INSURANCE COUNCIL OF AUSTRALIA

SENATE ECONOMICS REFERENCES COMMITTEE INQUIRY

CONSUMER PROTECTION IN THE BANKING, INSURANCE AND FINANCIAL SECTOR

Submission from the

Insurance Council of Australia

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INSURANCE COUNCIL OF AUSTRALIA

Contents

INSURANCE COUNCIL OF AUSTRALIA

1. Executive Summary

The Insurance Council of Australia[1] (Insurance Council) understands the importance of a robust consumer protection regulatory framework to ensure that the consumer-business relationship is transparent and fair. This is an essential component of a strong and stable financial services sector, enabling consumers to confidently buy the financial products and services they need.

The existing regulatory framework provides consumers with a strong level of protection in relation to the general insurance products they purchase. This protection is provided in particular through the *Insurance Contracts Act 1984* (Insurance Contracts Act), *Corporations Act 2001* (Corporations Act), the external dispute resolution mechanism provided by the Financial Ombudsman Service (FOS), the General Insurance Code of Practice (Code of Practice) and the Insurance Brokers Code of Practice. In parallel to this, it is also important to recognise the critical role of Australia's robust prudential regulatory framework in providing general insurance policyholders confidence that the promises made to them will be kept.

Notwithstanding the strength of the current regulatory framework, the Insurance Council and its members are committed to continually enhancing outcomes for consumers buying general insurance. This is why the Insurance Council is reviewing the Code of Practice and has undertaken large scale consumer research that will enable insurers to explore new strategies and tools for providing insurance policy information to consumers.

The Code of Practice, which has been adopted by members of the Insurance Council, commits insurers to mandatory standards of service above and beyond their statutory obligations. Though the Code of Practice was revised extensively following a thorough independent review in 2012, the Insurance Council launched a targeted review of the Code of Practice on 17 February 2017 to ensure it keeps pace with recent developments affecting the industry.

The general insurance industry, through the Insurance Council, is undertaking ground-breaking work to better engage with consumers to facilitate appropriate decision-making. The objective of this work program is to maximise the ability of consumers to determine the risks that need to be insured and select coverage that meets their needs. While the legislative consumer protections are essential, the industry has recognised the importance of empowering consumer decision-making to help prevent poor consumer outcomes.

Additionally, the Insurance Council and consumer representatives have formed the Consumer Liaison Forum to facilitate open discussions between the general insurance industry and consumer representatives. This is another key example of how the general

[1] The Insurance Council of Australia is the representative body of the general insurance industry in Australia. Our members represent more than 90 percent of total premium income written by private sector general insurers. Insurance Council members, both insurers and reinsurers, are a significant part of the financial services system. December 2016 Australian Prudential Regulation Authority statistics show that the private sector insurance industry generates gross written premium of $44.6 billion per annum and has total assets of $121.1 billion. The industry employs approximately 60,000 people and on average pays out about $124.2 million in claims each working day.

Insurance Council members provide insurance products ranging from those usually purchased by individuals (such as home and contents insurance, travel insurance, motor vehicle insurance) to those purchased by small businesses and larger organisations (such as product and public liability insurance, professional indemnity insurance, commercial property, and directors and officers insurance).

insurance industry is proactively adapting to further improve business practices and consumer outcomes.

It is also important to recognise that consumers will significantly benefit from impending reforms to the regulatory framework that will further strengthen the existing consumer protection framework applying to general insurance.

As recommended by the Financial System Inquiry (FSI) and accepted by the Government[2], financial services product issuers and distributors will soon be subject to additional obligations to ensure that product design and distribution processes result in appropriate consumer outcomes. The Australian Securities and Investments Commission (ASIC) will also be given product intervention powers that will substantially enhance its regulatory toolkit.

Furthermore, the Government has established a Taskforce to assess the suitability of the existing regulatory tools available to ASIC, including the adequacy of civil and criminal penalties, ASIC's information gathering powers, ASIC's powers to ban individuals from occupying company offices and the breach reporting regime. The establishment of the Taskforce is in addition to the $127.2 million reform package announced by the Government in April 2016 to bolster the supervisory and surveillance capabilities of ASIC.

It is clear that a comprehensive and substantial reform program is already underway. The Insurance Council submits that in assessing the adequacy of the consumer protection regime for general insurance policyholders, the focus must be on identifying whether there are examples of poor consumer outcomes that remain without a remedy. The Insurance Council is not aware of any issues that are not being actively addressed.

[2] See: the Financial System Inquiry Final Report, released 7 December 2014 (Chapter 4 refers); and the Government Response to the Financial System Inquiry, released 20 October 2015.

INSURANCE COUNCIL OF AUSTRALIA

2. Introduction

The general insurance industry employs approximately 60,000 people and on average pays out about $124.2 million in claims each working day ($31.1 billion worth of claims in the year ending 31 December 2016)[3]. Through the efficient management of risk, the general insurance industry plays an essential role in supporting the everyday activities of individual Australians and their communities and the broader operation of the Australian economy.

Notably, the general insurance industry plays a critical role in protecting the financial well-being of Australians by restoring their standard of living and helping their communities recover following natural catastrophes.

