INSURANCE COUNCIL OF AUSTRALIA

28 February 2020

Ms Kate O'Rourke
Acting Division Head
Financial System Division
Department of Treasury
Langton Crescent
CANBERRA ACT 2600

By email: FSRCconsultations@treasury.gov.au

Dear Ms O'Rourke

FINANCIAL SERVICES ROYAL COMMISSION: ENHANCING CONSUMER PROTECTIONS AND STRENGTHENING REGULATORS: DRAFT LEGISLATION

The Insurance Council of Australia (Insurance Council)[1] appreciates the opportunity to provide comments on the general insurance related aspects of the exposure draft legislation implementing the recommendations of the Financial Services Royal Commission (FSRC). We also appreciate the opportunity to have participated in the Treasury roundtable of 11 February 2020 with other industry associations and consumer advocates to discuss the exposure draft legislation. We look forward to further productive discussions with Treasury and the Australian Securities and Investments Commission (ASIC) as the development of this legislation is finalised.

The Insurance Council's key points for each of the specific measures in the draft legislation are as follows. All our recommendations, with supporting arguments, are presented in greater detail in Attachments A to G.

No hawking of insurance: Recommendation 4.1

The Insurance Council fully supports the policy intent of Recommendation 4.1, to protect customers from pressure sales tactics, as evidenced by our endorsement of ASIC's product intervention in relation to unsolicited telephone sales of direct life insurance and consumer

[1] The Insurance Council of Australia is the representative body of the general insurance industry in Australia. Our members represent approximately 95 percent of total premium income written by private sector general insurers. Insurance Council members, both insurers and reinsurers, are a significant part of the financial services system. December 2019 Australian Prudential Regulation Authority statistics show that the general insurance industry generates gross written premium of $50.2 billion per annum and has total assets of $129.7 billion. The industry employs approximately 60,000 people and on average pays out about $152.3 million in claims each working day.

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

credit insurance.[2] However, many customers will be left worse off if the proposed ant-hawking legislation is implemented as drafted. The proposed legislation goes well beyond the objective of protection from high pressure selling and will largely remove the ability of insurers to engage proactively with their customers about products to optimise their level of protection.

Crucially, the combined effect of the Design and Distribution Obligations (DDO) and the strengthened hawking prohibition will be that insurers will be required to take measures to prevent customers at a portfolio level accessing insurance products where they are not, or are no longer, in the target market but will not have the ability to discuss and offer products that could be more suitable for them. This will result in an increase in gaps in insurance cover which cannot be in the interests of individual consumers or the Australian community overall.

We ask the Government to consider a more appropriate approach to implementing Recommendation 4.1. In our view, the policy intent behind this recommendation could be more effectively achieved by targeted legislation which bans unsolicited telephone calls and other pressures sales tactics with appropriate levels of civil and criminal penalties. We would be pleased to work with the Government and the consumer groups to develop these ideas further.

Furthermore, we submit that:

- The commencement date of the anti-hawking rule should align with that for the Deferred Sales Model (DSM) for add-on insurance where there is a 12 month transitional period. As the draft legislation imposes significant new obligations going well beyond the current requirements set out in ASIC Regulatory Guide 38, the industry will need a realistic transitional period to update its compliance systems and retrain staff.

  Before full commencement of the regime, the most urgent concerns in relation to pressure sales can be addressed by insurers ceasing unsolicited outbound telephone calls (cold calling) to prospective customers (that is, those with whom we have no current product-based relationship) as of 1 July 2020.

- The draft legislation should make it clear that the mere provision of information, including through advertising, is not prohibited by the draft legislation. It is crucial for insurers to be able to speak with their customers generally about the full suite of products. Our concern is that the current drafting could be interpreted to cover a much broader set of conversations than "offers" of insurance products as set out in the current legislation.

- The new anti-hawking provisions should not result in customers being unable to benefit from speaking with their insurers about bundled home and motor products. We consider that this can be best achieved by clarifying in the legislation that an offer of a motor product is "*reasonably within the scope of the request*" for an offer of a home product, and vice versa. This is in our view clearly justified since homes and motor vehicles are most Australian households' two most important financial assets;

[2] Insurance Council, "ASIC consultation paper 317: Unsolicited telephone sales of direct life insurance and consumer credit insurance", 27 August 2019, available at http://www.insurancecouncil.com.au/assets/submission.

INSURANCE COUNCIL OF AUSTRALIA

ensuring adequate and affordable insurance coverage for both assets is essential to their financial wellbeing.

Deferred sales model (DSM) for add on insurance: Recommendation 4.3

The Insurance Council is seriously concerned by the widespread consumer detriment likely to occur as a result of the draft legislation to implement FSRC Recommendation 4.3 regarding the introduction of a DSM for add-on insurance. The DSM as proposed would significantly reduce a customer's ability to choose insurance products which provide them the coverage that they need, when they need it. The proposed DSM would also require substantial changes to our members' compliance systems, resulting in a large spike in ongoing costs, which will likely be passed on to customers by way of increased premiums.

Given this, we respectfully submit that the Government reconsider closely the Insurance Council's suggestion in its submission of 2 October 2019 regarding a default "Tier 3" exemption for all add on general insurance products, after which ASIC could use its PIP to require products of proven risks of serious consumer detriment to be sold with the DSM model under "Tier 2".[3]

If the legislation is implemented in its current form, the Insurance Council foresees substantial disruption as industry cannot be confident that ASIC will be able to provide timely exemptions for all the products which meet the legislated criteria. Without this, insurers will either need to withdraw the product from sale thereby reducing consumer choice or provide for the imposition of a DSM in case an exemption is not forthcoming before commencement of the legislation.

It would be much preferable for the regulator and industry to identify as an urgent priority those insurance products which provide such unquestioned value that they should be exempted in the legislation from a DSM requirement, as will be the case with comprehensive motor vehicle insurance. We also submit that insurance which customers are required to purchase under legislation, such as compulsory third party motor insurance, should be carved out from the DSM, as well as insurance required under commonly used standard contracts.

Furthermore, the DSM should provide consumers with the flexibility to shorten or waive the deferral period, as set out in the Treasury proposals paper of 9 September 2019. This would be consistent with the approach taken in the United Kingdom. Recent ASIC research shows that there are "in control" customers who read information provided by financial institutions and want to be well informed; these are the engaged customers envisaged in the Treasury proposal paper who would object to a paternalistic view that they cannot make well informed decisions without the imposition of a rigid deferral period.

Claims handling as a financial service: Recommendation 4.8

For the reasons outlined in our submission of 13 January 2020 on the draft legislation released by Treasury for consultation,[4] the industry continues to strongly believe that the most appropriate policy approach is for fulfilment providers without the authority to decline

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[3] Insurance Council, "Reforms to the sale of add on insurance products: Treasury proposal paper", 2 October 2019, available at http://www.insurancecouncil.com.au/assets/submission.

[4] Insurance Council, "Claims handling as a financial service: exposure draft legislation", 13 January 2020, available at http://www.insurancecouncil.com.au/assets/submission.

claims to be excluded from the definition of “representatives” for the purposes of Section 910A.[5]

In addition, we remain concerned that the obligation to provide customers with a Statement of Claims Settlement Options (SCSO) will add significantly to the level of costs and complexity for insurers and claimants which conflicts with industry focus on resolving claims expeditiously.

In the case of a total loss scenario (for example a bushfire event) where the building and contents were destroyed, a Home Assessor currently will attend the site, complete an assessment and determine on the spot that the cost of replacing the contents items would match or exceed the contents sum insured. In most cases, the Assessor will then immediately advise the customer that they will be cash settled for the contents items up to the sum insured. The General Insurance Code of Practice obliges insurers to not require customers to provide an itemised list of contents as the loss is evident. The customer is cash settled via their nominated bank account.

In comparison, the process under the new legislation would likely be:

- The customer needs to supply a list of all the contents items to the Home Assessor who would then be required to quantify the value via for example a quote.
- An itemised list of the loss is required to be submitted by the insurer back to the customer within the SCSO.
- The customer is required to review the SCSO and formally accept.
- Once all previous steps have been completed, only then will a payment be provided to the customer.

To avoid this and strike a reasonable balance, we recommend that insurers are only required to provide a SCSO where the claim is a total loss of any value or the cash settlement amount is above a minimum specified dollar value. Insurance Council members would be pleased to participate in a Treasury co-ordinated consultation process to develop a suitable threshold.

