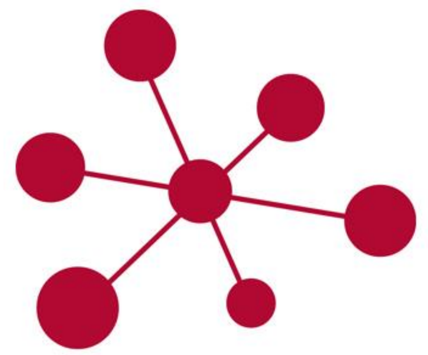

Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry

Submission in response to policy questions arising from Module 6

25 October 2018

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About the Public Interest Advocacy Centre

The Public Interest Advocacy Centre (**PIAC**) is an independent, non-profit legal centre based in Sydney. Established in 1982, PIAC works for a fair, just and democratic society, tackling issues that have a significant impact upon disadvantaged and marginalised people. We ensure basic rights are enjoyed across the community through legal assistance and strategic litigation, public policy development, communication and training.

Our work addresses issues such as:

- homelessness (through the Homeless Persons' Legal Service);
- access for people with disability to basic services like public transport, education and online services;
- indigenous disadvantage (through our Indigenous Justice Project and Indigenous Child Protection Project);
- discrimination against people with mental health conditions;
- access to energy and water for low-income and vulnerable consumers (the Energy and Water Consumers Advocacy Program);
- the exercise of police power;
- the rights of people in detention, including the right to proper medical care (including the Asylum Seeker Health Rights Project); and
- government accountability, including freedom of information.

PIAC's work on mental health and insurance

In 2012, Mental Health Australia and *beyondblue* approached PIAC concerned by levels of unfair and discriminatory practices in the insurance industry around mental health, in particular, with regard to the provision of general (particularly, travel) and life insurance products including income protection and total and permanent disability insurance.

Since then, PIAC has provided advice and legal representation to individuals across the country who believe general or life insurance providers have discriminated against them.

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

The current regulatory regime does not adequately protect consumers from unlawful disability discrimination under the *Disability Discrimination Act 1992* (Cth) (**DDA**) and state based anti-discrimination laws.

PIAC's Submission to the Royal Commission dated 26 April 2016 (**PIAC's Submission**) explains how life insurers unreasonably deny cover and apply broad, blanket mental health exclusions that are not supported by evidence and do not reflect the risk posed by the applicant to the insurer.

As set out in that submission, current methods of redress for individuals against insurers are ineffective. This is because of:

- deficiencies with the internal review process, which generally results in the insurer affirming its original decision. The Commission received evidence about inadequate internal review processes in Module 6. Following the internal review process, the individual has no choice but to pursue a formal complaint or claim to an external body;

- the individual is often denied access to some or all of the material relied on by the insurer, thereby making it extremely difficult for the individual to address the insurer's concerns; and

- some of the material relied on by insurers to demonstrate that an applicant for insurance poses too high a risk, for example, medical journal articles, requires expert analysis by lawyers, actuaries and medical experts in the field of psychiatry. Notably, in our experience, the data relied on by insurers is sometimes out-dated and/or irrelevant and/or has been misinterpreted by the insurer.

In addition, consumers find it difficult to obtain written reasons and the insurer refuses to provide actuarial or statistical data in support of its decision.

The result is that the only way a person can test whether an insurer has satisfied the insurance exemption in the DDA is for an individual to pursue a legal complaint at a court or tribunal, an arduous, time consuming and expensive process, due to the complexity of the issues in dispute and the need for legal representation and expert evidence. Due to the risk of an adverse costs order, many strong claims settle on terms that may be favourable to the claimant but are far less than they ought to be under the law. Most often respondent insurers insist that any such settlement be confidential. The result is that the impetus for making any long-lasting change to current practice is lost and no legal precedent is made.

In Module 6's second TAL case study, TAL gave evidence that it would not have offered the second insured a policy on any terms. As set out in our *Submissions on findings concerning the case study of the second insured and TAL* dated 28 September 2018, PIAC and the second insured dispute this and argue that such a decision would very likely breach the requirements of State and Federal anti-discrimination legislation. TAL is required to prove that its decision not to offer an insurance policy at all is based on actuarial and statistical data on which it is reasonable to rely, and that its decision is reasonable based on other relevant factors. On the basis of the information currently available, it is highly questionable that TAL would have satisfied the requirements under anti-discrimination legislation. However, the second insured accepted an

offer to settle her claim because the alternative was to engage in a long, difficult and expensive process to challenge TAL's decision, all while attempting to recover from cervical cancer.

