Parliamentary Joint Committee on Corporations and Financial Services

Life Insurance Industry

March 2018

978-1-76010-750-5

Printed by the Senate Printing Unit, Parliament House, Canberra.

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Chair's Foreword

The life insurance industry is a significant part of the financial services sector in Australia. It has a noble purpose in providing financial protection to policyholders in times of need and financial distress. Despite this, there are sections of the industry that can and must do better in delivering the protection they promise whilst remaining financially viable long into the future. The committee has taken a broad view of the life insurance industry covering direct, retail and group life insurance products including life cover, total and permanent disability cover, trauma cover, and income protection. The committee's inquiry has followed on from, and overlapped with, significant reviews and legislative changes, as well as ownership changes in the industry.

The committee's report has focussed on areas where substantial changes are required to ensure the life insurance industry is held to account in relation to:

- effective consumer protections and industry codes of practice;
- the transparency of remuneration, commissions, payments and fees;
- the provision of advice in the best interests of consumers;
- group life insurance arrangements that do not disadvantage certain groups of consumers;
- appropriate access to personal medical and genetic information; and
- fair claims handling practices.

Consumer protections

The consumer protections that currently apply to life insurance are substantially weaker than the consumer protections that apply to other financial and non-financial services and other products sold together with life insurance. This leads to confusion for consumers in understanding and asserting their rights. The committee also considers that the inconsistent application of consumer protection law also creates inappropriate incentives for industry participants that are subject to weaker consumer protections. The committee is therefore recommending that consumer protections for financial products including life insurance be aligned with Australian Consumer Law. This recommendation includes removing a number of exemptions that the life insurance industry currently enjoys compared to other financial services. To ensure that life insurance industry participants are treated fairly, the committee is recommending that the changes uniformly cover all types of life insurance, all sectors (direct, retail and group), and all industry participants.

Codes of practice

Industry codes of practice can form an effective means of guiding the interaction of corporations with their customers. The committee welcomes the recent development of two codes of practice in the life insurance industry. However, the committee is not convinced that a self-regulatory approach is sufficient. The committee is therefore

recommending that the co-regulatory approach foreshadowed by the ASIC Enforcement Review Taskforce position papers be adopted across the financial services sector including the life insurance industry. The committee encourages the implementation of one single combined code of practice. At a minimum, the co-regulatory approach should require codes to be registered with ASIC, be mandatory for all industry participants, give the code compliance committees the power to determine whether breaches have occurred, give the Australian Financial Complaints Authority the power to enforce compliance through determinations, and provide genuine remedies for breaches of the code, including financial remedies, thereby creating an incentive for compliance. It is recognised that any enforceable code with regards to insurance in superannuation would need to expressly permit trustees to act in members' best interests.

As a matter of practice, ASIC focusses its activities on systemic and systematic misconduct. However, under the proposed co-regulatory arrangements, ASIC may not have the power to undertake enforcement action for systemic and systematic code breaches. This would result in a very significant gap in consumer protections. The committee is therefore also recommending that ASIC be given the power to undertake enforcement action in relation to systemic or systematic breaches of codes of practice in the financial services sector, including in the life insurance industry.

Remuneration, commissions, payments and fees

The committee notes that the rules banning conflicted remuneration have been introduced specifically in order to mitigate some of the risks around conflicts of interest in the life insurance industry. However, evidence to the committee, particularly from ASIC, indicates that a plethora of hidden payments including commissions, fees, performance-related payments, soft dollar benefits, and non-financial benefits still exist within the various structures of the life insurance industry. These money flows continue to exist to varying degrees across all three sectors: retail, direct, and group. The wrong type of financial incentives have contributed significantly to a range of poor practices and misconduct in the financial services industry including misleading advice and mis-selling with poor outcomes for customers.

The committee is therefore recommending that ASIC and APRA conduct detailed examinations of all payments, benefits, and fees across all sectors of the life insurance industry and that the government consider further regulation following the results of those examinations.

Retail life insurance and approved product lists

Approved Product Lists (APLs) are used by advice licensees and advisers selling life insurance to maintain a list of life insurance products that they have available to sell. APLs are also used for providing financial advice. The way that APLs are currently constructed can lack transparency and generate conflicts of interest that lead to selling life insurance on the basis of misleading advice that herds customers to products from insurers that pay the most to be on the APL. The committee is not convinced that the

draft APL Standard being proposed by the Financial Services Council will adequately address the full range of concerns identified by this inquiry.

The committee is therefore recommending that the life insurance industry should have, as a matter of urgency, a balance of affiliated and non-affiliated products on their APLs, and if affiliated products are recommended, the affiliation should be disclosed, and the customer should be offered a comparison with non-affiliated products. Beyond this, the committee further recommends that the industry transition to open APLs.

Group life insurance

The committee considered issues associated with group life insurance through superannuation, including opt-out requirements, member awareness of cover, and the impact of premiums on small super balances.

Evidence to the committee from a broad range of stakeholders strongly supported the opt-out model for life insurance within group superannuation, particularly as a means of addressing the problem of under-insurance. Nevertheless, concerns were raised in relation to the opt-out model, particularly for those with low super balances such as low-income earners, women, and young people. The mechanism for opting out of life insurance held within group superannuation does not appear to be straightforward.

The committee views the current dearth of action by superannuation trustees and life insurers to fix the problem of duplicate insurance within group superannuation as completely unacceptable. The committee is therefore recommending that superannuation funds, superannuation trustees, and life insurers be more proactive in informing customers about the status of group life insurance accounts.

Access to medical information

Life insurers request authorisation to access a consumer's medical information. This request for authorisation may occur at the time a consumer acquires a life insurance policy and also at the time of making a claim. The amount and type of medical information a consumer authorises a life insurer to access and share is typically broad, particularly at the time of policy acquisition.

The committee is also very concerned about evidence provided that patients are reluctant to seek necessary treatment, particularly for mental ill health, due to concerns over life insurers having access to their full medical record and then using such information to limit or deny coverage or a claim.

The committee is firmly of the view that life insurers should only have access to targeted medical information. The committee is therefore recommending that the Financial Services Council and the Royal Australian College of General Practitioners collaborate to prepare and implement agreed protocols and standards for:

- requesting and providing relevant medical information only, not complete medical files;
- uniform authorisation forms for access to medical information;
- appropriate storage of medical information; and

- real-time disclosure to consumer about the progress of their claim, including requests for medical records.

Genetic information

As the use of genetic testing in health care increases, concerns have been raised around privacy and genetic discrimination. In response to concerns over genetic discrimination, several countries have enacted legislation or voluntary agreements to restrict or fully ban the use of genetic information by insurance companies.

The committee is of the view that it is inherently unfair to limit or deny a person access to products such as life insurance based on factors that are out of their control. The committee is concerned that the use of genetic information by life insurers has impacted on participation in public health research projects and other forms of research. The committee is recommending that the Financial Services Council, in consultation with the Australian Genetic Non-Discrimination Working Group, assess the consumer impact of imposing a moratorium on life insurers from using predictive genetic information.

Claims handling

The committee was concerned to hear about claims handling practices that may be used by life insurers as a means to delay or deny a claim or limit the amount of payment made when a claim is successful. The committee is also concerned about the transparency of the claims handling process and the lack of reasons provided to customers when claims are denied. Evidence to the committee highlighted that policies with technical definitions can have high decline rates.

The committee is therefore recommending that the life insurance industry must:

- regularly update all definitions in policies to align with current medical knowledge and research;
- standardise definitions across all types of polices and use clear and simple language in definitions;
- set industry standards for claim timeframes and limits on the number of medical examinations;
- clearly explain which associated conditions that may arise from the initial condition, including mental ill health, are covered by the policy; and
- develop a mandatory and enforceable Code of Practice for its members in relation to mental health life insurance claims and related issues.

The committee is also recommending that the current exemption under the Corporations law that excludes certain claims handling activities by life insurers from ASIC's oversight should be reviewed.

The committee considers that life insurance plays a vital role in Australia's social and economic life, and that the recommendations made in this report will help to improve the transparency, accountability, and effectiveness of the life insurance industry.

As Chair, I thank my fellow committee members for their collegiate approach to considering the issues that arose during the inquiry. The committee also thanks those individuals and witnesses that made submissions to, and appeared as witnesses before, the inquiry. Their contributions provided a strong evidence base which informed our deliberations.

Recommendations

Recommendation 2.1

2.80 The committee recommends that life insurance be included in the open banking regime.

Consumer protections

Recommendation 3.1

3.89 The committee recommends that:

- **consumer protections for financial and non-financial services are aligned to remove current inconsistencies;**
- **section 15 of the *Insurance Contracts Act 1985* be reformed to enable consumer protections to apply to life insurance contracts, with appropriate transitional and other arrangements to accommodate the challenges observed by ASIC to exist;**
- **consumer protections for life insurance are aligned with consumer protections for other financial services and products, including but not limited to removing the exemptions identified in Table 3.2 of this chapter;**
- **consumer protections for life insurance uniformly cover:**
    - **all life insurance industry sectors, including direct, retail and group;**
    - **all life insurance industry participants, including but not limited to insurers, distributors, licensees, advice licensees, advisers, superannuation trustees and employees of such organisations; and**
    - **all forms of life insurance, including but not limited to life, trauma, disability, income protection; funeral insurance; and**
- **consumer protections for general insurance are aligned with consumer protections for other financial services.**

Recommendation 3.2

3.94 The committee recommends that ASIC engage with life insurers to begin removing unfair terms from life insurance contracts as soon as possible.

Recommendation 3.3

3.98 The committee recommends that ASIC's proposed product intervention powers be amended to:

- **include funeral insurance;**
- **give ASIC the ability to make interventions in relation to remuneration; and**
- **increase the 18 month timeframe for which product intervention orders can apply.**

Recommendation 3.4

3.102 The committee recommends that the government's proposed Banking Executive Accountability Regime, financial product design and distribution obligations, and financial product intervention powers for ASIC, should apply to life insurance and life insurers.

Recommendation 3.5

3.106 The committee recommends that the scope of the Banking Executive Accountability Regime be extended to include consumer related conduct matters and enable ASIC powers to take action on these matters.

Recommendation 3.6

3.112 The committee recommends that the penalty amounts under ASIC-administered legislation, including the life insurance industry, should be set at three times the benefits obtained for every party to the transaction, including advisers, licensees and insurers.

Recommendation 3.7

3.113 The committee recommends that ASIC conduct random audits of 20 per cent of the life insurance adviser population over a three year period. Where misconduct is identified, appropriate entries should be recorded on the financial advisers register, and statistics on licensees and insurers should be published, so the public can be informed. Advisers that have been reviewed must also publish the outcome on their website in a highly visible location. If necessary ASIC should be provided with additional funding to allow these random audits to occur.

Codes of Practice

Recommendation 4.1

4.52 The committee recommends that the government implement the co-regulatory approach put forward in the ASIC Enforcement Review Taskforce Position Paper across the whole financial services sector, while ensuring, where possible, that there are no exemptions for any part of the life insurance industry and that codes are written in plain English.

Recommendation 4.2

4.58 The committee recommends that ASIC be given the power to undertake enforcement action (halting misconduct, remedies and sanctions) in relation to systemic or systematic breaches of codes of practice in the financial services sector, including in the life insurance sector.

Recommendation 4.3

4.61 The committee recommends that, in order for ASIC to approve any code of practice in the financial services sector, including life insurance, the code must apply to all relevant industry participants, without exemptions.

Recommendation 4.4

4.63 The committee recommends that, prior to seeking ASIC approval, the two codes of practice for the life insurance industry be combined into a single code of practice if possible.

Remuneration, commissions, payments and fees

Recommendation 5.2

5.105 The committee recommends that:

- **ASIC conduct a systematic review and risk assessment of all payments and benefits flowing between participants in each sector of the life insurance industry—direct, group, and retail—and inform the government of any regulatory gaps; and**
- **the government consider further regulation of payments between life insurance industry participants following the ASIC review.**

Recommendation 5.3

5.108 The committee recommends that ASIC and APRA immediately undertake an audit of all superannuation trustees to identify the nature, purpose and value of all payments, including any 'soft-dollar' benefits that occur between life insurers and trustees or any related parties in connection with the provision of default insurance to members of MySuper and choice superannuation products, including:

- **current and historical payments made by life insurers to trustees or any related parties and/or by trustees to life insurers under profit-sharing, premium adjustment models, experience share arrangements or any arrangement of a similar nature;**
- **the total premium value attributable to the existence of profit-sharing, premium adjustment models, experience share arrangements or any arrangement of a similar nature between a trustee and a life insurer; and**
- **payments, including any 'soft-dollar' benefits made or that may become payable by life insurers to trustees or any related parties of trustees for any**

purpose, for example, subsidisation of administration costs, technology, marketing, sponsorship, hospitality, staff expenses etc.

5.109 The committee also recommends that the report be published by ASIC and APRA as soon as practical to ensure confidence in the compulsory superannuation system.

Retail life insurance and approved product lists

Recommendation 6.1

6.45 The committee recommends that the life insurance industry should have, as a matter of urgency, a balance of affiliated and non-affiliated products on their approved product lists, and if affiliated products are recommended, the affiliation should be disclosed, and the customer should be given a comparison with non-affiliated products. Beyond this, the committee further recommends that the industry transition to open approved product lists.

Recommendation 6.2

6.48 The committee recommends that ASIC and the ACCC jointly investigate whether the past use of APLs in the life insurance industry breaches any anti-competitive laws they administer. The report of the investigation should also inform government whether the current legislation inappropriately constrains the capacity of ASIC or the ACCC to investigate anti-competitive behaviour in the financial service sector, including life insurance.

Group life insurance

Recommendation 7.1

7.41 The committee recommends that trustees that have access to information on accounts that are duplicate, have low balance risks or lack contributions, should be required to contact members annually to inform them, in summary form and in plain English, of:

- **the status of their accounts; and**
- **whether their insurance policy is still providing coverage.**

7.42 The committee further recommends that, in addition to annual notification, trustees should be required to contact members in a timely manner when trigger points such as low balance risk are reached.

Recommendation 7.2

7.47 The committee recommends that superannuation funds should be required to inform the Australian Tax Office of the type and status of the insurance that is held for the benefit of the member for each of their superannuation accounts.

Recommendation 7.3

7.48 The committee recommends that, when it sends out individual annual tax assessments, the Australian Tax Office also provide a statement of superannuation and insurance, subject to system capacities and cost effectiveness, including information on:

- **the number of superannuation accounts held;**
- **the number of life insurance accounts held through superannuation; and**
- **the insured's right to seek information from the superannuation trustee about the balance, and the continued coverage or otherwise of any insurance policy.**

Recommendation 7.4

7.52 The committee recommends that the life insurance industry fund a prominent media advertising campaign, particularly aimed at those most vulnerable to duplicate accounts and fee erosion, to alert consumers to:

- **the prevalence of duplicate life insurance accounts held within group superannuation;**
- **the negative impacts that duplicate life insurance accounts can have on superannuation account balances;**
- **the mechanisms for removing duplicate insurance policies within group superannuation; and**
- **the importance of seeking specific advice before making changes, if you have any pre-existing conditions.**

Recommendation 7.5

7.53 The committee recommends that the government appoint the appropriate existing body to undertake an immediate review of all superannuation trustees to determine their compliance with existing obligations under the *Superannuation (Industry) Supervision Act 1993*, including section 52(7)(c) covenants, *'to only offer or acquire insurance of a particular kind, or at a particular level, if the cost of the insurance does not inappropriately erode the retirement income of beneficiaries'*.

Recommendation 7.6

7.54 The committee recommends that, the Australian Government consider legislating to protect the retirement savings of members with low account balances and members who do not receive any value from default insurance.

Recommendation 7.7

7.55 The committee recommends that the Australian Government consider legislating to require life insurers and superannuation funds to provide regular updates to policyholders of the level, type, extent and cost of life insurance cover that they have using a standard form disclosure format, enabling them to compare with other funds or, in the case of superannuation, make them aware that they have access to life insurance.

Access to medical information

Recommendation 8.1

8.93 The committee recommends that:

- **the Financial Services Council and the Royal Australian College of General Practitioners collaborate to prepare and implement agreed protocols for requesting and providing medical information;**
- **the Financial Services Council develop a uniform authorisation form for access to medical information at the time of application and at the time of claim that must be used by all of its members;**
- **this uniform authorisation form explain to consumers/policyholders in clear and simple language how information will be stored and used by third parties; and**
- **a consumer/policyholder should be able to use the same uniform authorisation form between different life insurers and different life insurance products.**

Recommendation 8.2

8.94 If the Financial Services Council and the Royal Australian College of General Practitioners have not agreed to protocols within six months, the committee recommends that at the time of application, life insurers must only ask a consumer's General Practitioner, or other treating doctor where relevant, for a medical report specific to the consumer's relevant medical conditions. In circumstances where such a report cannot be prepared, life insurers cannot ask for access to clinical notes regarding the consumer/policyholder.

Recommendation 8.3

8.95 If the Financial Services Council and the Royal Australian College of General Practitioners have not agreed to protocols within six months, the committee recommends that at the time of a consumer/policyholder making a claim, life insurers can only ask a policyholder's General Practitioner, or other treating doctor where relevant, for a medical report that is specifically targeted to the subject matter of the claim. In circumstances where such a report cannot be prepared, life insurers cannot ask for access to clinical notes regarding the consumer/policyholder.

Recommendation 8.4

8.96 If the Financial Services Council and the Royal Australian College of General Practitioners have not agreed to protocols within 6 months, the committee recommends that life insurers must obtain consent from a policyholder each time it intends to:

- **request a policyholder's medical records, reports or other medical information from their General Practitioner or other treating doctor; and**
- **share a policyholder's information with a third party.**

Recommendation 8.5

8.97 The committee recommends that the Financial Services Council, in discussion with the Royal Australian College of General Practitioners, update the *Life Insurance Code of Practice* and relevant Standards to reflect Recommendations 8.1, 8.2, 8.3, and 8.4.

Recommendation 8.6

8.98 The committee recommends that if insurance contracts are to be subjected to consumer protections, including laws on unfair contract terms:

- **where the authorisation form for a life insurer to access a consumer's/policyholder's medical information is within the insurance contract, consumer protections apply, including laws on unfair contract terms; and**
- **where the authorisation form for a life insurer to access a consumer's/policyholder's medical information is outside of the contract, authorisation forms are to be brought within the contract to allow for the application of consumer protections, including laws on unfair contract terms.**

Recommendation 8.7

8.99 The committee recommends that it become the practice of life insurers to institute real-time disclosure that would allow consumers to track the progress of their claim.

Genetic information

Recommendation 9.1

9.98 The committee recommends that the Financial Services Council, in consultation with the Australian Genetic Non-Discrimination Working Group, assess the consumer impact of imposing a moratorium on life insurers using predictive genetic information, unless the consumer provides genetic information to a life insurer to demonstrate that they are not at risk of developing a disease.

Recommendation 9.2

9.99 The committee recommends that the Financial Services Council make any updates as necessary to Standard 16—Family History and the *Life Insurance Code of Practice* to support the recommended changes to Standard 11—Genetic Testing Policy as outlined in Recommendation 9.1.

Recommendation 9.3

9.100 The committee recommends that life insurers be banned from using predictive genetic information while the Financial Services Council is updating Standard 11—Genetic Testing Policy, Standard 16—Family History, and the *Life Insurance Code of Practice* to align with Recommendation 9.1.

Recommendation 9.4

9.101 The committee recommends that if the Financial Services Council and life insurers have adopted a moratorium on the use of predictive genetic information as outlined in Recommendation 9.1, the Australian Government should continue to monitor developments in genetics and predictive genetic testing to determine whether legislation or another form of regulation banning or limiting the use of predictive genetic information by the life insurance industry is required.

Claims handling

Recommendation 10.1

10.13 The committee recommends that the Australian Government review Corporations Regulation 7.1.33 to ascertain whether the exemption provided by this regulation limits in any way ASIC's ability to oversight the claims handling processes of insurance companies.

Recommendation 10.2

10.21 The committee recommends that a requirement be inserted, where necessary, into both the *Insurance Contracts Act 1984* and the *Disability Discrimination Act 1992* to the effect that an insurer must provide a person with written reasons when an application for insurance has been rejected or an insurance claim denied. The committee further recommends that the written reasons be provided as a plain English summary of such evidence and be targeted to the part of a person's medical history relied on by the insurer. The committee also recommends that the statistical and actuarial evidence and other material relied on by the insurer be available on request.

Recommendation 10.3

10.60 The committee recommends that in relation to definitions in life insurance policies, the life insurance industry must:

- **regularly update all definitions in policies to align with current medical knowledge and research;**
- **standardise definitions across all types of polices;**
- **use clear and simple language in definitions; and**
- **clearly explain which associated conditions that may arise from the initial condition, including mental ill health, are covered by the insurance policy.**

Recommendation 10.4

10.61 The committee recommends that the Financial Services Council's *Life Insurance Code of Practice* be updated to reflect Recommendation 10.3.

Recommendation 10.5

10.62 The committee recommends that the Insurance in Superannuation Working Group's *Insurance in Superannuation Code of Practice* be updated to reflect Recommendation 10.3.

Recommendation 10.6

10.82 The committee recommends that the Financial Services Council's *Life Insurance Code of Practice* include explicit commitments that:

- **where a pre-existing condition is to be used by an insurer as the basis for denying a claim or avoiding a contract a direct medical connection between the prognosis of a pre-existing diagnosed condition and the claim must be established; and**
- **the statistical and actuarial evidence and any other material used to establish a pre-existing condition, as well as a written summary of the evidence in simple and plain language, be provided by the life insurer to the consumer/policyholder on request.**

Recommendation 10.7

10.101 The committee recommends that after consultation with relevant medical professionals independent of the life insurance industry and mental health advocacy groups, the Financial Services Council establish a mandatory and enforceable Code of Practice for its members, or a dedicated part of its existing Code of Practice, specifically in relation to mental health life insurance claims and related issues.

10.102 The committee further recommends that these consultations discuss requiring insurers to:

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

- **refer applications for insurance that reveal a mental health condition or symptoms of a mental health condition to an appropriately qualified underwriter;**
- **give an applicant for insurance the opportunity to either withdraw their application or provide further information, including supporting medical documents, before declining to offer insurance or offering insurance on non-standard terms;**
- **where an insurer offers insurance on non-standard terms, for example, with a mental health exclusion or a higher premium than a standard premium, specify:**
    - **how long it is intended that the exclusion/higher premium will apply to the policy;**
    - **the criteria the insured would be required to satisfy to have the exclusion removed or premium reduced;**
    - **the process for removing or amending of the exclusion/premium; and**
- **develop, implement and maintain policies that reflect the above practices.**

Recommendation 10.8

10.103 The committee recommends that consideration be given to allowing insurers to more actively promote and fund evidence-based best-practice preventative health measures targeted at promoting good mental health at a general level.

Recommendation 10.9

10.129 The committee recommends that the Financial Services Council and the Insurance in Superannuation Working Group consult with financial legal services and mental health advocacy groups to determine appropriate timeframes for claims decisions and that the *Life Insurance Code of Practice* and the *Insurance in Superannuation Code of Practice* be updated to reflect the outcome of such consultation.

Recommendation 10.10

10.130 The committee recommends that after consultation with relevant stakeholders, including medical professionals that are independent of the life insurance industry and mental health advocacy groups, the Financial Services Council and the Insurance in Superannuation Working Group mandate through the *Life Insurance Code of Practice* and the *Insurance in Superannuation Code of Practice* an upper limit on the number of medical assessments that can be requested of a policyholder and the specific circumstances in which this upper limit could be deviated from.

Recommendation 10.11

10.138 The committee recommends that the concentration of power in the Claims Management Industry, as well as the Independent Medical Examiner market be monitored by the Australian Competition and Consumer Commission to ensure appropriate quality assurance practices are in place and conflicts of interests are managed.

Recommendation 10.12

10.142 The committee recommends that the government consider establishing mechanisms to ensure the appropriate bodies are able to undertake random audits of both historical and future medical reports procured by independent medical examination companies, comparing the original reports as drafted by doctors with those used by life insurance companies as the basis for the decision.

Recommendation 10.13

10.183 The committee recommends that the Australian Government introduce legislation to facilitate the rationalisation of legacy products noting that such legislative change should include a no-disadvantage rule whereby:

- **existing policyholders would, at a minimum, be no worse off from being transferred to a new policy; and**
- **the determination of whether existing policyholders are no worse off should be assessed on an individual case-by-case basis and not by considering what is best for a group of policyholders who hold the same legacy product. Though this may be done on a class basis, similar to classes within schemes of arrangement under Chapter 2F of the *Corporations Act 2001*.**

Recommendation 10.14

10.190 The committee recommends that the Australian Government conduct a thorough inquiry or consultation process before it progresses any reforms relating to life insurers funding rehabilitation services, including impacts on private health insurance, or Medicare, and any conflicts of interest that may arise for an insurer vis-a-vis their customer and the most appropriate care.

Recommendation 10.15

10.193 The committee recommends that the Financial Services Council, with the Royal Australian College of General Practitioners and key stakeholders, explore issues around those with dementia claiming on life insurance. Following this, the committee recommends that together they prepare and implement protocols within the Code specifically addressing the treatment by life insurers of those with dementia.

Abbreviations

ABC	Australian Broadcasting Corporation
ACCC	Australian Competition and Consumer Authority
ACL	Australian Consumer Law
ADI	Authorised Deposit-taking Institution
AGND	Australian Genetic Non-Discrimination Working Group
AFA	Association of Financial Advisers
AFCA	Australian Financial Complaints Authority
AFS	Australian Financial Services
AIA	AIA Australia
ALA	Australian Lawyers Alliance
ALRC Report	ALRC Report 96, *Essentially Yours: The Protection of Human Genetic Information in Australia*
AMA	Australian Medical Association
APL	Approved Product List
APP	Australian Privacy Principles
APRA	Australian Prudential Regulatory Authority
ASFA	Association of Superannuation Funds Australia
ASIC	Australian Securities and Investments Commission
ASIC Act	*Australian Securities and Investments Commission Act 2001*
ATO	Australian Tax Office
BEAR	Banking Executive Accountability Regime
BT	BT Financial Group
CAANZ	Consumer Affairs Australia and New Zealand
Code	FSC Life Insurance Code of Practice
CIO	Credit and Investments Ombudsman
Competition and Consumer Act	*Competition and Consumer Act 2010*
Corporations Act	*Corporations Act 2001*
Disability Discrimination Act	*Disability Discrimination Act 1992*

EDR	External Dispute Resolution
FOFA	Future of Financial Advice
FOS	Financial Ombudsman Service
FPA	Financial Planning Association of Australia
FRLC	Financial Rights Legal Centre
FSC	Financial Services Council
FSI	Financial Systems Inquiry
Genetic information	Predictive genetic information
GDP	Global Domestic Product
GP	General Practitioner
IDR	Internal Dispute Resolution
IME	Independent Medical Examiner
Insurance Contracts Act	*Insurance Contracts Act 1984*
ISWG	Insurance in Superannuation Working Group
LCCC	Life Code Compliance Committee
Life Insurance Act	*Life Insurance Act 1995*
LIF Reforms	*Corporations Amendment (Life Insurance Remuneration Arrangements) Act 2017*
Maurice Blackburn	Maurice Blackburn Lawyers
MySuper	Default superannuation account
OAIC	Office of the Australian Information Commissioner
PI	Professional Indemnity
PIAC	Public Interest Advocacy Centre
Privacy Act	*Privacy Act 1988*
PwC	Price Waterhouse Coopers
RACGP	Royal Australian College of General Practitioners
RANZCP	Royal Australian and New Zealand College of Psychiatrists
Report 413	ASIC, *Report 413: Review of Retail Life Insurance Advice*
Report 454	ASIC, *Report 454: Funeral insurance: A snapshot*
Report 470	ASIC, *Report 470: Buying add-on insurance in car yards*: *Why it can be hard to say no*

Report 471	ASIC, *Report 471: The sale of life insurance through car dealers: Taking consumers for a ride.*
Report 498	ASIC, *Report 498: Life insurance claims: An industry review*
Report 499	ASIC, *Report 499: Financial advice: Fees for no service*
RG 175	Regulatory Guide 175: *Licensing: Financial product advisers—conduct and disclosure*
RG183	Regulatory Guide 183 *Approval of financial service sector codes of conduct*
SCT	Superannuation Complaints Tribunal
SIS Act	*Superannuation Industry (Supervision) Act 1993*
Super Code	draft Insurance in Superannuation Code of Practice
Supermatch(2)	ATO system which provides trustees with information to assist with consolidating members accounts
Taskforce	ASIC Enforcement Review Taskforce
TPD	Total and Permanent Disability
Trowbridge review	Mr John Trowbridge, *Review of Retail Life Insurance Advice*, March 2015
UCT	Unfair Contract Terms
Zurich	Zurich Financial Services Australia Limited

Chapter 1

Introduction

Duties of the committee

1.1 The Parliamentary Joint Committee on Corporations and Financial Services (the committee) is established by Part 14 of the *Australian Securities and Investments Commission Act 2001* (the ASIC Act). Section 243 of the ASIC Act sets out the committee's duties as follows:

(a) to inquire into, and report to both Houses on:

(i) activities of ASIC or the Takeovers Panel, or matters connected with such activities, to which, in the Parliamentary Committee's opinion, the Parliament's attention should be directed; or

(ii) the operation of the corporations legislation (other than the excluded provisions); or

(iii) the operation of any other law of the Commonwealth, or any law of a State or Territory, that appears to the Parliamentary Committee to affect significantly the operation of the corporations legislation (other than the excluded provisions); or

(iv) the operation of any foreign business law, or of any other law of a foreign country, that appears to the Parliamentary Committee to affect significantly the operation of the corporations legislation (other than the excluded provisions); and

(b) to examine each annual report that is prepared by a body established by this Act and of which a copy has been laid before a House, and to report to both Houses on matters that appear in, or arise out of, that annual report and to which, in the Parliamentary Committee's opinion, the Parliament's attention should be directed; and

(c) to inquire into any question in connection with its duties that is referred to it by a House, and to report to that House on that question.[1]

1 *ASIC Act 2001*, s. 243.

Terms of reference

1.2 On 14 September 2016, the Senate referred an inquiry into the life insurance industry to the committee for report by 30 June 2017. The terms of reference are as follows:

(a) the need for further reform and improved oversight of the life insurance industry;

(b) assessment of relative benefits and risks to consumers of the different elements of the life insurance market, being direct insurance, group insurance and retail advised insurance;

(c) whether entities are engaging in unethical practices to avoid meeting claims;

(d) the sales practices of life insurers and brokers, including the use of Approved Product Lists;

(e) the effectiveness of internal dispute resolution in life insurance;

(f) the roles of the Australian Securities and Investments Commission and the Australian Prudential Regulation Authority in reform and oversight of the industry; and

(g) any related matters.[2]

Conduct of the inquiry

1.3 The committee advertised the inquiry on its webpage and invited submissions from a range of relevant stakeholders. The committee set a closing date for submissions of 18 November 2016.

1.4 On 21 September 2016 the committee resolved to inform submitters that:

- the committee welcomes individual stories that may identify widespread issues and recommendations for reform; and
- the committee is not able to investigate or resolve individual disputes.

Extension of the inquiry

1.5 The committee agreed to seek three extensions to the inquiry reporting date. On 29 March 2017 the Senate agreed to extend the reporting date to 31 October 2017.[3] On 14 September 2017 the Senate agreed to extend the reporting date to 7 December 2017.[4] On 15 November 2017 the Senate agreed to extend the reporting date to report by 31 March 2018.[5]

2 *Journals of the Senate*, No. 6, 14 September 2016, p. 193.

3 *Journals of the Senate*, No. 37, 29 March 2017, p. 1224.

4 *Journals of the Senate*, No. 63, 14 September 2017, p. 2013.

5 *Journals of the Senate*, No. 70, 15 November 2017, p. 2237.

Submissions

1.6 The committee received 77 submissions and a number of supplementary submissions as detailed in Appendix 1. The committee also received additional information including answers to questions taken on notice as listed in Appendix 1.

Hearings

1.7 The committee held the following hearings:

- 22 February 2017 in Melbourne;
- 24 February 2017 in Sydney;
- 03 March 2017 in Canberra;
- 26 May 2017 in Canberra;
- 18 August 2017 in Canberra;
- 8 September 2017 in Canberra; and
- 1 December 2017 in Canberra.

1.8 A list of witnesses who gave evidence at the public hearings is in Appendix 2.

Structure of this report

1.9 The structure of this report is as follows:

- Chapter 2 provides background on the life insurance industry;
- Chapter 3 considers consumer protections that apply to life insurance;
- Chapter 4 discusses the life insurance codes of practice;
- Chapter 5 discusses remuneration, commissions, payments and fees;
- Chapter 6 examines retail life insurance and approved product lists;
- Chapter 7 considers group life insurance;
- Chapter 8 considers the access life insurers have to a customer's medical information at the time of purchasing a policy and at the time of making a claim;
- Chapter 9 discusses the use of genetic information in life insurance; and
- Chapter 10 examines claims handling practices, including the use of surveillance, and legacy products.

Acknowledgements

1.10 The committee thanks all individuals and organisations who assisted with the inquiry.

Notes on references

1.11 References and page numbers for the committee Hansard are to the proof Hansard. Please note that page numbers may vary between the proof and official transcripts. In the report, the life insurance industry may also be referred to as 'the industry'.

Chapter 2

Background on the life insurance industry

Introduction

2.1 This chapter provides background on the life insurance industry. It begins by setting out the different types of life insurance policies that are available, the three ways in which policies may be purchased, and the revenue and expenses of the industry. It then covers the regulation of the industry including the revamping of the dispute resolution process. The remainder of the chapter summarises recent legislation, inquiries, reviews, reforms and other events relating to life insurance. The chapter concludes with some discussion of Treasury's capability and capacity to develop and maintain policy and regulatory settings in relation to life insurance. Proposals for red tape reduction are also noted.

Nature of the life insurance industry

2.2 As at September 2017, there were 29 life insurers in Australia.[1] The big four banks each owned life insurance businesses until 2017, when some of those life insurance businesses were either completely or partially sold. The compatibility of life insurance and banking, and the associated question of vertical integration, were significant issues during the inquiry and are discussed further in chapters 5 and 6.

2.3 Life insurance covers a range of insurance products including:

- life cover which is also known as term life insurance or death cover and pays a set amount of money when the insured person dies;
- Total and Permanent Disability (TPD) cover which covers the costs of rehabilitation, debt repayments and the future cost of living if the insured person is totally and permanently disabled;
- trauma cover (also referred to as 'critical illness' cover or 'recovery' insurance) which provides cover in the event of a diagnosis of a specified illness or injury, such as cancer or stroke; and
- income protection which replaces the income lost through an inability to work due to injury or sickness.[2]

2.4 Life only and income protection policies were the most common life insurance policies, comprising 32 per cent and 21 per cent respectively of the total policies in place in June 2013.[3]

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1 Australian Prudential Regulation Authority, *Quarterly Life Insurance Performance Statistics*, September 2017, p. 13.

2 Australian Securities and Investments Commission, *Life insurance: Be prepared for life's emergencies*, https://www.moneysmart.gov.au/insurance/life-insurance (accessed 20 October 2016).

2.5 To acquire life insurance, customers are generally charged a monthly premium that is calculated by the insurer using information about the customer's age and health status. Insurance premiums usually increase with age due to the increased likelihood of making a claim. For insurance such as life, TPD, or trauma cover, there is often a choice between stepped or level premiums:

- stepped premiums are insurance premiums that increase each year, but are usually cheaper in the beginning; and
- level premiums are insurance premiums that do not change over time. However, level premiums are generally more expensive than stepped premiums in the beginning. Level premiums may increase over time due to inflation adjustments or changes to the insurer's fees.[4]

2.6 The term 'underwriting' in the insurance industry has two distinct meanings. It can mean the act of providing insurance cover for a risk. It is often applied in this sense in the general insurance market. It can also mean the business process of assessing risk prior to the issue of a policy, or prior to agreeing to an increase in cover. In the life insurance market, this usually involves the following steps:

> a) The prospective insured completes and submits an application form which contains answers to detailed questions about the insured's medical conditions, medical treatments and lifestyle.
>
> b) This information is considered by an underwriter who applies the life insurer's risk appetite and underwriting guidelines to the risk. This step may require the underwriter to ask further questions of the applicant. It may also require the applicant to submit to medical tests or medical examination; and
>
> c) The underwriter determines whether the risk should be accepted, not accepted, or accepted subject to the imposition of exclusion clauses or increased premium (premium 'loading').[5]

2.7 Not all life insurance is underwritten at the time of purchase. Indeed, life insurance held in group superannuation is not ordinarily underwritten. Most direct life insurance is underwritten at the time of purchase. Retail life insurance procured through an adviser is typically fully underwritten at the time of purchase.[6]

2.8 The life insurance industry can be categorised into three sectors based on the three ways in which consumers may purchase life insurance:

- through an advice provider (retail);
- directly from an insurer (direct); or

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3 Australian Securities and Investments Commission, *REP: 413 Review of retail life insurance advice*, 9 October 2014, p. 19.

4 Australian Securities and Investments Commission, *Life insurance: be prepared for life's emergencies*, https://www.moneysmart.gov.au/insurance/life-insurance (accessed 1 November 2017).

5 Financial Services Council, *Submission 26.1*, p. 10.

6 Financial Services Council, *Submission 26.1*, p. 11.

- through their superannuation fund and the group life cover offered by the fund (group).[7]

2.9 The majority of life insurance policies are held within group superannuation. In 2015, there were 14 million group policies, 4 million retail policies, and 3.9 million direct policies.[8]

2.10 In each of the three sectors, there are different arrangements for purchasing life insurance, associated with the how the life insurance is sold:

- Direct or non-advised—provided directly by insurers or their distributers, partners or affiliates without any personal advice. The life insurance provided through this channel is often a simpler product. Consumers who choose not to seek advice may be able to understand and access this product themselves.
- Group—provided as a group policy purchased by the trustee of a superannuation fund or an employer, with fund members ultimately given the benefit of the cover under the policy. The default nature of the cover provided through this channel gives access to life insurance to the largest number of consumers, many of whom would not be able to afford premiums if they were individually underwritten or the premiums were not paid from their superannuation fund account. Cover is not tailored to a particular member's circumstances.
- Retail (advised)—provided by financial advisers. If appropriate personal advice is provided, consumers should be able to source a life insurance product through this channel that is based on their circumstances.[9]

2.11 Table 2.1 below provides a comparison some of the elements of the direct, group, and retail sectors of the life insurance industry including the features, numbers of policies, rates of claims accepted and denied, and risks identified by ASIC. These elements are considered in greater in later chapters of the report.

7 Australian Securities and Investments Commission, *REP: 413 Review of retail life insurance advice*, 9 October 2014, p. 4.

8 Australian Securities and Investments Commission, *REP: 498 Life insurance claims: An industry review*, October 2016, p. 35.

9 Australian Securities and Investments Commission, *Submission 45*, pp. 29–30.

Table 2.1: Comparison of life insurance industry sectors

Life Insurance	Direct / Non-advised	Group	Retail / Advised
Key features	Simpler products that consumers may be able to understand	Gives access to many consumers who may otherwise be unable to afford premiums	If appropriate personal advice is provided, consumers may have access to tailored life insurance that best fits their personal circumstances
Number of policies in 2015	3.9m	14.0m	4.0m
Claims declined (2013–2015)	12 per cent	8 per cent	7 per cent
Claims accepted in full (2013–2015)	74 per cent	77 per cent	76 per cent
Own occupation cover prohibited[#]		Since 1 July 2014	
Claim approval / Conditions of release	Insurer	Insurer / Trustees decisions on conditions of release	Insurer
Risks identified by the Australian Securities and Investments Commission (ASIC)	Sales practices Lapse rates Credit protections for businesses	Member awareness of cover and impact on superannuation balances No cover despite payments in some cases	Conflicted remuneration Poor quality advice Unnecessary switching

Source: Australian Securities and Investments Commission, *Submission 45*, pp. 30–31; Australian Securities and Investments Commission, *Report 498: Life Insurance Claims: An industry review*, October 2016, pp. 5, 35, 76, 107; Riskinfo Magazine, *Changes to insurance in Super*, http://magazine.riskinfo.com.au/15/changes-to-insurance-in-super/ (accessed 5 September 2017); Australian Prudential Regulation Authority, *Annual Superannuation Bulletin*, June 2016, p. 7. [#]in other parts of the industry both own and any occupation cover can be acquired.

2.12 Remuneration flows within and between the various components of the life insurance industry are complex. There are a range of commissions—upfront, trailing, hybrid, and level—and various fees and other monetary payments as well as non-monetary payments and so-called 'soft dollar' benefits. These payments are explored in greater detail in chapter 5.

Sustainability of the life insurance industry

2.13 Both revenue and expenses in the life insurance industry rose in the 2016–17 financial year. For the year ending 30 June 2017, total revenue was $34.0 billion, up from $28 billion in the previous 12 months. This revenue mainly comprised net policy revenue of $15.9 billion and investment revenue of $14.8 billion.[10]

2.14 For the year ending 30 June 2017, total expenses were $30.2 billion, up from $24.2 billion in the previous 12 months. Total expenses in the year ending June 2017 mainly comprised increases in net policy liabilities of $12.3 billion, net policy expenses due to claims of $9.4 billion and operating expenses of $8.4 billion.[11]

2.15 The Australian Prudential Regulation Authority (APRA) informed the committee that it has identified prudential risks in the life insurance industry, relating to issues including:

- long term sustainability risks for group life insurance arising from poor risk management practices and culture which led to poor profitability;
- the impact of scandals such as CommInsure; and
- poorly designed remuneration arrangements that drive poor behaviour.[12]

2.16 Price Waterhouse Coopers (PwC) indicated that revenues and profits are not predicted to grow in the life insurance industry for the next few years. This is in contrast with predicted 5 per cent growth in revenues and profits for other financial services such as deposits, loans and wealth management.[13]

2.17 PwC noted that the life insurance industry has significant issues with public trust. While 78 per cent of Australians view life insurance as important, only 42 per cent believe their life insurer will be there for them in their time of need. Several recent high profile reputational scandals have only widened the gap between insurers and customers when it comes to trust. As a population, Australians may be underinsured. For example, PwC noted that life insurance premiums as a proportion of

10 Australian Prudential Regulation Authority, *Quarterly Life Insurance Performance Statistics*, June 2017, p. 6.

11 Australian Prudential Regulation Authority, *Quarterly Life Insurance Performance Statistics*, June 2017, p. 6.

12 Australian Prudential Regulation Authority, *Submission 50*, pp. 14–21.

13 Price Waterhouse Coopers, *Future of Life Insurance in Australia: profitable growth in challenging times*, March 2017, p. 5.

GDP are much smaller than in comparable developed countries such as Sweden (1.5 times smaller) and Japan (2 times smaller).[14]

Regulation of life insurance

2.18 The responsibility for the regulation of the life insurance industry is divided between ASIC and APRA as follows:

- ASIC—licensing, conduct, product operation, product disclosure and marketing, and dispute resolution; and
- APRA—registration, prudential standards, and data collection.[15]

2.19 Life insurers and advisers are subject to the statutory standards and requirements of the Acts administered by ASIC and other agencies, including:

- the *Corporations Act 2001* (Corporations Act);
- the *Australian Securities and Investments Commission Act 2001* (ASIC Act);
- the *Insurance Contracts Act 1984* (Insurance Contracts Act); and
- the *Life Insurance Act 1995* (Life Insurance Act) and the Life Insurance Regulations 1995.[16]

2.20 Life insurance has also recently become subject to self-regulation through an industry code. This is discussed further in chapter 4.

Dispute resolution

2.21 All Australian Financial Service (AFS) licensees, credit licensees and trustee companies are required to have:

- a dispute resolution system, which includes an Internal Dispute Resolution (IDR) procedure and membership of an ASIC-approved External Dispute Resolution (EDR) scheme; and
- compensation arrangements, generally in the form of Professional Indemnity insurance.[17]

2.22 There are two ASIC-approved EDR schemes in Australia that deal with complaints from consumers and retail investors about financial services providers and credit service providers:

- the Financial Ombudsman Service (FOS); and

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14 Price Waterhouse Coopers, *Future of Life Insurance in Australia: profitable growth in challenging times*, March 2017, pp. 2–3.

15 Australian Securities and Investments Commission, *Submission 182 to the Senate Economics References Committee inquiry into scrutiny of financial advice*, p. 9.

16 Australian Securities and Investments Commission, *Submission 182 to the Senate Economics References Committee inquiry into scrutiny of financial advice*, p. 9.

17 Australian Securities and Investments Commission, *Submission 182 to the Senate Economics References Committee inquiry into scrutiny of financial advice*, p. 12.

- the Credit and Investments Ombudsman (CIO).

2.23 Superannuation fund members can make complaints to a third body, the Superannuation Complaints Tribunal (SCT) established under the *Superannuation (Resolution of Complaints) Act 1993*. As it is a statutory tribunal, the SCT is not directly subject to ASIC oversight. The SCT can review decisions and the conduct of superannuation providers, including:

- trustees of regulated superannuation funds and approved deposit funds;
- retirement savings account providers; and
- life companies providing annuity policies.[18]

2.24 In September 2017, the government announced it will implement the Ramsey review recommendation to create a single dispute resolution service called the Australian Financial Complaints Authority (AFCA) to replace the three existing schemes. The legislation to implement AFCA is intended to:

- strengthen governance by allowing the Minister to appoint a minority of the AFCA board on its establishment, including the independent chair;
- ensure that features of the SCT's complaints handling model, including requirements for handling death benefit complaints, the decision-making test and the unlimited monetary jurisdiction, will be enshrined in legislation, to provide certainty to stakeholders;
- provide for transition arrangements, including dealing with existing cases; and
- improve the transparency and accountability of IDR practices by providing for ASIC to publish data on IDR.[19]

2.25 The committee notes the creation of AFCA and notes that it will allow consumers to challenge decisions made by life insurers and obtain a binding judgement, without needing to go to court.[20]

Previous inquiries, reviews, reforms and events

2.26 There have been a number of recent developments and reforms in the life insurance industry. This section provides a brief summary and timeline of pertinent events relating to life insurance over the last few years, up until the start of this inquiry. Where reviews and significant events have occurred during the inquiry, those are discussed in the relevant chapter of the report.

18 Australian Securities and Investments Commission, *Submission 182 to the Senate Economics References Committee inquiry into scrutiny of financial advice),* pp. 12–13.

19 The Hon Kelly O'Dwyer, Minister for Revenue and Financial Services, *Putting consumers first – improving dispute resolution*, 14 September 2017.

20 Treasury, Fact Sheet, *The Australian Financial Complaints Authority (AFCA) – the Government's response to consultation*, September 2017, p. 2.

Insurance contracts amendment — 2013

2.27 The *Insurance Contracts Amendment Act 2013* made a number of amendments to the existing duty of utmost good faith provisions, such as:

- expanding the consequences of an insurer failing to act with utmost good faith;
- allowing ASIC to take action against the insurer on behalf of an insured person or third-party beneficiary in relation to a breach; and
- expanding the scope to include third-party beneficiaries.[21]

FOFA reforms — July 2013

2.28 In July 2013, the Future of Financial Advice (FOFA) reforms became mandatory. A series of amendments to the FOFA reforms were finalised in March 2016.[22] While life insurance was exempted from the conflicted remuneration provisions in FOFA, other elements of the FOFA reforms, such as the best interests duty, do apply to life insurance.[23]

ASIC's review of retail life insurance advice — October 2014

2.29 In October 2014, ASIC's Report 413 on retail life insurance advice made the following findings:

- 37 per cent of the personal advice reviewed failed to comply with the quality of advice conduct obligations in the Corporations Act; and
- there was a positive correlation between high upfront commissions and poor-quality advice to consumers.[24]

2.30 As a result of its findings, ASIC recommended that insurers change their remuneration arrangements, and that advisers review their business models to address structural barriers to the provision of compliant life insurance advice.[25]

2.31 Recent developments in remuneration arrangements for the life insurance industry are examined in chapter five of this report.

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21 Australian Securities and Investments Commission, *Submission 182 to the Senate Economics References Committee inquiry into scrutiny of financial advice*, p. 11.

22 The Treasury, *Future of Financial Advice*, http://futureofadvice.treasury.gov.au/Content/Content.aspx?doc=home.htm, (accessed on 8 November 2017).

23 Australian Securities and Investments Commission, *Submission 182 to the Senate Economics References Committee inquiry into scrutiny of financial advice*, p. 14.

24 Australian Securities and Investments Commission, *Submission 182 to the Senate Economics References Committee inquiry into scrutiny of financial advice*, p. 17.

25 Australian Securities and Investments Commission, *Submission 182 to the Senate Economics References Committee inquiry into scrutiny of financial advice*, p. 17.

Trowbridge Review — March 2015

2.32 In response to the ASIC review of retail life insurance, industry bodies commissioned the Trowbridge Review to develop recommendations that would enable the retail industry to implement ASIC's findings. The Trowbridge Review recommended:

- reforms to adviser remuneration, including commissions and constraints on the scale and frequency of initial advice payments;
- a prohibition on licensees receiving benefits from insurers that might influence product choices or advice;
- a requirement for Approved Product Lists (APLs) to provide sufficient market coverage; and
- a life insurance code of practice.[26]

Financial advisers register — March 2015

2.33 A register of financial advisers was launched in March 2015. It provides information to consumers on advisers who have findings against them for poor financial advice, including advice in relation to life insurance. The primary objective of the register is to improve transparency and therefore help consumers to choose a financial adviser. Secondary objectives include assisting AFS licensees to improve recruitment practices, manage risks, and monitor financial advisers.[27]

APRA action on group life insurance — May 2015

2.34 In December 2013, APRA wrote to group insurers with concerns about poor experiences for participants in the group life insurance market. Subsequently, APRA sought feedback from market participants and, in October 2014, released Prudential Practice Guide 270 on Group Insurance Arrangements.[28]

2.35 APRA intervened in the group life insurance industry again in May 2015 after identifying the existence of substantial losses arising from total and permanent disability policies issued to trustees of industry superannuation funds. The most common factors identified for the losses included:

- unemployment and weaker economic conditions;
- increased customer awareness of benefits due to promotional activity;
- increased lawyer involvement in claims processing;
- larger, longer and more complicated claims; and

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26 John Trowbridge, *Review of Retail Life Insurance Advice*, 26 March 2015, pp. 7–10.

27 Australian Securities and Investments Commission, *Submission 182 to the Senate Economics References Committee inquiry into scrutiny of financial advice*, p. 15.

28 Australian Prudential Regulation Authority, *Letter to Life Insurers on Group Insurance*, 18 May 2015, http://www.apra.gov.au/lifs/Pages/Letter-to-LI-entities-on-Group-Insurance-18-May-2015.aspx (accessed 1 November 2017).

- generous terms, conditions and acceptance limits.[29]

2.36 APRA issued a public letter to group life insurers setting out the above concerns, and requested insurers and trustees consider taking action on the following:

- board and management reporting;
- risk management;
- meeting capital targets;
- reviewing pricing assumptions and methodologies;
- ensuring that terms and conditions are appropriate for group life insurance;
- improving claims handling; and
- increasing engagement with superannuation trustees.[30]

Funeral insurance review — October 2015

2.37 Although not technically a form of life insurance, funeral insurance shares certain characteristics with other forms of insurance such as life insurance. In October 2015 ASIC released Report 454 on funeral insurance which identified concerns including:

- increasing premiums over time which can lead to the possibility of consumers paying more in premiums than policies are worth; and
- a high rate of policy cancellations potentially pointing to problems with the cost, design, marketing and selling of funeral insurance.[31]

2.38 Based on its findings, ASIC recommended that insurers:

- review product design;
- provide upfront total cost estimates;
- disclose any potential for premiums to exceed benefit amounts;
- ensure that consumers understand the features of funeral insurance; and
- provide longer grace periods before a policy is cancelled for non-payment of premiums.[32]

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29 Australian Prudential Regulation Authority, *Letter to Life Insurers on Group Insurance*, 18 May 2015, http://www.apra.gov.au/lifs/Pages/Letter-to-LI-entities-on-Group-Insurance-18-May-2015.aspx (accessed 1 November 2017).

30 Australian Prudential Regulation Authority, *Letter to Life Insurers on Group Insurance*, 18 May 2015, http://www.apra.gov.au/lifs/Pages/Letter-to-LI-entities-on-Group-Insurance-18-May-2015.aspx (accessed 2 November 2017).

31 Australian Securities and Investments Commission, *REP 454 Funeral Insurance: A snapshot*, October 2015, p. 6.

32 Australian Securities and Investments Commission, *REP454 Funeral Insurance: A snapshot*, October 2015, p. 6.

2.39 ASIC identified that high cost funeral insurance was being sold to people who were unlikely to benefit from it and that some customers had paid more in premiums than the benefit sum insured. ASIC also identified an 80 per cent cancellation rate on funeral insurance.[33]

2.40 ASIC is responsible for the licensing of life insurers which issue funeral insurance and funeral bonds. However, providers of the following products are exempt from the requirement to hold an AFS licence:

- funeral benefit: this covers the cost of funeral and burial or cremation services (for example, a pre-paid funeral plan provided by a funeral director); and
- funeral expenses only: this policy provides a benefit for the sole purpose of meeting the expenses of, and incidental to, a funeral and burial or cremation (for example, the payout will not exceed these substantiated expenses).[34]

2.41 The committee has recommended changes to consumer protections relating to funeral insurance in chapter 3.

Financial System Inquiry — October 2015

2.42 The Financial System Inquiry (FSI) which concluded in October 2015 set out to establish a direction for the future of Australia's financial system. Reforms to life insurance were proposed, including:

- a level commission structure to address the problem of misaligned interests of advisers and consumers;
- increasing the obligations of product issuers and distributors to act in the interest of consumers by introducing a targeted and principles-based product design and distribution obligation;
- a product intervention power that would enable ASIC to modify or ban harmful financial products where there is a risk of significant consumer detriment; and
- reviewing ASIC's penalties and powers to ensure that the enforcement regime provides a credible deterrent for poor behaviour and breaches of financial services laws.[35]

Life insurance reform package — November 2015

2.43 In November 2015, the government announced a reform package that was agreed to by the life insurance industry. The package addressed commissions and the

33 Australian Securities and Investments Commission, *REP 454 Funeral Insurance: A snapshot*, October 2015; see also Consumer Action Law Centre, *Submission 27*, p. 16.

34 Australian Securities and Investments Commission, answers to question on notice, 4 August 2017 (received 4 December 2017).

35 Australian Securities and Investments Commission, *Submission 182 to the Senate Economics References Committee inquiry into scrutiny of financial advice*, pp. 16, 17.

remuneration of life insurance advisers where life insurance is sold through advisers, including:

- limiting the upfront and ongoing commissions paid to advisers;
- requiring the repayment of commissions to insurers by advisers over a two-year retention period, if a policy lapses or a premium is reduced;
- banning other forms of conflicted remuneration, consistent with the FOFA reforms;
- a life insurance code of conduct to be developed by the industry;
- industry responsibility for widening coverage of APLs;
- fee-for-service products to be made available; and
- a review of statements of advice by ASIC.[36]

Standards for financial advisers — December 2015

2.44 Following recommendations made in the December 2014 report of the Parliamentary Joint Committee on Corporations and Financial Services,[37] in October 2015, the Australian Government announced proposed reforms to increase the professionalism, education and training standards of financial advisers.[38] In December 2015, the Government released draft legislation for consultation and is continuing to consult on some elements of the proposed legislation.[39]

2.45 On 22 February 2017, the *Corporations Amendment (Professional Standards of Financial Advisers) Act 2017* came into force. This Act includes requirements that both new and existing financial advisers satisfy compulsory education standards such as the passing of an examination and ongoing professional development. These requirements will commence from 1 January 2019 and new advisers must hold a relevant degree from this date. Existing advisers will have until 1 January 2021 to pass an examination and until 1 January 2024 to comply with other required education standards.[40]

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36 Australian Securities and Investments Commission, *Submission 182 to the Senate Economics References Committee inquiry into scrutiny of financial advice*, pp. 17–18.