Duty to take reasonable care not to make a misrepresentation to an insurer: Recommendation 4.5

The Insurance Council accepts the need for insurers to bear greater responsibility in informing the insured of the specific information which the insurer sees as relevant to them in taking on the risk. However, we submit that the Bill should be clarified to achieve the right balance. Section 20B should include an objective ‘reasonable person’ test and state that a misrepresentation made *dishonestly* is always taken as showing a lack of reasonable care.

We submit that Section 21B of the *Insurance Contracts Act 1984* (Cth) (IC Act) should be retained to facilitate a more efficient renewal process by not requiring the customer to answer questions again but only advise the insurer if their circumstances have changed. At the 11 February 2020 Treasury Roundtable, it was argued that, contrary to current practice, insurers needed to obtain information again from policyholders at renewal. However, independent consumer research commissioned by the Insurance Council in 2019 clearly shows that an

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[5] All legislative references are to the Corporations Act 2001 (Cth) unless stated otherwise.

overwhelming majority of customers would prefer to have their insurance policies renewed with pre-filled information from those existing policies, with the onus on the customer to inform the insurer if their circumstances change.

Breach reporting: Recommendations 1.6, 2.7, 2.8, 2.9 and 7.2

The Insurance Council agrees with the aim of the draft legislation to have breach reporting based on more objective criteria, as recommended by the ASIC Enforcement Review Taskforce. Making the criteria more objective will help to remove the uncertainty that licensees have had with the current more subjective criteria. However, there is a risk the legislation may have the opposite effect to that intended, by injecting more uncertainty and significantly increasing the compliance burden. This is of particular concern in light of the penalties for failing to report being very high, including 2 years imprisonment.

We submit that the factors which trigger a breach reporting requirement should be subject to a materiality threshold, such as the factors under proposed Section 912D(5) as to what constitutes significance or the types of investigations that should be reported under proposed Section 912D(1).

Enforceability of financial services industry codes: Recommendation 1.15

Attachment G recommends drafting refinements on the eligibility criteria for designating enforceable code provisions and makes some observations about the proposed framework.

Broader considerations

In addition to our submissions addressing specific issues in the draft legislation, we would also like to suggest a number of broader considerations which the Government could take into account in relation to the draft legislation.

Post implementation review

Consistent with best regulatory practice, we also ask that the Government undertake a post-implementation review of the regulatory impact of all general insurance related legislation stemming from the FSRC two years after the latest of the commencement date.

We have serious concerns about the limited time in which the industry has had to review and provide comments on such a large volume of draft legislation. We fully expect that as our members work through compliance with the new laws that significant issues will arise as to how they mesh together in practice. Given the potential for consumer outcomes to be compromised, we request that the Government commit to speedily making amendments to address these issues as they arise.

In light of the increased regulatory burden flowing from the proposed legislation, the post implementation review should access whether it has raised the barrier to market entry for smaller participants. Individual and small business customers stand to lose out the most from any reduction in competition.

Standard Cover Review

Once the FSRC recommendations have been implemented, the Government should make it a priority to progress the Disclosure in General Insurance policy reform agenda as outlined in the Government's consultation paper of December 2018. The general insurance industry recognises the importance of improving consumer understanding of insurance and for several years has worked to progress the initiatives in its Disclosure Action Plan

INSURANCE COUNCIL OF AUSTRALIA

(summarised in our March 2019 response to the Treasury paper). A Government commissioned review of the Standard Cover regime would provide an important first step in developing reforms which would improve consumer outcomes.

The Standard Cover regime provides the foundation on which insurance contracts are developed and is therefore inextricably linked to other key reforms such as Unfair Contract Term protections and the DDO. We submit therefore that getting the Standard Cover Regime “right” is equally as important to improving consumer outcomes as the recommendations on the FSRC Implementation Roadmap, and should be prioritised accordingly.

The Insurance Council has undertaken comprehensive testing of consumer preferences in relation to common coverage in insurance contracts. Commencing the review of the Standard Cover Regime would allow us to work with the Government, regulators and consumer groups to build on this research and facilitate informed improvements to disclosure in general insurance.

If you have any questions or comments in relation to our submission please contact John Anning, the Insurance Council's General Manager Policy, Regulation Directorate, on telephone: 02 9253 5121 or email: janning@insurancecouncil.com.au.

Yours sincerely

Robert Whelan
Executive Director & CEO

ATTACHMENT A

NO HAWKING OF INSURANCE: RECOMMENDATION 4.1

Recommendation	Supporting points
Recommendation 1: Commencement date aligned with deferred sales model for add on insurance The commencement date of the anti-hawking rule should align with that for the DSM for add-on insurance where there is a 12 month transitional period.	**Industry proposal to cease unsolicited outbound calls** Before full commencement of the regime, the most urgent concerns in relation to pressure sales can be addressed by insurers ceasing unsolicited outbound telephone calls (cold calling) to prospective customers as of 1 July 2020. This could conceivably be achieved by splitting the current Bill into 2 schedules. Schedule 1 could remove the existing telephone exemption effective from 1 July 2020. Schedule 2 would replace existing anti-hawking provisions with the new provisions in a year, streamlined with the commencement date for the Deferred Sales Model. **Compliance system changes** The industry will need a realistic transitional period to update its compliance systems and train staff. Small insurers in particular will simply not have the necessary resources to meet an earlier timeframe. We note that a staggered approach of a 1 July 2020 start date for anti-hawking and a 12 month delayed start date to the DSM could result in a doubling up of the required systems changes in relation to the unbundling of home and motor insurance. To provide an example of the changes required to implement the proposals, insurers would (at the very least) be required to undertake the following: • Re-train Sales and Service staff in Australian and (where applicable) overseas call centres, and staff of any third party distributors. For most insurers, there will be a large volume of staff to educate. • Depending on the outcome of the draft legislation and the clarity of the examples given in the Explanatory Memorandum, training efforts could be inhibited by not having acceptable conduct clearly delineated.

INSURANCE COUNCIL OF AUSTRALIA

Recommendation	Supporting points
	• Call centre and live chat scripting will need to be reviewed to remove any content which may be in breach of the prohibitions, and rewritten to ensure compliance with the new requirements. • Distribution model: negotiating amended third party distribution, referral and outsourcing contracts. • Algorithms/operating rules for any automated online tools such as chatbots will need to be updated. • Record keeping systems will need to be updated to ensure consumer requests and withdrawn requests are recorded, and to put controls in place to ensure that contact is not made after the proposed six-week period. • Privacy consents in privacy policies and/or privacy collection statements of insurers/their distributors will require a review to specify the period in which contact must not be made after a positive request has been made. • Marketing content will need to be reviewed to ensure any offer of the product does not require an immediate response (in real-time), and to review the operation of any consent boxes on promotions to enable positive requests to be made (if not already). • Monitoring and compliance: Designing and implementing controls to ensure new no hawking measures are operating effectively. • Where an insurer is prohibited from selling another product on a sales or service call relating to an additional but unrelated insurance product (i.e. out of "reasonable scope" of the primary insurance product sold on the call), notwithstanding that the customer has shown some interest in purchasing the additional product on the same call, the examples provided in the draft explanatory memorandum suggest this would not be considered a "positive" request. Insurers will need to build the systems to record the customer's

<table>
<tr><th>Recommendation</th><th>Supporting points</th></tr>
<tr><td></td><td>interest for use on the next call once a clear and informed "positive consent" is received to discuss that additional product. Our members submit that this would lead to the customer being inconvenienced to call back.</td></tr>
<tr><td>Recommendation 2: Home (building and contents) and motor products

The legislation should clarify that an offer of a motor product is "reasonably within the scope of the request" for an offer of a home product, and vice versa.</td><td>The anti-hawking rule should not result in existing customers no longer being able to benefit from speaking with their insurers about bundled home (building and contents) and motor products. This can in our view be best achieved by clarifying in the draft legislation that an offer of a motor product is "reasonably within the scope of the request" for an offer of a home product, and vice versa.

This is in our view clearly justified since homes and motor vehicles are most Australian households' two most important financial assets; ensuring adequate and affordable insurance coverage for both assets is essential to their financial wellbeing.

