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Ms Sally Loane
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By email: sphillips@fsc.com.au

9 September 2016

Dear Ms Loane,

AFA Submission – Life Insurance Code of Practice

The Association of Financial Advisers Limited (AFA) has served the financial advice industry for 69 years. Our objective is to achieve Great Advice for More Australians and we do this through:

- advocating for appropriate policy settings for financial advice
- enforcing a Code of Ethical Conduct
- investing in consumer-based research
- developing professional development pathways for financial advisers
- connecting key stakeholders within the financial advice community
- educating consumers around the importance of financial advice

The Board of the AFA is elected by the Membership and all Directors are required to be practising financial advisers. This ensures that the policy positions taken by the AFA are framed with practical, workable outcomes in mind, but are also aligned to achieving our vision of having the quality of relationships shared between advisers and their clients understood and valued throughout society. This will play a vital role in helping Australians reach their potential through building, managing and protecting wealth.

Summary of the AFA's position on the Life Insurance Code of Practice

The AFA considers that an effective and enforceable Code is an important part of the suite of measures agreed between the AFA, FSC, FPA and the Minister in November 2015 that taken together can increase trust and confidence in life insurance. A Code that falls short of fulfilling the intent of all parties to that agreement will reduce the overall effectiveness of the other measures introduced, thereby substantially weakening the package of reforms.

Achieving a consensus outcome on the Life Insurance Framework legislation (**LIF**) was extremely challenging and AFA Members continue to rightfully question how LIF improves consumer outcomes. Indeed, we have expressed concerns that **any gains to consumers from LIF may be minimal at best unless the Code improves life insurer practices**. The Code must encourage and enforce an alignment of institutional culture to community expectations which we consider will be best achieved by aligning life company organisational behaviours to consumers' best interests, and takes account of the role of the profession in arranging approximately 50% of the life insurance placed in Australia.

As we argued in January this year through our submission to Treasury on the draft LIF legislation, **restricting the Code to setting out best practice standards for insurers in relation to underwriting and claims management does not go far enough to addressing the poor culture and sales practices that work against consumers' interests**. The reforms affecting financial advisers' remuneration cannot be implemented for the community's good while advisers are continued to be offered incentives by insurer staff to operate outside of their legal obligations or contrary to their clients' best interests.

The Code must go further than has been described in the LIF legislation's draft Explanatory Memorandum. It needs to also **impact the organisational behaviours that unreasonably conflict an adviser in their best interest duty and induces inappropriate replacement advice**. This means the Code must contain commitments to the advice profession as well as to consumers. As far back as November 2014, as party to the Life Insurance and Advice Working Group (LIAWG), the AFA recommended a comprehensive Code be developed to, amongst other things, **ban the sales tactics of insurers that are likely to interfere with the quality of advice**. To this point, we again call for the Financial Services Council to draft a Code to enable this outcome for the common good and benefit of consumers.

Conflicts of interest are not the only areas that can be affected by the Code. The AFA considers that **insurer-driven policy lapses could be effectively controlled through the Code**. Without effective measures to drive fairness and consumer-centric practices amongst life insurers, uninformed perceptions about the causes of policy cancellations and lapses will continue to undermine confidence in the industry, inhibiting the ability of more Australians to protect their families with appropriate levels of life insurance cover and further burdening the public purse. **The Code can drive a culture of genuinely seeking new business instead of taking business from other insurers and thus improve the underinsurance challenge in Australia.**

The Code goes part of the way to driving product innovation and improving consumer understanding of life insurance, but more can and should be done. **This Code can drive the development of simpler life insurance products** rather than the set of largely homogenous life risk products that define quality by comprehensive appeal. The Code can also set a high hurdle to closing product series and instead focus on the needs of consumers to justify ending a product series. These are some of the measures that can be delivered by a more consumer-centric Code.

This Code could represent a catalyst to form a new culture within insurers; one that positions the consumer's health and wellbeing alongside sustainable financial performance and therefore restore the social licence granted to life insurers to protect Australian's families when they are at their most vulnerable. To address the under-insurance problem in Australia, people need to trust insurers to be fair and reasonable. **A Code could be the vehicle to restore this trust and social license – provided the Code is constructed to hold insurers to account for their commitments to consumers' best interests.** The Code should not be rushed to release until it captures these commitments.