37 Parliamentary Joint Committee on Corporations and Financial Services, *Inquiry into proposals to lift the professional, ethical and education standards in the financial services industry*, 19 December 2014.

38 Australian Securities and Investments Commission, *Submission 182 to the Senate Economics References Committee inquiry into scrutiny of financial advice*, p. 16.

39 Australian Securities and Investments Commission, *Submission 182 to the Senate Economics References Committee inquiry into scrutiny of financial advice*, p. 16.

40 The Hon Kelly O'Dwyer MP, Minister for Revenue and Financial Services, Media Release, *Professional Standards for Financial Advisors Introduced*, 23 November 2016, http://kmo.ministers.treasury.gov.au/media-release/102-2016/ (accessed 7 February 2018).

Life insurance sold through car dealerships — February 2016

2.46 In February 2016, ASIC released the following reports:

- Report 470—Buying add-on insurance in card yards: Why it can be hard to say no; and
- Report 471—The sale of life insurance through car dealers: Taking consumers for a ride.

2.47 ASIC's Report 471 concluded that car yard life insurance:

- is poor value for money, as it can be much more expensive than other forms of life insurance;
- can be sold when it is not necessary (for example, to young people with no dependants); and
- is characterised by:
    - excessive prices relative to other life insurance products;
    - low claim payouts relative to premiums (6.6 per cent);
    - upfront payment of the premium as a lump sum; and
    - high commissions of up to 50 per cent of the premium.[41]

2.48 ASIC suggested that follow-up actions may include:

- insurers redesigning products and supervision by authorised representatives to provide value to customers; and
- ASIC monitoring of individual insurers with the potential for enforcement actions, enhanced disclosure requirements, and training standards.[42]

2.49 In September 2016 ASIC's Report 492 on the sale of add-on insurance through car dealers revealed that add-on insurance products:

- are extremely poor value for consumers (with claims ratios of between four and ten cents in the dollar);
- car dealers benefit more than consumers: For 2012 to 2016, insurers earned $1.6 billion on the sale of add-on insurance products, with $602 million paid to car dealers as commissions, and only $144 million paid out in claims to consumers; and
- there were instances of misselling, such as products being sold to consumers who were not eligible to claim under them, or products having a 'negative

41 Australian Securities and Investments Commission, *Report 471: The sale of life insurance through car dealers: Taking consumers for a ride*, February 2016, pp. 1, 4.

42 Australian Securities and Investments Commission, *Report 471: The sale of life insurance through car dealers: Taking consumers for a ride*, February 2016, p. 12.

value' where the premium was more than the maximum amount payable by the insurer in the event of a claim.[43]

2.50 ASIC informed the committee that:

- ASIC has negotiated remediation programs with four of the main insurers in this market, refunding over $120 million to over 210 000 consumers for add-on products.
- All insurers have agreed to remediate consumers for the life component of the add-on insurance product premiums sold to young consumers with no dependents.
- As a result of the add-on insurance Working Group's recommendations, the Insurance Council of Australia is also looking to include good design and distribution principles in the 2018 amendments to its Code of Practice.
- Some outcomes to product redesign and practices that have already been achieved include:
    - Reducing premiums—most insurers have cut commissions to around 20 per cent, resulting in lower premiums for consumers; and
    - Withdrawal or redesign of products—most insurers have withdrawn zero or low value add-on insurance products from the market.[44]

ABC Four Corners coverage — March 2016

2.51 In March 2016, the ABC *Four Corners* aired a story raising allegations that CommInsure had inappropriately tried to avoid insurance payouts.[45]

Senate Economics Reference Committee Inquiry — March 2016

2.52 The Senate Economics References Committee was conducting an inquiry into the Scrutiny of Financial Advice in the 44th Parliament. In March 2016, the Senate referred additional terms of reference regarding the life insurance industry to that committee. The inquiry received a number of submissions and held one hearing prior to the inquiry lapsing with the dissolution of the 44th Parliament in 2016.[46]

The role of actuaries within insurers — June 2016

2.53 APRA released a discussion paper on the role of appointed actuaries within insurers in June 2016. APRA was concerned that appointed actuaries had become increasingly compliance focussed, limiting their ability to provide strategic advice to management, particularly for life insurance. APRA also noted an increased turn-over

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43 Australian Securities and Investments Commission, *Answers to questions on notice*, 8 February 2018 (received 12 February 2018.

44 Australian Securities and Investments Commission, *Answers to questions on notice*, 8 February 2018 (received 12 February 2018.

45 ABC, *Money for Nothing*, http://www.abc.net.au/4corners/stories/2016/03/07/4417757.htm (accessed 28 Nov 2017).

46 Senate Economics References Committee, *Inquiry into Scrutiny of Financial Advice*.

of appointed actuaries within the life insurance industry. APRA proposed reforms which required changed behaviour from insurers, actuaries and APRA including:

- introducing a purpose statement for appointed actuaries;
- implementing a clear actuarial advice framework;
- improving the management of potential conflicts of interest;
- improving reporting requirements and simplifying prudential standards.[47]

Life Insurance Code of Practice — October 2016

2.54 The Financial Services Council (FSC) released a draft Life Insurance Code of Practice (Code) for public consultation in August 2016. The finalised Code commenced on 1 October 2016, with a transition period until 30 June 2017.

> The Code applies to:
>
> a) registered life insurance companies issuing Life Insurance Policies that are covered under membership of the FSC; and
>
> b) any other industry participant, including a non-FSC member, which adopts the Code by entering into a formal agreement with the FSC and the Life [Code Compliance Committee] to be bound by the Code.
>
> The Code does not apply to:
>
> a) superannuation fund trustees;
>
> b) financial advice companies or financial advisers; or
>
> c) other industry participants, unless they have adopted the Code.[48]

2.55 Life insurance codes of practice are discussed further in chapter 4.

ASIC Review of life insurance claims — October 2016

2.56 In October 2016, ASIC released a review of life insurance claims. ASIC did not find evidence of cross-industry misconduct across the life insurance sector in relation to life insurance claims payments and procedures. However, ASIC did identify concerns in relation to declined claims rates and claims handling procedures associated with some types of insurance, such as total and permanent disability policies, some insurers for particular policy types and particular causes for some consumer disputes.[49]

2.57 ASIC also made the following observations in its review:

> Although the considerable majority of claims are paid, we are concerned that in some cases, claims are being declined on technical or contractual grounds that are not in accordance with the 'spirit' or 'intent' of the policy.

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47 Australian Prudential Regulation Authority, *The role of the Appointed Actuary and actuarial advice within insurers*, discussion paper, June 2016, pp. 4–5.

48 Financial Services Council, *Life Insurance Code of Practice*, 1 October 2016, pp. 2–3.

49 Australian Securities and Investments Commission, *REP 498 Life insurance claims: An industry review*, 12 October 2016, p. 6.

> We identified that fairness should be given greater consideration by insurers. Not all insurance claims will be successful, but an issue arises when a policyholder's reasonable expectations about policy coverage do not align with the technical wording in the policy.[50]

2.58 In its review, ASIC set out five actions to improve standards in life insurance claims handling:

- establishing, with APRA, a new public reporting requirement for life insurance industry claims data and claims outcomes;
- recommending to government the strengthening of the legal framework covering claims handling;
- recommending the consumer dispute resolution framework for claims handling be strengthened;
- targeted, follow-up ASIC reviews on areas of concern including individual insurers with high decline and dispute rates, as well as a new major review of life insurance sold directly to consumers without personal advice; and
- strengthening industry standards and practices, including through extension and enhancement of the life insurance code of practice.[51]

2.59 Subsequently, in March 2017, ASIC indicated that it had obtained agreement from life insurers to undertake an independent review of their life insurance claims management practices, procedures, and product design and structure. ASIC noted that as a result of the independent reviews, some insurers are looking at improving their claims processes and policy documentation.[52]

2.60 In November 2017, APRA and ASIC released an information paper on industry-aggregate results on a new data collection pilot on life insurance claims. The paper indicated that insurers finalised 103 100 claims during 2016, of which about 92 per cent were admitted and about 8 per cent were declined.[53]

2.61 ASIC also found that lapse rates were generally higher for direct or non-advised distribution channels, ranging from 12 per cent to 36 per cent. ASIC was concerned that these lapse rates may be a result of inappropriate sales tactics that target consumers who do not need or want the product. ASIC also noted that the government has announced that its proposed reforms on commissions (discussed in

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50 Australian Securities and Investments Commission, *REP 498 Life insurance claims: An industry review*, 12 October 2016, pp. 6–7.

51 Australian Securities and Investments Commission, *REP 498 Life insurance claims: An industry review*, 12 October 2016, pp. 10–11.

52 Mr Peter Kell, Deputy Chairman, Australian Securities and Investments Commission, *Life insurance claims handling*, Speech to Money Management's Claims Handling Breakfast, 16 March 2017, pp. 4–5.

53 Australian Prudential Regulation Authority, Media Release 17.43, *APRA and ASIC publish key industry data on life insurance claims*, 9 November 2017.

chapter 5) will also now apply to direct or non-advised life insurance sales. This may address some inappropriate sales practice issues.[54]

2.62 ASIC indicated that it will explore lapse rates in a review of direct sales practices. The review will assess what changes could be made to sales practices, including disclosure, so that the way in which policies operate is better aligned with consumers' expectations.[55]

ASIC investigation of CommInsure — October 2016

2.63 In April 2016, ASIC commenced an investigation into CommInsure. The investigation relates to a range of concerns regarding CommInsure's life insurance business, including its claims handling practices and procedures. The investigation commenced following concerns raised in the media earlier in 2016.[56]

2.64 In March 2017, ASIC released the findings of its investigation into CommInsure, noting:

> CommInsure had trauma policies with medical definitions that were out of date with prevailing medical practice, specifically for heart attack and severe rheumatoid arthritis. However, this was not against the law. This is because the law allows an insurer to set out the level of cover its policy provides, including out of date medical definitions as long as these are clearly disclosed in the policy.
>
> ASIC found no evidence to support allegations that CommInsure claims managers applied undue pressure on doctors to change or alter their medical opinions.
>
> In the course of the investigation, ASIC identified a number of areas where CommInsure needs to make improvements to its claims handling processes. Areas of improvement were also identified by Deloitte in their independent review of CommInsure's claim handling. Such improvements included, for example, better and more timely communications with consumers and enhanced training and assistance for claims managers.
>
> ASIC's investigation also examined CommInsure's surveillance processes and looked at whether there was any compromise of a CommInsure database. No breaches of the law were uncovered, but areas for improvement were identified.[57]

APRA expectations for claims handling — October 2016

2.65 In October 2016, APRA set expectations for improvements to claims handling, including:

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54 Australian Securities and Investments Commission, *Submission 45*, p. 31.

55 Australian Securities and Investments Commission, *Submission 45*, pp. 31–32.

56 Australian Securities and Investments Commission, *16-348MR Update on ASIC's investigation into CommInsure*, 12 October 2016.

57 Australian Securities and Investments Commission, Media Release 17-076MR, *ASIC releases findings of CommInsure investigation*, 23 March 2017.

- reviewing insurance benefit design and definitions with a stronger focus on delivering benefits appropriate for members at an appropriate level of cost;
- better sharing of information between insurers and trustees;
- closer co-operation and alignment between trustees, insurers and reinsurers to optimise outcomes for beneficiaries; and
- clarifying the approach to claims adopted by both the insurer and trustee to improve claimants' understanding of how claims will be managed.[58]

2.66 APRA indicated that where it is not satisfied with progress, it may consider taking supervisory actions such as requiring formal board-approved remediation plans, regular reporting to APRA, or other measures to address deficiencies and mitigate heightened conduct and operational risks.[59]

Insurance brokers annual review — October 2016

2.67 In October 2016, the Insurance Brokers Code of Practice Code Compliance Committee released its 2015–16 Annual Review. The review revealed that 32 per cent of brokers self-reported breaches, 23 per cent of breaches related to buying insurance, and 11 significant breaches were reported by nine insurers.[60]

2.68 In August 2017 the Insurance Brokers Code of Practice Code Compliance Committee released its 2016–17 Annual Review. Similar to the 2015–16 Annual Review, 42 per cent of brokers self-reported breaches and 23 per cent of breaches related to buying insurance. However, the 2016–17 Annual Review noted that the number of significant breaches reported by insurance brokers had increased to 34 from 11 in the previous year.[61]

2.69 With respect to the figures in the above reports, the committee notes that it has not been able to obtain disaggregated figures to separate life insurance from general insurance.

Australian banking industry: Initiatives update — October 2016

2.70 In October 2016, the second independent governance expert report on the Australian banking industry package of initiatives was released. The report proposed the following initiatives which are relevant to banking and life insurance:

- reviewing product sales commissions and product based payments;
- making it easier for customers when things go wrong;

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58 Australian Prudential Regulation Authority, Media release, *APRA sets expectations for improvements to claims handling*, 12 October 2016.

59 Australian Prudential Regulation Authority, Media release, *APRA sets expectations for improvements to claims handling*, 12 October 2016.

60 Insurance Brokers Code of Practice Code Compliance Committee, *Annual Review 2015–16*, September 2016, pp. 4, 14.

61 Insurance Brokers Code of Practice Code Compliance Committee, *Annual Review 2016–17*, August 2017, pp. 5, 14.

- support for employees who 'blow the whistle' on inappropriate conduct;
- removing individuals from the industry for poor conduct; and
- strengthening the Code of Banking Practice and supporting ASIC.[62]

2.71 The committee notes that its report on Whistleblower Protections was tabled on 13 September 2017 and includes recommendations on strengthening whistleblower protections in the corporate, public and not-for-profit sectors.[63]

Fees for no services — October 2016

2.72 On 27 October 2016, ASIC released Report 499 which examined the charging of advice fees without providing advice by major financial institutions.

2.73 ASIC noted that automatic payments may comprise initial and trailing commissions paid by financial product issuers to advice licensees and their representatives (advisers). In aggregate, these commissions increase the product costs or insurance premiums paid by customers. There is generally no specific advice service obligation tied to these commissions, which continue to be paid to advice licensees and advisers whether or not they give customers ongoing advice.[64]

2.74 ASIC found systematic failures across 21 holders of AFS licences. Most of the failures occurred prior to the mandatory implementation of the FOFA reforms in July 2013. ASIC noted that:

> During the period of time covered by this project, the financial advice industry still had a culture of reliance on automatic periodic payments, such as sales commissions and adviser service fees.
>
> Some advice licensees prioritised advice revenue and fee generation over ensuring that they delivered the required services.
>
> Cultural factors in the banking and financial services institutions covered by this report may have contributed to the systemic failures we observed.
>
> Some licensees and advisers failed to keep adequate records or to capture sufficient data electronically to enable monitoring and analysis.
>
> Some licensees did not develop and enforce effective monitoring and checking procedures to prevent systemic failures.
>
> On some occasions advice licensees proposed review and remediation processes that were legalistic and did not prioritise the interests of customers.[65]

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62 Mr Ian McPhee AO PSM, *Independent governance expert report on the Australian banking industry package of initiatives,* 21 October 2016, p. i.

63 Parliamentary Joint Committee on Corporations and Financial Services, *Whistleblower protections in the corporate, public and not-for-profit sectors*, September 2017.

64 Australian Securities and Investments Commission, *Report 499: Financial advice: Fees for no service*, October 2016, p. 11.

65 Australian Securities and Investments Commission, *Report 499: Financial advice: Fees for no service*, October 2016, pp. 6–8.

2.75 As at 31 August 2016, $23.7 million in compensation had been paid to 27 000 customers. ASIC estimates that, as the compensation process continues, a further $154 million may be paid to a further 176 000 customers.[66]

Open data regime — July 2017

2.76 In July 2017 the government announced that it had commissioned an independent review to recommend the best approach to implement an open banking regime in Australia, with the report due by the end of 2017. The open banking regime is intended to provide greater consumer access to their own banking data and data on banking products will allow consumers to seek out products that better suit their circumstances, saving them money and allowing them to better achieve their financial goals. It will also create further opportunities for innovative business models to drive greater competition in banking and contribute to productivity growth. In August 2017, the government released an issues paper for consultation. As at 6 February 2018, forty submissions had been published on the Treasury website.[67]

Committee view

2.77 Life insurance is often sold with other financial products by banks and other industry participants. The committee notes that if life insurance is not included in the open data regime, the mobility goals of the regime could be significantly reduced because life insurance would be less mobile than other related financial products.

2.78 Even if a customer held life insurance as a standalone product, an open data regime would enable customers to have easy access to all their life insurance information including medical and underwriting information. This should mean that similar mobility advantages to those proposed for banking would accrue within the life insurance industry.

2.79 In addition, if an open data regime applied to life insurance, a consumer would be able to present all their information to an adviser. This should reduce the work involved for the adviser and therefore reduce the costs of helping a consumer choose products that better suit their circumstances. In turn, this should reduce the fees and commissions paid to switch products.

Recommendation 2.1

2.80 The committee recommends that life insurance be included in the open banking regime.

66 Australian Securities and Investments Commission, *Report 499: Financial advice: Fees for no service*, October 2016, pp. 6–7.

67 Treasury, Review into open banking in Australia, https://treasury.gov.au/review/review-into-open-banking-in-australia/ (accessed 7 February 2018).

Red tape reduction

2.81 The FSC submitted a range of proposals to the committee regarding the reduction of red tape in the life insurance industry. The proposals included the following:

- changing the definition of a life policy to allow life insurers to offer consumer credit insurance contracts, income protection policies shorter than three years and accidental death and sickness policies less than one year;
- removing restrictions on annuities that are shorter than 10 years;
- giving APRA broader powers to make declarations on annuities that may relate to life insurers and retirement products;
- allowing life insurers to mortgage the assets held in their statutory funds and allowing investments into geared entities;
- removing requirements for marks or signatures when policies are transferred between policy holders;
- increasing limits on the amount of life insurance that can be paid out prior to estates being approved for probate or administration;
- increasing limits where a life insurer can appoint a life insured as a policy owner if the original policy owner has died;
- changing the unclaimed moneys process to require ASIC to pay claimants directly;
- modernising evidentiary requirements (including removing advertising requirements) from papers to electronic form for lost policies; and
- changing the signature requirements for voiding of war exclusions.[68]

Committee view

2.82 The committee notes that some of the proposals for red tape reduction put forward by the Financial Services Council were received later in the inquiry and are of a very substantial nature.

2.83 For example, the committee considers that the proposal to allow life insurers to mortgage the assets held in their statutory funds and invest those funds in geared entities appears to be a potentially high-risk proposition that requires serious discussion. The committee would be keen to hear from the Australian Prudential Regulation Authority on this matter.

2.84 Given these proposals from the Financial Services Council were received later in the inquiry, the committee did not have an opportunity to hear the views of other submitters and witnesses with respect to these proposals. The committee is of the view that such matters need a proper airing during the course of an inquiry in a manner that allows the views of a range of stakeholders to be ascertained and weighed.

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68 Financial Services Council, *Additional information*, received 12 November 2017, pp. 1–13.

2.85 Nonetheless, the committee did raise the Financial Services Council's proposal to allow life insurers to mortgage the assets held in their statutory funds and invest those funds in geared entities with the Australian Prudential Regulation Authority (APRA). The committee thanks APRA for the clarity and promptness of its responses which it has published on the committee's website.[69]

2.86 As part of its response, APRA informed the committee that:

> APRA has prudential concerns with geared investments undertaken directly from a statutory fund by mortgaging the assets of the fund. Statutory funds are an important mechanism for policy owner protection, and they operate by ensuring that assets held by the life company for the purposes of undertaking life insurance business are segregated for the purpose of meeting policy owner claims. The prohibition on mortgaging statutory fund assets is a fundamental part of a comprehensive regime regarding the management of statutory funds, along with other legislative provisions prohibiting reinsurance between funds, regulating how assets enter and leave the statutory fund, specifying the order in which assets are distributed in the event of the windup of an insurer and a range of other related matters. Allowing mortgaging of assets of the statutory fund risks weakening the policy owner preference afforded by the statutory fund as it provides the mortgagor with a claim on certain assets of the fund in preference to the protections and statutory priority afforded to policy owners.[70]

2.87 While the committee would likely endorse some of the more straight-forward measures proposed by the Financial Services Council, nevertheless, given the gravity of the response from APRA, the committee considers that the government should not progress any reforms on these matters until an appropriate inquiry or consultation process has been undertaken.

2.88 Finally, the committee notes that it retains the ability to monitor further developments in this area through its ASIC Oversight process.

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69 Parliamentary Joint Committee on Corporations and Financial Services, Inquiry into the life insurance industry, answers to questions on notice, numbers 59 and 61, https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Corporations_and_Financial_Services/LifeInsurance/Additional_Documents.

70 Australian Prudential Regulation Authority, Answers to questions on notice, 4 December 2017 (received 8 December 2017).

Chapter 3
Consumer protections

Introduction

3.1 The aim of consumer protections is to protect Australian consumers under a national law by ensuring that consumers have the same protections, and businesses have the same obligations and responsibilities, across Australia. However, as the evidence in this chapter illustrates, life insurance is currently exempt from several consumer protections.

3.2 This chapter begins by summarising the Australian Consumer Law (ACL) and its application to financial services. The chapter then examines the consumer protections that apply to life insurance and compares those protections to the ACL. A substantial list of exemptions is identified and some significant exemptions are discussed in detail to provide examples of the potential for reform. The proposed product design and distribution obligations and ASIC's product intervention powers, and the Banking Executive Accountability Regime (BEAR), are also considered.

3.3 Given that this chapter focusses on legislated consumer protections, the Life Insurance Code of Practice is discussed separately in chapter 4.

Australian Consumer Law

3.4 The ACL is a national consumer law in effect from 1 January 2011, covering:

- a national unconscionable conduct and unfair contract terms law covering standard form consumer and small business contracts;
- a national law guaranteeing consumer rights when buying goods and services;
- a national product safety law and enforcement system;
- a national law for unsolicited consumer agreements covering door-to-door and telephone sales;
- simple national rules for lay-by agreements; and
- penalties, enforcement powers and consumer redress options.[1]

3.5 The ACL is split across different Acts and regulators depending on the type of product or service that is being offered. The regulators for the ACL are:

- the Australian Competition and Consumer Commission (ACCC), in respect of conduct engaged in by corporations, and conduct involving the use of postal, telephonic and internet services under the *Competition and Consumer Act 2010* (Competition and Consumer Act);

1 Commonwealth of Australia, *The Australian Consumer Law*, http://consumerlaw.gov.au/the-australian-consumer-law/ (accessed 24 July 2017).

- state and territory consumer protection agencies, in respect of conduct engaged in by persons carrying on a business in, or connected with, the respective state or territory; and
- the Australian Securities and Investment Commission (ASIC) in relation to financial products and services under the *Australian Securities and Investments Commission 2001* (ASIC Act).[2]

Productivity Commission consideration of life insurance and the ACL

3.6 In 2008, the Productivity Commission considered whether consumer protections for financial services in the ASIC Act should be exempt from the generic provisions of the ACL.[3] The Productivity Commission stated that 'statutory carve outs of this nature can potentially provide unscrupulous operators with opportunities to make minor changes to their activities so as to slip between the regulatory cracks. To avoid this, there should be no exclusions of particular sectors from the new national generic consumer law.'[4]

3.7 The Productivity Commission considered that there was a strong underlying rationale for consumer law to encompass all sectors. The 2008 report recommended that the generic consumer law should apply to all consumer transactions, including financial services, with ASIC to remain the primary regulator.[5]

3.8 In its 2017 review of the ACL, Consumer Affairs Australia and New Zealand stated that a key strength of the ACL is its generic nature, applying across all sectors of the economy. Consumer Affairs Australia and New Zealand suggested that exemptions in the ASIC Act should be reviewed, with a view to removing those that are no longer in the public interest, particularly given the objective of providing a generic, economy-wide law. The review noted that:

> The ACL contains a number of exemptions, many of which were carried over from the former Trade Practices Act. CAANZ [Consumer Affairs Australia and New Zealand] considers that exemptions in the ACL risk undermining the benefits of a nationally consistent approach to consumer protection.
>
> CAANZ [is] proposing to extend the unconscionable conduct protections to publicly-listed companies and apply the unfair contract terms protections to standard form insurance contracts.[6]

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2 Australian Competition and Consumer Commission, *Unfair contract terms: A guide for business and legal practitioners*, March 2016, p. 6.

3 Productivity Commission, *Consumer Law Enforcement and Administration*, March 2017, pp. 32, 44.

4 Productivity Commission, *Review of Australia's Consumer Policy Framework*, April 2008, p. 24.

5 Productivity Commission, *Consumer Law Enforcement and Administration*, March 2017, pp. 32, 44.

6 Consumer Affairs Australia and New Zealand, *Australian Consumer Law Reform*, March 2017, pp. 72, 77, 98.

Life insurance consumer protections

3.9 This section summarises the consumer protections that currently apply to life insurance (the duty to act in utmost good faith) as well as those that are due to come into operation in 2018 (the FOFA conflicted remuneration provisions). The main protections that apply to life insurance are listed in Table 3.1.

Table 3.1: Life insurance consumer protections

Consumer Protections	**Non-financial services under the** *Competition and Consumer Act 2010*	**Financial services**	**Life insurance**
The duty of the utmost good faith	N/A	N/A	*Insurance Contracts Act 1984* Section 13 applies to each party
Insurers may not refuse to pay claims in certain circumstances	N/A	N/A	*Insurance Contracts Act 1984* Section 54
Remedies	N/A	N/A	*Insurance Contracts Act 1984* Sections 54-56
Pre 1/1/11 federal, state, territory laws	N/A (The former Trade Practices Act contained similar consumer protection provisions to those in the CC Act).	The ASIC Act contained consumer protection provisions predating the commencement of the CC Act.	*Insurance Contracts Act 1984* provisions dealing with the duty of utmost good faith that predated the *Competition and Consumer Act 2010* were amended in 2013.
Information Standards	Part 3-4: The Minister may set information standards.	Product Disclosure Statement requirements are contained in the Corporations Act and the National Consumer Credit Protection Act.	Product Disclosure Statement requirements under the Corporations Act.
FOFA and Conflicted Remuneration			From 1 January 2018, commission caps introduced over three years.

Source: Australian Securities and Investments Commission, *Submission 45*, p. 31; Australian Securities and Investments Commission, answers to question on notice, 4 August 2017 (received 4 December 2017).

Duty to act in the utmost good faith

3.10 Section 13 of the *Insurance Contracts Act 1984* (Insurance Contracts Act) requires each party to act towards the other party, in respect of any matter arising, with the utmost good faith.[7]

3.11 The ACL Review Final Report of March 2017 concluded that the duty to act in utmost good faith provided less consumer protection than that provided by ACL.[8]

3.12 In addition, ASIC's ability to commence proceedings under the Insurance Contracts Act is more restricted than for other consumer protection provisions. ASIC is limited to representative proceedings under the Insurance Contracts Act, intervening in existing proceedings, or taking licensing action under the Corporations Act.[9]

3.13 Furthermore, ASIC is not able to seek civil penalties for a breach of the duty of utmost good faith. A review of penalties is currently being considered by the government-established ASIC Enforcement Review Taskforce. ASIC has proposed that the government consider amending the sanctions regime that applies to life insurance in order to deter poor conduct by life insurers by:

- allowing civil penalties for breaches of the utmost good faith duty; and
- aligning penalties for directors of life insurance companies with the civil and criminal penalties that apply to directors of managed investment schemes.[10]

3.14 Further evidence received by the committee comparing the effectiveness of the duty of utmost good faith to unfair contract terms laws is discussed in the later section on unfair contract terms.

FOFA

3.15 The Future of Financial Advice (FOFA) reforms (Part 7.7A of the Corporations Act) include conduct obligations for the giving of personal advice to retail clients, and obligations to act in the best interests of the client, and to prioritise the interests of the client ahead of those of the advice provider. The FOFA reforms also included a ban on conflicted remuneration structures including commissions and

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7 *Insurance Contracts Act 1984*, Section 13.

8 Consumer Affairs Australia and New Zealand, *Australian Consumer Law Review*, March 2017, p. 53.

9 Australian Securities and Investments Commission, answers to questions on notice, 4 August 2017 (received 4 December 2017).

10 Australian Securities and Investments Commission, *Report 498: Life insurance claims: An industry review*, October 2016, p. 100; ASIC Enforcement Review Taskforce, Position Paper 7, *Strengthening Penalties for Corporate and Financial Sector Misconduct*, 23 October 2017, p. 70.

volume based payments. When they were originally introduced, however, the FOFA reforms excluded any bans on conflicted remuneration in relation to life insurance.[11]

3.16 However, from 1 January 2018, benefits will no longer be exempt, although the commission caps and clawback arrangements will be introduced over a three year transition period as discussed in chapter 5.[12]

Life insurance exemptions from consumer protections

3.17 A range of consumer protections apply to financial services. This section summarises the consumer protections from which the life insurance industry is currently exempted. The consumer protections that apply to financial services and from which the life insurance industry is exempted are listed in Table 3.2.

3.18 Table 3.2 also indicates equivalent or related consumer protections under the *Competition and Consumer Act 2010* that apply to non-financial services.

Section 15 of the Insurance Contracts Act 1984

3.19 Some of the most significant exemptions from consumer protections in the life insurance industry arise from section 15 of the Insurance Contracts Act. The explanatory memorandum to the Trade Practices Amendment (Australian Consumer Law) Bill (No. 2) 2010 set out the way in which insurance contracts are exempted from the operation of various consumer protections under the ACL:

> Section 15 of the *Insurance Contracts Act 1984* provides that a contract of insurance (as defined by that Act) is not capable of being made the subject of relief under any other Commonwealth Act, a State Act or an Act or Ordinance of a Territory. In this context 'relief' means relief in the form of:
>
> - the judicial review of a contract on the ground that it is harsh, oppressive, unconscionable, unjust, unfair or inequitable; or
> - relief for insureds from the consequences in law of making a misrepresentation,
>
> but does not include relief in the form of compensatory damages. The effect of section 15 is to mean that the unfair contract terms provisions of either the ACL or the ASIC Act do not apply to contracts of insurance covered by the *Insurance Contracts Act 1984*, to the extent that that Act applies.[13]

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11 Australian Securities and Investments Commission, answers to questions on notice, 21 August 2017 (received 8 September 2017); Australian Securities and Investments Commission, *FOFA—Background and implementation*, http://asic.gov.au/regulatory-resources/financial-services/future-of-financial-advice-reforms/fofa-background-and-implementation/ (accessed 8 November 2017).

12 Australian Securities and Investments Commission, answers to questions on notice, 21 August 2017 (received 8 September 2017).

13 Explanatory Memorandum, Trade Practices Amendment (Australian Consumer Law) Bill (No. 2) 2010, pp. 31–32.

Table 3.2: Consumer protections and exclusions for the life insurance industry

Protection	Consumer protections for non-financial services under the *Competition and Consumer Act 2010*	Consumer protections for financial services	Consumer protections for life insurance
Misleading or deceptive conduct	Part 2-1:	ASIC Act: Section 12DA: Misleading or deceptive conduct, including representations.	Excluded by section 15 of the *Insurance Contracts Act 1984.*
Unconsionable conduct	Part 2-2:	ASIC Act: Section 12CA – 12CC: Unconscionable conduct within the meaning of the unwritten law and also in connection with financial services. Conduct may be unconscionable if it is particularly harsh or oppressive, and is beyond hard commercial bargaining.	Excluded by section 15 of the *Insurance Contracts Act 1984*.
Unfair contract terms	Part 2-3: Standard form consumer and small business contracts.	ASIC Act: Section 12BF – 12BM: Standard form consumer and small business contracts.	Excluded by section 15 of the *Insurance Contracts Act 1984*.
Unfair practices	Part 3-1: False or misleading practices, unsolicited supplies, pyramid schemes, pricing.	ASIC Act: Section 12BB, 12DB – 12DM: False or misleading representations, pricing, rebates, bait advertising, referral selling, accepting payment without supply, harassment or coercion, pyramid selling, unsolicited supplies.	Excluded by section 15 of the *Insurance Contracts Act 1984*.
Unsolicited consumer agreements	Part 3-2: Relevant types of agreement are prescribed in regulations.	Sections 736, 992A and 992AA of the Corporations Act regulate the hawking of financial products.	There are limited exclusions in relation to certain insurance products under regulation 7.8.24 of the Corporations Regulations

Guarantees and warranties	Part 3-2: Guarantees consumer rights when buying goods and services.	Section 12ED: Warranties in relation to the supply of financial services that will be rendered with due care and skill and be fit for purpose. There is no warranty that financial services will be supplied within a reasonable time, although protection is provided by section 12DI of the ASIC Act.	Excluded by subsection 63(b) of the CC Act and subsection 12ED(3) of the ASIC Act.
Claims handling exemption	N/A	N/A	Excluded by Corporations regulations 7.1.33 (discussed in chapter 7)
Corporations Act Chapter 7	N/A	Protections on informed consumer about financial products and fairness, honesty and professionalism of providers	Section 765A of the Corporations Act, excludes insurance contracts and life policies that are not contracts.
Dollar disclosure	N/A	Section 947B – 947D set out what information is required in statements of advice. Section 1013D sets out what information is required in product disclosure statements.	Instrument 2016/767 provides exemptions for the life insurance industry from disclosing dollar amounts for costs, fees, charges, expenses, benefits and interests.
Product design distribution and intervention power	N/A	Proposed powers for ASIC to proactively intervene where it identifies significant consumer detriment.	Treasury's proposals paper appears to propose to exempt distributors who provide personal advice.
National Consumer Protection Act 2009			Lenders are not required to provide life insurance rebates to businesses that pay loans off early.

Source: Australian Securities and Investments Commission, *Submission 45*, p. 31; Australian Securities and Investments Commission, answers to question on notice, 4 August 2017 (received 4 December 2017); Treasury, answers to question on notice, 22 August 2017 (received 6 September 2017); Treasury Proposals Paper, *Design and Distribution Obligations and Product Interventions Power*, December 2016, p. 3.

3.20 Although the wording has varied over the time, the central aspects of section 15 which exclude relief in respect of harsh, oppressive, unconscionable, unjust, unfair or inequitable contracts have been in the Insurance Contracts Act since it came into effect in 1984.[14]

3.21 The introductory remarks on operating fairly in the first version of the Insurance Contracts Act state that it was:

> 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 the practices of insurers in relation to such contracts, operate fairly, and for related purposes.[15]

3.22 The explanatory memorandum for the bill which led to the Insurance Contracts Act argued that the duty to act in good faith meant that other consumer protections were not necessary:

> In view of the Bill's clear statement of the duty of good faith, a general power to review its terms is unnecessary. Furthermore, it is appropriate that there should be no question whether the Bill or State legislation or other Commonwealth legislation applies in a particular case and so no room for lengthy disputes as to which should apply.[16]

Unfair contract terms

3.23 Unfair Contract Terms (UCT) laws apply to standard form consumer contracts. A standard form contract will typically be one prepared by one party to the contract and not negotiated between the parties—it is offered on a 'take it or leave it' basis. The ASIC Act defines 'consumer contract' as follows:

> A consumer contract is a contract at least one of the parties to which is an individual whose acquisition of what is supplied under the contract is wholly or predominantly an acquisition for personal, domestic or household use or consumption.[17]

3.24 A term of a consumer contract is unfair if it:

- would cause a significant imbalance in the parties' rights and obligations arising under the contract;
- is not reasonably necessary to protect the legitimate interests of the party who would be advantaged by the term; and

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14 *Insurance Contracts Act 1984*, Act No. 80 of 1984.

15 *Insurance Contracts Act 1984*, Act No. 80 of 1984.

16 Insurance Contract Bill 1984, *Explanatory memorandum*, 1983–1984, p. 25.

17 Australian Competition and Consumer Commission, *Unfair contract terms: A guide for business and legal practitioners*, March 2016, pp. 7–8; *Australian Securities and Investments Commission Act 2001*, subsection 12BF(3).

- would cause detriment to a party if it were to be applied or relied on.[18]

3.25 The following actions can be pursued in relation to unfair contract terms:

- A court can declare a term of a standard form consumer contract to be unfair. Once a term is declared to be unfair, it will be void. However, the remainder of the contract will continue to apply, if it can continue without the void term.
- Individuals can apply to a court to have a term of a standard form contract they entered into declared unfair and accordingly, void.
- ASIC can also apply to have a term of a particular standard form contract declared unfair.
- The law does not impose a pecuniary penalty on a business that includes or seeks to rely on an unfair contract term. However, consumers can seek redress for any loss that is incurred as a result of a term of a standard form contract that is declared to be unfair.[19]

3.26 Some indication of the potential extent to which unfair terms may permeate contracts can be gained from the work that the ACCC has done in other industries. In 2013, the ACCC completed a review of the unfair contract terms in the airlines, telecommunications, fitness and vehicle rental industries, as well as some contracts commonly used by online traders. Following the review, 79 per cent of unfair terms were removed from standard form contracts following the ACCC finding that the following unfair terms were in standard form contracts:

> 1. Contract terms that allow the business to change the contract without consent from the consumer.
>
> 2. Terms that cause confusion about the agency arrangements that apply and that seek to unfairly absolve the agent from liability.
>
> 3. Terms that unfairly restrict the consumer's right to terminate the contract.
>
> 4. Terms that suspend or terminate the services being provided to the consumer under the contract.
>
> 5. Terms that make the consumer liable for things that would ordinarily be outside of their control.
>
> 6. Terms that prevent the consumer from relying on representations made by the business or its agents.
>
> 7. Terms seeking to limit consumer guarantee rights.

18 Australian Competition and Consumer Commission, *Unfair contract terms: A guide for business and legal practitioners*, March 2016, p. 11.

19 Australian Securities and Investments Commission, *Unfair contract terms for consumers*, http://asic.gov.au/about-asic/what-we-do/laws-we-administer/unfair-contract-terms-law/unfair-contract-term-protections-for-consumers/ (accessed 30 January 2018).

8. Terms that remove a consumer's credit card chargeback rights when buying the service through an agent.[20]

3.27 The committee also notes that, following the passage of unfair contract terms legislation for small business loans, major banks have reviewed those contracts and removed unfair contract terms.[21]

3.28 The ACCC has identified significant inconsistencies in the way that unfair contract terms legislation applies. For example, life insurance is covered by the Insurance Contracts Act and is therefore exempted from the unfair contract terms legislation. By contrast, private health insurance, state and Commonwealth government insurance, and re-insurance are not regulated by the Insurance Contracts Act and are therefore subject to the unfair contract terms laws.[22]

3.29 Divergent views were put to the committee about the proposal to subject the life insurance industry to the application of unfair contract terms. Broadly speaking, regulators and consumer groups were very much in favour of moves to apply unfair contract terms to life insurance, while the life insurance industry was, at best, somewhat reticent about such moves.

3.30 However, even amongst industry participants, the committee received different perspectives from life insurance companies and the Financial Services Council (FSC). For example, the FSC argued that there would be greater consumer benefit in amending the Life Insurance Code of Practice rather than extending unfair contract terms legislation or intervention powers.[23]

3.31 By contrast, some life insurance companies acknowledged that they were now generally supportive of subjecting life insurance contracts to some form of unfair contracts terms, while also noting that this would not be a straightforward matter. For example, ANZ indicated that, while it supported the extension of unfair contract terms laws to life insurance, it was of the view that consumer protections should be framed as an extension of the existing duty of utmost good faith rather than applying the current unfair contract terms laws to life insurance. ANZ gave the following reasons for this view:

- there are a number of existing consumer provisions in the *Insurance Contracts Act 1984*;
- there is inconsistency in the unfair terms provisions in the Competition and Consumer Act and the ASIC Act;

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20 Australian Competition and Consumer Commission, *Unfair contract terms Industry review outcomes*, March 2013, p. 1.

21 Australian Securities and Investments Commission, *17-278MR Big four banks change loan contracts to eliminate unfair contract terms*, 24 August 2017, http://asic.gov.au/about-asic/media-centre/find-a-media-release/2017-releases/17-278mr-big-four-banks-change-loan-contracts-to-eliminate-unfair-terms/ (accessed 8 November 2017).

22 Australian Competition and Consumer Commission, *Unfair contract terms: A guide for business and legal practitioners*, March 2016, pp. 9–10.

23 Financial Services Council, *Submission 26.1*, pp. 14–15.

- the 'subject matter' of a contract of insurance will be very different to the 'subject matter' of many standard form consumer contracts; and
- reasonable exclusions of cover which have been disclosed to consumers at the time they enter into the contract of insurance should either specifically fall within the 'subject matter' of the contract, or otherwise be exempt from the operation of the new law.[24]

3.32 ANZ also argued that the life insurance industry would need sufficient time to amend existing policies to ensure that they do not contain unfair terms.[25]

3.33 Mr Nicholas Scofield from Allianz Australia Insurance acknowledged that there were different views within the industry over the application of unfair contract terms to the life insurance industry. He noted that while the Insurance Council had come to the view that it wanted to 'work on the application of unfair contract terms to general insurance', he was of the view that there were particular challenges in achieving this. Mr Scofield indicated that, in his view, there was significant uncertainty as to what the 'subject matter' of a life insurance contract actually was, and that this may differ significantly from that for general insurance and other goods and services. Nevertheless, Mr Scofield said that Allianz was willing to work constructively with government and other stakeholders to address these matters.[26]

3.34 ASIC observed that the life insurance industry had argued against extending unfair contract terms to life insurance. ASIC acknowledged that there were issues that would need to be overcome in applying unfair contract terms to life insurance. However, ASIC supported extending unfair contract legislation to life insurance and was of the view that these challenges could be overcome and that the application of unfair contract terms to life insurance would be an important addition to the protections available for consumers.[27]

3.35 ASIC explained that the introduction of unfair contract terms was complicated by the fact that life insurance premiums are calculated on the actuarial risk that is assumed by the life insurer. In other words, it cannot necessarily be assumed that a contract that covers certain risks while excluding others is unfair because it may have been designed in that way in order to be able to offer it at a much lower price than a contract without the exclusions.[28]

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24 ANZ, *Submission 44.1*, pp. 1–2.

25 ANZ, *Submission 44.1*, p. 2.

26 Mr Nicholas Scofield, General Manager, Corporate Affairs, Allianz Australia Insurance, *Committee Hansard*, 18 August 2017, pp. 37–38.

27 Mr Michael Saadat, Senior Executive Leader, Deposit Takers, Credit and Insurers; Regional Commissioner, New South Wales, Australian Securities and Investments Commission, *Committee Hansard*, 8 September 2017, p. 39.

28 Mr Michael Saadat, Senior Executive Leader, Deposit Takers, Credit and Insurers; Regional Commissioner, New South Wales, Australian Securities and Investments Commission, *Committee Hansard*, 8 September 2017, p. 39.

3.36 Mr Nick Kirwan, Policy Manager at the FSC, drew the committee's attention to the difficulties experienced in the United Kingdom (UK) when unfair contract term provisions had been applied to life insurance. Specifically, the courts in the UK found that if one party was able to vary a contract (that is, increase the premium), then the other party had to have the right to cancel. The courts' interpretation was that the consumer had the right to cancel without a penalty. In addition, the court also decided that 'if the person's health had changed and they'd had a life insurance policy which they cancelled, they were suffering a penalty because they wouldn't be able to replace that insurance again'. Mr Kirwan was therefore of the view that if the government were to legislate for the removal of unfair contract terms from life insurance policies, the legislation would need to consider the UK experience and ensure that it does not result in significant premium increases.[29]

3.37 The committee notes that this has resulted in life insurance policies in the UK now being offered with fixed premiums with terms of only up to 10 years. This experience may necessitate specific life insurance provisions deeming unilateral premium adjustments by an insurer be 'fair' for the purposes of unfair contract term provisions where clear motive is given to the insured that premiums may increase and how.

3.38 However, Mr Peter Kell, Deputy Chairman of ASIC, explained that the unfair contract terms provisions already require certain tests to be satisfied to take into account the particular requirements of the life insurance industry:

> …it's a three-part test. One of the key elements of that test, for any industry sector, is the term 'necessary' from a business perspective, if you like. So there is the opportunity within the UCT [unfair contract terms] provisions, as they are currently constructed, to take into account particular issues within different sectors. That's one of the reasons we think it can and should be extended to insurance, and that it won't be an insurmountable problem to offer that additional level of protection.[30]

3.39 Several submitters and witnesses strongly disagreed with the arguments put forward by the life insurance industry about the duty of utmost good faith obviating the need for unfair contract terms to apply to life insurance. For example, the Financial Rights Legal Centre informed the committee that it has long been the view of consumer advocates that there is no sound reason to exempt the insurance industry from the unfair contract terms protections. The Financial Rights Legal Centre argued that the duty of utmost good faith had not prevented the use of unfair terms in insurance contracts and did not provide consumers with a remedy against their use:

> 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*

29 Mr Nick Kirwan, Policy Manager, The Financial Services Council, *Committee Hansard*, 1 December 2017, p. 25–27.

30 Mr Peter Kell, Deputy Chairman, Australian Securities and Investments Commission, *Committee Hansard*, 8 September 2017, p. 40.

> *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. 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.[31]

3.40 Similarly, CHOICE pointed out that the duty of utmost good faith was legally uncertain and had not prevented the spread of unfair terms in insurance contracts:

> The insurance industry has claimed that the duty to act in the utmost good faith under the *Insurance Contracts Act 1984* is sufficient protection for consumers and that an UCT prohibition is not required. The utmost good faith clause in the Insurance Contracts Act is unclear and jurisprudence is imprecise. This makes application of the law particularly difficult. The leading High Court case notes utmost good faith is more commonly applied in relation to requirements of honesty in the dealings and processes around the contract. This does not go to the fairness of particular terms to a contract. To date, the utmost duty of good faith has not put an end to the types of clauses outlined above.[32]

3.41 The Financial Rights Legal Centre argued that subjecting general and life insurance contracts to the unfair contract terms regime would have significant benefits including greater transparency and fairness for consumers, as well as allowing for the provision of 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.[33]

3.42 Likewise, CHOICE stated that, compared to the imprecision of the requirement to act in utmost good faith, the unfair contract terms provisions were clear, precise, and balanced and should be seen as best practice:

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31 Financial Rights Legal Centre, *Submission 17*, p. 21.

32 CHOICE, *Submission 49*, p. 14.

33 Financial Rights Legal Centre, *Submission 17*, p. 24.

> The UCT obligations are very clear; the legislation even provides an extensive list of the types of terms which would be considered unfair. This is a far cry from the amorphous 'utmost good faith' requirements. The UCT obligations are so clear that the Australian Competition and Consumer Commission and consumer organisations have used the laws to engage directly with businesses around removing unfair terms. This has seen many businesses voluntarily improve their terms. With limitations on regulator budgets and the cost of litigation for business compliance, the UCT provisions should be viewed as balanced best practice regulation.[34]

3.43 CHOICE also argued that there are actually much stronger arguments to apply unfair contract terms protections in insurance, and particularly life insurance, than in many other goods and services where they already apply. CHOICE considered that unfair contract terms goes to the heart of some of the cultural problems in the insurance industry in terms of appropriate conduct and the treatment of consumers. In CHOICE's view there are strong economic arguments for actually having consistent law that applies across product and service markets. Furthermore, CHOICE noted that unfair contract terms have been reviewed several times by government agencies and there have been multiple recommendations to remove the exemptions for the life insurance industry.[35]

3.44 The Consumer Action Law Centre informed the committee that it considers that there is no sound reason to carve out the insurance industry from these otherwise economy-wide provisions.[36]

3.45 In 2008, the Productivity Commission's review of Australia's consumer policy framework recommended a prohibition on unfair contract terms in standard form contracts and argued for a single, generic consumer law to apply across all sectors of the economy finding 'little reason for any variation' in its content.[37]

3.46 In 2012, the then Commonwealth 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 was referred to the committee.[38] However, the bill and the inquiry lapsed when the House of Representatives was dissolved in August 2013.

3.47 The Senate Economics References Committee also identified concerns with exemptions for the general insurance industry from consumer protections and specifically laws on unfair contract terms. That committee recommended removing the exemption following its conclusion that:

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34 CHOICE, *Submission 49*, p. 15.

35 Mr Alan Kirkland, Chief Executive Officer, CHOICE, *Committee Hansard*, 24 February 2017, p. 15.

36 Consumer Action Law Centre, *Submission 27*, p. 4.

37 Productivity Commission, *Review of Australia's Consumer Protection Policy Framework*, Inquiry Report No 45, 2008, Vol 2, pp. 58–61, 327.

38 Financial Rights Legal Centre, *Submission 17*, p. 23.

> General insurance plays an important role in maintaining the financial stability of consumers, and indeed, of the Australian economy. Given this, effective protections are essential during all stages of a consumer's relationship with an insurer. The committee is of the view that the exemption of general insurers from the unfair contract terms provisions…is unwarranted and creates a significant gap in consumer protections.[39]

3.48 As part of the consideration of life insurance policy reform (including proposals to make insurance contracts subject to the unfair contracts provisions), ASIC drew attention to the penalty provisions for breaches of the duty of utmost good faith which it considered to be inadequate at present.[40]

3.49 Consumer Affairs Australia and New Zealand has recently conducted a wide-ranging review of the ACL. Treasury advised that following the review findings, there was support amongst consumer affairs ministers to remove the exemption from the application of unfair contract terms laws currently enjoyed by the life insurance industry:

> While it has been argued that the duty of utmost good faith provides equivalent consumer protections to UCT provisions, a number of stakeholders have disagreed. Most recently, the final report of the Australian Consumer Law Review, released in March 2017, has proposed that this exemption be removed on the basis that this equivalence has not been demonstrated.
>
> Consumer affairs ministers considered the report on 31 August 2017 and supported the proposal to remove the exemption.[41]

3.50 Treasury informed the committee that it was now starting to look at unfair contract terms laws for life insurance with a view of providing advice to the minister.[42]

Product design and distribution obligations and product intervention powers

3.51 ASIC advised the committee that Australia's approach to the regulation of financial services in recent years has placed a heavy emphasis on product disclosure.[43] Mr John Price, ASIC Commissioner, told the committee that the emphasis on product

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39 Senate Economics References Committee, *Australia's general insurance industry*, August 2017, pp. ix–xi.

40 Mr Peter Kell, Deputy Chairman, Australian Securities and Investments Commission, *Committee Hansard*, 8 September 2017, p. 38.

41 Treasury, Answers to questions on notice, 22 August 2017 (received 6 September 2017).

42 Mr James Kelly, Principal Adviser, Financial Systems Division, *Committee Hansard*, 8 September 2017, p. 63.

43 Mr John Price, Commissioner, Australian Securities and Investments Commission, *Committee Hansard*, 16 June 2017, pp. 11.

disclosure assumed, perhaps somewhat optimistically, that the investor will be able to read the disclosure and understand it and will act rationally.[44]

3.52 However, there has been an acknowledgement that this light-touch approach may need to be augmented by further regulation. For example, one of ASIC's great concerns has been the lack of accountability around products that have been manufactured and marketed to groups of individuals for whom they are unsuited. In this regard, ASIC advised the committee that it was particularly pleased to see that the Financial System Inquiry (FSI) had recommended both product governance obligations and a product intervention power for ASIC.[45]

3.53 ASIC's submission noted that the FSI had concluded that the current disclosure arrangements were not sufficient to deliver fair treatment to consumers. The FSI therefore proposed the following reforms to the financial services sector:

- increase the obligations of product issuers and distributors to act in the interest of consumers by introducing a targeted and principles-based product design and distribution obligation, a serious breach of which would be subject to a significant penalty;
- provide ASIC with a product intervention power that would enable ASIC to modify or, if necessary, ban harmful financial products where there is a risk of significant consumer detriment; and
- review ASIC's penalties and powers to ensure that the enforcement regime provides a credible deterrent for poor behaviour and breaches of financial services laws (for example, giving ASIC greater ability to ban individuals from the management of financial services firms).[46]

3.54 Following the FSI conclusion that further measures were needed to ensure that consumer outcomes aligned with commercial incentives throughout the whole financial product lifecycle, Treasury instituted a consultation process on product design and distribution obligations and product intervention powers.[47]

3.55 Treasury categorised its approach to protecting financial consumers as an evolution that had moved from empowering consumers through disclosure to one where disclosure is supplemented by making financial service providers more accountable. Noting that the FOFA legislation already bans financial advisers from receiving some benefits that could conflict with advice (conflicted remuneration), the additional proposed measures include:

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44 Mr John Price, Commissioner, Australian Securities and Investments Commission, *Committee Hansard*, 16 June 2017, p. 13.

45 Mr John Price, Commissioner, Australian Securities and Investments Commission, *Committee Hansard*, 16 June 2017, pp. 11–12.

46 Australian Securities and Investments Commission, *Submission 45*, pp. 25–26.

47 Treasury Proposals Paper, *Design and Distribution Obligations and Product Interventions Power*, December 2016, p. 3.

- products to be targeted at consumers based on the ability of the product to meet consumer needs (design and distribution obligations); and
- powers for ASIC to proactively intervene where it identifies significant consumer detriment (product intervention power).[48]

3.56 The Treasury proposals paper indicated that distributors that provide personal advice will be excluded from the distributor obligations. Importantly, Treasury also indicated that the intervention power would not extend to remuneration of distributors selling products.[49]

3.57 In evidence to the committee, Mr Peter Kell, Deputy Chairman of ASIC was firmly of the view that the proposed laws would be improved by:

- extending the coverage of financial products to include funeral insurance;
- giving ASIC the ability to make interventions in relation to remuneration; and
- increasing the 18 month timeframe for which interventions can apply.[50]

3.58 Mr Greg Medcraft, then Chairman of ASIC, reinforced the point made by Mr Kell that remuneration is a critical part of the whole process because the incentives embedded in remuneration can influence the way that products are distributed and sold. Mr Medcraft suggested that it was therefore essential that ASIC's intervention powers include the ability to intervene with respect to remuneration.[51]

3.59 Mr Kell also pointed out a further benefit of the product intervention power, namely that it would assist industry sectors in removing unethical practices by relieving those participants with good intentions from the problem of losing market share by being the first to move.[52]

3.60 Consumer rights groups strongly supported the proposed changes. For example, the Consumer Action Law Centre submitted that it supports the implementation of the product design and intervention powers.[53]

3.61 The Financial Rights Legal Centre supported the proposed product design and intervention powers and argued that they should be put in place without exemptions:

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48 Treasury Proposals Paper, *Design and Distribution Obligations and Product Interventions Power*, December 2016, p. 3.

49 Treasury Proposals Paper, *Design and Distribution Obligations and Product Interventions Power*, December 2016, pp. 4, 31.

50 Mr Peter Kell, Deputy Chairman, Australian Securities and Investments Commission, *Committee Hansard*, 16 June 2017, p. 13.

51 Mr Greg Medcraft, Chairman, Australian Securities and Investments Commission, *Committee Hansard*, 16 June 2017, pp. 13–14.

52 Mr Peter Kell, Deputy Chairman, Australian Securities and Investments Commission, *Committee Hansard*, 16 June 2017, p. 14.