Alternatively, it could be clarified through by replacing Example 1.12 in the explanatory materials with other examples such as:
A home insurance customer who does not have not have motor insurance, discussion on adequate insurance for their motor vehicle:
Rochelle calls her insurer as she has moved and needs a new home insurance policy. During the call the agent asks if Rochelle has any other properties or cars that need cover as she may be eligible for multi policy discounts. Rochelle doesn't have any other homes to protect but she does have a car. The agent provides Rochelle a quote as she is an existing customer.</td></tr>
<tr><td>Recommendation 3: Distinction between banned unsolicited "offers" and permitted unsolicited "non-offer"</td><td>We understand from the Treasury roundtable of 11 February 2020 that the mere provision of information to customers is not intended to trigger the prohibition on hawking of financial products under the Proposed Section 992A. However, there is serious concern amongst our members that the ambit of the phrase "or request or</td></tr>
</table>

Recommendation	Supporting points
provision of information including advertising The legislation should clarify that the mere provision of information by an insurer without an offer to the customer is permitted.	*invite another person to ask or apply for"* in the Proposed Section 992A is unclear, and could be reasonably interpreted to capture a much broader set of conversations including advertising. Given this is a critical issue, in order to remove any doubt, we submit that the draft legislation should make it clear that Section 992A does not apply to the mere provision of information which does not contain an offer of an insurance product.
Recommendation 4: Breaking the nexus between and permitted unsolicited "non-offers" and subsequent offers The explanatory materials should clarify that the causal nexus between the unsolicited "non-offers" and the eventual subsequent offers can be broken where the customer makes a clear and informed request.	There should also be further illustration of when "significant time" would have lapsed from the initial unsolicited non-offer so that the subsequent offer can be made.
Recommendation 5: Clarification of what is reasonably within the scope of the original request The explanatory materials should clarify what would be regarded as an offering that was reasonably within the scope of the original request for the purposes of Proposed Section 992A(5)(a)(ii).	It would in our view be reasonably within the scope of the original request to discuss banking products to raise corresponding insurance products that offer coverage for associated risks, such as: • Landlord insurance with an investment property loan – lenders generally require customers to take out building cover before being able to take out a mortgage. • Car insurance with a personal loan – where the loan is taken out for the purpose of purchasing a car.

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<tr><th>Recommendation</th><th>Supporting points</th></tr>
<tr><td></td><td>Travel insurance with a traveller card or request for foreign currency for the purpose of use on a trip.
Home and motor insurance should also be considered related since home and motor vehicles are most Australian households' two most important financial assets.
Mortgage protection and landlord insurance for an investment property.</td></tr>
<tr><td>Recommendation 6: Clarification of treatment of mixed domestic/retail and business/wholesale circumstances

The explanatory materials should clarify the application to mixed domestic/retail and business/wholesale circumstances, where a single insurance policy may provide coverage for both aspects (for example farms and small businesses).</td><td>Some examples, assuming products are sold under a general advice model, are:

The customer asks about 'small business insurance' – this is a broad request so potentially all types of small business-related products are in scope as they relate to the same risk, the 'small business.

The customer asks about 'farm property insurance' – potentially both retail and wholesale property covers are within scope. Could related wholesale covers (such as crop) be offered to a customer that also meets the retail client definition?

The customer asks about 'agricultural liability insurance' for a large business – the customer is a wholesale client, however as part of the discussion the customer mentions a home on the property that is unrelated to the business. Can retail property cover be discussed?</td></tr>
<tr><td>Recommendation 7: Clarification of treatment of existing customers

The explanatory materials should clarify the treatment of existing customers.</td><td>The explanatory materials should clarify the treatment of a customer who has received a quote but does not follow through with the purchase. As part of the quote process, a customer may provide a privacy consent to be contacted from the insurer about products from time to time (with the ability to opt-out at any time). We submit that an outbound call to the customer at some time after the initial quote to discuss the full suite should be permitted.</td></tr>
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<tr><th>Recommendation</th><th>Supporting points</th></tr>
<tr><td></td><td>Other examples of conversations with existing customers which do not trigger the anti-hawking prohibition could include:
Amy calls her insurer to update her surname on her investment policy. During the call, the agent notices Amy doesn't have the tenant damage option selected. The agent mentions this to Amy as she may be underinsured. Amy thanks the agent, when she first bought the investment property her sister was living in the home, so Amy didn't think tenant damage was required. Her sister moved out six weeks ago and new tenants have moved in. Amy gets a quote to consider this option.</td></tr>
<tr><td>Recommendation 8: Non-telephone communication methods

The explanatory materials should clarify the treatment of non-telephone communication methods.</td><td>Emails
We continue to support the exclusion of emails from the anti-hawking rules given that they do not create an "expectation of immediate response from the other person". This is particularly given advances in filtering mechanisms in email applications and servers that allow users to effectively screen unwanted emails.

SMS texts
Telephone voice calls should in our view be distinguished from SMS texts which should not be treated as media that have an "expectation of immediate response from the other person" for the purposes of the Proposed Section 992A(4)(a)(iii). They should instead be treated more like messages sent on instant messaging applications such as WhatsApp or Facebook which like email clearly do not create expectations of an immediate response from the other person.

Webchats
Does the "request" for contact under Section 992A(4)(b)(i) also need to be a "positive" request, i.e. to mirror one or more of the requirements under Section 992A(5)? For example, it is unclear how webchat may continue to be serviced under the new anti-hawking provisions.</td></tr>
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Recommendation	Supporting points
	Webchat may be automatically initiated when a customer visits a product page (e.g. for a pro-longed period), or when a customer clicks into a webchat icon to initiate a session. It may be operated by a human sales officer or AI, and often uses "no advice" or general advice model. Webchat also proactively communicates information about products and services that are frequently asked by webchat users – which appear to fall foul of the new anti-hawking provisions: paragraph 1.41 of the explanatory materials, and Section 992A(4)(a)(iii). **Broader observations** At a broader level, we support the approach taken in the draft legislation to not apply the anti-hawking provisions to non-telephone communications such as emails given that they do not create what a reasonable person would consider to be an "expectation of an immediate response from the other person" for the purposes of the Proposed Section 992A(4)(a)(iii). We are not aware of any evidence that such non-telephone communications (to which can now be added social media advertisements) can lead to pressure sales of insurance products. This is consistent with the findings of the FSRC that the problem was unsolicited pressure sales over the telephone where customers were vulnerable to making purchases without adequately understanding what they were buying, or considering whether they needed the product in the first place. Our members have informed us that they currently email existing and prospective customers to promote products and provide a link where they can click through to obtain a quote. These methods of communication allow the potential insured to choose if, and when, they review information about insurance products. The recipient may then choose to proactively obtain a quote by following an on-line click through process.

Recommendation	Supporting points
	A potential insured can obtain information on coverage and pricing and, if desired, an insurance product, without engaging with any sales staff. This process is very different to pressure sales scenarios identified by the FSRC and, we believe, presents consumers with an opportunity to consider their insurance options at a time, and in a manner, which suits them. In this regard, we also note that unsolicited emails and texts without consent are already tightly controlled under Section 16 of the *Spam Act 2003 (Cth)*, as are unsolicited letters, faxes, brochures or other direct media advertising (press, radio, TV) without consent under the Privacy Act 1988.
Recommendation 9: Bundles of insurance and non-insurance products The explanatory materials should clarify that the anti-hawking rules do not apply to bundles of insurance and non-insurance products.	We submit that the anti-hawking rules cannot feasibly apply to the following scenario. • A consumer asks a pet store distributor about purchasing a pet wellness plan (a monthly or annual subscription-based service providing a range of preventive pet care services at a discount or free of charge) to help manage their pet care expenses. The pet store distributor provides them with information about the wellness plan. This also includes information about a 'bundled' product which comprises both the wellness plan plus an insurance product.
Recommendation 10: The 6 week contact period The legislation should provide greater flexibility in relation to the 6 week contact period under the Proposed Section 992A(5)(e).	As discussed at the 11 February 2020 roundtable, we believe that the requirement under the proposed Section 992A(5)(e) for a request to be made within 6 weeks is unreasonably inflexible, and there should be greater scope for the customer to override the requirement through an express request (for example, for the insurer to call back the customer in 6 months when the customer's financial circumstances change, or at renewal point in 8 months' time).