What should be changed to minimise consumer detriment?
We refer the Commission to paragraphs 87-103 of PIAC's Submission which details proposals for reform which particularly relate to mental health, but have implications beyond mental health. These include:

- Increasing transparency and accountability to applicants for insurance who have been denied cover or offered cover on non-standard terms due to a mental health condition;
- Defining 'other relevant factors' in disability discrimination legislation;
- Reversing the amendments made to section 29 of the *Insurance Contracts Act 1984* (Cth) (**Insurance Contracts Act**)*;*
- Amending the Insurance Contracts Act to require clear disclosure of policy exclusions;
- Increasing transparency and accountability to the community by requiring insurers to report annually to the Australian Human Rights Commission (**AHRC**);
- Giving power to the AHRC to investigate and enforce;
- Ensuring greater clarity in the application process by improving questions in health questionnaires; and
- Improving Industry Codes of Practice and accountability and oversight in the industry. Codes should 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.

PIAC supports:

- Recommendation 10.2 of the Parliamentary Joint Committee on Corporations and Financial Services (27 March 2018) which recommends that both the Insurance Contracts Act and the DDA be amended so that an insurer must provide a person with written reasons when an application for insurance has been rejected or an insurance claim denied, 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 and that the statistical and actuarial evidence and other material relied on by the insurer be available on request;

- Recommendation 10.7 of the Parliamentary Joint Committee on Corporations and Financial Services which recommends that after consultation with relevant medical professionals independent of the life insurance industry and mental health advocacy groups, the FSC 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. Such engagement must be genuine and meaningful.

PIAC also supports Recommendation 3.1 of the Parliamentary Joint Committee on Corporations and Financial Services, which recommends that:

(a) consumer protections for financial and non-financial services are aligned to remove current inconsistencies; and

(b) 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.

In this respect, we refer to the submissions of the Consumer Action Law Centre and Australian Lawyers Alliance.

A. PRODUCT DESIGN

2. Are there particular products – like accidental death and accidental injury products– which should not be sold?

Insurance products that apply blanket mental health exclusion clauses are likely to be in breach of anti-discrimination laws and should not be sold.

As noted at paragraphs 48-58 of PIAC's Submission, some life insurers are unreasonably denying cover and applying broad, blanket mental health exclusion clauses that are not supported by evidence, and do not reflect the risk posed by an individual applicant for insurance. In many instances insurers fail to adequately disclose the existence and breadth of a mental health exclusion clause, and when a person seeks to make a claim relating to mental health in relation under a policy with a blanket mental health exclusion, the methods of redress for individuals against insurers are ineffective (see paragraphs 59-69 of PIAC's Submission).

Since the decision of *Ingram v QBE Insurance (Australia) Ltd (Human Rights)* [2015] VCAT 193 and Financial Ombudsman Service (**FOS**) Case No 428120, where the relevant travel insurers

were unable to provide actuarial data specific to the risk proposed by the applicant for insurance, many travel insurers have revised their policies, and removed blanket mental health exclusion clauses. However blanket mental health exclusion clauses remain in the policies of many life and travel insurance providers[1].

Life insurers continue to sell policies with blanket mental health exclusion clauses, despite their effect being contrary to anti-discrimination legislation, because:

- these policies are not otherwise prohibited by enforceable industry codes of conduct; and
- in the absence of such compliance mechanism, challenging the legality of a blanket mental health exclusion requires an individual to pursue a legal complaint at a court or tribunal (which, as noted in our response to Question 1 above, is an arduous, time consuming and expensive process).

B. DISCLOSURE

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

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

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

No. The current disclosure regime is not adequately serving the interests of consumers.

The Commission has heard that the terms offered by life insurance contracts can be long, complex, extremely difficult for the average consumer to understand and ineffective in empowering consumers to make informed choices at the point of sale.

