-on insurance by motor dealers should be prohibited. The profits of insurers and car dealers—not customer need—are the rationale for the car yard add-on insurance market. The many, significant problems with add-on insurance sold in motor dealerships have been well-known for years. ASIC calls it 'a market that is failing consumers'.[42]

61. Reverse competition—through insurers paying commissions and incentives to dealers—has driven this market. IAG gave evidence to the Commission that it viewed motor dealers as its customers, and that its focus was on maintaining its car yard distribution network.[43] Because motor dealers rely on products such as add-on insurance for their profits, IAG admitted under cross-examination that in some cases incentivising dealers to sell add-on insurance was 'more likely to result in inappropriate sales'.[44]

62. This perverse market rationale and structure has led to significant consumer detriment, including high commissions, pressure selling of unsuitable and poor-value products. This has caused the following problems for consumers:

    a. Insurers having paid dealers four times more in commissions than they paid to consumers in benefits. These commission have been as high as 79 per cent.[45]

    b. The sale of very poor-value products, with an average CCI claims ratio of 5 per cent, and an average claims ratio of 9 per cent across all products in motor dealerships.[46]

    c. The sale of insurance which is unsuitable, for example, because it has little to no value or the consumer is ineligible to claim on it. The issues which ASIC identified with IAG products in 2017 exemplify many of the suitability problems with add-on insurance.[47] IAG, which was at one time a significant player in this market, admitted at the hearings that a 'significant number' of its add-on insurance products 'were of questionable or little value to the consumer'.[48] This systemic problem has resulted in insurers agreeing to pay over $122 million in remediation to more than 257,000 customers who were mis-sold add-on insurance in motor dealerships.[49]

    d. Rampant mis-selling of add-on insurance products is clear from the experiences of the almost 600 people who have claimed close to $1.5 million using Consumer Action's DemandARefund.com website. As submitted in our Module 6 case study submission, the sale of low-value add-on

[42] ASIC, *A market that is failing consumers, The sale of add-on insurance through car dealers*, Report No 492 (2016).
[43] Transcript, Benjamin Bessell, 18 September 2018, 6097–8.
[44] Transcript, Benjamin Bessell, 18 September 2018, 6105–6.
[45] ASIC, *A market that is failing consumers, The sale of add-on insurance through car dealers*, Report No 492 (2016), 7 [20].
[46] ASIC, *A market that is failing consumers, The sale of add-on insurance through car dealers*, Report No 492 (2016), 14–15 [45] and [47].
[47] Transcript, Benjamin Bessell, 18 September 2018, 6137–40.
[48] Transcript, Benjamin Bessell, 19 September 2018, 6140.
[49] Productivity Commission, *Competition in the Australian Financial System*, Inquiry Report No 89 (2018), 425.

insurance by motor dealers could constitute unconscionable conduct and/or a breach of the duty of utmost good faith.[50] Typical examples of conduct by motor dealers include:

i. 'hiding' add-on insurance in lengthy documentation, without the consumer realising they are being sold the insurance;

ii. telling consumers that they must take out add-on insurance to get a car loan, or that they will have a better chance of being approved for a loan if they take out the insurance; and

iii. making consumers feel rushed into making a decision to buy a complex insurance product, when the consumer is focused on buying a car.

Recommendation

63. The sale of add-on insurance by motor dealers should be prohibited.

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

64. We reiterate that add-on insurance should not be sold in motor dealerships, However, if the products continue to be sold, they should only be sold under a deferred sales model in which the customer proactively opts-in to buying the insurance. This should apply to all add-on insurance products and distribution channels, including banks, credit unions and other finance providers.

65. The current proposals for a deferred sales model are split by distribution channels. ASIC is expected to shortly consult on a deferred sales model for motor dealerships.[51] The new Code of Banking Practice (**CofBP**) includes a very limited—and, in our view, inadequate—deferred sales model for some CCI products and sales channels.[52] As the Productivity Commission recently stated, 'the regulatory paradigm appears to involve ASIC in a game of whack-a-mole with insurers and their retailing partners'.[53]

66. The Productivity Commission has proposed that ASIC should proceed as soon as possible with its motor dealership deferred sales model, and that the deferral period should be a minimum of seven days from when the consumer applies for the primary products. The Productivity Commission has also proposed that a Treasury working group be established to implement an industry-wide deferred sales model. The group would consider the trigger event, length of the deferral period, whether 'bridging insurance' should be sold, and ways consumers can opt-out.[54]

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[50] Consumer Action Law Centre, Submission on Round 6 Hearings — Case Studies, 1 October 2018, 14–18 ([52]–[72]).
[51] See Alice Uribe, 'ASIC's deferred model for sale of car-yard cover questioned', *Australian Financial Review* (Sydney), 13 March 2018.
[52] Australian Banking Association, *Code of Banking Practice* (2019), ch 18.
[53] Productivity Commission, *Competition in the Australian Financial System*, Inquiry Report No 89 (2018), 430.
[54] Productivity Commission, *Competition in the Australian Financial System*, Inquiry Report No 89 (2018), 431–2.

67. In our view, the Productivity Commission proposal may not deliver the desired outcome of curbing consumer detriment caused by add-on insurance. An effective, economy-wide deferred sales model would take into account understandings of consumer behaviour and would have the following features:

   a. **Comprehensiveness and consistency**: A consistent model would apply to all distribution channels and products. This would enable consistent regulation and compliance and set industry and consumer expectations of what a legitimate sale of add-on insurance sale may look like. It would ensure that all consumers are equally protected from pressure-selling and paying for products they do not understand or need.

   b. **Customer opt-in**: The customer would need to proactively contact the insurer after the deferral period to purchase the insurance. This is a critical element. Without this requirement, pressure-selling will continue to take place at some point in the sale. While the consensus position of industry rejects this feature, we note that the ICA admitted in evidence that it would be 'better' for the customer to initiate contact at the end of the deferral period.[55]

   c. **A genuine 'break' in the sale**: The model would clearly separate the sale of a car, finance or credit from the sale of add-on insurance, ideally by 30 days. However, the length of the deferral period should not be the primary mechanism for separating the primary sale from the sale of add-on insurance. An effective model would only allow the add-on insurance sale *after* the primary transaction is complete. In our view, the Productivity Commission proposal and CofBP model are materially lacking on this feature.

   d. **No 'bridging insurance'**: 'Bridging insurance' would not address any issue particular to a deferred sales model. Existing add-on insurance products typically have waiting periods. The introduction of 'bridging insurance' would simply create a new opportunity for high-pressure selling and make consumers feel invested in replacing the 'bridging' cover with an add-on insurance product after the deferral period.[56] 'Bridging insurance' would be a bridge to unsuitable add-on insurance for consumers.

   e. **Monitoring and evaluation**: Insurers and distributors would maintain robust data on who they are selling add-on insurance to, and how these sales take place. This process would involve record-keeping, shadow shopping and other check, and regular reporting to ASIC. ASIC would take a proactive role in monitoring sales, particularly where there are high risks sales identified. These would include sales through car yards and to categories of people who are more likely to be ineligible to claim (for example, a wide range of people who are not in full-time employment).