INSURANCE COUNCIL OF AUSTRALIA

Recommendation	Supporting points
	Consumer advocates' concerns about the scope for manipulation could be addressed through an express legislative provision giving ASIC the power to prohibit schemes that are intended to circumvent the anti-hawking provisions. It is unclear what the objective is of introducing a 6 week limit for following up consumer requests, nor is it apparent whether actual consumer experience or research has informed the design of this requirement. Asking consumers to tick a box to provide consent for future contact (e.g., on a website during the online application process) is a common practice of obtaining consumer consent. If the concern is that such practices may result in unwanted contact over time, we suggest a more direct policy solution would be to require product providers to cease contact if consumers ask to opt-out of future communication. We are concerned that arbitrarily setting a blanket time limit to apply to all products and consumers would result in poorer outcomes for some consumers. Consumer research conducted by the Insurance Council shows that, even for relatively simple products like home and motor insurance, there are numerous pathways to purchase and no single consumer is the same; some consumers would expend a considerable amount of time collecting information and analysing their needs, whilst others take a more condensed route to decision-making.
Recommendation 11: The form of contact as requested by the customer The legislation should provide a reasonableness test to the Section 992A(5)(d) requirement for contact to be made in the form specified by the customer.	Under proposed Section 992A(5)(d), if the customer specified the form of contact, the contact must be in that form. There should be a "reasonableness test" e.g. a requirement on the insurer to take such steps as are reasonable in the circumstances to contact the customer in that form. For example, where the customer provides insufficient or invalid contact details (such as a misspelt email address), can the insurer contact the customer by an alternative form, say, after three failed attempts via the specified form?) The insurer may then "reconfirm" the customer's consent at

INSURANCE COUNCIL OF AUSTRALIA

Recommendation	Supporting points
	the beginning of the contact, and only continue with positive consent from the customer.
Recommendation 12: The requirement that the "other person understood what was being requested" The explanatory materials should clarify how insurers would get assurance regarding the inherently subjective requirements of proposed Section 992A(5)(c) that "the other person understood what was being requested".	We understand that the intent is that insurers will be able to rely on the words of the individual. We submit the better approach would be to allow insurers to comply with this requirement if a reasonable person in the given circumstances is expected to understand the request.
Recommendation 13: Medical indemnity insurance The draft legislation should exclude medical indemnity insurance from the anti-hawking rules.	Medical indemnity insurance should be excluded from the operation of the anti-hawking rules given it is legally required, well-defined and highly regulated. Expectations of doctors that medical indemnity insurers will engage in open and frank ways, as do professionals with their insurer in other professional indemnity contexts carved out of hawking. Limitations it would pose on long-standing methods of how insurers as medical defence organisations engage with the profession in a range of contexts. No concerns have been raised around how medical indemnity insurance is marketed or sold.

INSURANCE COUNCIL OF AUSTRALIA

ATTACHMENT B

DEFERRED SALES MODEL (DSM) FOR ADD ON INSURANCE: RECOMMENDATION 4.3

Recommendation	Supporting points
Recommendation 1: Flexibility to shorten the deferral period The legislation should provide engaged consumers with the flexibility to shorten the deferral period, consistent with the proposal set out in the Treasury proposals paper of 9 September 2019, and consistent with the UK's DSM for GAP insurance.	The proposal to provide greater flexibility for engaged customers to shorten or waive the deferral period is in our view supported by recent ASIC research showing that there are "in control" customers who read information provided by financial institutions and want to be well informed; these are the engaged customers envisaged in the Treasury proposal paper who would object to a paternalistic view that they cannot make well informed decisions without being hindered by the deferral period.[6] We also understand from the 11 February 2020 roundtable discussions that the decision to move away from the proposal to provide engaged consumers with the flexibility to shorten the deferral period was in response to concerns about creating loopholes resulting in products being sold to vulnerable customers. In this regard, we ask that due recognition is given to the considerable impact of other recent reforms to enhance consumer outcomes including the DDO, the Product Intervention Power (PIP) and the Code. Combined together, the DDO, PIP and the Code provide an impressive new regulatory framework to protect vulnerable customers. Additional layers of regulation like not providing flexibility to shorten the deferral period for engaged customers are unnecessary and counterproductive; they will only serve to inhibit consumer choice without tangibly improving consumer protections.

[6] ASIC and the Dutch Authority for Financial Markets (AFM), *Disclosure: why it shouldn't be default,* 14 October 2019, found that "one size does not fit all" – customers have diverse and context specific decision making styles, and there are "in control" customers who read information and want to be well informed (page 36). The ASIC/AFM report cites with approval the Insurance Council's research on this topic including our 2015 report *Too Long; Didn't Read – Enhancing General Insurance Disclosure* and our 2017 report *Consumer research on general insurance product disclosures*.

INSURANCE COUNCIL OF AUSTRALIA

Recommendation	Supporting points
Recommendation 2: Home and contents insurance The legislation should exempt home and contents insurance from the DSM.	We submit that the definition of add-on insurance should be refined so that it does not capture insurance which does not provide cover for the primary product. This would then exclude home building insurance sold by financial institutions when arranging a loan. If this approach is not acceptable, we submit that home building and contents insurance should be exempted from the DSM. This is given that home and contents insurance is a separate and unrelated purchase to the home loan, and while financial institutions generally require buildings insurance to be purchased before a home loan is finalised, consumers are aware that home insurance can be purchased directly and from other insurers. Without this change, we are concerned that the regime would unnecessarily impede the purchase of home insurance. We note that for home loans, the deferral period cannot start until the time at which the consumer is informed in writing of the approval of the credit facility. It is unclear whether this means conditional pre-approval of a loan facility, or unconditional approval of a loan. If the latter, this would effectively mean that financial institutions which require insurance as a condition of loan approval will no longer be able to issue home insurance with a home loan application. We note that under the draft Bill, and contrary to previous proposals, consumers will be unable to actively choose to purchase insurance during the deferral period. This will be problematic for consumers who may have a limited window of time to purchase insurance. For example, in Queensland, consumers purchasing a home are responsible for the property the day after the property contract is signed (rather than settlement), which would bring forward the need to purchase insurance.
Recommendation 3: Insurance required to be purchased under law and contract	There is for example a contractual obligation under the standard form Real Estate Institute of Queensland Contract for House and Residential Land (which is used for most residential sales in that State). The buyer of a property assumes legal risk for the property from 5 pm on the day after the contract is signed by the parties (cl 8.1

INSURANCE COUNCIL OF AUSTRALIA

Recommendation	Supporting points
We submit that the explanatory materials should clarify that insurance that customers are required to purchase under legislation, such as compulsory third party motor insurance, should be carved out from the DSM, as well as when it is required under commonly used standard contracts.	extracted below) – both public liability risk for injury or damage that occurs on the property and damage to the residential building and contents and fittings. Further, most lenders require that, since the risk passes to the buyer, that the buyer obtain insurance cover to both protect the lender's capital risk and ensure that a consumer is not left in a situation where they owe a debt to the lender and no longer have the residential asset for which the loan was made. This practice also accords with the intent of ASIC's RG 209 on responsible lending, and APRA's Prudential Standard APS 220 on credit risk management and its supporting Prudential Practice Guide APG 223 (for example APG 223, page 24, para 75).
Recommendation 4: Comprehensive motor insurance The legislation should clarify exempt comprehensive motor insurance and similar types of cover from the DSM.	As proposed, comprehensive motor insurance will be exempt from the regime, as recommended by the Royal Commission. However, the exemption as drafted will only apply to comprehensive motor insurance and not to other types of cover including third party property and third party fire and theft. However, there is no reason why the exemption should not also apply to third party property and third party fire and theft insurance.
Recommendation 5: Compulsory third party insurance We submit that the draft legislation should be amended to clarify that all CTP insurance, no matter the particulars of the scheme under which it is provided will be exempt from the DSM.	Our members have informed us that their reading of proposed Sections 12DO(1)(a) and 12BAA8(c) is that not all CTP schemes (which differ from state to state) involve the entering into insurance jointly by the state and insurers. Also, it is unclear whether CTP issued in the Australian Capital Territory would be captured by this exemption at all. There would be no benefit to consumers of deferring the sale of mandatory CTP insurance. The schemes are highly regulated, with minimal (to no) differences in both price and coverage across the market.
Recommendation 6: Deferral period trigger point	The deferral period trigger point should continue to be the entry into financial commitments as currently stipulated in the Proposed Section 12DO(3) and Proposed Regulation 3B of the draft legislation, rather than the point of delivery of the primary