53 Consumer Action Law Centre, *Submission 27*, pp. 3–4.

> …exclusions are not justified and would limit 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 [product intervention powers] across the entirety of the financial products and services it regulates.[54]

3.62 The Financial Planning Association of Australia (FPA) supported the Financial System Inquiry recommendation on product intervention powers with the caveat that product intervention powers should not be used solely to rectify product disclosure. The FPA suggested that a limited form of merits regulation, along the lines of regulating for product safety, market integrity, and/or systemic stability, would be an appropriate use of product intervention powers. The FPA noted that a similar approach has been adopted by the European Union and the European Securities and Markets Authority.[55]

Corporations Act—Chapter 7—financial product exemptions

3.63 Section 765A of the Corporations Act provides that a range of products are not financial products for the purposes of Chapter 7 of the Corporations Act, including health insurance, insurance provided by the Commonwealth, states and territories, a contract for insurance, and a life policy that is not a contract.[56]

3.64 These financial product exemptions may limit ASIC's powers to enforce the object of Chapter 7 of the Corporations Act which is to promote:

> (a) confident and informed decision making by consumers of financial products and services while facilitating efficiency, flexibility and innovation in the provision of those products and services; and
>
> (b) fairness, honesty and professionalism by those who provide financial services; and
>
> (c) fair, orderly and transparent markets for financial products; and
>
> (d) the reduction of systemic risk and the provision of fair and effective services by clearing and settlement facilities.[57]

3.65 Consumer Affairs Australia and New Zealand suggested that it is not sufficiently clear in the drafting of the ASIC Act that its existing protections that mirror certain ACL protections apply to financial products as well as financial services. In light of this lack of clarity, Consumer Affairs Australia and New Zealand recommended that the ASIC Act be amended to clarify that all ACL-related consumer protections that already apply to financial services also apply to financial products.[58]

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54 Financial Rights Legal Centre, *Submission 17*, p. 33.

55 Financial Planning Association of Australia, *Submission 21*, pp 5–7.

56 *Corporations Act 2011*, s. 765A.

57 *Corporations Act 2011*, s. 760A.

58 Consumer Affairs Australia and New Zealand, *Australian Consumer Law Reform*, March 2017, pp. 6, 72.

Banking Executive Accountability Reform

3.66 In the 2017–18 budget, the government announced the proposed introduction of the Banking Executive Accountability Regime (BEAR). The BEAR aims to enhance the responsibility and accountability of banks and their directors and senior executives.[59]

3.67 The proposed legislation would empower APRA to more easily remove or disqualify directors and impose financial consequences on individuals and banks. The proposed measures would require banks to register individuals with APRA before appointing them as senior executives and directors. In July 2017 the government released a consultation paper on the proposed reforms.[60]

3.68 ASIC explained that the proposed BEAR addresses the prudential aspects of bank executives and directors conduct. Prudential matters are supervised by APRA. The BEAR does not cover conduct in relation to customers or shareholders, matters which are supervised by ASIC.[61]

3.69 By contrast, ASIC noted that the executive accountability regime in the United Kingdom covers conduct in relation to customers and shareholders issues as well as conduct in relation to prudential issues.[62]

3.70 ASIC also indicated that the current BEAR proposal is restricted to banks, whereas in the United Kingdom, the regime applies to financial services more generally.[63]

3.71 Mr Greg Medcraft, then Chairman of ASIC, acknowledged that while the BEAR legislation probably needed to start with the banks, it should then be broadened to include insurance companies.[64]

3.72 Mr Medcraft also expressed support for extending the application of the BEAR to conduct issues in addition to the proposed systemic prudential matters that the BEAR currently proposes to address. In this regard, Mr Medcraft argued that the most frequent issues that arise in financial services are conduct issues that affect consumers and investors rather than major systemic matters that have prudential consequences. Extending the BEAR to conduct issues would allow ASIC to take

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59 Treasury, Consultation paper, *Banking executive accountability regime*, 13 July 2017, pp. 1–2.

60 Treasury, Consultation paper, *Banking executive accountability regime*, 13 July 2017, pp. 1–4.

61 Mr Greg Medcraft, Chairman, Australian Securities and Investments Commission, *Committee Hansard*, 11 August 2017, pp. 29–30.

62 Mr Greg Medcraft, Chairman, Australian Securities and Investments Commission, *Committee Hansard*, 11 August 2017, pp. 29–30.

63 Mr Greg Medcraft, Chairman, Australian Securities and Investments Commission, *Committee Hansard*, 11 August 2017, p. 30.

64 Mr Greg Medcraft, Chairman, ASIC, Senate Economics Legislation, *Committee Hansard*, 26 October 2017, p. 9.

action against senior management on matters that had adversely affected consumers and investors.[65]

3.73 Treasury informed the committee that the proposed BEAR focuses on banks due to both the critical role that banks play in the economy and in response to community concern regarding recent poor behaviour by the banks.[66]

3.74 Treasury also explained that the scope of the BEAR is intended to include all entities within a group with an Authorised Deposit Taking Institution (ADI) parent. This would include subsidiaries of ADIs, including those that provide non-banking services and those that are foreign subsidiaries. The proposed scope would mean that the BEAR may apply in relation to a business such as a life or general insurer that is part of an ADI group or subgroup. Importantly, however, the BEAR would not apply to a life insurer that was not part of an ADI group or subgroup.[67]

3.75 On 24 November 2017, the Senate Economics Legislation Committee recommended that the BEAR legislation be passed with the implementation date to be extended to one year from the passage of the bill. That committee also argued that:

> Consumer protections are just as important as prudential matters in establishing and maintaining community trust in the financial sector. While the BEAR is a welcome and important start, the committee believes that, in time, heightened accountability obligations should be extended to non-ADI firms in the financial sector and also to matters that affect consumer outcomes (as has been done in the United Kingdom).[68]

Committee view

Consumer Protections

3.76 Evidence to the inquiry highlighted inconsistencies in consumer protections between the financial services sector and other sectors of the economy. Given the increasingly integrated nature of the economy and the bundling of products both within financial services and with non-financial services (such as loans for cars or houses), the committee considers that such inconsistencies create:

- barriers for consumers in understanding and asserting their rights; and
- unnecessary operating complexities and costs for business.

3.77 The committee notes that the 2008 Productivity Commission found a strong underlying rationale for a generic consumer law to encompass all sectors of the economy, including financial services. The committee endorses this view and

65 Mr Greg Medcraft, Chairman, ASIC, Senate Economics Legislation, *Committee Hansard*, 26 October 2017, p. 9.

66 Treasury, answers to questions on notice, 22 August 2017 (received 6 September 2017).

67 Treasury, answers to questions on notice, 22 August 2017 (received 6 September 2017).

68 Senate Economics Legislation Committee, *Treasury Laws Amendment (Banking Executive Accountability and Related Measures) Bill 2017 [Provisions]*, November 2017, p. 29.

considers that it is in the interests of both consumers and businesses for consumer protections in relation to financial and non-financial services to be aligned.

3.78 More specifically, the committee also notes that consumer protections are not harmonised across financial services including life insurance. In addition to the impacts on consumers' rights and regulatory burdens on business discussed above, such inconsistent applications of the consumer protection law also create inappropriate incentives for industry participants that are subject to weaker consumer protections. The committee considers that financial products, including life insurance, that are sold together or in product bundles should all be subject to harmonised consumer protections. The committee is therefore recommending that consumer protections apply consistently to all financial services and products.

3.79 The committee is particularly concerned that consumer protections in relation to life insurance are grossly inadequate due to the very large number of exemptions, some of which are summarised in Table 3.2.

3.80 A glaring example of the lack of adequate consumer protections is Section 15 of the Insurance Contracts Act which rules out judicial review of contracts which are harsh, oppressive, unconscionable, unjust, unfair or inequitable. This appears to leave an enormous gap in consumer protections for an industry as large as life insurance that has performed poorly in protecting consumers.

3.81 Furthermore, the symmetrical nature of the good faith duty is incompatible with the highly asymmetrical nature of the relationship between an individual or small business dealing with large powerful life insurance companies.

3.82 The committee notes that in the early 1980s with an industry dominated by mutual life insurers, it may have been possible to sustain an argument that a duty to act in good faith may have been sufficient to offset the loss of substantial consumer protections through the application of section 15 of the Insurance Contracts Act.

3.83 However, persistent misconduct by today's corporate life insurance industry demonstrates that the rationale for Section 15 of the Insurance Contracts Act is no longer credible. It is simply no longer reasonable to exempt the life insurance industry from the application of consumer protections.

3.84 The committee is not swayed by arguments from the life insurance industry that the industry needs special provisions due to the nature of risk involved in the industry, or the potentially high value of transactions. Instead, the committee considers that such points are an argument for stronger, not weaker, consumer protections because when the life insurance industry is not accountable for its share of the contracted risk, the consumer ends up being fleeced and left carrying all the risk.

3.85 While this inquiry is focussed on life insurance, the committee is convinced the same consumer protections should apply to all insurance, including both life and general insurance. The committee is therefore recommending that Section 15 of the Insurance Contracts Act be reformed to enable consumer protections to apply to life insurance contracts, with appropriate transitional and other arrangements to accommodate the challenges observed by ASIC to exist.

3.86 The committee notes that this recommendation is consistent with the intended operation of the Australian Consumer Law, namely that consumers have the same protections, and businesses have the same obligations and responsibilities, across Australia.

3.87 Furthermore, the committee notes that the 2017 Senate Economics References Committee inquiry into General Insurance recommended removing the exemptions which the general insurance industry currently enjoys with respect to unfair contract terms provisions.

3.88 While the committee has considered unfair contract terms in some detail, it considers that the same conclusions can be drawn about other consumer protections under the Australia Consumer Law.

Recommendation 3.1

3.89 The committee recommends that:

- **consumer protections for financial and non-financial services are aligned to remove current inconsistencies;**
- **section 15 of the *Insurance Contracts Act 1985* be reformed to enable consumer protections to apply to life insurance contracts, with appropriate transitional and other arrangements to accommodate the challenges observed by ASIC to exist;**
- **consumer protections for life insurance are aligned with consumer protections for other financial services and products, including but not limited to removing the exemptions identified in Table 3.2 of this chapter;**
- **consumer protections for life insurance uniformly cover:**
    - **all life insurance industry sectors, including direct, retail and group;**
    - **all life insurance industry participants, including but not limited to insurers, distributors, licensees, advice licensees, advisers, superannuation trustees and employees of such organisations; and**
    - **all forms of life insurance, including but not limited to life, trauma, disability, income protection; funeral insurance; and**
- **consumer protections for general insurance are aligned with consumer protections for other financial services.**

3.90 The committee notes that, following the passage of unfair contract terms legislation for small business loans, major banks have reviewed those contracts and removed unfair contract terms.

3.91 The committee also notes that following a review in 2013 by the Australian Competition and Consumer Commission, 79 per cent of unfair contract terms were removed from standard form contracts across a range of other industries.

3.92 The above examples suggest that it would not be unreasonable to expect that contracts for life insurance might also contain unfair contract terms.

3.93 The committee therefore observes that life insurers could take a proactive approach and immediately begin reviewing their contracts with a view to removing any unfair contract terms. Indeed, life insurers should not need to wait for the passage of legislation that requires the removal of unfair contract terms. Nevertheless, experience has shown that the life insurance industry is unlikely to remove unfair terms unless required to do so. The committee therefore recommends that, in addition to its recommendation above on removing the exemptions from consumer protections that the life insurance industry currently enjoys, that ASIC engage with life insurers to begin removing unfair contract terms from life insurance contracts as soon as possible.

Recommendation 3.2

3.94 The committee recommends that ASIC engage with life insurers to begin removing unfair terms from life insurance contracts as soon as possible.

Design and distribution obligations and ASIC's product intervention powers

3.95 The committee notes the government's proposed design and distribution obligations and ASIC's product intervention powers. The committee endorses the key features of the Treasury Proposals Paper, namely that:

- products are to be targeted at consumers based on the ability of the product to meet consumer needs (design and distribution obligations); and
- ASIC is to have powers to proactively intervene where it identifies significant consumer detriment (product intervention power).

3.96 However, the committee notes that ASIC's proposed product intervention powers do not include the ability to make interventions in relation to remuneration. The committee considers that the nature of remuneration, and in particular the incentives that it puts in place, can have a profound and not always positive influence on the way that products and services are sold. All too often, certain types of remuneration have sent the wrong signals with the effect that customer outcomes have come a poor second to the self-interest of certain industry participants.

3.97 The committee therefore endorses the suggestions made by both the Deputy Chairman and then Chairman of ASIC that the proposed legislation would be improved by:

- extending the coverage of financial products to include funeral insurance;
- giving ASIC the ability to make interventions in relation to remuneration; and
- increasing the 18 month timeframe for which product intervention orders can apply.

Recommendation 3.3

3.98 The committee recommends that ASIC's proposed product intervention powers be amended to:

- **include funeral insurance;**
- **give ASIC the ability to make interventions in relation to remuneration; and**
- **increase the 18 month timeframe for which product intervention orders can apply.**

3.99 The committee notes that several proposed pieces of legislation cover financial services but not necessarily life insurance. Examples include the Banking Executive Accountability Regime (BEAR) and the proposed product design and distribution obligations and ASIC's product intervention powers.

3.100 The committee considers that where new legislation is proposed, there should be a presumption that the legislation would apply uniformly to all financial services including life insurance.

3.101 In this regard, the committee also endorses the views expressed by the then ASIC Chairman that, once implemented, the BEAR regime should be extended to cover life insurance.

Recommendation 3.4

3.102 The committee recommends that the government's proposed Banking Executive Accountability Regime, financial product design and distribution obligations, and financial product intervention powers for ASIC, should apply to life insurance and life insurers.

3.103 The committee also endorses the views expressed by the ASIC Chairman with respect to the scope of the BEAR. In this regard, the committee agrees that most of the issues that have come before this committee over the last decade have been poor conduct or misconduct that has resulted in substantial adverse impacts on consumers and investors.

3.104 The committee supports the notion that the scope of the BEAR should be extended to cover consumer and investor matters and that ASIC have the requisite power to take action on conduct in relation to those matters. The committee is of the view that extending the scope of the BEAR in this manner would alter the risk calculus of senior management within the financial services industry. The committee considers that such a shift would have positive outcomes for consumers and investors.

3.105 The committee recognises that widening the scope of the BEAR will not happen immediately and that the proposed regime first needs to be bedded down. Nevertheless, the committee is persuaded of the importance of including conduct matters under the BEAR. On this basis, the committee is recommending that the scope of the BEAR be extended to include consumer related conduct matters and enable ASIC powers to take action on these matters.

Recommendation 3.5

3.106 The committee recommends that the scope of the Banking Executive Accountability Regime be extended to include consumer related conduct matters and enable ASIC powers to take action on these matters.

3.107 Finally, the committee notes that the Financial System Inquiry recommended a review of ASIC's penalties and powers to ensure that the enforcement regime provides a credible deterrent for poor behaviour and breaches of financial services laws.

3.108 The committee endorses the view put forward by the Chairman of ASIC that creating a sufficient deterrent for misconduct in the financial services sector requires both significant penalties and a reasonable prospect of being caught. ASIC has long advocated for penalties to significantly exceed the benefits obtained, so that penalties provide a deterrent, rather than just becoming a cost of doing business.[69]

3.109 The committee welcomes the establishment of the ASIC Enforcement Review Taskforce. The committee supports the ASIC Enforcement Review Taskforce proposal for a substantial increase in civil penalty amounts under ASIC-administered legislation. The penalties proposed by the Taskforce would be three times the benefits obtained.[70]

3.110 In light of both the views of the corporate regulator and the ASIC Enforcement Review Taskforce, the committee is therefore recommending that penalty amounts under ASIC-administered legislation be three times the benefits obtained for every life insurance industry participant involved in a transaction, including advisers, licensees and insurers.

3.111 The committee is also recommending that ASIC undertake a major audit of financial product advice in the life insurance industry that will audit one in every five advisers over a three year period. This will create a reasonable prospect that advisers, licensees and insurers engaging in misconduct are caught.

Recommendation 3.6

3.112 The committee recommends that the penalty amounts under ASIC-administered legislation, including the life insurance industry, should be set at three times the benefits obtained for every party to the transaction, including advisers, licensees and insurers.

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69 See, for example, Mr Greg Medcraft, Chairman, Australian Securities and Investments Commission, *Senate Economics Legislation Committee Hansard*, 26 October 2017, p. 6.

70 See Australian Government, The Treasury, ASIC Enforcement Review, *Positions Paper 7—Strengthening Penalties for Corporate and Financial Sector Misconduct*, p. 4, https://treasury.gov.au/consultation/c2017-t229819/ (accessed 17 November 2017).

Recommendation 3.7

3.113 The committee recommends that ASIC conduct random audits of 20 per cent of the life insurance adviser population over a three year period. Where misconduct is identified, appropriate entries should be recorded on the financial advisers register, and statistics on licensees and insurers should be published, so the public can be informed. Advisers that have been reviewed must also publish the outcome on their website in a highly visible location. If necessary ASIC should be provided with additional funding to allow these random audits to occur.

Chapter 4
Codes of practice

Introduction

4.1 One of the key issues considered in this report is appropriate industry regulation. The notion of a code of practice for the life insurance industry is a recent phenomenon with the Financial Services Council (FSC) instigating a self-regulatory code for its members and the Insurance in Superannuation Working Group (ISWG) developing a draft code of practice for superannuation trustees and insurers.

4.2 However, serious questions arose during this inquiry as to whether industry codes based on self-regulation are in fact sufficient to prevent poor practices. Consequently, several submitters and witnesses favoured a co-regulatory model which, they argued, had far greater potential to not only facilitate best-practice in the life insurance industry, but also to restore consumer confidence in the sector.

4.3 This chapter covers codes of practice in the life insurance industry and:

- summarises codes of practice across the financial services sector;
- examines the use of codes of practice in the life insurance sector to date;
- considers evidence received during the inquiry on codes of practice; and
- considers the co-regulatory model proposed by the ASIC Enforcement Review Taskforce.

Terminology

4.4 During the inquiry submitters and witnesses used the terms 'code of practice' and 'code of conduct' interchangeably. This report uses the term code of practice, except where evidence referring to a code of conduct is quoted.

Financial services codes of practice

4.5 Codes of practice have existed in the financial services sector since the late 1980s. Most of these industry-based codes were voluntary for industry participants. The codes aimed, on the one hand, to provide flexibility to industry participants, and on the other hand, to protect consumers of financial products and services through the setting of best practice standards of conduct and providing a system of informal dispute resolution.[1]

4.6 Regulatory Guide 183 *Approval of financial service sector codes of conduct* (RG183) sets out requirements for a code to be approved by ASIC under the Corporations Act. RG183 includes requirements for the code to be written in plain

1 ASIC Enforcement Review Taskforce, *Position and Consultation Paper 4 Industry Codes on the Financial Sector*, 28 June 2017, pp. 1, 4.

language, to address stakeholder issues, to provide for consistent monitoring and compliance, and for mandatory three-year code reviews.[2]

4.7 Currently, there are 11 codes for financial services including banking, insurance, financial planning, brokering, and ePayments.[3]

4.8 The only self-regulatory code to be approved by ASIC is the Financial Planning Association's Professional Ongoing Fees Code.[4]

Life insurance codes of practice

4.9 The committee received evidence that a self-regulatory voluntary life insurance industry code of practice was established in 1995 and an HIV/AIDS life insurance code of practice was established in 1998. Apparently, neither code was embraced by the life insurance industry and, consequently, both codes fell into disuse.[5]

4.10 In 2015, the Trowbridge Review of Retail Life Insurance Advice recommended that a life insurance code be developed and modelled on the General Insurance Code of Practice and aimed at settings standards of best practice for life insurers, licensees and advisers (Policy Recommendation 6).[6]

4.11 The FSC led the development of the Life Insurance Code of Practice (Code). The Code came into effect from 11 October 2016 and all FSC life insurer members (which does not include all industry participants) were bound by the Code from 1 July 2017.[7]

4.12 The FSC has over 100 members from Australia's retail and wholesale funds management businesses, superannuation funds, life insurers, financial advisory networks and licensed trustee companies.[8] The FSC website indicates that 22 life insurance companies are members and are bound by the Life Insurance Code of

2 ASIC Enforcement Review Taskforce, *Position and Consultation Paper 4 Industry Codes on the Financial Sector*, 28 June 2017, p. 5.

3 ASIC Enforcement Review Taskforce, *Position and Consultation Paper 4 Industry Codes on the Financial Sector*, 28 June 2017, p. 5.

4 ASIC Enforcement Review Taskforce, *Position and Consultation Paper 4 Industry Codes on the Financial Sector*, 28 June 2017, p. 5.

5 Berrill & Watson Lawyers, *Submission 19*, pp. 1–2.

6 Mr John Trowbridge, *Review of Retail Life Insurance Advice*, March 2015, p. 10.

7 Financial Services Council, *Submission 26*, pp. 1, 6; ASIC Enforcement Review Taskforce, *Position and Consultation Paper 4 Industry Codes on the Financial Sector*, 28 June 2017, p. 4.

8 Financial Services Council, *FSC full members*, https://www.fsc.org.au/about/fsc-members/ (accessed 7 February 2018).

Practice from 30 June 2017.[9] There are currently 29 life insurers registered in Australia under section 21 of the *Life Insurance Act 1995*.[10]

4.13 The Code will be subject to an independent governance framework through the Life Code Compliance Committee (LCCC). The LCCC includes three independent experts including a consumer advocate. The LCCC is able to require life insurers who do not comply with the Code to take corrective action and be subject to sanctions.[11] Sanctions may include:

- a requirement that particular rectification steps be taken within a specified timeframe, taking into account any rectification related to the breach imposed by any regulatory body;

  a formal warning;
- a requirement that a code compliance audit be undertaken;
- a requirement to undertake corrective advertising or write directly to the customers impacted by the breach; and/or
- publication of non-compliance on the company's own website and on the FSC website.[12]

4.14 The Code covers customer service, plain language disclosure, updating medical definitions, conduct and monitoring of sales, remedies for mis-selling, claims handling, claims investigations, interviews and surveillance. The Code requires:

- prescribed timeframes for deciding claims;
- insurers to keep customers informed about the process and progress of a claim;
- insurers to provide reasons for information requests;
- alternative methods of verifying information prior to arranging surveillance and that surveillance be discontinued where there is evidence from an independent medical examiner that it negatively impacts the claimant's recovery;
- monitoring of sales practices and the offer of remedies, such as refund or replacement policy, where the insurer discovers that an inappropriate sale has occurred; and
- reviews of key medical definitions every three years.[13]

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9 Financial Services Council, *Code of Practice*, https://www.fsc.org.au/policy/life-insurance/code-of-practice/ (accessed 7 February 2018).

10 Australian Prudential Regulation Authority, *Registered Life Insurance Companies*, http://www.apra.gov.au/lifs/Pages/registered-life-insurers.aspx (accessed 7 February 2018).

11 Financial Services Council, *Submission 26*, p. 10.

12 Financial Service Council, *Life insurance Code of Practice*, p. 26.

13 Financial Services Council, *Submission 26*, p. 10.

4.15 The above Code did not extend to superannuation trustees involved with group life insurance. In response to that concern, the Insurance in Superannuation Working Group (ISWG) was established to develop a code of practice for superannuation trustees and insurers.[14]

4.16 In September 2017, the ISWG released a draft Insurance in Superannuation Code of Practice (Super Code) to apply to superannuation funds that offer insurance. The draft Super Code includes:

- Benefit design: to ensure automatic insurance benefits are appropriate and affordable for all segments of members, notably younger members, those making low or infrequent contributions, as well as those nearing retirement.
- Premium limits: trustees to design benefits to ensure the level and cost of cover does not exceed 1 per cent of estimated earnings and 0.5 per cent for members under 25.
- Cessation arrangements: to come into effect only after communicating with members; insurance premiums will stop being deducted 13 months after a member's contributions cease.
- Duplicate insurance cover: trustees required to ask new members for permission to help them identify any other insurance cover held within superannuation.
- Member communication initiatives: to assist members to understand what insurance products they hold and the impact insurance premiums can have on their retirement savings.
- Better claims handling initiatives: to include response times and better information provided to members.[15]

4.17 Mr David Haynes, Executive Manager for Policy and Research at the Australian Institute of Superannuation Trustees, informed the committee that the Super Code should lead to substantive improvements in the provision of life insurance within superannuation. For example, in areas such as claims handling, there will be an enforceable code to which the whole of the industry signs up and which is then endorsed and effectively overseen by ASIC.[16]

4.18 During the course of the inquiry, the draft Super Code was proceeding through a consultation and review process. The Super Code is intended to bind superannuation fund trustees that offer insurance within an APRA-regulated superannuation fund. The ISWG is currently contemplating options (including regulatory options) for ensuring the Super Code is mandatory for all superannuation

14 ASIC Enforcement Review Taskforce, *Position and Consultation Paper 4 Industry Codes on the Financial Sector*, 28 June 2017, p. 7.

15 Insurance in Superannuation Working Group, *Super industry consults on draft Code of Practice to improve outcomes for members*, 20 September 2017, pp. 7–12.

16 Mr David Haynes, Executive Manager Policy and Research, Australian Institute of Superannuation Trustees, *Committee Hansard*, 22 February 2017, p. 57.

trustees, in order to achieve broad industry change. The ISWG is also considering whether the two life insurance codes of practice—that is the FSC-coordinated Code and the ISWG-coordinated Super Code—could be combined.[17]

4.19 The final ISWG Super Code was released in December 2017 and takes effect from 1 July 2018.[18] As the final version of the code was released well after the committee had received submissions and taken evidence during hearings, the committee's report has made reference to evidence it received on the draft ISWG Super Code.

4.20 The FOS acknowledged that while there may be technical difficulties in establishing a single life insurance code that would be far preferable to multiple codes which may add to complexity for consumers and difficulties in ensuring consistent standards across the industry for subscribers.[19]

Evidence received on life insurance codes of practice

4.21 The FSC submitted that the Code sets standards above existing laws in many areas. As such, the FSC argued that the Code is intended to strengthen industry standards for the benefit of all Australians.[20]

4.22 Under the current self-regulatory model, the codes are voluntary and are not approved by ASIC. While a code could be approved by ASIC, ASIC would not have the power to enforce the code, which can be monitored by the LCCC. In this regard, Mr Peter Kell, Deputy Chairman of ASIC, observed:

> The industry has also indicated to us that their intention is to submit the code for our approval. That doesn't necessarily mean that ASIC would enforce all the provisions, but we would only approve it if we were confident that the enforceability was robust.[21]

4.23 BT Financial supported the Code, informing the committee that in its view, the measures will foster trust, transparency and accountability across all aspects of the life insurance industry.[22]

4.24 FOS supported recent industry initiatives to develop the Code. FOS noted, however, that a code is only as good as its implementation. FOS therefore emphasised

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17 Insurance in Superannuation Working Group, *Consultation Paper: Insurance in Superannuation Code of Practice*, September 2017, pp. 5–6.

18 Insurance in Superannuation Working Group, *Insurance in superannuation voluntary code of practice*, December 2017.

19 Financial Ombudsman Service Australia, *Submission 28*, p. 14.

20 Financial Services Council, *Submission 26*, p. 1.

21 Mr Peter Kell, Deputy Chairman, Australian Securities and Investments Commission, *Committee Hansard*, 8 September 2017, p. 55.

22 BT Financial, *Submission 13*, p. 1.

the importance of clear communication to policy holders and consumers about the content of the Code, and in particular, the processes relating to claims assessment.[23]

4.25 The FOS also suggested improvements in the next version of the Code including:

- covering all services provided by life insurers;
- holding subscribers accountable for the actions and conduct of employees;
- timeframes for handling complaints;
- standardising medical definitions where appropriate;
- a single uniform approach to the cancellation of policies for non-payment of premiums; and
- making the code easier for consumers to understand.[24]

4.26 FOS also argued that the Code should become part of the contract with the consumer, and also that the code should be approved by ASIC:

> What we would say about the code, for example, is that it currently does not form part of the contract between the applicant or the insured and the insurer and that perhaps, going forward in the second iteration, that is something that could indeed occur. We feel that that would allow the individuals who have rights under the code to enforce them more sufficiently. We also understand that the FSC is looking to have that code approved. Again, we feel that that is a good step because it will send a message to consumers that the code can be trusted and that it will be enforced and monitored, and that life insurers will be held accountable, as they should be, under the code.[25]

4.27 Consumer groups and lawyers were critical of shortcomings in the Code. In particular, there was a broad recognition from consumer groups, lawyers, and FOS that the Code must be registered with ASIC in order to increase its effectiveness.[26]

4.28 Maurice Blackburn Lawyers argued that a self-regulated code is insufficient, and represents a wasted opportunity to effect genuine change in the industry. In addition, Maurice Blackburn Lawyers suggested that the Code should:

- regulate the conduct of insurance companies in assessing claims;
- provide for the fair and reasonable exchange of documentation relied upon in assessing claims; and

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23 Mr Shane Tregillis, Chief Ombudsman, Financial Ombudsman Service Australia, *Committee Hansard*, 22 February 2017, p. 61.

24 Financial Ombudsman Service Australia, *Submission 28*, pp. 14–15.

25 Dr June Smith, Lead Ombudsman, Investment and Advice, Financial Ombudsman Service Australia, *Committee Hansard*, 22 February 2017, p. 66.

26 Consumer Action Law Centre, *Submission 27*, p. 12; Financial Rights Legal Centre, *Submission 17*, p. 7; Financial Ombudsman Service, *Submission 28*, p. 13; Australian Lawyers Alliance, *Submission 20*, p. 24.

- include hard time frames so that claims are assessed in a timely manner.[27]

4.29 The FRLC stated that the Code does not meet best practice standards and does little, if anything, to restore confidence in the industry. The FRLC argued for greater oversight by ASIC to bring the industry into line with community standards.[28]

4.30 The FRLC also had concerns about the process in the Code for updating medical definitions:

> 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 eyes of consumers.[29]

4.31 The Consumer Action Law Centre acknowledged that the Code may lead to improved claims handling timeframes and greater protections for policyholders during investigations and surveillance processes.

4.32 However, Consumer Action Law Centre also pointed to significant weaknesses in the Code, including that:

- the Code is not enforceable by courts or tribunals, or registered with ASIC;
- the claims timeframes do not apply to people who have life insurance in their superannuation, which is the majority of life insurance; and
- the three-yearly reviews by a 'relevant' medical specialist do not have to be undertaken independently of the insurers. The Code also only guarantees some updates to medical definitions for 'on sale' policies only, excluding the many people whose policies are no longer 'on sale'.[30]

4.33 Likewise, the Australian Lawyers Alliance (ALA) identified significant shortcomings in the Code, including that it:

- does not do enough to protect the rights and interests of consumers;
- provides no real remedy for its breach and therefore no incentive for compliance;
- has limited scope and coverage; and
- does not cover all participants in the industry.[31]

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27 Maurice Blackburn Lawyers, *Submission 12,* pp. 15–16.

28 Financial Rights Legal Centre, *Submission 17,* p. 8.

29 Financial Rights Legal Centre, *Submission 17,* pp. 8–9.

30 Consumer Action Law Centre, *Submission 27,* p. 11.

31 Australian Lawyers Alliance, *Submission 20,* p. 24.

4.34 The ALA was also critical of the role of the LCCC because the LCCC cannot take any direct action to assist a consumer who may the victim of a breach of the Code. While, the LCCC can impose rectification steps, they are not defined. Indeed, the ALA argued that the strongest identified sanction that can be imposed by the LCCC is that the insurer will have to write to the consumer about the issue.[32]

4.35 While the vast bulk of the evidence to the committee argued that the Code was weak, limited in scope, and should be approved by ASIC, at the other end of the spectrum, one submitter did not support the Code because, in their view, the Code was unnecessary and went too far. That submitter argued that the Code would drive up premiums, reduce the adviser network, and cause even greater levels of under-insurance in Australia.[33]

ASIC Enforcement Review Taskforce—Co-regulation

4.36 In October 2016, the government announced an ASIC Enforcement Review Taskforce (Taskforce) to review the adequacy of ASIC's enforcement regime, including in relation to codes of practice.[34]

4.37 In June 2017 the Taskforce released a consultation paper on industry codes in the financial sector. The consultation paper considered the merits of self-regulatory and co-regulatory approaches:

> The impact on the lives of those affected by poor practices, as brought to light in media reports and in Parliamentary and other inquiries, has resulted in the Australian financial sector coming under intense public and regulatory scrutiny in recent times and in the impairment of consumer confidence in the sector. In this context it is apt to consider whether self-regulatory initiatives such as industry codes are achieving their potential, and whether that potential could better be achieved by the introduction of a co-regulatory model – at least for codes in relation to key services provided to retail and small business customers.[35]

4.38 The Taskforce observed that where self-regulation is non-existent or has proved ineffective, and a legislative solution is not appropriate, co-regulation could significantly improve the content, consistency and enforceability of codes.[36]

4.39 While the content of the code and the rules regulating industry behaviour are still determined by the industry participants, a co-regulatory model is a stronger form

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32 Australian Lawyers Alliance, *Submission 20*, p. 25.

33 Rate Detective, *Submission 56*, p. 2.

34 The Hon Kelly O'Dwyer MP, Minister for Revenue and Financial Services, Media Release, *ASIC Enforcement Review Taskforce*, 19 October 2016, http://kmo.ministers.treasury.gov.au/media-release/104-2017/ (accessed 8 November 2017).

35 ASIC Enforcement Review Taskforce, *Position and Consultation Paper 4 Industry Codes on the Financial Sector*, 28 June 2017, p. 1.

36 ASIC Enforcement Review Taskforce, *Position and Consultation Paper 4 Industry Codes on the Financial Sector*, 28 June 2017, p. 16.

of regulation than self-regulation because a co-regulatory code requires approval by ASIC, participation is mandatory, and the code is enforceable.

4.40 The introduction of an enforceable co-regulatory code in appropriate parts of the financial sector could boost consumer confidence in financial services.[37]

4.41 The Taskforce consultation paper proposed a co-regulatory model for the financial services sector with the following components:

- The content and governance arrangements for relevant codes should be subject to approval by ASIC.
- Entities engaging in activities covered by an approved code should be required to subscribe to that code.
- Approved codes should be binding and enforceable against subscribers by contractual arrangements with a code monitoring body.
- An individual customer should be able to seek appropriate redress through the subscriber's internal and external dispute resolution arrangements for non-compliance with an approved code.
- The code monitoring body, comprising a mix of industry, consumer and expert members, should monitor the adequacy of the code and industry compliance with it over time, and periodically report to ASIC on these matters.[38]

4.42 The Taskforce considered that the proposed co-regulatory approach should apply to sectors of the industry that would be covered by an external dispute resolution body such as the proposed Australian Financial Complaints Authority (AFCA).[39]

4.43 If a consumer lodged a complaint about an insurer's compliance with the code, the external dispute resolution body would apply the code of practice to any dispute between the insurer and the insured.[40]

4.44 As noted above, codes may also give rise to enforceable rights in court actions as codes may form part of the contract between the parties. In addition, the ASIC Act

37 ASIC Enforcement Review Taskforce, *Position and Consultation Paper 4 Industry Codes on the Financial Sector*, 28 June 2017, p. 1.

38 ASIC Enforcement Review Taskforce, *Position and Consultation Paper 4 Industry Codes on the Financial Sector*, 28 June 2017, pp. 1–2.

39 ASIC Enforcement Review Taskforce, *Position and Consultation Paper 4 Industry Codes on the Financial Sector*, 28 June 2017, pp. 2, 6.

40 Mr Michael Sadaat, Senior Executive Leader, Deposit Takers, Credit and Insurers, Regional Commissioner, New South Wales, Australian Securities and Investments Commission, *Committee Hansard*, 8 September 2017, p. 55.

provides that a court may have regard to an industry code in determining whether the conduct of a financial services supplier is unconscionable.[41]

4.45 The Electronic Funds Transfer Code of Practice (now known as the ePayments code) is the only co-regulatory code currently operating in the retail financial services system.[42]

Committee view

4.46 The committee notes that while the Financial Services Council argued that the Life Insurance Code of Practice set standards above current legislative requirements, consumer groups argued that the Code falls well short of best practice and some community expectations.

4.47 Furthermore, the Insurance in Superannuation Working Group has only just released a code of practice for superannuation trustees and insurers. Given that most life insurance is held in superannuation, the committee considers this to be a somewhat tardy response to a pressing issue. In addition, there is no mechanism for ASIC or a consumer to enforce the present industry Code, or to seek compensation.

4.48 The committee has considered the current self-regulatory approach adopted by the Financial Services Council and the Insurance in Superannuation Working Group. The committee is not persuaded that the current voluntary approaches to industry self-regulation put forward by the Financial Services Council and Insurance in Superannuation Working Group are sufficient to deter misconduct and address the poor practices that have become all too prevalent in the life insurance industry.

4.49 The committee also notes that previous self-regulatory codes in the life insurance industry fell into disuse. The committee considers that it would be unacceptable for such a situation to recur.

4.50 In light of the above, the committee welcomes the co-regulatory approach proposed by the ASIC Enforcement Review Taskforce. The committee is persuaded that co-regulation would have greater potential to foster best-practice in the life insurance industry and, as a consequence, help restore much-needed consumer confidence in the sector.

4.51 In particular, the committee considers that, with respect to the life insurance industry, a co-regulatory approach must, at a minimum, deliver a code that:

- is written in plain English that regulates the conduct of life insurance companies in assessing claims;
- is mandatory for all industry participants;
- is registered with ASIC;

41 ASIC Enforcement Review Taskforce, *Position and Consultation Paper 4 Industry Codes on the Financial Sector*, 28 June 2017, p. 6.

42 ASIC Enforcement Review Taskforce, *Position and Consultation Paper 4 Industry Codes on the Financial Sector*, 28 June 2017, pp. 1, 4.

- is enforceable in order to create accountability; and
- provides genuine remedies for its breach, including financial remedies, thereby creating an incentive for compliance.

Recommendation 4.1

4.52 The committee recommends that the government implement the co-regulatory approach put forward in the ASIC Enforcement Review Taskforce Position Paper across the whole financial services sector, while ensuring, where possible, that there are no exemptions for any part of the life insurance industry and that codes are written in plain English.

4.53 The co-regulatory approach would give the code compliance committees the power to determine whether breaches had occurred and the Australian Financial Complaints Authority the power to enforce compliance through determinations. However, both those processes only generally relate to individual breaches of codes, as they are unlikely to be effective in addressing systemic or systematic breaches of codes.

4.54 As a matter of practice, ASIC focusses its activities on systemic and systematic misconduct. However, under the proposed arrangements, ASIC may not have the power to undertake enforcement action for systemic and systematic code breaches. This would result in a very significant gap in consumer protections.

4.55 In its recent inquiry into Whistleblower Protections, the committee's recommendation 5.2 would include breaches of industry codes within the definition of disclosable conduct.[43]

4.56 In other words, if that particular recommendation was implemented, whistleblowers would receive protection for blowing the whistle about serious misconduct such as systemic or systematic breaches of codes of practice. This may allow a company to receive and take action in relation to such a disclosure. However, under the proposed co-regulatory model a regulator, such as ASIC, would not have the power to take effective enforcement action in relation to the disclosure.

4.57 The committee therefore considers that it is essential for regulators to have appropriate enforcement powers in relation to systemic or systematic breaches of industry codes of practice in addition to the proposed co-regulatory model.

Recommendation 4.2

4.58 The committee recommends that ASIC be given the power to undertake enforcement action (halting misconduct, remedies and sanctions) in relation to systemic or systematic breaches of codes of practice in the financial services sector, including in the life insurance sector.

4.59 The committee also notes that the Life Insurance Code of Practice does not place obligations on financial advisers or planners selling or advising on life

43 Parliamentary Joint Committee on Corporations and Financial Services, *Whistleblower Protections*, September 2017, p. xiii.

insurance. This is another in a very long list of exemptions from adequate consumer protections that the life insurance industry currently exploits. The committee considers the exemption to be a serious flaw, particularly given the poor conduct of some advisers identified in several recent inquiries and reviews.

4.60 The committee therefore considers that, in order for codes of practice in the financial services sector (including life insurance) to be approved by ASIC, they must apply to all relevant industry participants, without exceptions.

Recommendation 4.3

4.61 The committee recommends that, in order for ASIC to approve any code of practice in the financial services sector, including life insurance, the code must apply to all relevant industry participants, without exemptions.

4.62 Finally, the committee supports the view, put forward by the Financial Ombudsman Service amongst others, that it would be much easier for consumers for there to be a single life insurance code of practice. The committee therefore recommends that, prior to seeking ASIC approval, the Life Insurance Code of Practice and the Insurance in Superannuation Code of Practice be combined into a single code for the life insurance industry if possible.

Recommendation 4.4

4.63 The committee recommends that, prior to seeking ASIC approval, the two codes of practice for the life insurance industry be combined into a single code of practice if possible.

Chapter 5
Remuneration, commissions, payments and fees

Introduction

5.1 Over the last two decades in Australia, there has been a significant shift in the approach to the regulation of financial markets including the conduct of the industry participants. Much of that shift can be attributed to the fall-out from the global financial crisis.

5.2 Back in 1996, the Wallis inquiry into the Australian Financial System was established to assess the results of financial deregulation since the 1980s.[1]

5.3 In terms of conduct and disclosure, the Wallis inquiry identified the need for:

- a single set of requirements for investment sales and advice concerning minimum standards of competency and ethical behaviour;
- the disclosure of fees and adviser's capacity;
- rules on handling client property and money;
- financial resources or insurance available in cases of fraud or incompetence; and
- responsibilities for agents and employees.[2]

5.4 However, in 2009, in the aftermath of the global financial crisis, ASIC commented that the disclosure-focused approach to protecting consumers from remuneration incentives as advocated by the Wallis inquiry may no longer be appropriate, particularly given the breadth of retail investors:

> [ASIC is] querying whether it has gone far enough in protecting retail investors, given the important role, which was not foreseen by the Wallis inquiry, that retail investors would play in the market. They had not foreseen and could not have foreseen the impact that the superannuation levy has had on investment in our markets. In that situation, you have a much broader range of retail investors and retirees. You have groups of people who lose money at the wrong time in their life and it is no answer to them to say: Well, it was a risk, you know. There was disclosure. You should have read the disclosure statement. The fact is that they cannot easily come back into the workforce.[3]

---

1 Mr Stan Wallis (Inquiry Chairman), *Financial System Inquiry Final Report*, March 1997, p. 6.

2 Phil Hanratty, *The Wallis Report on the Australian Financial System: Summary and Critique*, Parliamentary Library, Research Paper 16, 1996 – 97, Chapter 7.

3 Mr Tony D'Aloisio, Chairman, Australian Securities and Investments Commission, *Official Committee Hansard*, Inquiry into Financial Product and Services, Parliamentary Joint Committee on Corporations and Financial Services, 16 September 2009, p. 7.

5.5 Particularly since the corporate collapses triggered by the global financial crisis, the issue of remuneration has been front and centre of debate about the problems that have plagued the financial services industry. In the last few years, a range of stakeholders have highlighted the way in which remuneration structures in the financial services sector generate conflicts of interest that have led corporations and advisers to put their interests (maximising their own revenue, remuneration and profit) ahead of the interests of the client (ensuring that the client gets the right product and service that suits their needs).

5.6 For example, Mr Greg Medcraft, then Chairman of ASIC, noted that the wrong type of financial incentives have contributed significantly to a range of poor practices and misconduct in the financial services industry including misleading advice and mis-selling.[4]

5.7 In its 2009 inquiry into financial products and services in Australia, the committee concluded that commissions (both up-front and trailing), volume bonuses, sales target rewards, and soft-dollar incentives place financial advisers in the role of both broker (that is, seller) and expert adviser. The committee commented that:

> A significant conflict of interest for financial advisers occurs when they are remunerated by product manufacturers for a client acting on a recommendation to invest in their financial product.
>
> These payments place financial advisers in the role of both broker and expert adviser, with the potentially competing objectives of maximising remuneration via product sales and providing professional, strategic financial advice that serves clients' interests.[5]

5.8 The 2009 inquiry made recommendations to address these conflicts of interests including:

- a fiduciary duty requiring advisers to places their customer's interests ahead of their own;
- surveillance of advice and annual shadow shopping exercises;
- disclosure of conflicts of interest; and
- that the government consult with industry on removing payments from product manufacturers to advisers.[6]

5.9 In recent years, governments have enacted legislation in response to a series of scandals in the financial services sector. Much of this legislation has been directed at trying to remove or reduce the conflicted remuneration and inappropriate incentives

4 Mr Greg Medcraft, Chairman, Australian Securities and Investments Commission, *Committee Hansard*, 16 June 2017, pp. 13–14.

5 Parliamentary Joint Committee on Corporations and Financial Services, *Inquiry into financial products and services in Australia*, November 2009, pp. 75–76.

6 Parliamentary Joint Committee on Corporations and Financial Services, *Inquiry into financial products and services in Australia*, November 2009, pp. 150–151.

that have permeated the financial services sector. Further detail on these reforms is provided later in this chapter.

5.10 This chapter focuses on the remuneration arrangements in the life insurance industry. The chapter begins by illustrating the web of money flows between industry participants within the three industry sectors: direct, group, and retail. The extent of existing and proposed regulation of remuneration arrangements is then discussed. This is followed by consideration of shelf space and training fees.

Remuneration, commissions, payments and fees in the life insurance industry

5.11 During the course of the inquiry, it became apparent that a range of commissions, payments and fees exist in some form or another within the life insurance industry.

5.12 The committee was greatly assisted by ASIC in identifying the types of payment or remuneration that occur between participants of the life insurance industry. ASIC provided the committee with a series of diagrams (Figures 5.1, 5.2, and 5.3) that illustrate some of the money flows within the life insurance industry of which ASIC is currently aware.

Terminology

5.13 With respect to the terminology used around conflicted remuneration, Transparency International defines conflicts of interest as arising in situations where an individual or entity is confronted with choosing between the duties of their position and their own private interests. Transparency International also defines corruption as the abuse of entrusted power for private gain.[7]

5.14 The above terminology can be useful when exploring some of the situations that may arise in the life insurance industry involving conflicted remuneration. For example, as illustrated later in this chapter, there is the potential for the risks inherent in a conflict of interest to manifest as corruption if an individual adviser (who holds a position of trust) makes a personal financial gain from financial incentives to recommend products that are not in a customer's best interests.

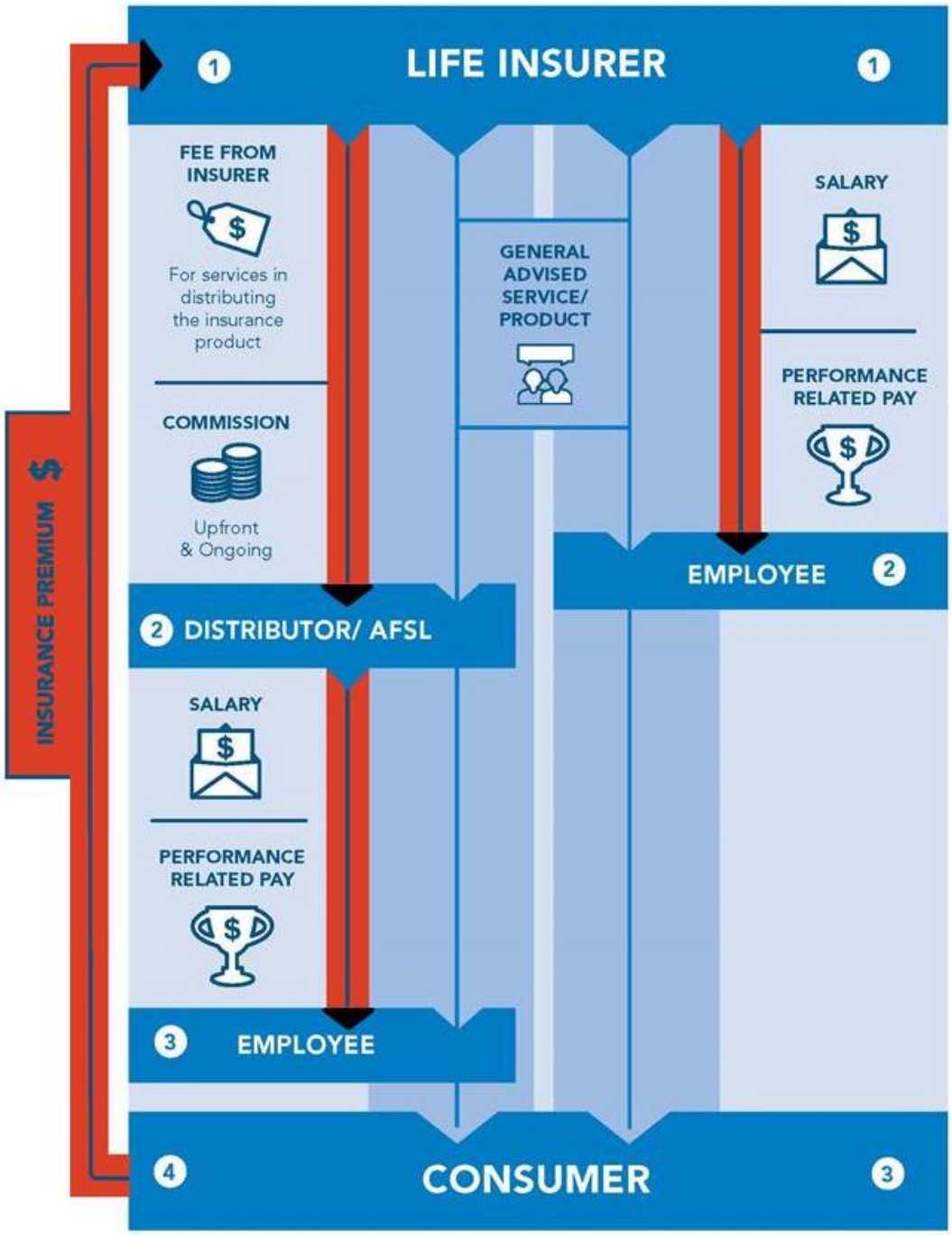
Remuneration arrangements in direct life insurance

5.15 This section outlines the remuneration flows associated with direct life insurance sales. Figure 5.1 indicates two remuneration scenarios:

- where a distributor is involved, and the life insurer may pay fees and commissions to the distributor and the distributor may pay salary and performance payments to staff; and
- where no distributor is involved, and the life insurer may pay salary and performance payments may be made to the insurers staff.

7 Transparency International, *Anti-corruption glossary*, https://www.transparency.org/glossary (accessed 3 November 2017).

Figure 5.1: Who gets paid in direct life insurance sales



Source: Australian Securities and Investments Commission, answers to questions on notice, 3 April 2017 (received 9 August 2017).

5.16 While the committee did not receive evidence specific to the money flows within direct life insurance sales, the committee makes some preliminary remarks about potential concerns with the remuneration flows indicated in Figure 5.1 above.

5.17 Firstly, there appears to be the potential for performance related pay, commissions, and fees to create incentives to upsell products that are not in the customers best interests. In essence, there is the problem of conflicted remuneration.

Conflicted remuneration and recent reforms are considered further in later sections on retail-advised life insurance and government reforms and are also set out in Table 5.2.

5.18 Secondly, as noted in chapter 2, direct insurance occurs without the provision of financial advice. Consequently, some of the consumer protections associated with personal advice do not apply because there is no 'personal advice' from an adviser.

5.19 Thirdly, because direct insurance does not contain an intermediary in the form of an adviser, consumers may have an expectation that direct life insurance would be free from hidden fees, commissions and performance related pay.

Remuneration arrangements in group life insurance

5.20 This section summarises some of the issues identified during the inquiry with remuneration arrangements in group life insurance. The remuneration flows associated with group life insurance shown in Figure 5.2 indicate three scenarios:

- where a consumer is defaulted into a super fund by their employer;
- where a consumer becomes a member of a super fund by choice without personal advice; and
- where a consumer becomes a member of a super fund by choice with personal advice.

Profit sharing arrangements

5.21 Figure 5.2, which is a reproduction of a diagram provided by ASIC, shows that profit sharing arrangements appear in all three models for group life insurance.

5.22 Mr Brett Clark, Chief Executive Officer and Managing Director of TAL, told the committee that rebate arrangements occur where premiums exceed claims paid and operating expenses. Mr Clark argued that excess premiums and rebates provide price stability for premiums.[8]

5.23 Mr Clark also made the point that, in line with the FOFA regulations, some insurers require the rebates from any excess profits or excess premiums to be used entirely for the benefit of members. He indicated that the contracts that TAL had with trustees gave it audit rights that would allow TAL to verify that those rebates are used for the benefit of members.[9] However, the committee notes that trustees of superannuation funds are legally required to act in the best interests of their members. It would not be in the interest of members to have premiums, paid out of members' funds, returned to trustees and taken as profit.

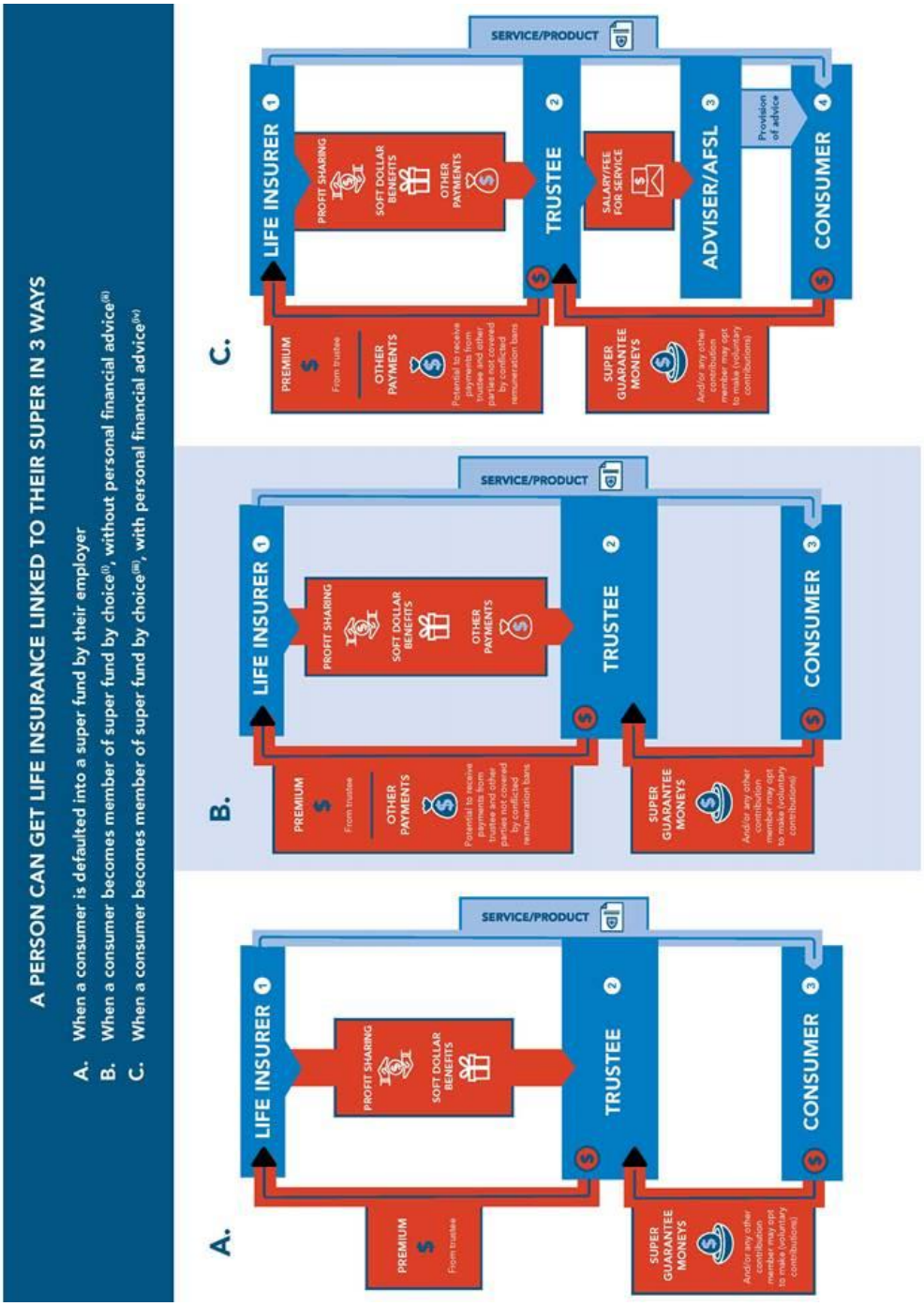
5.24 ASIC informed the committee that of the 47 trustees involved with its review of insurance and superannuation, seven or eight have some form of profit sharing, premium sharing, or other arrangements with life insurers. ASIC indicated that when

8 Mr Brett Clark, Chief Executive Officer and Managing Director, TAL, *Committee Hansard*, 18 August 2017, pp. 3, 17.

9 Mr Brett Clark, Chief Executive Officer and Managing Director, TAL, *Committee Hansard*, 18 August 2017, pp. 3, 17.

its review is completed it may be able to clarify whether profit sharing arrangements have been used by life insurers as inducements to trustees.[10]

Figure 5.2: Who gets paid in group life insurance sales



Source: Australian Securities and Investments Commission, answers to questions on notice, 3 April 2017 (received 9 August 2017).