Recommendation

68. If add-on insurance continues to be sold, this should be done through a deferred sales model in which the customer proactively opts-in to buying the insurance. A consistent model should apply to all add-on products and sales channels, and should have the features identified in our response to question 14.

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[55] Transcript, Robert Whelan, 21 September 2018, 6403.
[56] See Consumer Action Law Centre et al, Joint submission: Options to reform the sale of add-on insurance and warranties in car yards, 23 October 2017, 11–12.

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

69. There are several forms of insurance for which a deferred sales model may benefit consumers:

    a. unsolicited sales of any insurance;
    b. add-on sales of travel insurance; and
    c. add-on sales of ticket insurance.

70. If unsolicited sales of financial products are not prohibited—as canvased in question 10—a deferred sales model should apply to products sold via cold-calling or unsolicited meetings. This would be a much more effective consumer protection than existing cooling-off rights. It would remove the 'endowment effect' or 'status quo bias' which causes people to see value in products they have already purchased and hold on to those products.[57]

71. The most common types of add-on insurance by sales volume are travel insurance and ticket event or cancellation insurance, which together account for 65 per cent of all add-on insurance sales.[58] Add-on travel insurance sold through airlines and travel agents has been found to be lower-value than the same insurance purchased direct online.[59] However these products have 'bypassed scrutiny' while the focus has been on CCI and other add-on insurance sold with cars, finance and credit.[60] There is strong rationale for applying the deferred sales model to travel and ticket insurance also, particularly as these products can be poorly designed and low-value.

Recommendation

72. If the unsolicited selling of financial products is not prohibited, a deferred sales model should apply to products sold through unsolicited calls and meetings.

73. A deferred sales model should be considered for add-on travel insurance and ticket insurance.

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

74. In our view, there is sufficient evidence to support:

    a. an outright prohibition on the sale of add-on insurance in motor dealerships (see our response to question 13); and

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[57] See further Daniel Kahneman et al, 'Anomalies: The Endowment Effect, Loss Aversion, and Status Quo Bias' (1991) 5(1) *Journal of Economic Perspectives* 193.
[58] General Insurance Code of Practice Code Governance Committee, *Who is selling insurance?* (2018), 5 < https://www.fos.org.au/custom/files/docs/code-governance-committee-who-is-selling-insurance-report.pdf>.
[59] Pedersen-McKinnon (2017), in Productivity Commission, *Competition in the Australian Financial System*, Inquiry Report No 89 (2018), 429.
[60] General Insurance Code of Practice Code Governance Committee, *Who is selling insurance?* (2018), 6 < https://www.fos.org.au/custom/files/docs/code-governance-committee-who-is-selling-insurance-report.pdf>.

b. a ban on conflicted remuneration for general insurance products (see our response to question 7).

75. Commissions drive the sale of add-on insurance in motor dealerships. A ban on these commissions could remove the reason for the market's existence and reduce consumer harm. However, a ban on these commissions could also leave open the risk of regulatory arbitrage, for example, by insurers providing 'soft' benefits. This could play out similarly to the example of Freedom and ClearView providing 'training'. conferences and other benefits to salespeople to circumvent the current ban on conflicted remuneration.[61]

76. Imposing a cap on commissions would not stem the damage caused to consumers by add-on insurance sales. Commissions on personal-use CCI are already capped at 20 per cent, and criminal penalties apply for breach of this cap.[62] This has obviously not prevented poor product design, pressure-selling and unsuitable sales of CCI in motor dealerships. In 2017, the ACCC rejected the application by insurers for a 20 per cent commission cap on all add-on insurance sold in motor dealerships. The ACCC stated:

> *[T]he ACCC considers that a commission cap is unlikely to:*
>
> - *remove incentives for the sale of poor value add on insurance policies*
> - *reduce the overall price paid by consumers for add on insurance policies*
> - *improve the quality of add on insurance policies*
> - *remove the risk of inappropriate sales practices in the car dealership channel, or*
> - *ensure that consumers have access to adequate information to make an informed purchasing choice at the time of purchase.*
>
> *Accordingly, the ACCC is not persuaded that the proposed conduct is likely to result in any significant public benefit.*

77. We support the ACCC's view. Capping commissions is not an effective way to prevent significant consumer harm in a market solely driven by conflicted remuneration.

Recommendation

78. In the alternative to a ban on the sale of add-on insurance in motor dealerships, commissions on add-on insurance sales through motor dealerships should be prohibited. The risk of circumvention of this ban must be taken into account in the legislative drafting and regulatory approach.

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[61] Transcript, Craig Orton, 11 September 2018, 5465; Transcript, Gregory Martin, 11 September 2018, 5390.

[62] *National Consumer Credit Protection Act 2009* (Cth) sch 1 ('*National Credit Code*') s 145. The criminal penalty is 100 penalty units: s 145(3).

E. CLAIMS HANDLING

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

79. Insurance claims handling should be brought within the definition of 'financial service', so that insurers are required to comply with section 912A of the Corporations Act when they handle and settle claims.

80. Claims handling is currently largely self-regulated, due to the exemption that the insurance industry negotiated from section 912A. The self-regulation model has failed, as evidenced by the gruelling and damaging experiences of consumers in the case studies of AAI, Youi, CommInsure and TAL. Claims-handling disputes continue to be high at the Financial Ombudsman Service (**FOS**), suggesting that these case studies are not isolated instances.[63]

81. From a consumer's perspective, claims handling is the most critical part of an insurer's business. The evidence adduced has shown that the claims handling practices of insurers may not meet the requirements of section 912A of the Corporations Act. For example, if section 912A applied to claims handling:

    a. The claims delays and very poor dealings with consumers by CommInsure, TAL, AAI and Youi in those case studies would point to a failure to provide a financial service 'honestly, efficiently and fairly';[64] and
    b. TAL's claims team being responsible for resolving claims, but also having KPIs relating to the time in which claims should be resolved, irrespective of the claims outcomes,[65] could mean the arrangements for managing conflicts of interest in claims handling are inadequate.[66]

Recommendation

82. Insurance claims handling should be defined as a 'financial service' and subject to the general AFSL holder obligations under section 912A of the Corporations Act.

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

83. If insurance claims handling was brought within the Corporations Act definition of 'financial service', ASIC would have greater remit over claims handling. This would mean ASIC could apply a licence condition, or suspend or cancel a licence, if an insurer breached section 912A in its claims handling.

84. In addition to the administrative penalties currently available, the ASIC Enforcement Taskforce recommended reforms to strengthen the role of the regulator in relation to breaches of section 912A. The

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[63] There were 8,603 general insurance disputes in 2017-18. While this is 2 per cent less than the previous year, it follows increases of 26 per cent and 28 per cent in the two years prior to that: FOS, *Annual Review 2017–18* <https://www.fos.org.au/public/file/FOSAnnualreview2017-18.pdf>.
[64] As required under *Corporations Act 2001* (Cth) s 912A(1)(a).
[65] Transcript, Loraine van Eeden, 14 September 2018, 5735.
[66] This could breach *Corporations Act 2001* (Cth) s 912A(1)(aa).