Recommendation	Supporting points
The deferral period trigger point should continue to be the entry into financial commitments as currently stipulated in the draft legislation.	goods or services. As the Insurance Council noted at the 11 February 2020 Treasury Roundtable, there are considerable practical difficulties with this proposal, particularly given that the point of delivery would be too late in relation to insurance cover required under law or contract (e.g. building insurance in relation to home purchases).
Recommendation 7: The requirement for post-deferral period contact to be in writing The requirement in Section 12DS for the post-deferral period customer contact to be in writing should allow for telephone or face to face meeting conversations if the customer's preference is for the latter.	We submit that the current requirements are unnecessarily inflexible and do not allow insurers to appropriately take customer preferences into account. Customers increasingly expect insurers to be able to respond to their requests at once and in any form by which they have contacted them or asked to be contacted in a particular way.
Recommendation 8: Criteria for exemptions by regulations The legislation should incorporate additional criteria for exemption by regulation from the DSM.	In addition to the criteria for exemption by regulations set out in proposed Section 12DX(2), the following criteria should also be considered as additional criteria that the Minister must have regard to: • The consequences for consumers of non-insurance. This can range from limited impact to catastrophic, with examples of the latter being driving with no third party property damage insurance or international travel with no medical expenses insurance. • The extent to which the product is available on a stand-alone basis, as well known, widely available alternative sales channels reduce the likelihood of poor consumer choices; • The existence of a regulated cap on commissions, as this removes much of the incentive for high pressure selling;

Recommendation	Supporting points
	• The value in a digital age to the consumer of a quick, convenient purchase; • Whether the insurance comprehensively covers the entire primary product or service, rather than just having a mere ancillary relation to it (e.g. tyre and rim insurance); • In order not to impede innovation, particular consideration be given to exempting new insurance products without a track record of having "historically good value for money" or good consumer familiarity, but likely to meet this criterion given time; and • The regulatory situation in comparable foreign jurisdictions.
Recommendation 9: Bundles of insurance and non-insurance products The legislation and explanatory materials should clarify that insurance embedded into a non-insurance products (such as personal accident and public liability insurance which comes with sporting club membership) are not subject to the DSM.	The premiums for which are built into individual membership fees, and provide insurance coverage in relation to those members – cannot practically be separated out from the principal product (the sporting club membership) and should not be subject to the DSM.
Recommendation 10: Complimentary insurance products The legislation should clarify that complimentary insurance products and those provided on a temporary basis (e.g.	Requiring consumers to be subject to the DSM for these products could result in consumers missing out on cover in circumstances where pressure-selling issues are not relevant.

Recommendation	Supporting points
interim cover, bridging insurance) offered to the consumer at no extra charge are not subject to the DSM.	
Recommendation 11: Exemption for customer initiated sales through different channels or brands The explanatory materials should clarify that the insurer would not be in breach of the prohibition on selling add on insurance under Proposed Section 12DQ as a result of customer initiated sales through one channel or brand where a deferral period has commenced through another channel or brand.	This is necessary as insurers will not be able to track customers moving between different channels or brands if the customer decides to initiate completely new contacts at each time. In relation to channels: an insurer cannot for example track a customer who initiates contact at a physical shopfront, and then subsequently makes contact with the same insurer via online without making reference to the shopfront contact. In relation to brands: an insurers cannot track a customer who initiates contact with one brand, and then subsequently makes contact with another brand owned by the same owner without making reference to the previous contact.
Recommendation 12: Referrals The legislation should clarify that the DSM does not apply to referrals.	As proposed, referrals made by intermediaries selling the primary product will be caught by the reforms. The explanatory materials (at paragraph 1.23) state that insurance that is offered by a third party as a result of a referral by a principal provider to the third party will be considered add-on insurance, assuming the insurance covers risks associated with the principal product or service. The rationale for applying the DSM to referrals is weaker than for insurance which is sold at the same time as the primary product. For referrals, there has already been a separation between the purchase of the primary product (e.g. the home loan in this example) and the insurance product. The risk of consumers making poor decisions due to information overload is mitigated by the separation of the points of sale for the primary product and the insurance product.

Recommendation	Supporting points
Recommendation 13: Third party transactions The legislation should clarify that the DSM would not apply if customers separately purchase add-on insurance from third parties without the knowledge of the issuer.	There may be a risk that the issuer of a principal product would be guilty of an offence where they have an arrangement with a third party, and that party sells an add-on insurance product during the deferral period. It is acknowledged that this is an offence if the issuer is aware of the sale, as set out in Example 1.7 of the EM. However, it should not be considered an offence if the sale results from a direct approach from the customer to the third party where the principal was unaware of and had no reason to suspect the sale would occur. To prevent a breach occurring without any fault on the part of the principal product issuer, the legislation should apply the "recklessness" test which is used elsewhere for sales/offers by third parties. Illustrative example: Fred buys a pet at PetStore. PetStore has an arrangement with PetInsure. If PetStore refers Fred for the immediate sale of pet insurance then both PetInsure and PetStore have breached. If, alternatively, the customer buys pet insurance from PetInsure the same day, completely independently of the arrangement between PetInsure and PetStore, then PetStore has the defence of not having been "reckless". It had no way of knowing the customer had earlier that day bought a pet from PetStore. However, it appears that under 12DQ(2) PetStore will be guilty of an offence because there is no "recklessness" defence that it could not have known the customer had independently researched pet insurance and bought it from PetInsure.

ATTACHMENT C: IMPACT OF THE DSM ON SALES PRACTICES

(Information requested by Treasury at the 11 February 2020 roundtable)

Frontline consultants in large organisations which span across insurance, banking and other sectors are multi-skilled in order to assist customers with a broad range of sales and service enquiries.

The additional complexity introduced by the draft legislation would materially increase the knowledge base required by consultants to understand how the new legislation affects their interaction with customers. In response to the heightened complexity and increased risk for frontline consultants, organisations will need to:

- Make a wide range of changes to relevant systems (particularly Customer Relationship Management systems, channel platforms and quote-to-buy capabilities), processes, monitoring and assurance to reduce the risk burden on frontline consultants.
- Deliver and embed new compliance training and engagement frameworks for consultants to operate within.

The draft legislation links consent for a solicited contact specifically to a customer’s request, with the customer to specify the products within scope and the channel via which they wish to be contacted. In addition, it introduces the requirements for the customer to be able to manage this request through any available channel. Specifically, organisations will need to be able to manage customer processes to opt-out, vary the scope of their request or change the channel by which they wish to be contacted.

The channel networks of large organisations are managed across a range of material technology platforms and vendors. Enabling customers to make and manage requests across a channel network will require new technology solutions, integrated to all customer touchpoints to manage consent based on a customer request. The real-time and multi-channel nature of customer purchase journeys will make this particularly complex.

Technology solutions to meet this need represent a material investment which would require at least 12 months to design, develop, test and implement to ensure confident in its effectiveness and protect against adverse customer outcomes.

INSURANCE COUNCIL OF AUSTRALIA

ATTACHMENT D

MAKING CLAIMS HANDLING A FINANCIAL SERVICE: RECOMMENDATION 4.8

This attachment sets out several additional recommendations in response to more recent policy discussions. It complements, and does not replace, the Insurance Council's recommendations in our submission of 13 January 2020.[7]

Recommendation	Supporting points
Recommendation 1: Threshold to be applied to Statement of Claims Settlement Options (SCSO) The legislation should apply a threshold test above which a Statement of Claims Settlement Options must be provided	Division 3A should be amended so that a SCSO does not need to be provided to a customer in any situation where a total loss has occurred or where the cash settlement offer is below an agreed monetary threshold. This drafting amendment will provide that a statement must be provided unless one of the above exceptions applies. The amendment ensures higher value claims receive a statement, whilst lower value claims do not. This balances consumer protection, timeliness and cost effectively.
Recommendation 2: Prescribed circumstances where insurers do not have control or authority Section 912A should not apply in a limited number of prescribed circumstances where insurers do not have control or authority over key factors	Section 912A should not apply to the insurer: • In relation to third party claimants whose claims entitlements are determined outside the terms and conditions of the insurance contract (for example where public liability claims are determined by a court ruling). • Where insurers are relying on the advice and actions of experts (for example doctors and other registered health professionals) operating under independent accreditation and regulatory frameworks (including for consumer protection) which they inherently do not have the capacity to question. These

[7] Insurance Council, "Claims handling as a financial service: exposure draft legislation", 13 January 2020, available at http://www.insurancecouncil.com.au/assets/submission.