Over the past 20 years, there has been a significant increase in exposure to natural catastrophes across many parts of Australia. For instance, total insurance losses from declared catastrophe events over the past decade ($19 billion) is almost 4 times higher than total losses in the previous corresponding period ($5 billion)[4].

The contributions of the industry to the recovery of Australian communities from natural catastrophes are significant not only in terms of the billions of dollars of claims paid, but also because of the evolving risk mitigation and emergency management initiatives that help enhance community resilience.

The general insurance industry issued or renewed around 52 million general insurance policies in the year to 30 June 2015[5]. The large majority of these were personal insurance policies (around 48 million policies) in the home, motor and travel classes – collectively, these accounted for more than three quarters of all personal insurance policies.

Out of the total number of policies issued or renewed, consumers and businesses lodged around 4 million general insurance claims. General insurers only declined 3 per cent of claims – this percentage has been broadly consistent for a number of years.

Of the 3 per cent of claims (or around 130,000 claims) that were declined, around 23,000 of these resulted in internal disputes received by general insurers. Therefore, the number of internal disputes received by general insurers, represented as a proportion of the 52 million general insurance policies issued or renewed in 2014-15, was 0.04 per cent (or about 4 disputes received by general insurers for every 10,000 policies issued or renewed).

Furthermore, the number of disputes which went on to be accepted for resolution by the FOS in 2014-15 was 6,780. This represented about 0.01 per cent of the 52 million general insurance policies issued or renewed in 2014-15, or about 1 dispute accepted for resolution by FOS for every 10,000 general insurance policies issued or renewed).

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[3] Based on data from the Australian Bureau of Statistics and the Australian Prudential Regulation Authority.

[4] Based on data from the Insurance Council of Australia's *Data Globe*.

[5] The data in this section of this submission on the number of general insurance policies issued or renewed, number of claims (lodged and denied), internal disputes and disputes accepted by FOS was obtained from the General Insurance Code Governance Committee's '*The General Insurance Industry Data Report 2014-2015, 2012 General Insurance Code of Practice*'. Released 2 June 2016. The 2015-16 edition will be released this year. All related calculations are based on these data.

Nevertheless, the Insurance Council recognises that there are some areas for improvement, and takes the problems identified by ASIC with the sale of add-on insurance through motor vehicle dealerships very seriously. The Insurance Council and its members are engaged in discussions with ASIC and consumer advocates to refine a range of initiatives to increase the protection and value consumers receive from add-on products.

The Insurance Council's submission focusses on:

- The legislative framework in Australia that protects consumers in relation to general insurance they purchase, including the market conduct and prudential regulation frameworks administered by ASIC and the Australian Prudential Regulation Authority (APRA), respectively.
- The comprehensive and substantial regulatory reform program that is already underway in Australia.
- The role of the FOS in providing consumers a free, fair and accessible dispute resolution process.
- The Insurance Council's review of the Code of Practice.
- The range of general insurance industry-led initiatives that are designed to achieve higher standards and better outcomes for consumers buying general insurance.

INSURANCE COUNCIL OF AUSTRALIA

3. Legislative Protections

Insurance Contracts Act

Australian consumers when purchasing general insurance benefit from robust protection provided by the detailed provisions of the Insurance Contracts Act. When it was introduced into Parliament in December 1983, the Insurance Contracts Act's purpose was stated as to:

- improve the flow of information between the insurer and insured so that the insured can make an informed choice as to the contract of insurance he enters into and is fully aware of the terms and limitations of the policy, and
- provide a uniform and **fair** set of rules to govern the relationship between the insurer and insured[6]. [Our emphasis].

The preamble to the Insurance Contracts Act describes it as:

> *"An Act to reform and modernise the law relating to certain contracts of insurance so that a **fair** balance is struck between the interests of insurers, insureds and other members of the public and so that the provisions included in such contracts, and practices of insurers in relation to such contracts, operate **fairly**, and for related purposes."* [Our emphasis].

Insurance is a rare but important example where, decades ago, Parliament had the forethought to establish a comprehensive set of rights and obligations specifically around the insurance contract. Importantly, amendments made to the Insurance Contracts Act in 2013 strengthened the protections available to insureds; of particular relevance:

- a failure to comply with the duty of utmost good faith is a breach of the Insurance Contracts Act (section 13(2);
- where an insurer fails to comply with the duty of utmost good faith in the handling of a claim or settlement of a claim or potential claim, ASIC may treat this failure as a breach of financial services laws under the Corporations Act (section 14A); and
- ASIC has the power to intervene in any proceedings relating to a matter under the Insurance Contracts Act (section 11F). This provides ASIC significant enforcement powers to punish insurers for such breaches, including the withdrawal of an insurer's Australian Financial Services Licence (AFSL).

Key protections under the Insurance Contracts Act 1984

Sections 13 and 14 – utmost good faith

Two very important obligations are contained in sections 13 and 14 of the Insurance Contracts Act. These sections require a contract of insurance to be based on "*the utmost good faith*", which in effect renders any unfair clause void.

Section 13 provides: "*A contract of insurance is a contract based on the utmost good faith and there is implied in such a contract a provision requiring each party to it to act towards the other party, in respect of any matter arising under or in relation to it, with utmost good faith*."

[6] See Senate Hansard, 1 December 1983, pp3134-3138.