Federal Treasurer has proposed to introduce legislation in this regard.[67] These additional, complementary reforms include:

a. civil penalties for a breach of the section 912A obligations;
b. a relinquishment power to prevent unjust enrichment associated with the breach of a civil penalty provision; and
c. new civil penalties and increased criminal penalties for breach of the requirement under section 912D of the Corporations Act to notify ASIC of a breach of section 912A.

85. Other reforms proposed by the ASIC Enforcement Taskforce which are yet to be progressed by the Federal Government include a directions power to enable ASIC to address or prevent harm for consumers.

86. While ASIC can take licensing action for breach of the duty of utmost good faith in relation to claims handling, ASIC cannot currently seek a civil or criminal penalty for breach of this provision.[68] The abovementioned proposed legislation does additionally propose a civil penalty framework for the IC Act, including for breach of utmost good faith.[69]

87. This is welcome, however extending the general obligations in section 912A to insurance claims handling is likely to allow ASIC to provide greater oversight to ensure claims handling is conducted 'efficiently, honestly and fairly'. This obligation is likely to meet community expectations in a way in which the duty of utmost good faith cannot.[70]

Life insurance

Question 19: Should life insurers be prevented from denying claims based on the existence of a pre-existing condition that is unrelated to the condition that is the basis for the claim?

88. Insurers should not deny claims on the basis of unrelated pre-existing medical conditions.

89. The problem of life insurers denying claims on the basis of non-disclosure of unrelated conditions by the insured when the policy was entered into is significant and widespread. TAL's attempt to deny a claim for anxiety on the false basis that it was a pre-existing condition, due to previous work and other stress, is a typical example of this.[71]

90. We note that an insured person who has a pre-existing condition which is not known to the insurer, and which they do not know is relevant to the insurer, may be paying for 'illusory' cover. Improvements to the

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[67] Exposure Draft, Treasury Laws Amendment (ASIC Enforcement) Bill 2018 ss 61, 103. See The Hon Josh Frydenberg MP, *Strengthening penalties for white collar crime* (Media Release, 21 October 2018) <http://jaf.ministers.treasury.gov.au/media-release/033-2018/>.
[68] *Insurance Contracts Act 1984* (Cth) s 14A.
[69] *Exposure Draft, Treasury Laws Amendment (ASIC Enforcement) Bill 2018* (Cth), Schedule 4, item 2.
[70] See our commentary and case studies in Consumer Action Law Centre, *DENIED: Levelling the playing field to make insurance fair* (2018), 6-12 [1.2.1].
[71] Transcript, Loraine van Eeden, 13 September 2018, 5786-9.

insured's duty of disclosure (see our response to question 32) could address these problems, as the problem only emerge when a consumer makes a claim and is in a vulnerable situation.

Question 20: Should life insurers who seek out medical information for claims handling purposes be required to limit that information to information that is relevant to the claimed condition?

91. Life insurers should only be able to obtain information relevant to the claimed condition.

92. This is a significant aspect of insurance claims handling which the industry inappropriately self-regulates. Clause 8.5 of the LICOP states that, in relation to claims, that: 'We will only ask for and rely on information and assessments that are relevant to your claim and policy, and we will explain why we are requesting these.' This provides insurers with a broad remit to request any information relevant to the 'policy', not just the claimed condition. This does not guarantee protection or privacy for claimants during the claim.

Recommendation

93. The law should require life insurers to only request information relevant to the claimed condition when assessing a claim.

Question 21: Should life insurers be prevented from engaging in surveillance of an insured who has a diagnosed mental health condition or who is making a claim based on a mental health condition? If not, are the current regulatory requirements sufficient to ensure that surveillance is only used appropriately and in circumstances where the surveillance will not cause harm to the insured? If the current regulatory requirements are not sufficient, what should be changed?

94. In our view, surveillance of claimants by insurers should not be prohibited entirely. However, it should not be allowed in relation to mental health conditions. The TAL case study demonstrated that the way insurers and their service suppliers undertake surveillance of claimants has lacked empathy and respect, and could exacerbate a claimant's mental illness.[72] This clearly falls far short of community standards, and is another example of claims handling should be properly regulated, not just governed by industry codes.

95. Surveillance is not an appropriate way of gathering information about mental health conditions which are, by their nature, 'hidden'. Surveillance is unlikely to be an effective method of finding information about a person's mental illness. There are other methods which insurers could use to gather information, such as interviews with third parties.

96. Financial Rights Legal Centre (**Financial Rights**) examined claims investigations and surveillance in its report *Guilty until proven innocent: Insurance investigations in Australia*.[73] Financial Rights reported that almost one in four calls to its Insurance Law Service related to concerns with insurance investigations. It also reported that many allegations of fraud by an insurer were not upheld in EDR.[74] The report found,

[72] Transcript, Commissioner Hayne, 6484–5.
[73] Financial Rights Legal Centre, *Guilty until proven innocent: Insurance investigations in Australia* (March 2016) <http://financialrights.org.au/wp-content/uploads/2016/03/Guilty-until-proven-innocent.pdf>.
[74] Financial Rights Legal Centre, *Guilty until proven innocent: Insurance investigations in Australia* (March 2016), 7 <http://financialrights.org.au/wp-content/uploads/2016/03/Guilty-until-proven-innocent.pdf>.

relevantly to surveillance, that people felt bullied and harassed by investigators and in some cases racially profiled.[75]

97. We understand that ICA intends to implement some of these recommendations in its GICOP. However, the problem of inappropriate and damaging investigations and surveillance is significant and systemic. In our view, these problems are better addressed through law reform.

98. Current regulation is clearly not adequate. To address the issues seen in *Guilty until proven innocent*, uniform laws for surveillance and private investigators should be introduced.

Recommendations

99. The problems with surveillance of claimants with a mental illness should be addressed by:

    a. regulating insurance claims handling as a financial service, to ensure the general obligations of AFSL holders apply;
    b. banning the use of surveillance in relation to claimants for claims in relation to a mental health condition;
    c. introducing uniform laws for surveillance devices and private investigators.

General insurance

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

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

100. It is clear that insurers' current cash settlement practices do not meet community standards or expectations, and that these types of clauses should not continue to operate to the detriment of consumers.

101. AAI's current AAMI home building insurance cash settlement clause allows AAI to settle a claim for a 'reasonable cost', being 'the amount we determine. Reasonable cost is the lesser amount of any quotes obtained by us and/or by you. Discounts may be available to us through our suppliers.'[76] This means that AAI can settle a claim for less than it would cost the insured person to repair or rebuild the home, irrespective of the sum insured. AAI submitted that this clause did not fall below community expectations and standards, because the 'PDS is clear: AAI will pay the amount it would cost AAI to repair or rebuild.'[77]

102. In our view, the AAI PDS and submission to the Commission fundamentally misunderstand what the community expects of insurers, particularly considering that people make home building insurance

[75] Financial Rights Legal Centre, *Guilty until proven innocent: Insurance investigations in Australia* (March 2016), 7 <http://financialrights.org.au/wp-content/uploads/2016/03/Guilty-until-proven-innocent.pdf>.
[76] AAMI, *Home Building Insurance: Supplementary Product Disclosure Statement* (9 January 2018) <https://www.aami.com.au/aami/documents/personal/home/spds-building-05-03-2018.pdf>.
[77] AAI, Round 6 Insurance: Submissions on behalf of AAI re natural disaster insurance, 1 October 2018, [25].

claims at some of the worst time of their lives, financially and personally.[78] This position also disregards the reality that the way AAMI advertised its home building insurance product did not reflect the PDS, and that, in any case, it is well-established that very few people read or understand insurance product disclosure documents.[79]

103. While amendment to the GICOP may improve people's claims experiences, self-regulation is once again not an appropriate or proportionate response to the systemic problem of inadequate cash settlements by insurers, which many people feel pressured to accept. The requirements proposed in question 22 could instead be introduced into law through two key reforms:

    a. **22.1 act fairly**: if insurance claims handling are brought under section 912A of the Corporations Act, insurers would have to act fairly when deciding to cash settle claims as part of their general obligations.[80]
    b. **22.2 ensure that the policyholder is indemnified against the loss insured**: If insurance contracts are brought within the unfair contract terms regime, a policy clause which allows an insurer to cash settle a claim for an amount which would not enable the insured to complete the necessary works (within the policy sum insured) should be specified to be an example of an unfair contract term.