Consumers purchase policies to provide financial protection for themselves and their families in the event the consumer experiences serious injury or death. The product disclosure regime is intended to ensure that consumers are purchasing products that meet their identified needs. Unclear or confusing contract terms therefore have potentially serious consequences for the very individuals that those policies are marketed to protect.

There is clear agreement from industry that the current regime is ineffective. The Commission heard from IAG that the process as to how to best convey to consumers the key terms and exclusions of policies is “an ongoing process. I don’t think we have reached the ideal model yet”

[1] PIAC has published a list of insurers that impose mental health exclusion clauses on their policies: https://www.piac.asn.au/examples-of-insurance-policies-with-blanket-mental-health-exclusions/

but part of the solution lies in “a combination of plain and simple language product disclosure statements as well as appropriate follow up.”[2]

The Commission also heard from the Insurance Council of Australia (**ICA**) that the current disclosure regime, comprised of product disclosure statements, financial services guides and key facts sheets, is failing consumers.[3] The ICA acknowledged that “…principal concerns that the industry has to grapple with is the failure of the customer being able to understand the products that they’re buying and the features and benefits of those products…”[4]

It would be of benefit to consumers if Division 4 of Part IV of the Insurance Contracts Act is extended to apply to life insurance policies. However, facts sheets have limitations and are not the only solution.

Insurers should be required to advise at the time of offering the policy, clearly and in plain English:

a. all exclusions that apply to the policy;

b. all limitations of the policy;

c. any non-standard terms on the policy, including exclusions and premiums, the effect of those non-standard terms, how long those non-standard terms will apply, the process for removing those non-standard terms and the criteria that would be needed to be satisfied to remove those non-standard terms;

d. definitions of key terms and concepts. For example, if a threshold to obtaining a TPD payment is that the claimant is “incapable” of obtaining work, this should be clearly defined and explained upfront, with practical examples.

Life insurers should also be encouraged to provide information to consumers through a range of methods and mediums, so that consumers can select a method of receiving that information that best suits them and their needs. These should be tested on consumers and constantly reviewed to ensure language is simple, clear and understandable.

Life insurers should be required to provide examples of the types of claims that will and will not be covered under its policies. These examples should be set out in short, simple case studies that are intended to be illustrative of the application of the policy terms in practice.

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

No. The standard cover regime in Division 1 of Part V of the Insurance Contracts Act does not currently apply to contracts of life insurance.

[2] T6143.38-44

[3] T6418.42-45

[4] T6419.7-9

The purpose of the standard cover regime is to ensure that the insurer brings any exclusions and other limitations of the policy to an applicant's attention before they enter into the contract of insurance. It would be of benefit to consumers if Division 1 of Part V of the Insurance Contracts Act is extended to apply to life insurance policies.

However, notably, many insurers already advise an applicant for insurance, in writing, that an exclusion has been applied to a policy and to set out the terms of the exclusion. The issue is that the terms of the exclusion are often confusing and unclear and the effect of the exclusion is generally not explained. It is PIAC's experience that a high proportion of consumers either do not know that an exclusion has been placed on their policy or misunderstand the scope of its operation.

6. Is there scope for insurers to make greater use of standardised definitions of key terms on insurance contracts?

Yes. There is scope for insurers to make greater use of standardised definitions of key terms on insurance contracts. As CHOICE has told the Commission, non-standard definitions are one of the contributors to a lack of understanding on the part of consumers about what they are covered for. The Commission also received evidence in relation to non-standard definitions in CommInsure and Freedom policies and the confusing at best and seriously averse at worst impacts on consumers.

Using mental health as a specific example, terms that are commonly included in life insurance application forms but not defined include the terms "episodes" (how many episodes have you had of the mental health condition?) and "stress" (have you had symptoms of, been diagnosed with or received medical treatment for stress?). The failure to define these terms means consumers are left to interpret these questions alone.

"Stress" in particular has the potential to surprise a significant number of consumers who have, most likely, disclosed at some point in their lives, periods of stress to their GP in the course of standard appointments. Those consumers are at an extremely high risk of an insurer treating those attendances at their GP as evidence of "episodes" of "stress".