Although there is no statutory definition of the requirement to act in utmost good faith, it has been held by the Courts that it means to act with scrupulous fairness and honesty and the courts have broadly interpreted this concept. The High Court in *CGU v AMP* (2007) HCA 36 discussed utmost good faith in detail[7]. Gleeson CJ and Crennan J noted at paragraph 15 of the judgment that the concept of good faith is not limited to dishonesty; further, their Honours stated:

> "*In particular we accept that utmost good faith may require an insurer to act with due regard to the legitimate interests of an insured, as well as to its own interests. The classic example of an insured's obligation of utmost good faith is a requirement of full disclosure to an insurer, that is to say, a requirement to pay regard to the legitimate interests of the insurer. Conversely, an insurer's statutory obligation to act with utmost good faith may require an insurer to act, consistently with commercial standards of decency and fairness, with due regard to the interests of the insured. Such an obligation may well affect the conduct of an insurer in making a timely response to a claim for indemnity.*"

Justice Kirby J noted at paragraph 127:

> "*The language of s13* [of the Insurance Contracts Act] *including the statement of the general principle as a legal obligation separate from the implication of a provision into the contract, supports AMP's submission that s13 of the Act had the effect of introducing a larger and reciprocal obligation between the insurer and the insured in place of what had, for all practical purposes, previously been a one-way street. Such a view of s13 would fit comfortably with other protections for consumers, introduced into the Act, based on the report of the Australian Law Reform Commission.*"

Justice Kirby J further stated at paragraph 176 to 178:

> "*The principle is that the parties to insurance contracts in Australia, <u>unlike most other contracts known to the law</u>* [our emphasis], *owe each other, in equal reciprocity, an affirmative duty of utmost good faith. This is so now by s13 of the Act. In the context of that section, emphasis must be placed on the word "utmost". The exhibition of good faith alone is not sufficient. It must be good faith in its utmost quality.*
>
> *The resulting duty is one that pervades the dealings of the parties to an insurance contract with each other. In consequence of the Act, and of the reform that it introduced in s13, the duty of good faith as between insurer and insured now takes on a true quality of mutuality. It governs the conduct of insurers whereas, previously, as a practical matter, the duty of good faith was confined to a duty cast upon insureds because the remedies for proof of the absence of good faith were usually of no real use to the insured.*
>
> *The duty is more important than a term implied in the insurance contract, giving rise to remedies for breach, although, by the express provision of s13, it is certainly that. The duty imposes obligations of a stringent kind in respect of the conduct of insurer and insured with each other, wherever that conduct has legal consequences.*"

Callinan and Heydon JJ noted at paragraph 257:

[7] See also: *Australian Associated Motor Insurers Ltd v Ellis* (1990); *Sheldon v Sun Alliance Ltd* (1989); *Barbaro v NZI Insurance Australia Ltd* (1994); and *Maksimovic v Royal & Sun Alliance Life Assurance Australia Ltd* (2003).

> "*From the outset we should say that we agree with the Chief Justice and Crennan J that a lack of utmost good faith is not to be equated with dishonesty only. The analogy may not be taken too far, but the sort of conduct that might constitute an absence of utmost good faith may have elements in common with an absence of clean hands according to equitable doctrine which requires that a plaintiff seeking relief not himself be guilty of tainted relevant conduct.*"

Importantly, the 2013 amendments to the Insurance Contracts Act added at section 13(2): "*A failure by a party to a contract of insurance to comply with the provision implied in the contract by subsection (1) is a breach of the requirements of this Act*".

Kelly and Ball[8] refer to a number of cases decided in relation to the duty of utmost good faith imposed by the Insurance Contracts Act to suggest that a more stringent standard applies in relation to conduct by the insurer than the insured, noting that: dishonest or fraudulent conduct by an insurer is certainly sufficient for a breach of the duty of utmost good faith; and conduct that is capricious or unreasonable, or amounts to unfair dealing may also be sufficient to breach the duty of good faith.

Section 14(1) provides: "*If reliance by a party to a contract of insurance on a provision of the contract of insurance would be to fail to act with the utmost good faith, the party may not rely on the provision*". This section renders any unfair clause void – the effect is the same as under the unfair contracts provision of the Australian Consumer Law[9].

As part of the 2013 amendments to the Insurance Contracts Act, section 14A was introduced:

> "*1) This section applies if an insurer under a contract of insurance has failed to comply with the duty of the utmost good faith in the handling or settlement of a claim or potential claim under the contract.*
>
> *2) Despite any provision of Chapter 7 of the Corporations Act 2001 or any regulation made under that Chapter, ASIC may exercise its powers under Subdivision C of Division 4 of Part 7.6 of that Act or Subdivision A of Division 8 of that Part in relation to the insurer as if the insurer's failure to comply with the duty of the utmost good faith were a failure by the insurer to comply with a financial services law.*"

The duty of good faith imposed by sections 13 and 14 of the Insurance Contracts Act are not limited to contractual matters. The duty between an insurer and insured applies in respect of any matter arising under or in relation to the contract. In this regard, the duty of good faith goes further than the question of whether a particular term in a contract is 'unfair' in the circumstances.

The unique character of insurance contracts (covering a wide range of possible factual circumstances and turning on a large number of risk factors) means that they require a separate legal modality for their management. We submit this modality has been the subject of careful and appropriate management in the framework of the Insurance Contracts Act.

