Financial Rights
LEGAL CENTRE

Submission by the

Financial Rights Legal Centre

Parliamentary Joint Committee on Corporations and Financial Services

Inquiry into the Life Insurance Industry

November 2016

About the Financial Rights Legal Centre

The Financial Rights Legal Centre is a community legal centre that specialises in helping consumer's understand and enforce their financial rights, especially low income and otherwise marginalised or vulnerable consumers. We provide free and independent financial counselling, legal advice and representation to individuals about a broad range of financial issues. Financial Rights operates the Credit & Debt Hotline, which helps NSW consumers experiencing financial difficulties. We also operate the Insurance Law Service which provides advice nationally to consumers about insurance claims and debts to insurance companies. Financial Rights took over 25,000 calls for advice or assistance during the 2015/2016 financial year.

Financial Rights also conducts research and collects data from our extensive contact with consumers and the legal consumer protection framework to lobby for changes to law and industry practice for the benefit of consumers. We also provide extensive web-based resources, other education resources, workshops, presentations and media comment.

This submission is an example of how CLCs utilise the expertise gained from their client work and help give voice to their clients' experiences to contribute to improving laws and legal processes and prevent some problems from arising altogether.

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Monday – Friday 9.30am-4.30pm

Introduction

Thank you for the opportunity to provide input into the Parliamentary Joint Committee into Corporations and Financial Service's Life Insurance Inquiry. The Financial Rights Legal Centre (**Financial Rights**) has provided significant input into recent parliamentary and industry-led inquiry's and reviews into the life insurance sector drawing on our experience in working with consumers including:

- numerous public and confidential submissions to the Financial Services Council regarding drafts of the Life Insurance Code of Practice[1] and the FSC's Minimum Standard Medical Definitions guidelines;[2]
- submission to the Senate Scrutiny of Financial Advice Inquiry;[3]

As the committee would be aware there have been a series of reviews and reforms over the last half decade seeking to investigate and address issues in the life insurance industry. These include amongst others:

- the 2012 Future of Financial Advice reforms[4] including a prospective ban on conflicted remuneration structures and volume based payment, in relation to distribution of and advice and a duty of financial advisers to act in the best interests of their clients, subject to a 'reasonable steps' qualification. Further amendments were passed in March 2016.
- 2014's Financial System Inquiry (FSI) including recommendations on lifting the standards of financial advice including by introducing minimum professional, ethical and education standards and ensuring remuneration structures in life insurance do not adversely affect the quality of advice consumers receive;
- the Senate Economics References Committee Scrutiny of Financial Advice Inquiry 2014-2016 including additional terms of reference on the life insurance industry (2 March 2016).[5]

The Australian Securities and Investments Commission (**ASIC**) has also conducted a long series of investigations and surveillances including:

[1] http://financialrights.org.au/wp-content/uploads/2016/09/160914_FRLCCALC_LICOPSub__FINAL.pdf and http://financialrights.org.au/wp-content/uploads/2016/02/160129_FSCDraftLICOP_Submission_FINAL.pdf
[2] http://financialrights.org.au/wp-content/uploads/2016/11/161111_FSCDraftMedicalDefinitions_Submission_FINAL.pdf
[3] http://financialrights.org.au/wp-content/uploads/2016/04/160422_SOFA-joint-consumer-sub_FINAL.pdf
[4] Including amongst other inquiries the Parliamentary Joint Committee on Corporations and Financial Services inquiry into the Corporations Amendment (Future of Financial Advice) Bill 2011 and the Parliamentary Joint Committee on Corporations and Financial Services inquiry into the Corporations Amendment (Further Future of Financial Advice Measures) Bill 2011 both of which made specific recommendations about the need to monitor the quality of advice about the sale of risk insurance.
[5] http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Economics/Scrutiny_of_Financial_Advice

- Report 413 Review of Retail life insurance advice, October 2014[6]
- Report 454 Funeral insurance: A Snapshot, October 2015[7]
- Report 470 Buying add-on insurance in car yards: Why it can be hard to say no, February 2016[8]
- Report 471 The sale of life insurance though car dealers, February 2016[9]
- Report 492 A Market that is failing consumers: The sale of add-on insurance through car dealers[10] and
- Report 498 Life Insurance claims: An industry review[11]

ASIC's 2014 Report 413 *Review of Retail life insurance advice* recommended the development of industry led solutions regarding misaligned incentives that ASIC found influenced the quality of life insurance advice. This subsequently led to the Association of Financial Advisers and the Financial Services Council (**FSC**) establishing the independent Trowbridge Review in 2014. The final (**Trowbridge Report**)[12] made significant recommendations on adviser remuneration; licensee remuneration; quality of advice; and other insurer practices. The report, has led to a number of reforms, many of which are the basis of the yet to be implemented *Corporations Amendment (Life Insurance Remuneration Arrangements) Bill.*[13]

The Trowbridge Report also recommended the development of a Code of Practice. The FSC began work on this in late 2015 and the first iteration of the Code was launched in October 2016. While this is a welcome step for consumers, taking a closer look at the document it is clear that it is a modest one. Consumer representatives feel that while there have been a few gains for consumers with the Code moving beyond the law, more hard work is required from the life insurance sector to deliver genuinely improved consumer protections.

Financial Rights acknowledges that are a number of positive elements in the Code. Most significantly the Code, for the first time in life insurance, provides protections for people who are subjected to investigations and surveillance while their claims are being assessed. Financial Rights has been aware that for some time a significant proportion of our case work on the Insurance Law Service has been devoted to providing advice to policyholders who found themselves subject to insurance investigations. Financial Rights was so concerned that in 2015 we undertook significant research into the area resulting in *Guilty Until Proven Innocent – Insurance Investigations in Australia.*[14] While the report focuses largely on the general insurance sector, the findings and recommendation made in this report equally apply to the life insurance sector. The inclusion therefore of clauses under the Life Insurance Code of Practice applying to

[6] http://download.asic.gov.au/media/2012616/rep413-published-9-october-2014.pdf
[7] http://asic.gov.au/regulatory-resources/find-a-document/reports/rep-454-funeral-insurance-a-snapshot/
[8] http://download.asic.gov.au/media/3549387/rep470-published-29-february-2016.pdf
[9] http://download.asic.gov.au/media/3549384/rep471-published-29-february-2016.pdf
[10] http://download.asic.gov.au/media/4042960/rep-492-published-12-september-2016-a.pdf
[11] http://download.asic.gov.au/media/4042220/rep498-published-12-october-2016a.pdf
[12] John Trowbridge, March 2015, Review of Retail Life Insurance Advice: Final Report, http://www.fsc.org.au/downloads/file/MediaReleaseFile/FinalReport-ReviewofRetailLifeInsuranceAdvice-FinalCopy(CLEAN).pdf
[13] http://www.aph.gov.au/Parliamentary_Business/Bills_LEGislation/Bills_Search_Results/Result?bId=r5611
[14] http://financialrights.org.au/wp-content/uploads/2016/03/Guilty-until-proven-innocent.pdf

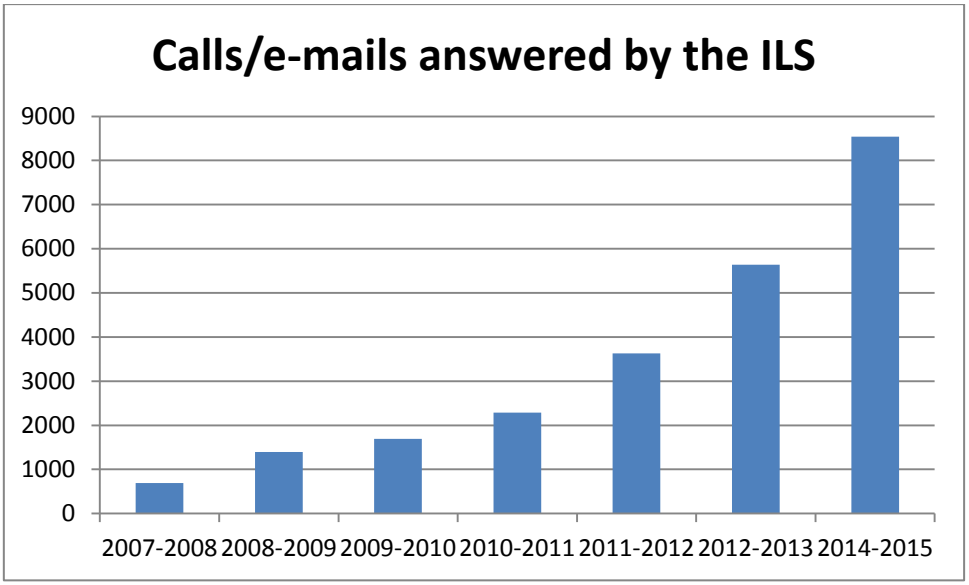
the carrying out of interviews (clause 8.11) and surveillance (clause 8.12) are a significant acknowledgement of the issues faced by consumers on the ground level and, while still not quite best practice, are an important step to ensure better practice.