Questions around stress are generally included as part of the mental health question in the application process (that is, alongside other mental health conditions such as depression, anxiety, bipolar, schizophrenia etc) and so most consumers assume a greater threshold when answering the question and assume that day to day stress is not intended to be caught. Indeed, the American Psychiatric Association of Diagnostic and Statistical Manual of Mental Health Disorders (known as the DSM), does not contain a stand-alone definition of a mental health condition called "stress" in its chapter on Trauma and Stressor Related Disorders.

It is hardly surprising then, that in applying for insurance consumers generally answer they have not experienced stress, only to be caught out later when the insurer identifies something of passing relevance in their medical records. Conversely, a consumer might disclose the everyday stress that we all experience out of an abundance of caution, only to be offered a policy with a blanket mental health exclusion.

Often blanket mental health exclusions are so disproportionate to the disclosures made by the consumer during the application process, that the consumer applies their own understanding of the operation and effect of the mental health exclusion, based on/limited to their personal history (thereby misunderstanding the broad scope of its operation).

The Commission received evidence in Module 6 about outdated definitions (the CommInsure case study) which further shows the need for standardised definitions, and regular review and updates of definitions to align with current medical knowledge.

PIAC supports Recommendation 10.3 of the Parliamentary Joint Committee on Corporations and Financial Services into the Life Insurance Industry that life insurers must regularly update all definitions in policies to align with current medical knowledge and research, standardise definitions, use clear and simple language in definitions and clearly explain which associated conditions that may arise from the initial condition, including mental illness, are covered by the insurance policy.

E. CLAIMS HANDLING

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

Yes. As set out in PIAC's Submission, we are of the view that the industry Codes of Practice administered by the ICA and the Financial Services Council (**FSC**) should be approved by ASIC in accordance with ASIC Regulatory Guide 183 'Approval of Financial Services Sector Codes of Conduct'.

There is currently no specified process for the approval of industry Code of Practices applying to the insurance industry and the current codes do not adequately protect consumers. ASIC Regulatory Guide 183 provides a more stringent and uniform process for code development and approval, requiring codes to meet certain threshold and statutory criteria to meet approval. Importantly these criteria include ensuring codes are drafted in plain language, that a genuine consultative process was undertaken for code development and incudes amongst over things, are requirement that there be effective and independent code administration, that a code is enforceable against subscribes, that compliance is monitored and enforced and appropriate remedies and sanctions exist for breach of a code.

PIAC supports Recommendation 4.2 of the Parliamentary Joint Committee on Corporations and Financial Services into the Life Insurance Industry 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 the life insurance sector. We also support Recommendation 4.3 of the Parliamentary Joint Committee Report, 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.

PIAC also supports Recommendations 18–22 of the ASIC Enforcement Review Taskforce Report of December 2017 concerning industry codes in the financial sector.

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

Yes. There are clear and persuasive public interest reasons to limit insurers' ability to avoid policies for non-disclosure of an unrelated condition to cases of fraud.

Currently, insurers may avoid a policy for non-disclosure or misrepresentation where the insurer would not have offered a policy on the exact same terms. When asserting that they would not have offered a policy on the same terms, insurers rely on their internal underwriting guidelines. The underwriting guidelines are a commercial product developed by the insurer or its reinsurer/underwriter and are rarely provided to a consumer on request, even where a consumer has formally engaged in alternative dispute resolution. The test is therefore a test developed and controlled by insurers with very little by way of external accountability. As stated above, the only way for a consumer to obtain an objective analysis of the insurer's position (and whether it complies with anti-discrimination legislation) is to engage in expensive litigation.

Prior to 2014 amendments to the Insurance Contracts Act, an insurer could only avoid a policy if it would not have offered a policy (that is, a policy on any terms). The pre-2014 provision generally operated to ensure that an insurer could not avoid a policy for non-disclosure of a matter unrelated to a claim (though other options remained open to it, including to vary the policy so that cover was no longer provided in respect of the matter that was the subject of the purported non-disclosure or misrepresentation).

The current regime has a disproportionate impact in favour of insurers and the result is deeply unfair for consumers. This was one of the issues explored in the second TAL case study. In its evidence, TAL stated that it now places further scrutiny on decisions to avoid policies for non-disclosure of an unrelated condition by having additional sign-off procedures to ensure that policies are only avoided in fraudulent cases and not where there has been innocent non-disclosure.[5] In the case of the insured in the second TAL case study, TAL's decision to avoid her policy had a significant impact on her both personally and financially.