10 Mr Gerard Fitzpatrick, Senior Executive Leader, Investments Managers and Superannuation, Australian Securities and Investments Commission, *Committee Hansard*, 8 September 2017, p. 52; Mr Peter Kell, Deputy Chairman, Australian Securities and Investments Commission, *Committee Hansard*, 8 September 2017, p. 53.

5.25 The Insurance and Superannuation Working Group (ISWG) draft code of practice for life insurance in superannuation includes a standard on premium adjustments. This code was discussed in chapter 4. The ISWG consultation paper released in September 2017 indicates that:

> Some trustees have in place a premium adjustment arrangement with their insurers, to either return surplus premium to the trustee's insurance reserve when the cost of members' claims turns out to be less than the insurer expected when determining the pricing of our insurance cover, or to adjust future premiums to reflect a premium deficit.
>
> Section 8 of the Code requires any premium adjustment payments to be passed onto insured members through adjustments to future premiums.[11]

Other payments

5.26 Other payments from life insurers to trustees and from trustees to life insurers are shown in Figure 5.2 for situations when a consumer becomes a member of a superannuation fund by choice. This appears to occur regardless of whether the customer sought personal financial advice.

5.27 It is unclear what the nature of these other payments are, how much they are, whether they are one-off or ongoing, to what extent they are deducted from a consumers super contributions and life insurance premiums, and whether there are any consumer protections in place.

5.28 It is also unclear whether these payments are creating a disincentive for consumers to choose their super fund rather than accept the default fund.

Fee for service with advised group life insurance

5.29 Figure 5.2 also indicates that when a consumer becomes a member of a super fund by choice with personal financial advice, the trustee pays a salary or fee for service directly to the adviser. It is unclear what practical choice a consumer has in relation to who the financial adviser is and what control the consumer has over the fee paid.

Remuneration arrangements in retail life insurance

5.30 This section summarises some of the issues identified during the inquiry with remuneration arrangements in retail life insurance.

5.31 Figure 5.3 depicts the financial flows when life insurance is purchased in the retail sector. Figure 5.3 indicates that four different types of remuneration models operate within retail life insurance.

5.32 In the three commission-based models, namely upfront, hybrid, and level:

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11 Insurance and Superannuation Working Group, *Consultation paper: Insurance in Superannuation Code of Practice*, September 2017, p. 14.

- the commission is built into the premium that is paid by the customer to the life insurer;
- the life insurer pays the commission to the advice licensee; and
- the licensee then pays the adviser an agreed commission.

5.33 Up until 31 December 2017, the following arrangements operated in the three commission-based systems:

- Upfront commissions—the life insurer pays the advice licensee up to 130 per cent of the first year's premium and up to 10 per cent of renewal premiums.
- Hybrid commissions—the life insurer pays the advice licensee up to 70 per cent of the first year's premium and up to 20 per cent of renewal premiums.
- Level commissions—the life insurer pays the advice licensee a flat rate commission of around 30 per cent of the first year's premium every year for the life of the policy. In other words, there is an ongoing flat rate commission of around 30 per cent on renewal premiums.[12]

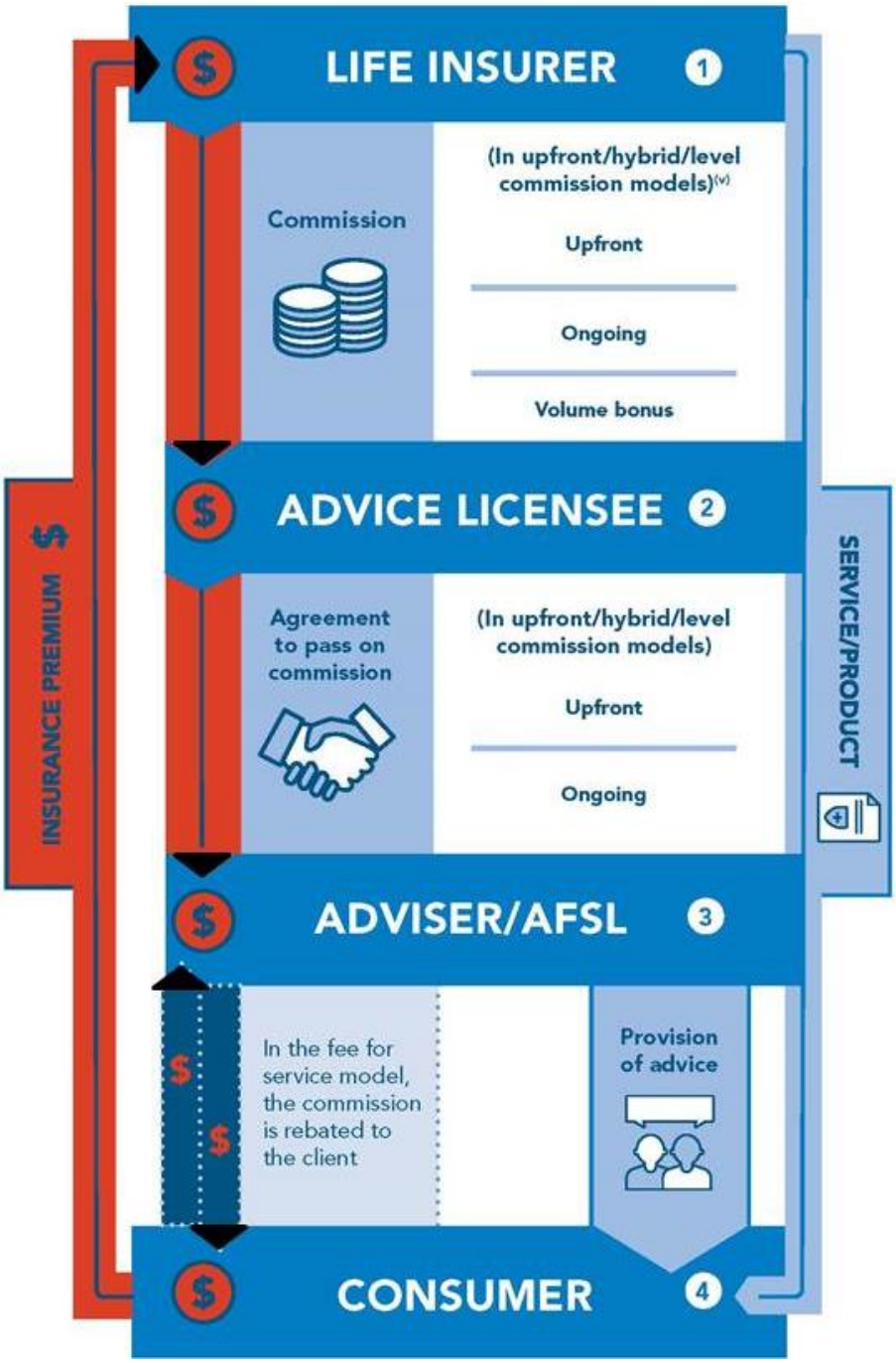
5.34 By contrast, in fourth model, the no commission model, a fee for service is charged. However, Figure 5.3 indicates that, as ASIC understands it, in parallel with the fee for service being paid to an adviser by a consumer, the adviser and licensee are still receiving a commission from the insurer which is then rebated to the customer.

5.35 Table 5.1 below sets out:

- the different types of commissions that are used in retail life insurance;
- the flow of the commission;
- the amount of the commission;
- the ongoing nature of the commission; and
- the changes that will be required in commission models from 1 January 2018.

12 Australian Securities and Investments Commission, answers to questions on notice, 3 April 2017 (received 9 August 2017).

Figure 5.3: Who gets paid in retail life insurance sales



Source: Australian Securities and Investments Commission, answers to questions on notice, 3 April 2017 (received 9 August 2017).

Table 5.1 Flow of commissions in advised sales of life insurance

Commission type	Flow of commission	Amount of commission	Ongoing commissions	Changes from 2018
Upfront commission	The commission is built into the premium that is paid by the customer to the life insurer. The life insurer pays the commission to the advice licensee. The advice licensee then pays the adviser an agreed commission.	Insurer pays the advice licensee up to 130% of the first year's premium. A percentage of this will be paid to the adviser.	Up to 10% of renewal premiums. Volume bonuses may be paid.	From 1 January 2018, upfront commissions will reduce to 80% of the first year's premium. Ongoing commissions will be capped at 20%. By January 2020, upfront commissions will be further reduced to 60% of the first year's premium. Ongoing commissions will be capped at 20%. Volume bonuses will be banned. Two year clawback requirements commence on 1 January 2018.
Hybrid commission		Insurer pays the advice licensee up to 70% of the first year's premium. A percentage of this will be paid to the adviser.	Up to 20% of renewal premiums. Volume bonuses may be paid.	
Level commission		Flat rate commission of around 30% of the first year's premium and for every year of the life of the policy. A percentage of this will be paid to the adviser.	Flat rate commission of around 30% on renewal premiums. Volume bonuses may be paid.	The commission caps and clawback requirements will not apply to level commissions. Volume bonuses will be banned.
No commission	Client pays fee to adviser.	Fee-for-service remuneration.	None	The commission caps and clawback requirements should not affect fee-for-service arrangements.

Source: Australian Securities and Investments Commission, answers to questions on notice, 3 April 2017 (received 9 August 2017).

5.36 Table 5.1 shows that, from 1 January 2018, when the *Corporations Amendment (Life Insurance Remuneration Arrangements) Act 2017* (also known as the LIF reforms) comes into effect, the commission caps within life insurance will change for upfront and hybrid commission structures, but will not change for level commissions. These changes are explained below.

5.37 It should be noted that these reforms will also apply to commission structures within direct life insurance sales. For example, while the paragraphs below relate to,

for example, payments from a life insurer to an advice licensee, payments from a life insurer to a distributor within direct life insurance sales would also be captured by the government's reform package. This is illustrated later in Table 5.2.

5.38 For upfront commission structures, the amount the life insurer will be able to pay the advice licensee is reduced from 130 per cent to 80 per cent of the first year's premium. However, the cap for ongoing commissions is increased from up to 10 per cent to 20 per cent of renewal premiums. By January 2020, the upfront commission will be further reduced to 60 per cent of the first year's premium, with 20 per cent ongoing commissions.[13]

5.39 For hybrid commission structures, the amount the life insurer will be able to pay the advice licensee is increased from 70 per cent to 80 per cent of the first year's premium. The ongoing commissions remain unchanged at 20 per cent of renewal premiums. By January 2020, the upfront commission will be reduced from 80 per cent to 60 per cent of the first year's premium. Ongoing commissions will remain unchanged at 20 per cent of renewal premiums.[14]

5.40 For level commission structures, the commission caps will not apply. In other words, the life insurer will continue to be able to pay the advice licensee a flat rate commission of around 30 per cent of the first year's premium and for every year of the life of the policy.[15]

5.41 The commission caps should not have any effect on fee-for-service arrangements.[16]

5.42 The remainder of the changes arising from the LIF reforms, including in relation to clawback arrangements and volume bonuses, are discussed in the later section on the government reform package.

The impact of FOFA on retail life insurance commissions

5.43 The Future of Financial Advice (FOFA) reforms to the Corporations Legislation which commenced in July 2012 implemented a ban on conflicted remuneration structures, including commissions and volume based payments, in relation to the distribution of, and advice on, retail investment products.[17]

5.44 The Corporations Act now defines conflicted remuneration as:

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13 Australian Securities and Investments Commission, answers to questions on notice, 3 April 2017 (received 9 August 2017).

14 Australian Securities and Investments Commission, answers to questions on notice, 3 April 2017 (received 9 August 2017).

15 Australian Securities and Investments Commission, answers to questions on notice, 3 April 2017 (received 9 August 2017).

16 Australian Securities and Investments Commission, answers to questions on notice, 3 April 2017 (received 9 August 2017).

17 Australian Securities and Investments Commission, *FOFA – Background and implementation*, http://asic.gov.au/regulatory-resources/financial-services/future-of-financial-advice-reforms/fofa-background-and-implementation/ (accessed 22 September 2017).

> …any benefit, whether monetary or non-monetary, given to a financial services licensee, or a representative of a financial services licensee, who provides financial product advice to persons as retail clients that, because of the nature of the benefit or the circumstances in which it is given:
>
> (a) could reasonably be expected to influence the choice of financial product recommended by the licensee or representative to retail clients; or
>
> (b) could reasonably be expected to influence the financial product advice given to retail clients by the licensee or representative.[18]

5.45 However, the FOFA reforms contain provisions that exclude most forms of life insurance from the bans on conflicted remuneration:

- direct and non-adviser group life insurance are excluded from the conflicted remuneration bans, because they are not sold with 'financial product advice' and therefore fall outside the above definition of conflicted remuneration; and
- retail life insurance is explicitly exempted by section 963B of the Corporations Act.[19]

ASIC review of retail life insurance advice

5.46 In October 2014, ASIC Report 413 reviewed retail life insurance advice. The report showed poor advice about life insurance was being provided to consumers. Specifically, the report found that 37 per cent of personal advice failed to comply with the quality of advice obligations.[20]

5.47 Some examples of poor advice reported on in Report 413 included:

- cases where advisers were selling clients policies with premiums that became unaffordable, even after the clients specifically said they wanted affordable policies;
- advisers recommending clients pay premiums from superannuation in a way that ran down clients' superannuation balances; and
- advice where there was inadequate consideration of a person's circumstances.[21]

5.48 ASIC also found evidence of poor life insurance advice that resulted in considerable detriment to consumers, including:

> (a) evidence that advisers failed to adequately consider their clients' personal circumstance and needs, leading to situations where consumers received inferior policy terms, paid more for cover, had health issues

18 *Corporations Act 2001*, s. 963A.

19 *Corporations Act 2001*, s. 963A, 963B.

20 Australian Securities and Investments Commission, answers to questions on notice, 21 August 2017 (received 8 September 2017).

21 Australian Securities and Investments Commission, answers to questions on notice, 21 August 2017 (received 8 September 2017).

> excluded and, in some cases, had claims denied where they previously had cover; and
>
> (b) evidence of unnecessary or excessive switching of clients between policies to maximise commission income, with a failure to consider or recommend insurance that reasonably correlated to clients' personal circumstances or objectives.[22]

5.49 ASIC recommended in Report 413 that insurers address misaligned incentives in their distribution channels and review their remuneration arrangements to ensure that they support good-quality outcomes for consumers and better manage the conflicts of interest within those arrangements. In particular, ASIC recommended that AFS licensees:

> (a) ensure that remuneration structures support good-quality advice that prioritises the needs of the client;
>
> (b) review their business models to provide incentives for strategic life insurance advice;
>
> (c) review the training and competency of advisers giving life insurance advice; and
>
> (d) increase their monitoring and supervision of advisers with a view to building 'warning signs' into file reviews and create incentives to reward quality, compliant advice.[23]

5.50 The problems with life insurance advice are not confined to one segment of the retail-advised industry. ASIC's Report 413 considered advice from both unaligned financial advisers and the vertically integrated channel of advisers and uncovered significant problems across both groups of advisers. The problems were more acute in the independently owned financial advice licensees, for which over half the advice failed to comply with the law.[24]

5.51 Bombora challenged the validity of the findings in Report 413, arguing that the review lacked a control group and did not focus sufficiently on quality of advice.[25]

5.52 However, ASIC's more recent general surveillance and enforcement work identified similar advice failure rates to those set out in Report 413 from 2014. Once again, ASIC found that inappropriate financial incentives continue to be commonly associated with poor sales practices in the life insurance industry:

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22 Australian Securities and Investments Commission, *Report 413: Review of retail life insurance advice*, October 2014, p. 5.

23 Australian Securities and Investments Commission, *Report 413: Review of retail life insurance advice*, October 2014, pp. 7–8.

24 Australian Securities and Investments Commission, answers to questions on notice, 21 August 2017 (received 8 September 2017).

25 Bombora Advice Pty Ltd, *Submission 64*, p. 16.

> ASIC's recent general surveillance and enforcement work reflects similar rates of non-compliant life insurance advice to that set out in REP 413, that is, we have not seen changes in this trend.[26]

5.53 Mr Peter Kell noted that of the 46 financial advisers banned during the last financial year, about a quarter of those were in relation to poor life insurance advice.[27]

Trowbridge review of retail life insurance advice

5.54 In March 2015, the Trowbridge review of retail life insurance advice considered the remuneration paid to advice licensees. The Trowbridge review identified a whole range of benefits commonly available to licensees, including:

> …volume-based payments, free or subsidised business equipment and services, hospitality-related benefits, shares or other interests in a product issuer or dealer group, marketing assistance and some buyer of last resort arrangements.[28]

5.55 The Trowbridge review recognised that the incentives embedded in the gamut of non-commission remuneration and benefits identified above had the potential to create conflicts of interest:

> These practices can create conflicts of interest for licensees that affect advised clients because in effect the conflicts are transmitted to their advisers. The advisers themselves may not always be aware of these practices of their own licensees.[29]

5.56 The Trowbridge review recognised that the attendant conflicts of interest generated by benefits flowing from life insurers through to advice licensees and advisers could undermine the attempts to reform the commission structures prevalent in the life insurance industry. To this end, the Trowbridge review recommended that 'licensees be prohibited from receiving benefits from life insurers that might influence recommended product choices or the advice given by the licensees' advisers'.[30]

Government reform package

5.57 In November 2015, the government announced a reform package that included proposals to address conflicts of interest in remuneration. The resulting package was the *Corporations Amendment (Life Insurance Remuneration Arrangements) Act 2017* (LIF reforms).

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26 Australian Securities and Investments Commission, answers to questions on notice, 21 August 2017 (received 8 September 2017).

27 Mr Peter Kell, Deputy Chairman, Australian Securities and Investments Commission, *Senate Economics Legislation Committee Hansard*, 26 October 2017, p. 6.

28 Mr John Trowbridge, *Review of retail life insurance advice*, March 2015, p. 8.

29 Mr John Trowbridge, *Review of retail life insurance advice*, March 2015, p. 8.

30 Mr John Trowbridge, *Review of retail life insurance advice*, March 2015, p. 9.

5.58 ASIC confirmed that commissions within life insurance constitute conflicted remuneration, but that the LIF reforms capped these commissions from 1 January 2018.[31]

5.59 In June 2017, ASIC released the ASIC Corporations (Life Insurance Commission) Instrument 2017/510, which set the caps and clawback arrangements. The impacts of those changes for upfront, hybrid and level commissions are summarised in Tables 5.1 and 5.2.

5.60 The commission caps were explained earlier. The 'clawback' reforms require a certain portion of the upfront commission to be paid back to the life insurer by the financial adviser in the event that the policy is cancelled or the premium is reduced in the first two years seeks. The aim of the 'clawback' reform is to neutralise the incentive for 'churning', which is the incentive for an adviser to move an existing client onto a new policy in order to receive another high upfront commission.[32]

5.61 The LIF reforms also ban the volume bonuses that were previously available under upfront, hybrid, and level commission structures. A volume bonus was an arrangement under which the insurer pays the licensee a volume-based bonus that is calculated by reference to the number of life products sold by the licensee.[33]

5.62 Table 5.2. below summarises the various payments identified in Figures 5.1, 5.2, and 5.3 and in the previous sections on remuneration in direct, group and retail life insurance.

5.63 Table 5.2 is broken into three sections: direct, group, and retail. The final column in Table 5.2 indicates the extent to which various payments—life insurer to distributor; life insurer to employee; distributor to employee; life insurer to trustee; trustee to life insurer; trustee to adviser / advice licensee; life insurer to advice licensee; advice licensee to adviser—are regulated. Unregulated payments in the final column are shaded in pale grey.

31 Ms Louise Macauley, Senior Executive Leader, Financial Advisers, Australian Securities and Investments Commission, *Committee Hansard,* 8 September 2017, p. 37.

32 Maurice Blackburn Lawyers, *Submission 12*, p. 9.

33 CHOICE, *Financial adviser reforms long overdue*, March 2015, https://www.choice.com.au/money/financial-planning-and-investing/financial-planning/articles/fofa-financial-adviser-reform (accessed 21 November 2017).

Table 5.2: Regulation of commissions, fees, and payments in the life insurance industry

	Type	Payment From – To	Regulation from 1 January 2018
Direct			
1	Commission – upfront	Life insurer to Distributor	From 1/1/18: Conflicted remuneration—banned, unless the commission complies with the commission caps and clawback requirements.
2	Commission – ongoing		From 1/1/18: Conflicted remuneration—banned, unless the commission complies with the commission caps and clawback requirements.
3	Commission – level		The conflicted remuneration provisions do not apply to level commissions.
4	Performance pay	Life insurer to Employee	A performance benefit paid for the direct sale of life insurance will not be conflicted remuneration if it complies with the commission caps and clawback requirements.
5	Performance pay	Distributor to Employee	
6	Volume bonus	Life insurer to Distributor	From 1/1/18: Presumed to be conflicted remuneration—banned unless it can be shown that the benefit could not reasonably be expected to influence the sale of the life insurance product.
Group			
7	Profit sharing/Premium adjustment	Life insurer to Trustee	Not regulated under the conflicted remuneration regime if there is no advice to a retail client, although rules for profit sharing and premium adjustments are proposed by the Insurance and Superannuation Working Group in the Insurance in Superannuation Code of Practice.
8	Soft dollar benefits		
9	Other payments		
10	Other payments	Trustee to Life insurer	Not regulated under the conflicted remuneration regime if there is no advice to a retail client.
11	Salary / fee for service	Trustee to Adviser / Advice licensee	Regulated by the conflicted remuneration regime, particularly in MySuper.
Retail			
12	Commission upfront	Life insurer to Advice licensee	From 1/1/18: Conflicted remuneration—banned, unless the commission complies with the commission caps and clawback requirements.
13	Commission ongoing (trail)		From 1/1/18: Conflicted remuneration—banned, unless the commission complies with the commission caps and clawback requirements.
14	Commission		From 1/1/18: Conflicted remuneration—banned,

	hybrid upfront and ongoing		unless the commission complies with the commission caps and clawback requirements.
15	Commission – level		The conflicted remuneration provisions do not apply to level commissions.
16	Volume bonus		From 1/1/18: Presumed to be conflicted remuneration—banned unless it can be shown that the benefit could not reasonably be expected to influence the sale of the life insurance product.
17	Shelf fees (not volume or training based)		From 1/1/18: Conflicted remuneration—banned unless the fee could not reasonably be expected to influence the choice of financial product recommended or the advice or an exception applies.
18	Training fees		Limited bans from 1/1/18. Non-monetary benefits such as training fees are exempt in certain circumstances (e.g. if the training is relevant to the financial services business and requirements such as time and cost are met).
19	Commission upfront	Advice licensee to Adviser	From 1/1/18: Conflicted remuneration—banned, unless the commission complies with the commission caps and clawback requirements.
20	Commission ongoing (trail)		From 1/1/18: Conflicted remuneration—banned, unless the commission complies with the commission caps and clawback requirements.
21	Commission hybrid upfront and ongoing		From 1/1/18: Conflicted remuneration—banned, unless it complies with the commission caps and clawback requirements.
22	Commission – level	Advice licensee to Adviser	The conflicted remuneration provisions do not apply to level commissions.
23	Fee for service with rebated commissions		Commission rebated to a consumer is less likely to be conflicted remuneration as it is unlikely to influence the advice.

Source: Australian Securities and Investments Commission, Additional information received 13 November 2017. Key: Unregulated payments are shaded in pale grey.

5.64 The committee received a large body of evidence about the LIF reforms and their impact on the retail-advised sector. There was, not surprisingly, a substantial divergence in views. For example, consumer groups, while welcoming the LIF reforms, argued that the reforms needed to go much further because, in their view, a commission-based insurance sales model leads to poor consumer outcomes. By contrast, many retail advice businesses were critical of the LIF reforms because they felt the reforms would have a negative impact on their businesses and their customers while, at the same time, failing to address significant issues in other parts of the industry.

5.65 The Financial Rights Legal Centre (FRLC) acknowledged that the LIF reforms were an important step in the right direction. However, the FRLC argued that,

given the harm caused by commissions and up-front commissions in particular, the reforms needed to extend much further to include a clear phase-out date for the removal of all commissions in the life insurance industry.[34]

5.66 CHOICE had similar views, indicating that the LIF reforms are promising first steps. But given the overwhelming evidence of consumer harm from commission-based sales, CHOICE were firmly of the view that commissions needed to be permanently banned, as they are for other types of financial advice:

> We acknowledge that ASIC plans to review the impact of these reforms to measure their effectiveness. As part of this review, ASIC should introduce a glide path to zero for the removal of life insurance commissions, with the aim of giving advisors a reasonable timeframe to develop new revenue streams while protecting consumers from further exploitation.[35]

5.67 Maurice Blackburn Lawyers argued that while the LIF reforms are a welcome start, they do not address other systemic flaws in the life insurance sales system that are a root cause of poor customer outcomes, namely:

- the pervasive vertically integrated cross selling practices by large institutions through overly narrow Approved Product Lists (APLs); and
- the payment of shelf space fees by insurers to advisers to have their product listed on the adviser's APL.[36]

5.68 ClearView life insurance and advice group also welcomed the LIF reforms. However, they argued that the reforms should be extended in two ways:

- the 'grandfathering' relief provided to existing conflicted remuneration should be limited in time in order to avoid a perverse incentive for advisers to keep clients in old products; and
- payments for 'education and training' should be subject to limitations so that they cannot be used or abused in a way that limits market access or competition.[37]

5.69 The FSC supported the LIF reforms as set out in the bill. The FSC also suggested that the life insurance industry had been proactive in supporting reform to amend remuneration arrangements between life insurers and advisers to minimise conflicts of interests.[38]

5.70 By contrast, several advisers, adviser groups, and their representative organisations expressed concern that the LIF reforms would have a negative impact, particularly on smaller advice firms.

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34 Financial Rights Legal Centre, *Submission 17*, p. 31.

35 CHOICE, *Submission 49*, pp 18–19.

36 Maurice Blackburn Lawyers, *Submission 12*, p. 9.

37 Clearview, *Submission 10*, p. 11.

38 Financial Services Council, *Submission 26*, p. 1.

5.71 The FPA speculated that the LIF reforms may disproportionally affect small advice firms because large firms may be able to cross subsidise any associated costs by other business activities.[39] The Life Insurance Customer Group also suggested that the LIF Reforms will adversely impact small business and favour larger firms due to the potential for cross-subsidies.[40]

5.72 The Association of Financial Advisers indicated that while the measures that have already started are welcome, without qualitative data analysing the effects of existing levels of insurance and advice, government policy making on life insurance will be piecemeal and may not be targeted where it is required most.[41]

5.73 Several advisers and adviser groups did not support the LIF Reforms for various reasons, including concerns about the consultation process,[42] the reforms may not address churn across the entire industry,[43]or other problems in the life insurance industry.[44]

5.74 Bombora Advice also argued that under the reforms, insurers and customers will pay more commissions overall in most circumstances. This is because the higher permissible rates of ongoing commissions would add to a greater overall cost than the pre-reform arrangements which had lower ongoing commissions and higher up front commissions.[45]

5.75 Finally, the committee notes that the Life Insurance Code of Practice and the proposed Insurance in Superannuation Code of Practice do not appear to place any significant controls on remuneration arrangements, except for premium adjustments in group life insurance and some restriction on incentives for declining claims.[46]

Shelf space fees and training fees

5.76 Further flows of money not specifically identified in Figure 5.3 are shelf space fees and training fees. A shelf space fee is a fee paid by an insurance company to an advice licensee in order to ensure the licensee includes certain products from that insurance company on the licensees' APL.

5.77 Evidence to this inquiry identified a range of concerns with shelf space and training fees, some of which are set out below.

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39 Financial Planning Association of Australia, *Submission 21*, p. 3.

40 Life Insurance Customer Group, *Submission 63*, p. 4.

41 Association of Financial Advisers, *Submission 22*, pp. 20–21.

42 Rate Detective, *Submission 56*, p. 6; Bombora Advice Pty Ltd, *Submission 64*, p. 15; Mr Mark Schroeder, *Submission 68*, p.13.

43 Life Insurance Direct, *Submission 59*, p. 8.

44 Bombora Advice Pty Ltd, *Submission 64*, p. 10.

45 Bombora Advice Pty Ltd, *Submission 64*, pp. 11, 48.

46 FSC, *Life Insurance Code of Practice*, p. 18; Insurance in Superannuation Working Group, Consultation paper, *Insurance in Superannuation Code of Practice*, September 2017, p. 14.

5.78 Clearview argued that shelf space fees are an arbitrary and prohibitive cost charged by large licensees (often institutional) to external product manufacturers to get on their APLs. ClearView estimated that insurers currently pay $10–15 million per year in shelf space fees. Individual shelf space fees range from $80 000 to $500 000.[47]

5.79 Furthermore, ClearView recommended that, in order to be able to provide a service in the best interest of clients, advisers should be able to recommend any APRA-regulated retail insurer in the market.[48]

5.80 Maurice Blackburn Lawyers argued that shelf space fees are a systemic flaw in the life insurance sales system because shelf space fees cause a conflict of interest.[49] This conflict of interest between the licensee/adviser and the best interests of the client arises because the adviser is restricted to recommending the products that are on the licensee's shelf. As a consequence, the adviser may recommend a product that is not necessarily in the client's best interests. This results in a poor outcome for the customer.

5.81 Maurice Blackburn therefore suggested that the use of shelf space fees should be either banned, or properly regulated by ASIC to ensure robust disclosure obligations.[50]

5.82 ASIC indicated that it has not conducted reviews of shelf space fees. However, ASIC noted that while volume-based shelf space fees are banned under section 964A of the Corporations Act, other shelf space fees are not specifically banned. Whether a shelf-space fee will be conflicted remuneration will depend on the circumstances in each case. Relevant circumstances include:

- the size of the fee;
- how the fee is calculated (for example, is it linked to the sale of the insurer's products);
- how the licensee uses the fee;
- whether the fee is passed onto advisers, and in what form; and
- how the insurer's products are presented on the APL and to the advisers.[51]

5.83 The committee heard evidence that certain non-monetary benefits have the potential to function as de-facto shelf space fees. For example, Mr William Crawford informed the committee that the life insurance industry may be finding loopholes that allow other fees with similar conflict of interest risks to shelf space fees to continue to be paid. He noted that, in order to avoid the conflicted remuneration laws, the way

47 Clearview, answers to questions on notice, 2 March 2017, (received 23 March 2017).

48 Clearview, answers to questions on notice, 2 March 2017, (received 23 March 2017).

49 Maurice Blackburn Lawyers, *Submission 12*, pp. 9, 12.

50 Maurice Blackburn Lawyers, *Submission 12*, pp. 9, 12.

51 Australian Securities and Investments Commission, answers to questions on notice, 3 April 2017 (received 9 August 2017).

shelf space fees operate has changed from a direct payment from the life insurer to the AFS licensee, to a more discrete method through the use of education and training funds. In this regard, Mr Crawford explained that not only do life insurance companies pay training money to dealer groups and advice licensees, but the life insurance companies also provide the training from their own resources.[52]

5.84 The committee received confirmation of this arrangement when Zurich revealed that it would not only pay for the training provided to a licensee, but Zurich would also provide that training as well:

> Senator O'NEILL: And they think you are pretty good to put you on, and then they say, 'We think you're really good, but you'll have to pay us some money as well,' and they then use the money that you pay to them to do what?
>
> Mr Bailey: Predominantly education and training of their advisers.
>
> Senator O'NEILL: Which is provided by you, or provided by somebody else. Do you pay them to let you train their people?
>
> Mr Bailey: It supports the cost of training on the Zurich proposition.
>
> Senator O'NEILL: So you pay them, but you do the training as well. You pay them twice: you pay them money and you also pay them with your expertise.
>
> Mr Bailey: We need to contribute some of the expertise, clearly, yes.
>
> Senator O'NEILL: But you pay them money as well?
>
> Mr Bailey: To support their costs associated with that education and training.
>
> Senator O'NEILL: Which you provide.[53]

Committee view

5.85 Evidence to the committee, particularly from ASIC, indicates that a plethora of hidden payments including commissions, fees, performance-related payments, soft dollar benefits, and non-financial benefits exist within the various structures of the life insurance industry. These money flows exist to varying degrees across all three sectors: retail, direct, and group.

5.86 The committee also received evidence about a vast range of hidden remuneration that does not even appear in Figure 5.3 in relation to remuneration within retail life insurance. These money flows constitute what used to be termed shelf space fees. These are fees paid by a life insurer to an advice licensee in order to ensure the licensee includes certain products from that insurance company on the licensees' APL.

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52 Mr William Crawford, Private capacity, *Committee Hansard*, 18 August 2017, pp. 55–56.

53 Exchange between Mr Tim Bailey, Chief Executive Officer, Life and Investments, Zurich Financial Services Australia Ltd., and Senator O'Neill, *Committee Hansard*, 26 May 2017, p. 36.

5.87 Evidence to the committee indicated that insurers currently pay $10–15 million per year in shelf space fees and that individual shelf space fees range from $80 000 to $500 000. These are substantial sums of money in anyone's language.

5.88 The committee endorses the view expressed by the Trowbridge review that the incentives embedded in non-commission remuneration and benefits has the potential to create conflicts of interest for advice licensees and advisers.

5.89 The committee also supports the Trowbridge review recommendation that licensees be prohibited from receiving benefits from life insurers that might influence recommended product choices or the advice given by the licensees' advisers.

5.90 In light of the recommendations made in the Trowbridge review, the committee was particularly disconcerted by the evidence it received that life insurers and advice licensees are finding ways to work around the conflicted remuneration restrictions that commenced on 1 January 2018 regarding shelf space fees.

5.91 While the committee recognises that each case will be assessed on its individual circumstances, the committee is concerned that life insurers are continuing to pay, and advice licensees continuing to receive, shelf space fees by disguising the payments as education and training fees.

5.92 The committee was disturbed to receive confirmation from Zurich, a major life insurer, that it would both provide training to an advice licensee and pay the advice licensee for that training. This appears to be nothing more than a re-badging exercise. That is, what used to be referred to as shelf space fees are now rebadged as training fees merely in order to circumvent the new rules on conflicted remuneration.

5.93 The committee emphasises that the rules banning conflicted remuneration have been introduced specifically in order to mitigate some of the risks around conflicts of interest in the life insurance industry. It bears repeating that the wrong type of financial incentives have contributed significantly to a range of poor practices and misconduct in the financial services industry including misleading advice and mis-selling with poor outcomes for customers.

5.94 The committee reiterates its finding from its 2009 inquiry into financial products and services in Australia, namely that commissions (both up-front and trailing), volume bonuses, sales target rewards, and soft-dollar incentives place financial advisers in the role of both broker (that is, seller) and expert adviser. As the committee stated in 2009, a significant conflict of interest for financial advisers arises when they are remunerated by product manufacturers because these payments place financial advisers in the role of both broker and expert adviser, with the potentially competing objectives of maximising remuneration via product sales and providing professional, strategic financial advice that serves clients' interests.

5.95 In this regard, the committee is of the view that shelf space, education, and training fees should also be treated as remuneration and benefits. The committee struggles to see how the continued existence of these payments and benefits has any benefit for the consumer.

5.96 As such, the committee considers that the current remuneration arrangements in the life insurance industry lack transparency and create conflicts of interest that

could continue to have detrimental outcomes for consumers. Furthermore, the lack of transparency surrounding many of these payments makes it difficult for policy makers, regulators and consumers to make informed decisions.

5.97 The committee recognises that action has been taken to address conflicted remuneration through ASIC reviews, the introduction of Future of Financial Advice reforms, and the *Corporations Amendment (Life Insurance Remuneration Arrangements) Act 2017*. The committee notes these latest reforms.

5.98 The committee also acknowledges the concerns raised by retail advisers regarding the impact of the LIF reforms on their businesses. In this regard, the committee notes that while commission caps and clawback requirements will apply to upfront and hybrid commission structures, the cap on ongoing (trailing) commissions has been increased from 10 per cent to 20 per cent and there is no anticipated cut-off period for ongoing commissions. Furthermore, for level commission structures, the commission caps and clawback requirements will not apply, meaning that the life insurer will continue to be able to pay the advice licensee a flat rate commission of around 30 per cent of the first year's premium and for every year of the life of the policy.

5.99 An approximate calculation of the commission payments on a hypothetical life insurance policy with a $1000 premium indicates that after six years, under the old regime, the commission payments would amount to about $1800 ($1300 first year commission plus five years of ongoing commissions at $100 each). Under the LIF reforms, the commission payments would still amount to about $1800 ($800 first year commission plus five years of ongoing commissions at $200 each). Finally, under a level commission structure, the commission payments would also amount to about $1800 ($300 first year commission plus five years of ongoing commissions at $300 each). In other words, the quantum of the commission stream has not necessarily decreased. Indeed, for any policy held for more than six years, the LIF reforms allow a higher level of commissions to accrue to an advice licensee.

5.100 Nevertheless, in light of the substantial commission flows that appear likely to continue within the life insurance industry, as well as the substantial monetary and non-monetary flows associated with various fees (shelf space, training, and education), the committee considers that further transparency around the remuneration arrangements in the life insurance industry is required in order to mitigate any risks of corruption that may arise from conflicts of interest.

5.101 During the inquiry, the committee asked life insurers to provide data on remuneration, commission, payment and fee flows within the life insurance industry. The committee then provided the data to ASIC and asked ASIC to analyse it in a series of written questions on notice. As at 22 March 2018, ASIC had not responded to the committee's questions. The committee will make ASIC's responses available when they are received.

5.102 The committee regards a thorough and comprehensive review as particularly important because of the potential linkages between commissions and shelf space fees (or their equivalent). For example, the committee can envision a situation arising where a life insurer agrees to pay an advice licensee a higher rate of commission up to

the legal maximum as part of a deal to secure space for that life insurer's product on that advice licensee's shelf. It is partly out of an awareness of these potential linkages that the committee has considered shelf space fees in this chapter on remuneration, although the committee recognises that shelf space fees are intimately linked to approved product lists (APLs) which are the topic of the next chapter.

5.103 The committee therefore recommends that ASIC conduct a systematic review and risk assessment of all payments and benefits (monetary and non-monetary) between participants in each sector of the life insurance industry with a view to advising the government of any outstanding risks and regulatory gaps. To spell this out, the committee expects that this would include, but not be restricted to, all commissions and fees including training and education fees and the like.

5.104 In addition, the committee considers that it is particularly important that reforms resulting from the ASIC review are progressed in parallel for the direct, group and retail sectors in order to avoid any inappropriate regulatory induced flow of customers between the sectors.

Recommendation 5.2

5.105 The committee recommends that:

- **ASIC conduct a systematic review and risk assessment of all payments and benefits flowing between participants in each sector of the life insurance industry—direct, group, and retail—and inform the government of any regulatory gaps; and**
- **the government consider further regulation of payments between life insurance industry participants following the ASIC review.**

5.106 The committee notes that the life insurance industry may argue that some of these matters will be addressed in future iterations of its code of practice. However, the committee is not convinced. Apart from a reference to profit sharing payments in the draft Insurance in Superannuation Code of Practice, the industry's code of practice has not addressed the lack of transparency and conflict-of-interest risks with the payments described in this chapter and set out in Figures 5.1, 5.2, and 5.3 and Table 5.2.

5.107 The committee also notes that payments made from life insurers to trustees remain unregulated by conflicted remuneration provisions and can include payments arising from profit sharing arrangements that exist between trustees and life insurers in the provision of default insurance funded by superannuation guarantee contributions. The committee also notes that there is no transparency around other payments that may exist between life insurers and trustees including soft dollar benefits. The committee believes that given the compulsory nature of superannuation and the automatic provision of insurance, transparency around the exact nature of the value of these arrangements is critical for confidence in the superannuation system.

Recommendation 5.3

5.108 The committee recommends that ASIC and APRA immediately undertake an audit of all superannuation trustees to identify the nature, purpose and value of all payments, including any 'soft-dollar' benefits that occur between life insurers and trustees or any related parties in connection with the provision of default insurance to members of MySuper and choice superannuation products, including:

- **current and historical payments made by life insurers to trustees or any related parties and/or by trustees to life insurers under profit-sharing, premium adjustment models, experience share arrangements or any arrangement of a similar nature;**
- **the total premium value attributable to the existence of profit-sharing, premium adjustment models, experience share arrangements or any arrangement of a similar nature between a trustee and a life insurer; and**
- **payments, including any 'soft-dollar' benefits made or that may become payable by life insurers to trustees or any related parties of trustees for any purpose, for example, subsidisation of administration costs, technology, marketing, sponsorship, hospitality, staff expenses etc.**

5.109 The committee also recommends that the report be published by ASIC and APRA as soon as practical to ensure confidence in the compulsory superannuation system.

Chapter 6

Retail life insurance and approved product lists

Introduction

6.1 Approved Product Lists (APLs) are used by advice licensees and advisers selling life insurance to maintain a list of life insurance products that they have available to sell. APLs are also used for providing financial advice. This chapter examines issues arising from the use of APLs when they are used for providing financial product advice in relation to life insurance. The chapter begins by summarising what APLs are and how they are used. Evidence received during the inquiry that raises issues with APLs is then discussed. The chapter concludes with the committee's views and recommendation for reform.

The nature of APLs

6.2 An APL is a pre-selected product list maintained by an AFS licensee, which contains the range of financial products that advisers can sell. APLs are not mandated by the Corporations Act or ASIC regulatory policy but are commonly used throughout the industry. The best-interests duty does not prevent or require the use of APLs. However, satisfying the best-interests duty with respect to the use of an APL would depend on how the APL was used. At this juncture, there are no standards or requirements for the number of products or product issuers that must be represented on an APL. In other words, an APL may contain products from only one insurer or a large number of insurers.[1]

6.3 In its submission, ASIC noted some of the potential benefits of an APL:

- APLs are often used by AFS licensees and their representatives as a risk management tool to assist licensees in meeting their legal obligations when providing financial product advice;
- APLs may facilitate the provision of higher quality or better value products if the quality of the products is assessed before their inclusion; and
- APLs may reduce the risk that information provided to consumers is incorrect, because APLs limit the number of products that advisers need to understand.[2]

6.4 Nonetheless, ASIC also observed that, in order to act in a customer's best interests, an adviser may need to consider products in addition to those on their licensee's APL.[3] ASIC's Regulatory Guide 175 (RG 175), sets out the circumstances in which advisers are required to consider products that are not currently on their APL:

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1 Australian Securities and Investments Commission, *Submission 45*, pp. 43–44.

2 Australian Securities and Investments Commission, *Submission 45*, pp. 43–44.

3 Australian Securities and Investments Commission, *Submission 45*, p. 44.

> In some cases, an advice provider can conduct a reasonable investigation into financial products under s961B(2)(e) by investigating the products on their AFS licensee's approved product list.
>
> In other cases, an advice provider will need to investigate and consider a product that is not on their AFS licensee's approved product list to show that they have acted in the best interests of the client when providing them with personal advice, for example:
>
> (a) if the client's existing products are not on the approved product list of the advice provider's licensee and these products might be able to meet the client's relevant circumstances;
>
> (b) if an approved product list used by an advice provider is restricted to one class of product and there are products that are not in that class that would better meet the client's relevant circumstances, considering the subject matter of the advice sought by the client; or
>
> (c) if the client requests the advice provider to consider a specified financial product that is not on the approved product list of the advice provider's licensee.[4]

6.5 RG 175 states unambiguously the obligations that the best-interests duty places on an adviser with respect to an APL and the provision of client advice:

> If an advice provider is unable to recommend products outside their AFS licensee's approved product list, and they need to do this to meet their obligations in Div 2 of Pt 7.7A, the advice provider must not provide the advice.[5]

6.6 The effectiveness of APLs was considered in the 2015 Trowbridge review. That review noted that licensees operate an APL that contains a selection of life insurers from among the 13 providers that serviced the retail life insurance market at the time of the review. Some licensees use as few as one insurer while other licensees have an 'open architecture' approach that lists all 13 insurers.[6]

6.7 The Trowbridge review noted that in order to ensure quality advice is provided to consumers and that competition between life insurers flows through to consumers, the industry needs to strike a balance between a licensee's desire to limit its APL so as to contain administrative costs and the need for advisers to meet the obligations to their clients.[7]

6.8 The Trowbridge review identified the following issues with APLs:

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4 Australian Securities and Investments Commission, *Regulatory Guide 175 Licensing: Financial product advisers–Conduct and disclosure*, March 2017, p. 83.

5 Australian Securities and Investments Commission, *Regulatory Guide 175 Licensing: Financial product advisers–Conduct and disclosure*, March 2017, p. 84.

6 Mr John Trowbridge, *Review of Retail Life Insurance Advice*, March 2015, p. 9.

7 Mr John Trowbridge, *Review of Retail Life Insurance Advice*, March 2015, p. 48.

- Limited APLs unnecessarily restrict competition and can prevent advisers from offering their clients access to a broad range of life insurance products and services. While advisers can request to go outside the licensees APL, doing so can be time consuming and difficult. As a result it is common for advisers to stay within the APL for most of their recommendations.
- Limited APLs also create incentives for advisers to push products that can lead to consumer detriment. Courts have noted that limited APLs fundamentally fail to meet the objectives around the provision of advice in a client's best interest. A recent example is (*Commonwealth Financial Planning Ltd v Couper 2013*,) where it was found the advice was incomplete due to the role played by a very narrow APL.[8]

6.9 The Trowbridge review recommended that APLs in the retail life insurance advice sector should include at least half of the authorised retail life insurance providers and be prohibited from receiving benefits from insurers and potentially influence advice.[9]

6.10 ASIC agreed that the Trowbridge recommendation could lead to improvements in the industry. ASIC submitted that expanded APLs may address the following risks that are associated with narrow APLs:

- Lower quality/poor value products—Advice providers who can only recommend a limited number of products from an APL will be less able to give quality advice which complies with their conduct obligations if the products on the APL are too restricted, not suitable, or of poor quality.
- Conflicts of interest—APLs that favour products issued within the vertically integrated group will not allow effective management or avoidance of conflicts of interest, which can lead to poor outcomes for consumers.
- Lack of innovation—APLs that are too narrow or static may prevent consumers from accessing new and innovative products with features that are better for them.[10]

6.11 However, ASIC also informed the committee that expanded APLs would not be a sufficient reform by itself to improve the quality of advice, because:

- advice providers operating within a vertically integrated group tend to recommend in-house products over non-related products even where their APL includes a wide range of non-related products;
- a wider APL may not protect consumers from the poor outcomes that can result where the adviser has a conflict of interest; and

8 Mr John Trowbridge, *Review of Retail Life Insurance Advice*, March 2015, p. 49.

9 Mr John Trowbridge, *Review of Retail Life Insurance Advice*, March 2015, p. 9.

10 Australian Securities and Investments Commission, *Submission 45*, pp. 44–45;

- the drivers of poor quality retail life insurance advice also include adviser incentives and failure to consider the relationship between life insurance and superannuation.[11]

6.12 In November 2015, the Government announced as part of the LIF Reforms that industry would be responsible for widening APLs through the development of a new industry standard.[12]

6.13 The FSC noted in its November 2016 submission to this inquiry that it is currently developing a life insurance APL Standard to encourage high standards in life insurance APL construction practices that support quality consumer outcomes.[13]

6.14 In April 2017 the FSC released a draft standard for life insurance APLs for consultation until 10 May 2017. The FSC is seeking to finalise the standard in the coming months. The FSC indicated that the standard:

- is intended to be compulsory for all FSC members once approved;
- requires a reasonable basis for APLs to be formulated with the best interests duty in mind;
- requires life insurance APLs to contain a choice of multiple life insurance providers and to be supported by robust off-APL processes so alternative products can be recommended; and
- would encourage disclosure of how many products and providers are on the APL.[14]

6.15 At an ASIC Oversight hearing in October 2017, ASIC confirmed to the committee that it is 'looking at how APLs work in practice and whether advisers do use the full range of products on approved product lists'.[15]

Arguments supporting the use of APLs

6.16 The FSC suggested that APLs are an important element in the advice process that facilitates the delivery of advice based on quality researched products for licensees and advisers. Licensees review and assess products for inclusion in an APL for advisers to offer their clients. APLs serve as a risk management tool for advisers and licensees whereby products have been assessed for suitability prior to being

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11 Australian Securities and Investments Commission, *Submission 45*, p. 45.

12 The Hon Kelly O'Dwyer MP, Minister for Revenue and Financial Services, *Government announces significant improvements to life insurance industry*, 6 November 2015, http://kmo.ministers.treasury.gov.au/media-release/024-2015/ (accessed 8 November 2017).

13 Financial Services Council, *Submission 26*, p. 29.

14 Financial Services Council, *Submission 26.1*, p. 16; Financial Services Council, *FSC releases draft APL standard for consultation*, 12 April 2017, https://www.fsc.org.au/_entity/annotation/38dbc220-2b2e-e711-80fc-c4346bc5c274 (accessed 16 October 2017).

15 Mr Peter Kell, Deputy Chairman, Australian Securities and Investments Commission, *Committee Hansard*, 27 October 2017, p. 4.

included on the list. The FSC argued that this facilitates appropriate products being recommended to clients. The FSC noted that the development of APLs commonly involves assessments of experience with underwriting, claims and other services which are likely to impact the customer or adviser experience.[16]

6.17 MLC informed the committee that, in its view, APLs function as a way for licensees to manage risk by supporting their recommendation with products that have undergone qualitative research. Further, MLC argued that because an APL ensures products meet agreed minimum standards and are issued by a reputable manufacturer, they function to protect both the advisor and their client. In addition, if the products on an APL do not suit the specific needs of a customer, most licensees have a process in place to gain approval for the use of an alternative, non-APL product.[17]

6.18 At a hearing in March 2017, Mr Brad Cooper, Chief Executive Officer of BT Financial Group (BT), confirmed that BT only has their own life insurance products on the APL used by their financial advisers.[18]

6.19 Mr Cooper explained how a vertically-integrated business with such a narrow APL meets the best interests test under the FOFA regulations. In particular, Mr Cooper noted that BT has very highly-ranked products tailored to the needs of their customers, as well as an off-APL process whereby advisers can select a competitor's product as necessary:

> Perhaps I can explain for a moment about the APL and how that works—
>
> …and how we use that to ensure that we deliver on that best interests test. Our salaried financial advisers work for our group. Predominantly their customers are customers of the bank. You would imagine that we know those customers very well and we use our knowledge of those customers in making sure that the development of our products suits the vast majority of those needs. By way of example, our products are one of the only products that would have income protection for homemakers; it is one of the only set of products with a SME segment that has a key personal insurance policy that covers the revenue at risk to the business if that person was ill. So there are a range of covers that our products have that others do not.
>
> As I said earlier, IRIS rates our product No. 1 in six out of eight times and it is second on the other two. Both Investment Trends and Strategic Insight also rate our product No. 1 in the market. In the vast majority of cases, our product is most suitable for those customers, and that is the product on our APL. But we do recognise that it does not meet every circumstance. So we have what we call an off-APL process that, if one of our advisers meets a customer and they do not believe that our product meets that customer's best interests, they can use a competitor's product that is not on our APL. In 2016, our advisers did that over 1,200 times, which was one in 20 of our

16 Financial Services Council, *Submission 26*, p. 29; Financial Services Council, *Submission 26.1*, p. 15.

17 MLC, *Submission 30*, pp. 8–9.

18 Mr Brad Cooper, *Committee Hansard*, 3 March 2017, p. 43.

> claims, and they used some seven providers off the APL. I am the licensee, if you like, of the AFSL and I am responsible for meeting that best interests test.
>
> The way we do that for our customers of our salaried financial advisers is by making sure that, where appropriate, they use the products that we know well and which are best suited for the customer. When they choose to go off that APL, we have a process where it goes into our research team and we are making sure in those circumstances that the ultimate product better meets that customer's requirements.[19]

6.20 In November 2017, BT announced that it intended to add other insurers to its APL by March 2018.[20]

Arguments for widening or banning APLs

6.21 The committee received a substantial body of evidence that argued for increasing the number of life insurance companies, and the number of non-affiliated products, represented on an APL as a matter of some urgency.

6.22 Berrill & Watson Lawyers suggested that mandating a minimum number of insurance companies to be included in APLs would have the advantage of substantially diluting the ability of advisers to guide clients towards particular products for commission-driven motives.[21]

6.23 Clearview argued against APLs as, in its view, APLs result in a 'pay to play' model which enables many product manufacturers to effectively buy access to advisers and distribution. Shelf space and other fees mean that the products on these restricted APLs are not necessarily the best products available, nor would they necessarily be best-suited to the customer's needs.[22]

6.24 Clearview advocated for open APLs to be a regulatory requirement if industry failed to immediately move voluntarily to open APLs. Clearview acknowledged that the FSC had a process underway, but was critical of the time being taken.[23]

6.25 TAL supported further reform of APLs, suggesting that a requirement to have a range of products and suppliers in any APL would return the focus of such lists to being about quality and choice. TAL also supported the introduction of a new APL standard to widen APLs.[24]

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19 Mr Brad Cooper, *Committee Hansard*, 3 March 2017, p. 44.

20 Insurancenews.com.au, *BT to expand life product offerings*, 6 November 2017, http://www.insurancenews.com.au/life-insurance/bt-to-expand-life-product-offerings (accessed 8 February 2019).