Despite these improvement there are however significant flaws in the final version of the Code that require development, improvement and, where intractable, legislative reform. We explore many of these flaws below. We also explore a number of issues that are unable to be addressed in a Code and require legislative reform or regulatory intervention. Despite the large number of investigations, inquiries and reports as well as resulting legislative and industrial reform, there remains much to be done to improve the consumer experience and interaction with the life insurance industry. These are addressed below.

However to start with it is important to understand that there is significant and increasing consumer demand for legal assistance arising out of the harm caused by the lack of effective regulation and self-regulation of the insurance industry (including both life and general insurance). Financial Rights believes it is important to acknowledge up front the impact of this overwhelming demand for legal assistance relating to insurance matters.

Legal services for insurance consumers

Since 2007, the Financial Rights Legal Centre's national Insurance Law Service ("ILS") has provided a free and independent advice service for vulnerable consumers impacted by natural disasters, motor vehicle accident, theft, illness and injury. Over this time demand for the service has consistently increased from close to 700 calls in 2007-08 to over 8500 calls in the 2014-15.



At current funding levels the ILS does not meet the overwhelming demand for the service, answering only 58% of calls on average. The ILS will however cease to be viable if proposed Commonwealth cuts to Community Legal Centres go ahead in 2017 – the same time as one-off funding from the Victorian Fire Services Levy consumer refund process dries up. The ILS only

being able to engage one solicitor to work the ILS phone service, run cases and produce consumer education resources.

Aside from a clear and demonstrable consumer need for the ILS, Government and the insurance industry are increasingly reliant on the consumer focussed expertise that Financial Rights can provide for policy development and regulatory review processes. Over the past year alone Financial Rights has:

- been invited onto and actively engaged with the Financial Service Council Code of Practice Steering Committee in the wake of the CommInsure scandal following well-regarded submissions on the topic;
- assisted ASIC with their investigations into CommInsure's practices through the provision of hundreds of call records identifying systemic issues;
- quoted extensively in the Northern Australia Insurance Premiums Taskforce Report;
- garnered considerable media coverage of our insurance investigations report and the lack of rights for consumers (7.30, SMH, Choice, Insurance News).

Furthermore it is important to understand the critical role community legal centres generally and the ILS specifically plays in assisting insurance consumers through the external dispute resolution regime.

The Financial Ombudsman Service (FOS) refers a large and increasing number of consumers to the Insurance Law service for independent advice. Financial Rights received 1,363 client referrals from FOS in 2014, increasing to 1,838 referrals in 2015 and 1,102 referrals in the first nine months of 2016. In light of difficulties in tracking referrals, these figures significantly underestimate the actual number of referrals and need for assistance.

EDR schemes are intended to be accessible, free and fair. In theory, consumers should not need an advocate assisting with their dispute. In practice, however, some financial disputes are technically and legally complex. Independent legal advice is critical for consumers faced with complex matters, confused by the multiplicity of schemes and requiring assistance to navigate the rules and processes. Many consumers are simply overwhelmed by the process, compounding the stress arising from the substantive issues in dispute.

Given there is a current review of the dispute resolution framework (and funding for these arrangements) the Government must acknowledge and account for the heavy reliance that the EDR system place on the Insurance Law Service to function properly. This reliance may be appropriate but increasingly problematic given forth-coming funding cuts.

At a time where there is greater need than ever for free and independent legal advice on insurance matters, cutting funding to the Insurance Law Service will leave consumers, government and the insurance industry without an essential resource.

Recommendation

That the Government reverse planned Community Legal Centre funding cuts and provide appropriate, ongoing funding to the Insurance Law Service to meet the growing demand for free and independent legal services from in-need consumers of insurance.

Legal status of the Life Insurance Code of Practice

The Life Insurance Code of Practice as launched in October while a modest first step is not enforceable by courts or tribunals, is not an express term of the contract with consumers and is not registered with ASIC in accordance with RG 183. This is of serious concern to Financial Rights. Prima facie, it means that the Code does meet the minimum standards expected of a Code of Practice.

Now that the first iteration of the Code has been launched, the industry must begin the FSC must move to begin the registration process as soon as possible so that Australians can have confidence in the code. Financial Rights notes in announcing the Code the FSC stated it will merely "*consider* making an application for ASIC approval of the second iteration of the Code. (*our emphasis*)"[15]

Mere consideration is unacceptable. This is not the expectation of consumers, consumer representatives or the Government. We note that the Minister for Revenue and Financial Services, the Hon. Kelly O'Dwyer MP stated in response to the launch of the Life Insurance Code of Practice in October that:

> *…she expects the FSC and life insurance industry will take the necessary steps to ensure that the Code is enforceable across the whole industry, by gaining ASIC approval of the Code.*
>
> *ASIC should work collaboratively with the FSC and the industry to approve the Code. Once the Code is approved, the Government will give ASIC the necessary powers to enforce the Code, so as to ensure financial services licensees' compliance with the Code.*[16]

We maintain that as a priority the Life Insurance Code of Practice must be registered with ASIC in accordance with ASIC's *Regulatory Guidance 183: Approval of financial sector codes of conduct, March 2013.*

Registration would increase public confidence in the financial services sector, ensure that the Code meets best practice standards and send a strong signal to consumers that the Code is one in which they can have confidence. Registration would also demonstrate that the banking industry proactively responds to identified and emerging consumer issues and that the Code works to deliver substantial benefits to consumers.

Code registration would also mean that:

- investigative or enforcement action can be undertaken if misrepresentations are made about the code;
- ASIC can monitor the Code based on issues raised by consumers, External Dispute Resolution schemes or industry consultations;

[15] FSC, *Media Release: Life Insurance Code of Practice*, http://www.fsc.org.au/downloads/file/MediaReleaseFile/2016_1110_MediaRelease_LifeInsuranceCodeofPractice_final.pdf

[16] Minister for Revenue and Financial Services, *Media Release: Key life insurance reforms to assist consumers*, 12 October 2016 http://kmo.ministers.treasury.gov.au/media-release/091-2016/

- there is greater certainty that consumer concerns and independent review recommendations will be taken seriously and more likely implemented – rather than what can occur now which is that some recommendations for change are watered down or rejected outright;
- consumers can have confidence that there is specific government/ASIC oversight of the Code and its ongoing development;
- the life insurance industry is making a public statement that it is strong and confident enough to subject its self-regulatory instrument for scrutiny against regulator standards;
- members will not walk away from the Code.

Confidence in the life insurance industry is at rock bottom. Consumer representatives expected the life insurance industry to respond to widespread community concern with the establishment of a registered, enforceable set of best practice standards. As it stands, the Code does not meet best practice standards and does little if anything to restore confidence in the industry. Greater oversight by ASIC would go a long way to bringing the industry into line with community standards.

Recommendation

That the Financial Services Council as soon as possible register the Life Insurance Code of Practice in accordance with ASIC RG183.

Minimum Standard Medical definitions

Out of date, complex and inappropriate medical definitions in life insurance policies have been a central issue of concern for consumers for some time – an issue raised to prominence in the Fairfax/Four Corners investigation in May 2016.[17]

The Life Insurance Code has included a clause that promises three-yearly reviews by a 'relevant' medical specialist: clause 3.2. The FSC have recently released a draft Minimum Standard Medical Definitions document detailing standard definitions for cancer (excluding early stage cancers); severe heart attack (measured by specific tests) and stroke (resulting in permanent impairment).

Financial Rights continues to have concerns with respect to the design of these clauses and guidelines. Central to our concerns is that the 'relevant' medical specialist does not have to be independent of the insurers. Who is a "relevant" medical specialist is entirely at the discretion of insurers and the FSC. This fundamentally undermines the appearance of impartiality and raises questions as to the validity of the draft and any review into medical definitions, in the

[17] ABC, 4 Corners, *Money for Nothing*, http://www.abc.net.au/4corners/stories/2016/03/07/4417757.htm

eyes of consumers. It also guarantees updates to medical definitions but for 'on sale' policies only—this is likely to leave gaps for many people whose policies are no longer 'on sale'.[18]

Financial Rights also notes ASIC's concern regarding upgrading policies medical definitions and that, as recommended in the FSI report, the Government needs to introduce a mechanism to facilitate the rationalisation of legacy products in the life insurance sector.[19] ASIC also notes the effect of s9A of the Life Insurance Act, which provides that an insurer can only pass on the benefit of a change to a policy if they do not charge the consumer more as a result.[20] Financial Rights supports policy reform to "allow upgrades of existing life insurance policies on a portfolio basis to more current definitions, where this is beneficial to policyholders, allowing any premium impact to be spread across the portfolio."[21]

Recommendations

That the any minimum standard medical definitions be drafted and reviewed regularly by *independent* medical specialists.