Sections 21, 21A, 22 and 28 – non-disclosure

[8] *Kelly and Ball Principles of Insurance Law*: Contract of Insurance: Chapter 5 Terms of the Contract - The duty of utmost good faith.
[9] See: *Barwon Region Water Authority v CIC Insurance Ltd* (1997); *Banks v NRMA Insurance Ltd* (1988); and *ACN 007 838 584 v Zurich Australia Ltd* (1997).

These sections place significant limits on when an insurer can rely on non-disclosure by an insured to reduce or refuse a claim. For example, for eligible policies of insurance (being motor, home, sickness & accident, consumer credit and travel) when cover is first offered, an insurer is required by law to ask specific questions rather than just relying on a general duty of disclosure.

Sections 23, 24, 26, 27 and 28 - misrepresentation

These sections place significant limits on when an insurer can rely on misrepresentation to refuse to pay a claim. For example, section 26 provides that where a statement that was made by a person in connection with a proposed contract of insurance was in fact untrue but was made on the basis of a belief that the person held, being a belief that a reasonable person in the circumstances would have held, the statement shall not be taken to be a misrepresentation. Section 27 provides that a person shall not be taken to have made a misrepresentation by reason only that the person failed to answer a question included in a proposal form or gave an obviously incomplete or irrelevant answer to such a question.

Sections 35 and 37 – notification requirements

These sections place obligations on insurers to make consumers aware of key terms in the contract. Section 35 requires insurers in relation to prescribed contracts to clearly inform customers up front as to how their contract terms differ from standard contract terms which are outlined in the Regulations to the Insurance Contracts Act. Section 37 requires insurers in relation to non-prescribed contracts to clearly inform the insured up front as to unusual terms in their policies.

If section 35 or section 37 is not complied with, the insurer will not be able to rely on those terms (except in the case of section 35 where the insured or a reasonable person in the circumstances could have been expected to have known of the term).

Section 39 – instalment of premium

This section provides that an insurer cannot refuse to pay a claim in whole or part by reason of non-payment of an instalment of the premium unless the instalment has remained unpaid for a period of at least 14 days and before the contract was entered into the insurer informed the insured in writing of the effect of the provision.

Section 46 – defect or imperfection in property

This section provides that where at the time when the policy was entered into, the insured was not aware of, and a reasonable person in the circumstances could not be expected to have been aware of, a defect or imperfection in the property insured, the insurer may not rely on a provision included in the policy that has the effect of limiting or excluding the insurer's liability under the policy by reference to the condition of the property, at a time before the policy was entered into.

Section 53 – contract variation

This section makes void a term of an insurance contract that seeks to authorise or permit the insurer to vary, to the prejudice of the insured, the contract.

Section 54 – refusal to pay claims

This section limits the ability of an insurer to rely on terms of the policy in relation to acts or omissions of an insured. If the act or omission could not be reasonably regarded as being capable of causing or contributing to the loss (or even if it could but the insured proves none

of the loss was actually caused by an act or omission), the insurer cannot rely on a clause in the policy to refuse the claim on the basis of that act or omission unless it can prove actual prejudice. Further if the act or omission only partly contributed to the loss, the insurer can only reduce the claim by the extent the act or omission caused or contributed to the loss.

Australia's conduct regulation framework

As well as the obligations under the Insurance Contracts Act, general insurance products are also subject to the comprehensive financial services regulatory regime under chapter 7 of the Corporations Act.

Importantly, the Corporations Act requires all providers of financial services to obtain an Australian Financial Services Licence (AFSL). Licensees are required to meet a number of obligations, including to:

- do all things necessary to ensure that the financial services covered by the licence are provided efficiently, honestly and fairly (section 912A(1)(a));
- have in place adequate arrangements for the management of conflicts of interest that may arise (section 912A(1)(aa));
- ensure that its representatives are adequately trained, and are competent, to provide the financial services covered by the licence (section 912A(1)(f));
- have a dispute resolution system if providing services to a retail client (section 912A(1)(g)); and
- have arrangements for compensating retail clients for loss or damage suffered because of breaches to financial services law (section 912B).

In granting an AFSL, ASIC is empowered to impose, vary or revoke conditions on a licence – ASIC may also suspend or cancel a licence.

A significant part of the conduct regulation framework aims to ensure transparency in the sale of financial products through a comprehensive disclosure regime. General insurers are required to provide consumers with a Product Disclosure Statement (PDS) outlining information about any significant benefits, costs, terms and conditions of the policy.

This obligation is in addition to the Insurance Contracts Act, which requires the disclosure of any non-standard term as well as any unusual term in policies. For home building and home contents insurance products, insurers are also required to provide a Key Facts Sheet providing a summary of a policy's coverage in respect of key prescribed events (such as flood, storm, actions of the sea, etc.).

Other rules in the Corporations Act applying to general insurance products include:

- requirements surrounding the provision of general and personal advice;
- the prohibition on hawking;
- the use of advertising and other promotional material for financial products;
- the statutory cooling off period, enabling consumers to return a product within 14 days; and

- the provision of false and misleading statements, dishonest conduct and misleading or deceptive conduct.