Recommendations

104. The problems with unfair and inadequate cash settlement of insurance claims should be addressed by:

    a. Bringing claims handling within section 912A of the Corporations Act; and
    b. Bringing insurance contracts under the unfair contract terms regime.

[78] The 'intangible' social costs of natural disasters—including increased mental illness, risky alcohol consumption, chronic diseases, family violence and short-term unemployment—have been estimated to be at least as high as the tangible, physical costs: see Deloitte Access Economics, 'The economic cost of the social impact of natural disasters' (Report, March 2016) < http://australianbusinessroundtable.com.au/assets/documents/Report%20-%20Social%20costs/Report%20-%20The%20economic%20cost%20of%20the%20social%20impact%20of%20natural%20disasters.pdf>.
[79] Justin Malbon and Harmen Oppewal, *(in)Effective Disclosure: An experimental study of consumers purchasing home insurance* (2018) <https://australiancentre.com.au/wp-content/uploads/2018/09/InEffectiveDisclosure-final.pdf>; Insurance Council of Australia, 'Consumer Research on General Insurance Product Disclosures' (Research findings report, February 2017) <http://www.insurancecouncil.com.au/assets/report/2017_02_Effective%20Disclosure%20Research%20Report.pdf>.
[80] Under *Corporations Act 2001* (Cth) s 912A(1)(a).

F. INSURANCE IN SUPERANNUATION

Question 24: Should group life insurance policies offered to MySuper members be permitted to us a definition of "total and permanent incapacity" that derogates from the definition of "permanent incapacity" contained in regulation 1.03C of the *Superannuation Industry (Supervision) Regulations 1994* (Cth)?

105. Insurers should not derogate from the definition of 'permanent incapacity' in the *Superannuation Industry (Supervision) Regulations 1994* (Cth) (**SIS Regulations**) in MySuper products.

106. There is a broad range of total and permanent incapacity/disability (**TPD**) definitions in group life insurance policies. Many of these vary significantly from the definition in the *Superannuation Industry (Supervision) Regulations 1994* (Cth) (**SIS Regulations**), which provides:

> *[A] member of a superannuation fund or an approved deposit fund is taken to be suffering permanent incapacity if a trustee of the fund is reasonably satisfied that the member's ill-health (whether physical or mental) makes it* ***unlikely that the member will engage in gainful employment for which the member is reasonably qualified by education, training or experience****.*[81]

107. In practice, many policies require members to meet much more specific and narrow definitions of TPD than this definition. In particular, some require a person to be unable to perform several of the activities of daily living (**ADL**), such as dressing, bathing, going to the toilet and eating, to be eligible to make a TPD insurance claim.[82] These ADL definitions are a radical departure from the SIS Regulations, and in practice are an extraordinarily high bar. People must be severely disabled to make a successful claim. ADL definitions may make group policies less expensive and prevent premiums eroding account balances. However, these policies are unfair 'junk' and cause many people to not make a claim or to see their claims declined by insurers.

108. Many superannuation funds have minimised members' insurance premiums at the expense of appropriate cover. Some superannuation funds, such as the construction industry fund Cbus, have members who are at a higher risk of accidents and illnesses, and therefore TPD claims. Yet the Cbus MySuper product has the SIS Regulations definition for most members, and an ADL definition for people who have been unemployed for 12 months or more.[83] This trustee appears to have dealt with affordability by reducing benefits, rather than reducing the number of eligible claimants. Life insurance in superannuation is an example of a 'disengaged' consumer market, where consumers have low understanding of their own needs. In this type of non-functional markets, a strong 'product safety' approach is necessary. A standard definition of permanent incapacity which aligns with the SIS

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[81] *Superannuation Industry (Supervision) Regulations 1994* (Cth) r 1.03C.
[82] See for example the TPD standard for people employed part-time, contract or casual under the MLC policy: MLC, *MLC Masterkey Super Fundamentals Insurance Guide* (1 October 2018), 21 <https://www.mlc.com.au/content/dam/mlc/fb/common/packs/73783_mk_super_and_pension_fund_offer_combo.pdf>.
[83] CBUS, *Death and disability insurance guide* (5 October 2018), 25 <https://www.cbussuper.com.au/content/dam/cbus/files/forms-publications/insurance/Death-TPD-Insurance-Handbook-Industry.pdf>.

Regulations will help ensure that people are not left with junk TPD policies which fail them when they need a safety net.

Recommendations

109. All MySuper group life insurance policies should include definitions of total and permanent incapacity which match the definition of 'permanent incapacity' in the SIS Regulations, or are more favourable to the policy beneficiaries. This means ADL definitions should be prohibited in MySuper group life insurance policies.

110. When the unfair contract terms regime is extended to insurance contracts, ADL definitions in should be specified as an example of an unfair contract term.

Question 28: Are the terms set out in the Insurance in Superannuation Voluntary Code of Practice sufficient to protect the interests of fund members? If not, what additional protections are necessary?

111. The Insurance in Superannuation Voluntary Code of Practice (**ISVCOP**) is not a genuine attempt at self-regulation. Consumer advocates were involved in the development of the ISVCOP in 2017 but withdrew from the process when it became clear that superannuation fund trustees would not make basic commitments to their millions of members. As the ISVCOP stands:

- it is not binding or enforceable;
- there is no administrative or governance body to investigate breaches;
- there are no measures to prevent insurance premiums eroding people's account balances, beyond what is already in the law;[84]
- there is no commitment to standardising or improving insurance policy terms.
- superannuation funds do not have to fully comply until 30 June 2021.

112. The Productivity Commission recently recommended that the ISVCOP be amended to:

- include common eligibility and exemption definitions, particularly for TPD insurance, to 'address the potential use of unreasonable exemptions to address cost pressures', such as ADL definitions (see our response to question 24 above);[85]
- require fund trustees to tailor policy benefits to fund members;
- improve to communication with members;
- strengthen the ISVCOP to the standard required for ASIC registration, including by making it binding and enforceable on trustees.[86]

113. In our view, all participants in the life insurance industry should subscribe to one LICOP. Law reform and/or enforcement should then address systemic problems of inappropriate insurance, account balance erosion and poor claims handling.