21 Berrill & Watson Lawyers, *Submission 19*, pp. 6–7.

22 Clearview, *Submission 10*, pp. 4–7.

23 Clearview, *Submission 10*, p. 8.

24 TAL, *Submission 31*, p. 7.

6.26 AIA also supported the Trowbridge recommendation that APLs in the retail life insurance advice sector should include at least half of the authorised retail life insurance providers. AIA argued that the benefit of broader market coverage in APLs is that it will increase the level of product choice, competition, and consumer access to life insurance products. AIA suggested that this will allow consumers to compare and select the best product.[25]

6.27 ANZ informed the committee that it supports a minimum of three providers being offered on APLs. ANZ advised the committee about the size of its APLs, indicating that:

- ANZ Financial Planning has four providers on its APL, one of which is OnePath; and
- ANZ dealers groups have nine providers on their APL, which also includes OnePath.[26]

6.28 Maurice Blackburn Lawyers (Maurice Blackburn) were critical of APLs, noting that dealer groups utilising a vertical integration model are not obliged to have any retail life risk insurance product on their APLs other than their own affiliated product. Vertically-integrated advice is where an adviser recommends purchase of a financial product (including life insurance) from entities with which they are associated. This is often to the exclusion of more suitable non-affiliated products. Maurice Blackburn suggested that this inherent conflict has given rise to much litigation in recent years, the most notable case being Commonwealth Financial Planning Ltd v Couper. Maurice Blackburn noted that these inherent conflicts were highlighted by Roy Morgan research which stated that over a three year period, these dealer groups allocated an average of over 70 per cent of their sales to their own products.[27]

6.29 Maurice Blackburn argued that the recent LIF Reforms have not addressed the issues arising from APLs, suggesting the Explanatory Memorandum to the Corporations Amendment (Life Insurance Remuneration Arrangements) Bill 2016 (the Bill) did not discuss these issues directly nor propose any substantive reform.[28] Maurice Blackburn suggested that potential reforms could include a requirement that:

- APLs include a balance of affiliated and non-affiliated products, and/or a minimum proportion of non-affiliated products; and
- if affiliated products are recommended, the affiliation should be disclosed, and the customer should be given a comparison with non-affiliated products.[29]

25 AIA Australia, *Submission 32*, p. 33.

26 ANZ, *Submission 44*, pp. 2, 17.

27 Maurice Blackburn Lawyers, *Submission 12*, pp. 10–11.

28 Maurice Blackburn Lawyers, *Submission 12*, pp. 10–11.

29 Maurice Blackburn Lawyers, *Submission 12*, p. 11.

6.30 The Australian Lawyers Alliance argued for a legislated solution informing the committee that the government previously entrusted the industry with responsibility for widening APLs through the development of a new industry standard. The ALA suggested that a passive response is inappropriate given the industry's poor track record of self-regulation and its manifest commercial interest in continuing to sell in-house products.[30]

6.31 The Association of Financial Advisers informed the committee that reduced licensing fees have been used by licensees to incentivise advisers to select narrow APLs over boarder APLs, further compromising an adviser's capacity to meet their best interests duty.[31]

6.32 The committee received evidence from Mr Stephen Perera, Director of advice firm Perera Crowther, who advocated banning the use of APLs within retail life insurance primarily because an APL is used to manipulate distribution and money flows by artificially restricting choice for no discernible consumer benefit:

> APLs are used among AFSL holders to control distribution of insurance products where they (the AFSL) have profit share arrangements.
>
> The above-mentioned behaviour is particularly concentrated among vertically integrated AFSLs. By way of example, one vertically integrated AFSL excludes over half of the insurers that currently manufacture Life Insurance products.
>
> APLs inhibit choice for consumers for the benefit of AFSL holders who are interested in meeting their Key Performance Indicators to meet their volume based bonuses.
>
> There is no benefit for consumers to retain APLs.[32]

Committee view

6.33 A large body of evidence to the inquiry recommended substantial reform to the way that APLs are currently constructed and used. As discussed in both this chapter and the previous chapter with respect to shelf space, education, and training fees, the committee received evidence that the way APLs operate lacks transparency and generates conflicts of interest that lead to mis-selling, that is, selling a life insurance product on the basis of misleading advice.

6.34 The risks of mis-selling arise from the potential for APLs to be used:

- to herd customers to the insurer that is prepared to pay the most to be on the APL; or
- to herd customers to in-house products through vertically integrated arrangements.

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30 Australian Lawyers Alliance, *Submission 20*, p. 29.

31 Association of Financial Advisers, *Submission 22*, p. 16.

32 Mr Stephen Perera, Director, Perera Crowther Financial Services, *Submission 58*, p. 5.

6.35 The committee notes that the following recent developments could address some issues with APLs:

- the Trowbridge recommendation that APLs must contain at least half of the authorised retail life insurance providers; and
- the draft APL standard developed by the FSC.

6.36 In spite of these recent developments, the committee has the following reservations:

- firstly, the relationship between the APL standard and the Life Insurance Code of Conduct is not clear;
- secondly, the draft standard may only cover FSC members who hold AFS licenses, thus leaving out many other industry participants; and
- thirdly, the voluntary self-regulatory nature of the standard means it lacks rigor and enforceability.

6.37 The committee is particularly concerned about the risk of conflicts of interest that arise when an APL is used as the basis for giving financial product advice. In this situation, a customer should be able to expect that the advice they are given is independent, genuinely in their best interest, and has not been influenced by deals and secret payments to get a product onto an APL.

6.38 The committee considers that, in order to satisfy the Future of Financial Advice (FOFA) best-interests test, an adviser must be able to select products from a broad APL that contains a balance of non-affiliated products, and freely give, without encumbrance, financial product advice that may include a recommendation that the best product for a customer is a product that the adviser does not sell.

6.39 In this regard, the committee notes that BT, a vertically-integrated life insurance business, appeared before the committee and confidently asserted that their own in-house products are ranked the best on the market and, on that basis, they see no need to stock any other products on their APL. The committee accepts that a business may indeed be capable of producing the best products on the market for a year or even for a few years. But it stretches credulity that a company would be able to do so indefinitely. As a corollary, therefore, a question arises as to how a vertically-integrated business that only stocked its own products on its APL could meet the duty to act in the best interests of the client under the FOFA regulations on an ongoing basis. In other words, it may be possible for that business to meet the FOFA requirements for a year or even several years, but it seems unlikely that such a business arrangement could be deemed to meet the best-interests duty indefinitely. The committee is not persuaded that the ability to occasionally select an off-APL product is sufficient to counter-balance the hazards of continuing to maintain such a narrow APL.

6.40 The committee notes the arguments of some industry participants that APLs reduce risks by removing poor quality products. However, the committee is not convinced that restrictive APLs influenced either by vertically integrated arrangements or by a secretive array of shelf space fees, and various other fees such as

training fees, are the best way to protect consumers from poor quality products. Indeed, the committee has heard many persuasive arguments to the contrary from a range of consumer groups that the prevalence of hidden fees that shape APLs are detrimental to consumers because consumers may end up being sold an inferior product merely because a life insurer has paid a fee to enable that product to be put on an advice providers shelf.

6.41 In light of these circumstances, the committee considers that, as currently configured, APLs are severely lacking in transparency. At a bare minimum, an APL should have a balance of affiliated and non-affiliated products, and if affiliated products are recommended, the affiliation should be disclosed, and the customer should be given a comparison with non-affiliated products.

6.42 Beyond this, however, the committee is not convinced that the draft APL Standard being proposed by the FSC will adequately address the full range of concerns articulated by the committee in this and the previous chapter. The committee is of the view that the life insurance industry should be transitioning to open APLs. The committee considers that the advantages of open APLs in terms of transparency and improved consumer outcomes far outweigh any risks to consumers.

6.43 While the committee is prepared to allow the industry some flexibility in making this transition, the committee draws attention to Recommendation 5.2 from the previous chapter in which the committee recommended that ASIC conduct a systematic review and risk assessment of all payments and benefits (monetary and non-monetary) flowing between participants in each sector of the life insurance industry with a view to advising the government of any outstanding risks and regulatory gaps.

6.44 Based on both the findings of that review and the extent to which industry has taken the initiative to move towards open APLs, the committee suggests that the government may like to consider whether further regulation in this space is required to enforce greater transparency and improve consumer outcomes.

Recommendation 6.1

6.45 The committee recommends that the life insurance industry should have, as a matter of urgency, a balance of affiliated and non-affiliated products on their approved product lists, and if affiliated products are recommended, the affiliation should be disclosed, and the customer should be given a comparison with non-affiliated products. Beyond this, the committee further recommends that the industry transition to open approved product lists.

6.46 The committee observes that the manner in which APLs have been configured may potentially breach competition laws. The committee therefore considers that it is appropriate that ASIC and the ACCC jointly investigate whether the past use of APLs in the life insurance industry breaches any competition laws they administer including, but not limited to, anti-competitive agreements.

6.47 The committee also considers that the report of the above joint investigation should also inform government whether the current legislation inappropriately

constrains the capacity of ASIC or the ACCC to investigate anti-competitive behaviour in the financial service sector, including life insurance.

Recommendation 6.2

6.48 The committee recommends that ASIC and the ACCC jointly investigate whether the past use of APLs in the life insurance industry breaches any anti-competitive laws they administer. The report of the investigation should also inform government whether the current legislation inappropriately constrains the capacity of ASIC or the ACCC to investigate anti-competitive behaviour in the financial service sector, including life insurance.

Chapter 7
Group life insurance

Introduction

7.1 This chapter considers issues associated with group life insurance, including opt-out requirements, member awareness of cover, the impact of premiums on small super balances, the continuing deduction of premiums from a member's account despite that member no longer qualifying for cover, and duplicate insurance.

Opt-out versus opt-in requirements

7.2 The *Superannuation Industry (Supervision) Act 1993* (SIS Act) requires MySuper members to generally be offered life and TPD cover on an opt-out basis.[1]

7.3 Many submitters and witnesses supported retaining the present opt-out system.[2] For example, both the Australian Institute of Superannuation Trustees and Industry Super Australia argued that the opt-out model has helped to combat underinsurance in Australia.[3]

7.4 The Association of Superannuation Funds Australia (ASFA) submitted that the evolution of group insurance over the past 20 years has seen up to 92 per cent of the working population afforded some type of insurance coverage that would otherwise not be in place. ASFA argued that:

> While member engagement with insurance in superannuation is typically low, some ASFA members have reported to us that up to 15 per cent of members 'opt-up' and increase their default level of insurance cover, whilst less than 5 per cent opt out and cancel their cover. This behaviour indicates that fund members associate a high degree of value and benefit with insurance in superannuation and that for many individuals increased levels of cover are required to meet their needs.[4]

7.5 Similarly, the FSC submitted that the majority of Australians would not have adequate cover if it was not for their default, opt-out superannuation fund arrangements. The FSC argued that the superannuation system has proved to be the most efficient and effective means of providing an affordable level of insurance cover to almost all working Australians. Over 90 per cent of the working population are

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1 *Superannuation Industry (Supervision) Act 1993*, Section 68AA.

2 Maurice Blackburn Lawyers, *Submission 12*, p. 14; Berrill & Watson Lawyers, *Submission 19*, pp. 5; Australian Lawyers Alliance, *Submission 20*, pp. 5–8; Australian Institute of Superannuation Trustees and Industry Super Australia; *Submission 23*, p. 5; Financial Services Council, *Submission 26*, p. 20; Association of Superannuation Funds Australia, *Submission 29*, p. 5; Breast Cancer Network Australia, *Submission 72*, p. 1.

3 Australian Institute of Superannuation Trustees and Industry Super Australia, *Submission 23*, pp. 5, 12.

4 Association of Superannuation Funds Australia, *Submission 29*, p. 5.

afforded some type of insurance cover that would not otherwise be in place, particularly for those unlikely to have considered their insurance needs.[5]

7.6 In light of the coverage afforded by an opt-in model, the FSC raised the following concerns about an opt-in model:

> In contrast, where there is an opt-in arrangement significantly fewer people are likely to be covered. The average opt-in rate is very low for voluntary arrangements of insurance cover, such as income protection. An opt-in arrangement would result in more expensive insurance costs potentially making cover unaffordable for many Australians who are already covered today.
>
> Many Australians, for example those working in heavy industry or suffering from a pre-existing medical condition, may not be given access to cover under an opt-in arrangement.[6]

7.7 Berrill and Watson Lawyers submitted that while improvements need to be made to group life insurance, it has operated as a very efficient means of delivering life insurance to Australians. Noting that the proportion of total life insurance held within superannuation funds was 71 per cent for death cover, 88 per cent for TPD cover, and 59 per cent for income protection cover,[7] Berrill and Watson Lawyers argued that any significant movement away from the current opt-out model would have huge adverse implications for the availability of affordable life insurance and would drastically reduce the amount of Australians who have life insurance.[8]

7.8 The Australian Lawyers Alliance (ALA) submitted that opt-out cover in superannuation is indispensable for retaining high levels of life insurance cover for Australians. The ALA did acknowledge, however, that both the products being offered to consumers, and the claims handling processes being used by insurers, require improvement in order to balance consumer rights with market viability.[9]

7.9 Nevertheless, despite widespread support for the current opt-out system in group life insurance, several submitters and witnesses raised specific concerns about various aspects of the opt-out system, including some of the issues discussed in the following sections.

Making it easier to opt out of group life insurance

7.10 The SIS Act includes a requirement for trustees to allow MySuper members to elect not to receive (opt out of) life insurance relating to permanent incapacity benefits or death benefits in section 68AA:

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5 Financial Services Council, *Submission 26*, p. 20.

6 Financial Services Council, *Submission 26*, p. 20.

7 Berrill & Watson Lawyers, *Submission 19*, p. 4.

8 Berrill & Watson Lawyers, *Submission 19*, p. 5.

9 Australian Lawyers Alliance, *Submission 20*, pp. 5–6.

> (5) Each trustee of a regulated superannuation fund must ensure that each MySuper member of the fund may elect either or both of the following:
>
> > (a) that permanent incapacity benefit will not be provided to the member by the fund;
> >
> > (b) that death benefit will not be provided in respect of the member by the fund.
>
> (6) The trustees of a regulated superannuation fund may require that MySuper members who wish to make an election in accordance with subsection (5):
>
> > (a) must make the election in relation to both permanent incapacity benefit and death benefit; or
> >
> > (b) must make the election in relation to death benefit if they make the election in relation to permanent incapacity benefit.[10]

7.11 AMP informed the committee that customers can call AMP to opt out of group insurance and that AMP is investigating ways to make that an easier process online.[11]

7.12 Treasury informed the committee that the government has tasked APRA with making it easier for MySuper members to opt out of automatic life insurance policies. Treasury noted that there is no guidance to funds on how to implement the requirement to allow customers to opt out. Treasury also noted that there were currently no regulatory impediments to trustees making it easy for consumers to opt out. Treasury therefore suggested that:

> The sense is maybe that trustees make it very easy to get more insurance, but very hard to opt out of insurance.
>
> [I]deally you would be able to go onto the fund's website and you would be able to opt out by pressing a button, like you could press a button now to apply for additional life insurance.[12]

7.13 The draft Insurance in Superannuation Code of Practice would require trustees to make the process of cancelling, or opting out of, automatic cover straightforward and transparent for members. The draft code indicates that members should be able to cancel through a fund's website, over the phone or via email. The final version of the ISWG code appears to have retained most of these features.[13]

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10 *Superannuation Industry (Supervision) Act 1993*, s. 68AA.

11 Ms Megan Beer, Group Executive, Insurance, AMP Ltd, *Committee Hansard*, 18 August 2017, p. 26.

12 Mr Ian Beckett, Principal Adviser, Retirement Income Policy Division, Treasury, *Committee Hansard*, 8 September 2017, pp. 57, 62; see also, The Hon Kelly O'Dwyer MP, Minister for Revenue and Financial Services, Media release, *Reforms to give consumers more power at the heart of a stronger superannuation system*, 24 July 2017.

13 Insurance in Superannuation Working Group, Consultation paper, *Insurance in Superannuation Code of Practice*, September 2017, p. 9; Insurance and Superannuation Working Group, *Insurance in Superannuation Voluntary Code of Practice*, December 2017, p. 6.

Inadequate member awareness of cover

7.14 ASIC pointed out that superannuation fund members may often be unaware that they have insurance cover, how to claim on a policy, or that the cover may change or even cease in certain circumstances.[14]

7.15 Furthermore, members may receive inconsistent information as a result of trustees relying on data from employers. This issue is potentially exacerbated when a superannuation trustee changes their insurance arrangements, which can occur every three years. This can result in fund members not being aware of the details of their current cover, and of any relevant changes to the claims process.[15]

7.16 ASIC indicated that it is undertaking a review of the information provided to consumers by superannuation trustees in relation to the underlying insurance policy entered into by the insurer and the superannuation trustee.[16]

7.17 CHOICE raised concerns about how information on group life insurance is presented to consumers, submitting that application forms are confusing and do not provide clear information about the cost of default cover. Instead, consumers are directed to supplementary documents, such as insurance guides and product disclosure documents. CHOICE indicated that these documents often display the cost for units of cover which may differ across age groups, requiring consumers to conduct mathematical calculations to discover the cost of life insurance premiums. CHOICE argued that because such a small percentage of consumers read and understand such documents, it is unrealistic to expect that consumers are making informed decisions when deciding whether to opt-out of group life insurance.[17]

Duplicate group life insurance accounts

7.18 During the inquiry, concerns were raised about the extent of duplicate life insurance policies in group superannuation resulting from people moving between occupations. The committee notes that, in some cases, people may deliberately choose to maintain multiple group life insurance accounts. However, evidence to the committee also indicated many people are unaware that they have group life insurance and, potentially, multiple group life insurance accounts.

7.19 The Australian Taxation Office (ATO) data indicates that 40 per cent of people have more than one superannuation account, with 15 per cent having three or more. Thirty per cent of people under 25 have more than one superannuation account. The greatest proportion of multiple superannuation accounts is around 47 per cent for 36 to 50 year olds.[18]

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14 Australian Securities and Investments Commission, *Submission 45*, p. 34.

15 Australian Securities and Investments Commission, *Submission 45*, p. 34.

16 Australian Securities and Investments Commission, *Submission 45*, p. 34.

17 CHOICE, *Submission 49*, pp. 10–11.

18 Australian Taxation Office, *Super Accounts Data Overview*, https://www.ato.gov.au/About-ATO/Research-and-statistics/In-detail/Super-statistics/Super-accounts-data/Super-accounts-data-overview/ (accessed 18 October 2017).

7.20 CHOICE submitted to the committee that modelling indicates that Australian consumers are potentially losing over a billion dollars each year due to duplicate insurance through superannuation. CHOICE suggested that younger consumers in particular are paying for insurance which does not match their needs and is eroding their retirement balances:

> Using current ATO figures on the number of duplicate accounts, up $1.96 billion across the economy every year is potentially lost due to duplicate insurance, an average of $131 per account holder. Modelling from the Financial System Inquiry found that removing duplicate accounts could increase superannuation balances at retirement by around $25 000 and retirement incomes by up to $1600 per year. About two thirds of this cost or $16 000 was due to duplicate insurance. This is clearly not an efficient use of resources, with fund erosion due to fees ultimately leading to an increased impost on the aged pension.[19]

Negative impact on superannuation balance for casual or intermittent workers

7.21 When a member ceases employment, the default payment of insurance premiums will generally continue until an account balance limit has been reached. This limit, set by the trustee, represents the point below which the trustee considers benefits are being unnecessarily eroded by the premium payment. Fund members with small balances may find that their superannuation balance has fallen below the limit and may not always be advised or aware that their cover is ceasing as a result.[20]

No cover despite premium payments

7.22 ASIC informed the committee that, in some instances, consumers are charged premiums when they no longer have cover. For example, cover may cease after a person has left a particular employer. Yet, if the notification from the employer is not sent to the trustee (noting that sometimes it is not clear whether a person has 'left' employment, particularly for casual workers), premiums continue to be deducted from the member's account balance. ASIC observed that a member could reasonably infer from this that they have cover. However, the fact that the member has left the employer may only become known when a claim is lodged. While premiums may be refunded, the claim is likely to be declined and the consumer is left without cover.[21]

7.23 A similar situation arises when non-contribution is the employer's failure to make compulsory superannuation guarantee payment, which can then also lead to the member not having insurance cover they may require and believe they have such cover, not realising their superannuation is not being paid.

7.24 On the other hand, there are policies that do not cease after a person has left a particular employer. If the policy under the superannuation that a worker had while at a previous employer does continue, then it may provide coverage where a new policy would not. An example would be the return of a cancer after a change of employer.

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19 CHOICE, *Submission 49*, p. 4.

20 Australian Securities and Investments Commission, *Submission 45*, pp. 34–35.

21 Australian Securities and Investments Commission, *Submission 45*, p. 35.

The exclusion for pre-existing conditions may apply for the new policy, meaning the worker would not be covered, but if they have a policy in a still operative earlier account, that may cover them.

Treasury initiatives

7.25 During the inquiry Treasury was progressing three processes that are relevant to life insurance and superannuation. The first was a government bill, introduced in September 2017, to amend the SIS Act to improve accountability and members' outcomes in superannuation including MySuper. The amendments propose a new law to require trustees to make an annual determination, in writing, as to whether the financial interests of the members in the MySuper product are being promoted. The trustee is required to have regard to a range of factors including:

- whether the insurance strategy for the MySuper product is appropriate to those beneficiaries; and
- whether any insurance fees charged in relation to the MySuper product inappropriately erode the retirement income of those beneficiaries.[22]

7.26 The Senate Economics Legislation Committee recommended that the bill be passed.[23]

7.27 Treasury also pointed to two further initiatives. In the first, the government has tasked APRA with making it easier for MySuper members to opt out of automatic life insurance and TPD policies. In the second, the Productivity Commission is currently undertaking the third stage of its review of the competitiveness and efficiency of the superannuation sector. The terms of reference for this review explicitly require the Productivity Commission to examine the appropriateness of current arrangements for insurance in superannuation.[24]

Supermatch

7.28 Since 2015, the Australian Tax Office (ATO) has provided an online system called Supermatch2 which provides trustees with information to assist with consolidating members accounts. Prior to 2015, an earlier version of Supermatch was available. Trustees are able to submit single or batch requests, and Supermatch2 will provide information on members accounts including:

- the name of the superannuation fund;
- the member account number;

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22 Explanatory Memorandum, Treasury laws amendment (improving accountability and member outcomes in superannuation measure No. 1) Bill 2017, pp. 17–20.

23 Senate Economics Legislation Committee, *Treasury Laws Amendment (Improving Accountability and Member Outcomes in Superannuation Measures No. 1) Bill 2017, Superannuation Laws Amendment (Strengthening Trustee Arrangements) Bill 2017*, October 2017, p. 29.

24 Mr Ian Beckett, Principal Adviser, Retirement Income and Policy Division, Treasury, *Committee Hansard*, 8 September 2017, p. 57.

- the member identifier and full name of member;
- the tax file number of the member;
- an insurance indicator (not for new member accounts);
- a defined benefit indicator (not for new member accounts);
- the activity status of the account;
- indicators if the ATO held superannuation; and
- account balances.[25]

Committee view

7.29 Evidence to the committee from a broad range of stakeholders strongly supported the opt-out model for life insurance within group superannuation, particularly as a means of addressing the problem of under-insurance.

7.30 Nevertheless, concerns were raised in relation to the opt-out model, particularly for those with low super balances such as low-income earners, women, and young people. The mechanism for opting out of life insurance held within group superannuation does not appear to be straightforward.

7.31 The committee welcomes moves by the government to task the Australian Prudential Regulation Authority (APRA) with making it easier for MySuper members to opt out of automatic life insurance policies. The committee is reassured by the Insurance in Superannuation Code of Practice which would require trustees to make the process of cancelling, or opting out of, automatic cover straightforward and transparent for members including via a fund's website, over the phone or by email.

7.32 However, the committee is firmly of the view that trustees should move swiftly on this matter and institute an online system that could be as simple as an opt-out button on the fund's website. The committee is puzzled by how long it has taken to institute what would, on its face, appear to be a straightforward reform. The committee therefore considers that further delay in simplifying the opt-out mechanism is unacceptable.

7.33 Beyond simple mechanics, however, evidence to the inquiry revealed that duplicate life insurance held within group superannuation accounts is a substantial drain on superannuation balances with significant adverse consequences for retirement incomes, particularly for those with low super balances and/or not engaged with their accounts. Consumer groups told the committee that up to $1.96 billion is lost each year through duplicate life insurance accounts held in group superannuation.

7.34 By contrast, it is estimated that superannuation balances at retirement would rise by around $16 000 in total if duplicate insurance accounts were removed. This would be a significant boost to retirement savings. Women, low-income earners and

25 Australian Taxation Office, *Supermatch2; SuperMatch 2 User Guide*, https://www.ato.gov.au/Super/SuperStream/In-detail/Validation-services/SuperMatch2/ (accessed 18 October 2017).

young people would benefit in particular as they are disproportionately adversely affected by insurance premiums eroding their superannuation balances.

7.35 The committee views the current dearth of action by trustees and life insurers to fix the problem of duplicate insurance within group superannuation as completely unacceptable given that systems already exist which can be used to remedy the matter.

7.36 The committee considers that the Supermatch2 system is likely to already give superannuation trustees access to most of the information necessary to assist members in resolving problems, including duplicate superannuation and life insurance accounts and the associated duplication of fees and premiums.

7.37 Given that the Supermatch systems have been available to trustees for some years, the committee is particularly concerned that trustees and life insurers have been profiting from fees and premiums and have not used the already available resources to assist members to resolve issues including consumers having:

- life insurance that they unaware of;
- duplicate accounts for which duplicate fees and premiums have been taken;
- accounts with small balances that may be eroded by premiums; and
- accounts with life insurance upon which, in all probability, the member would be unable to make a successful claim.

7.38 Given both the inaction by trustees and life insurers, and the fact that 40 per cent of people have more than one super account and therefore potentially a similar number of duplicate life insurance accounts, the committee considers that urgent action is required to inform account holders of the status of their accounts.

7.39 The committee supports the general principle that buyers should be aware and should make reasonable efforts to inform themselves. However, the committee considers that when fund members, by virtue of the current opt-out system, automatically make superannuation contributions and related premium payments, it is inexcusable for those trustees entrusted to act in the members' best interest to collect duplicate fees and premiums when they have ready access to the relevant information and would be in a position to inform their members.

7.40 The committee notes that the final version of the Insurance in Superannuation Voluntary Code of Practice requires complying life insurers to contact automatic insurance members with balances under $600, nine and 13 months after their last contributions.[26]

26 Insurance and Superannuation Working Group, *Insurance in Superannuation Voluntary Code of Practice*, December 2017, p. 8.

Recommendation 7.1

7.41 The committee recommends that trustees that have access to information on accounts that are duplicate, have low balance risks or lack contributions, should be required to contact members annually to inform them, in summary form and in plain English, of:

- **the status of their accounts; and**
- **whether their insurance policy is still providing coverage.**

7.42 The committee further recommends that, in addition to annual notification, trustees should be required to contact members in a timely manner when trigger points such as low balance risk are reached.

7.43 The committee observes that even if the government were to immediately implement the above recommendation, it may take some years to resolve the issues. In the meantime, fund members would continue to lose significant sums of money, particularly women, young people and low-income earners, and trustees and life insurers would continue to make improper gains.

7.44 The committee notes that taxpayers are able to use their myGov account to check the status of their superannuation accounts, including:

- details of all superannuation accounts;
- finding lost superannuation held by superannuation funds;
- finding ATO-held superannuation—if the government, superannuation funds or employers are unable to find an account to transfer the superannuation to;
- combining multiple superannuation accounts by transferring superannuation into a preferred superannuation account; and
- checking for the existence of life insurance held through superannuation.[27]

7.45 The committee is concerned by the evidence presented during this inquiry that many people are either unaware that they hold life insurance accounts through their superannuation, or unaware that they can check on such accounts through the myGov system.

7.46 The committee therefore considers that it would be appropriate to inform people of the information held by the Australian Tax Office on individuals' superannuation and life insurance accounts with the aim of improving member engagement.

27 Australian Taxation Office, *Keeping Track of Your Super*, https://www.ato.gov.au/Individuals/Super/Keeping-track-of-your-super/ (accessed 25 October 2017).

Recommendation 7.2

7.47 The committee recommends that superannuation funds should be required to inform the Australian Tax Office of the type and status of the insurance that is held for the benefit of the member for each of their superannuation accounts.

Recommendation 7.3

7.48 The committee recommends that, when it sends out individual annual tax assessments, the Australian Tax Office also provide a statement of superannuation and insurance, subject to system capacities and cost effectiveness, including information on:

- **the number of superannuation accounts held;**
- **the number of life insurance accounts held through superannuation; and**
- **the insured's right to seek information from the superannuation trustee about the balance, and the continued coverage or otherwise of any insurance policy.**

7.49 The committee notes that the ASIC's MoneySmart Website[28] includes useful information on a range of issues that consumer should be aware of. However, duplicate insurance accounts held within group superannuation does not feature on ASIC's website.

7.50 Given the scale of the problem and the lack of action from superannuation trustees and life insurers supplying the group superannuation market, the committee considers that there is a need for a public information campaign to raise awareness of these matters.

7.51 To this end, the committee considers that it would be appropriate for the industry to fund a prominent media advertising campaign to alert consumers to the prevalence of duplicate life insurance held within superannuation accounts, the negative impacts that this can have on superannuation account balances, and the mechanisms for removing duplicate insurance policies.

28 Australian Securities and Investments Commission, *Insurance through super*, https://www.moneysmart.gov.au/superannuation-and-retirement/how-super-works/insurance-through-super (accessed 15 November 2017)

Recommendation 7.4

7.52 The committee recommends that the life insurance industry fund a prominent media advertising campaign, particularly aimed at those most vulnerable to duplicate accounts and fee erosion, to alert consumers to:

- **the prevalence of duplicate life insurance accounts held within group superannuation;**
- **the negative impacts that duplicate life insurance accounts can have on superannuation account balances;**
- **the mechanisms for removing duplicate insurance policies within group superannuation; and**
- **the importance of seeking specific advice before making changes, if you have any pre-existing conditions.**

Recommendation 7.5

7.53 The committee recommends that the government appoint the appropriate existing body to undertake an immediate review of all superannuation trustees to determine their compliance with existing obligations under the *Superannuation (Industry) Supervision Act 1993*, including section 52(7)(c) covenants, *'to only offer or acquire insurance of a particular kind, or at a particular level, if the cost of the insurance does not inappropriately erode the retirement income of beneficiaries'*.

Recommendation 7.6

7.54 The committee recommends that, the Australian Government consider legislating to protect the retirement savings of members with low account balances and members who do not receive any value from default insurance.

Recommendation 7.7

7.55 The committee recommends that the Australian Government consider legislating to require life insurers and superannuation funds to provide regular updates to policyholders of the level, type, extent and cost of life insurance cover that they have using a standard form disclosure format, enabling them to compare with other funds or, in the case of superannuation, make them aware that they have access to life insurance.

7.56 The committee notes that this inquiry has focused on group insurance within the superannuation environment. However, it is important to recognise that group insurance also exists outside superannuation and should be investigated at some future time.

Chapter 8
Access to medical information

Background

8.1 The duty of disclosure under section 21A of the *Insurance Contract Act 1984* (Insurance Contracts Act) requires a person applying for insurance to disclose relevant matters, such as their medical history, to an insurer. The disclosure of relevant matters required by this duty allows an insurer to have access to the information necessary to determine through a risk assessment whether a person can be provided with insurance and, if so, the level of the insurance coverage.

8.2 In order to facilitate the disclosure process regarding a person's medical history, life insurers request authorisation to access a consumer's medical information. This request for authorisation may occur at the time a consumer acquires a life insurance policy and also at the time of making a claim. The request for authorisation is usually accompanied by information on the life insurer's privacy policy as well as the third parties with whom a consumer's information may be shared. The amount and type of medical information a consumer authorises a life insurer to access and share is typically broad, particularly at the time of policy acquisition. Such broad authority is obtained by life insurers regardless of the nature or type of the life insurance policy.

8.3 This chapter begins by examining how life insurers receive authorisation to access a consumer's information. This is followed by consideration of why life insurers require a consumer's medical information as well as concerns raised with the committee regarding the breadth of medical information that life insurers can access. How medical information is used during the claims handling stage is examined in Chapter 8 of this report.

Privacy framework

8.4 The *Privacy Act 1988* (Privacy Act) and the 13 principles known as the Australian Privacy Principles (APPs) govern how a life insurer who is an APP entity can obtain, store and share the information with other parties.[1] Under the Privacy Act and the APPs, medical information has the special status of 'Sensitive Information'.

8.5 Under APP 3, life insurers must only collect information where it is reasonably necessary for the functions of the organisation and a consumer has consented to the collection.[2] The Office of the Australian Information Commissioner (OAIC) explained to the committee that consent must be informed, voluntarily given,

1 Office of the Australian Information Commissioner, answers to questions on notice, 22 August 2017 (received 8 September 2017).

2 Office of the Australian Information Commissioner, answers to questions on notice, 22 August 2017 (received 8 September 2017).

up-to-date and provided by an individual who has the capacity to understand and communicate consent.[3]

8.6 Where an APP entity receives information that it did not solicit and the organisation determines that it could not obtain such information in line with the requirements of consent and reasonable necessity, the information must be de-identified or destroyed.[4]

8.7 APP 11 requires that an APP entity ensure the security of the personal information it holds and actively consider whether it is allowed to retain personal information.[5] Reasonable steps must be taken by an APP entity to protect information from interference, loss or misuse, unauthorised access, disclosure or modification.[6] Steps that are reasonable for an entity to take depend on factors such as the size and resources of the entity, the amount of information held, the consequences for an individual if the information is released, and the practical implications of implementing security measures.[7]

8.8 APP 8 and section 16C of the Privacy Act establish a framework for APP entities disclosing personal information across borders. However, the framework does not apply where an individual has consented to a secondary use of the information, such as the disclosure of the information to overseas recipients or mailing houses.[8]

8.9 While the OAIC does not have data specific to the life insurance industry in terms of breaches of the APPs, it provided the committee with data on breaches and investigations for financial services (including superannuation) and the insurance industry as a whole.[9]

8.10 Such data applied to all information received, not just medical information. The data indicated that in 2016–17, 366 breaches were reported to the OAIC in relation to financial services (including superannuation) and 94 reports of breaches were received in relation to insurance. However, as breaches are to be reported to the OAIC only

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3 Office of the Australian Information Commissioner, answers to questions on notice, 22 August 2017 (received 8 September 2017).

4 Office of the Australian Information Commissioner, answers to questions on notice, 22 August 2017 (received 8 September 2017); *Privacy Amendment (Enhancing Privacy Protection) Act 2012*, Schedule 1, Australian Privacy Principle 4.

5 Office of the Australian Information Commissioner, *Chapter 11: APP 11 – Security of personal information*, March 2015, p. 2; Explanatory Memorandum, Privacy Amendment (Enhancing Privacy Protection) Bill 2012, p. 86.

6 *Privacy Amendment (Enhancing Privacy Protection) Act 2012*, Schedule 1, Australian Privacy Principle 11.1.

7 Office of the Australian Information Commissioner, *Chapter 11: APP 11 – Security of personal information*, March 2015, p. 3.

8 *Privacy Amendment (Enhancing Privacy Protection) Act 2012*, Schedule 1, Australian Privacy Principles 6, 8.

9 Office of the Australian Information Commissioner, answers to questions on notice, 22 August 2017 (received 8 September 2017).

after the complainant has tried to resolve the matter with the organisation it claims has carried out the breach, it is unclear how many actual breaches there were in 2016–17.[10]

8.11 In terms of investigations carried out by the OAIC in 2016-17, 86 investigations were conducted into the financial services sector (including superannuation) and 41 investigations were conducted in relation to the insurance industry.[11]

8.12 In the last five years one privacy complaint against an insurer was determined by the Information and Privacy Commissioner.[12] This case involved the sharing of a customer's tax file number with a third party.[13]

Authorisation to access medical information

8.13 The Financial Services Council's (FSC) Life Insurance Code of Practice (Code) is a self-regulatory regime that contains a series of clauses pertinent to accessing medical information.

8.14 In order to facilitate the disclosure process as required under the Insurance Contracts Act, clause 8.6 of the Code states that life insurers are to obtain a general authority from consumers to access information from parties such as a person's doctor.[14] The clause further outlines that the general authority is to only be used by the insurer to obtain information that is relevant to the policyholder's claim.[15]

8.15 While clause 8.6 allows a person to deny an insurer authorisation to access their medical information, it is noted within the clause that such a refusal may delay the assessment of a claim or mean that a claim cannot be assessed at all.[16]

8.16 A number of life insurers provided the committee with the forms used to obtain the general authority described in clause 8.6 of the Code as well as their privacy statements.[17] The forms demonstrated that the authorisation obtained by life insurers for access to medical information can be presented to consumers as a

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10 Office of the Australian Information Commissioner, answers to questions on notice, 22 August 2017 (received 8 September 2017).

11 Office of the Australian Information Commissioner, answers to questions on notice, 22 August 2017 (received 8 September 2017).

12 Office of the Australian Information Commissioner, answers to questions on notice, 22 August 2017 (received 8 September 2017).

13 Office of the Australian Information Commissioner, answers to questions on notice, 22 August 2017 (received 8 September 2017).

14 Financial Services Council, *Life Insurance Code of Practice*, October 2016, clause 8.6.

15 Financial Services Council, *Life Insurance Code of Practice*, October 2016, clause 8.6.

16 Financial Services Council, *Life Insurance Code of Practice*, October 2016, clause 8.6.

17 The forms provided to the committee can be accessed at: https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Corporations_and_Financial_Services/LifeInsurance/Additional_Documents.

standalone form often titled 'Medical Authority' or as part of a form often titled 'General Authority' or 'Authority'.[18] 'General Authority' or 'Authority' forms may relate to medical information as well as other types of information.

8.17 The forms and privacy statements received by the committee also demonstrated a difference in language used by insurers and distributors, as well as across different insurance products. While not limited to the below, differences also appeared in relation to:

- the types of third parties that will also have access to a consumer's information, including companies based overseas; and
- the level of explanation provided to a consumer regarding the insurer's privacy policy and storage practices.

8.18 In terms of third parties who can access a consumer's information, life insurers' privacy disclosure/policy statements provided to consumers at the time of claim varied and included the following statements:

> - To assist us with the purposes outlined above, we may disclose information collected to our related companies or with third parties including our re insurers, advisors, medical service providers and claims investigators. Some of the related companies we may disclose personal information to may be located overseas including the United Kingdom, India, the United States of America and Switzerland.
> - We may also disclose your personal information overseas to countries in certain circumstances that are likely to include India and USA.
> - We are unlikely to send your personal information to any foreign jurisdiction and we take steps to ensure our service providers don't either.[19]

8.19 It is not clear from the privacy statements submitted to the committee whether the information disclosed in the above circumstances would include sensitive information, such as medical information.

8.20 The forms also provided examples of how much information a consumer was given regarding the life insurer's privacy policy. Examples from authorisation forms at the time of claim included:

> - Declaration and consent: I/We have read and consent to the handling, collection, use and disclosure of my/our personal and sensitive information in the manner described in this form and the

18 For example see Zurich Financial Service Australia Limited, answers to questions on notice, 26 May 2017 (received 9 June 2017).

19 While the privacy disclosure/policy statements and the authorisation forms referred to in this and subsequent paragraphs are drawn from the forms referenced in footnote 17, the committee has not attributed the various statements to particular life insurance companies because the aim of this section is to illuminate potential systemic concerns rather than individual cases.

Privacy Policy on the [redacted] website as updated from time to time…

- Our Privacy Policy, a copy of which can be found at [redacted], sets out how you can access and correct information we hold about you, how you can complain about a breach by us of your privacy rights and how your complaint will be handled. It also contains a more comprehensive list of countries to which your information may be disclosed and will be updated regularly.
- You may contact our Privacy Officer in relation to your personal information (or to opt out of marketing) on [redacted] or [redacted]

8.21 A common element present in almost all of the authorisation forms received by the committee was the broad nature of the general authority obtained by life insurers to access all of a consumer's medical information, regardless of the nature of the life insurance policy purchased or the claim made. The following examples demonstrate this:

- I/We hereby authorise any medical practitioner, medical provider, health professional, hospital, dentist or other person who has attended me/us, to release to [redacted] or its representatives **all information with respect to any sickness or injury, medical history, consultations, prescriptions, or treatment and copies of all hospital or medical records**.
- Medical Authority: I [NAME] agree that any medical practitioner, health care professional, hospital or other health service provider, whether named by me or not, who has been consulted by me, shall be and is hereby authorised and directed by me, to divulge to the insurer, or the insurer's agent **all medical or surgical information** he/she may have acquired with regard to myself.
- Policy Owner/Life Insured's consent to obtain a medical report: I hereby consent to [redacted] and [redacted] being provided with medical information, **including copies of any medical reports, clinical reports or otherwise, from any Medical Practitioner who at any time has attended me concerning anything which affects my physical or mental health**.[20]

8.22 During the inquiry, the committee became aware that life insurers were unsure of the amount of consumer's information that they held in storage. The committee received evidence from life insurers regarding the fact that, while they adhered to the requirements of the Privacy Act, life insurers were unable to determine the amount of

20 The committee has used bold text for emphasis.

personal sensitive information, including a person's complete medical record, that they had in their possession.[21]

8.23 As a consumer has to provide a broad authority to each insurer with whom they take out a policy, the committee understands it is likely that, to the extent that individuals have more than one life insurance policy, those individual's full medical records may be held by more than one life insurer.

8.24 Mr Peter Kell, Deputy Chairman, and Mr Michael Saadat, Senior Executive Leader at the ASIC, while not necessarily presenting an argument for or against the use of a broad general authority by life insurers, acknowledged the complexity of the issue due to the contractual and statutory requirements of disclosure.[22]

Arguments for a broad authority to access medical information

8.25 The FSC expressed the view that the duty of disclosure requires a broad authority to ensure that there is a factual basis from which claims can be managed. A broad authority at the time of application also ensures that enough information is obtained at the underwriting stage for risk assessment so that requests for information are limited at the claims stage.[23] AMP submitted a similar view noting that a broad authority may prevent delays to an application or a claim.[24]

8.26 The FSC explained that while a broad general authority allows an insurer to obtain all of a consumer's medical information, such access is not unfettered or unregulated as processes are in place to ensure an excessive amount of medical records are not obtained.[25] Additionally, Zurich Financial Service Australia Limited (Zurich) believed that the consumer understands that the insurer's need for as much information as possible is in the consumer's best interest.[26]

8.27 Beyond these general statements, however, the main reason put forward by the FSC and life insurers, such as Zurich and CommInsure, for a broad general

21 Commonwealth Bank of Australian, answers to questions on notice, 8 September 2017 (received 29 September 2017); Ms Helen Troup, Managing Director, CommInsure, Commonwealth Bank of Australia, *Committee Hansard*, 8 September 2017, p. 15.

22 Mr Peter Kell, Deputy Chairman, Australian Securities and Investments Commission and Mr Michael Saadat, Senior Executive Leader, Australian Securities and Investments Commission, *Committee Hansard*, 8 September 2017, pp. 53–54.

23 Financial Services Council, *Submission 26.1*, pp. 7–8.

24 Mr Craig Meller, Chief Executive Officer, AMP, answers to questions on notice, 3 July 2017 (received 28 July 2017).

25 Financial Services Council, *Submission 26.1*, pp. 7–8.

26 Zurich Financial Service Australia Limited, answers to questions on notice, 26 May 2017 (received 9 June 2017).

authority to access medical information is to enable an insurer to pool risk and prevent anti-selection due to information asymmetry.[27]

8.28 Zurich explained that at the foundation of insurance is the principle of pooled risk.[28] This means that, rather than an individual bearing a financial risk if a certain event occurs, the individual is able to be a part of a pool with other insured people, thus allowing for the risk to be spread amongst the insured pool.[29]

8.29 However, in order for the pool to be sustainable and equitable for its members, the premium paid by an individual within the pool must appropriately reflect the individual's level of risk.[30]

8.30 For this risk to be accurately priced, the risk must be assessed by the insurer. This is known as a form of underwriting as outlined in chapter 2 of this report. The insurer requires as much information as possible in order to assess risk during the underwriting stage and will consider factors such as gender, age, occupation, and smoker status.[31]

8.31 Insurers will also consider whether the individual's risk warrants certain exclusions in their insurance cover or a denial of insurance cover altogether.[32]

8.32 Accurate pricing of risk ensures that more affordable cover is available, the risk pool is sustainable, and the life insurer is able to pay claims.[33]

8.33 Zurich was of the view that thorough underwriting that accurately assesses risk will, in turn, reduce the pressure on public health and social safety nets.[34]

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27 Financial Services Council, *Submission 26.2*, pp. 2, 5–7; Zurich Financial Service Australia Limited, answers to questions on notice, 26 May 2017 (received 9 June 2017); Commonwealth Bank of Australia, answers to questions on notice, 3 July 2017 (received 31 July 2017).

28 Zurich Financial Service Australia Limited, answers to questions on notice, 26 May 2017 (received 9 June 2017).

29 Zurich Financial Service Australia Limited, answers to questions on notice, 26 May 2017 (received 9 June 2017); Commonwealth Bank of Australia, answers to questions on notice, 3 July 2017 (received 31 July 2017).

30 Zurich Financial Service Australia Limited, answers to questions on notice, 26 May 2017 (received 9 June 2017); Commonwealth Bank of Australia, answers to questions on notice, 3 July 2017 (received 31 July 2017).

31 Zurich Financial Service Australia Limited, answers to questions on notice, 26 May 2017 (received 9 June 2017); Commonwealth Bank of Australia, answers to questions on notice, 3 July 2017 (received 31 July 2017).

32 Zurich Financial Service Australia Limited, answers to questions on notice, 26 May 2017 (received 9 June 2017); See also, Commonwealth Bank of Australia, answers to questions on notice, 3 July 2017 (received 31 July 2017).

33 Zurich Financial Service Australia Limited, answers to questions on notice, 26 May 2017 (received 9 June 2017); See also, Commonwealth Bank of Australia, answers to questions on notice, 3 July 2017 (received 31 July 2017).

34 Zurich Financial Service Australia Limited, answers to questions on notice, 26 May 2017 (received 9 June 2017).

8.34 Both the FSC and Zurich explained that anti-selection will occur where an insurer cannot accurately price risk due to limited information provided by a consumer.[35]

8.35 Furthermore, anti-selection is not equitable to others in the pool because premiums will be increased to cover an individual risk that was not initially assessed.[36] This in turn can affect the sustainability of the pool to pay claims as policyholders are likely to exit the pool in response to increased premiums.[37] Anti-selection may also cause underinsurance for certain sections of the community.[38]

8.36 The importance of insurers having access to as much information as possible in order to determine and price risk accurately was also acknowledged by the Productivity Commission in its report *Data Availability and Use*.[39]

8.37 The Productivity Commission's report noted that economics has long recognised information asymmetry (the consequence of not sharing enough information) as detrimental to competitive markets.[40] The Productivity Commission also noted that sharing information can alleviate such information asymmetries and allow for both competition amongst suppliers and appropriately priced products.[41]

8.38 The *Disability Discrimination Act 1992* (Disability Discrimination Act) is intended to ensure that people with disabilities have the same rights as the rest of the community and to eliminate, as far as possible, discrimination against persons on the grounds of disability. Nonetheless, the Disability Discrimination Act allows the insurance industry to uphold the principle of pooled risk by allowing insurers, in some instances, to use medical information to accurately price risk and make decisions about a policyholder.[42]

8.39 Treasury informed the committee that section 46 of the Disability Discrimination Act provides an exemption to insurers in some situations.[43] The broad effect of this exemption is that insurance premiums and/or policy terms are permitted to vary according to variations in factors that affect risk, including, as previously explained in this chapter, the age and gender of the insured. In order to be able to rely

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35 Financial Services Council, *Submission 26.2*, p. 6; Zurich, answers to questions on notice, 26 May 2017 (received 9 June 2017).

36 Zurich Financial Service Australia Limited, answers to questions on notice, 26 May 2017 (received 9 June 2017); Financial Services Council, *Submission 26.2*, p. 6.

37 Zurich Financial Service Australia Limited, answers to questions on notice, 26 May 2017 (received 9 June 2017); Financial Services Council, *Submission 26.2*, p. 6.

38 Zurich Financial Service Australia Limited, answers to questions on notice, 26 May 2017 (received 9 June 2017); See also, Financial Services Council, *Submission 26.2*, p. 6.

39 Productivity Commission, *Data Availability and Use*, No. 82, 2017, p. 87.

40 Productivity Commission, *Data Availability and Use*, No. 82, 2017, p. 16.

41 Productivity Commission, *Data Availability and Use*, No. 82, 2017, pp. 62, 87.

42 *Disability Discrimination Act 1992*, s. 3.

43 Treasury, answers to questions on notice, 22 August 2017 (received 6 September 2017).

on this exemption, insurers must base their decision on actuarial or statistical evidence and, in the case where no such evidence exists, have regard to other relevant factors.[44] Additionally, some accountability is provided by Section 107 of the Disability Discrimination Act which gives the Disability Discrimination Commissioner the power to require an insurance company to present the actual or statistical data or risk being found to have breached the law.[45]

8.40 As set out in this and the prior section, the evidence from both the FSC and life insurers shows that the words used by insurers in their forms actually requests as much information as possible from consumers. However, in contrast to the wording contained in the medical request forms and the reasons given by various life insurers, Ms Sally Loane, Chief Executive Officer of the FSC, appeared to contradict the position that the FSC had previously put forward. Appearing before the committee on 1 December 2017, Ms Loane stated that life insurers do not want 'to go through more information than they need to assess an application or a claim'. Instead, Ms Loane said that life insurers only want information pertaining to specific issues.[46]

8.41 The FSC also expressed that they 'are committing to reframe [clauses] 8.5 and 8.6 [of the Code] because we do understand the concerns'.[47] Ms Loane stated that the life insurance industry would welcome a recommendation from the committee that the industry develop a framework with the Royal Australian College of General Practitioners (RACGP) for GPs and insurers to use when determining what information should be provided to the insurer. This framework would be included in the next iteration of the Code.[48]

Arguments against a broad authority to access medical information

8.42 The committee received evidence from medical organisations and mental health advocacy organisations that raised various concerns about life insurance companies having a broad authority to obtain copies of patient medical records, including consultation notes. These concerns included:

- the appropriateness of life insurers gaining access to potentially highly sensitive but not necessarily relevant personal medical information;

44 Treasury, answers to questions on notice, 22 August 2017 (received 6 September 2017).

45 *Disability Discrimination Act 1992*, s. 46, s.107; See also, Disability Discrimination Bill 1992, *Explanatory Memorandum*.

46 Ms Sally Loane, Chief Executive Officer, Financial Services Council, *Committee Hansard*, 1 December 2017, pp. 22, 28–29; See also, Mr Nick Kirwan, Policy Manager, Financial Services Council, *Committee Hansard*, 1 December 2017, pp. 29–30.

47 Mr Nick Kirwan, Policy Manager, Financial Services Council, *Committee Hansard*, 1 December 2017, p 29.

48 Ms Sally Loane, Chief Executive Officer, Financial Services Council, *Committee Hansard*, 1 December 2017, pp. 22, 28–29; See also, Mr Nick Kirwan, Policy Manager, Financial Services Council, *Committee Hansard*, 1 December 2017, pp. 29–30.

- the difficulty for a medical practitioner in determining whether the release of complete medical records would be in the patient's best interest;
- the difficulty in determining whether a patient's prior consent to release medical information can reasonably be taken to be up-to-date;
- the risk that doctors may under-document a patient's condition in their consultation notes because of concerns about how a life insurer might use or misinterpret certain information; and
- the risk that a patient may not fully disclose their condition, for example, mental health, for fear of how a life insurer might use that information to assess cover or a subsequent claim.[49]

8.43 Dr Edwin Kruys, Vice President and Chair of the Royal Australian College of General Practitioners (RACGP) Queensland, explained the difference between 'medical records' and 'medical reports'. He told the committee that 'medical records' reflect a patient's encounters with a GP and can include reports and consultation notes. By contrast, 'medical reports' are prepared by GPs after they have reviewed 'medical records' and may contain facts and opinion, where an opinion is requested by a third party.[50]

8.44 Dr Bastian Seidel, President of the RACGP, explained that while a medical record may contain a diagnosis of a patient, it will not necessarily include a prognosis. Dr Seidel emphasised the vital importance of a prognosis when considering a patient's future risk of illness and life expectancy because it may take account of treatment options and lifestyle changes.[51]

8.45 Zurich stated that they only ask for medical reports on a customer's medical history during the underwriting stage for risk assessment.[52] However, the RACGP shared its belief that there has been a movement by life insurers towards requesting whole medical records due to the lower costs associated with accessing a full medical

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49 See, for example, Dr Edwin Kruys, Vice President and Chair, RACGP Queensland, Royal Australian College of General Practitioners, *Committee Hansard*, 8 September 2017, p. 24; Ms Anne Trimmer, Secretary General, Australian Medical Association, *Committee Hansard*, 8 September 2017, p. 34; Associate Professor Stephen Bradshaw, Practitioner Member, Medical Board of Australia, *Committee Hansard*, 8 September 2017, p. 26; Dr Stephen Carbone, Policy, Research and Evaluation Leader, beyondblue, *Committee Hansard*, 22 February 2017, pp. 16, 17; Dr Bastian Seidel, President, Royal Australian College of General Practitioners, *Committee Hansard*, 1 December 2017, pp. 13, 14.

50 Royal Australian College of General Practitioners, answers to questions on notice, 8 September 2017 (received 26 September 2017).

51 Dr Bastian Seidel, President, Royal Australian College of General Practitioners, *Committee Hansard*, 1 December 2017, p. 18.

52 Zurich Financial Service Australia Limited, answers to questions on notice, 26 May 2017 (received 9 June 2017).

record compared to obtaining a tailored report.[53] Dr Kruys noted that currently 50 per cent of requests for medical information made by life insurers are for whole medical records rather than medical reports.[54] Furthermore, Associate Professor Stephen Bradshaw, a Practitioner Member of the Medical Board of Australia, suggested this may be higher indicating that he has 'never had a targeted inquiry'.[55] Dr Seidel was firmly of the view that the cost of a medical record should not be a relevant consideration in terms of determining whether a medical record or a medical report should be obtained by an insurer. In this regard, Dr Seidel noted that 'a patient's medical record is not a tradeable commodity'.[56]

8.46 The committee also heard concerns from medical bodies in relation to how a broad authority will apply to electronic health records. Ms Anne Trimmer, Secretary General, Australian Medical Association (AMA) raised with the committee the possibility that electronic health records alongside a broad authority will present a further challenge for a GP and/or treating doctors who will have to collate all reports placed on the electronic record by different doctors.[57] This will mean that what the current GP or treating doctor provides to the insurer will consist of documentation outside of their relationship with the patient.[58]

8.47 MDA National, a Medical Defence Organisation informed the committee that it does not record the exact number of times its members ask for assistance regarding an insurer's request for patient records.[59] However, MDA National did confirm that it provides such assistance to GPs every week.[60]

8.48 In terms of the advice provided to its members, MDA National explained that this broadly involves assisting its members in identifying what has been specifically requested and whether patient consent has been granted.[61]

8.49 The Medical Indemnity Protection Society also stated that they regularly provide advice on this matter but noted there has been no increase in requests for

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53 Royal Australian College of General Practitioners, answers to questions on notice, 8 September 2017 (received 26 September 2017).

54 Dr Edwin Kruys, Vice President and Chair, RACGP Queensland, Royal Australian College of General Practitioners, *Committee Hansard*, 8 September 2017, p. 25.

55 Associate Professor Stephen Bradshaw, Practitioner Member, Medical Board of Australia, *Committee Hansard*, 8 September 2017, p. 27.

56 Dr Bastian Seidel, President, Royal Australian College of General Practitioners, *Committee Hansard*, 1 December 2017, p. 14.

57 Ms Anne Trimmer, Secretary General, Australian Medical Association, *Committee Hansard*, 8 September 2017, p. 32.

58 Ms Anne Trimmer, Secretary General, Australian Medical Association, *Committee Hansard*, 8 September 2017, p. 32.

59 MDA National, answers to questions on notice 27 September 2017 (received 12 October 2017).

60 MDA National, answers to questions on notice 27 September 2017 (received 12 October 2017).

61 MDA National, answers to questions on notice 27 September 2017 (received 12 October 2017).

advice.[62] Medical Insurance Group Australia, another Medical Defence Organisation, also noted that it has not seen an increase in the number of requests for advice.[63]

8.50 Dr Kruys raised concerns about the appropriateness of life insurers having access to full medical records:

> For any organisation or business, we would find it inappropriate if you would ask your customers to provide information about their sexual health, for example. Yet insurers requesting all this information, including sexual health and other intimate information, that's stored in that record is apparently appropriate.[64]

8.51 Associate Professor Stephen Bradshaw, a Practitioner Member of the Medical Board of Australia, highlighted that ultimately the problem of providing full medical records is of an ethical nature. For Associate Professor Bradshaw, a broad authority places GPs and other medical doctors in an invidious position in that doctors are being asked to provide information to life insurers that may not be in the best interest of the patient.[65]

8.52 This difficulty in determining whether the release of medical records would be in the patient's best interest is compounded by the fact that the issue of consent in relation to insurers' access is fraught, as such consent can be out-dated and provided to an insurer prior to any specific insurance claim being made.[66]

8.53 Dr Kruys drew the committee's attention to the experiences of RACGP members that have been required to explain to patients that an insurer having access to their medical information could lead to higher premiums or their claims being denied.[67] The committee also heard that where a GP explains to the patient what they were actually consenting to, a number of patients withdraw their consent.[68] However,

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62 The Medical Indemnity Protection Society Ltd, answers to questions on notice, 27 September 2017 (received 16 October 2017).