The loss of the benefit of an insurance policy, particularly after a consumer has become unwell, has significant financial consequences, not just in terms of the lost benefit under the policy but also as a result of the loss of the benefit of the policy altogether, for a significant period of the insured's life. As a result of the illness for which the insured is making a claim on the policy, it is highly unlikely that they will obtain cover for that illness from another insurer.

PIAC supports Recommendation 10.6 of the Parliamentary Joint Committee on Corporations and Financial Services into the Life Insurance Industry that, where insurers deny claims or avoiding policies on the basis of a pre-existing condition, a direct medical connection between the prognosis of a pre-existing 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 plain language, be provided to the consumer on request.

Notably, while section 31 of the Insurance Contracts Act allows a Court to disregard avoidance where it would be hard or unfair to allow the avoidance, this only applies to avoidance for

[5] T5768.11-T5768.9

fraudulent non-disclosure or misrepresentation. Taking the second TAL case study as an example, the second insured had no remedy available to her under section 31. Presumably section 31 operates in this way because, unlike non-fraudulent non-disclosure or misrepresentation in which a three-year time limit to avoid the policy is imposed on insurers, no such time limit exists for insurers to avoid a policy for fraudulent non-disclosure or misrepresentation. However, the resulting gap in the law and remedies available under the Insurance Contracts Act to an insured whose policy has been avoided for innocent non-disclosure or misrepresentation is a stark oversight.

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

Yes. Life insurers who seek out medical information for claims handling purposes should be required to limit that information to information that is relevant to the claimed condition.

In addition, insurers should only be permitted to obtain records dating back a reasonable period of time, for example, five years prior to policy inception and not medical records dating back to the insured's childhood.

Although insurers should be entitled to seek records relevant to their assessment of a claim, insurers are using claim time as an opportunity to call for every document and report from the insured's medical practitioners, seeking to identifying a purported non-disclosure that might entitle it to avoid the policy. This exercise is clearly not in good faith and cannot be permitted to continue.

In the case of mental health, the risks of avoidance are even higher for a consumer. Insurers are increasingly relying on what they say are symptoms of mental health conditions revealed by medical records and not disclosed during the application process to avoid policies. Such purported symptoms can include lethargy, stress, feeling down or sad. It is possible, even likely, that insurers could re-create undisclosed mental health histories for almost every person who holds a life insurance policy. As the community's understanding of these practices grow, a consequence is an increasing reluctance to manage one's mental health (as opposed to one's mental health condition).

Accordingly, there should be parameters on the use that insurers place on the records. An insurer should not be permitted to reconstruct a history of a particular illness based on medical records. If the insurer is concerned that there may have been a non-disclosure or misrepresentation, the insurer should obtain, at its expense, a report from the insured's treating medical professional. In the case of the second TAL case study, TAL clearly attempted to impute that the insured had failed to disclose a mental health condition as well as symptoms leading to the insured's diagnosis with cervical cancer. The individuals who made these imputations were employees of TAL who were motivated by a desire to avoid the policy. An objective standard must be required of all insurers and that objective standard must place significant weight on the opinion of the treating medical practitioner and not the opinion formed by an unqualified medical assessor.

21. Should life insurers be prevented from engaging in surveillance of an insured who has a diagnosed mental health condition or who is making a claim based on a mental health condition? If not, are the current regulatory requirements sufficient to ensure that

surveillance is only used appropriately and in circumstances where the surveillance will not cause harm to the insured? If the current regulatory requirements are not sufficient, what should be changed?

Life insurers should be prevented from engaging in surveillance of an insured who has been diagnosed with a mental health condition or who is making a claim based on a mental health condition.

The Commission heard damning evidence in relation to TAL's use of surveillance techniques on an insured with a mental health condition and the serious personal consequences experienced by the insured, including an exacerbation of her mental health condition.

A consumer's mental health cannot be known by surveillance. The only relevant factor is the opinion of the consumer's treating medical practitioner.

If ASIC's powers are extended in relation to claims handling, this will assist in ensuring there is appropriate regulatory overnight of the use of surveillance. Industry codes of conduct should also be amended to specifically address mental health insurance claims, as per Recommendation 10.7 of the Parliamentary Joint Committee on Corporations and Financial Services into the Life Insurance Industry.