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[84] ISVCOP clause 2.3 does not go beyond the requirement in the *Superannuation Industry (Supervision) Act 1993* (Cth) s 52(7)(c).
[85] Productivity Commission, *Superannuation: Assessing Efficiency and Competitiveness*, Draft Report (2018), 348.
[86] Productivity Commission, *Superannuation: Assessing Efficiency and Competitiveness*, Draft Report (2018), 348.

114. The Government has recently introduced law reform to tackle the long-standing systemic problem of insurance premiums eroding account balances.[87] We are broadly supportive of these reforms, although our recommendations for improvements to these reforms were not adopted by the Government.[88] We would welcome further law reform to improve the suitability of insurance in superannuation and the regulation of claims handling.

Recommendation

115. Insurers, advisers, superannuation fund trustees and others in the life insurance industry should be bound by one single, enhanced LICOP, which should be approved by ASIC (see further our response to question 34 in relation to the enforceability of codes).

116. The law should:

    c. mandate clearer requirements for insurance suitability on superannuation trustees; and
    d. regulate claims handling under section 912A of the Corporations Act.

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

Question 29: Is there any reason why unfair contract terms protections should not be applied to insurance contracts in the manner proposed in "Extending Unfair Contract Terms Protections to Insurance Contracts", published by the Australian Government in June 2018?

117. We refer to our submission to Treasury on the Government's proposal to extend unfair contract terms protections to insurance contracts.[89] We strongly support the majority of the features of the model proposed by Treasury. In our view, insurers should guarantee their customers a basic level of fairness in their contracts as does every other industry.

118. The exemption of insurance contracts from unfair contract terms laws is another loophole created through industry lobbying, which has added complexity and inconsistency to financial services regulation and significantly weakened consumer protections. AAI's cash settlement clause, Youi's requirement for a building to be kept to current code standard and Freedom's 'accident' definition in accidental death insurance policies[90] are all examples of terms which, in our view, would be unfair under the regime.

119. We strongly support the Treasury model on the following points:

    a. applying the ASIC Act to insurance contracts, to ensure consist application of the regime;

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[87] Treasury Laws Amendment (Protecting Your Superannuation Package) Bill 2018 (Cth).
[88] Consumer Action Law Centre and Financial Rights Legal Centre, *Joint submission: Protecting Your Super package: Exposure Draft* (9 July 2018) <https://policy.consumeraction.org.au/2018/07/11/protecting-your-super-package/>.
[89] Consumer Action Law Centre, *Submission: Extending unfair contract terms protections to insurance contracts*, (24 August 2018) <https://policy.consumeraction.org.au/2018/08/27/submission-extending-unfair-contract-terms-protections-to-insurance-contracts/>.
[90] Transcript, Gary Dransfield, 20 September 2018, 6283, Transcript, Jason Storey, 19 September 2018, 6194–7; Transcript, Craig Orton, 11 September 2018, 5441–3.

b. a narrow definition of 'main subject-matter', in line with existing insurance law, to ensure key terms must pass the fairness test;
c. application to standard form contracts where some variation is available;
d. the meaning of 'unfair' under the regime;
e. examples of terms that may be considered unfair, such as some cash settlement clauses, however we have suggested additional terms which should be include in the 'grey list';
f. a range of remedies being available where a term is found to be unfair but voidance would result in an unfair outcome for the consumer; and
g. coverage of contracts which are for the benefit of a third-party individual or small business;

120. However, the proposed Treasury model may not be effective due to the following features:

a. **Inclusion of excess within the definition of 'upfront price'**: This would exclude excesses from review under the fairness test. Excesses can be opaque and even unknown. If they are considered part of the upfront price, there is a risk of regulatory arbitrage, that is, insurers could legally pursue profits by keeping premiums low but significantly increasing excesses.
b. **Tailoring the unfair contract terms regime to insurance**: To the greatest extent possible, these reforms should occur through removing the exclusions in section 15 of the IC Act, with specific detail contained in the Explanatory Memorandum to the amending legislation and in ASIC guidance. Consistency is critical to these reforms.
c. **Transitional arrangements**: Transitional arrangements should be drafted to ensure that certain types of insurance contracts, such as guaranteed renewable life insurance policies, are not effectively carved out of the regime.

Question 30: Does the duty of utmost good faith in section 13 of the *Insurance Contracts Act 1984* (Cth) apply to the way that an insurer interacts with an external dispute resolution body in relation to a dispute arising under a contract of insurance? Should it?

121. It does not appear that the duty of utmost good faith applies to an insurer's dealings with an EDR body.[91] The duty only requires:

a. the two parties to the contract to act towards each other with the utmost good faith; and
b. an insurer acts with the utmost good faith towards third party beneficiaries, post-contractually.[92]

122. There is doubt as to whether the duty of utmost good faith extends to the conduct of litigation.[93] However, it could apply to EDR, as it is possible that it could and should apply to the way an insurer conducts a dispute through the Australian Financial Complaints Authority (**AFCA**). The duty ceases once the

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[91] *Insurance Contracts Act 1984* (Cth) ('*Insurance Contracts Act*') s 13. The *Insurance Contracts Amendment Act 2013* (Cth) amended the *Insurance Contracts Act* to apply the duty of utmost good faith to an insurer's dealings with third party beneficiaries to an insurance contract from 28 June 2013.
[92] *Insurance Contracts Act* s 13. Amendments under the *Insurance Contracts Amendment Act 2013* (Cth) applied the duty of utmost good faith to third party beneficiaries from 28 June 2013.
[93] See Mann, *Mann's Annotated Insurance Contracts Act* (Lawbook Co, 7th ed, 2016), 85–88 citing *Imaging Applications Pty Ltd v Vero Insurance Ltd* [2008] VSC 178. Cf *Silbermann v CGU Insurance Ltd* (2003) 57 NSWLR 469.

obligations under the contract cease, so it is not clear that an insurer's dealings in all types of disputes would be covered.[94]

123. Even if the duty did apply to an insurer's dealings with AFCA, there is currently no penalty for breach of the duty.[95] It is unclear how this would be a practical or effective protection for consumer, or what benefit it may provide to AFCA in case management or decision-making.

Recommendations

124. The duty of utmost good faith should be strengthened to:

a. apply to the way that an insurer interacts with an EDR body in relation to a dispute arising under a contract of insurance; and
b. include penalties for breach.

Question 31: Have the 2013 amendments to section 29 of the Insurance Contracts Act 1984 (Cth) resulted in an "avoidance" regime that is unfairly weighted in favour of insurers? If so, what reform is needed?

125. The 2013 amendments to section 29 of the IC Act have made it easier for insurers to avoid paying a claim by showing that they would not have insured the claimant under that specific contract. This is a simpler task for the insurer than showing the insurer would not have insured the person on any terms. We have seen insurers use this provision to avoid claims in a range of scenarios where they have alleged non-disclosure by the insured person.

Recommendation

126. Section 29 of the IC Act should be reformed to reflect the position prior to the 2013 reforms, to prevent insurers avoiding claims in ways which do not meet community expectations.

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

127. It remains important for people to disclose to an insurer information that will affect the insurer's underwriting risk at the inception of the policy. The problem with the current IC Act requirement is how strongly the onus sits on consumers to ensure this happens, considering they are the less informed party when it comes to insurance matters.