That policy reform be implemented, as recommended by ASIC, to allow upgrades of existing life insurance policies on a portfolio basis to more current definitions, where this is beneficial to policyholders, allowing any premium impact to be spread across the portfolio.

Consumer Protections under Group Insurance

The clearest and most obvious flaw of the Life Insurance Code is that it does not cover superannuation fund trustees. Financial Rights had argued throughout the drafting of the Code that the FSC needed to bring superannuation fund trustees into the process early on to ensure that they would be covered. People making claims under group policies held by superannuation fund trustees will now not benefit from key elements of the Code, such as claim timeframes and communication obligations. Given that most life insurance in Australia is held under group policies, the exclusion of fund trustees is a serious failing of the Code.

Case Study – Lisa - CLSIS 138747

Lisa was diagnosed with stage 4 melanoma. She realised she had benefits in her superannuation, and so made a claim. The claim is currently with the superfund. It has been 5 months. She never hears from the fund. She follows up with them, and she is often asked

[18] For further information see our joint submission to the FSC's consultation on their draft Minimum Standard Medical Definitions, http://financialrights.org.au/wp-content/uploads/2016/11/161111_FSCDraftMedicalDefinitions_Submission_FINAL.pdf
[19] Para 370 *Report 498 Life insurance claims: An industry review*, October 2016 http://asic.gov.au/regulatory-resources/find-a-document/reports/rep-498-life-insurance-claims-an-industry-review/
[20] Op cit, ASIC, para371
[21] Op cit, ASIC, para 372

to re-send documents she has already sent in. She has received further news from her treating doctors that her prognosis is getting worse. She is seeking advice from Financial Rights about what are the expected time frames. We explain to her that there are no timeframes currently, that the Life Insurance Code of Practice is implementing a time frame of 6 months for claims like hers with insurers, however, the start of 6 months commences from when the superfund makes claim with insurer. It is not clear whether her claim is with the fund or the insurer. No one is talking to her.

We note a Superannuation Industry Working Group has been established to draft and finalise a code of practice by the end of next year. While we support this work to ensure that the consumer protections created by the life insurance code are similarly provided to those consumers who access their insurance via group insurers, we would also recommend that this Code be registered with ASIC in accordance with RG 183.

A number of issues need to be looked at. For example, where there is a complaint about a Life Insurance Policy owned by a superannuation fund trustee life insurers under the new Code will respond to the superannuation fund trustee so that it can provide a final response to a complaint in writing within 90 calendar days: clause 9.10. This is mandated under section 19, Superannuation (Resolution of Complaints) Act 1993. There is no reason that this should be twice the length faced by those consumers who have life insurance directly with an insurer. Financial Rights believe that a total of three months to deal with a complaint is completely unreasonable and impacts upon policyholders suffering financial hardship, injury and/or illness. Either an improvement is written into the upcoming Code or a change to the legislation is required.

Case Study – Heather – CLSIS 138763

Heathers husband passed away 3 months ago. He was on income protection during his last few months. On his passing, Heather made a claim for his death benefits. She does not understand the delay. The insurer stated they are waiting for the superfund, and the superfund, vice versa. She was not sure whether it was due to any issues around the payment of benefits to the nominees or whether they were questioning the claim itself. They kept passing her off to other departments and didn't get a straight answer. Heather has a mortgage to pay, and this is distressing. They treated him poorly when he was sick, they kept asking for medical statements even though he was dying and they knew it. She just wants to know how long she has to wait for a decision

Another common issue faced by consumers is the lack of availability of product disclosure statements on superannuation websites and insurers refusing to provide them to the beneficiary at the request of the superfund. This is also true for other group policies, through alternative arrangements such as employer benefit programs. This is an incredibly frustrating problem for many consumers placing many in limbo for months. The Life Insurance Code

makes a commitment to making their PDS's available online to view: clause 3.7. However where it has been prepared for a third party, life insurers will only will only refer the claimant to the relevant party for a copy and will merely encourage those that they work with to make these available online. Group insurers need to step up and provide all their past and present PDS documents online immediately.

Recommendation

We recommend that the superannuation sector work with stakeholders including the FSC to develop a Code of Practice that works symbiotically with the Life Insurance Code of Practice and that this new Code also be registered with ASIC in accordance with RG 183

Problem products and junk insurance

The Life Insurance Code fails to adequately address problem products such as funeral insurance and Consumer Credit Insurance (CCI). There is now ample evidence about consumer problems with funeral insurance[22] and consumer credit insurance.[23] It is time for the life insurance industry to acknowledge those problems and commit to either improving the value of these products or stop selling them. We believe that at a minimum the Code should have included the following commitments:

- Funeral insurance:
    - not selling funeral insurance cover without first making a proper assessment of whether the customer can afford the cover;
    - is not sold to people under 50 years of age, at the absolute youngest,
    - premiums should be fixed for the life of the policy, and the Code should prohibit stepped premiums,
    - premiums should cease once the benefit amount is reached (or a very small % above that). Insurers have the benefit of holding the money paid in premiums, which should be sufficient for their profit;

[22] Most recently, see ASIC Report 454, *Funeral Insurance: A Snapshot*, 29 October 2015 *http://asic.gov.au/regulatory-resources/find-a-document/reports/rep-454-funeral-insurance-a-snapshot/*

[23] See ASIC reports 256: *Consumer credit insurance: A review of sales practice by authorised deposit taking institutions*, 19 October 2011 http://asic.gov.au/regulatory-resources/find-a-document/reports/rep-256-consumer-credit-insurance-a-review-of-sales-practices-by-authorised-deposit-taking-institutions/ and ASIC Report 361: *Consumer credit insurance policies: Consumers' claims experiences*, 31 July 2013, http://asic.gov.au/regulatory-resources/find-a-document/reports/rep-361-consumer-credit-insurance-policies-consumers-claims-experiences/ and Consumer Action Law Centre's *Junk Merchants* report, December 2015 http://consumeraction.org.au/junk-merchants-report-how-australians-are-being-sold-rubbish-insurance-and-what-we-can-do-about-it/

- providing real responses for consumers who buy funeral insurance and later struggle to make payments because of financial hardship

- CCI:

  - where CCI includes life-insurance, there should be a delayed opt-in, that is, four clear days after the sale of the loan, a consumer can opt-in to the purchase of the CCI. This aligns with best practice, that is, equivalent requirements in the UK, and

  - CCI premiums should not be financed – if a direct debit option is available, this will always be cheaper than a financed single premium option.

We understand that the FSC has stated that

> *"In response to recent ASIC reports on funeral insurance and consumer credit insurance, the industry will address the issues raised including through limitations on sales and premium structures. These standards would require the second iteration of the Code to be submitted for ACCC approval."*

From Financial Rights perspective the ongoing harm to vulnerable consumers by funeral insurance and CCI is such that action needs to take place sooner rather than later and cannot wait for another 18 months for possible curtailment that are in no way guaranteed to take place in a review of the Code.

Recommendations

That the next iteration of the Life Insurance Code of Practice that life insurers should agree to restrictions on the sale of problem products – specifically with funeral insurance and CCI. If the industry cannot take the appropriate steps to curtail the harm that these products produce, the Government must act to either ban the products or regulate them.

Sales practices, advertising and marketing

Poor life insurance advice and sales practices have been an issue for many years highlighted by a string of Government inquiries[24] and ASIC investigations and surveillances.

Report 470 found that many consumers who had purchased add-on insurance products:

(a) were not aware of which add-on products they had actually purchased, how much each policy cost and what risks it covered, or when they would be able to lodge a claim;

[24] Parliamentary Joint Committee on Corporations and Financial Services (PJC) inquiry into the *Corporations Amendment (Future of Financial Advice) Bill 2011*; and the PJC Inquiry into the *Corporations Amendment (Further Future of Financial Advice Measures) Bill 2011*. Both of these made specific recommendations about the need to monitor the quality of advice about the sale of risk insurance.

(b) if they could recall the purchase, regretted their decision to buy add-on insurance;
(c) had no awareness of add-on insurance products before entering a dealership to buy a motor vehicle;
(d) were unaware of the cost of, or cover or value provided by, add-on insurance products and most purchases were made solely on the basis of information provided in the car dealership; and
(e) were actively sold, and sometimes pressured to buy, add-on insurance products.

ASIC Report 471 found that

> *"individual sales have identified transactions where consumers were sold car yard life insurance (and other add-on products) without their knowledge or consent, or where the authorised representative of the life insurer told the consumer they had to buy the add-on products to get the car loan.*
>
> *When a product is sold to a consumer (compared to when a consumer actively seeks out or buys a product) the consumer usually has little or no awareness of the product beforehand. This lack of consumer awareness about what car yard life insurance is and what it costs means that insurers are able to price these policies in an uncompetitive manner."*[25]

ASIC's most recent Report 498 found that "problematic sales practices may lead to poor claims outcomes"[26] including policies sold that were manifestly unsuitable and consumers being misled about the cover under the policy.