<table>
<tr><th>Recommendation</th><th>Supporting points</th></tr>
<tr><td>determining key claims outcomes for customers.</td><td>experts operate under independent accreditation and regulatory frameworks, and are relied upon to act professionally within their areas of expertise. Similar policy justifications to those used to exclude the legal activities prescribed in the Proposed Section 766G(1) would apply to exempt other categories of experts.
For clarity we want to reiterate our support for the ongoing exclusion of the legal activities prescribed in the Proposed Section 766G(1) (notwithstanding concerns raised by several participants at the 11 February 2020 roundtable about lawyers engaging in claims advocacy activities).
Where fulfilment providers (under a cash settlement scenario) and intermediaries (such as brokers, travel agents, and vets) are engaged directly by customers (and where the insurer does not subsequently enter into separate contractual arrangements with those providers).</td></tr>
<tr><td>Recommendation 3: Definitions of “loss assessors” and “insurance claims managers”

The legislation should precisely define the terms “loss assessor” and “insurance claims managers” in the Proposed Section 761A in order to ensure that only those entities that carry on loss assessment and claims management as their principal business activities are caught.</td><td>This would exclude persons who may from time to time undertake such investigations as ancillary activities but do not have loss assessment as their main business activity.
Qualifications: The definition of loss assessor should recognise the qualifications required under industry practice to work as loss assessors. For example, we note that the Australasian Institute of Chartered Loss Adjusters provides a framework of education standards, courses and qualifications for loss adjusters in Australia and New Zealand.
Experts: Experts (for example medical, building consultants, engineers, hydrologists, forensic accountants, valuers) provide specific expertise to enable the insurer to make a claims decision and it is possible that such experts may fall within the broad definition of a “loss assessor”. These experts operate under independent accreditation and regulatory frameworks, and are relied upon to act professionally within their areas of expertise. Similar policy justifications to those</td></tr>
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INSURANCE COUNCIL OF AUSTRALIA

Recommendation	Supporting points
	used to exclude from the definition of handling and settling a claim the legal activities prescribed in the Proposed Section 766G(1) would apply to exempt other categories of experts. • *Forensic investigators:* The proposed explanatory materials should clarify that forensic investigators, who provide scientific expert opinions regarding forensic matters arising as part of claims should not be regarded as loss assessors for the purposes of Proposed Section 761A.
Recommendation 4: Medical indemnity insurance The legislation should exclude claims in relation to medical indemnity insurance from the licensing requirements.	Medical indemnity related claims should be excluded given that this type of insurance is already highly regulated – under the Medical Indemnity Act 2002 (Cth) and the Medical Indemnity (Prudential Supervision and Product Standards) Act 2003 (Cth). For insurers who provide access to certain government schemes, further contractual obligations are in place to ensure access for cover for medical practitioners.

INSURANCE COUNCIL OF AUSTRALIA

ATTACHMENT E

DUTY TO TAKE REASONABLE CARE TO NOT MAKE A MISREPRESENTATION: RECOMMENDATION 4.5

Recommendation	Supporting points
Recommendation 1: Definition of consumer insurance contract The legislation should retain the current definition of "eligible contracts" under the Insurance Contracts Act (being a prescribed list of classes of insurance) with a mechanism to include additional products, from time to time.	The new duty will apply to a sub-set of insurance contracts based on whether they fall within the definition of a "consumer insurance contract" (section 11AB). A consumer insurance contract (CIC) will be one that is obtained "wholly or predominantly for the personal, domestic or household purposes of the insured". This new definition appears to require insurers to understand the subjective purpose of entering into the insurance contract by each relevant individual. Also, the onus is on an insurer to prove that an insurance contract is not a CIC if it is alleged by the insured to be one. The Insurance Council believes that the current definition of "eligible contracts" under the Insurance Contracts Act should be retained (being a prescribed list of classes of insurance) with a mechanism to include additional products. This approach will avoid introducing additional complexity and cost which will be inevitable if insurers are to inquire into the specific purpose of entering into the insurance contract for each individual (particularly where no or general advice only is provided). For example, we would envisage that with the proposed new definition, insurers will have to require individuals to provide information or declarations about their proposed purpose.
Recommendation 2: Impact on renewal process The legislation should include an equivalent of the current Section 21B of the IC Act to facilitate a more efficient renewal process by not requiring the insurer to contact the customer and ask questions again but merely advise the	Proposed Section 20B(5) states that if the customer fails to answer a question then they will not be taken to have made a misrepresentation. The effect of this section along with the repeal of Section 21B is that if an insurer does not obtain an answer to a question at renewal then the customer will not have made a misrepresentation. This would make the renewal process more onerous. Insurers will need to burden customers with further information requests at renewal to ensure that customers continue to meet their acceptance criteria before renewing any contract.

INSURANCE COUNCIL OF AUSTRALIA

Recommendation	Supporting points
insurer if their circumstances have changed (which would be the effect of the proposed Section 20B(5) without an equivalent to Section 21B of the IC Act).	Currently, Section 21B of the IC Act provides an exemption to Section 21(3) of the IC Act if at renewal, the insurer: asks specific questions again (like new business); or presents to the insured their previous disclosure asking for details of any change. If the insured does not tell the insurer that anything has changed, then it is deemed that there are no changes to the answer to the previous disclosure. As drafted, it is likely that the new duty will not allow an insurer to use a process similar to 21B(3)(b). This is despite 20B(2) allowing the circumstances of renewal to be considered when determining whether the duty has been complied with. Due to a lack of specific reference to the renewal process such as in the current legislation, insurers would not be able to safely rely on an insured's response or absence of response when an insurer requests that the consumer inform them of any changes to their disclosure. Our reading of the draft legislation and the explanatory materials is that there is no policy intent to change the approach of the law to renewals. We note that at the 11 February 2020 Treasury Roundtable it was advocated that, contrary to current practice, insurers should obtain information again from policyholders at renewal. However, independent consumer research commissioned by the Insurance Council in 2019 clearly shows that an overwhelming majority of customers would prefer to have their insurance policies renewed with pre-filled information from those existing policies, with the onus on the customer to inform the insurer if their circumstances change: • Home and contents insurance: ○ When asked directly what should happen at renewal time, the majority (70%) of survey participants believed it is the responsibility of the policyholder to let their insurer to know if their situation has changed.

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For the 30% that expect the insurer to contact the policyholder to confirm if their details had changed, 82% believe that the insurer should take it that nothing has changed and renew the policy if they are unable to get in contact with the insurer or confirm.
Car insurance:
When asked directly what should happen at renewal time, the majority (74%) of survey participants believed it is the responsibility of the policyholder to let their insurer to know if their situation has changed.
For the 26% that expect the insurer to contact the policyholder to confirm if their details had changed, 75% believe that the insurer should take it that nothing has changed and renew the policy if they are unable to get in contact with the insurer or confirm.
We submit that:
a new paragraph should be added to sec 20B(3) to the effect that before a consumer insurance contract is renewed, the insurer has given the insured a copy of any matter previously disclosed by the insured in relation to the consumer insurance contract and requested the insured to disclose to the insurer any change to that matter or to inform the insurer that there is no change to that matter;
alternatively, a similar clause could be included elsewhere in sec 20B to make it clear that, subject to other relevant circumstances, the proposed duty may apply with respect to such a process; and
it should be clarified for the purpose of sec 20B(5), that where an insurer has given the insured such a statement and the insured does not disclose any
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INSURANCE COUNCIL OF AUSTRALIA

Recommendation	Supporting points
	change to the matters in it, they may, subject to other relevant circumstances, be taken to have informed the insurer that there is no change to the matter. This approach would be consistent with the intent behind the proposed duty in sec 20B. All relevant circumstances would still need to be considered in determining whether the duty has been met.
Recommendation 3: Proposed Section 20B(6) Section 20B should include an objective 'reasonable person' test and state that a misrepresentation made *dishonestly* is always taken as showing a lack of reasonable care.	The duty of disclosure was developed to ensure that insurers can make an accurate assessment of the risk they are taking on. As currently applied, the consumer has a positive duty to disclose what is relevant to the insurer. Insurers need to be able to rely on the disclosures made by consumers to ensure they can provision adequately to pay claims and to have remedies available when a consumer purports to rely on a policy that an insurer would not have otherwise accepted the risk for. The Insurance Council accepts the need for insurers to bear greater responsibility in informing consumers of the specific information which the insurer sees as relevant to them in taking on the risk. We also support the recommendation to replace the duty of disclosure with a duty to take reasonable care not to make a misrepresentation ('New Duty'), as was implemented in the UK under the *Consumer Insurance (Disclosures and Representations) Act.* However, the Insurance Council submits that the proposed new section 20B should be more closely modelled on the UK provisions to achieve the right balance and more accurately reflect the recommendation made by Commissioner Hayne. That recommendation was founded on the need to protect consumers who act "honestly and reasonably" – not consumers who behave dishonestly but fall slightly short of committing fraud. Compared to the modelled UK provisions, as proposed, the new duty:

INSURANCE COUNCIL OF AUSTRALIA

Recommendation	Supporting points
	• removes the objective element of 'reasonableness', leaving the test entirely subjective; and • replaces the deemed breach test of 'dishonesty' with 'fraud' (proposed section 20B(6)). Further, the new duty imposes the burden of proof on the insurer to prove both that the contract issued is a consumer contract, and that the consumer has breached the new duty. Taken together, these issues give rise to serious concerns that the standard for the new duty will, in some cases, be reduced to an unsustainably low level. What should be a duty on the consumer to act 'honestly and reasonably' in accordance with the standards of honesty that decent people expect, will become a highly context dependent inquiry that likely will, in some cases, allow dishonesty to be rewarded to the detriment of the majority of consumers who are honest. It should not be the case in Australian law that a consumer who acts dishonestly has behaved acceptably. For clarity, we note that we are not proposing that the tests for remedies under Part IV, Division 3 of the *Insurance Contract Act* be changed. The 'dishonesty' threshold we explain above applies to deem that dishonest conduct of a consumer entitles an insurer to apply a remedy. The nature of the remedy will then depend upon whether the consumer's behaviour was fraudulent. (This is the position under the UK law, although the 'fraud' test for a remedy is described by the words 'deliberate or reckless'.) Having shown a consumer to have dishonestly answered a question, insurers will still have to apply the 'minimum remedy' approach currently set out in Part IV, Division 3, consistent with the original policy intent of the *Insurance Contracts Act*.

ATTACHMENT F

BREACH REPORTING: RECOMMENDATIONS 1.6, 2.7, 2.8, 2.9 AND 7.2

Recommendation	Supporting points
Recommendation 1: A materiality test for factors which constitute significance The legislation should link the factors under Section 912D(5) as to what constitutes significance to a materiality threshold.	Under proposed Section 912D, there is a reportable situation if a licensee or its representative has breached a core obligation or is likely to do so, or if the licensee has commenced an investigation into whether the licensee or its representative has breached a core obligation. The breach or likely breach must be 'significant'. The breach is taken to be 'significant' and reportable under proposed Section 912D(5) if it is punishable on conviction by penalty that may include imprisonment, the breach constitutes a contravention of a civil penalty provision, the breach results or is likely to result in loss or damage to clients, or any other circumstances prescribed by the regulations exist. We have a number of queries and concerns about the factors which determine significance and where there is a reportable situation: • *Proposed Section 912D(5)(b): Contravention of a civil penalty:* A breach is taken to be significant and reportable if it is a contravention of a civil penalty provision. Without any further threshold, this will clearly have the result of dramatically increasing the number of potentially reportable matters, and putting further pressure on resourcing. • *Proposed Section 912D(5)(c): Breach results or is likely to result in loss or damage:* One criterion for counting a breach as significant is whether the breach results or is likely to result in loss or damage to clients. This could be problematic, as there is no quantum for loss indicated. A 'significant breach' as defined could involve a small loss. Further, the criterion does not consider circumstances where a customer has been remediated in a timely manner. • Under Example 2.3, it suggests that a single customer complaint about not being provided a Financial Services Guide could be a significant breach that is reportable to ASIC. Without any materiality attached to what constitutes 'loss or damage to

Recommendation	Supporting points
	clients', then previously considered 'minor' breaches would now need to be reported to ASIC. Insurers with large numbers of customers may find the administrative burden of complying very difficult. Especially where there is small loss to the consumer, there is little benefit to the consumer in extra compliance costs where that loss has been remediated. The accumulated result of all these factors potentially is that the scope of the reporting provisions is too wide and onerous, with little counter balancing gain in terms of driving better consumer outcomes. The number of situations a licensee would have to report would be significantly larger and would put pressure on resourcing. We submit that the factors under proposed Section 912D(5) which go to significance should be linked to materiality so that matters which are reported are those which constitute truly significant breaches. In order to achieve this, the factors under Section 912D(5) could be linked directly to factors under Section 912D(6) which includes having regard to the number or frequency of similar breaches.
Recommendation 2: Commencing an investigation The legislation should clarify the definition of an 'investigation', including a threshold for the types of reportable investigations under Proposed Section 912D(1)	Proposed Section 912D(1) requires a licensee to report a breach when it has commenced an investigation within 30 days of its commencement and 10 days after the conclusion of the investigation. Whilst the ASIC Enforcement Review Taskforce recommended that investigations by the licensee should be reported, it was intended to apply when the investigation has been going on for 30 days and no conclusion had been reached. It should be recognised that the investigation is being undertaken for the very purpose of finding out whether a breach is significant. The licensee will not know for certain whether the breach is significant until it has undertaken an investigation. This requirement may create an unnecessary compliance burden in many instances where an investigation taken for prudent reasons yields no evidence of breach.

Recommendation	Supporting points
	If reporting the commencement of an investigation is deemed desirable, we submit there should be clear threshold criteria for the type of investigations which are reported, beyond the current draft criteria that an investigation has been commenced into whether there has been a breach of a 'core obligation.' At first instance, frontline staff will notify compliance staff about potential issues and it is up to the compliance staff to determine whether a more substantive investigation is warranted. The initial notification of a potential issue by frontline staff should not trigger a reporting requirement. There should be a distinction made between investigations and routine inquiries made by the business into customer concerns. Licensees should be encouraged to investigate any potential breach without being hampered by unnecessary compliance.
Recommendation 4: Appointment of an agent by the insured The explanatory memorandum should provide greater clarity on how the duty applies where the insured had engaged an agent.	According to proposed Section 20B(3)(e) (as illustrated in Paragraph 1.43 and 1.44 of the draft explanatory memorandum) the appointment of an agent by the insured may be evidence that the insured has taken reasonable steps to fulfil their duty (depending on the nature of the agent's involvement). It is unclear whether the insured having an agent means that the insured is more likely or less likely to have met the duty. The explanatory memorandum also provides no indication as to the nature of the agent's involvement which would make it more likely that the insured has met the duty. For instance, would the appointment of a sibling without professional qualifications as an agent, mean that the insured has taken reasonable steps to meet their duty? A potential result could be that insurers may only want to take information from a broker. We submit that the involvement of an agent lifts the standard of care required by the insured, which is the position in the UK.
Recommendation 5: Reference to target markets	Is the reference to target markets pointing to the Section 994A of the *Corporations Act 2001 (Cth)* which states that a "target market" is a class of retail clients described in the target market determination for the product in question? This in our view introduces an

Recommendation	Supporting points
The explanatory memorandum should provide greater clarity on the reference to "target markets" in Proposed Section 20B(3)(a).	unnecessary additional layer of complexity for compliance systems in determining whether the duty to take reasonable care has been met. This is particularly since the recent draft ASIC regulatory guide requires that target markets be defined in a much more granular way than what the Treasury seems to expect in Examples 1.1 and 1.2.
Recommendation 6: Additional suggestions regarding the explanatory materials	We submit that Example 1.2 incorrectly identifies Lesley as having discharged her duty. It claims that Lesley discharges her duty by merely having an initial conversation with an employee in the local branch, even though she has not disclosed relevant matters in her application. This seems like an odd result, as it is through the formal application that an insured enters into the consumer contract, not through the verbal exchange with the employee, and it is the formal application which the insurer will rely on when deciding whether to take on the risk. Proposed Section 20B(3)(b) provides that explanatory material or material publicly produced or authorised by the insurer can be taken into account when determining whether an insured has taken reasonable care not to make a misrepresentation. We welcome Paragraph 1.36 and Example 1.3 of the explanatory memorandum which indicate that extra materials provided by the insurer would raise the standard of care required to discharge the duty (we assume that the word 'lowered' in Paragraph 1.36 is supposed to say 'raised', otherwise Paragraph 1.36 and Example 1.3 would contradict). However, does Paragraph 1.36 conversely also indicate that that if the material the insurer provides is not clear enough, then it changes the standard of care owed by the insured under the duty? We believe it would be helpful in that regard for Treasury to prescribe a form of notice or provide further clarification in the explanatory memorandum which sets out what kind of material would help an insurer provide appropriate disclosure to a consumer of the information considered relevant when taking on the risk.