63 Medical Insurance Group Australia, answers to questions on notice, 27 September 2017 (received 18 October 2017).

64 Dr Edwin Kruys, Vice President and Chair, RACGP Queensland, Royal Australian College of General Practitioners, *Committee Hansard*, 8 September 2017, p. 25.

65 Associate Professor Stephen Bradshaw, Practitioner Member, Medical Board of Australia, *Committee Hansard*, 8 September 2017, pp. 26, 30, 32.

66 MDA National, answers to questions on notice, 27 September 2017 (received 12 October 2017).

67 Dr Edwin Kruys, Vice President and Chair, RACGP Queensland, Royal Australian College of General Practitioners, *Committee Hansard*, 8 September 2017, p. 26.

68 Dr Edwin Kruys, Vice President and Chair, RACGP Queensland, Royal Australian College of General Practitioners, *Committee Hansard*, 8 September 2017, p. 26; See also, Dr Bastian Seidel, President, Royal Australian College of General Practitioners, *Committee Hansard*, 1 December 2017, p. 15.

Ms Trimmer and Associate Professor Bradshaw pointed out that most doctors would not have the time to have such a conversation with their patients.[69]

8.54 MDA National asked the committee to consider recommending a requirement that life insurers must inform the patient/policyholder of any requests they make for the patient's/policyholder's medical records and provide the patient/policyholder with the opportunity to say no to such a request.[70]

8.55 This approach would be similar to how parties in litigation are informed when a subpoena is issued to a third party.[71] It was MDA National's belief that such a requirement placed on insurers would provide 'greater certainty for medical practitioners who are the subject of such requests, often where the issue of consent is not clear'..[72]

8.56 The committee also heard that GPs may be under-documenting a patient's risk for fear of what consequences this would have for a patient to obtain insurance or make an insurance claim.[73]

8.57 For example, the RACGP explained to the committee that consultation notes are not created for the purpose of a life insurer to assess an individual's risk.[74] Rather, as Dr Kruys explained to the committee, 'consultation notes are…a comprehensive written record of the conversations that have taken place, containing sensitive information to support us when providing quality care'.[75]

8.58 However, the inclusion of consultation notes in the documentation provided to life insurers under a broad authority places GPs in a difficult situation where they want to record a patient's consultation appropriately and in line with 'medico-legal' obligations, but must also consider the broader impact such notes will have on a patient, such as obtaining insurance or making an insurance claim.[76]

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69 Ms Anne Trimmer, Secretary General, Australian Medical Association, *Committee Hansard*, 8 September 2017, p. 24; Associate Professor Stephen Bradshaw, Practitioner Member, Medical Board of Australia, *Committee Hansard*, 8 September 2017, p. 26.

70 MDA National, answers to questions on notice, 27 September 2017 (received 12 October 2017).

71 MDA National, answers to questions on notice, 27 September 2017 (received 12 October 2017).

72 MDA National, answers to questions on notice, 27 September 2017 (received 12 October 2017).

73 Dr Edwin Kruys, Vice President and Chair, RACGP Queensland, Royal Australian College of General Practitioners, *Committee Hansard*, 8 September 2017, p. 24.

74 Royal Australian College of General Practitioners, *Submission 76*, p. 2.

75 Dr Edwin Kruys, Vice President and Chair, RACGP Queensland, Royal Australian College of General Practitioners, *Committee Hansard*, 8 September 2017, p. 24.

76 Royal Australian College of General Practitioners, *Submission 76*, p. 2.

8.59 In addition, the RACGP noted that its members are concerned about life insurers misinterpreting consultation notes, and the risk this poses for both GPs and patients.[77]

8.60 In this regard, the forms provided to the committee from life insurers illustrated the following references to clinical notes at the time of a customer making a claim:

- I /we authorise any treating doctor, physician, rehabilitation specialist or other medical or health care provider, ambulance service, hospital, police, social security or other government department, workers compensation insurer, employer, accountant, other insurer (or entity providing insurance type services), to provide/release to [redacted] all medical information… I am / we are aware that clinical notes, or part of the clinical notes, will inevitably include confidential medical information, which is irrelevant to the claim.
- I hereby authorise [redacted] to provide my personal information (which may including sensitive or health information) to any physician, hospital or any other health care provider that has attended or examined me in order for them to supply [redacted] with full particulars of my medical history, including copies of all hospital or medical records, referral letters, reports and details of any clinical notes that have been made.

8.61 Dr Kruys observed that GPs, or any other medical doctor, are subject to legal and ethical obligations to produce truthful medical reports that do not omit important issues.[78]

8.62 In addition to the concerns raised above regarding the risks to overall patient welfare posed by the release of full medical records including consultation notes, Dr Kruys and Dr Seidel were of the view that a targeted medical report would be more appropriate for insurers as the information contained in the report would be easier to apply a risk assessment to, rather than a life insurer potentially having to consider years of raw data.[79]

77 Royal Australian College of General Practitioners, *Submission 76*, p. 2.

78 Dr Edwin Kruys, Vice President and Chair, RACGP Queensland, Royal Australian College of General Practitioners, *Committee Hansard*, 8 September 2017, p. 26.

79 Dr Edwin Kruys, Vice President and Chair, RACGP Queensland, Royal Australian College of General Practitioners, *Committee Hansard*, 8 September 2017, p. 25; Dr Bastian Seidel, President, Royal Australian College of General Practitioners, *Committee Hansard*, 1 December 2017, pp. 13, 14, 18.

8.63 In light of the above, both the RACGP and the AMA argued that life insurers should only be authorised to obtain targeted medical reports rather than complete medical records.[80]

8.64 In terms of how a broad authority affects patients, Dr Stephen Carbone, Policy, Research and Evaluation Leader at beyondblue, expressed the view that patients may be reluctant to share their problems with GPs for fear of how insurers will use the information when deciding whether to provide cover or when assessing a claim.[81] Such fears seem to be particularly related to mental health conditions being used to deny cover or a claim unrelated to mental health.[82] The committee was told that this may lead to patients not receiving adequate treatment or appropriate care for mental health conditions.[83]

8.65 In terms of being able to purchase life insurance, it was pointed out to the committee that a beyondblue study found that 67 per cent of the study's participants 'agreed it was difficult to obtain life and income protection insurance' due to mental health conditions.[84]

8.66 Furthermore, the study noted that while people with mental health conditions can obtain life insurance, this at times is at a higher cost due to mental illness or through a policy that has mental health exclusions.[85]

8.67 Ms Nadine Bartholomeusz-Raymond, General Manager of Education, Families and Diversity and Access at beyondblue, told the committee that it is not just having a

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80 Dr Edwin Kruys, Vice President and Chair, RACGP Queensland, Royal Australian College of General Practitioners, *Committee Hansard*, 8 September 2017, p. 24; Dr Bastian Seidel, President, Royal Australian College of General Practitioners, *Committee Hansard*, 1 December 2017, pp. 13, 14; Ms Anne Trimmer, Secretary General, Australian Medical Association, *Committee Hansard*, 8 September 2017, p. 24.

81 Dr Stephen Carbone, Policy, Research and Evaluation Leader, beyondblue, *Committee Hansard*, 22 February 2017, pp. 16, 17; Dr Bastian Seidel, President, Royal Australian College of General Practitioners, *Committee Hansard*, 1 December 2017, p. 17.

82 Dr Stephen Carbone, Policy, Research and Evaluation Leader, beyondblue, *Committee Hansard*, 22 February 2017, pp. 16, 17.

83 Dr Stephen Carbone, Policy, Research and Evaluation Leader, beyondblue, *Committee Hansard*, 22 February 2017, pp. 16, 17; See also, Dr Bastian Seidel, President, Royal Australian College of General Practitioners, *Committee Hansard*, 1 December 2017, p. 17; Mr Joshua Fear, Director, Policy and Projects, Mental Health Australia, *Committee Hansard*, 1 December 2017, pp. 1-2; Mrs Lucinda Brogden, Co-Chair, National Mental Health Commission, *Committee Hansard*, 1 December 2017, p. 2; Dr Michelle Blanchard, General Manager, Research, Policy and Programs, SANE Australia, *Committee Hansard*, 1 December 2017, p. 5.

84 Mental Health Council of Australia and beyondblue, *Mental Health, Discrimination & Insurance–A survey of consumer experiences 2011*, 2011, p. 17.

85 Mental Health Council of Australia and beyondblue, *Mental Health, Discrimination & Insurance–A survey of consumer experiences 2011*, 2011, p. 26; See also, Dr Stephen Carbone, Policy, Research and Evaluation Leader, beyondblue, *Committee Hansard*, 22 February 2017, pp. 13–14.

mental health condition that may make it difficult to obtain insurance, but also the fact that a person may have seen a counsellor once and this was documented in consultation notes.[86] Such documentation was claimed to be used by insurers to deny access to insurance products.[87] Claims handling is discussed in detail in chapter 10 of this report.

8.68 The RACGP, beyondblue and the Royal Australian and New Zealand College of Psychiatrists (RANZCP) pointed out that the way in which a person's mental health information is used by an insurer for risk assessment purposes is problematic.[88]

8.69 Specifically, these groups believed that it is unclear what data is being used by insurers to make underwriting decisions that include assessment of mental health information, whether such data is up to date, and if the data reflects the fact that mental illness takes many forms and affects individuals differently.[89]

8.70 Ms Michelle Marie Cohen, Senior Solicitor at the Public Interest Advocacy Centre, shared similar concerns and Ms Alexis Goodstone, Principal Solicitor at the Public Interest Advocacy Centre, added that she believed these concerns relate to a range of insurers.[90]

8.71 In its response to the concerns raised about the use of mental health information by life insurers, the FSC informed the committee that it is very rare for a blanket exclusion to be in place for pre-existing mental health conditions when applying for life insurance. Furthermore, the FSC was not aware of any of its

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86 Ms Nadine Bartholomeusz-Raymond, General Manager, Education, Families and Diversity and Access, beyondblue, *Committee Hansard*, 22 February 2017, p. 13; See also, Dr Stephen Carbone, Policy, Research and Evaluation Leader, beyondblue, *Committee Hansard*, 22 February 2017, pp. 13–14.

87 Ms Nadine Bartholomeusz-Raymond, General Manager, Education, Families and Diversity and Access, beyondblue, *Committee Hansard*, 22 February 2017, p. 13.

88 Royal Australian College of General Practitioners, *Submission 76*, p. 2; Ms Nadine Bartholomeusz-Raymond, General Manager, Education, Families and Diversity and Access, beyondblue, *Committee Hansard*, 22 February 2017, p. 13; Dr Kym Jenkins, President Elect, Royal Australian and New Zealand College of Psychiatrists, *Committee Hansard*, 22 February 2017, p. 12; See also, Mr Joshua Fear, Director, Policy and Projects, Mental Health Australia, *Committee Hansard*, 1 December 2017, pp. 1-2; Mrs Lucinda Brogden, Co-Chair, National Mental Health Commission, *Committee Hansard*, 1 December 2017, p. 2; Dr Michelle Blanchard, General Manager, Research, Policy and Programs, SANE Australia, *Committee Hansard*, 1 December 2017, p. 3.

89 Ms Nadine Bartholomeusz-Raymond, General Manager, Education, Families and Diversity and Access, beyondblue, *Committee Hansard*, 22 February 2017, p. 13; Dr Kym Jenkins, President Elect, Royal Australian and New Zealand College of Psychiatrists, *Committee Hansard*, 22 February 2017, p. 12; Royal Australian College of General Practitioners, *Submission 76*, p. 2.

90 Ms Michelle Marie Cohen, Senior Solicitor, Public Interest Advocacy Centre, *Committee Hansard*, 24 February 2017, pp. 5–6; Ms Alexis Goodstone, Principal Solicitor, Public Interest Advocacy Centre, *Committee Hansard*, 24 February 2017, pp. 5–6.

members denying complete insurance coverage due to pre-existing mental health conditions.[91]

8.72 In addition, the FSC submitted that there is a range of life insurance cover that is available for mental health.[92]

8.73 The FSC also stated that while most insurance providers meet their legal obligation to clearly explain the duty of disclosure to consumers, the misunderstanding regarding blanket exclusions and mental health conditions reflected a need for greater education of consumers. [93]

8.74 In this regard, the FSC explained it is creating a key fact sheet to improve consumer understanding regarding disclosure for insurance within superannuation.[94]

Committee view

8.75 The committee agrees with the view put to it by ASIC that the issue of life insurers accessing a broad range of a consumer's personal information is complex due to the statutory requirements for consumers to disclose relevant information to an insurer.

8.76 The committee notes the evidence it received from the Financial Services Council and from life insurers explaining the principles of pooled risk and underwriting that underlie insurance and why this serves as a justification for a broad general authority to access a customer's medical information.

8.77 The committee further notes the claim made by life insurers that while a broad range of information may be obtained, life insurers only use information that is relevant to assessment of a policyholder's risk.

8.78 However, it remains unclear to the committee why approximately half of life insurers ask for complete medical records considering the assertion made by the industry that only relevant information is used by the insurer. The committee believes that the view that this is a less expensive way of obtaining information is insufficient justification.

8.79 It is also unclear how information within the records is both determined to be relevant and assessed for risk purposes, particularly in relation to mental health. The committee discusses and makes recommendations on the assessment of mental health issues during the claims process in chapter 10.

8.80 While the committee acknowledges that life insurers have not been found to have breached Australian Privacy Principles in relation to the access and sharing of a consumer's information, the committee is concerned that life insurers are unable to determine the number of full medical records kept in storage. This is problematic

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91 Financial Services Council, *Submission 26.1*, pp. 3, 5.

92 Financial Services Council, *Submission 26.1*, p. 3.

93 Financial Services Council, *Submission 26.1*, p. 5.

94 Financial Services Council, *Submission 26.1*, p. 5.

when not all of the medical information requested or received by life insurers is required to determine a claim. It is also particularly problematic that, in some instances, insurers may share information with third parties overseas, the extent and oversight of which is unclear.

8.81 The committee notes that the authorisation forms used by life insurers vary between insurers and products, and that consumers are offered an opportunity to decline to provide life insurers with a broad authorisation to access medical information. However, declining to provide a broad authorisation may lead to delays in the approval of an application or a claim. Given the consequent risk of delay, the committee questions whether the option to decline to provide a broad authority actually represents a genuine choice for consumers. In fact, the tone and language of the current FSC Code does not reflect assertions by the industry that full medical records are rarely required.

8.82 Chapter 3 of this report considered consumer protections in the financial services sector, including life insurance. As set out in chapter 3, the committee recommended legislative reform such that consumer protections would apply to all insurance. As such, the committee is of the view that forms requesting access to a consumer or policyholder's information should be subject to consumer protections including laws on unfair contract terms. Where the forms requesting such access do not form a part of the contract, the committee considers that the forms should be brought into the insurance contract so that consumer protections apply.

8.83 The access of life insurers to full medical records and related documentation rather than targeted reports has placed medical doctors, particularly GPs, in an invidious position. Evidence to the committee from medical organisations emphasised the ethical dilemma that medical practitioners face in terms of having to provide information to life insurers that may not be in their patients' best interest.

8.84 The committee is very concerned about evidence provided that patients are reluctant to seek necessary treatment, particularly for mental ill health, due to concerns over life insurers having access to their full medical record and then using such information to limit or deny coverage or a claim. Individuals should not have to trade off financial stability, which could be secured through life insurance, against their health.

8.85 Based on the evidence provided to the committee about the effect a broad authorisation has on both GPs and patients, as well as the questions raised regarding the utility of insurers obtaining all of a consumer's medical information, the committee is firmly of the view that life insurers should only have access to targeted information.

8.86 This more targeted approach will ensure unnecessary information is not kept in storage and will protect the privacy of individuals. It should also improve the doctor-patient relationship, ease some of the ethical burden placed on GPs, and no longer impact on an individual's decision to seek treatment.

8.87 In relation to informed and up-to-date consent, the committee notes the need for medical practitioners, particularly GPs, to be sure that their patient is aware that they have provided consent to a life insurer to access their medical records.

8.88 The committee agrees with MDA National's position that a life insurer should inform the patient/policyholder when the life insurer requests access to a patient's medical records, reports or other medical information. In addition, the committee is of the view that a life insurer should inform the patient/policyholder when the life insurer seeks to provide their medical information to any third party, including any overseas third party. The committee feels that this would be best served by progressing to a system of real-time disclosure that would allow consumers to track the progress of their claim.

8.89 The committee considers that the interests of consumers are paramount, but recognises that two competing consumer interests at play, namely the consumer's interest in privacy and the consumer's interest in reduced costs.

8.90 The committee is also of the view that doctors have a responsibility to only provide the information that is requested and not provide a patient's full medical record, particularly as doctors also have a responsibility to protect the privacy of their patients.

8.91 The committee is also of the view that a patient/policyholder should have the opportunity to decline a request for medical information, including the provision of that information to a third party. The committee acknowledges that any objection to the release of medical information may affect the assessment of a claim. In this regard, the committee is of the view that requiring life insurers to request a medical report rather than having access to full medical records would substantially alleviate any possibility that a patient/policyholder would deny access to medical information relevant to the proper determination of a claim.

8.92 The committee notes that data storage in the life insurance industry is currently regulated by APRA and the National Privacy Principles. These cover onshore and offshore arrangements.

Recommendation 8.1

8.93 The committee recommends that:

- **the Financial Services Council and the Royal Australian College of General Practitioners collaborate to prepare and implement agreed protocols for requesting and providing medical information;**
- **the Financial Services Council develop a uniform authorisation form for access to medical information at the time of application and at the time of claim that must be used by all of its members;**
- **this uniform authorisation form explain to consumers/policyholders in clear and simple language how information will be stored and used by third parties; and**
- **a consumer/policyholder should be able to use the same uniform authorisation form between different life insurers and different life insurance products.**

Recommendation 8.2

8.94 If the Financial Services Council and the Royal Australian College of General Practitioners have not agreed to protocols within six months, the committee recommends that at the time of application, life insurers must only ask a consumer's General Practitioner, or other treating doctor where relevant, for a medical report specific to the consumer's relevant medical conditions. In circumstances where such a report cannot be prepared, life insurers cannot ask for access to clinical notes regarding the consumer/policyholder.

Recommendation 8.3

8.95 If the Financial Services Council and the Royal Australian College of General Practitioners have not agreed to protocols within six months, the committee recommends that at the time of a consumer/policyholder making a claim, life insurers can only ask a policyholder's General Practitioner, or other treating doctor where relevant, for a medical report that is specifically targeted to the subject matter of the claim. In circumstances where such a report cannot be prepared, life insurers cannot ask for access to clinical notes regarding the consumer/policyholder.

Recommendation 8.4

8.96 If the Financial Services Council and the Royal Australian College of General Practitioners have not agreed to protocols within 6 months, the committee recommends that life insurers must obtain consent from a policyholder each time it intends to:

- **request a policyholder's medical records, reports or other medical information from their General Practitioner or other treating doctor; and**
- **share a policyholder's information with a third party.**

Recommendation 8.5

8.97 The committee recommends that the Financial Services Council, in discussion with the Royal Australian College of General Practitioners, update the *Life Insurance Code of Practice* and relevant Standards to reflect Recommendations 8.1, 8.2, 8.3, and 8.4.

Recommendation 8.6

8.98 The committee recommends that if insurance contracts are to be subjected to consumer protections, including laws on unfair contract terms:

- **where the authorisation form for a life insurer to access a consumer's/policyholder's medical information is within the insurance contract, consumer protections apply, including laws on unfair contract terms; and**
- **where the authorisation form for a life insurer to access a consumer's/policyholder's medical information is outside of the contract, authorisation forms are to be brought within the contract to allow for the application of consumer protections, including laws on unfair contract terms.**

Recommendation 8.7

8.99 The committee recommends that it become the practice of life insurers to institute real-time disclosure that would allow consumers to track the progress of their claim.

Chapter 9

Genetic information

9.1 Genetic testing and genetic information can be predictive or diagnostic in nature. Predictive genetic testing refers to the testing of a person who does not present any signs or symptoms of a disease but whose family history places them at a higher risk.[1] Diagnostic genetic testing is used to confirm a person's diagnosis when a disease is suspected based on the presentation of certain signs and symptoms.[2]

9.2 While genetic information may indicate a possibility of an individual or their family member contracting an inherited condition, such information is not of itself a guarantee of this as other factors, such as lifestyle, may play a role.[3]

9.3 It is also not possible to predict from genetic test results the exact time when a condition will be diagnosable, the rate in which a condition will progress, how severe it will be or when a person will die.[4] However, genetic information has the ability to potentially improve health outcomes by allowing for early medical intervention and lifestyle changes.[5] This potential has seen an investment by the Victorian, New South Wales and Queensland Governments of approximately $25 million each into implementing genomics into clinical healthcare.[6]

9.4 Currently, predictive genetic testing is available for inherited conditions such as some forms of cancer and heart disease as well as some neurological conditions,

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1 Human Genetics Society of Australasia, *Position Statement: Genetic Testing in Life Insurance in Australia*, March 2016, p. 1, https://www.hgsa.org.au/documents/item/20 (accessed 20 September 2017).

2 Human Genetics Society of Australasia, *Position Statement: Genetic Testing in Life Insurance in Australia*, March 2016, p. 1, https://www.hgsa.org.au/documents/item/20 (accessed 20 September 2017); Professor Margaret Otlowski, Law Dean, University of Tasmania; and Chair, Australian Genetic Non-Discrimination Working Group, *Committee Hansard*, 26 May 2017, p. 62.

3 Human Genetics Society of Australasia, *Position Statement: Genetic Testing in Life Insurance in Australia*, March 2016, pp. 1, 2, https://www.hgsa.org.au/documents/item/20 (accessed 20 September 2017).

4 Human Genetics Society of Australasia, *Position Statement: Genetic Testing in Life Insurance in Australia*, March 2016, p. 1, https://www.hgsa.org.au/documents/item/20 (accessed 20 September 2017).

5 Human Genetics Society of Australasia, *Position Statement: Genetic Testing in Life Insurance in Australia*, March 2016, p. 2, https://www.hgsa.org.au/documents/item/20 (accessed 20 September 2017); See also, Dr Kate Stockhausen, Manager, Ethics, Australian Medical Association, *Committee Hansard*, 8 September 2017, p. 29.

6 Professor Margaret Otlowski, Law Dean, University of Tasmania; and Chair, Australian Genetic Non-Discrimination Working Group, *Committee Hansard*, 26 May 2017, p. 66.

such as Huntington's disease.[7] Continual developments and technological advances mean that the number of inherited conditions that predictive genetic testing is available for, as well as the methods for such testing, is increasing. For example, the identification of predisposition to inherited conditions is now available through direct-to-consumer testing and whole genome sequencing.[8]

9.5 As the use of genetic testing and the role of genomics in health care increases, concerns have been raised around privacy and genetic discrimination.[9] Genetic discrimination has been defined as 'the differential treatment of asymptomatic individuals or their relatives on the basis of their actual or presumed genetic characteristics'.[10] At its core, genetic discrimination reflects the belief that, as a person has no control over their genetic makeup, it would be unfair to discriminate against them.[11]

9.6 Genetic discrimination raises important questions about how predictive genetic test results affect an individual and their family's ability to obtain life insurance, as well as associated questions regarding research participation and public health outcomes.

9.7 This chapter will focus on the use of predictive genetic information (genetic information) by the life insurance industry and begins by looking at developments in the use of genetic information by insurance companies in several international jurisdictions. The use of genetic information by insurance companies in Australia is then considered, followed by a discussion of reform, including arguments for a ban on life insurers using genetic information on one side, and continued self-regulation by the life insurance industry on the other. The chapter concludes with the committee's views and recommendations.

Genetic information and the life insurance industry in international jurisdictions

9.8 In response to the rapid developments in the area of genetic testing and research and concerns over genetic discrimination, several countries have enacted

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7 Human Genetics Society of Australasia, *Position Statement: Genetic Testing in Life Insurance in Australia*, March 2016, p. 1, https://www.hgsa.org.au/documents/item/20 (accessed 20 September 2017).

8 Human Genetics Society of Australasia, *Position Statement: Genetic Testing in Life Insurance in Australia*, March 2016, p. 2, https://www.hgsa.org.au/documents/item/20 (accessed 20 September 2017); Dr Kate Stockhausen, Manager, Ethics, Australian Medical Association, *Committee Hansard*, 8 September 2017, p. 31.

9 Professor Margaret Otlowski, Law Dean, University of Tasmania; and Chair, Australian Genetic Non-Discrimination Working Group, *Committee Hansard*, 26 May 2017, p. 59.

10 M. Otlowski, S. Taylor and Y. Bombard, 'Genetic Discrimination: International Perspectives', *Annual Review of Genomics and Human Genetics*, vol. 13, 2012, p. 434.

11 M. Otlowski, S. Taylor and Y. Bombard, 'Genetic Discrimination: International Perspectives', *Annual Review of Genomics and Human Genetics*, vol. 13, 2012, p. 434.

legislation or voluntary agreements to restrict or fully ban the use of genetic information by insurance companies.

United Nations Educational, Scientific and Cultural Organization

9.9 The Universal Declaration on Human Genome and Human Rights was passed by the United Nations Educational, Scientific and Cultural Organisation in 1997. This declaration aims to protect against the use of genetic information in a way that is contrary to human rights and dignity.[12]

European Union

9.10 Genetic discrimination is prohibited in countries in the European Union through the Council of Europe's *Convention on Human Rights and Biomedicine*.[13] Legislation has also been enacted in European countries such as Belgium, Denmark, Holland and Sweden that prohibits insurers using genetic information when setting premium levels.[14]

United Kingdom

9.11 An agreement in the form of a voluntary concordat (a concordat is an agreement between parties relating to matters of mutual interests) and a moratorium regarding the use of a customer's genetic information by life insurers is in place in the United Kingdom.[15]

9.12 The Concordat and Moratorium are agreed to by both the United Kingdom Government and the Association of British Insurers. The Concordat is an agreement to uphold the principle that insurance companies should, unless otherwise stated, have access to relevant information in order to fairly price risk for the benefit of all consumers.[16] The Moratorium is a separate document that sits alongside the Concordant and allows consumers to obtain significant levels of life insurance without having to disclose the results of genetic testing.[17]

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12 Library of Parliament, *Legislative Summary – Bill S-201: An Act to prohibit and prevent genetic discrimination*, 6 December 2016, p. 3.

13 Australian Genetic Non-Discrimination Working Group, *Submission 60*, p. 4.

14 Australian Genetic Non-Discrimination Working Group, *Submission 60*, p. 4.

15 HM Government and Association of British Insurers, *Concordat and Moratorium on genetics and Insurance*, 2014.

16 HM Government and Association of British Insurers, *Concordat and Moratorium on genetics and Insurance*, 2014, clause 1.

17 HM Government and Association of British Insurers, *Concordat and Moratorium on genetics and Insurance*, 2014, clause 21(c); Genetic Alliance UK, *Insurance, Privacy and the Concordat and Moratorium*, 12 May 2016, pp. 1–2, http://www.geneticalliance.org.uk/information/living-with-a-genetic-condition/insurance-privacy-and-the-concordat-and-moratorium/ (accessed 24 August 2017).

9.13 The exception to this, as stated in the Moratorium, is a predictive genetic test for Huntington's disease where life insurance is sought for over £500 000.[18] Such an exception is only in place due to the United Kingdom Government seeking advice from experts regarding an application from the Association of British Insurers to use the genetic test results of Huntington's disease. Under the Moratorium any such applications to use genetic information from the Association of British Insurers must go through this process.[19]

9.14 The Moratorium also prohibits the use of results from direct-to-consumer tests as well predictive or diagnostic test results acquired as a part of clinical research, such as through the 100 000 Genomes Project.[20]

9.15 The 100 000 Genomes Project will sequence 100 000 genomes from around 70 000 people with the aim of creating a new genomic medicine service for the National Health Service that will offer a diagnosis for patients, potentially identify new and effective treatments, and enable new medical research.[21]

9.16 Under the Moratorium, consumers and policyholders are allowed to use genetic test results to demonstrate that they are not at risk of an inherited disease.[22]

9.17 While the agreement is in operation until November 2019, the UK Government does not see a reason to introduce legislation regarding the use of genetic information or family history.[23] A review of the agreement was scheduled to take place in 2016.[24] At the time of this report, the status of this review is unclear.

9.18 Table 6.1 below illustrates the positions taken in response to the use of genetic information by insurers in European Union countries and the United Kingdom. The table outlines whether a country has a regime of self-regulation or not as well as:

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18 HM Government and Association of British Insurers, *Concordat and Moratorium on genetics and Insurance*, 2014, clause 21(d); Genetic Alliance UK, *Insurance, Privacy and the Concordat and Moratorium*, 12 May 2016, pp. 1–2, http://www.geneticalliance.org.uk/information/living-with-a-genetic-condition/insurance-privacy-and-the-concordat-and-moratorium/ (accessed 24 August 2017).

19 HM Government and Association of British Insurers, *Concordat and Moratorium on genetics and Insurance*, 2014, clause 35.

20 HM Government and Association of British Insurers, *Concordat and Moratorium on genetics and Insurance*, 2014, clauses 21(c), 36.

21 Genomic England, *The 100,000 Genomes Project*, 2017, https://www.genomicsengland.co.uk/the-100000-genomes-project/ (accessed 20 September 2017).

22 HM Government and Association of British Insurers, *Concordat and Moratorium on genetics and Insurance*, 2014, clause 22.

23 HM Government and Association of British Insurers, *Concordat and Moratorium on genetics and Insurance*, 2014, clauses 3, 38.

24 HM Government and Association of British Insurers, *Concordat and Moratorium on genetics and Insurance*, 2014, clause 38.

- the stage at which insurers are limited or banned from using genetic information;
- whether the limitation or ban is restricted to certain products and/or to a financial limit of insurance coverage;
- whether a consumer can disclose their test results if they choose to and whether an insurer can ask a consumer to undertake a genetic test; and
- whether the regulation of the use of genetic information by insurers includes how an insurer can use a consumer's family history.

Table 6.1: European approaches to the use of genetic information by life insurance companies

Country	Type of regulation/ self-26.2regulation	Policy stage	Are restrictions product specific?	Are there financial limits to regulations?	Can the consumer disclose a test by choice?	Can insurers ask consumers to take a test?	Is Family History included?
UK	Voluntary agreement	Applications	Yes	Yes	Yes	No	No
Germany **Switzerland**	Law	All	Yes	EUR 300,000 CHF 400,000	No	No	No
Holland **Sweden**	Law	All	No	EUR 250,000 SEK 1,284,000	No	No	No
Belgium	Law	All	Yes	No	No	No	Yes
Portugal	Law	All	No	No	No	No	Yes
Ireland	Law	Applications	No	No	No	No	No
Austria **Denmark** **France**	Law	All	No	No	No	No	No

Source: Financial Services Council, *Submission 26.2*, p. 8.[25]

25 See also M. Otlowski, S. Taylor and Y. Bombard, 'Genetic Discrimination: International Perspectives', *Annual Review of Genomics and Human Genetics*, 13, 2012, p. 443; The information provided by this source was accurate at its time of publication in 2012.

United States

9.19 The *Genetic Information Non-Discrimination Act* is an American federal law providing protection for individuals from genetic discrimination in relation to health insurance and employment. The Act prevents health insurers from using genetic information in relation to decisions about eligibility, coverage, underwriting or premium setting. This protection includes persons who have tested positive for a predisposition to Huntington's disease prior to presenting any symptoms.[26] As a federal law, the Act sets the minimum level of protection that states in the United States must provide.[27] The Act is not retroactive, meaning it does not apply to genetic discrimination prior to the Act's enactment.[28]

Canada

9.20 On 4 May 2017, the *Genetic Non-Discrimination Act* was passed into federal Canadian law. Under the Act insurers are prohibited from requesting that a person undergo a genetic test or from requiring the disclosure of previous or future genetic test results. The Act aims to protect predictive and diagnostic genetic tests and information obtained in clinical and research settings.[29]

9.21 However, the Act does not prohibit an insurer's access to family medical history. This means that a person will have to report their medical condition if a family member applies for insurance but not their genetic test results.[30] The Act also does not indicate whether someone would have to inform an insurer that they have had a genetic test. Under the Act, genetic discrimination may be a criminal offence.[31]

9.22 Prior to the enactment of the Act, the Canadian Institute of Actuaries released a research paper to support its position in opposing the Act. The paper noted that the Act will have a substantial impact on insurance companies with premiums increasing from between 30 to 50 per cent.[32]

9.23 The Canadian Life and Health Insurance Association believes that legislative regulation is unnecessary and announced that it would include in its Industry Code a commitment that insurers would not request or use genetic test information for life

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26 Genetic Information Nondiscrimination Act, *Genetic Information Nondiscrimination Act*, June 2010, p. 3, http://www.ginahelp.org/GINAhelp.pdf (accessed 24 August 2017).

27 Genetic Information Nondiscrimination Act, *Genetic Information Nondiscrimination Act*, June 2010, p. 7, http://www.ginahelp.org/GINAhelp.pdf (accessed 24 August 2017).

28 Genetic Information Nondiscrimination Act, *Genetic Information Nondiscrimination Act*, June 2010, p. 7, http://www.ginahelp.org/GINAhelp.pdf (accessed 24 August 2017).

29 *Genetic Non-Discrimination Act*, s. 3.

30 Canadian Association of Genetic Counsellors, *Genetic Non-Discrimination Act (GNA)*, 17 May 2017, p. 2, https://www.cagc-accg.ca/doc/S201%20fact%20sheet%20-%20final%20copy%20-%20May%2017%202017.pdf (accessed 20 September 2017).

31 *Genetic Non-Discrimination Act*, s. 7.

32 Canadian Institute of Actuaries, *Canadian Institute of Actuaries' Proposed Amendment to Bill S-201, An Act to prohibit and prevent genetic discrimination*, 21 November 2016, p. 2.

insurance application up to $250 000.[33] This would mean that about 85 per cent of applications would not require disclosure of genetic information.[34]

9.24 Unlike Australia where the *Life Insurance Code of Practice* is mandatory for all members of the Financial Services Council (see the next section for further details), the Canadian Industry Code and proposed commitments is voluntary for members of the Canadian Life and Health Insurance Association.

9.25 The Office of the Privacy Commissioner in Canada published two reports that considered the effect that the Act would have on the Canadian insurance industry.[35] Both reports found that there would be no significant impact on the industry or insurance markets by banning the use of genetic information.[36]

9.26 A primary reason for this finding was that severe single gene disorders certain to cause premature death and requiring a high level of expensive coverage, such as Huntington's disease, occur so rarely as to have minimal effect on the insurance markets and the notion of pooled risk.[37]

9.27 However, both the Canadian Office of the Privacy Commissioner and the Library of the Canadian Parliament found that such a position may change as technology continues to advance and the reliability and predictability of genetic test results, as well as the number of conditions that can be identified, increases.[38]

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33 Canadian Life and Health Insurance Association, *Canada's Life and Health Insurers Announce Commitment on Use of Genetic Testing Information*, 11 January 2017, https://www.clhia.ca/domino/html/clhia/clhia_lp4w_lnd_webstation.nsf/page/07AC1F9D1616B528852580A4006D544E (accessed 20 September 2017).

34 Canadian Life and Health Insurance Association, *Canada's Life and Health Insurers Announce Commitment on Use of Genetic Testing Information*, 11 January 2017, https://www.clhia.ca/domino/html/clhia/clhia_lp4w_lnd_webstation.nsf/page/07AC1F9D1616B528852580A4006D544E (accessed 20 September 2017); Simmie Palter, 'The Genetic Non-Discrimination Act: Bill S-201', *DDO Health Law*, http://ddohealthlaw.com/the-genetic-non-discrimination-act-bill-s-201/ (accessed 20 September 2017).

35 Office of the Privacy Commissioner of Canada, *The Actuarial Relevance of Genetic Information in the Life and Health Insurance Context*, July 2011; Office of the Privacy Commissioner of Canada, *The Potential Economic Impact of a Ban on the Use of Genetic Information for Life and Health Insurance*, March 2012.

36 Office of the Privacy Commissioner of Canada, *The Actuarial Relevance of Genetic Information in the Life and Health Insurance Context*, July 2011, p. 2; Office of the Privacy Commissioner of Canada, *The Potential Economic Impact of a Ban on the Use of Genetic Information for Life and Health Insurance*, March 2012, p. 2.

37 Office of the Privacy Commissioner of Canada, *The Actuarial Relevance of Genetic Information in the Life and Health Insurance Context*, July 2011, p. 2.

38 Office of the Privacy Commissioner of Canada, *Statement on the use of genetic test results by life and health insurance companies*, 10 July 2014, p. 4, https://www.priv.gc.ca/en/opc-news/news-and-announcements/2014/s-d_140710/ (accessed on 20 September 2017); Office of the Privacy Commissioner of Canada, *The Potential Economic Impact of a Ban on the Use of Genetic Information for Life and Health Insurance*, March 2012, pp. 2–3; Library of Parliament, *Legislative Summary – Bill S-201: An Act to prohibit and prevent genetic discrimination*, 6 December 2016, p. 2.

9.28 The Library of the Canadian Parliament also found that it was difficult to determine the prevalence of genetic discrimination in Canada and internationally with different parties claiming 'discrimination is already a problem' or 'that there is no evidence that [discrimination] is widespread' or that 'there is not enough reliable information on which to base conclusive statements'.[39]

9.29 Currently, the constitutionality of the Act is being challenged, with the argument made that the Act seeks to legislate matters that are in the jurisdiction of Canadian provinces.[40]

Genetic information and the life insurance industry in Australia

Background

9.30 As explained in chapter 8 of this report on access to medical information by insurers, a consumer has a duty to disclose all relevant information. Additionally, the *Privacy Act 1988* and the *Disability Discrimination Act 1992* allow insurers in Australia to use a consumer's genetic information where such information has been obtained with consent and its use is both justifiable and reasonable.

9.31 Life insurers explained to the committee that the reason they require a customer's genetic information is due to the principle of pooled risk. This principle was examined in chapter 8 of this report on access to medical information by insurers.

9.32 The 2003 report *Essentially Yours: The Protection of Human Genetic Information in Australia* by the Australian Law Reform Commission and the Australian Health Ethics Committee of the National Medical and Research Council (ALRC report) considered, in response to the rapidly developing area of human genetic information, how best to protect privacy, prevent unfair discrimination, and ensure high standards are in place for research.[41]

9.33 The ALRC report made note of how the area of genetics has produced two conflicting yet equally powerful reactions. The first being public support for advancements in medicine for better treatments and diagnosis. The second being concerns over privacy and genetic discrimination and how the use of genetic information will be regulated.[42]

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39 Library of Parliament, *Legislative Summary – Bill S-201: An Act to prohibit and prevent genetic discrimination*, 6 December 2016, p. 2.

40 Library of Parliament, *Legislative Summary – Bill S-201: An Act to prohibit and prevent genetic discrimination*, 6 December 2016, p. 7.

41 Australian Law Reform Commission and the National Medical and Research Council, *Protection of human genetic information*, 6 May 2003, https://www.alrc.gov.au/inquiries/protection-human-genetic-information (accessed 18 October 2017).

42 Australian Law Reform Commission and the National Medical and Research Council, *Protection of human genetic information*, 6 May 2003, https://www.alrc.gov.au/inquiries/protection-human-genetic-information (accessed 18 October 2017).

9.34 A key recommendation of the ALRC report was that a standing committee, known as the Human Genetics Commission of Australia, be established to provide high-level technical and strategic advice on emerging issues in genetics to the Australian Government, industry and community.[43]

9.35 The ALRC report also recommended that this advisory body be consulted in the development of guidelines and policy for genetics.[44] Other recommendations included, but were not limited to; the Human Genetics Commission of Australia determining what types of genetic tests should be used by insurers.[45]

9.36 The government established the Human Genetics Commission of Australia for a three year period from 2012–2015. In terms of recommendations relevant to life insurance, the government noted that the majority of the recommendations were directed at greater self-regulation of the life insurance industry.[46]

Self-regulation and use of genetic information by the life insurance industry

9.37 The Financial Services Council (FSC) is responsible for a self-regulatory regime that consists of commitments presented in the Life Insurance Code of Practice (Code) and a series of standards. The Code and standards are mandatory for FSC members, including a number of life insurers, to adhere to.[47]

9.38 Standard 11 relates to the use of genetic test results in life insurance underwriting and Standard 16 relates to the use of family history information. Standard 11 was first adopted by members of the IFA (the former name of the FSC) in 1998 and was updated on 7 December 2016. Standard 16 was first approved by the FSC Board on 1 December 2005 and was updated 7 December 2016. The updates to both standards were done in consultation with Associate Professor Kristin Barlow-Stewart, Director of the Master of Genetic Counselling at The University of Sydney.[48]

9.39 The FSC submitted that they have been working with the geneticist community, including geneticists both within and outside of the insurance industry,

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43 Australian Law Reform Commission and the National Medical and Research Council, *Essentially Yours: The Protection of Human Genetic Information in Australia- Executive Summary*, March 2003.

44 Australian Law Reform Commission and the National Medical and Research Council, *Essentially Yours: The Protection of Human Genetic Information in Australia- Executive Summary*, March 2003.

45 Australian Law Reform Commission and the National Medical and Research Council, *Essentially Yours: The Protection of Human Genetic Information in Australia- List of Recommendations*, March 2003.

46 Australian Government, *Full Australian Government Response to ALRC Report 96*, 9 December 2005, http://www.alrc.gov.au/inquiries/health-and-genetics/full-australian-government-response-alrc-report-96 (accessed 28 September 2017); Australian Genetic Non-Discrimination Working Group, *Submission 60*, p. 4.

47 Financial Services Council, *Submission 26.2*, pp. 2–4.

48 Financial Services Council, *Submission 26.2*, p. 4.

since the early 1990s to develop standards that balanced the interest of the individual consumer with a risk management focus required by insurers.[49] The FSC believe that the standards promote best practice and allow customers to be proactive in their health care management without fear of insurance implications.[50]

9.40 The FSC informed the committee that Standard 11 specifies that insurers must not ask a consumer to undergo a genetic test.[51] However, where an applicant has already undertaken a genetic test prior to the application process, insurance companies do have access to the results of such tests.[52] Standard 11 also ensures that genetic test results are only used in assessing the applicant's risk and not risk associated with their family members.[53]

9.41 The FSC asserted that Standard 11 does not dissuade consumers from participation in medical and scientific research.[54] However, the disclosure of genetic information obtained through such studies is required where the consumer is aware of such results, that is, where participation in the research is not anonymous.[55]

9.42 In addition, the FSC drew the committee's attention to the FSC's updated Standard 11 of 7 December 2016 made in response to the rapid advancement in the field of genetics.[56] The update included new suggested wording to be used by life insurers when asking insurance applicants about genetic testing. These words are:

> 10.11 Members should give consideration to the following uniform wording when developing wording in personal statements with regard to genetic tests
>
> 10.11.1 Have you ever had or are you considering having a genetic test where you have received (or are currently awaiting) an individual result?[57]

9.43 Standard 11 explains that such words will provide insurance applicants with clarity where they have participated in a medical research project but have not received individual results.[58]

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49 Financial Services Council, *Submission 26.2*, p. 2.

50 Financial Services Council, *Submission 26.2*, p. 2.

51 Financial Services Council, *Submission 26.2*, p. 3.

52 Financial Services Council, *FSC Standard No. 11 Genetic Testing Policy*, 7 December 2016, clause 10.2.

53 Financial Services Council, *Submission 26.2*, p. 3.

54 Financial Services Council, *Submission 26.2*, p. 3.

55 Financial Services Council, *FSC Standard No. 11 Genetic Testing Policy*, 7 December 2016, clauses 10.3–10.3.2.

56 Financial Services Council, *Submission 26.2*, p. 3.

57 Financial Services Council, *FSC Standard No. 11 Genetic Testing Policy*, 7 December 2016, clauses 10.11–10.11.1.

58 Financial Services Council, *FSC Standard No. 11 Genetic Testing Policy*, 7 December 2016, clause 10.11.2.

9.44 However, at the public hearing on 1 December 2017, Mr Nick Kirwan, Policy Manager at the FSC, acknowledged that the question contained in clause 10.11.1 was 'horrible'. To this end, he explained to the committee that the FSC is prepared to commit to changing the question.[59]

9.45 The FSC has a Genetic Testing Underwriting Database which commenced in 2000.[60] This database records any underwriting decision made by a member of the FSC involving genetic test results.[61]

9.46 Under Standard 11, FSC members must provide the FSC with de-identified data on applications involving genetic testing.[62] FSC members must also agree to the data regarding genetic testing and insurance applications being made publicly-available as a means to support research.[63]

9.47 The committee was interested in understanding how many applications for life insurance involve genetic information. Noting the requirements under Standard 11 for FSC members to provide the FSC with de-identified data on applications involving genetic testing, the committee asked the FSC for the total number of applications for life insurance that involved genetic information since the approval of Standard 11. Importantly, the committee was only interested in a numerical total, not the raw data itself.

9.48 Nevertheless, the FSC were unable to provide the committee with the number of applications involving genetic testing. Instead, the FSC informed the committee that academics at the University of Sydney intended to publish their findings based on the independent review of the database, and that the data is highly sensitive and would require skilled analysis in order to be of any use.[64]

9.49 The FSC also stated that to its knowledge, the number of Australians who have had predictive genetic testing is low, although this number is likely to increase significantly in response to continuing developments in the field of genetics and the reduced costs of accessing genetic testing.[65]

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59 Mr Nick Kirwan, Policy Manager, Financial Services Council, *Committee Hansard*, 1 December 2017, p. 31.

60 Financial Services Council, *FSC Standard No. 11 Genetic Testing Policy*, 7 December 2016, clause 10.16.

61 Financial Services Council, *Submission 26.2*, pp. 2, 5.

62 Financial Services Council, *FSC Standard No. 11 Genetic Testing Policy*, 7 December 2016, clause 10.16.

63 Financial Services Council, *FSC Standard No. 11 Genetic Testing Policy*, 7 December 2016, clause 10.16.

64 Financial Services Council, answers to questions on notice, 31 August 2017 (received 27 September 2017).

65 Financial Services Council, answers to questions on notice, 31 August 2017 (received 27 September 2017).

9.50 It is the FSC's understanding that where genetic information is used by life insurers for underwriting decisions, it is common for the decision to be made by a Chief Underwriter with the potential involvement of a Chief Medical Officer or a specialist reinsurance company with access to geneticists and other medical specialists.[66] The Chief Medical Officer or specialist reinsurer may also consult with external geneticists.[67]

9.51 Life insurers submitted that, in line with FSC standards, they only ask consumers whether they have had a genetic test.[68] Insurers do not request consumers to undergo genetic testing or inform insurers of results from anonymous research trials.[69]

9.52 Life insurers such as TAL and Zurich also told the committee that circumstances where genetic information has to be provided by the consumer is uncommon. For example, Mr Brett Clark, Chief Executive Officer and Managing Director of TAL, stated that out of 33 000 applications for retail insurance, only 750 applications contained genetic information.[70] Likewise, Mr Tim Bailey, Chief Executive Officer of Zurich, commented that it would be extremely rare for genetic information to be disclosed at the time of underwriting.[71]

9.53 Furthermore, Ms Helen Troup, Managing Director of CommInsure, explained that where genetic information is provided, the credibility of the information, including whether it was analysed in an accredited testing facility, would be considered prior to deciding how much credence to place on such information.[72] Ms Troup noted that a pre-disposition to an illness would not in itself preclude a person from having a successful claims outcome unless the condition had been formally diagnosed.[73]

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66 Financial Services Council, *Submission 26.2*, p. 5.

67 Financial Services Council, *Submission 26.2*, p. 5.

68 Ms Helen Troup Managing Director, CommInsure, Commonwealth Bank, *Committee Hansard*, 8 September 2017, p. 21.

69 Mr Tim Bailey, Chief Executive Officer, Zurich Financial Service Australia Limited, answers to questions on notice, 26 May 2017 (received 9 June 2017); MLC Life Insurance, answers to questions on notice, 26 May 2017 (received 9 June 2017).

70 Mr Brett Clark, Chief Executive Officer and Managing Director, TAL, *Committee Hansard*, 18 August 2017, p. 12.

71 Mr Tim Bailey, Chief Executive Officer, Zurich Financial Service Australia Limited, *Committee Hansard*, 26 May 2017, p. 41; See also, Mr Philip Anderson, Chief operating Officer, Life and Investments, Zurich Financial Service Australia Limited, *Committee Hansard*, 26 May 2017, p. 41.

72 Ms Helen Troup Managing Director, CommInsure, Commonwealth Bank of Australia, *Committee Hansard*, 8 September 2017, p. 22.

73 Ms Helen Troup Managing Director, CommInsure, Commonwealth Bank of Australia, *Committee Hansard*, 8 September 2017, p. 22; See also, Mr Craig Harrison, General Manager, Life Product and Distribution, Commonwealth Bank of Australia, *Committee Hansard*, 8 September 2017, p. 22.

9.54 While the FSC acknowledged that the debate over whether life insurers should use genetic information was complex, the FSC was of the view that self-regulation, through the Code and standards, was the most appropriate way to manage the use of genetic information.[74]

9.55 Moreover, the FSC believed that countries that have introduced legislation in response to the issue of genetic information do not have the same 'robust self-regulation mechanism' as Australia.[75]

9.56 The FSC submitted that their regime of self-regulation also allows for the industry to quickly respond to any developments in technology and research relating to genetic testing, unlike legislation which could take years to reflect any changes.[76]

9.57 The FSC also informed the committee that placing limits on, or banning the use of, genetic information will have consequences for consumers. One such consequence is that a consumer will not be allowed to use a negative test result to demonstrate to an insurer that they are not at risk of developing a condition.[77]

9.58 In terms of a moratorium type response to the use of genetic information, Mr Kirwan explained that the FSC does not support such an approach as it provides no certainty to consumers about what will happen with their genetic test results or any future test results once the moratorium concludes.[78]

9.59 Another consequence identified by the FSC and other insurers was the potential for anti-selection and information asymmetry. This position was examined in chapter 8 of this report on access to medical information by insurers.

9.60 Life insurers such as AMP, CommInsure, MLC and Zurich supported the FSC's position that the use of genetic information by insurers is a developing and complex area that requires further debate.[79]

9.61 MLC opposed any changes in legislation that would prohibit the use of genetic information by life insurers and, like the FSC, noted that genetic test results could benefit a customer by demonstrating to an insurer that they are not at risk.[80]

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74 Financial Services Council, *Submission 26.2*, p. 9.

75 Financial Services Council, *Submission 26.2*, p. 9.

76 Financial Services Council, *Submission 26.2*, p. 9; See also, Mr Nick Kirwan, Policy Manager, Financial Services Council, *Committee Hansard*, 1 December 2017, p. 32.

77 Financial Services Council, *Submission 26.2*, p. 7; See also, Mr Nick Kirwan, Policy Manager, Financial Services Council, *Committee Hansard*, 1 December 2017, pp. 31, 32.

78 Mr Nick Kirwan, Policy Manager, Financial Services Council, *Committee Hansard*, 1 December 2017, pp. 31, 32.

79 Mr Craig Meller, Chief Executive Officer, AMP, additional information received 5 September 2017, pp. 7–8; Ms Helen Troup Managing Director, CommInsure, Commonwealth Bank, *Committee Hansard*, 8 September 2017, p. 21; MLC Life Insurance, answers to questions on notice, 26 May 2017 (received 9 June 2017); Mr Tim Bailey, Chief Executive Officer, Zurich Financial Service Australia Limited, *Committee Hansard*, 26 May 2017, p. 41.

9.62 Likewise, AMP explained to the committee that, as the use of genetic information by the industry in not common at the moment, a full discussion on the appropriateness of a ban with stakeholders should take place before decisions are made on how to respond to the issue.[81]

Arguments for reform

9.63 In summary, the arguments presented to the committee for reform of how life insurers use genetic information recommended that the use of such information should ideally be banned in order to protect consumers against genetic discrimination. In addition, concerns were raised about the FSC's current regime of self-regulation, the accuracy and interpretation of genetic test results, and how the use of genetic information by insurers effects participation in research.

Concerns about self-regulation

9.64 Professor Margaret Otlowski, Dean of Law at the University of Tasmania and Chair of the Australian Genetic Non-Discrimination Working Group (AGND Working Group) called for legislation that would restrict or ideally ban the use of genetic information by life insurers and a moratorium prohibiting the use of genetic information until such legislation is enacted.[82]

9.65 The AGND Working Group argued that a legislative response was necessary due to the inherent conflicts of interest within a self-regulatory regime such as the FSC's Code and Standards. The AGND Working Group argued that a conflict exists between the benefits that accrue to the life insurer from obtaining as much information as possible, and the consumer's loss of privacy and potential exposure to genetic discrimination.[83]

9.66 As noted earlier in this chapter, the update made to FSC Standard 11 in December 2016 included a question about whether a consumer is considering taking a genetic test. The AGND Working Group argued that the appropriateness of this

80 Mr Andrew Hagger, Chief Customer Officer, National Australia Bank, answers to questions on notice, 26 May 2017 (received 9 June 2017).

81 Mr Craig Meller, Chief Executive Officer, AMP, additional information received 5 September 2017, pp. 7–8.

82 Professor Margaret Otlowski, Law Dean, University of Tasmania; and Chair, Australian Genetic Non-Discrimination Working Group, *Committee Hansard*, 26 May 2017, pp. 59, 62.

83 Australian Genetic Non-Discrimination Working Group, answers to questions on notice, 26 May 2017 (received 9 June 2017); Professor Margaret Otlowski, Law Dean, University of Tasmania; and Chair, Australian Genetic Non-Discrimination Working Group, *Committee Hansard*, 26 May 2017, pp. 59, 62; See also, Ms Jane Tiller, Legal and Social Adviser, Public Health Genomics, Department of Epidemiology and Preventative Medicine, School of Public Health and Preventative Medicine, Monash University; and Member, Australian Genetic Non-Discrimination Working Group, *Committee Hansard*, 26 May 2017, pp. 67–68.

question was not subject to independent oversight, and saw it as allowing insurers to obtain more information than is necessary.[84]

9.67 While the FSC informed the committee that a geneticist was consulted in the revising of Standard 11, the AGND Working Group claimed that the geneticist community is not adequately represented in consultations undertaken by the insurance industry.[85]

9.68 The AGND Working Group also claimed that, due to self-regulation, it is unclear whether there is a systematic use of expert geneticists when reviewing and developing actuarial modelling to assess risk associated with predictable genetic disease.[86]

9.69 Both the Australian Medical Association (AMA) and the Royal Australian College of General Practitioners (RACGP) agreed that the self-regulated way in which insurers may or may not use genetic information obtained from a consumer is problematic.[87]

9.70 In relation to industry arguments that information is needed in order to prevent anti-selection and increased premiums, the AGND Working Group stated that no evidence had been provided by the life insurance industry to substantiate these claims.[88]

9.71 Furthermore, the AGND Working Group noted that the two reports commissioned by the Office of the Privacy Commissioner in Canada found that there would be no significant impact on the life insurance industry or insurance markets as a result of a ban on life insurers using genetic information.[89]

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84 Professor Margaret Otlowski, Law Dean, University of Tasmania; and Chair and Ms Jane Tiller, Legal and Social Adviser, Public Health Genomics, Department of Epidemiology and Preventative Medicine, School of Public Health and Preventative Medicine, Monash University; and Member, Australian Genetic Non-Discrimination Working Group, *Committee Hansard*, 26 May 2017, p. 67; Australian Genetic Non-Discrimination Working Group, answers to questions on notice, 26 May 2017 (received 9 June 2017)

85 Dr Paul Lacaze, Head, Public Health Genomics, Department of Epidemiology and Preventative Medicine, School of Public Health and Preventative Medicine, Monash University; and Founding Member and Ms Jane Tiller, Legal and Social Adviser, Public Health Genomics, Department of Epidemiology and Preventative Medicine, School of Public Health and Preventative Medicine, Monash University; and Member, Australian Genetic Non-Discrimination Working Group, *Committee Hansard*, 26 May 2017, pp. 67–68.