The Life Insurance Code fails to fully address the serious concerns consumers have with sales practices, particularly commission-based and add-on models. While the Code does include commitments to be clear and not misleading (clause 4.1) and ensure sales rules are in place to ensure staff conduct sales appropriately and prevent pressure selling or other unacceptable sales practices (clause 4.3), the Code does not address add-on sales techniques, via effective methods such as mandated delay and opt-in days after the sale of the loan – a practice that has been introduced in the UK. The Code does not address other problematic practices such as unsolicited marketing calls, the inclusion of which would have improved the protections offered under anti-hawking rules, which provides some exemptions for life insurance.[27]

ASIC has stated in Report 498 that it will conduct a thematic industry review of life insurance sales practices, focusing on non-advised policy sales, and take enforcement action where necessary. While Financial Rights supports this process, we already hold the view that many of these techniques are known and can be addressed either through outright bans or through regulation by:

- introducing a mandated delay regime including an opt-in days after the sale of the loan
- removing the exemptions for life insurance under the anti-hawking rules to prevent unsolicited;

[25] Para 22, ASIC, *Report 471: The sale of life insurance through car dealers: Taking consumers for a ride*, http://download.asic.gov.au/media/3549384/rep471-published-29-february-2016.pdf
[26] Op Cit. ASIC, para 93
[27] *Corporations Act 2001* (Cth) s 992A(3)(a)-(e).

- requiring insurers publicise their claims pay-out ratios, as occurs in the UK, in order to signal to a regulator and the consumer whether these products are a problem.

On the latter, ASIC has stated in Report 498 that:

> *ASIC and APRA will work with insurers and other stakeholders during 2017 to establish a consistent public reporting regime for claims data and claims outcomes, including claims handling timeframes and dispute levels across all policy types. Data will be made available on an industry and individual insurer basis.*

It is important that this information be provided to consumers on all consumer facing life insurance product documentation in a legible and easily understandable fashion, rather than kept on the APRA, ASIC or industry funded website where consumers are unlikely to look before purchasing.

It is also important that this data be fully transparent and that when reporting ASIC should name insurers who are rejecting large amounts of claims.

Advertising and marketing

With respect to advertising and marketing, Financial Rights notes that the Code does nothing to move beyond what is already expected on them under the law and current ASIC good practice guidelines. There remains significant failing examine advertising and representations that insurers, and trustees, make about the scope of cover to ensure that this is aligned with the definitions and cover provided, and report any discrepancies to us.

Financial Rights recommended that the Code needed to improve consumer protections available through advertising and marketing commitments by:

- making explicit the nature of stepped premiums and level premiums;
- prohibiting the use of terms such as "no cost," "without cost," "no additional cost" or "at no extra cost"
- not promoting products to customers in situations where it is evident that the product is worthless or of very low value to that customer; and
- not engaging in high pressure sales practices, practices based on exploiting anxiety or guilt, or other ethically or legally questionable selling techniques.

These recommendations were not taken up. It is Financial Rights view that it is worth ASIC review 2012's *RG 234 Advertising products and advice services including credit: Good practice guidance*[28] and consider developing a separate guideline specific to the life and general insurance industries.

[28] http://asic.gov.au/regulatory-resources/find-a-document/regulatory-guides/rg-234-advertising-financial-products-and-advice-services-including-credit-good-practice-guidance/

Recommendations

Given the FSC has failed to adequately address issues of add-on sales techniques and unsolicited marketing calls the Government must address these through law reform including:

- introducing a mandated delay regime including an opt-in days after the sale of a loan
- removing the exemptions for life insurance under the anti-hawking rules to prevent unsolicited sales;
- requiring insurers publicise their claims pay-out ratios, as occurs in the UK, in order to signal to a regulator and the consumer whether these products are a problem
- ASIC review 2012's *RG 234 Advertising products and advice services including credit: Good practice guidance* to tighten the rules around life insurance (and general insurance) marketing claims.

Claims Handling

Financial Rights provided a significant proportion (16%) of the data relating to poor claims handling cases for aggregate use in the recent ASIC Report 498 centring on claims between January 2013 and March 2016. We provided cases that involved:

- claims handling delays
- hardship caused by delays
- unreasonable requests for information
- piecemeal evidence gathering tactics
- issues with surveillance
- alleged discrimination
- issues with doctor/forum shopping
- mis-selling arising from bad advice or commissions
- no PDS available

Financial Rights puts forward a number of recommendations to address some of these issues elsewhere in this submission. However we wish to note our support for the findings and recommendations of ASIC Report 498.

ASIC found that there are significant limitations in relation to their power to oversee and regulate life insurer's claims handling process.[29] Financial Rights supports the recommendations made by ASIC to improve this situation, including removing the exemption

[29] Op cit, ASIC, para 58. Claims handling matters outside the scope of the Corporations Act include: (a) negotiations on settlement amounts; (b) interpretation of relevant policy provisions; (c) estimates of loss or damage and value or appropriate repair; (d) recommendations on mitigation of loss and increases in limits or different cover options to protect against the same loss in the future; and (e) claims strategy (e.g. the making of claims under an alternative policy).

under the Corporations legislation for "handling insurance claims" and that more significant penalties for misconduct in relation to insurance claims handling are also included in the review of ASIC's penalty powers.

We also wish to emphasise that issues around delays and the piecemeal gathering of evidence by insurers are among the most common complaints our solicitors hear on the Insurance Law Service. We have serious concerns that such delays are in fact unethical strategies used to drag out claims leading to consumers to tire out and disengage with their claims. The onerous demands placed by life insurers on policyholders lead many to withdraw their claim, not due to any admission of fraudulent behaviour but simply because the process is too burdensome or invasive for many consumers to bear. Anecdotally at least Financial Rights believes that the high withdrawal rates related to this issue is such that they are systemic and needs close examination and legal reform to ensure that such tactics are prohibited. We note that the ASIC Report 498 found that some insurers had relatively high numbers of 'withdrawn' claims, with three insurers having 34%, 29% and 23%of retail policy claims withdrawn.[30] On particular forms of cover one insurer's withdrawn claim rate was 33% and for income protection another insurer's was 30%. For one insurer, the trauma cover withdrawn claim rate was 26%.[31]

Case Study – Jackie - CLSIS 130006

Jackie has been receiving income protection payments since 1998 – approximately 17 years and is continues to receive it. CPI increases were not applied correctly and Jackie provided her Tax Notice of Assessment. However, her insurer wants her Income Tax Returns. They haven't paid CPI for the last two years but the insurer are asking Jackie for 17 years of tax returns (that is her tax return for every year since 1998) and wanting her to consent to them accessing full ATO records.

The extent of the information and documentation requested in the above case study and the following case study is suggestive of fishing exercises for any material that may be used against a claimant.

Case Study– Kenneth - CLSIS 112240

Kenneth obtained an income protection policy in 2010. 10 months later Kenneth had workplace accident. After his workers compensation benefits ran out, Kenneth made an income protection insurance claim in late 2012. After 12 months there was still no resolution to his claim.

In November 2012, Kenneth signed authorisation for his insurer to access his Medicare and PBS records for the previous five years. A year later Kenneth was asked by his insurer to sign a new form authorising release of information from 1984. When he asked why his insurer told him that it is because he hadn't dated the authorisation form he

[30] Op cit, ASIC, para 186-190
[31] Op cit, ASIC para 194.

signed in November 2012, which according to Kenneth was not true – he had dated it. When queried further, the claims officer stated that the reason they are asking Kenneth to sign release for full medical record going back 20 years to 1984 is that they were looking further into Kenneth's medical history. This, a year after the claim was made.

Financial Rights hear from many clients who are asked to provide excessive amounts of information to maintain their claims. This drip feed of information requests can not only delay claims but in the following case can exacerbate the problems for which they are receiving benefit payments in the first place.

Case Study – Karolina - CLSIS 106041

Karolina has Income Protection Insurance a life insurer. Karolina has been unable to work for a number of years and has been receiving insurance payments from his insurer. Karolina has a number of issues with her insurer including the fact that her Claims Manager and Rehab Manager and other staff have been rude to her and made her cry; her benefit payments are always paid late and the insurer didn't want to pay money toward her fitness programme, which Karolina says she was entitled to under her policy. The insurer eventually paid for the fitness programme. Karolina reports also that the Claims Manager would keep telling her she was better and that she should go back to work, in face of all medical evidence to the contrary.

However Karolina is most affected by the amount of information that she needs to provide her insurer. Her insurer used to make Karolina keep an Activity Diary where every 2 hours she'd have to write down her symptoms. Karolina reports she has medical evidence to show this process of noticing and recording her symptoms was actually making her worse because it made her think about her illness constantly.