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

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

As stated above, PIAC supports the extension of unfair contract terms protections to insurance contracts.

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

Yes. An insurer's duty of good faith to an insured continues after commencement of the policy. The language of section 13 of the Insurance Contracts Act is intentionally broad so as to require the duty "in respect of any matter arising under or in relation to it". An insurer should not be permitted to act contrary to its duty of good faith simply because an insured has lodged a dispute with the external dispute resolution body. Indeed, the common law duty has been held in Australia to continue even after litigation commences.[6] The existence of the duty, however, is of limited utility if the remedies available for breach of the duty are insufficient.

There is no reason why the duty of utmost good faith should not apply to the way an insurer interacts with an external dispute resolution body in relation to a dispute arising under a contract of insurance. As the Commission itself observed during the hearings, external dispute resolution

[6] *Horbelt v SGIC* (unreported, Supreme Court of South Australia, 26 June 1992).

schemes like FOS are an important mechanism for redress for consumers in their dealings with insurance companies. When insurance companies fail to be open, transparent, and responsive in their dealings with FOS, it undermines the effectiveness of external dispute resolution mechanisms as an effective mechanism for redress.[7]

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

Yes, as stated in answer to question 19 above, the amendments to section 29 of the Insurance Contracts Act have resulted in an avoidance regime that is unfairly weighted in favour of insurers.

Applying to contracts for life insurance entered into, and in some cases varied, from 28 June 2014, section 29 of the Insurance Contracts Act was amended to expand the remedies available to insurers where an insured has not complied with their duty of disclosure.[9] The purpose of the amendments was largely to introduce more flexible remedies for insurers to better cater for the strong market emergence of non-traditional life insurance (i.e., products that do not have a surrender value and do not provide cover on death – in other words, products such as income protection insurance, total and permanent disability insurance).[8]

Prior to the amendments, consumers had greater protection from cancellation based on innocent non-disclosures because to cancel a policy an insurer would have needed to show that it would not have been prepared to enter into *a* contract of life insurance on *any terms* if the duty of disclosure had been complied with.[9]

As a result of the amendments, an insurer can cancel a policy if it can show it would not have been prepared to enter into the same contract of life insurance. Insurers continue to be able to vary a contract of insurance *at any time*, whether the non-disclosure is fraudulent or non-fraudulent, to adjust the sum insured using a statutory formula for proportionality[10],or to vary the terms of the contract to place the insurer in the position they would have been in if the duty of disclosure had been complied with. [11] The discretion as to whether to vary or to cancel a contract of insurance rests solely with insurers.

Consumers are being disadvantaged by the reforms to the remedies available to insurers under section 29 of the Insurance Contracts Act. As stated above, the second TAL case study is a prime example. The insured was accused by TAL of failing to comply with her duty of disclosure. The purported non-disclosures related to the insured's mental health history. The question of the insured's compliance with her duty of disclosure arose as a result of TAL's consideration of the

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[7] T6476.12-16

[8] The reasons for the amendments to the remedies available to insurers are discussed in the Explanatory Memorandum, Insurance Contract Amendment Bill 2013 (Cth) at [1.113] – [1.119] and [2.117] – [2.122]. The Explanatory Memorandum notes that many of the amendments adopt the recommendations made by the Review Panel commissioned by the Australian Government in 2003 to review the Insurance Contracts Act.

[9] Insurance Contracts Act s 29(3) as then applicable.

[10] Insurance Contracts Act s 29(4).

[11] Insurance Contracts Acts 29(6).

insured's claim for income protection benefits following her disclosure with cervical cancer. The insured's mental health history and diagnosis with cervical cancer were completely unrelated.

Under the pre-June 2014 regime, TAL would not have been able to avoid the insured's policy (though other remedies were still available to it). However, under the post June 2014 regime, TAL was able to cancel the policy entirely. In evidence, TAL stated that it no longer cancels policies as a result of non-disclosure of an issue unrelated to the insured's claim. The regime under section 29 should not permit avoidance of policies in such broad circumstances.

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

As noted above, applicants for insurance are faced with long application forms which ask broad, unclear and open-ended questions about the applicant's health history. If applicants misinterpret a question because it is vague or unclear, this gives rise to the risk that an applicant could be accused of failing to comply with their duty of disclosure or of making a misrepresentation.