86 Professor Margaret Otlowski, Law Dean, University of Tasmania; and Chair, Australian Genetic Non-Discrimination Working Group, *Committee Hansard*, 26 May 2017, pp. 66–67.

87 Ms Anne Trimmer, Secretary General, Australian Medical Association, *Committee Hansard*, 8 September 2017, p. 32; Dr Edwin Kruys, Vice President and Chair, RACGP Queensland, answers to questions on notice, 8 September 2017 (received 26 September 2017).

88 Australian Genetic Non-Discrimination Working Group, answers to questions on notice, 26 May 2017 (received 9 June 2017).

89 Professor Margaret Otlowski, Law Dean, University of Tasmania; and Chair, Australian Genetic Non-Discrimination Working Group, *Committee Hansard*, 26 May 2017, p. 64.

Accuracy of genetic testing

9.72 Dr Paul Lacaze, the Head of Public Health Genomics at Monash University and a founding member of the AGND Working Group, claimed that more research was needed to understand genetics and its relationship to the future prediction of disease risk, and that the information presently obtained from genetic testing is not sufficiently robust to justify its use in actuarial modelling.[90]

9.73 Dr Kate Stockhausen, Manager of Ethics at the AMA, also highlighted issues around the accuracy of genetic results, particularly from direct to consumer tests.[91]

9.74 While genetic test results obtained in Australia are subject to oversight and quality control, direct-to-consumer genetic tests are not regulated in terms of how the results are interpreted or where the testing occurs.[92]

9.75 Dr Lacaze advised the committee that direct-to-consumer test results are based on risk calculations that are not scientifically supported. Additionally, no genetic counselling is provided for such results and there is no medical oversight of how the results are interpreted.[93] Ms Jane Tiller, a Legal and Social Adviser in Public Health Genomics at Monash University and a member of the AGND Working Group observed, however, that despite the absence of these counselling and oversight processes, such test results would still need to be disclosed to an insurer.[94]

Adverse impact on potentially life-saving genetic testing and participation in research

9.76 The committee was told that the ability of life insurers to use genetic information is also adversely impacting the public's willingness to undergo genetic testing due to fears that their access to appropriate insurance may be compromised.

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90 Dr Paul Lacaze, Head, Public Health Genomics, Department of Epidemiology and Preventative Medicine, School of Public Health and Preventative Medicine, Monash University; and Founding Member, Australian Genetic Non-Discrimination Working Group, *Committee Hansard*, 26 May 2017, pp. 61, 63.

91 Dr Kate Stockhausen, Manager, Ethics, Australian Medical Association, *Committee Hansard*, 8 September 2017, p. 31; see also Royal Australian College of General Practitioners Queensland, answers to questions on notice, 8 September 2017 (received 26 September 2017).

92 Australian Genetic Non-Discrimination Working Group, *Submission 60*, pp. 2, 6; Dr Paul Lacaze, Head, Public Health Genomics, Department of Epidemiology and Preventative Medicine, School of Public Health and Preventative Medicine, Monash University; and Founding Member, Australian Genetic Non-Discrimination Working Group, *Committee Hansard*, 26 May 2017, p. 65.

93 Dr Paul Lacaze, Head, Public Health Genomics, Department of Epidemiology and Preventative Medicine, School of Public Health and Preventative Medicine, Monash University; and Founding Member, Australian Genetic Non-Discrimination Working Group, *Committee Hansard*, 26 May 2017, p. 65.

94 Ms Jane Tiller, Legal and Social Adviser, Public Health Genomics, Department of Epidemiology and Preventative Medicine, School of Public Health and Preventative Medicine, Monash University; and Member, Australian Genetic Non-Discrimination Working Group, *Committee Hansard*, 26 May 2017, p. 65.

According to the AGND Working Group, such fears may lead to an additional burden on the public health system as people avoid being tested and therefore cannot make the necessary lifestyle changes to be healthy.[95]

9.77 Similarly, Dr Stockhausen told the committee that the AMA does not want a situation arising where the actions, or potential actions, of a third party might cause a person to avoid having genetic testing.[96]

9.78 Ms Tiller told the committee that life insurers having access to genetic test results negatively impact on the number of people participating in research studies. Unlike the United Kingdom, where individuals can participate and obtain their results from the public 100 000 genomes research project without insurance implications, this is not currently possible in Australia.[97]

9.79 Likewise, Dr Simon Longstaff AO, Executive Director of The Ethics Centre, believed that people should not have to fear the insurance implications of participating in research as research has an inherent community benefit.[98]

9.80 Dr Lacaze also noted that a lack of participation in research may affect the future competitiveness and progress of the Australian research industry as well as the identification of emerging health issues. He provided evidence that in one study over half of the individuals who choose not to participate indicated that insurance concerns were the reason why.[99]

9.81 Dr Longstaff explained to the committee that, at its core, insurance is a means to respond to the uncertainty of life. Individuals pool their risk so that when an adverse event occurs, the pool's resources can be used to respond to the event.[100]

9.82 In Dr Longstaff's view, the insurance industry's trend towards trying to determine with greater precision the likely fate of an individual will, at some point,

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95 Australian Genetic Non-Discrimination Working Group, *Submission 60*, p. 5.

96 Dr Kate Stockhausen, Manager, Ethics, Australian Medical Association, *Committee Hansard*, 8 September 2017, pp. 28–29.

97 Ms Jane Tiller, Legal and Social Adviser, Public Health Genomics, Department of Epidemiology and Preventative Medicine, School of Public Health and Preventative Medicine, Monash University; and Member, Australian Genetic Non-Discrimination Working Group, *Committee Hansard*, 26 May 2017, p. 62.

98 Dr Simon Longstaff AO, Executive Director, The Ethics Centre, *Committee Hansard*, 26 May 2017, pp. 70–71.

99 Dr Paul Lacaze, Head, Public Health Genomics, Department of Epidemiology and Preventative Medicine, School of Public Health and Preventative Medicine, Monash University; and Founding Member, Australian Genetic Non-Discrimination Working Group, *Committee Hansard*, 26 May 2017, pp. 62–68; See also, Productivity Commission, *Data Availability and Use*, No. 82, 2017, p. 5.

100 Dr Simon Longstaff AO, Executive Director, The Ethics Centre, *Committee Hansard*, 26 May 2017, p. 70.

become at odds with the purpose of insurance and the community benefit it provides.[101]

9.83 Dr Longstaff advised the committee that while the current situation regarding life insurers' use of genetic information is appropriate, he would be cautious about allowing insurers to 'push too far in terms of either demanding testing or using the results of testing in order to risk-weight the individual'.[102]

Committee view

9.84 The committee is of the view that the evidence to the inquiry indicated that, at present, genetic data is not presently sufficiently accurate or reliable, particularly in relation to the increasingly popular direct to consumer genetic testing, for a duty to disclose to be appropriate.

9.85 Evidence presented to the committee indicated that an individual's genetic information can be used by insurers to charge a higher premium, exclude insurance cover for certain conditions or deny insurance. This has occurred even in instances where individuals have taken proactive steps to reduce their likelihood of having a certain condition. However, it was never used to reduce premiums.

9.86 While it may be difficult to ascertain the prevalence of genetic discrimination, the continual developments in the area of genetics, as well as costs reductions, means that the reliability, availability, and number of genetic tests is increasing. Thus, the problem of genetic discrimination is likely to become even more significant in the near future.

9.87 The committee notes the reasoning underlying the insurance industry's need for genetic information. However, fears that adverse selection as a consequence of consumers not having to disclose predictive genetic testing results would make the life insurance market unsustainable may be overstated. In addition, the Canadian Office of the Privacy Commissioner found that the sustainability of the Canadian insurance industry is not likely to be affected at this time by a ban on the use of genetic information. Life insurers did not provide strong evidence to the contrary.

9.88 Though the committee considers the fears overstated, the committee acknowledges adverse selection as a phenomenon in insurance. The committee's primary concern in that regard is the potential for higher costs for consumers if information asymmetry between insurers and insureds causes insurers to seek to put up premiums to compensate. However, on balance, the committee believes there is presently greater benefit to consumers in preventing a duty of disclosure from arising in respect of predictive genetic tests for the reasons referred to above.

9.89 Furthermore, the committee is concerned that the use or perceived use of genetic information by life insurers has impacted on participation in public health

101 Dr Simon Longstaff AO, Executive Director, The Ethics Centre, *Committee Hansard*, 26 May 2017, p. 70.

102 Dr Simon Longstaff AO, Executive Director, The Ethics Centre, *Committee Hansard*, 26 May 2017, p. 71.

research projects and other forms of research. The committee is also concerned that reduced participation by the public in research projects may compromise Australia's competitiveness in international research.

9.90 The committee is highly concerned about evidence received that individuals are not undertaking potentially life-saving genetic testing due to fears of unfair treatment by life insurers.

9.91 The committee notes that the FSC were unable to provide the committee with the exact number of its member's of life insurance applications that involved genetic information since the approval of Standard 11.

9.92 Nevertheless, given that it appears that the use of genetic information by life insurers remains low, and the understanding of genetic testing and its predictive accuracy is developing, the committee is not persuaded that legislation should be the first response.

9.93 As a first step, the committee considers that the FSC, in discussion with the AGND Working Group, should update the Code and Standards 11 and 16 in order to prohibit any life insurers from using the outcomes of predictive genetic tests at least in the medium term. This should be done as a matter of some urgency and take a form similar to the United Kingdom's Moratorium. However, similar to the United Kingdom's Moratorium, this prohibition should not prevent a consumer from being able to provide genetic information to a life insurer in order to demonstrate that they are not at risk of developing an inherited condition. The moratorium should be reviewed five years after being imposed, with the review to take into account consumer impacts (for consumers generally, and for consumers who have adverse genetic test results). Any moratorium arrangements should apply indefinitely to predictive genetic test results obtained before the lifting of the moratorium, if it is lifted, to avoid sharp jumps in premiums for existing insureds.

9.94 The committee acknowledges the significant concerns raised during this inquiry about the conflicts of interest inherent in the FSC's self-regulatory regime. As set out in chapter 4, the committee supports the co-regulatory approach outlined in the ASIC Enforcement Review Taskforce Position Paper, particularly the requirements for industry codes to be registered. The committee is firmly of the view that some of the concerns regarding self-regulation would be alleviated if the government provided ASIC with the appropriate enforcement powers to implement a co-regulatory approach.

9.95 In terms of the recommendations made in this chapter regarding the Code and Standards 11 and 12, the committee is of the view that these safeguards would be significantly strengthened by them becoming part of a registered co-regulatory approach between ASIC and the FSC. The committee considers that a co-regulatory approach would strike an appropriate balance between safeguarding against the improper use of genetic information by the life insurance industry while still allowing it to operate efficiently.

9.96 The committee further considers that the government should monitor the FSC's adoption of the changes to the Code and Standard 11 and 16 as well as whether

life insurers are abiding by such changes. If life insurers fail to implement and abide by the revised Code and standards, then the committee suggests that the government implement legislation to ban the use of genetic information by life insurers, except where the consumer provides genetic information to a life insurer to demonstrate that they are not at risk of developing a disease. In this instance, the government should closely consider the approach taken by Canada.

9.97 The committee also suggests that the government should maintain a watching brief on developments in the field of genetics and predictive genetic testing in order to be in a position to consider whether legislation or another form of regulation banning or limiting the use of genetic information is required in light of future developments.

Recommendation 9.1

9.98 The committee recommends that the Financial Services Council, in consultation with the Australian Genetic Non-Discrimination Working Group, assess the consumer impact of imposing a moratorium on life insurers using predictive genetic information, unless the consumer provides genetic information to a life insurer to demonstrate that they are not at risk of developing a disease.

Recommendation 9.2

9.99 The committee recommends that the Financial Services Council make any updates as necessary to Standard 16—Family History and the *Life Insurance Code of Practice* to support the recommended changes to Standard 11—Genetic Testing Policy as outlined in Recommendation 9.1.

Recommendation 9.3

9.100 The committee recommends that life insurers be banned from using predictive genetic information while the Financial Services Council is updating Standard 11—Genetic Testing Policy, Standard 16—Family History, and the *Life Insurance Code of Practice* to align with Recommendation 9.1.

Recommendation 9.4

9.101 The committee recommends that if the Financial Services Council and life insurers have adopted a moratorium on the use of predictive genetic information as outlined in Recommendation 9.1, the Australian Government should continue to monitor developments in genetics and predictive genetic testing to determine whether legislation or another form of regulation banning or limiting the use of predictive genetic information by the life insurance industry is required.

Chapter 10
Claims handling

Introduction

10.1 Claims handling practices by life insurers are subject to certain legislative requirements as well as commitments made by life insurers who are subject to the Financial Services Council's (FSC) self-regulatory mechanism known as the Life Insurance Code of Practice (Code). Work is also being done by the Insurance in Superannuation Working Group to establish the Insurance in Superannuation Code of Practice (Super Code) in relation to both default and retail group insurance and trustees. The Super Code is currently in draft form and the Insurance in Superannuation Working Group envision that it will also consist of commitments similar to the FSC's Code, some of which will govern claims handling processes.[1]

10.2 This chapter considers the evidence provided to the committee during this inquiry regarding claims handling by life insurers. The evidence highlighted the concerns held by a number of individuals and groups that certain claims handling practices may be used by life insurers as a means to delay or deny a claim or limit the amount of payment made when a claim is successful. This chapter also considers the evidence submitted regarding the developments in the life insurance industry in response to claims handling concerns.

10.3 The following issues are discussed in this chapter:

- Oversight of claims handling practices;
- A policyholder's right to reasons where a claim has been denied;
- Inconsistency in claims handling data;
- Definitions in insurance policies;
- Pre-existing conditions and non-disclosure;
- Mental health claims;
- Delays;
- Independent medical examiners;
- Incentives for staff to reject or delay claims;
- Underwriting direct insurance;
- Legacy products; and
- Early intervention—rehabilitation payments.

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1 The Insurance in Superannuation Working Group, *Discussion Paper*: *Claims Handling*, pp. 5, 6.

Oversight of claims handling practices

10.4 The Australian Securities and Investments Commission (ASIC) informed the committee that Corporations Regulation 7.1.33 excludes certain insurance claims handling activities by advisers and life insurers from being defined as a 'financial service' for the purposes of sections 766A(1)(b) and 766A(2)(b) of the *Corporations Act 2001* (Corporations Act).[2]

10.5 As a result, ASIC's powers under the Corporations Act generally do not apply to oversighting the conduct of insurers and financial advisers in this claims handling context, including whether insurers have provided financial services in an efficient, honest and fair way.[3]

10.6 Additionally, ASIC informed the committee that the current exemption limits ASIC's ability to respond to conduct such as:

> (a) an insurer relying on the terms of the contract to deny a claim (even where the exclusion clause relied on may be outdated or restrictive);
>
> (b) unnecessary or extensive delays in handling claims;
>
> (c) incentives for claims handling staff and management, including whether they are in conflict with the insurer's obligation to assess each claim on its merit; and
>
> (d) surveillance practices by investigators, particularly for mental health claims.[4]

10.7 ASIC acknowledged it is aware of arguments that sector-specific legislation through the *Insurance Contracts Act 1984* (Insurance Contracts Act) should be sufficient in ensuring claims are handled appropriately. However, ASIC was of the view that claims handling practices, like other financial products and activities, should be captured under the Corporations Act.[5]

10.8 Doing so would provide ASIC with greater scope to address non-compliance with the matters that are currently excluded. It would also allow the overarching requirement to act efficiently, honestly and fairly to be applied to the claims handling processes.[6]

10.9 Treasury explained that the government is considering the merits of ASIC's recommendation that would mean the claims handling processes of insurers would be captured under the definition of a financial service in the Corporations Act, thereby

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2 Corporations Regulations 2001, s. 7.1.33; Australian Securities and Investments Commission, *Submission 45*, p. 21.

3 Australian Securities and Investments Commission, *Submission 45*, p. 21.

4 Australian Securities and Investments Commission, *Submission 45*, p. 21.

5 Mr Peter Kell, Deputy Chairman, Australian Securities and Investments Commission, *Committee Hansard*, 8 September 2017, p. 39.

6 Mr Peter Kell, Deputy Chairman, Australian Securities and Investments Commission, *Committee Hansard*, 8 September 2017, p. 39.

allowing ASIC to address claims handling conduct.[7] Treasury has conducted targeted consultation on the matter and is now determining the best way forward prior to providing advice to the Minister.[8]

10.10 Consumer and not-for-profit groups, such as the Financial Rights Legal Centre (FRLC) and the Consumer Action Law Centre, supported ASIC's proposal to remove the exemption in Corporations Regulation 7.1.33.[9]

10.11 Both the FRLC and the Consumer Action Law Centre were also of the view that the review of ASIC's penalty powers should include consideration of more significant penalties in relation to claims handling misconduct.[10]

Committee view

10.12 The committee notes that Corporations Regulation 7.1.33 excludes certain insurance claims handling activities by advisers and life insurers from being defined as a 'financial service' for the purposes of sections 766A(1)(b) and 766A(2)(b) of the Corporations Act.

10.1 The committee recognises that the ability of a regulator to oversight the claims handling processes of insurers and address non-compliance is crucial to ensuring that consumers are protected through means that are both appropriate and transparent.

Recommendation 10.1

10.13 The committee recommends that the Australian Government review Corporations Regulation 7.1.33 to ascertain whether the exemption provided by this regulation limits in any way ASIC's ability to oversight the claims handling processes of insurance companies.

A policyholder's right to reasons where a claim has been denied

10.14 As discussed in chapter 8 on access to medical information, the *Disability Discrimination Act 1992* (Disability Discrimination Act) exempts life insurers from its application in order to assess an individual's risk when setting premiums or policy terms. However, insurers can only use the exemption to make decisions that are based

7 Department of the Treasury, answers to questions on notice, 22 August 2017 (received 6 September 2017); Mr James Kelly, Principal Adviser, Financial Systems Division, Treasury, *Committee Hansard*, 8 September 2017, p. 63.

8 Mr James Kelly, Principal Adviser, Financial Systems Division, *Committee Hansard*, 8 September 2017, p. 63.

9 Financial Rights Legal Centre, *Submission 17*, pp. 15–16, 33; Consumer Action Law Centre, *Submission 27*, p. 3.

10 Financial Rights Legal Centre, *Submission 17*, p. 15–16, 33; Consumer Action Law Centre, *Submission 27*, p. 3.

on actuarial or statistical evidence and in the case where no such evidence exists, have regard to other relevant factors.[11]

10.15 This exemption was further explained by Dr Stephen Carbone, Policy, Research and Evaluation Leader at beyondblue, who noted that while a consumer has a right to know how an insurer reached its decision under section 75 of the Insurance Contracts Act, the customer must ask for such reasons. This means that there is no positive obligation for insurers to explain to a consumer why an application has been denied.[12]

10.16 Additionally, Ms Michelle Cohen, Senior Solicitor at the Public Interest Advocacy Centre (PIAC), told the committee about how it is difficult to obtain written reasons for why a decision has been made. Ms Cohen stated that even where written reasons are provided under section 75 of Insurance Contracts Act, they are not targeted to the part of a person's medical history relied on by the insurer when making a decision.[13]

10.17 PIAC suggested that insurers who rely on the exemption under the Disability Discrimination Act should be required to provide copies of the actuarial and statistical data or any other material relied on, along with a plain English summary to the insured party. Furthermore, PIAC argued that this documentation should be provided to the insured party without them needing to contact the insurer or lodge a formal complaint to the Disability Discrimination Commissioner.[14]

Committee view

10.18 The committee notes that section 75 of the Insurance Contracts Act already provides that policyholders have a right to know how a life insurer has reached a decision. However, the committee also notes that there is currently no positive obligation on an insurer to provide the reasons for a decision to a policyholder.

10.19 The committee recognises the importance of transparent processes in enabling consumers to understand how the decisions made by life insurers have been reached.

10.20 To this end, the committee is of the view that life insurers should be required to provide a policyholder with written reasons when making a decision to reject an application or deny a claim for life insurance. Furthermore, these reasons should be provided as a plain English summary of the evidence and should be targeted to the part of a person's medical history relied on by the insurer. The committee is also of the view that any statistical and actuarial evidence and other material relied on by the insurer should be made available on request.

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11 Department of the Treasury, answers to questions on notice, 22 August 2017 (received 6 September 2017).

12 Dr Stephen Carbone, Policy, Research and Evaluation Leader, beyondblue, *Committee Hansard*, 22 February 2017, p. 18; See also, *Insurance Contracts Act 1984*, s. 75.

13 Ms Michelle Marie Cohen, Senior Solicitor and Ms Alexis Goodstone, Principal Solicitor, Public Interest Advocacy Centre, *Committee Hansard*, 24 February 2017, pp. 7–8.

14 Public Interest Advocacy Centre, *Submission 9*, pp. 11–12.

Recommendation 10.2

10.21 The committee recommends that a requirement be inserted, where necessary, into both the *Insurance Contracts Act 1984* and the *Disability Discrimination Act 1992* to the effect that an insurer must provide a person with written reasons when an application for insurance has been rejected or an insurance claim denied. The committee further recommends that the written reasons be provided as a plain English summary of such evidence and be targeted to the part of a person's medical history relied on by the insurer. The committee also recommends that the statistical and actuarial evidence and other material relied on by the insurer be available on request.

Inconsistency in claims handling data

10.22 ASIC's report on claims handling in the life insurance industry (Report 498) did not identify any cross-industry misconduct in relation to the payment of life insurance claims or claims procedures within the life insurance industry.[15]

10.23 Report 498 found that once claims decisions are made, 90 per cent of claims are paid, with 96 per cent of death claims being paid once decided.[16]

10.24 However, Report 498 also identified the need for data on life insurance claims to be consistent and more transparent. Report 498 proposed that ASIC and the Australian Prudential Regulation Authority (APRA) work with insurers and other stakeholders in order to establish a consistent reporting regime regarding claims data, outcomes, timeframes and disputes across policy types that is publicly available.[17] The FSC submitted that it will be working with both ASIC and APRA to develop a consistent reporting framework.[18]

10.25 The FRLC also recommended a public reporting regime similar to the one proposed in Report 498. However, the FRLC proposed that data regarding claims and claims outcomes be made available to consumers when purchasing and renewing a life insurance policy and that such data include the names of insurers alongside claims rates.[19]

10.26 The committee notes that on 9 November 2017, ASIC and APRA released the initial results from the pilot data collection on life insurance claims. The initial data complemented ASIC's finding in Report 498 that insurers pay 90 per cent of life

15 Australian Securities and Investments Commission, *Report 498 Life insurance claims: An industry review*, 12 October 2016, p. 6.

16 Australian Securities and Investments Commission, *Report 498 Life insurance claims: An industry review*, 12 October 2016, p. 6.

17 Australian Securities and Investments Commission, *Report 498 Life insurance claims: An industry review*, 12 October 2016, pp. 10–11.

18 Financial Services Council, *Submission 26*, p. 12.

19 Financial Rights Legal Centre, *Submission 17*, p. 18.

insurance claims in the first instance. ASIC and APRA also released an information paper outlining common data quality issues and the next steps in their joint data project. The information paper announced a second round of pilot data collection and highlighted that definitions for insurers regarding claims handling terms will be released shortly.[20]

10.27 ASIC informed the committee that the consistent reporting regime and the final data collected is expected to be released sometime in 2018.[21]

Committee view

10.28 The committee recognises that with three different distribution channels operating in life insurance—retail, direct, and group—a consistent and publicly available reporting regime regarding claims data, outcomes, timeframes and disputes across policy types is of vital importance.

10.29 The committee welcomes the collaboration between ASIC and APRA on this project and looks forward to the findings from the next stage of the joint data project.

10.30 The Committee acknowledges that APRA previously gave evidence that it was concerned that insurers do not have a sufficient understanding of declined claims data which may present a prudential risk if not rectified soon. ASIC later stated that it is working with APRA to establish a transparent public reporting regime for life insurance claims information.[22]

Definitions in insurance policies

10.31 This section considers policy definitions used by life insurers and specifically, concerns related to life insurers relying on inconsistent and out-dated definitions for certain conditions during the claims assessment process. Arguments were made to the committee for the standardisation of policy definitions across life insurance products.

10.32 Report 498 found that while the overall number of disputes about policy definitions in life insurance was low, policies that have traditionally technical definitions such as Total and Permanent Disability (TPD) and trauma policies had higher decline rates.[23]

10.33 The Financial Ombudsman Service Australia's (FOS) submission also highlighted a potential misalignment between community expectations and insurance

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20 Australian Prudential Authority, *APRA and ASIC publish key industry data on life insurance claims*, 9 November 2017, http://www.apra.gov.au/MediaReleases/Pages/17_43.aspx (accessed 9 November 2017).

21 Mr Michael Saadat, Senior Executive Leader, Deposit Takers, Credit and Insurers; Regional Commissioner, New South Wales, Australian Securities and Investments Commission, *Committee Hansard*, 8 September 2017, p. 41.

22 Mr Geoff Summerhayes, Member, Australian Prudential Regulation Authority, *Committee Hansard*, 24 February 2017, p. 68; Mr Peter Kell, Deputy Chair, Australian Securities and Investments Commissions, *Committee Hansard*, 8 September 2017, p. 37.

23 Australian Securities and Investments Commission, *Report 498 Life insurance claims: An industry review*, 12 October 2016, p. 65.

definitions and noted that disputes regarding policy definitions occur in circumstances where the definition is ambiguous, restrictive and does not reflect current medical understanding.[24]

10.34 Report 498 found a variance in the definitions used for medical conditions across the industry and that even a subtle difference in definitions affected the amount of cover provided.[25]

10.35 Report 498 also found that claims had not been paid by some insurers due to a technicality or an out-of-date policy definition while other insurers did provide a claim payment as an ex-gratia payment even where a definition was not satisfied, as the payment reflected the intent of the policy.[26]

10.36 Mr John Berrill of Berrill and Watson Lawyers explained the problem of out-of-date definitions with the example of a trauma policy that included definitions for a number of conditions such as heart attack, cancer and stroke. With changes and advances in medicine over time, the way conditions are defined change as well. However, if a policyholder held a trauma policy for 20 years prior to having a heart attack, the definition of a heart attack would be the definition in the 20 year old policy and would not reflect new medically approved definitions. As Mr Berrill pointed out, this could render the policy useless despite the policyholder meeting the current medical definition of a heart attack.[27]

10.37 Life insurers noted that they are aware of the potential for misalignment between medical definitions and policy definitions. In response to such misalignment, the FSC stated that under the Code, life insurers who are FSC members will be required to 'review key medical definitions every three years for relevant policies and update them where necessary to ensure definitions remain current'.[28]

10.38 As at July 2017, the Code has minimum standards for Trauma/Critical Illness, Cancer, Heart Attack and Stroke. In November 2016, the FSC informed the committee that the consultation process for such definitions would include external medical specialists, be subject to approval from the Australian Competition and Consumer Commission (ACCC), and will provide confidence to those policyholders with trauma insurance that they have a base level of cover.[29]

10.39 In terms of implementation and oversight of the minimum standards committed to in the Code, FOS recommended that the new standards set out in the Code be:

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24 Financial Ombudsman Service Australia, *Submission 28*, p. 15.

25 Australian Securities and Investments Commission, *Report 498 Life insurance claims: An industry review*, 12 October 2016, p. 65.

26 Australian Securities and Investments Commission, *Report 498 Life insurance claims: An industry review*, 12 October 2016, p. 65.

27 Mr John Berrill, Berrill & Watson Lawyers, *Committee Hansard*, 22 February 2017, pp. 29–30.

28 Financial Services Council, *Submission 26*, pp. 10–11.

29 Financial Services Council, *Submission 26*, pp. 10–11.

- extended to all medical definitions;
- kept up to date with medical practice and community expectation;
- easier to understand; and
- standardised against a minimum benchmark.[30]

10.40 The Association of Financial Advisers (AFA) proposed the establishment of a medical advisory board, subject to public scrutiny, to conduct an independent review every three years of definitions used in insurance and to determine whether an upgrade of policy definitions is required.[31]

10.41 Mr Brett Clark, Chief Executive Officer and Managing Director of TAL, stated that TAL has used the minimum standards set out in the Code and backdated definitions in polices to August 2009 to reflect the Code's minimum standards.[32]

10.42 Similarly, Ms Helen Troup, Managing Director of CommInsure, explained that CommInsure had backdated the definition of heart attack to 2012 in their policies to reflect the universal definition of a heart attack. In terms of rheumatoid arthritis, CommInsure had backdated the definition by two years to reflect advancements and understanding in medicine.[33]

10.43 Ms Annabel Spring, Group Executive Wealth Management at the Commonwealth Bank of Australia, noted the work the FSC has done in creating minimum standards around trauma, with the FSC definition now covering 80 per cent of claims. However, Ms Spring proposed that there should be a standard definition for TPD.[34]

10.44 Both the Australian Lawyers Alliance (ALA) and Ms Kim Shaw, a Principal at Maurice Blackburn Lawyers (Maurice Blackburn), also raised specific concerns with how TPD is currently defined for insurance within superannuation. These concerns focused on the differences in how 'permanent incapacity' is defined by the *Superannuation Industry (Supervision) Act* 1993 (SIS Act) and how TPD polices are defined by insurers. Specifically, concerns related to differing views on a person being 'unlikely' to return to work versus being 'unable' to return, as well as the type of employment such a person could return to.

10.45 Maurice Blackburn explained that the most prevalent change to the group insurance industry is the shift by insurers away from the legal test of 'unlikely' in

30 Financial Ombudsman Service Australia, *Submission 28*, pp. 16–17.

31 Association of Financial Advisers, *Submission 22*, p. 7.

32 Mr Brett Clark, Chief Executive Officer and Managing Director, TAL, *Committee Hansard*, 18 August 2017, p. 1.

33 Ms Helen Troup, Managing Director, CommInsure, Commonwealth Bank, *Committee Hansard*, 8 September 2017, pp. 3, 4.

34 Ms Annabel Spring, Group Executive, Wealth Management, Commonwealth Bank, *Committee Hansard*, 8 September 2017, p. 2.

relation to a person's ability to return to work to that of 'unable'. The 'unlikely' test in relation to 'permanent incapacity' is defined by the SIS Act as:

> …if a trustee of the fund is reasonably satisfied that the member's ill health (whether physical or mental) makes it **unlikely** that the member will engage in **gainful employment for which the member is reasonably qualified** by education, training or experience.[35]

10.46 While under Regulation 4.07D of the Superannuation Industry Supervision Regulations 1994, TPD definitions for group insurance must be 'consistent' with the 'unlikely' test, insurers have moved away from this.[36] Maurice Blackburn submitted that in 2014 a fund with over a million members removed the word 'unlikely' from the definition of TPD and replaced it with a requirement that a person be 'unable' to ever engage in any employment for which, through education, training or experience, they are or may become suited to.[37]

10.47 The interpretation of 'unlikely' by Australian courts in relation to TPD includes consideration of the job market and the prospects of a disabled job applicant obtaining and maintaining employment. [38]

10.48 However, Maurice Blackburn were of the view that the life insurance industry determine whether someone is 'unable' to return to work based only a medical assessment that is separate from real world considerations, noting:

> …it is possible to argue that even a quadriplegic is theoretically capable of work and may not satisfy an "unable" definition, notwithstanding that their actual employment prospects in a competitive employment market are negligible.

10.49 Maurice Blackburn argued that the move away from the 'unlikely' test is evidence of a clear intention by insurers to limit the amount of claims they have to pay. This is despite the fact that the claimant may never be able to work at a level similar to that before the claim was made.[39]

10.50 The ALA also submitted that insurers are moving away from the requirements of 'qualified' as contained in the SIS Act towards requirements of 'any employment' for TPD claims. The ALA noted that the SIS Act definition of 'permanent incapacity' does not refer to any employment that a person is or may become suited to through retraining or further education.[40]

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35 Maurice Blackburn Lawyers, *Submission 12*, p. 4; Superannuation Industry (Supervision) Regulation 1994, reg 1.03C. The committee has used bold text for emphasis; See also, Australian Lawyers Alliance, *Submission 20*, pp. 9–11.

36 Maurice Blackburn Lawyers, *Submission 12*, pp. 4–5.

37 Maurice Blackburn Lawyers, *Submission 12*, p. 5.

38 Maurice Blackburn Lawyers, *Submission 12*, pp. 4–5.

39 Maurice Blackburn Lawyers, *Submission 12*, p. 5.

40 Australian Lawyers Alliance, *Submission 20*, pp. 10–11, 14.

10.51 It was the ALA's view that a person's inability to return to an occupation that reflects their current education, training and experience will impact on both their financial position and their ability to save for retirement. Where an insurer requires a person to return to employment in a new field, this is often only possible after significant re-training. However, it is not clear who is responsible for paying for the re-training. Furthermore such employment would likely be at a lower level and salary. In the ALA's opinion these consequences are ones that should be covered by life insurance, not created because of it.[41]

10.52 Conversely, the Association of Superannuation Funds of Australia (ASFA) submitted that the regulatory definition for TPD as stated in the SIS Act has caused difficulties and drawn out decision making processes as the SIS Act definition does not make provision for any future rehabilitation or changes in technology that may allow the TPD claimant to return to work. Additionally, a one-time assessment of disability to determine whether it meets the SIS Act definition may in fact incentivise a claimant to not recover some ability due to fears of not being paid a lump-sum TPD benefit.[42]

10.53 The ALA asserted that minimum standards and clear policy definitions for group insurance, including medical and policy definitions, must be legislated. Those covered by group life insurance are vulnerable as they do not receive any advice on whether their group coverage is correctly matched to their circumstances. Legislated minimum standards and clear policy definitions in group insurance are required to:

- protect consumers and provide certainty that the product matches their needs;
- reduce complexity for insurers by making it easier for them to appropriately price products; and
- ensure that there is meaningful oversight of the implementation and use of the standards and definitions.[43]

10.54 The consultation paper for the draft Super Code notes that the Insurance in Superannuation Working Group considered the extent to which the standardisation of definitions in insurance within superannuation can occur, but concluded that this is a longer term project that will be considered in future iterations of the Super Code.[44]

Committee view

10.55 Evidence to the committee highlighted that policies with technical definitions can have high decline rates. This suggests that there may be a significant gap between how society may define a certain event, such as a heart attack, and how the same event is defined by life insurers. The move by life insurers away from the common

41 Australian Lawyers Alliance, *Submission 20*, pp. 10–11, 14.

42 Association of Superannuation Funds of Australia, *Submission 29*, p. 3.

43 Australian Lawyers Alliance, *Submission 20*, pp. 9, 10.

44 The Insurance in Superannuation Working Group, *Consultation Paper: Insurance in Superannuation Code of Practice*, September 2017, pp. 10–11.

understanding of TPD and an individual's ability to return to employment, as encapsulated in the SIS Act, also demonstrates this gap.

10.56 The committee notes the work being done by the FSC to ensure policy definitions of certain conditions are up-to-date. The Insurance in Superannuation Working Group's position that it will consider the standardisation of definitions in the future iterations of the Super Code is also noted. However, the committee is concerned that the Insurance in Superannuation Working Group has postponed consideration of minimum standardised definitions.

10.57 In this regard, the committee is firmly of the view that all definitions should be up-to-date and standardised across all types of life insurance policies. This would provide certainty to consumers and policyholders about what they are covered for, including the extent to which any associated conditions that may arise from the initial condition, such as mental ill health, are covered by the insurance policy.

10.58 The committee also believes that the FSC and the Insurance in Superannuation Working Group should seek the views of a panel of independent medical experts—that is, medical experts independent of the life insurance industry—when reviewing the appropriateness of all definitions, noting a review may need to occur more frequently than every three years.

10.59 As detailed in chapter 4 of this report, the committee supports the co-regulatory approach outlined in ASIC's Enforcement Review position paper, particularly the requirements for codes to be registered. Such a co-regulatory approach will allow for appropriate oversight of the commitments made in a code, including those relating to keeping policy definitions up-to-date and ensuring review of these definitions occur in a timely fashion.

Recommendation 10.3

10.60 The committee recommends that in relation to definitions in life insurance policies, the life insurance industry must:

- **regularly update all definitions in policies to align with current medical knowledge and research;**
- **standardise definitions across all types of polices;**
- **use clear and simple language in definitions; and**
- **clearly explain which associated conditions that may arise from the initial condition, including mental ill health, are covered by the insurance policy.**

Recommendation 10.4

10.61 The committee recommends that the Financial Services Council's *Life Insurance Code of Practice* be updated to reflect Recommendation 10.3.

Recommendation 10.5

10.62 The committee recommends that the Insurance in Superannuation Working Group's *Insurance in Superannuation Code of Practice* be updated to reflect Recommendation 10.3.

Pre-existing conditions and non-disclosure

10.63 In the context of life insurance, pre-existing conditions are illnesses or conditions that a consumer may have had prior to obtaining an insurance policy. Life insurance policies often contain exclusions for some or all pre-existing conditions.

10.64 As discussed in chapter 8 on access to medical information, under the Insurance Contracts Act, a consumer must disclose all relevant information to an insurer. This means that where a consumer has a pre-existing condition this must be disclosed to the insurer when applying for insurance.

10.65 Where relevant information has not been disclosed to the insurer, section 29(3) of the Insurance Contracts Act allows an insurer to avoid the policy within the first three years, even in circumstances where the failure to disclose was not fraudulent. Remedies for insurers other than contract avoidance due to non-fraudulent non-disclosure also include adjusting the monetary amount that is insured and the retrospective varying of the contract to allow the insurers to be placed in the position they would have been in if the non-disclosure did not occur. If the failure to disclose was fraudulent, section 29(2) of the Insurance Contracts Act allows an insurer to avoid the contract at any time.[45]

10.66 In Report 498, ASIC found that the definition for pre-existing condition exclusions varied greatly across policies and that, in general, for policies that were non-advised such as direct and group policies, all pre-existing conditions were excluded from coverage.[46]

10.67 ASIC also found that pre-existing condition exclusions did not necessarily require the diagnosis of the condition but rather whether symptoms existed that would lead a reasonable person to obtain medical treatment or assistance.[47]

10.68 ASIC also noted that non-disclosure of pre-existing conditions happened for a number of reasons, such as the policyholder not being formally diagnosed with the condition or being told that they have been cured of the condition. There can also be disagreement between insurer, policyholders and doctors about whether a pre-existing condition relates to a claim.[48]

10.69 Mr Peter Kell, Deputy Chairman of ASIC, discussed ASIC's concerns over life insurers looking at a customer's medical history to identify a pre-existing condition that was not disclosed in order to inappropriately deny claims. Mr Kell stated that

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45 *Insurance Contracts Act 1984*, s. 29.

46 Australian Securities and Investments Commission, *REP 498 Life insurance claims: An industry review*, 12 October 2016, p. 67.

47 Australian Securities and Investments Commission, *REP 498 Life insurance claims: An industry review*, 12 October 2016, p. 67.

48 Australian Securities and Investments Commission, *REP 498 Life insurance claims: An industry review*, 12 October 2016, p. 67.

ASIC is of the view that law reform regarding how insurers use medical evidence to identify pre-existing conditions may be beneficial.[49]

10.70 The committee received evidence about insurers determining a person had a pre-existing undisclosed mental health condition despite a lack of evidence to support such a conclusion. For example, beyondblue submitted that in some cases where claims have been denied or contracts avoided due to the insurer's determination that a customer did not disclose a past mental health condition, the insurer has actually only relied on the fact the person had a single mental health episode, or simply required assistance with managing every day stress, or made a passing comment about their mood to a treating doctor.[50]

10.71 Likewise, PIAC observed that an insurer usually only makes an allegation of non-disclosure against the policyholder after the policyholder has made a claim for a benefit.[51] Ms Michelle Marie Cohen, Senior Solicitor at PIAC, referred to the distress and humiliation felt by a client of PIAC when an insurer imputed that they had a pre-existing mental health condition.[52]

10.72 The labelling of a mental health issue as a pre-existing condition also concerned some witnesses such as Dr Kym Jenkins, President Elect Royal Australian and New Zealand College of Psychiatrists, who informed the committee that insurers use a one-size-fits-all approach that views mental illness as a homogenous illness with no regard to severity or length.[53]

10.73 Additionally, Dr Carbone argued that the term pre-existing is too broad and questioned why a condition that was present a decade or two ago can be seen as pre-existing to circumstances that exist currently.[54]

10.74 Dr Carbone also drew attention to the adverse consequences of people not seeking medical treatment due to a fear of insurers using mental health as a pre-existing condition to deny claims.[55]

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49 Mr Peter Kell, Deputy Chairman, Australian Securities and Investments Commission, *Committee Hansard*, 8 September 2017, p. 54.

50 beyondblue, *Submission 18*, pp. 16–17; Ms Nadine Bartholomeusz-Raymond, General Manager, Education, Families and Diversity and Access, beyondblue, *Committee Hansard*, 22 February 2017, p. 13; Dr Stephen Carbone, Policy, Research and Evaluation Leader, beyondblue, *Committee Hansard*, 22 February 2017, p. 14.

51 Public Interest Advocacy Centre, answer to questions on notice, 24 February 2017 (received 16 March 2017), pp. 2–3.

52 Ms Michelle Marie Cohen, Senior Solicitor, Public Interest Advocacy Centre, *Committee Hansard*, 24 February 2017, pp. 3–4.

53 Dr Kym Jenkins, President Elect, Royal Australian and New Zealand College of Psychiatrists, *Committee Hansard*, 22 February 2017, p. 17; See also, Mr John Berrill, Berrill & Watson Lawyers, *Committee Hansard*, 22 February 2017, p. 31.

54 Dr Stephen Carbone, Policy, Research and Evaluation Leader, beyondblue, *Committee Hansard*, 22 February 2017, p. 16.

10.75 The FSC stated that insurers only investigate a policyholder's non-disclosure in specific circumstances. Triggers for an investigation can include the amount of time between a policyholder acquiring a policy and making a claim, with a longer period between acquisition and claim unlikely to be a trigger, and where a treating doctor has mentioned a non-disclosed condition in a report relating to a claim.[56]

10.76 The FSC explained that insurers assess the non-disclosed condition by reviewing sufficient medical information regarding the policyholder's history. The FSC assert that where the non-disclosure is not relevant to the claim, policyholders are protected by the following principles as established by courts and disputes bodies:

> 1. The non-disclosure has to be significant enough for an underwriter to deem that the insurer would not have accepted the risk on the same terms.
>
> 2. The insurer has to be satisfied that a reasonable person would have disclosed the condition.[57]

Committee view

10.77 The evidence submitted by the FSC emphasised the obligations insurers are under to ensure that non-disclosure can only be used to deny a claim or avoid a contract in circumstances where the disclosure is significant enough that the insurer would have charged higher premiums had it known about the pre-existing condition and where a reasonable person would have disclosed the condition.

10.78 However, other evidence provided during this inquiry suggests that life insurers use pre-existing conditions to unfairly deny claims. The committee heard that this can occur when a life insurer imputes that a policyholder had, for example, a pre-exiting mental health condition despite their being little evidence on which to base such a claim.

10.79 The committee is particularly concerned about allegations that seemingly benign information, such as a discussion with a doctor about a mood, is used by life insurers as a basis for determining someone has a pre-existing mental health condition. The committee is concerned that such behaviour, or the perception of such behaviour by life insurance companies, is highly likely to dissuade people from seeking appropriate treatment and evidence was presented that this was already occurring. Furthermore, such behaviour is inimical to the proper recognition of the complex and non-homogenous nature of mental health conditions.

10.80 The committee is of the view that its recommendations in chapter 8 regarding an insurer's access to medical information may help prevent the inappropriate use of information to determine the non-disclosure of a pre-existing condition.

10.81 Nevertheless, in addition to those earlier recommendations, the committee is also of the view that the FSC should include explicit commitments within its Code to

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55 Dr Stephen Carbone, Policy, Research and Evaluation Leader, beyondblue, *Committee Hansard*, 22 February 2017, p. 19.

56 Financial Services Council, *Submission 26.1*, pp. 8–9.

57 Financial Services Council, *Submission 26.1*, p. 9.

the effect that a pre-existing condition is to be used by an insurer as the basis for denying a claim or avoiding a contract only where a direct medical connection between the pre-existing condition and the claim can be established. Furthermore, the Code should require the life insurer to provide the statistical and actuarial evidence and any other material used to establish a pre-existing condition, as well as a written summary of the evidence, to the policyholder.

Recommendation 10.6

10.82 The committee recommends that the Financial Services Council's *Life Insurance Code of Practice* include explicit commitments that:

- **where a pre-existing condition is to be used by an insurer as the basis for denying a claim or avoiding a contract a direct medical connection between the prognosis of a pre-existing diagnosed condition and the claim must be established; and**
- **the statistical and actuarial evidence and any other material used to establish a pre-existing condition, as well as a written summary of the evidence in simple and plain language, be provided by the life insurer to the consumer/policyholder on request.**

Mental health claims

10.83 Report 498 found that policyholders making a mental health claim face a challenging burden in demonstrating to insurers the validity of their condition. ASIC noted that the evidence required for a mental health claim is substantial and includes 'the need for policyholders to attend psychiatric assessments, complete activity diaries, submit regular progress claim forms, provide medical reports and attend interviews with private investigators, as well being the subject of surveillance'.[58]

10.84 Based on its findings, ASIC concluded that industry standards for the assessment of mental health claims are required in order to adequately protect policyholders.[59]

10.85 beyondblue submitted that a person's mental health condition can be exacerbated or re-emerge in response to an insurer, or a specialist working for an insurer, questioning the validity of their mental health claim.[60] Dr Michelle Blanchard,

58 Australian Securities and Investments Commission, *REP 498 Life insurance claims: An industry review*, 12 October 2016, pp. 62–63.

59 Australian Securities and Investments Commission, *REP 498 Life insurance claims: An industry review*, 12 October 2016, p. 62.

60 beyondblue, *Submission 18*, p. 16.

General Manager of Research, Policy and Programs with SANE Australia provided several case studies that reinforced beyondblue's evidence.[61]

10.86 Dr Kym Jenkins, President Elect of The Royal Australian and New Zealand College of Psychiatrists, was critical of the way that life insurers have a tendency to treat mental health as a homogenous issue. She also questioned the selection of data used by life insurers to assess a mental health claim, and also whether such data is up-to-date.[62] Other witnesses including representatives from Mental Health Australia, the National Mental Health Commission and SANE Australia raised similar questions.[63]

10.87 Evidence was presented to the committee that individuals may not seek treatment for mental ill health due to concerns of how this information will be used by life insurers.

10.88 In terms of how the life insurance industry has responded to mental health claims, the FSC stated that the industry pays a large and growing amount of benefits in response to mental health conditions The FSC also noted that the industry is considering mental health as a potential area of focus for the second iteration of the Code and will require life insurers to ask specific and clearer questions in relation to mental health issues.[64] However, the FSC have stated that they 'are not going to have a specific mental health chapter'. The FSC has also established a steering group with mental health representatives to better understand mental health conditions that may lead to impairment or absence from work. The FSC has also held two roundtable sessions with mental health advocacy groups such as the National Mental Health Commission and Mental Health Australia.[65]

10.89 Under Standard 21 that sits alongside the Code, life insurers who are FSC members must have a minimum standard mental health education and training program that staff interacting with customers must undertake to ensure that staff have adequate mental health awareness. The FSC was of the opinion that many insurers go

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61 Dr Michelle Blanchard, General Manager, Research, Policy and Programs, SANE Australia, *Committee Hansard*, 1 December 2017, p. 3; SANE Australia, *Experiences of people with mental illness with regard to life insurance*, December 2017 (tabled 1 December 2017).

62 Dr Kym Jenkins, President Elect, The Royal Australian and New Zealand College of Psychiatrists, *Committee Hansard*, 22 February 2017, p. 12.

63 Mr Joshua Fear, Director, Policy and Projects, Mental Health Australia, *Committee Hansard*, 1 December 2017, pp. 1-2; Mrs Lucinda Brogden, Co-Chair, National Mental Health Commission, *Committee Hansard*, 1 December 2017, p. 2; Dr Michelle Blanchard, General Manager, Research, Policy and Programs, SANE Australia, *Committee Hansard*, 1 December 2017, p. 3.

64 Financial Services Council, *Submission 26.1*, p.3; Ms Sally Loane, Chief Executive Officer, Financial Services Council, *Committee Hansard*, 1 December 2017, p. 22.

65 Ms Sally Loane, Chief Executive Officer, Financial Services Council, *Committee Hansard*, 1 December 2017, pp. 22, 27; Mr Jesse Krncevic, Senior Policy Manager, Financial Services Council, *Committee Hansard* , 1 December 2017, p. 27; See also, Mrs Lucinda Brogden, Co-Chair, National Mental Health Commission, *Committee Hansard*, 1 December 2017, p. 6; Mr Joshua Fear, Director, Policy and Projects, Mental Health Australia, *Committee Hansard*, 1 December 2017, pp. 6, 7.

beyond the minimum standard required.[66] The FSC also asserted that there is a trend amongst insurers to have mental health claims teams, most of which consist of allied health professionals and relevant medical expertise.[67]

Surveillance

10.90 Viewed as a necessary part of the claims process, insurers believe surveillance provides them with a way to guard against false claims and fraud. [68] However, ASIC's Report 498 noted that five per cent of the evidence-related disputes that it examined concerned allegations of surveillance practices that were seen as unfair or even caused a person's mental health condition to worsen.[69]

10.91 Mental health professionals provided real life examples that reflected ASIC's finding. Dr Jenkins explained to the committee that for someone who has made a mental health claim, it can be destructive to subject them to surveillance when their mental health has since improved and they are trying to move forward.[70]

10.92 In terms of how insurers engage with surveillance practices, the FSC informed the committee that only an estimated one to five per cent of claims are subject to surveillance. The FSC believe that surveillance in relation to mental health is even rarer.[71]

10.93 Additionally the Code provides commitments that life insurers will only use surveillance, which must be undertaken by a legitimate investigator, where there is an inconsistency in the information provided. The Code also contains a commitment that surveillance will cease where it is shown that it is negatively impacting the claimant's recovery.[72]

Committee view

10.94 Mental health advocacy groups advised the committee that it remains unclear what data is used by life insurers to assess mental health claims and whether this data is up-to-date.

10.95 The committee believes that providing consumers and policyholders with appropriate written reasons, as discussed earlier in this chapter, will illuminate the nature of the actual data that is being used by insurers in relation to both assessing mental health claims and in their determination of whether there has been non-disclosure of a mental health pre-existing condition.

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66 Financial Services Council, *Submission 26.1*, p. 6.

67 Financial Services Council, *Submission 26.1*, p. 5.

68 Financial Services Council, *Submission 26.1*, p. 6.

69 Australian Securities and Investments Commission, *REP 498 Life insurance claims: An industry review*, 12 October 2016, p. 63.

70 Dr Kym Jenkins, President Elect, Royal Australian and New Zealand College of Psychiatrists, *Committee Hansard*, 22 February 2017, p. 19.

71 Financial Services Council, *Submission 26.1*, p. 6.

72 Financial Services Council, *Submission 26.1*, p. 6.

10.96 Furthermore, the committee believes that the release of such data will allow for a conversation between mental health advocacy groups and the life insurance industry regarding the appropriateness of the data.

10.97 The committee agrees with ASIC's position that industry standards for the assessment of mental health claims are needed. A suitable way to achieve this may be through a separate Code with commitments specific to mental health claims and other related issues. The committee notes that if ASIC's proposal for a co-regulatory system, as discussed in chapter 4, is implemented by the government the enforceability of such a code would be strengthened.

10.98 With around half of Australians expected to experience a mental illness at some point during their life and evidence presented to the committee suggesting that 'psychological conditions are the most common reasons for patients to visit a GP in the first place',[73] the committee is strongly of the view that mental health needs to be addressed in a specific manner by life insurers.

10.99 In addition, the committee is highly concerned about evidence presented that individuals are not seeking treatment for mental ill health due to concerns about the use of this information by life insurers. This is undermining our public health message which continues to work to reduce the stigma that remains around mental health experiences. Any role life insurers have in impacting on individuals seeking necessary treatment must be addressed.

10.100 The committee deals with rehabilitation below, and for sound reasons as articulated in the section on early intervention and rehabilitation payments at the end of this chapter, is cautious about allowing insurers to be directly involved in funding rehabilitation. However, the committee considers that broad-based preventative initiatives is in a different category, and believes that consideration should be given to allow insurers to more actively promote and fund evidence-based best-practice preventative health measures targeted at promoting good mental health at a general level.

Recommendation 10.7

10.101 The committee recommends that after consultation with relevant medical professionals independent of the life insurance industry and mental health advocacy groups, the Financial Services Council establish a mandatory and enforceable Code of Practice for its members, or a dedicated part of its existing Code of Practice, specifically in relation to mental health life insurance claims and related issues.

10.102 The committee further recommends that these consultations discuss requiring insurers to:

73 Dr Seidel, Royal Australian College of General Practitioners, *Committee Hansard*, 1 December 2017, p. 13.

- **ensure that applications for insurance that reveal a mental health condition or symptoms of a mental health condition are not automatically declined;**
- **refer applications for insurance that reveal a mental health condition or symptoms of a mental health condition to an appropriately qualified underwriter;**
- **give an applicant for insurance the opportunity to either withdraw their application or provide further information, including supporting medical documents, before declining to offer insurance or offering insurance on non-standard terms;**
- **where an insurer offers insurance on non-standard terms, for example, with a mental health exclusion or a higher premium than a standard premium, specify:**
    - **how long it is intended that the exclusion/higher premium will apply to the policy;**
    - **the criteria the insured would be required to satisfy to have the exclusion removed or premium reduced;**
    - **the process for removing or amending of the exclusion/premium; and**
- **develop, implement and maintain policies that reflect the above practices.**

Recommendation 10.8

10.103 The committee recommends that consideration be given to allowing insurers to more actively promote and fund evidence-based best-practice preventative health measures targeted at promoting good mental health at a general level.

Delays

10.104 The committee received evidence about the financial and health burden delays during the claims process may cause. The committee also heard allegations about life insurers deliberately delaying the assessment or payment of claims. However, while evidence also pointed to a lack of transparency around the claims process, life insurers did inform the committee of the measures they are taking to improve communication and reduce delays when making a claims decision.