Further, section 991A of the Corporations Act states, "*A financial services licensee must not, in or in relation to the provision of a financial service, engage in conduct that is, in all the circumstances, unconscionable*". If a person suffers loss or damage because a financial services licensee contravenes this provision, they may recover the amount of the loss or damage against the licensee. This provision is not impacted by the section 15 exemption in the Insurance Contracts Act.

Australia's prudential regulation framework

Additionally, APRA's prudential regulation framework provides an important mechanism for protecting insurance policyholders.

The FSI Interim Report emphasised[10] that prudential regulation is a fundamental consumer protection mechanism, which operates as a preventative measure to promote sustainable financial institutions that can deliver on their financial promises.

APRA promotes safety and soundness in business behaviour and risk management on the part of the institutions it supervises. It establishes and enforces prudential standards and practices designed to ensure that, under all reasonable circumstances, financial promises made by the institutions it supervises are met within a stable, efficient and competitive financial system[11]. If an APRA-regulated institution becomes financially distressed, APRA has the primary responsibility for ensuring its return to health or managing its orderly failure.

APRA also has responsibility for administering the Financial Claims Scheme (the Scheme), which is an Australian Government scheme of last resort for compensation that applies to depositors of authorised deposit-taking institutions and general insurance policyholders.

The purpose of the Scheme is to protect depositors of authorised deposit-taking institutions (banks, for example) and general insurance policy holders from potential loss due to the failure of these institutions[12].

The Scheme was established by the Government in 2008 and was introduced at the height of the Global Financial Crisis as one of several measures designed to address heightened perceptions of risk in the global financial system.

In the unlikely event that a general insurer fails and cannot meet its financial obligations, such as to payout claims to its policy holders, the Government may activate the Scheme to provide general insurance policyholders and other claimants with access to funds to meet insurance claims.

Under the Scheme, most policyholders with an affected general insurer are covered for valid claims up to $5,000. This also includes other persons or third parties who may be able to claim under eligible insurance policies with the affected general insurer. For any claims of

[10] Financial System Inquiry Interim Report. Page 3-50, refers. Released July 2014.
[11] APRA website, '*APRA Vision, Mission and Values*'.
[12] Council of Financial Regulators website, '*Financial Claims Scheme*'.

over $5,000, the policyholder or claimant must meet certain eligibility criteria such as being an Australian citizen or resident[13].

Indeed, any deliberation on the need for another last resort scheme should carefully consider the key schemes that are already operating in the financial sector, including the Scheme, the National Guarantee fund (the compensation fund applying to investors who trade in shares on the Australian Securities Exchange) and Part 23 of the *Superannuation Industry (Supervision) Act 1993* (financial assistance applying to certain superannuation entities).

It is also critical for any deliberation to be targeted. Complaints concerning financial advisors present the greatest risk of consumers not being paid their compensation awards. This was emphasised as a key problem in the 2012 Report by Richard St. John[14] on compensation arrangements for consumers of financial services. To appropriately address this sector-specific problem, the Insurance Council believes that more should be done to improve the quality of financial advice and the consumer protection arrangements in place for that sector.

However, in considering the need for another last resort compensation scheme, another key issue that would require careful consideration is the moral hazard that would result from removing (or reducing) risk from financial decision making. This issue was also emphasised in the 2012 St. John Report, which noted that a last resort scheme would not address the underlying problem of improving the standards of licensee behaviour or motivate a greater acceptance by them of responsibility for the consequences of their own conduct[15].

Impending regulatory reforms

The FSI initiated wide-ranging reforms to financial services regulation. The Government has accepted key recommendations that relate to improving consumer outcomes, including the following which are relevant to the general insurance industry:

- strengthening product issuer and distributor accountability by introducing a product design and distribution obligation;
- introduce a product intervention power that would enhance the regulatory toolkit available where there is risk of significant consumer detriment;
- facilitate innovative disclosure by removing regulatory impediments to innovative product disclosure and communication with consumers;
- align the interests of financial firms and consumers by enhancing ASIC's power to ban individuals from management;
- improve guidance and disclosure in general insurance; and
- strengthening ASIC's funding and powers by introducing an industry funding model and providing ASIC with stronger regulatory tools.

[13] The Financial Claims Scheme website, '*General Insurers*'.

[14] Australian Government: *Compensation arrangements for consumer of financial services Report by Richard St. John April 2012* refers.

[15] Australian Government: *Compensation arrangements for consumer of financial services Report by Richard St. John April 2012*. Page 143 refers.

As the Committee may be aware, work on implementing many of these recommendations has significantly progressed.

As noted above, importantly, the Australian Treasury released in December last year a proposals paper on product design and distribution obligations, and product intervention powers for ASIC. It is proposed that product issuers, including general insurers, be made subject to a number of product design obligations, including the need to adequately consider the needs and requirements of the target market when designing products. When distributing products, general insurers and their representatives would also be required to consider whether the distribution channel is appropriate for the identified target market.

Significantly, ASIC will be empowered to intervene and ban products, specific product features or distribution arrangements if there is risk of significant consumer detriment. The Insurance Council and its members are broadly supportive of the objective of the proposals. .

In addition to these reforms, the Government has established an ASIC Enforcement Review Taskforce to assess the suitability of the existing regulatory tools available to ASIC. Key areas to be reviewed include the:

- adequacy of civil and criminal penalties for serious contraventions relating to the financial system;
- need for alternative enforcement mechanisms;
- adequacy of ASIC's information gathering powers;
- adequacy of ASIC's powers in respect of licensing of financial services providers; and
- adequacy of the breach reporting framework.