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[94] See Mann, *Mann's Annotated Insurance Contracts Act* (Lawbook Co, 7th ed, 2016), 84.
[95] We note that this will change with the proposed *Treasury Laws Amendment (ASIC Enforcement) Bill 2018* (Cth), Schedule 4, item 2.

128. When the ALRC recommended a duty of disclosure on insured people, it recommended that people must disclose information which a reasonable person in the circumstances would know must be disclosed, having regards to literacy, knowledge, experience and cultural background.[97] However, the current duty of disclosure, despite amendments in 2013,[98] continues to be onerous on consumers due to the information asymmetry between insurers and their customers.

129. The requirement to disclose 'every matter that is known to the insured' which 'a reasonable person could be expected to know' gives significant scope for an insurer to decide what the insured person *should* have disclosed, irrespective of what the actual insured person knew or understood at the time of inception. Section 21 is tempered by section 21A, which modifies the applicant's duty of disclosure to only require them to answer specific questions put by the insurer in relation to major types of general insurance.[99] The IC Act also provides, in relation to misrepresentation by an insured person, that, if an insurer's question is ambiguous, the question will be given the meaning that the person answering the question believed it had, if a reasonable person in the circumstances would have understood the question that way.[100] Despite the limits on the section 21 duty, in practice insurers exercise broad discretion to avoid claims.

130. Conversely to section 21, the UK's test of taking reasonable care not to make a misrepresentation is a more practical and fair approach. It is a clearer and more cohesive approach to misrepresentation than that under Part IV Division 2 of the IC Act. The changes made in the UK in 2012 abolished the consumer's duty to volunteer information, and stopped a consumer's representations being a warranty under the insurance contract.[101] Now, consumers are required to answer questions honestly, and take reasonable care that replies are accurate. It provides different remedies for insurers depending on whether the insured person's non-disclosure was deliberate or reckless, or merely careless.

131. The UK model better recognises the information asymmetry between insurers and insured people, and the realities of people's lives when they deal with insurers. For example, the UK courts have found in favour of insured people when their non-disclosure was on the basis of the insured suffering an aggressive form of dementia,[102] and when the insured partly lived at two separate addresses and did not disclose one of those addresses.[103] The alternative to the duty of disclosure is a reasonable model to consider when addressing the unfair avoidance of claims in Australia.

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[97] Australian Law Reform Commission, *Insurance Contracts*, Report 20, 1982, para 183.
[98] Under the *Insurance Contracts Amendment Act 2013* (Cth).
[99] *Insurance Contracts Act* s 21A applies to new contracts for motor vehicle, home building and contents, sickness and accident, travel and consumer credit insurance: see *Insurance Contracts Regulations 2017* (Cth) Note to regulation 6.
[100] *Insurance Contracts Act* s 23.
[101] Explanatory Notes, Consumer Insurance (Disclosure And Representations) Bill (HL Bill 68), [10] and [41]. Note that under section 24 of the *Insurance Contracts Act*, representations by an insured person are also not warranties under the contract.
[102] *R v Financial Ombudsman Service* [2017] EWHC 35.
[103] *Southern Rock Insurance Company Ltd v Hadar Hafeez* [2017] CSOH 12.

Recommendation

132. Section 21 of the IC Act should be replaced by a duty on an insured person to take reasonable care not to make a misrepresentation to an insurer. Other provisions limiting the insured person's duty of disclosure, including those under section 21A, should apply to the new duty.

H. REGULATION

Question 33: Should the Life Insurance Code of Practice and the General Insurance Code of Practice apply to all insurers in respect of the relevant categories of business?

133. The GICOP and LICOP should apply to all insurers and to all service suppliers, representatives and anyone else involved in selling insurance and/or handling claims, including claims assessors and surveillance operators.

134. However, self-regulation has not been sufficient or effective. If codes have a future it should be co-regulation, that is, all industry codes should be approved by the regulator and approval should be on the basis of certain clear factors including:

   a. that the code responds to the consumer concerns and/or undesirable practices in the sector;
   b. that the code is enforceable, not just through EDR but also as a contractual right;
   c. that the code contains meaningful sanctions that incentivise compliance; and
   d. that the relevant code monitoring body has sufficient resources to effectively oversee compliance.

135. Codes should also be regularly reviewed to ensure that they are responding to market developments. Reviews should be conducted independently and in accordance with the principles published by the Consumers' Federation of Australia on consumer advocate involvement and expectations of development and reviews of industry codes.[104]

Recommendation

136. The GICOP and LICOP should apply to all insurers and others involved in selling insurance and/or handling claims.

[104] Consumers Federation of Australia, *Good Practice Principles: Consumer advocate involved and expectations of development and reviews of industry codes and external dispute resolution (EDR) schemes* (2018) <http://consumersfederation.org.au/wp-content/uploads/2018/05/Guidelines-Codes-EDR-Schemes.pdf>.

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

> **34.1 a failure to comply with financial services laws (for the purpose of section 912A of the Corporations Act 2001 (Cth));**
>
> **34.2 a failure to comply with an Act (for example, the Corporations Act 2001 (Cth) or the Insurance Contracts Act 1984 (Cth))?**

137. We note that the Commissioner put to the ICA during hearings:

> *'[I]f the promise [under a code] 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?'*[105]

138. As a general principle, our view is that codes of practice should lift industry standards above the law, and not be a substitute for regulation. Industry codes are largely authored by industry participants themselves, therefore we do not support them being given the force of law per se. That model would, in effect, result in the industry writing the law, which is clearly inappropriate.

Legal status of codes

139. The GICOP and LICOP are currently not registered with ASIC and not enforceable as a term of the consumer contract.

140. The Australian Banking Association's new Code of Banking Practice (**CofBP**) was recently registered by ASIC and that code is enforceable as a term of the contract.[106] The courts have interpreted the terms of the CofBP to be warranties to the contract between the bank and customer, but not essential terms (conditions) of the contract.[107]

141. Under the *Competition and Consumer Act 2010* (Cth) (**Competition and Consumer Act**), there are two types of codes with different legal statuses:

   a. A *mandatory industry code* is prescribed by regulation and is mandatory for all relevant industry participants.[108] Examples include the Franchising Code of Conduct, the Food and Grocery Code of Conduct and the Retail Grocery Industry (Unit Pricing) Code of Conduct. Breach of these codes may incur penalties.[109]
   b. A *voluntary industry code* is developed by a particular industry to improve its legal compliance, transparency and stakeholder confidence, in a flexible and proactive way.[110] Breach of voluntary

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[105] Transcript, Commissioner Hayne, 21 September 2018, 6426.
[106] Australian Banking Association, *Code of Banking Practice* (2019), cl 2.
[107] See for example *National Australia Bank Ltd v Rice* [2015] VSC 10.
[108] Under *Competition and Consumer Act 2010* (Cth) s 51AE.
[109] For example, civil penalties apply for breach of some provisions of the Franchising Code of Conduct.
[110] ACCC, *Guidelines for developing effective voluntary industry codes of conduct* (July 2011), 3 <https://www.accc.gov.au/system/files/Guidelines%20for%20developing%20effective%20voluntary%20industry%20codes%20of%20conduct.pdf>.

codes is not a breach of the law. The Australian Competition and Consumer Commission (**ACCC**) can be involved with these codes by:

i. authorising anti-competitive conduct contained in a code, on the grounds that it will provide a 'net public benefit',[111] for example, the Solar Retailer Code of Conduct published by the Clean Energy Council.[112]
ii. providing general guidance.