The insurer also requests that Karolina go to her GP to fill in paperwork every month. Her GPs say that she needs to only go once every 3 months as it is not likely for Karolina to recover any time soon.

The insurer also makes Karolina go to Independent Medical Examinations (IMEs). Lately it has been every two months. But in the past it was once a year. Karolina says the Independent Medical Examinations are exhausting and unnecessary. Karolina says she has Doctors', Physios and Psychologists' reports all saying that the insurer's treatment of her is making her medical condition worse.

Another aspect to the unreasonable requests for information is that sometimes the burden placed upon a claimant to gather the information can be overly burdensome.

Case Study – Jaunnie - CLSIS 136131

Jaunnie took out life insurance policy in 1993 with her insurer. In 2010/2011 C started having mental health problems. Jaunnie lodged a claim in about January 2015 for TPD due to her mental health problem. She's had to provide medical information to them however they're now requesting that she attend an appointment with one of their psychiatrists whose office is approx. 110km away.

On this point we emphasise our support of ASIC recommendation to undertake targeted surveillance work to examine the reasons for substantially higher than average decline rates and withdrawn claim rates for particular insurers, and consider regulatory options where these reasons cannot be justified.

Financial Rights acknowledges that the new Life Insurance Code of Practice has included a commitment to decide life insurance claims within a maximum of 12 months (clauses 8.16 and 8.17). While the implementation of this timeframe will provide consumers some certainty where none existed previously, 12 months remains a long time. Financial Rights is of the view that given the unenforceability of the Code of Practice, the Government needs to consider legislative reform to ensure that impose strict time limits on life insurers to decide claims.

Recommendations

As recommended in ASIC Report 498, Financial Rights recommends that:

ASIC establish, with APRA, a new public reporting regime for life insurance industry claims data and claims outcomes and that this data be made accessible and available to all consumers at point of sale and renewal. ASIC should also ensure that this data is fully transparent including attaching insurer names to the claim rates.

The Government strengthen the legal framework covering claims handling including the removal of the exemption of 'handling insurance claims' from the conduct provisions of the Corporations legislation and that more significant penalties for misconduct in relation to insurance claims handling be introduced in ASIC's penalty powers.

The consumer dispute resolution framework for claims handling be strengthened under the Government response to the current Ramsay review by ensuring better and more effective consideration of issues of fairness to supplement the existing jurisdiction and giving better access to consumers with complaints about delays in claims handling and ensure better remedies when these complaints are found in favour of the consumer.

ASIC undertake targeted follow-up reviews on areas of concern, including for individual insurers with high decline, withdrawal and dispute rates, as well as review life insurance sold directly to consumers without personal advice.

The insurance sector comply with ASIC's expectation that in undertake an immediate review of the currency and appropriateness of policy definitions; examine and ensure advertising and representations about the cover align with the definitions and the policy, and report any discrepancies to ASIC; ensure that claims timeframes are consistent with industry standards

and expected claims timeframes are adequately communicated to policyholders; and ensure that incentives and performance measurements for claims handling staff and management do not conflict with the obligation to assess each claim on its merit. The results of this should be report by ASIC in the lead up to the first review of the newly introduced Code.

The Government consider legislative reform to ensure that impose strict time limits on life insurers to decide claims.

Surveillance and investigations

As Financial Rights notes above, the Life Insurance Code does include significant commitments on surveillance interviewing and investigations, our *Guilty Until Proven Innocent* Report did identify serious issues with respect to the state of private investigator regulations.

The report found that the state of private investigator licensing in Australia is a mess.[32] There is vast variability across jurisdictions in the content and coverage of licensing schemes, training methods and quality control, and a multiplicity of associations and self regulatory codes. This is confusing to consumers. It is not clear there is any uniform competency and accountability of private investigators across Australia. This mess is at least in part acknowledged by the industry itself.[33] One private investigator told Financial Rights that they are a member of an Australian association only because he had to be and would not be a member otherwise. He and his colleagues have chosen to be a member of the US based Association of Fraud Examiners which has Sydney and Melbourne chapters. This association provides significant training and certification standards unavailable in Australia.

Financial Rights also notes the substantial ambiguity with respect to whether insurance investigators need to be licensed. As noted above, all state licensing schemes exempt insurance companies, loss adjusters and their employees from the need to be licensed as a private investigator. The General Insurance Code requires third party investigators to hold a current licence but only "if required by law".[34] Some insurance companies do however require their external investigators to be licenced. Ultimately this means that some of the investigators working in insurance investigations will be licenced and others will not. Not that this ultimately means much to a policyholder given the variability of regulations, dearth of standards and lack of clear avenues of redress applying to their conduct.

The ALRC recommended in its 2008 Report on Privacy Law and Practice that the Federal Governments through the Council of Australian Governments consider developing uniform private investigator regulations. As a part of this there should be a uniform enforceable code of conduct that supersedes the mess of ineffective and unsubstantial self-regulatory codes that currently exists.

[32] For full details of this mess see pp. 70-76, *Guilty Until Proven Innocent*
[33] ALRC Report on Privacy Law and Practice, 2008, para. 44.76
[34] GICOP 2014, s. 6.3(b)

In order to ensure greater confidence in the sue of third party private investigators in the life insurance (and general) insurance industries, the Federal and State Governments through the Council of Australian Governments develop uniform private investigator licensing regulations with an enforceable code of conduct.

In addition the Federal and State Governments through the Council of Australian Governments develop uniform surveillance and listening devices laws that provide for strong consumer protections. The ALRC Report *For Your Information Only*[35] recommended that surveillance device laws should be uniform across Australia, a recommendation supported by the majority of submissions. Financial Rights supports this recommendation as well. Such legislation should: provide stricter protections for members of the public; provide greater certainty to consumers and businesses; be technologically neutral to ensure that all (known and developing) forms of surveillance be captured; and should remove "participant monitoring" exceptions (found in Qld, Vic, and NT), that is outlaw the recording by one party to a private conversation or activity without the consent of other parties.

Recommendations

That the Federal and State Governments through the Council of Australian Governments develop uniform private investigator licensing regulations with an enforceable code of conduct.

That the Federal and State Governments through the Council of Australian Governments develop uniform surveillance and listening devices laws that provide for strong consumer protections including stricter protections for members of the public; greater certainty to consumers and businesses; technological neutrality to ensure that all (known and developing) forms of surveillance be captured; and removal of "participant monitoring" exceptions (found in Qld, Vic, and NT), i.e. outlaw the recording by one party to a private conversation or activity without the consent of other parties.

Unfair contract terms

When the Australian Consumer Law (**ACL**) commenced in January 2011 it replaced and amalgamated 17 existing laws and included new unfair contract terms (**UCT**) provisions. However, as recently noted in the ACL Review Issues paper, the UCT regime does not apply to insurance contracts. The *Insurance Contracts Act 1984* (Cth) does not include protections against unfair contract terms and excludes any Commonwealth, state or territory laws regarding contractual 'unfairness' from applying to contracts of insurance regulated under that Act, such as the unfair contract terms provisions in the ACL and ASIC Act.

[35] Australian Law Reform Commission (ALRC), (2008). *For Your Information Only: Australian Privacy Law and Practice*, ALRC Report No. 108, http://www.alrc.gov.au/publications/44.%20New%20Exemptions%20or%20Exceptions/private-investigators

This means that unfair contract term protections currently apply to every other contract an Australian consumer is ever likely to enter apart from insurance including financial products and service contracts under Subdivision BA of Division 2 of Part 2 of the *ASIC Act 2001 (Cth)*.

It has long been the view of consumer advocates that there is no sound reason to exempt the insurance industry.

There have been a number of arguments put forward by the insurance industry against imposing the UCT regime on insurers. One, for example is that the duty of utmost good faith as codified in the *Insurance Contracts Act 1984* (Cth) is adequate to ensure consumers are protected.. Insurers have argued that this duty covers the same issues that arise with unfair contracts and imposing the UCT regime on insurers would add an additional layer of regulatory complexity. Financial Rights strenuously disagrees with this view and believes that the duty of utmost good faith has neither prevented the spread of unfair terms in insurance contracts nor has it provided the courts or external resolution schemes with any power to provide a remedy to consumers when an unfair term has been used.

Sections 13 and 14 of the Insurance Contracts Act do not provide that an insurer is in breach of the duty of utmost good faith merely because of the fact that they wish to rely on a contractual term that is unfair. Most consumers do not argue on the basis of good faith at the Financial Ombudsman Service and it is not commonly relied upon, if at all as a basis, for relief from an unfair term. The Financial Ombudsman Service has struggled in determinations to deal with unfair contact terms due to the limitation in the Insurance Contracts Act 1984 and the limited scope of the duty of utmost good faith.

Unfair terms are usually hidden away in the fine print of an insurance contract or product disclosure statement and are rarely read or understood by a consumer when selecting coverage.