Recommendation	Supporting points
Recommendation 6: Reporting of investigations transition period The legislation should provide a longer transition period than the proposed commencement of 1 April 2021.	The breach reporting regime will require significant systems changes and the employment of additional resources for compliance, training and monitoring, particularly with the large volume of regulatory reforms that insurers will need to prepare to comply with. A longer transition period than the proposed commencement of 1 April 2021 will be needed.

ATTACHMENT G

RECOMMENDATION 1.15 ENFORCEABILITY OF INDUSTRY CODES

The Insurance Council has a strong interest in the development of the overarching regulatory framework that will allow for enforceable provisions in ASIC-approved codes.

We understand the policy intention for the framework is to introduce a discrete number of provisions in an industry-developed code that are backed by ASIC-administered incentives to comply. These enforceable code provisions would offer consumer protections which fill gaps in the law, or otherwise extend existing legal protections for consumers.

We will work towards having designated enforceable provisions in the General Insurance Code of Practice by 30 June 2021 as recommended by Commissioner Hayne. Following the enactment of the reform legislation, we look forward to the release of ASIC's updated RG 183 and its updated approach to compliance and enforcement for enforceable code provisions so we can work towards this date.

On 1 January 2020, the Insurance Council published an updated General Insurance Code of Practice[8], following an extensive two-year review of the 2014 Code. The review considered feedback from Insurance Council members, ASIC, consumer representatives, the Code Governance Committee, FOS (a predecessor Ombudsman scheme to AFCA) and other interested parties[9]. The updated Code has been approved by the Insurance Council's Board. Code subscribers have until 1 January 2021 to complete their transition to the updated Code. The new Code also implements Commissioner Hayne's recommendation 4.10.

In this Attachment G, we recommend that the drafting of proposed Section 1101A(2) be revised to clarify the eligibility criteria for designating enforceable code provisions.

We also make observations about:

- clarifying the process for identifying enforceable code provisions;
- updating ASIC's code approval power in the way Commissioner Hayne intended;
- ASIC's powers to enforce code provisions; and
- recognising the unique character of insurance contracts during code approval.

1. Clarifying the process for identifying enforceable code provisions

The Insurance Council recommends the drafting of eligibility criteria to designate an enforceable code provision be revised in three key ways:

Recommendation	Supporting points
Recommendation 1: Replace 'could' with 'would in proposed Section 1101A(2)(b)	The drafting of proposed Section 1101A(2)(b) should be revised to replace 'could' with 'would'. This is so there is more than a theoretical possibility of significant detriment to a customer or undermining the Australian public's confidence for a provision to be designated as enforceable.

[8] Insurance Council of Australia, *General Insurance Code of Practice (published 1 January 2020)*
[9] See: http://codeofpracticereview.com.au/

INSURANCE COUNCIL OF AUSTRALIA

Recommendation	Supporting points
Recommendation 2: 'Significant detriment' should flow from a breach of an essential code provision, or provision that goes to the heart of the customer arrangement	The drafting of proposed Section 1101A(2)(b)(i) should be qualified to confirm that for a code provision to be designated as enforceable, the significant detriment to the customer must flow from the breach of a code provision that is *essential* to the proper performance of the product or goes to the heart of the customer arrangement rather than a non-essential term of the customer arrangement. This will ensure the framework best reflects the policy intention of Commissioner Hayne as discussed in his Final Report (Vol 1), page 108). We note the *Corporations Act*, at section 1023E(1) already provides considerations for ASIC to gauge whether there would be 'significant detriment' to customers. We expect a consistent interpretation would be adopted for enforceable code provisions.
Recommendation 3: Avoid the creation of parallel enforcement regimes for the same consumer protection	The drafting of proposed Section 1101A(2) should be revised to exclude from designation, code provisions that are already subject to existing legal protections, for example, in the *Corporations Act*, *Insurance Contracts Act*, or another law within the remit of another regulatory body (e.g. the Office of Information Commissioner). This would avoid unnecessary duplication of laws and the creation of parallel or mirror enforcement regimes for the same consumer protection.

We also encourage Treasury to consider how the regulatory framework may be future-proofed so ASIC's ability to approve codes with enforceable provisions can keep pace with changing community expectations of the types of consumer protections that should be enforceable in an industry-developed code. For example, whether there would be merit in providing some flexibility for other eligibility criteria to be added by regulation.

It is our understanding that the proposed framework anticipates an applicant (such as an industry association like the Insurance Council), would put forward its nominated enforceable code provisions for designation when applying to ASIC for code approval; and that during the course of the approval process, ASIC would work collaboratively with the applicant, and may suggest additional provisions be designated, or negotiate drafting amendments to the designated provisions for legal effect.

A key concept for the Insurance Council is that the General Insurance Code maintains its status as an industry driven document that can harness the benefit of collective knowledge and drive positive change for consumers. While there are no legislative parameters around how an applicant and ASIC should negotiate approval, it is our understanding from the consultation process that the framework would support an ASIC approach to code approval that focuses on designating a limited number of provisions for ASIC-enforceable status.

In the absence of parameters, and in the event of the remote possibility that ASIC cannot approve a code under the new code approval framework, it would be desirable for there to be a right of review to an independent authority, such as the AAT or another appropriate body. It

would be unfortunate if a code applicant's only avenue is a trajectory towards a mandatory code, simply because ASIC must not approve a code under the proposed framework.

Updating ASIC's code approval power in the way Commissioner Hayne intended

The Insurance Council agrees with Treasury that ASIC's general power for approving a code in section 1101A of the Corporations Act be updated in the way Commissioner Hayne intended. It is clear from his Final Report (Vol 1, page 111) that Commissioner Hayne valued, and wished to preserve the benefits of self-regulation in the financial services sector and did not intend for all provisions in a code to be enforceable:

> *I do not intend to interfere with the broader development of, or operation of, industry codes. Nor do I intend to modify or limit ASIC's powers to approve the non-enforceable provisions of industry codes. With that said, I consider that the law should be amended to provide that ASIC may take into consideration whether particular provisions of an industry code of conduct have been designated as 'enforceable code provisions' in determining whether to approve a code.*

In our view, it is highly desirable for an ASIC code approval test to preserve co-existence of enforceable code provisions with other code provisions that may serve a range of self-regulatory purposes (e.g. builds customer awareness of an existing consumer right or performs an educative role). Preserving code provisions that serve other functions would be necessary for an industry developed code to comprehensively augment existing consumer protection laws and meet the policy intention of Commissioner Hayne.

The exposure draft reform bill proposes a new test for ASIC's approval of codes – ASIC must not approve a code unless satisfied that – to the extent the code is inconsistent with existing federal laws administered by ASIC – *the code imposes an obligation on a subscriber that is more onerous than the law*. There may not be a shared understanding of what 'more onerous' than the law means. On a plain English reading, it could mean 'burdensome' or involve a great deal of effort, trouble or difficulty to comply with. We find this a curious threshold to meet, especially when regulation should not be imposing unnecessary cost burdens on industry.

ASIC's powers to enforce code provisions

The Insurance Council will continue to work with the relevant agencies, ASIC, AFCA and the General Insurance Code Governance Committee to ensure the framework for enforceable code provisions can co-exist efficiently and effectively with other code provisions that are not designated as ASIC-enforceable.

We note the reform bill gives ASIC new enforcement tools to add to its suite of existing enforcement tools, such as the ability to issue an infringement notice for breach of an enforceable code provision and to apply for a court ordered direction to direct a community benefit service, establish a program to improve employee compliance, training and awareness or direct revised internal procedures. We understand these enforcement tools are modelled on Part VI, of the *Competition and Consumer Act*. We also note another reform bill will introduce Hayne recommendation 7.2 that gives ASIC a new directions power to complement these code specific enforcement powers.

We look forward to the release of ASIC's updated RG 183 and its updated approach to compliance and enforcement for enforceable code provisions so we may have a greater appreciation of how ASIC might use its much broader suite of enforcement tools.

Recognising the unique character of insurance contracts during code approval

We welcome in the explanatory memorandum, as an alternative to incorporating enforceable code provisions within the customer contract, that code subscribers may contract directly

with the independent person or body who administers compliance with the code to be able to obtain ASIC's code approval.

This approach will better recognise the unique characteristics of an insurance contract in that the *Insurance Contracts Act* provides for a contract of indemnity and the terms on which an insurer will agree to respond to a claim on the policy. As a contract of indemnity, the insuring clauses, exclusions and conditions form the basis of the contract between the customer and the insurer, with the General Insurance Code dealing mainly with remaining operational or service delivery standards with respect to customer service, claims and complaints handling.