The duty of disclosure in section 21 of the Insurance Contracts Act may be better served by a duty to take reasonable care not to make a misrepresentation, in that it puts the onus on the insurer to ensure it is seeking all relevant material clearly and ensures that an insurer considers the seriousness of the misrepresentation. However, PIAC also understands there are many similarities between current application of the Australian and UK duties and therefore any change to the duty alone is insufficient to address the issues relating to disclosure revealed in Module 6.

H. REGULATION

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

Yes. Compliance with either the Life Insurance Code of Practice or the General Insurance Code of Practice should be a requirement of obtaining an Australian financial services licence.

The current framework of the Life Insurance Code focuses on types of businesses, rather than ensuring consistent regulation for type of product, and ineffectually does not place obligations on financial advisers or planners, or superannuation trustees, unless they voluntarily adopt the code.

PIAC supports the intention of the FSC to extend the Life Insurance Code to cover life insurance products held within a superannuation fund from July 2019[12]. Unless the Life Insurance Code binds superannuation trustees which provide life insurance cover, the high number of Australians who hold their life insurance within their super funds will not benefit from the code.

[12] https://www.fsc.org.au/_entity/annotation/4280d85e-3091-e811-8162-70106fa11a21

Currently the Life Insurance Code does not apply to entities that distribute insurance policies on behalf of life insurers[13]. PIAC supports the intention of the FSC to bind distributors of life insurance to the Code. The Life Insurance Code cannot sufficiently deal with systemic problems relating to selling practices and quality of advice without binding all entities that sell or advise on insurance products.

Reinsurers that are members of the FSC are bound by the Life Insurance Code, but only to the extent they are required to comply with the overarching principles of the Code, as set out in clauses 1.5 and 1.6 of the code. Clause 2.7 of the Life Insurance Code states reinsurers must also assist insurers to meet their commitments under the Code. Reinsurers play a key role in the design and pricing of life insurance policies in the Australian market, particularly with respect to the development of underwriting guidelines, and as such, should be bound by the Life Insurance Code. Similarly, the General Insurance Code of Practice should apply to reinsurers.

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

34.1. a failure to comply with financial services laws (for the purpose of section 912A of the *Corporations Act 2001* (Cth));

34.2 a failure to comply with an Act (for example, the *Corporations Act 2001* (Cth) or the *Insurance Contracts Act 1984* (Cth))?

Yes. A breach of either the General Insurance Code of Practice or the Life Insurance Code of Practice should become a breach of law, and there should be legal consequences for breaching the code in addition to any mechanisms taken by administrators of the codes to enforce the codes. Requiring legal compliance is critical to ensure codes are effective, and insurers consider themselves bound by their provisions.

The ICA have deposed their view that the General Insurance Code of Practice has only achieved wide coverage as a consequence of being a voluntary code, and to make it subject to legislation would 'serious reduce the level of commitment to the code… by members.'[14] PIAC does not agree with this assessment, and says that evidence of non-compliance and lack of enforcement with respect to the Code shows the pitfalls of the existing voluntary regime.

I. COMPLIANCE AND BREACH REPORTING

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

No. The evidence provided by the ICA and FSC to the Royal Commission shows that there is insufficient external oversight of the adequacy of the compliance systems life and general insurance industries. Effective regulation is critical to creating a culture of compliance in the industry, and should play a key role in revealing and responding to systemic issues relating to compliance.

[13] T.6439.27-31.

[14] T6426.15-20

Despite thousands of breaches of the General Insurance Code of Practice since 2014, the Code Governance Committee has not imposed any sanctions on general insurers in response to those breaches.[15] The ICA has confirmed it is not part of the Code to ensure sanctions for breaches, and accepts that sanction can act as a deterrent of breach. Similarly the FSC has not imposed any sanctions on any subscribers of the code since it came into effect in late 2016.[16]

ASIC should oversee insurance industry codes of conduct

The ICA has deposed that it supports providing ASIC a greater role in the oversight of the General Insurance Code of Practice as a way of 'giving confidence to the marketplace and to customers that the key regulator of conduct in the industry has agreed that this code is an effective, useful consumer instrument and its prepared to accept that and approve it.[17]