Financial Rights regularly come across unfair contract terms in insurance cause a significant imbalance in the parties' rights and obligations arising under the contract; are not reasonably necessary in order to protect the legitimate interests of the party who would be advantaged by the term; and would cause detriment (whether financial or otherwise) to a party if it were to be applied or relied on.

Financial Rights provides the following general insurance examples to illustrate

The insurer RAA included the following statement in its comprehensive car insurance:

> *"If your claim has been investigated and you withdraw your claim or we refuse to accept it, you may have to pay any costs incurred for the investigation of your claim."*[36]

This term is both a significant incentive for the insurer to investigate every case and delay payouts. It also acts as a significant disincentive to make a claim when the policyholder knows that they could be up for the cost of an investigation.

[36] RAA, (2014). *Comprehensive Car Insurance, Product Disclosure Statement* http://www.raa.com.au/documents/comprehensive-car-insurance-pdsapr15 p22

AVEA include the following term in their Motor Vehicle Insurance:

> *If You are responsible for damage to another person's Vehicle, We will pay the costs of hiring a substitute Vehicle for that person at publicly available commercial rates not exceeding $100.00 per day to a total of $1,500.00. See Additional Benefits Section for details about how rates are calculated.*[37]

and

> *If You are responsible for damage to another person's Vehicle, We will pay the reasonable costs of hiring a substitute Vehicle for that person at the lowest publicly available commercial rate, not exceeding $100.00 per day. This benefit is limited to $1500.00*[38]

These terms limit liability for 3rd parties seeking damages against the at fault party insured with AVEA. They limit the cover to $1500 when most other policies have liability cover up to $20 million.

RSPCA Pet Insurance includes the following cancellation term:

> *We will only accept notices of cancellation given in writing and signed by you. We will not accept cancellation requests by telephone or email unless agreed to by us, If you return your policy during the cooling off period, we will refund any premiums paid since commencement or renewal, less any reasonable administrative and other transaction costs incurred by us which we are unable to recover and any taxes or duties that we are unable to refund.*[39]

Limiting cancellation to the provision of notice in writing "unless agreed by us" and retention of "reasonable administrative costs" that are not specified unreasonably disadvantages the consumer and causes enormous difficulties to consumers trying to cancel a policy.

Youi's Uninsured motorist extension provides cover in the following limited circumstances:

> *Under Third Party, Fire and Theft or Third Party Property Only cover, up to $5,000 or the car's market value, whichever is the lesser, for accidental damage to the car, if there was an uninsured third party motorised vehicle involved and if:*
>
> *…*
>
> *we agree that the third party was completely to blame for the accident;*
>
> *you provide us with the name, residential address, contact phone number and vehicle make and registration number of the other party; …*[40]

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[37] AVEA *Product Disclosure Statement – Motor Vehicle Insurance* https://www.avea.com.au/download/product_disclosure_statements/MotorVehicle_V011214_Web.pdf p.6

[38] AVEA *Product Disclosure Statement – Motor Vehicle Insurance* https://www.avea.com.au/download/product_disclosure_statements/MOT_V011115_Web.pdf p.8

[39] RSPCA Pet insurance p24. https://www.rspcapetinsurance.org.au/RSPCA/media/Document/rspca-policy-booklet.pdf

[40] Youi, *Car Product Disclosure Statement* p12 https://www.youi.com.au/GetPDS/?riskType=VEH

This term permits the insurer to make an arbitrary decision to exclude if they do not agree and do not have to base this on the facts or evidence before them. The requirement to provide name, residential address, contact phone, vehicle make, model and rego is unreasonable if the driver at fault refuses to provide the details or flees the scene. The cover here is not limited in this way under comprehensive cover policies.

Finally Financial Rights solicitors regularly see terms that involve the automatic renewal of policies or fixed term contracts. The UK Financial Conduct Authority lists automatic renewal of a fixed-length contract where the deadline to cancel is unreasonably short, as an unfair contract term. In Australia, ASIC last year reviewed six insurers' car insurance renewal practices.[41] They found that:

> *"consumers were not always clearly informed by insurers, when first purchasing the policy, that it would automatically renew unless the consumer advised otherwise. In most cases consumers were only informed about the automatic renewal practice in the product disclosure statement (which may not be received by the consumer until after the insurance is purchased) and renewal notice."*

The law does not prevent insurers from automatically renewing insurance policies and in some cases consumers seek this feature out, however by structuring the sales and disclosure practice in such a way that does not fully inform consumers of this renewal practice unreasonably advantages the insurer. Where consumers inadvertently find themselves insured twice, they struggle to obtain a refund for the full premium and are often limited in only recovering 50% of the overpaid premium on the basis the insurer was "on risk".

With respect to life insurance claims, Financial Rights points to the recent ABC 7:30 report on a life insurance claim being rejected on the basis that MLC would only pay out if a patient had been intubated in intensive care with a tube down their throat for 10 days. The patient in the report had had this for 7 days and therefore his claim was not paid. The average for intubation is 4 days. This clearly is unfair and a definition that is simply impossible to meet. In a sense life insurance is providing illusory cover.

We believe that these terms and the examples provided above prima facie meet the definition of an unfair term in that they cause a significant imbalance in the parties' right and obligations arising under the contact, are unnecessary and can and do cause detriment to consumers. Furthermore none of these terms could arguably fall within the duty of utmost good faith nor be remedied by a court or external dispute resolution service.

In 2012 the Federal Government introduced a Bill to extend the protections from unfair contract terms available for consumer contracts of other financial products and services to general insurance contracts. The Bill never entered into law. Financial Rights notes that the UK has banned unfair terms in insurance contracts under their Consumer Rights Act 2015.

[41] ASIC, 15-345MR ASIC drives better disclosure of automatic renewal of car insurance, 19 November 2015
http://asic.gov.au/about-asic/media-centre/find-a-media-release/2015-releases/15-345mr-asic-drives-better-disclosure-of-automatic-renewal-of-car-insurance/

Financial Rights believes that subjecting general and life insurance contracts to the unfair contract terms regime would allow remedies for consumers who have suffered significant detriment because an insurer relied on an unfair term. It would create an incentive for insurers to draft their contracts with an eye to fairness and would further incentivise insurers to review their existing contracts and remove terms which may be unfair, rather than face enforcement action later. It would also improve the fairness of insurance contract fine print—making policies easier to read and compare, giving consumers stronger protection under the law, and promoting genuine competition.

Recommendation

That the government remove the exemption for insurance products under the Unfair Contract Terms regime.

Dispute Resolution

Financial Rights notes that ASIC recommends in Report 498 that the consumer dispute resolution framework for claims handling be strengthened. Financial Rights fully supports this recommendation. In the data we provided to ASIC for this report, a significant recurring issue raised by the cases was poor dispute resolution processes.

ASIC has recommended that the coverage of life insurance claims by dispute resolution schemes should be considered as part of the current inquiry into external dispute resolution (EDR) schemes review including a need to:

> (a) ensure better and more effective consideration of issues of fairness to supplement the existing jurisdiction; and
>
> (b) give better access to consumers with complaints about delays in claims handling and ensure better remedies when these complaints are found in favour of the consumer.

We would go further and argue that ASIC should have an enhanced role in responding to complaints about poor IDR. Consumer representatives have raised concerns regarding ineffective IDR process in our joint submission to the Ramsay Review. We have recommended that ASIC publicly name Financial Services Providers including life insurers where complaints and systemic issues are raised by recognised consumer groups or by a sufficient number of consumers.

Financial Rights also notes that, along with the consumer movement, we have argued for the creation of one EDR scheme covering all financial institutions including life insurers, effectively merging the FOS, CIO and Superannuation Complaints Tribunal (**SCT**).

Financial Rights has had ongoing concerns about the structure, funding and operation of the SCT, the venue where a significant number of life insurance complaints turn. The SCT is

significantly underfunded,[42] is inflexible and complex and is unable to provide legal advice to applicants (as detailed in the Joint Consumer Submission to the Ramsay Review.[43] This has led to significant and unacceptable delays for justice. As at April 2016, the SCT had a complaints backlog of at least 1,500 cases, with some complaints dating back to 2012. This has disastrous implications for consumers waiting on a determination, and significantly impairs its effectiveness as dispute resolution forum.

Recommendation

That three current EDR schemes including the SCT should be integrated into a single, industry-funded ombudsman scheme.

That ASIC publicly name Financial Services Providers including life insurers where complaints and systemic issues are raised by recognised consumer groups or by a sufficient number of consumers.

Improved Disclosure

Consumers continue to face significant complexity, confusion and exhaustion when purchasing insurance products. Consumers know they need insurance but shopping around is difficult and time consuming. This leads to people choosing on price or brand rather than detailed consideration of features. At renewal time, the complexity means consumers are reluctant to shop around and this creates an incentive for insurers to increase price more than necessary in expectation that consumers will tend to be apathetic and remain where with their insurer.