The strengthening of ASIC's regulatory toolkit will be assisted by the additional $127.2 million in funding announced by the Government in April 2016. The Australian Treasury released in February this year an Exposure Draft of legislation to implement an industry funding model for ASIC, commencing in the second half of 2017.

INSURANCE COUNCIL OF AUSTRALIA

4. Financial Ombudsman Service

As part of their licensing, the Corporations Act requires general insurers to be a member of an external dispute resolution scheme. Almost all general insurers choose to be members of the Financial Ombudsman Service (FOS).

The FOS is an independent umpire that provides free, fair and accessible dispute resolution for consumers that are unable to resolve a dispute directly with their general insurer.

External dispute resolution processes can help to resolve disputes through negotiation or conciliation as an alternative to court proceedings and can make decisions which are binding on participating general insurers. In dealing with disputes, the FOS:

- "*must do what in its opinion is appropriate with a view to resolving disputes in a cooperative, efficient, timely and fair manner;*
- *shall proceed with the minimum formality and technicality; and*
- *shall be as transparent as possible, whilst also acting in accordance with its confidentiality and privacy obligations."* [16]

Clause 8.2 of the ASIC-approved FOS Terms of Reference state that in deciding a dispute:

"… FOS will do what in ***its opinion is fair*** [our emphasis] *in all the circumstances... "* [17].

In this regard, the FOS only has to have 'regard' to the law, industry codes, good industry practice and previous FOS decisions; but is not bound by them. In this sense, FOS has a de-novo jurisdiction to review contract terms that might be unfair.

[16] Financial Ombudsman Service Terms of Reference, effective from January 2015. Clause 1.2 refers.
[17] Financial Ombudsman Service Terms of Reference, effective from January 2015. Clause 8.2 refers.

INSURANCE COUNCIL OF AUSTRALIA

5. General Insurance Code of Practice

The General Insurance Code of Practice (the Code of Practice), which has been adopted by members of the Insurance Council, has the following objectives:

- commitment to high standards of service;
- promotion of better, more informed relations between insureds and insurers;
- maintenance and promotion of trust and confidence in the general insurance industry;
- provision of fair and effective mechanisms for the resolution of complaints and disputes; and
- promotion of continuous improvement of the general insurance industry through education and training.

In regard to retail products clause 7.2 of the Code states: *"We will conduct claims handling in an honest, fair, transparent and timely manner* [our emphasis]*."*

As emphasised by ASIC[18], codes sit at the apex of industry self-regulatory initiatives. A code is a set of enforceable rules that sets out a progressive model of conduct and disclosure for industry members that are signed up. Codes should therefore improve consumer confidence in a particular industry. The primary role of a financial services sector code is to raise standards and to complement the legislative requirements that already set out how product issuers and licensed firms (and their representatives) deal with consumers.

A distinct advantage of a code is that it is a living document, with inherent flexibility, enabling it to respond quickly to changing consumer expectations and needs. For example, after the significant impact of natural disasters in 2010-11 (most notably the Queensland floods and Cyclone Yasi), improvements were made to the catastrophe provisions in the Code of Practice in response to public feedback. The quick revision of Code provisions delivered enhanced consumer protection at a speed unlikely to have been achieved through legislative or other regulatory mechanisms.

Review of the General Insurance Code of Practice

The Code of Practice was first introduced in 1994, and has undergone multiple enhancements to ensure that it remains relevant and continues to meet its objectives.

The Code of Practice was last reviewed in 2012-13, when the Insurance Council commissioned an independent review[19] by Mr Ian Enright. The 2012-13 review resulted in a thorough rewrite of the Code of Practice, with the current revised Code of Practice commencing on 1 July 2014.

The enhancements made in 2014 included a broadening of rights for consumers, and the introduction of a more independent and transparent governance framework, with the Code Governance Committee being set up to monitor and enforce compliance with the Code of

[18] Australian Securities and Investments Commission Regulatory Guide 183, '*Approval of financial services sector codes of conduct*'. Page 4 refers. Released March 2013.
[19] Insurance Council of Australia, '*General Insurance Code of Practice Independent Review 2012-2013*' Final Report May 2013.

Practice. The 2014 Code of Practice was also written in plain English, and contained clearer processes for making claims and complaints.

As explained earlier, the Code of Practice is a living document, and the Insurance Council will continue to make improvements as and when required. In addition to formal independent reviews of the Code of Practice, the Insurance Council can review the Code of Practice on an ad-hoc basis in consultation with stakeholders.

While the 2014 Code of Practice remains the benchmark for financial services self-regulation in Australia, recent external developments impacting the general insurance industry have led the Insurance Council to carry out a targeted review of the Code of Practice. The Terms of Reference for the review are provided at the Appendix of this submission.

External developments to be taken into account during the review include the Federal Government's proposed response to recommendations of the FSI, recently announced Senate inquiries, the independent review of the financial system external dispute resolution framework, relevant ASIC reports and reviews, the work of the Code Governance Committee, and the findings of the Insurance Council's Effective Disclosure Taskforce research.