Inadequacy of industry self-regulation

142. As demonstrated during the hearing, leaving industry to self-regulate is an inadequate approach to the serious and systemic risks in the business of insurance.

143. The ICA and FSC, as industry lobbying organisations as well as the owners of the GICOP and LICOP respectively, have clearly conflicted and limited roles. The ICA gave evidence as to its limited role in taking steps to address problems with add-on insurance:

> *'[W]e have limitations in the actions that we can take. We are a member-based company. It's – it's voluntary. And for us to enforce upon members to withdraw from a market or change a product is really outside the powers that we have.* ***We're not a regulator.****'*[113]

144. The FSC gave evidence that obligations under the LICOP were merely 'aspirational', although did not identify which specific obligations were aspirational.[114]

145. Both the ICA and FSC gave evidence that sanctions have not been applied under their respective codes.[115] The GICOP and LICOP have weak sanctions compared to the New Zealand equivalent, the Fair Insurance Code, which can fine or expel insurers from the Insurance Council of NZ for significant breaches of the code.[116]

146. It is clear that a different approach to regulation of insurance, particularly claims handling, is long overdue.

Scope for reform

147. As the Corporations Act currently stands, a breach of section 912A would only leave insurers open to administrative penalties. The ASIC Enforcement Taskforce reforms will see civil penalties apply for breach of section 912A,[117] which could significantly bolster its effectiveness as a compliance tool.

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[111] *Competition and Consumer Act 2010* (Cth) s 90(7)(b).
[112] See Clean Energy Council, *Solar Retail Code of Conduct* (October 2015) <https://www.solaraccreditation.com.au/retailers.html>.
[113] Transcript, Robert Whelan, 21 September 2018, 6400.
[114] Transcript, Sally Loane, 21 September 2018, 6454.
[115] Transcript, Robert Whelan, 21 September 2018, 6423; Transcript, Sally Loane, 21 September 2018, 6453.
[116] Insurance Council of New Zealand, *Fair Insurance Code* (2016), cl 49.
[117] Exposure Draft, Treasury Laws Amendment (ASIC Enforcement) Bill 2018 ss 61, 103.

148. The ASIC Enforcement Taskforce recommended that all industry codes be registered and that all participants be required to subscribe to the relevant code.[118] Our view is that, in addition to those proposals:

a. industry codes should be required to be enforceable by consumers as a term of the contract in order to be registered with ASIC;
b. everyone operating in the insurance industry, including service suppliers such as claims assessors, surveillance operators, as well as authorised representatives and others who sell insurance or manage claims, must be covered by an industry code; and
149. for ASIC to approve a code, it must not only ensure that it deals with relevant consumer protection matters, but that the code oversight body has sufficient resourcing and powers for effective compliance.

150. Along with these reforms, systemic breaches of industry codes should be taken into account by regulators in determining breaches of the law, including section 912A of the Corporations Act and other legislative provisions. This could provide meaningful sanctions while not elevating industry self-regulation to the status of the law.

151. These changes could mean codes have a more robust role in regulating consumer protection and industry conduct.

Recommendations

152. Codes should be required to be enforceable as a term of the consumer contract in order to be registered with ASIC.

153. All operating in the insurance business must subscribe to the relevant industry code.

154. Systemic breaches of industry codes should be taken into account when a regulator determines breaches of the law.

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

155. Infringement notices under the ASIC Act 'are intended to facilitate payment of relatively small financial penalties in relation to relatively minor contraventions'.[119] They are an important regulatory tool, as in a practical sense, ASIC cannot pursue every breach of the law through enforcement action. The penalties which apply to infringement notices relating to consumer protection laws are lower than those relating to market integrity rules and continuous disclosure obligations, due to the latter having 'potentially greater impact on the market of the conduct involved'.[120]

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[118] See recommendations 18 and 19: Treasury, *ASIC Enforcement Review Taskforce Report* (2018), xv,
[119] ASIC, *ASIC's Approach to Enforcement*, Information Sheet 151 (16 September 2013), 7.
[120] ASIC, *ASIC's Approach to Enforcement*, Information Sheet 151 (16 September 2013), 7.

Community standards and expectations

156. In the Commission case studies which examined CommInsure's and AAI's misleading advertising, the community standard of what constitutes a 'relatively minor' contravention of the law may not align with ASIC's assessment and its decision to issue infringement notices rather than take more serious action. This is particularly true when ASIC has stated that 'consumers are heavily influenced by advertisements' and that advertisements that do not fairly represent the product can 'create unrealistic expectations that may lead to poor financial decisions'.[121] Considering the significant harm that may be caused by misleading advertising of financial products, it is difficult to rationalise the relatively low penalties which were paid by AAI and CommInsure in those case studies.

157. In addition to the community expectations of advertising, financial services entities can see paying an infringement notice as a cost of doing business, which is preferable to defending an enforcement action. This is exemplified by the fact that, after paying an infringement notice for misleading advertising, AAI has subsequently denied to the Commission that it had engaged in misleading and deceptive conduct.[122]

When infringement notices are appropriate

158. ASIC does not appear to have issued specific, detailed guidance on the factors it considers when deciding whether to issue an infringement notice for breach of consumer protection laws. However, it does detail the factors considered in relation to continuous disclosure obligations and by the Market Disciplinary Panel when deciding whether to issue infringement notices.[123]

159. ACCC guidance states that the ACCC is more likely to issue an infringement notice if:

    a. the relevant conduct is relatively minor or less serious;
    b. the non-compliance is isolated or non-systemic;
    c. the level of consumer harm or detriment is lower;
    d. the facts are not in dispute or the circumstances are not controversial; and
    e. the infringement notice forms part of a broader industry or sector-wide compliance and enforcement program.[124]

160. The ACCC will be less likely to issue an infringement notice if:

    a. the concerns are more serious and warrant consideration by the court;
    b. the alleged conduct has caused significant detriment;
    c. the alleged conduct may be continuing;
    d. the alleged conduct may not have occurred within the 12-month period in which the ACCC can issue an infringement notice;
    e. the matter raises complex questions about the interpretation of a provision of the Australian Consumer Law; and

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[121] ASIC, *Regulatory Guide 234* (November 2012), [234.2].
[122] AAI, 'Round 6 – Insurance: Submissions on behalf of AAI re Natural Disaster Case Studies', 1 October 2018.
[123] ASIC, *Regulatory Guide 216* (29 July 2010), [216.36]; ASIC¸*Regulatory Guide 73* (31 October 2017), [73.7].
[124] ACCC, *Guidelines on the use of infringement notices by the Australian Competition and Consumer Commission* (2012), s 4.

f. the ACCC or another regulator has previously taken action against the person involved in the alleged contravention—particularly where recent or very similar.[125]

161. For the ACCC, infringement notices can be issued in multiples and/or can accompany court-enforceable undertakings.[126] Conversely, ASIC states that where an infringement notice is complied with, no further regulatory action can be taken for the breach.[127] These are distinct positions. Infringement notices appear to be a less flexible component of the regulatory toolkit for ASIC than they are for the ACCC. Consideration should be given to ASIC having a broader view of the role of infringement notices, similarly to the ACCC approach.