Financial Rights believe that life insurers should commit to providing the previous year's premium on the annual renewal notice. Information can include

- the price of the new policy if the consumer renews;
- any difference between the new price and the old price; and
- the reasons for any change.

Such a change will alter consumer behaviour by prompting consumers to think about their insurance, ask their insurer about the price and features, and make informed decisions.

This move would be an important step in improving price transparency and assist consumers in making more informed decisions. The information at renewal is an important opportunity for consumers to consider their financial situation and make appropriate decisions. Information

42

43

http://www.treasury.gov.au/~/media/Treasury/Consultations%20and%20Reviews/Consultations/2016/Review%20of%20the%20financial%20system%20external%20dispute%20resolution%20framework/Submissions/PDF/Joint_Consumer_Groups.ashx

about (a) the risks of switching and (b) any premium hardship options available under their existing policy may be of benefit to consumers. The industry should consider what best practice may apply at the point of renewal to prevent lapses, unnecessary churning, and other consumer harms.

With respect to the risks of switching, Financial Rights acknowledges that the FSC have included in the new Life Insurance Code of Practice at clause 4.8 that

> *When you tell our sales staff that you are replacing an existing Life Insurance Policy, they will tell you that you should not cancel any existing cover until your new application is accepted, and explain the general risks of replacing an existing policy, including the loss of any accrued benefits, the possibility of waiting periods to start again, and the implications of any non-disclosure on your new application (even where unintentional).*

While we support the inclusion of this as an important step towards improved disclosure we do not feel that this goes far enough. Replacing or switching one's insurance cover is a critical moment of interaction between the insurer and policyholder. The failure of these interactions to fully inform the policyholder of the implications and risks of a switch leads to many of the issues that we hear on the Insurance Law Service. One key issue that arises, for example is a failure to fully understand one's own duty of disclosure. This one failure leads to increased levels of investigations and delays at claim time. Financial Rights believes it is incumbent upon insurers to provide full and meaningful information to every potential and current policyholder about the risks of switching, waiting periods, loss of accrued benefits, the duty of disclosure etc. Although it is welcome, it is simply not enough that sales staff explain this, merely when the policyholder "tells our sales staff that [they] are replacing an existing Life Insurance Policy." Financial Rights believes that there are more steps that insurers should take to improve insurance literacy. Online and hardcopy application forms should have Schumer Box-like information summarising the implications of a replacement policy. The Duty of disclosure should be better explained and policyholders should be assisted and encouraged to provide as many details as possible. Behavioural research needs to be undertaken to investigate the best approach to improving literacy in this regard.

Financial Rights also notes that there is a significant difference between the disclosure practices of insurance products obtained directly or via superannuation. As mentioned above trying to obtain a PDS of a group insurance product is incredibly difficult. PDS's are generally not supplied to group insurance policyholders and generally speaking have no idea what they are covered for. They are also subject to the commercial whims of trustees switching covered for and whether their coverage has been reduced to save money. This too leads to a real risk of underinsurance for group insurance policyholders – something they are rarely if ever aware of or even able to find out.

Recommendations

That it be mandated that insurers (including life insurers) provide the previous year's premium on the annual renewal notice including

- the price of the new policy if the consumer renews;

- any difference between the new price and the old price; and
- the reasons for any change.

Life Insurers should provide more meaningful information regarding the risks of replacing insurance products, the design of which should be informed by peer-reviewed behavioural research.

Life insurers should provide premium hardship options under every policy they provide and provide this information on the renewal notice.

Increased Data Availability

Financial Rights notes that the Productivity Commission has recently released a report on Data Availability – a report that is mainly directed at examining options for improving availability and use of both public sector and private sector data.

Financial Rights however has serious concerns regarding the greater availability and use of data particularly with respect to the insurance industry.

The insurance industry is increasingly integrating data collection into their service provisions. AIA and MLC for example provide discounts and benefits on life insurance products[44] if you use a personal fitness tracking device and share this data with the insurer. While the value proposition being put forward is that the offer promotes fitness, encourages a healthy life style and provides financial savings, the key issue is that insurers will be more empowered to identify risks and uninsure or reduce coverage of certain tracked policyholders.[45]

This has huge implications for government as some of the highest risk consumers will be priced out of coverage. The AI Report identifies a number of significant issues:

Firstly greater risk transparency can facilitate better behavior and insurers can provide incentives to undertake risk mitigation but what is the insurer's responsibility to disclose risk information to the consumer, especially health-related material. This may is not clear and may be misused by the insurance industry to benefit their bottom line (through cost savings) rather than ensure fair coverage of consumers.

AI argues that Government may have a role to play when the insurance market armed with volumes of granular data do not deliver adequate cover at an affordable price. That is will government need to step in to protect those people with uncontrollable risks identified by for example, genetic testing. Will society want individuals to pay a 'fair price' for insurance that reflects risk or do we want everyone to have affordable access to insurance regardless of the

[44] AIA Vitality https://www.aiavitality.com.au/vmp-au /; MLC Life Insurance on Track https://www.mlc.com.au/personal/important-updates/on-track

[45] Actuaries Institute, *The Impact of Big Data on the Future of Insurance*, *Green Paper*, October 2016 https://www.actuaries.asn.au/Library/Opinion/2016/BIGDATAGPWEB.pdf

risk? Genetic discrimination in insurance is not inconceivable development given the troubles already faced by those with mental illnesses and current moves to implement non-discrimination principles through self-regulation.[46]

Insurers in Australia are currently not permitted to require a genetic test of a consumer applying for insurance, but are entitled, under the principle of disclosure to the results of previously undertaken genetic tests. This is not the case in US, Sweden, Germany and France, which all prohibit genetic discrimination.

Consumers will also face a dilemma over risk reduction versus privacy. AI state:

> *Increased awareness of consumer behaviour, gleaned from the capture and analysis of higher volumes of detailed data, allows service and product providers to improve their offerings to individuals. Individuals will also get the opportunity to receive tailored information from their insurer about the risks they face. Insurers can develop services which give customers signals about how to reduce their risk levels and hence their insurance premiums. This will lead to a society-wide risk reduction benefit.*
>
> *Nevertheless, the increase in the volume of data held on people and the way it is used (or perceived to be used) may lead to an increase in privacy and discrimination concerns. Government will need to consider the adequacy of currency privacy rules and rules for access, ownership and use of personal data.*

The AI report details a list of potential policy responses to the influx of big data including:

- placing limits on life insurance premiums as currently occurs under CTP and health insurance as a social good;
- the government entering the market as "insurer of last resort" as it currently does in relation to commercial interruptions arising from terrorism;
- the Government may want to consider whether any restrictions should be placed on what information an insurer may seek. It could require insurers to be more transparent

[46] In 2003, the then Investment and Financial Services Association (IFSA) (now the Financial Services Council) representing life insurers developed memorandum of understanding between life insurers and a coalition of mental health sector stakeholders (MHSS) in recognition of the issues faced by people with a mental health disorder. The MHSS included the Mental Health Council of Australia, Beyond Blue the Australian Psychological Society and five other representative organisations. The aim of the memorandum was to "improve the industry's understanding of mental health conditions, their risk management practices and ultimately the life insurance outcomes for Australians with mental health conditions." The memorandum has led to a number of significant developments including new guidelines for underwriting and claims treatment, a mechanism to address complaints, consumer facts sheets detailing the process, information sheets to assist the community to understanding the implications of applying for insurance products and the importance of making accurate statements about their health, annual data collection and the introduction of the Financial Services Council's Standard No. 21 Mental Health Education Program and Training. Financial Rights also notes that the FSC has announced as part of the launch of the current Life Insurance Code that

> *The next iteration of the code will seek to increase obligations on insurers when interacting with consumers suffering mental health issues. o The FSC will work with groups like Beyond Blue, Lifeline, Mental Health Australia and the Public Interest Advocacy Centre to determine how to better serve those consumers with mental health issues.*

about the use of data and whether it will be sold or passed on. It might also confirm the right of the insured to understand whether their social network footprint or internet browsing history is being used.

- the Government could consider restricting the use of certain data on uncontrollable risks for pricing, to avoid the potential for consumers' adverse decision making by insurers.
- the Government needs to consider the insurer's responsibility to share knowledge of risk with the consumer, particularly where there is no incentive to do so or a financial interest not to do so.

Recommendations

That the Government undertake a review of the impact of data on both the life and general insurance industries, examining the social impact and developing preemptive policy approaches.

That the FSC address issues of data collection privacy and discrimination in the next iteration of the Life Insurance Code of Practice.