The Insurance Council's review of the Code of Practice will be conducted in close consultation with consumer advocate groups, ASIC, the FOS and other key stakeholders to ensure that full consideration is given to consumer expectations and needs.

INSURANCE COUNCIL OF AUSTRALIA

6. Other Industry Initiatives

Enhancing consumer engagement

While the comprehensive product disclosure regime provides the foundation for transparency, the industry has recognised that the provision of mandated disclosure documents, without a clear objective to aid decision-making, has not always effectively engaged consumers. This appears to be a challenge for consumer contracts of all kinds around the world. While the regulatory consumer protections are essential, the industry has recognised the importance of empowering consumer decision-making to help prevent poor consumer outcomes from occurring in the first instance.

Taking on this challenge, the Insurance Council Board established an independent Effective Disclosure Taskforce (the Taskforce) in 2015 to assess the effectiveness of, and recommend initiatives to enhance, disclosure. The Taskforce consisted of experts from the industry, consumer movement, academia and the field of behavioural sciences. The report[20] handed down by the Taskforce made 16 recommendations, which were endorsed in full by the Insurance Council Board. Key recommendations include:

- the industry should shift from a minimum mandated disclosure approach to best practice transparency to better assist consumers to choose a product that meets their needs;
- insurers should explore and adopt new forms of electronic disclosure that enable information to be delivered in more relevant and personalised ways;
- the Insurance Council and industry should work with ASIC and the Government to improve the advice regime in order to enable the disclosure of more targeted information to consumers; and
- the Insurance Council and the industry should conduct a review of product comparability options to identify methods of improving consumer understanding of coverage differences between products.

In considering the effectiveness of the disclosure regime, the Taskforce found a notable absence of empirical research around how general insurance consumers actually use disclosure documents to inform their decision-making. To ensure that future reforms have positive impacts, the Taskforce concluded that a comprehensive research program was required to better understand how consumers actually use insurance disclosures and the impact of these disclosures on decision-making at the point of sale.

The Insurance Council has since undertaken a large scale research project, and reported[21] on the findings from this research. The research confirms that the often subjective process of selecting "the right" policy is tackled by consumers in varied ways, and the industry needs to be nimble and innovative in engaging with a diverse range of consumers. The research also suggests that the industry needs to do more to ensure that consumers are not just focused on the price of a policy, but are cognisant of the importance of selecting the right type and level of cover. While these are ambitious goals, the industry has never been better

[20] Insurance Council of Australia, Effective Disclosure Taskforce (2015), '*Too Long; Didn't Read. Enhancing General Insurance Disclosure*', report to the Board of the Insurance Council of Australia.
[21] Insurance Council of Australia (2017), '*Consumer research of general insurance disclosures*', research report.

placed than in the current digital era to design more targeted and engaging information and tools.

The Insurance Council is currently midway through a two-year work program to implement all 16 of the Taskforce's recommendations.

General insurance industry Consumer Liaison Forum

The Insurance Council and its members are committed to maintaining constructive and open dialogue with consumer advocates on a range of matters arising for consumers of general insurance products in Australia. This is an important objective of the Insurance Council.

The free exchange of information and views is vital to the ongoing work of the Insurance Council in supporting the everyday activities of individual Australians and their communities, and the broader operation of the Australian economy.

This is why the Insurance Council and consumer representatives have formed the Consumer Liaison Forum. The key objectives of this forum is to facilitate open discussions between the general insurance industry and consumer representatives and, importantly, encourage the appropriate development of insurer and industry practices that are supportive of higher standards and better outcomes for consumers buying general insurance.

This is another key example of how the general insurance industry is proactively engaging with consumer advocates and is willing to adapt to further enhance consumer outcomes. The Insurance Council would be pleased to provide the Committee with further details of this important initiative.

Improving consumer outcomes for add-on insurance products

The Insurance Council and its members have been working with ASIC over the past year to improve outcomes for consumers who purchase add-on insurance products through the motor dealer channel. The industry has actively engaged in a review by ASIC into general insurance products distributed through this channel, including consumer credit (CCI), guaranteed asset protection (GAP), tyre and rim, and mechanical breakdown insurance.

The limited opportunities available to insurers to sell add-on products to consumers, outside the context of a motor vehicle purchase, gives motor vehicle dealerships significant bargaining power in negotiating with insurers. Accordingly, insurers may pay higher commissions or other benefits to motor vehicle dealerships; described by ASIC as "*reverse competition*"[22]. ASIC is concerned that the higher commissions paid to motor vehicle dealerships results in reduced value to consumers where these costs are reflected in higher premiums. There is also a concern that commissions may incentivise inappropriate sales conduct.

In response to ASIC's concerns, the industry developed a package of reforms to address the issues raised and improve the value of add-on products for consumers. A significant component of this reform package has to date been a proposal to extend the legislative 20 per cent cap on consumer credit insurance (CCI) products under the National Credit Code to all add-on insurance products distributed through the motor vehicle dealership channel. The

[22] Australian Securities and Investments Commission, Report 492. Released September 2016.

cap would apply to all insurance products sold through the channel with the exception of compulsory third party (CTP) insurance, which is separately regulated by state and territory legislation.