PIAC does not agree with the FSC's assessment that it is not problematic that ASIC doesn't have the power to enforce breaches of any obligation to act efficiently, honestly and fairly in relation to claims handling'.[18]

As stated above, PIAC submits that the industry Codes of Practice administered by the Insurance Council of Australia the FSC should be binding and enforceable, and be approved by ASIC in accordance with ASIC Regulatory Guide 183 "Approval of Financial Services Sector Codes of Conduct. PIAC supports the ICA's recommendations that certain amendments be made to the next iteration of the General Code of Practice, including that:

- the Code to meet the requirements for ASIC approval of the Code[19];
- changes made to the Code should include clarifying that the code is enforceable through the oversight and sanction powers of the Code Governance Committee;
- that FOS (and in the future, AFCA) should take code breaches into account when determining disputes; and
- through enabling the Code Governance Committee to report systemic code breaches and serious misconduct to ASIC.

The ICA has deposed that it supports providing ASIC a greater role in the oversight of the General Insurance Code of Practice as a way of 'giving confidence to the marketplace and to customers that the key regulator of conduct in the industry has agreed that this code is an effective, useful consumer instrument and its prepared to accept that and approve it.[20]

PIAC does not agree with the FSC's assessment that it is not problematic that ASIC doesn't have the power to enforce breaches of any obligation to act efficiently, honestly and fairly in relation to claims handling'.[21]

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[15] T-6423.15-30

[16] T-6453.17-20

[17] T-6422.30-35

[18] T-6442.43

[19] T-6422.15-26

[20] T-6422.30-35

[21] T-6442.43

Insurers should be required to report annually to the AHRC

PIAC reiterates the position in our Submission (to the Royal Commission dated 26 April 2016) that to increase transparency and accountability, insurers should be required to report annually to the AHRC regarding discrimination.

It is difficult to hold the industry accountable when so many of its practices are hidden from public view. Insurance companies have known for over a decade that reform is needed in the area of mental health, however, that reform has largely not occurred because the industry lacks sufficient regulatory oversight and accountability to consumers.

At a minimum, insurance companies should be required to report annually to the AHRC on the number of times they have declined to provide insurance or offered insurance on non- standard terms on the ground of disability. This information should specify whether the insurer has relied on actuarial or statistical data in making their decision and the type of disability invoked by the insurance exemption. The AHRC should publish the information every year by each insurer on its website and/or in its annual report.

Each insurer should be required to report publicly (for example, in its annual report) the number of policies that it cancelled in the previous 12 months.

The AHRC should have the power to investigate and enforce matters relating to discrimination in the insurance industry

The AHRC has the power to inquire into, and attempt to conciliate, individual complaints of unlawful discrimination.[22] While this power allows people to seek redress on a case by case basis, its utility is limited in addressing systemic breaches of the DDA.

Part 9 of the *Equal Opportunity Act 2010* (VIC) empowers the Victorian Equal Opportunity and Human Rights Commission to conduct investigations into any matter relating to the operation of the Act if:

a. the matter:

i. raises an issue that is serious in nature;
ii. relates to a class or group of persons; and
iii. cannot reasonably be expected to be resolved by dispute resolution or by filing an application in the Victorian Civil and Administrative Tribunal; and
iv. there are reasonable grounds to suspect that one or more contraventions of the Act have occurred; and
v. the investigation would advance the objectives of the Act.

[22] Section 11(1)(aa) of the *Australian Human Rights Commission Act 1986* (Cth).

The AHRC should be provided with similar powers to conduct investigations into suspected breaches of the DDA. The power should be sufficiently broad to permit the AHRC to conduct an audit of an insurer's actuarial and statistical data where it seeks to rely on section 46 of the DDA.

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

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

Yes. As reflected in our answers to questions 34 and 36 above, insurance industry codes need to be more robust and should be considered a breach of the law. Further, there should be more effectual and timely consequences for insurers that breach the law or other regulatory obligations.

As set out in PIAC's Submission, and above, there are very few consequences for insurers that breach anti-discrimination laws. Industry codes of conduct should set out guidance about insurers' obligations under the DDA to ensure these obligations are obvious to both insurers and consumers. This guidance should be drawn from the AHRC Guidelines.