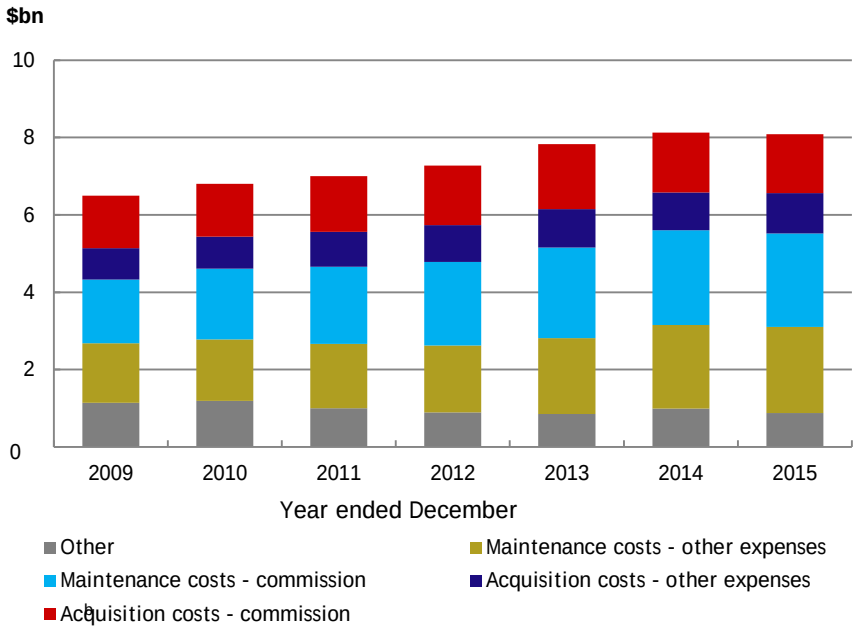
That the Government and the Productivity Commission in its current Data Availability review adequately take into account genuine community concerns about privacy protections and adequately fund the Office of the Australian Information Commission.

Remuneration

Consumers buying life insurance directly will often use a financial adviser to make the arrangements. These financial advisers are still able to receive high upfront and ongoing commissions for selling life insurance, even though commissions are banned for all other kinds of personal advice.

The cost to insurers for life insurance distribution through adviser channels is significant, with ongoing and upfront commissions costing the life insurance industry billions each year.

Graph: Life Insurer Operating Expenses[47]



Despite the high costs to insurers, there has been significant resistance from all sections of industry to removing commissions from life insurance advice.

Commissions give an adviser a strong incentive to place consumers in the policy that attracts the biggest payment for them, not necessarily the policy that's best for the client. There is clear evidence that advisers who receive commissions are more likely to recommend inappropriate products for their client and are more likely to switch a client into a new product unnecessarily. A 2014 ASIC review of retail life insurance advice found high levels of churn across the industry, where clients are placed into new products. 37 percent of advice failed to prioritise the needs of the client and comply with the law. High upfront commissions are strongly correlated with poor advice; 45% of advisers who were paid through up front commissions failed to comply with the law.[48]

The ASIC report clearly found that high upfront commissions led to the worst consumer outcomes. The report concluded that:

"High upfront commissions give advisers an incentive to write new business. The more premium they write, the more they earn. There is no incentive to provide advice that does not result in a product sale or to provide advice to a client that they retain an existing policy unless the advice is to purchase additional covers or increase the sum insured."[49]

Current remuneration arrangements encourage advisers to sell products rather than provide quality personal advice. Being sold an inappropriate life insurance product causes long-term

[47] Australian Prudential Regulation Authority Quarterly Life Insurance Performance Statistics, issued 16 February 2016 http://www.apra.gov.au/lifs/Publications/Pages/quarterly-life-insurance-statistics.aspx
[48] ASIC (2014), *Report 413: Review of retail life insurance advice*, pp. 5-7.
[49] Ibid para 147.

financial and personal harm to consumers. It means consumers waste money on a product they can't use, and should something go wrong, they or their families are not covered as expected. Over time, widespread mis-selling and poor behaviour from advisers means consumers will lose trust in the financial system.

The Federal Government has introduced a legislative package to reduce toxic upfront commissions and decrease the likelihood of inappropriate product churn.[50] The *Corporations Amendment (Life Insurance Remunerations Arrangements) Bill (2015)* and associated regulations place limits on how financial advisers arranging life insurance can be remunerated. It does this by removing the current exemption that allows advisers to receive commissions for life insurance products and enabling ASIC to determine acceptable remuneration arrangements. In the short-term ASIC will cap upfront and trail commissions and introduce a two-year clawback requirement to reduce the risk of inappropriate product churn.[51]

This suite of reforms is an important step in the right direction but needs to be taken much further. Given the harm that commissions cause consumers they should be banned in life insurance advice, just as they are for other kinds of advice.

Recommendations

That the *Corporations Amendment (Life Insurance Remunerations Arrangements) Bill (2015)* is passed as soon as possible without amendment.

That the Federal Government sets a clear date for the removal of all commissions in life insurance advice, starting by phasing out up-front commissions shown to lead to the worst consumer outcomes.

Australian Securities and Investments Commissions' role

ASIC plays an essential role in regulating life insurance providers and distributors. ASIC has however been constrained by limited resources and needs additional powers to protect consumers.

ASIC funding

In 2014-15, ASIC's budget was reduced by $120 million over four years, in addition to an efficiency dividend reduction of $47 million over the same period.[52]

ASIC needs adequate funds that will allow it to be proactive (able to uncover and investigate suspected misconduct rather than waiting for a crisis), independent (accountable to the Federal Government and Parliament, but able to set its own agenda), flexible (able to keep up with rapid change in the industries it regulates) and able to offer salaries in line with the financial services industry.

[50] http://kmo.ministers.treasury.gov.au/media-release/024-2015/
[51] Op cit, ASIC
[52] ASIC (2015), *Annual Report.* ASIC (2014), *Annual Report.*

In its response to the Financial System Inquiry, the Federal Government has committed to consider three-year funding arrangements and an industry-pays funding model for ASIC. This offers a more reliable funding option for ASIC however, we don't know when this will be implemented. The initial funding proposal put forward by Treasury would not lead to increased funding for ASIC and some aspects of the proposal pose risks to ASIC's independence. [53]

What's needed is an industry-pays funding model for ASIC that leads to secure, increased and non-conflicted funding in the long-term. Until future funding arrangements are confirmed and take effect, ASIC requires additional funds to properly fulfil its mandate and protect consumers.

Recommendations

In the short-term the Federal Government should provide additional funds to restore ASIC's funding to pre-2013-14 levels plus reasonable growth for wages and costs. The case for additional funding should consider, at a minimum, funds necessary to restore staffing levels to 2013-14 capacity (as staffing reductions occurred proactively in the lead up to the 2014-15 budget) and conduct increased surveillance activity.

In the medium-to-long-term the Federal Government should establish an industry-pays funding model for ASIC that leads to secure, increased and non-conflicted funding.

Additional powers for ASIC

Currently ASIC has limited proactive powers to prevent harm to consumers and act in cases where products are being sold inappropriately, like in the case of funeral insurance sold to young, indigenous consumers.

The Final Report of the Financial System Inquiry recommended two new powers for ASIC. These were:

- a targeted and principles-based product design and distribution obligation.
- a proactive product intervention power (PIP) that would enhance the regulatory toolkit available where there is risk of significant consumer detriment.[54]

The Federal Government has supported these recommendations in principle and has committed to consulting further on the detail of reform.

Giving ASIC oversight of product design and distribution and providing new PIP powers will help consumers of life insurance in Australia. The new powers will allow ASIC to encourage insurers to promote fair treatment of consumers, intervene where necessary to prevent harmful marketing or sales practices or the sale of harmful products and reduce the number of consumers buying products that do not match their needs.

[53] The problems with the proposed industry funding model are explained in detail in the joint consumer advocate submission to the proposal, available here: http://consumeraction.org.au/proposed-industry-funding-model-for-the-australian-securities-and-investments-commission-joint-submission/

[54] Financial System Inquiry (2015), *Final Report*, recommendations 21-22.

However, it's important to note that the Financial System Inquiry has recommended that PIP powers should not extend to "large numbers of consumers have incurred a small detriment".[55] These exclusions are not justified and would limits ASIC's ability to take action in the life insurance market, particularly against dodgy sales practices. It is our view that ASIC needs the ability to use PIPs across the entirety of the financial products and services it regulates.

Financial Rights also reiterates its support for extended powers for ASIC has already referred to above namely:

- ASIC establish, with APRA, a new public reporting regime for life insurance industry claims data and claims outcomes and that this data be made accessible and available to all consumers at point of sale and renewal.
- The Government strengthen the legal framework covering claims handling including the removal of the exemption of 'handling insurance claims' from the conduct provisions of the Corporations legislation and that more significant penalties for misconduct in relation to insurance claims handling be introduced in ASIC's penalty powers.

Recommendations

That all financial service providers are required to meet targeted and principles-based product design and distribution obligations. ASIC should be responsible for monitoring and enforcing these new obligations.

That ASIC is given a proactive product intervention power that will allow broad action to prevent consumer harm.

[55] Financial System Inquiry (2015), *Final Report*, pp. 206-207.