10.105 Report 498 found that a life insurer's requests for evidence and claims management practices, such as the handling of documentation, contributed to delays

in the claims process.[74] Delays also occurred as a result of matters such as the level of insurance cover and the complexity of the claim.[75]

10.106 The Code contains a commitment that life insurers who are FSC members will make all efforts in meeting timeframes prescribed in the Code. The Code outlines that for non-income related claims, a decision will be made in 10 working days, once the life insurer has all the information that it reasonably requires.[76]

10.107 However, such a commitment comes with the caveat that unexpected circumstances may affect how long it takes for a claims decision to be made. Examples of unexpected circumstances include where a superannuation trustee is carrying out their legal obligation to review the life insurer's decision, as well as the time a policyholder or their doctor takes to provide information to the life insurer.[77] If such unexpected circumstances have occurred, a life insurer will make a decision within one year after it is notified of the claim.[78]

10.108 In addition, the Code also contains a commitment that life insurers will assist a policyholder during the assessment of their claim where the policyholder can demonstrate that they are in urgent financial need.[79]

10.109 In terms of default and retail group insurance in superannuation, Berrill and Watson Lawyers submitted that delays may be a result of the claims being passed back and forth between the life insurer and the superannuation trustee in circumstances where the life insurer requests more information from the policyholder and the trustee must carry out their obligation to review each of the life insurer's requests and decisions.[80] Mr Berrill told the committee that there are no statutory time limits for the processing of life insurance claims in superannuation, unlike those that are applicable to workers compensation insurance.[81]

10.110 The Insurance in Superannuation Working Group has created non-statutory timeframes in its draft Super Code for the processing of life insurance claims in

74 Australian Securities and Investments Commission, *REP 498 Life insurance claims: An industry review*, 12 October 2016, p. 87.

75 Australian Securities and Investments Commission, *REP 498 Life insurance claims: An industry review*, 12 October 2016, p. 86.

76 Financial Services Council, *Life Insurance Code of Practice*, October 2016, Clauses 8.14, 8.15.

77 Financial Services Council, *Life Insurance Code of Practice*, October 2016, Clause 8.14.

78 Financial Services Council, *Life Insurance Code of Practice*, October 2016, Clause 8.17.

79 Financial Services Council, *Life Insurance Code of Practice*, October 2016, Clauses 8.27–8.30.

80 Berrill & Watson Lawyers, *Submission 19*, p. 8.

81 Mr John Berrill, Berrill & Watson Lawyers, *Committee Hansard*, 22 February 2017, p. 31.

superannuation. The draft Super Code builds on the timeframes currently committed to in the Code.[82]

10.111 Industry Super Australia stated that the new code for group insurance will improve communication with consumers and policyholders about how long a claim will take to be assessed.[83]

10.112 Mr Shane Tregillis, Chief Ombudsman at FOS, informed the committee that while the Code has commitments regarding timeframes for claims; such commitments must be implemented. Mr Tregillis was of the view that timeframes regarding claims should be clearly communicated to policyholders and only deviated from by insurers in exceptional circumstances, with such circumstances explained to the policyholder.[84]

10.113 The FRLC expressed concern that delays serve as an unethical way for insurers 'to drag out claims'. Policyholders when faced with a heavy financial burden and subjected to invasive practices become worn out and, as a result, withdraw their claims.[85]

10.114 The FLRC were of the view that, due to its self-regulatory and unenforceable nature, the Code was insufficient to prevent unreasonable delays in claims assessment and that law reform was therefore necessary to protect policyholders.[86]

10.115 It should be noted that Report 498 found that 3 out of 14 insures had high rates of withdrawn claims ranging from 20 to 24 per cent. However, ASIC were unable to draw any conclusions as to why high claims withdrawal rates occurred. This is in part due to varying definitions of 'withdrawn' amongst insurers. ASIC noted that it will explore the issue of withdrawn rates as a part of its further work.[87]

10.116 The ALA, like the FLRC, argued for legislation to be enacted for group insurance regarding timeframes for claims handling. The ALA noted that while the common law allows a court to make a decision in circumstances where an insurer has taken too long to assess a claim, legislated timeframes for a claims decision along

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82 The Insurance in Superannuation Working Group, *Discussion Paper*: *Claims Handling*, April 2017, pp. 5, 6, 7–9; The Insurance in Superannuation Working Group, *Consultation Paper: Insurance in Superannuation Code of Practice*, September 2017, pp. 11–12, Appendix 1, pp. 12–17.

83 Mr Richard Watts, Consultant, Industry Super Australia, *Committee Hansard*, 22 February 2017, p. 54.

84 Mr Shane Tregillis, Chief Ombudsman, Financial Ombudsman Service Australia, *Committee Hansard*, 22 February 2017, p. 65.

85 Financial Rights Legal Centre, *Submission 17*, p. 16.

86 Financial Rights Legal Centre, *Submission 17*, pp. 16, 18; see also Ms Julia Angrisano, National Secretary, Finance Sector Union of Australia, *Committee Hansard*, 22 February 2017, p. 50.

87 Australian Securities and Investments Commission, *REP 498 Life insurance claims: An industry review*, 12 October 2016, pp. 57–58.

with consequences for non-compliance need to be enacted as this will allow for an accountable, clearer and more transparent process.[88]

10.117 As noted in earlier sections, the assessment process for making a mental health claim for life insurance can place substantial additional stress on a policyholder. In addition to those elements already discussed, mental health advocates, such as beyondblue, informed the committee that delays in claims due to multiple requests for evidence and a number of medical assessments can cause a person's mental health condition to worsen.[89]

10.118 In a survey conducted by the Mental Health Council of Australia and beyondblue, respondents shared their experiences of increased stress as a result of the insurance claims process. This was particularly the case where the claims process was delayed due to extensive requests for evidence by insurers, including requests to undertake medical examinations by examiners not known to the person making the claim.[90] It was unclear to Dr Carbone why multiple medical assessments are needed, other than to allow for insurers to find an assessment that would allow it to deny a claim.[91] Dr Blanchard from SANE Australia provided several case studies to the committee that reinforced the findings made by Mental Health Australia and beyondblue.[92]

10.119 Berrill and Watson Lawyers noted that there is a lack of transparency around claims handling processes, particular in relation to timeframes. Berrill and Watson Lawyers explained that all insurers have claims manuals which outline to staff the claims assessment process, the documents that are required for claims assessment, and the processing timeframes. However, in its experience 'claims manuals have sometimes operated as a blunt instrument to delay claims'.[93]

10.120 Based on its observation of industry practice, Berrill and Watson Lawyers recommended that claims manuals be provided to customers in order to improve the transparency of the process.[94]

10.121 In response to these concerns, BT Financial stated that the Code will positively influence the claims process and encourage timely management of claims.[95]

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88 Australian Lawyers Alliance, *Submission 20*, p. 21.

89 beyondblue, *Submission 18*, p. 16.

90 Mental Health Council of Australia and beyondblue, *Mental Health, Discrimination & Insurance – A survey of consumer experiences 2011*, 2011, p. 45.

91 Dr Stephen Carbone, Policy, Research and Evaluation Leader, beyondblue, *Committee Hansard*, 22 February 2017, p. 20.

92 Dr Michelle Blanchard, General Manager, Research, Policy and Programs, SANE Australia, *Committee Hansard*, 1 December 2017, p. 3; SANE Australia, *Experiences of people with mental illness with regard to life insurance*, December 2017 (tabled 1 December 2017); See also, Ms Jenny Branton, Executive Officer, Mental Health Carers Australia, *Committee Hansard*, 1 December 2017, pp. 2–3, 6.

93 Berrill & Watson Lawyers, *Submission 19*, pp. 5–6.

94 Berrill & Watson Lawyers, *Submission 19*, pp. 5–6.

10.122 BT Financial acknowledged that while training and accreditation in relation to claims handling exists, there is no industry standard or prescribed continuing education. BT Financial therefore saw an opportunity for the Australasian Life Underwriters & Claims Association and the FSC to create an industry accredited program for claims handlers.[96]

10.123 The committee was also informed of initiatives being undertaken by life insurers in order to alleviate claims delays. For example, MLC are continuing to improve their claims handling processes and reduce delays by working towards customers having a dedicated case consultant to ensure proper communication between parties and faster decision making.[97]

Committee view

10.124 The committee acknowledges the commitment made in the Code to timeframes an insurer must abide by when assessing a claim. The committee also recognises that life insurers to whom the Code applies have only recently been bound by the Code and are still taking steps to implement the Code's commitments.

10.125 Nevertheless, based on the evidence received, the committee recommends that the FSC and the Industry Superannuation Working Group should consult with financial legal services and mental health advocacy groups to determine appropriate timeframes for claims decisions. The Code and the draft Super Code should be updated to reflect the outcomes of such consultation. This approach will ensure that the timeframes committed to in each code will balance the needs of the life insurance industry and policyholders.

10.126 Furthermore, the committee received a body of evidence that policyholders may have to undergo multiple medical assessments, the reasons for which appear, at times, unclear to a policyholder. The committee is concerned that multiple medical assessments can delay a claim, have a detrimental effect on a policyholder's health, and create a financial burden.

10.127 The committee is concerned that there does not seems to be an upper limit on the number of medical assessments that life insurers can ask a policyholder to undergo. While the committee is not inclined to prescribe an upper limit on the number of medical assessments, the committee is firmly of the view that the FSC and the Industry Superannuation Working Group should consult with relevant stakeholders, including medical professionals that are independent of the life insurance industry and mental health advocacy groups, to determine an acceptable upper limit for medical assessments to be included in both the Code and the Super Code.

10.128 As stated in the sections of this chapter on definitions and mental health claims, the committee supports the co-regulatory approach outlined in ASIC's

95 BT Financial, *Submission 13*, p. 6.

96 BT Financial, *Submission 13*, p. 8.

97 MLC Life Insurance, *Submission 30*, p. 6.

Enforcement Review position paper, particularly the requirements for codes to be registered. Such a co-regulatory approach will allow for appropriate oversight of the commitments made in a code to timeframes for claims decisions and the number of medical assessments to be undertaken by a policyholder.

Recommendation 10.9

10.129 The committee recommends that the Financial Services Council and the Insurance in Superannuation Working Group consult with financial legal services and mental health advocacy groups to determine appropriate timeframes for claims decisions and that the *Life Insurance Code of Practice* and the *Insurance in Superannuation Code of Practice* be updated to reflect the outcome of such consultation.

Recommendation 10.10

10.130 The committee recommends that after consultation with relevant stakeholders, including medical professionals that are independent of the life insurance industry and mental health advocacy groups, the Financial Services Council and the Insurance in Superannuation Working Group mandate through the *Life Insurance Code of Practice* and the *Insurance in Superannuation Code of Practice* an upper limit on the number of medical assessments that can be requested of a policyholder and the specific circumstances in which this upper limit could be deviated from.

Independent medical examiners

10.131 A life insurer may use an Independent Medical Examiner (IME) to provide a medical report on a policyholder's claim before it makes a claims decision. IMEs are usually registered medical practitioners and as such are subject to the same legal and ethical obligations and standards as all other registered medical practitioners.[98]

10.132 The FSC explained that an IME will be used particularly in circumstances where there is a difference of opinion between a policyholder's General Practitioner and their specialist.[99]

10.133 The committee was also interested in understanding how the IME market operates as well as the market share of different medico/legal businesses. The committee was keen to ascertain whether any undue concentration of power may exist in this market that could impact on the practices of IMEs.

10.134 While not willing to share its exact market share, Mr Tim Morphy, Director and Chief Executive Officer of MedHealth, told the committee that MedHealth owns

98 Ms Anne Trimmer, Secretary General, Australian Medical Association, *Committee Hansard*, 8 September 2017, pp. 23–24.

99 Financial Services Council, *Submission 26.1*, p. 7.

and operates six business units, all of which mostly facilitate the provision of IMEs to life insurers in Australia.[100]

10.135 In answers to questions on notice regarding the growth of MedHealth's medico/legal businesses, Mr Morphy stated that during 2014–2016, the medico/legal business of MedHealth has had an average organic growth rate of 6.3 per cent per annum.[101]

Committee view

10.136 Despite numerous requests to witnesses and research into the matter, the committee was unable to obtain information on the market share of medico/legal businesses providing IME services. The committee is concerned that this information either does not exist or is not easily accessible. Understanding market concentration is important for determining the competitiveness of the IME market. A lack of competitiveness in the IME market may lead to a risk that IME businesses will not maintain appropriate practices for both quality assurance and managing conflicts of interest between an IME as a medical professional and the commercial objectives of the IME business.

10.137 The committee is also unclear about the extent to which the IME market is currently monitored. To this end, the committee is of the view that the IME market is worthy of greater scrutiny and oversight to ensure that appropriate practices are adhered to.

Recommendation 10.11

10.138 The committee recommends that the concentration of power in the Claims Management Industry, as well as the Independent Medical Examiner market be monitored by the Australian Competition and Consumer Commission to ensure appropriate quality assurance practices are in place and conflicts of interests are managed.

10.139 During the course of the inquiry, the committee was particularly concerned to hear allegations that medical reports had been altered in order to enable life insurance companies to avoid paying claims. Senator Williams spoke to two doctors who stated that they had completed medical reports for independent medical examination companies, only to find out later that important elements of their reports had been altered before transmission to the life insurance companies. The committee was unable to call the doctors before it out of regard that their professional identities not be revealed.

10.140 Nevertheless, the committee is of the view that the seriousness of the allegations merits further investigation in order to determine whether malpractice is occurring and, if so, the extent to which it is occurring. The committee recognises that

100 Mr Tim Morphy, Director and Chief Executive Officer, MedHealth, *Committee Hansard*, 26 May 2017, p. 43.

101 Mr Tim Morphy, Director and Chief Executive Officer, MedHealth, answers to questions on notice, 26 May 2017 (received 9 June 2017).

one way forward would be for an audit to take place. That audit would compare the original medical reports as drafted and kept on file by doctors with those used by life insurance companies as the basis for the decision.

10.141 The prospect of a comprehensive audit should be sufficient to ensure that the highest standards of probity pertain to the entire independent medical examination process. At the very least, if no evidence of report tampering is found, such an audit should restore confidence in the independent medical examination process. On the other hand, if evidence of report tampering is found, the legal consequences are substantial.

Recommendation 10.12

10.142 The committee recommends that the government consider establishing mechanisms to ensure the appropriate bodies are able to undertake random audits of both historical and future medical reports procured by independent medical examination companies, comparing the original reports as drafted by doctors with those used by life insurance companies as the basis for the decision.

Incentives for staff to reject or delay claims

10.143 During the inquiry, the committee examined whether life insurers incentivise staff to reject claims through key performance indicators and other benefits. Ms Julia Angrisano, the National Secretary of the Finance Sector Union, discussed with the committee how call centre staff had a target imposed on them regarding the number of policyholders they referred to the retention team, who would then try to convince the policyholder to hold off from seeking payment for a claim.[102]

10.144 Mr Kell informed the committee that in relation to CommInsure and its claims staff, ASIC had found that 'net-loss ratios and income protection termination rates' were a part of claims staff's key performance indicators. ASIC found this to be an unacceptable conflict of interest.[103]

10.145 However, Mr Kell observed that CommInsure had since removed these key performance indicators, and that the Code now prohibits such incentives.[104]

Committee view

10.146 The committee is very disturbed by any incentives that life insurers had in place to incentivise staff to reject claims through key performance indicators and other benefits. The committee considers this to have been particularly egregious. As noted

102 Ms Julia Angrisano, National Secretary, Finance Sector Union of Australia, *Committee Hansard*, 22 February 2017, p. 50.

103 Mr Peter Kell, Deputy Chairman, Australian Securities and Investments Commission *Committee Hansard*, 8 September 2017, p. 48.

104 Mr Peter Kell, Deputy Chairman, Australian Securities and Investments Commission *Committee Hansard*, 8 September 2017, p. 48; See also Financial Services Council, *Life Insurance Code of Practice*, October 2016, Clause 4.3.

in chapter 5 of this report, the then ASIC Chairman Mr Greg Medcraft has stated on several occasions that incentives send signals and the wrong type of incentives send the wrong signals.

10.147 The committee notes ASIC's monitoring of these matters and welcomes the move by the FSC to prohibit such incentives within the Code.

10.148 At the risk of being overly repetitive, however, the committee reiterates its support for co-regulation of industry codes as a means to ensure that measures such as the prohibition of perverse incentives are not only mandatory, but also enforceable.

Underwriting direct insurance

10.149 This section discusses the prevalence of underwriting at the time that a customer purchases direct life insurance, as well as arguments put to the committee about consumers not being underwritten at the time of purchasing direct insurance.

10.150 As discussed in chapters 2, 8 and 9 of this report, underwriting can be a process of risk assessment conducted by the life insurer that aims to ensure the premiums paid by the prospective policy-holder are proportionate to the risks faced by that individual.

10.151 As also discussed in chapter 2, retail-advised insurance is underwritten at the time of purchase as part of the service provided by the adviser.

10.152 Retail advisers outlined some of the risks for consumers of not being underwritten at the time of purchasing direct life insurance. The Association of Financial Advisers submitted that if a consumer was not underwritten at the time of purchase, the life insurer would only assess that person's risk, and in turn the level of their cover, at the time of claim. This could mean that the policyholder may be unaware that they were paying premiums for a policy without technically being covered by that policy.[105]

10.153 Mr Mark Schroeder, a financial adviser from Schroeder Capital Pty Ltd, held a similar view and argued that the likelihood of a policyholder being paid at the time of claim was significantly reduced for a direct policy not underwritten at the time of purchase.[106]

10.154 ASIC Report 498 found that across the distribution channels of direct, retail and group life insurance, direct life insurance had the highest decline rate in terms of claims outcomes. For direct insurance 12 per cent of claims were denied, compared with 7 per cent in retail and 8 per cent in group life insurance.[107]

105 Association of Financial Advisers, *Submission 22*, pp. 9–10.

106 Mr Mark Schroeder, Schroeder Capital Pty Ltd, *Submission 68*, p. 7.

107 Australian Securities and Investments Commission, *REP 498 Life insurance claims: An industry review*, 12 October 2016, p. 53.

10.155 However, Report 498 also found that the claims acceptance rate across the three channels of distribution were fairly similar with direct found to have a 74 per cent acceptance rate, retail 76 per cent and group 77 per cent.[108]

10.156 ASIC did not draw any concrete conclusions about whether the higher claims decline rates were due to underwriting practices at the time of claim by direct insurers. In light of Report 498's findings, ASIC will undertake a review of the direct life insurance industry.[109]

10.157 The FSC pointed out that the perceived higher decline rate for direct insurance in comparison to the other channels of distribution for insurance is likely due to the fact that in retail and group insurance the relevant adviser or trustee will filter out any claims that are likely to be declined prior to submitting the claim to an insurer. As direct insurance does not have an intermediary such as a trustee or an adviser, all claims are submitted to the insurer.[110]

10.158 The FSC submitted that a spectrum of underwriting options existed in the direct market and that underwriting at time of purchase occurs for many direct products. In situations where underwriting did not occur as part of the application process, the insurer would then determine whether the claim met the policy terms and conditions including any exclusions for a pre-existing condition.[111]

10.159 For example, Mr Andrew Hagger, Chief Customer Officer at the National Australia Bank, explained that for those MLC direct products that are not underwritten at the time of purchase, consumers are made aware of policy exclusions through product disclosure statements and the questions that consumers are asked at the time of application.[112]

10.160 Mr Brett Clark, Chief Executive Officer and Managing Director of TAL, stated that TAL offers underwriting to all its direct customers. However, in about 30 per cent of cases the consumer chooses not to complete the underwriting. In such circumstances, TAL offers policies that exclude pre-existing, known conditions for a waiting period comprising the first five years of cover, after which, the customer is

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108 Australian Securities and Investments Commission, *REP 498 Life insurance claims: An industry review*, 12 October 2016, pp. 55–56.

109 Australian Securities and Investments Commission, *16–347 MR ASIC issues industry review of life insurance claims*, http://asic.gov.au/about-asic/media-centre/find-a-media-release/2016-releases/16-347mr-asic-issues-industry-review-of-life-insurance-claims/ (accessed 6 November 2017).

110 Financial Services Council, *Supplementary Submission 26.1*, p. 12.

111 Financial Services Council, *Supplementary Submission 26.1*, pp. 11–12.

112 Mr Andrew Hagger, Chief Customer Officer, Customer Banking and Wealth Management, National Australia Bank, *Committee Hansard*, 26 May 2017, p. 10.

fully covered. Additionally, consumers are fully informed of the status of their cover.[113]

10.161 Mr Richard Enthoven, Chairman of Greenstone Pty Ltd, stated that Greenstone Pty Ltd fully underwrites Real Insurance direct policies at the time of purchase through a tele-underwriting process that involves a series of up to 100 questions.[114] Mr Bernard Grobler, Chief Operating Officer of Greenstone Pty Ltd, explained to the committee that an insurance product will only be sold after the questions have been answered.[115] Mr Grobler explained that this practice provides the customer with the certainty of knowing what their policy covers them for.[116]

10.162 Mr Grobler also informed the committee that in the last 12 months only 33 direct insurance claims were denied, in most cases, due to non-disclosure of pre-existing conditions.[117] Furthermore, where a claim was denied due to non-disclosure, all premiums were returned to the policyholder.[118]

10.163 Similarly, Mr Nicholas Scofield, General Manager of Corporate Affairs at Allianz Australia Insurance, explained that all of Allianz's direct life insurance customers are underwritten at the time of purchase.[119]

Committee view

10.164 Based on the evidence before it, the committee is unable to assess what proportion of direct life insurance is underwritten at the time of purchase.

10.165 The committee notes that ASIC Report 498 found that while direct insurance claims have a higher decline rate compared to other types of insurance, the rate of claims that are accepted is similar across the three distribution channels. It is unclear from the data released by ASIC whether these high denial rates relate predominantly to direct insurance that is not underwritten at the time of purchase.

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113 Mr Brett Clark, Chief Executive Officer and Managing Director, TAL, *Committee Hansard*, 18 August 2017, pp. 9–10; TAL, answers to questions on notice, 18 August 2017 (received 1 September 2017).

114 Mr Richard Enthoven, Executive Chairman, Greenstone Pty Ltd, *Committee Hansard*, 26 May 2017, pp. 18, 19; See also, Mr Bernard Grobler, Chief Operating Officer, Greenstone Pty Ltd, *Committee Hansard*, 26 May 2017, p. 19.

115 Mr Bernard Grobler, Chief Operating Officer, Greenstone Pty Ltd, *Committee Hansard*, 26 May 2017, p. 19.

116 Mr Bernard Grobler, Chief Operating Officer, Greenstone Pty Ltd, *Committee Hansard*, 26 May 2017, p. 24.

117 Mr Bernard Grobler, Chief Operating Officer, Greenstone Pty Ltd, *Committee Hansard*, 26 May 2017, pp. 19, 20, 25; See also, Mr Richard Enthoven, Executive Chairman, Greenstone Pty Ltd, *Committee Hansard*, 26 May 2017, p. 20.

118 Mr Bernard Grobler, Chief Operating Officer, Greenstone Pty Ltd, *Committee Hansard*, 26 May 2017, pp. 19–20.

119 Mr Nicholas Scofield, General Manager, Corporate Affairs, Allianz Australia Insurance, *Committee Hansard*, 18 August 2017, pp. 34, 36.

10.166 The committee also notes the evidence from the FSC that decline rates in direct insurance could be due to the fact that, unlike retail and group insurance, there is no intermediary in direct insurance to filter out the claims that are likely to be unsuccessful.

10.167 The committee is firmly of the view that there needs to be far greater clarity and transparency around the data on the proportion of direct life insurance that is not underwritten at the time of purchase as well as the data on the rates of denied claims within the direct sector including the links, if any, between decline rates and underwriting practices.

10.168 To this end, the committee strongly encourages ASIC to include data on the connection between denied claims and underwriting practices in its review into the direct life insurance industry. ASIC is also strongly encouraged to assess the extent to which advisers and trustees filter the claims that are submitted to an insurer in the group and retail sectors and the effect this has on the rate of declined claims, as compared to the absence of a similar intermediary in direct insurance and the rate of declined claims in direct insurance.

10.169 In addition, the committee is concerned that some consumers may not fully appreciate the claims process if they are not underwritten at the time of sale, and what this may mean in terms of their coverage and any increased likelihood of their claim being denied. The committee endorses the approach taken by Greenstone and Allianz in which a person is underwritten after answering a series of questions at the time of purchasing direct insurance.

Legacy products

10.170 Life insurers produce and release products that reflect the needs of consumers and the market. However, as the social, legal, medical and financial environments continually change, more up-to-date products are released by life insurers. This means that older products, referred to as legacy products, are no longer made available to new consumers but are still administered to the customers who obtained them previously in accordance with the terms of the older policy.[120]

10.171 Mr Stephen Perera, Director of advice firm of Perera Crowther Financial Services, stated that policyholders who have a legacy product are often left isolated and bound by outdated terms and conditions.[121]

10.172 Mr Perera explained that individuals who are healthy would be able to pass an insurance risk assessment that would enable them to access new and better products. However, those individuals with legacy products who are less healthy than they were when they initially purchased the product would be unlikely to pass any risk assessment for a new insurance product. This means that an individual would be

120 Financial Services Council, *Submission 26*, p. 11; See also Australian Prudential Regulation Authority, *Submission 184 to the Senate Economics References Committee – Inquiry into the Scrutiny of Financial Advice*, p. 10.

121 Mr Stephen Perera, Director, Perera Crowther Financial Services, *Submission 58*, p. 3.

forced to keep the out-dated legacy product in order to have some form of insurance coverage.[122] Furthermore, Mr Perera pointed out that these policyholders 'are eventually priced out by premium increases'.[123]

10.173 From an industry perspective, the FSC noted that legacy products are difficult and expensive to administer and lead to problems such as economically inefficient products and out-of-date medical definitions within policies.[124]

10.174 The FSC supported the need to address the issues posed by legacy products through reform that allows for product rationalisation.[125]

10.175 The FSC also observed that such reform required legislative change as the law does not allow life insurers to change the definitions and terms of a policy unilaterally.[126] This restriction on life insurers and the need for legislative change was also noted by the Australian Prudential Regulation Authority (APRA) in its submission to the Senate Economics References Committee's Inquiry into the Scrutiny of Financial Advice.[127]

10.176 The FSC observed that consumers would be protected under product rationalisation due to a requirement that changes to policies can only be made by the product issuer where this is in the best interest of policyholders. This would be known as a consumer interest test.[128]

10.177 However, the consumer interest test proposed by the FSC would be applied at the group level, meaning it would be applied to the bundle of rights consumers with the same policy have. As the FSC noted, the application of a group test would not consider the best interest for each individual. The FSC submitted that the consumer interest test should be:

- Based on the monetary benefits and rights enjoyed by the consumer as at the Transition Date (rather than intangible product features, unless these represent a monetary benefit or right);

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122 Mr Stephen Perera, Director, Perera Crowther Financial Services, *Submission 58*, p. 4.

123 Mr Stephen Perera, Director, Perera Crowther Financial Services, *Submission 58*, p. 3.

124 Financial Services Council, *Submission 26*, p. 12; Financial Services Council, Product rationalisation working group proposal, additional information received 12 November 2017, p. 3.

125 Financial Services Council, *Submission 26*, p. 11; Financial Services Council, Product rationalisation working group proposal, additional information received 12 November 2017, p. 3.

126 Financial Services Council, *Submission 26*, p. 11.

127 Australian Prudential Regulation Authority, *Submission 184 to the Senate Economics References Committee inquiry into the Scrutiny of Financial Advice*, p. 10.

128 Financial Services Council, *Submission 26*, p. 12; Financial Services Council, Product rationalisation working group proposal, additional information received 12 November 2017, p. 3; See also Australian Prudential Regulation Authority, *Submission 184 to the Senate Economics References Committee inquiry into the Scrutiny of Financial Advice*, p. 10.

- Determined as the accrued value of those benefits;
- Calculated by an independent expert or the Appointed Actuary; and
- Based on the overall bundle of rights consumers have and not at the individual feature level.[129]

10.178 Evidence to the committee from life insurers such as TAL reflected the FSC's position. Mr Clark from TAL told the committee that the *Life Insurance Act 1995* should be updated to respond to the complexity surrounding legacy products and the burden it places on consumers and industry.[130]

10.179 The Financial System Inquiry recommended that product rationalisation should be implemented to address the problems presented by legacy products.[131] In part, product rationalisation would reduce the number of products available on the market that no longer serve the interest of the consumer. The Australian Government accepted this recommendation and announced that a mechanism would be introduced to 'facilitate the rationalisation of legacy products'. The government also recognised that there should be no disadvantage to the consumer in this transition.[132]

Committee view

10.180 Evidence to the committee from life insurers strongly supported the introduction of a legislative mechanism that would facilitate the rationalisation of legacy products. The committee recognises the administrative burden that legacy products impose on life insurers. The committee also notes that the insurance industry would prefer to rationalise legacy products by applying a consumer interest test at the group level.

10.181 However, the committee is also aware that many consumers still hold, and are potentially trapped into still holding, outdated legacy policies. The committee is keen to ensure that the rights of existing policyholders are protected and that any product rationalisation does not disadvantage this cohort of consumers. To this end, the committee recommends that a 'no disadvantage' rule apply to any rationalisation of legacy products such that existing policyholders would, at a minimum, be no worse off from being transferred to a new policy.

10.182 To be clear, the committee is recommending that the determination of whether policyholders are no worse-off under product rationalisation should be done on an individual case-by-case basis and not by considering what is best for a group of policyholders who hold the same legacy product. Though this may be done on a class

129 Financial Services Council, Product rationalisation working group proposal, additional information received 12 November 2017, p. 3.

130 Mr Brett Clark, Chief Executive Officer and Managing Director, TAL, *Committee Hansard*, 18 August 2017, p. 2.

131 Financial System Inquiry, *Final Report*, 7 December 2014, Recommendation 43.

132 Australian Government, *Improving Australia's financial system: Government response to the Financial System Inquiry*, 20 October 2015, p. 18.

basis, similar to classes within schemes of arrangement under Chapter 2F of the Corporations Act.

Recommendation 10.13

10.183 The committee recommends that the Australian Government introduce legislation to facilitate the rationalisation of legacy products noting that such legislative change should include a no-disadvantage rule whereby:

- **existing policyholders would, at a minimum, be no worse off from being transferred to a new policy; and**
- **the determination of whether existing policyholders are no worse off should be assessed on an individual case-by-case basis and not by considering what is best for a group of policyholders who hold the same legacy product. Though this may be done on a class basis, similar to classes within schemes of arrangement under Chapter 2F of the *Corporations Act 2001*.**

Early intervention—rehabilitation payments

10.184 The FSC informed the committee about regulatory constraints on the ability of life insurers to provide early rehabilitation benefits and medical expenses.[133] The FSC argued that the potential improvement of an insurance policy over its life would incentivise life insurers to invest in more active rehabilitation strategies and lead to better social outcomes for individuals. In addition, the FSC noted that higher return to work rates would reduce the costs borne by government.[134]

10.185 The FSC argued that current regulations prevent life insurers from funding medical treatment and services to support early return to work. As a result, life insurers are increasingly employing rehabilitation specialists to provide occupational or vocational rehabilitation support to manage ongoing disability claims. The FSC indicated that under current legislation, life insurers are not permitted to provide a benefit to a claimant under a continuous disability policy for treatment costs where either a corresponding Medicare benefit is payable or where the treatment is a hospital treatment or general treatment. The FSC argued that these restrictions should be removed.[135]

133 Financial Service Council, *Submission 26*, pp. 5, 13, 14; Financial Services Council, Early intervention, additional information received 12 November 2017, p. 1.

134 Financial Services Council, Early intervention, additional information received 12 November 2017, p. 1.

135 Financial Services Council, Early intervention, additional information received 12 November 2017, pp 3–5.

10.186 Some other industry participants also raised the issue of restrictions on rehabilitation payments.[136] The Commonwealth Bank suggested that the government consider reviewing legislation to explore opportunities to allow life insurers to fund rehabilitative treatments and assist workers in their return to the workplace.[137] ASFA argued that members' best interests could be served by modifying or removing the regulatory impediments that prevent insurers from providing targeted rehabilitation benefits and/or staged payments.[138]

10.187 In contrast, Dr Stephen Carbone, Policy, Research and Evaluation Leader at beyondblue, had concerns about some of the early intervention proposals put forward by life insurers. Dr Carbone supported early intervention practices that aimed to prevent the preconditions that can lead to people becoming unfit for work, for example, early intervention practices that aimed to prevent job stress leading to depression. However, Dr Carbone drew attention to a conflict of interest that could arise when early intervention practices are focussed on treatment because the life insurer would be both paying the policy claim and also be closely involved in seeking the early return to work of the policyholder:

> I think there needs to be an arms-length sort of relationship because you can get perverse incentives. You can get pressure on the consumer—the consumer being told that they are better than they believe themselves to be and being forced into work that perhaps they are not ready for or suitable for. It is just a complex situation when the person paying the tab is also the one trying to get you back to work.[139]

Committee view

10.188 The committee acknowledges the importance of early intervention and welcomes proposals that would better enable early intervention and thereby improve the rehabilitation prospects of people who have suffered injury or illness.

10.189 The committee notes the arguments put forward by the FSC for the removal of regulatory constraints on the ability of life insurers to provide early rehabilitation benefits and medical expenses. The committee also notes that there was only limited discussion during the inquiry of the issues raised by this proposal. Due to the late arrival of the much more detailed proposal from the FSC, the committee has not had the opportunity to hear from other witnesses and submitters about any potential unintended consequences that may arise as a result of the FSC's proposals. The

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136 Mr Brett Clark, Chief Executive Officer and Managing Director, TAL, *Committee Hansard*, 18 August 2017, p. 2; Mr Andrew Hagger, Chief Customer Officer, Consumer Banking and Wealth Management, National Australia Bank, *Committee Hansard*, 26 May 2017, p. 9; Ms Alexis George, Group Executive, Wealth Australia, Australia and New Zealand Banking Group Ltd, *Committee Hansard*, 3 March 2017, p. 58; Mr Damian Hill, Chief Executive Officer, REST Industry Super, *Committee Hansard*, pp. 53–54.

137 Commonwealth Bank of Australia, *Submission 24*, pp 10–11.

138 Association of Superannuation Funds of Australia, *Submission 29*, p. 3.

139 Dr Stephen Carbone, Policy, Research and Evaluation Leader, beyondblue, *Committee Hansard*, 22 February 2017, p. 17.

committee is therefore recommending that the government does not progress any reforms into life insurance funding for rehabilitation services until a thorough inquiry or consultation process is undertaken.

Recommendation 10.14

10.190 The committee recommends that the Australian Government conduct a thorough inquiry or consultation process before it progresses any reforms relating to life insurers funding rehabilitation services, including impacts on private health insurance, or Medicare, and any conflicts of interest that may arise for an insurer vis-a-vis their customer and the most appropriate care.

10.191 The committee is concerned that people struggling with dementia are having difficulties claiming on life insurance. More than 500 000 Australians will have dementia by 2025 and dementia is now the leading cause of death for Australian women.

10.192 With this background, the committee is concerned that the Financial Services Council was not aware of instances of those with dementia having difficulties claiming on life insurance.

Recommendation 10.15

10.193 The committee recommends that the Financial Services Council, with the Royal Australian College of General Practitioners and key stakeholders, explore issues around those with dementia claiming on life insurance. Following this, the committee recommends that together they prepare and implement protocols within the Code specifically addressing the treatment by life insurers of those with dementia.

Mr Steve Irons MP

Committee Chair

Appendix 1

Submissions and additional information received

Submissions

1 Name Withheld
2 Mr Brenton White
3 Mr Richard Ruggiero
4 Mr Terence Dwyer
5 Mr Phillip Sweeney
6 Name Withheld
7 Association of Independently Owned Financial Professionals (AIOFP)
8 Mr Max Clay
9 Public Interest Advocacy Centre (PIAC)
10 ClearView Wealth Limited
11 Finance Sector Union of Australia
12 Maurice Blackburn Lawyers
13 BT Financial Group
14 National Insurance Brokers Association of Australia (NIBA)
15 Royal Australian and New Zealand College of Psychiatrists (RANZCP)
16 Mental Health Australia
17 Financial Rights Legal Centre
18 Beyondblue
19 Berrill & Watson Lawyers
20 Australian Lawyers Alliance
21 Financial Planning Association of Australia (FPA)
22 Association of Financial Advisors
23 Australian Institute of Superannuation Trustees & Industry Super Australia
24 Commonwealth Bank of Australia
25 Australian Health Practitioner Regulation Agency
26 Financial Services Council
27 Consumer Action Law Centre
28 Financial Ombudsman Service Australia
29 Association of Superannuation Funds of Australia (ASFA)
30 MLC Life Insurance
31 TAL
32 AIA Australia
33 Confidential
34 Confidential
35 Confidential
36 Confidential
37 Confidential
38 Confidential
39 Confidential
40 Confidential
41 Ms Robyn Abrahams
42 Name Withheld
43 Mr Greg Newton

44 ANZ
45 Australian Securities & Investments Commission (ASIC)
46 Name Withheld
47 Ms Lorraine Beard
48 Mr David Ward
49 CHOICE
50 Australian Prudential Regulation Authority (APRA)
51 Confidential
52 Mr Godfrey Phillips
53 Mr Keith Barnes
54 Mr Jeffrey Suggars
55 Mr Brendan Lynch
56 Rate Detective
57 REST Industry Super
58 Mr Stephen Perera
59 Life Insurance Direct
60 Australian Genetic Non-Discrimination Working Group
61 ALI Group Pty Ltd
62 Name Withheld
63 Life Insurance Customer Group
64 Bombora Advice Pty Ltd
65 Mr Maurice Barry
66 Mr Hugh Crawford
67 Name Withheld
68 Mr Mark Schroeder, Schroeder Capital Pty Ltd
69 Mr Damien McColl
70 Ms Tamara Gillman
71 MBS Insurance
72 Breast Cancer Network Australia
73 Confidential
74 Mr Stephen Knight, Knight Management Services Pty Ltd
75 Name Withheld
76 Royal Australian College of General Practitioners
77 Ms Lynley Shanahan

Additional Information

1. Form letters received:
   Form letter 1 – received from 33 individuals
   Form letter 2 – received from 54 individuals
2. Background document provided on 15 May 2017 by National Australia Bank.
3. Background document provided on 16 May 2017 by Zurich Financial Services Australia Limited.
4. Background Document provided on 23 May 2017 by MedHealth Pty Ltd.
5. Additonal information arising from hearing on 26 May 2017 provided on 30 May 2017 by Zurich Financial Services Australia Limited.
6. Additional information provided on 5 September 2017 by AMP.
7. Additional information provided on 13 November by Australian Securities and Investments Commission.
8. 'Red tape issues' provided on 12 November 2017 by Financial Services Council.
9. 'Early intervention' provided on 12 November 2017 by Financial Services Council.

10. 'Product rationalisation working group proposal' provided on 12 November 2017 by Financial Services Council.
11. 'Unfair terms in insurance contracts' provided on 13 November 2017 by Financial Services Council.
12. Additional information provided on 11 Dec 2017 by CBUS.

Additional Hearing Information

1. Correction to evidence provided on 8 September 2017 by Australian Securities and Investments Commission.
2. Corrections to evidence from public hearing 18 August 2017 provided by TAL on 1 September 2017.
3. Corrections to evidence from public hearing 26 May 2017 provided by Australian Genetic Non-Discrimination Working Group on 8 February 2018.

Tabled Documents

1. ANZ Bank: Opening Statement (public hearing, Canberra, 3 March 2017).
2. Royal Australian and New Zealand College of Psychiatrists: Opening Statement (public hearing, Melbourne, 22 February 2017).
3. Credit & Investments Ombudsman: Opening Statement (public hearing, Melbourne, 22 February 2017).
4. Insurance in Superannuation Working Group: Joint Statement (public hearing, Melbourne, 22 February 2017).
5. Association of Independently Owned Financial Professionals: Opening Statement (public hearing, Melbourne, 22 February 2017).
6. Mr Keith Barnes: Opening Statement (public hearing, Melbourne, 22 February 2017).
7. Life Insurance Customer Group: Life Insurance Framework Survey 2015 (public hearing, Sydney, 24 February 2017).
8. REST Industry Super: Opening Statement (public hearing, Sydney, 24 February 2017).
9. Perera Crowther Financial Services: Example table comparing direct, retail and group insurance (public hearing, Sydney, 24 February 2017).
10. Australian Prudential Regulation Authority: Opening Statement (public hearing, Sydney, 24 February 2017).
11. Bombora Advice: Infographics "What is Churn?" and "The Vicious Circle" (public hearing, Melbourne, 22 February 2017).
12. SANE Australia: Experiences of people with mental illness with regard to life insurance (public hearing, Canberra, 1 December 2017).

Answers to Questions on Notice

1. Superannuation Complaints Tribunal: Answers to questions taken on notice from public hearing 22 February 2017 (received 3 March 2017).
2. The Royal Australian and New Zealand College of Psychiatrists: Answers to questions taken on notice 22 February 2017 (received 17 March 2017).
3. Australian Institute of Superannuation Trustees: Answers to questions taken on notice from public hearing 22 February 2017 (received 17 March 2017).
4. Financial Rights Legal Centre: Answers to questions taken on notice from public hearing 24 February 2017 (received 27 February 2017).
5. Public Interest Advocacy Centre: Answers to questions taken on notice from public hearing 24 February 2017 (received 16 March 2017).

6. Australian Prudential Regulation Authority: Answers to questions taken on notice from public hearing 24 February 2017 (received 17 March 2017).
7. Association of Superannuation Funds of Australia: Answers to questions taken on notice from public hearing 24 February 2017 (received 17 March 2017).
8. National Insurance Brokers Association of Australia: Answers to questions taken on notice from public hearing 03 March 2017 (received 15 March 2017).
9. Financial Services Council: Answers to questions taken on notice from public hearing 03 March 2017 (received 17 March 2017).
10. Australia and New Zealand Banking Group: Answers to questions taken on notice from public hearing 03 March 2017 (received 17 March 2017).
11. MLC Life Insurance: Answers to questions taken on notice from public hearing 03 March 2017 (received 17 March 2017).
12. AIA Australia: Answers to questions taken on notice from public hearing 3 March 2017 (received 17 March 2017).
13. Association of Financial Advisers: Answers to questions taken on notice from public hearing 24 February 2017 (received 19 March 2017).
14. Bombora Advice: Answers to questions taken on notice from public hearing 22 February 2017 (received 17 March 2017).
15. BT Financial Group: Answers to questions taken on notice from public hearing 3 March 2017 (received 17 March 2017).
16. ClearView Wealth: Answers to questions on notice posed 2 March 2017 (received 23 March 2017).
17. Commonwealth Bank of Australia: Answers to questions on notice posed 3 April 2017 (received 5 May 2017).
18. Australian Genetic Non-Discrimination Working Group: Answers to questions taken on notice from public hearing 26 May 2017 (received 9 June 2017).
19. Greenstone Pty Ltd: Answers to questions taken on notice from public hearing 26 May 2017 (received 9 June 2017).
20. Zurich Financial Service Australia Limited: Answers to questions taken on notice from public hearing 26 May 2017 (received 9 June 2017).
21. MedHealth Pty Ltd: Answers to questions taken on notice from public hearing 26 May 2017 (received 9 June 2017).
22. National Australia Bank: Answers to questions taken on notice from public hearing 26 May 2017 (received 9 June 2017).
23. MLC Life Insurance: Answers to questions taken on notice by National Australia Bank and referred to MLC Life Insurance from public hearing 26 May 2017 (received 9 June 2017).
24. St Andrew's Life Insurance Pty Ltd: Answers to questions on notice posed 3 July 2017 (received 28 July 2017).
25. Medibank Private Ltd: Answers to questions on notice posed 3 July 2017 (received 25 July 2017).
26. QBE Insurance (Australia) Ltd: Answers to questions on notice posed 3 July 2017 (received 28 July 2017).
27. Australia and New Zealand Banking Group: Answers to questions on notice posed 3 July 2017 (received 27 July 2017).
28. BT Financial Group: Answers to questions on notice posed 3 July 2017 (received 31 July 2017).
29. Zurich Financial Service Australia Limited: Answers to questions on notice posed 3 July 2017 (received 28 July 2017).
30. RAC: Answers to questions on notice posed 3 July 2017 (received 28 July 2017).

31. Commonwealth Bank of Australia: Answers to questions on notice posed 3 July 2017 (received 31 July 2017).
32. Commonwealth Bank of Australia: Answers to questions on notice posed 3 July 2017 (received 31 July 2017).
33. Allianz Australia Insurance Ltd: Answers to questions on notice posed 3 July 2017 (received 4 August 2017).
34. AMP: Answers to questions on notice posed 3 July 2017 (received 28 July 2017).
35. Woolworths Group: Answers to questions on notice posed 3 July 2017 (received 31 July 2017).
36. ClearView Wealth: Answers to questions on notice posed 3 July 2017 (received 27 July 2017).
37. Australian Securities and Investments Commission: Answers to questions on notice posed 3 April 2017 (received 9 August 2017).
38. Australian Health Practitioner Regulation Agency: Answers to questions on notice posed 4 July 2017 (received 4 August 2017).
39. Australian Medical Association: Answers to questions on notice posed 4 July 2017 (received 27 July 2017).
40. TAL: Answers to questions on notice posed 3 July 2017 (received 1 August 2017).
41. HSBC Bank Australia Limited: Answers to questions on notice posed 3 July 2017 (received 27 July 2017).
42. REST Industry Super: Answers to questions on notice posed 3 July 2017 (received 17 July 2017).
43. TAL: Answers to questions on notice taken from public hearing 18 August 2017 (received 1 September 2017).
44. Department of the Treasury: Answers to questions on notice posed 22 August 2017 (received 6 September 2017).
45. Australian Securities and Investments Commission: Answers to questions on notice posed 21 August 2017 (received 8 September 2017).
46. Office of the Australian Information Commissioner: Answers to questions on notice posed 22 August 2017 (received 6 September 2017).
47. AMP: Answers to questions on notice taken from public hearing 18 August 2017 (received 5 September 2017).
48. Metlife: Answers to questions on notice posed 3 July 2017 (received 28 July 2017).
49. Royal Australian College of General Practitioners: Answers to questions taken on notice from public hearing 8 September 2017 (received 26 September 2017).
50. Australian Health Practitioner Regulation Agency: Answers to questions taken on notice from public hearing 8 September 2017 (received 5 October 2017).
51. MDA National: Answers to questions on notice posed 27 September 2017 (received 12 October 2017).
52. Medical Indemnity Protection Society: Answers to questions on notice posed 27 September 2017 (received 16 October 2017).
53. Medical Insurance Group Australia: Answers to questions on notice posed 27 September 2017 (received 18 October 2017).
54. Financial Services Council: Answers to questions on notice posed 31 August 2017 (received 27 September 2017).
55. Commonwealth Bank of Australia: Answers to questions taken on notice from public hearing 8 September 2017 (29 September 2017).
56. Australian Securities and Investments Commission: Answers to questions on notice posed 4 August 2017 (received 4 December 2017).
57. Royal Australian College of General Practitioners: Answers to questions taken on notice from public hearing 1 December 2017 (received 7 December 2017).

58. Australian Securities and Investments Commission: Answers to questions taken on notice on 4 December 2017 (received 8 December 2017).
59. Australian Prudential Regulation Authority: Answers to questions taken on notice on 4 December 2017 (received 8 December 2017).
60. Association of Superannuation Funds of Australia (ASFA): Answers to questions taken on notice from public hearing 1 December 2017 (received 20 December 2017).
61. Australian Prudential Regulation Authority: Answers to questions on notice posed 19 December 2017 (received 22 January 2018).
62. Australian Securities and Investments Commission: Answers to questions on notice posed 8 February 2018 (received 12 February 2018).
63. Financial Services Council: Answers to questions taken on notice from public hearing 1 December 2017 and questions posed 4 December 2017 (received 21 December 2017).

Appendix 2

Public hearings and witnesses

22 February 2017, Melbourne

Finance Sector Union of Australia

Ms Julia Angrisano, National Secretary

Private capacity

Mr Keith Barnes

beyondblue

Ms Nadine Bartholomeusz-Raymond, General Manager, Education, Families and Diversity and Access

Dr Stephen Carbone, Policy, Research and Evaluation Leader

Berrill & Watson Lawyers

Mr John Berrill, Partner

Consumer Action Law Centre

Mr Gerard Brody, Chief Executive Officer

Ms Susan Quinn, Senior Policy Officer

Superannuation Complaints Tribunal

Ms Helen Davis, Chairperson

Bombora Advice Pty Ltd

Mr Wayne Handley, Managing Director

Ms Antoinette Handley, Representative

Synchron

Mr Michael Harrison, Chairman

Australian Institute of Superannuation Trustees

Mr David Haynes, Executive Manager Policy and Research

Mr Richard Webb, Policy and Regulatory Analyst

The Royal Australian and New Zealand College Of Psychiatrists

Dr Kym Jenkins, President Elect

Association of Independently Owned Financial Professionals

Mr Peter Johnston, Executive Director

Private Capacity

Mr Jason Keiller

Private Capacity

Mr Phillip O'Sullivan

Rate Detective

Mr Damon Rasheed, Chief Executive Officer

Private Capacity

Mr Richard Ruggiero

Maurice Blackburn Lawyers

Ms Kim Shaw, Principal

Financial Ombudsman Service Australia

Mr Shane Tregillis, Chief Ombudsman

Dr June Smith, Lead Ombudsman, Investment and Advice

Credit and Investments Ombudsman

Mr Raj Venga, Chief Executive Officer and Ombudsman

Private Capacity

Mr David Ward

Industry Super Australia

Mr Richard Watts, Consultant

24 February 2017, Sydney

Association of Financial Advisers

Mr Marc Bineham, National President

Mr Brad Fox, Chief Executive Officer

Ms Samantha Clarke, General Manager, Policy and Professionalism

Australian Prudential Regulation Authority

Mr Stuart Bingham, General Manager

Mr Adrian Rees, General Manager

Mr Geoff Summerhayes, APRA Member

Life Insurance Customer Group

Mr Russell Cain, Joint Chairperson

Mr Mark Schroeder

Public Interest Advocacy Centre

Ms Alexis Goodstone, Principal Solicitor

Ms Michelle Marie Cohen, Senior Solicitor

Financial Planning Association of Australia

Mr Neil Kendall, Chair

Mr Dante De Gori, Chief Executive Officer

REST Industry Super

Mr Damian Hill, Chief Executive Officer

Mr Andrew Howard, Chief Operating Officer

Financial Rights Legal Centre

Ms Alexandra Kelly, Principal Solicitor

CHOICE

Mr Alan Kirkland, Chief Executive Officer

Mr Xavier O'Halloran, Policy and Campaigns Adviser

Association of Superannuation Funds of Australia

Mr Glen McCrea, Chief Policy Officer

Mr Ken Whitton, Senior Policy Advisor

Australian Lawyers Alliance

Mr Josh Mennen, Spokesperson, Superannuation and Insurance

Private capacity

Mr Stephen Perera

ClearView Wealth Limited

Mr Simon Swanson, Managing Director

3 March 2017, Canberra

National Insurance Brokers Association of Australia

Mr Dallas Booth, Chief Executive Officer

BT Financial Group

Mr Brad Cooper, Chief Executive Officer

Ms Sue Houghton, General Manager, Insurance

Private capacity

Mr Hugh Crawford

MLC Life Insurance

Mr David Hackett, Chief Executive Officer

Mrs Suzanne Smith, Chief Customer Officer, Group Insurance

Mrs Natalie Eckersall, General Manager, Claims

Australia and New Zealand Banking Group Ltd

Ms Alexis George, Group Executive, Wealth Australia

Mr Gavin Pearce, Managing Director, Insurance, Wealth Australia

Financial Services Council

Ms Sally Loane, Chief Executive Officer

Mr Allan Hansell, Director of Policy and Global Markets

Mrs Bianca Richardson, Senior Policy Manager

AIA Australia Ltd

Mr Damien Mu, Chief Executive Officer

Ms Stephanie Phillips, Chief Group Insurance Officer

Commonwealth Bank

Ms Annabel Spring, Group Executive, Wealth Management

Ms Helen Troup, Managing Director, CommInsure

26 May 2017, Canberra

Zurich Financial Services Australia Ltd

Mr Philip Anderson, Chief Operating Officer, Life and Investments

Mr Tim Bailey, Chief Executive Officer, Life and Investments

Greenstone Pty Ltd

Mr Richard Enthoven, Executive Chairman

Mr Brenard Grobler, Chief Operating Officer

National Australia Bank

Mr Andrew Hagger, Chief Customer Officer, Consumer Banking and Wealth Management

Mr Greg Miller, Executive General Manager, Wealth Advice

Australian Genetic Non-Discrimination Working Group

Professor Margaret Otlowski, Law Dean, University of Tasmania; and Chair

Dr Paul Lacaze, Head, Public Health Genomics, Department of Epidemiology and Preventative Medicine, School of Public Health and Preventative Medicine, Monash University; and Founding Member

Ms Jane Tiller, Legal and Social Adviser, Public Health Genomics, Department of Epidemiology and Preventative Medicine, School of Public Health and Preventative Medicine, Monash University; and Member

The Ethics Centre

Dr Simon Longstaff AO, Executive Director

MedHealth Pty Ltd

Mr Timothy Morphy, Chief Executive Officer and Director

18 August 2017, Canberra

AMP Ltd

Mr Craig Meller, Chief Executive Officer

Ms Megan Beer, Group Executive, Insurance

Productivity Commission

Ms Karen Chester, Deputy Chair

TAL

Mr Brett Clark, Chief Executive Officer and Managing Director

Ms Anne Clarke, Chief Risk Officer and Chief General Counsel

Dr Sally Phillips, General Manager, Health, Commercial and Operations

Private capacity

Mr William Crawford

Allianz Australia Insurance

Ms Nadine Whitaker, Head of Life Insurance

Mr Nicholas Scofield, General Manager, Corporate Affairs

8 September 2017, Canberra

Treasury

Mr Ian Beckett, Principal Adviser, Retirement Income Policy Division

Mr James Kelly, Principal Adviser, Financial System Division

Medical Board of Australia

Associate Professor Stephen Bradshaw, Practitioner Member

Australian Securities and Investments Commission

Mr Peter Kell, Deputy Chairman

Mr Michael Saadat, Senior Executive Leader, Deposit Takers, Credit and Insurers; Regional Commissioner, New South Wales

Ms Louise Macaulay, Senior Executive Leader, Financial Advisers

Ms Emma Curtis, Group Senior Manager, Deposit Takers, Credit and Insurers

Mr Gerard Fitzpatrick, Senior Executive Leader, Investment Managers and Superannuation

Australian Health Practitioner Regulation Agency

Mr Matthew Hardy, National Director, Notifications

The Royal Australian College of General Practitioners

Dr Edwin Kruys, Vice President and Chair, RACGP Queensland

Australian Medical Association

Ms Anne Trimmer, Secretary General

Dr Kate Stockhausen, Manager, Ethics

Commonwealth Bank

Ms Annabel Spring, Group Executive, Wealth Management

Ms Helen Troup, Managing Director, CommInsure

Ms Jo Brennan, General Manager, Life Customer Solutions

Mr Craig Harrison, General Manager, Life Product and Distribution

1 December 2017, Canberra

SANE Australia

Dr Michelle Blanchard, General Manager, Research, Policy and Programs

Mental Health Carers Australia

Ms Jenny Branton, Executive Officer

National Mental Health Commission

Mrs Lucinda Brogden, Co-Chair

Cbus

Ms Robbie Campo, Group Executive Officer, Brand, Advocacy, Marketing and Product

Mr Noel Lacey, Head, Insurance, Complaints and Compliance Line

Association of Superannuation Funds of Australia

Dr Martin Fahy, Chief Executive Officer

Mr Glen McCrea, Chief Policy Officer

Mr Ken Whitton, Senior Policy Advisor

Mental Health Australia

Mr Joshua Fear, Director, Policy and Projects

Financial Services Council

Ms Sally Loane, Chief Executive Officer

Mr Allan Hansell, Director of Policy and Global Markets

Mr Nick Kirwan, Policy Manager

Mr Jesse Krncevic, Senior Policy Manager

Royal Australian College of General Practitioners

Dr Bastian Seidel, President

Australian Genetic Non-Discrimination Working Group

Ms Jane Tiller, Member