As ASIC preferred the industry develop a self-regulatory solution, the industry needed to seek authorisation by the Australian Consumer and Competition Authority (ACCC) to implement the cap on a voluntary-basis. However, the ACCC has indicated it will not authorise the cap and the industry will explore with ASIC the need for a regulatory or legislative solution. An important consideration is the possible adoption of a deferred sales model, requiring a time gap between provision of information about an insurance product and when the insurance is sold.

The industry has also proposed a range of other measures to improve the product design and sales process, and is currently working with ASIC to refine these proposals. Key measures include:

- strengthening of sales systems to identify and prevent sales to consumers who would receive little or no benefit from the products;
- refunds for future customers who buy policies they were unable to substantially benefit from at the time of purchase;
- strengthening of dealership training on compliance and systems to ensure that appropriate conduct is clearly defined;
- independent reviews of insurer compliance and risk management procedures relating to products distributed through the dealership channel;
- regular review of policy inclusions and exclusions to maximise product coverage for the benefit of consumers;
- more effective point of sale disclosure designed with insights from behavioural economics research and strengthened post sale communication practices;
- offering consumers financed and non-financed premium payment options;
- strengthening the General Insurance Code of Practice to ensure continued high standards of service are maintained; and
- a new financial literacy initiative to increase consumer understanding of add-on insurance products.

While add-on insurance products are a relatively small part of the overall general insurance market, the industry is confident these changes will enhance the protection and value consumers receive.

INSURANCE COUNCIL OF AUSTRALIA

7. Appendix: Terms of Reference for the Review of the General Insurance Code of Practice

Terms of Reference

Background

The General Insurance Code of Practice (Code) requires the ICA to commission formal independent reviews of the Code from time to time. A thorough independent review of the Code was undertaken in 2012-13 by Mr Ian Enright, with significant stakeholder consultation.

The Code was subsequently significantly amended to incorporate recommendations made by Mr Enright, and the current revised Code commenced on July 1, 2014, with a 12-month transition period.

In addition to formal independent reviews of the Code, the ICA can review the Code on an ad hoc basis in consultation with stakeholders. In light of recent external developments impacting the general insurance industry since the commencement of the 2014 Code, the ICA Board has instructed the ICA to carry out a further, more targeted review of the Code.

Recent developments

Relevant recent and ongoing reviews, reports and developments include:

- The Federal Government's December 2016 Proposals Paper on product design and distribution obligations and ASIC's product intervention power, in response to recommendations of the Financial System Inquiry
- The Senate inquiry into the general insurance industry, due to report on 22 June 2017
- The Senate inquiry into consumer protection in the banking, insurance and financial sector, due to report on March 30 2018
- The independent review of the financial system external dispute resolution framework, due to report by March 31 2017
- ASIC's 2016 reports on the sale of add-on insurance through motor vehicle dealers
- ASIC's 2016 report on its industry-wide review of life insurance claims
- ASIC's Enforcement Review Taskforce's pending consideration of the adequacy of ASIC's enforcement regime in relation to industry codes of conduct to deter misconduct and foster consumer confidence
- The findings of the ICA's consumer research into effective disclosure of product information
- The commencement of the FSC's Life Insurance Code of Practice in October 2016, which includes provisions concerning product design and disclosure, vulnerable consumers, sales practices and advertising, CCI-specific sales and disclosure requirements, and restrictions on claimant interviews and surveillance
- The Australian Bankers' Association's independent review of the Code of Banking Practice

- The ICA's Effective Disclosure Taskforce's recommendation to develop guidance on the principles of transparency in fulfilling the Code's objectives of more informed relations between insurers and their customers, and the promotion of trust and confidence in the industry
- The General Insurance Code Governance Committee's ongoing own-motion inquiry into claims investigations and outsourced services
- Mental Health First Aid Australia's recently released principles for working with people with mental health problems and financial difficulties

Scope of review

Taking into account the Code objectives, and the above recent developments, the review of the Code will consider the operation and effectiveness of:

- Section 4: Buying insurance
- Section 5: Standards for employees, authorised representatives and authorised financial services licensees acting on behalf of a Code subscriber
- Section 6: Standards for service suppliers
- Section 7: Claims
- Section 8: Financial hardship
- Section 10: Complaints and disputes
- Section 13: Monitoring, enforcement and sanctions

The review should also consider expansion of the scope of the Code in response to any of the above listed reports, reviews and other industry codes.

In addition, the review should consider the extent to which the Code complies with the requirements of ASIC's *Regulatory Guide 183: Approval of financial sector codes of conduct* (RG 183) and the implications of seeking approval of the Code from ASIC.

The review may consider any other matter relevant to the Code, and it must take into account changes in law and practice since the 2012-13 independent review.

The review must specifically take into account any relevant recommendations or findings concerning the conduct of insurers from ASIC, the Financial Ombudsman Service (FOS) and the Code Governance Committee (CGC).

Process

The ICA is responsible for carrying out the review.

The ICA must consult during the course of the review and in relation to any proposed findings or recommendations with:

- The ICA's National Code Committee
- The ICA's Consumer Liaison Forum
- The CGC

- ASIC
- FOS

The ICA may consult with any other organisation or individual as it sees fit, and may seek expert advice on specific matters as it sees fit.

The ICA must provide a quarterly report to the ICA Board on the progress of the review until its conclusion.

The review may be conducted in stages as appropriate in order to take account of forthcoming external reports or reviews.