Increased penalties

162. An increase in penalties under section 12GXC of the ASIC Act would increase the flexibility of infringement notices as part of ASIC's regulatory toolkit. The existing approach of applying higher penalties under infringements for market integrity rules and continuous disclosure obligation breaches, due to their impact on the market, could be applied at a more granular level for breaches of consumer provisions. For example, breaches of consumer law which are likely to result in higher levels of consumer harm or detriment should attract higher penalties. However, there still needs to be more clarity on the purpose of infringement notices and how ASIC decides whether to issue an infringement notice, particularly considering the community expectations of when an infringement notice is appropriate.

Recommendations

163. Infringement notices should be able to be issued by ASIC in conjunction with other regulatory actions.

164. Higher and tiered penalties should apply to infringement notices.

165. ASIC should issue guidance on the factors it considers when deciding whether to issue an infringement notice.

I. COMPLIANCE AND BREACH REPORTING

Question 36: Is there sufficient external oversight of the adequacy of the compliance systems of financial services entities? Should ASIC and APRA do more to ensure that financial services entities have adequate compliance systems? What should they do?

166. Based on the case studies seen at the Commission—particularly Allianz's misleading online marketing copy and subsequent failure to notify ASIC of its breach—compliance systems appear to be left largely to entities themselves. In our view, the Allianz case study showed, because independent reports on compliance may be influenced by the company commissioning the report, these reports should not be

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[125] ACCC, *Guidelines on the use of infringement notices by the Australian Competition and Consumer Commission* (2012), s 5.
[126] ACCC, *Guidelines on the use of infringement notices by the Australian Competition and Consumer Commission* (2012), s 4(b).
[127] ASIC, *ASIC's Approach to Enforcement*, Information Sheet 151 (16 September 2013), 7.

taken as an adequate or appropriate way to gauge the robustness of an entity's systems and compliance culture per se.

167. The move to 'embed' ASIC supervisors within financial services entities[128] could play a significant role in lifting compliance standard across industry. ASIC could expand beyond its initial focus on the big four banks and AMP, and undertake external 'spot checks' or targeted audits of particular aspects of compliance systems, based on risk factors and priorities of the regulator. ASIC should also be resourced to undertake thematic reviews of compliance systems and to make recommendations. The Hong Kong Securities and Futures Commission (**SFC**) conducts a range of on-site monitoring to gauge a business's level of legal and regulatory compliance. The FSC's activities include:

   a. routine inspections of systems and controls and compliance with regulation;
   b. special inspections of companies believed to pose imminent risks to the market and/or their customers (for example, misappropriation of client assets);
   c. thematic inspections to assess specific sector-crossing risks; and
   d. less formal 'prudential visits' to meet management and gain information.[129]

Recommendation

168. ASIC should be empowered and resourced to undertake ongoing, targeted compliance audits within financial services entities.

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

37.1 preventing breaches of financial services laws and other regulatory obligations; and
37.2 ensuring that any breaches that do occur are remedied in a timely fashion?

169. There should be far greater consequences for businesses which operate with inadequate compliance systems, to deter poor practices and lift industry standards. The new penalties for breaches of section 912A and section 912D of the Corporations Act,[130] which will apply to failures to adequately design, maintain and resource compliance systems, are significant and promising reforms. If these reforms are effective, they should compel better practice within industry.

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

170. The evidence adduced by the Commission has exposed many examples of cultures and systems which do not reward or value compliance. A 'culture' which does not value compliance will have two clear indicators:

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[128] The Hon Kelly O'Dwyer MP, 'Turnbull Government expands ASIC's armoury' (Media Release, 7 August 2018) <http://kmo.ministers.treasury.gov.au/media-release/092-2018/>.
[129] Securities and Futures Commission, *Approach to Supervision of Intermediaries* (June 2011), 7–8 <https://www.sfc.hk/web/doc/EN/aboutsfc/Approach_IS.pdf>.
[130] Exposure Draft, Treasury Laws Amendment (ASIC Enforcement) Bill 2018 ss 61, 62, 103.

a. heavy reliance on conflicted remuneration at all levels of the business, which compels and rewards selling practices which fall below community expectations and breach the law; and
b. key performance indicators (**KPIs**) which recognise and reward things such as high-volume sales and fast claims resolution (irrespective of the result), rather than strong customer service and compliance with the letter and spirit of the law.

171. An entity which identifies these things in its business should restructure its remuneration and KPIs. From a regulatory perspective, a prohibition on conflicted remuneration would have the most significant positive impact on the culture of financial services entities. While conflicted remuneration persists, the problems exposed at the Commission will undoubtedly persist. Once this core problem is addressed, measures such as regulatory audits would aid ongoing compliance.

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

172. We strongly support the recommendations of the ASIC Enforcement Review Taskforce Report. However, in addition to the recommendations of that report, consumers would benefit significantly from the following amendments, both in insurance and in financial services more broadly:

a. Amending the misleading and deceptive conduct and unfair contract terms provisions to make them offence and civil penalty provisions.[131] This would strengthen some of the most important consumer protections under the ASIC Act.
b. Amending all ASIC-administered legislation to require the court to consider, when setting a penalty, whether that penalty is sufficient to ensure deterrence and meet community expectations. This would address concerns that, despite an increase to maximum penalties, courts may not be willing to impose higher penalties.[132]
c. Specifying that, in relation to a relinquishment order for breach of a civil penalty provision, a court can in appropriate circumstances order payment directly to consumers, or funds for the benefit of consumers. Relinquishment orders are more akin to restitution or refunds than a pecuniary penalty, and would deliver benefit to the people directly affected by significant breaches.

Recommendations

173. In addition to the recommendations of the ASIC Enforcement Review Taskforce Report. the following reforms should be made:

a. the misleading and deceptive conduct and unfair contract terms provisions should be offence and civil penalty provisions;

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[131] The ACCC has called for breach of UCT laws to be illegal and for civil penalties and infringement notices to apply: see ACCC, *Submission to Inquiry into the operation and effectiveness of the Franchising Code of Conduct* (11 May 2018), 6 (Recommendation 3).
[132] See Organisation for Economic Co-operation and Development, *Pecuniary Penalties for Competition Law Infringements in Australia 2018* (2018); Consumer Action Law Centre, *Reforms to strengthen penalties for corporate and financial sector misconduct – Draft Legislation* (Submission, 18 October 2018) <https://policy.consumeraction.org.au/2018/10/18/submission-reforms-to-strengthen-penalties-for-corporate-and-financial-sector-misconduct-draft-legislation/>.

b. all ASIC-administered legislation should require the court to consider, when setting a penalty, whether that penalty is sufficient to ensure deterrence and meet community expectations; and
c. in relation to a relinquishment order for breach of a civil penalty provision, a court should in appropriate circumstances order payment directly to consumers, or funds for the benefit of consumers.