The FSC must resist the urge to rush this version of the Code to market, or to think that it could be improved progressively in subsequent reviews – there is an opportunity to get it right before releasing it. **The Code should not be released whilst so many necessary issues remain unaddressed.** Accordingly, we have provided below comprehensive feedback on achievable and reasonable improvements as recommended by the life insurance experts who make up the AFA. In the Attachment to this submission, we have also included a sample of the correspondence from AFA Members to help bring contextual understanding of key concerns.

The AFA's recommendations to improve the Code

The AFA considers that to **adequately protect consumers from inappropriate conduct and to drive a more consumer-centric culture within life insurance businesses**, the following measures that we have previously recommended and are yet to see represented in the Code should be incorporated by the FSC:

1. Financial advice be given prominence within the Code to **drive a culture of life insurer staff caring about consumers receive appropriate levels and types of cover**. Capturing commitments to financial advisers, beyond acknowledging the important role of advisers, is critical to the fabric of all the reforms underway given that approximately 50 per cent of policy holders choose to establish their life insurance policies through life insurance financial advisers,

2. **Ban insurers' sales practices that are likely to interfere with the quality of financial advice**. It is essential that insurers respect the obligations of financial advisers to act only in the best interests of their client and to do this a number of current insurer practices need to stop while other practices need to be introduced. Whilst drafting improvements seem to have been made to direct sales practices in the revised Code,[1] similar commitments must be extended to the conduct of business distribution staff with particular commitments to:

    a) **train life insurer business distribution staff to better understand financial advisers' best interest duty**, and

    b) **cease offering incentives in any form that may conflict with an adviser's obligations**. Inappropriate incentives include:

        - offering or otherwise agreeing to arrangements for use of in-house product, to attract product loyalty, to transfer multiple clients from one insurer to another or to reward or mandate threshold based volumes/quotas from either individual advisers or licensees,

        - offering or otherwise agreeing to excessive payments related to education and training. Genuine education and training can and should be provided but excessive payments to licensees and advisers to undertake that education and training affect integrity, and

        - influencing the restriction of Approved Product Lists (**APLs**) with reduced licensee pricing for advisers to incentivise selecting the reduced APL over a broader APL, which is likely to compromise an adviser meeting their best interests duty.

3. A commitment that life insurer staff and executives be subject to remuneration structures that **incentivise retention of existing policies and fair treatment of existing clients** appropriately weighted against attracting new business.

4. Life insurers to commit to **auto-upgrade existing policies when revising features** rather than incorporate those revised features within a new product. Upgrading policy series facilitates product choices for advisers to act in the client's best interests and reduces the level of unnecessary policy cancellations. Further, the Code needs principles and guidance around providing a legitimate upgrade

[1] Clauses 4.3 and 4.4 of the Code.

path for clients covered under current policy series and a commitment to **develop simplified products that better balance affordability issues against insurance needs**,

5. Life insurers to **comply with the duty of utmost good faith by assisting a customer to make informed decisions about replacing policies** sought to be replaced with group and direct-sold policies. This would not require life insurance staff or representatives to necessarily provide personal advice to a customer because mere possession of personal information does mean that personal advice is provided.[2] Instead, factual information about a customer's existing policies should be required to be obtained by sales staff before proceeding with a sale and that information should be presented in a factual comparison for the customer to consider before deciding to proceed with the offered policies, and

6. **A commitment to underwrite all insurance products at the time of application instead of at the time of claim**. This is critical to ensuring the integrity of the system that consumers rely upon in their times of need and has downstream implications for government social support and health systems.

In addition to the above, the AFA and its Members also further consider that the following measures are required to improve the standard of practices amongst life insurer staff:

7. The Code must at all times be a customer-centric document with a focus on continual improvement for the benefit of *all* customers, not just selected policy holders. To achieve this, **the Code must necessarily omit the current carve outs, exemptions and unnecessary qualifications that make the Code only applicable to a small part of the market**:

    a) By carving out superannuation trustees and other group policy-owners, **nearly a third of all policies currently held will not be subject to the Code protections**.[3]

    b) **The desire of insurers to "maintain the flexibility" of continuing to provide cover without underwriting is unacceptable given the consequences to consumers** who may not be aware that they are not actually covered until they claim. We support the standards in section 5 of the Revised Code applying to all policy holders.

    c) **Whole-of-life and endowment policies are still in existence and they deserve protection as well**.[4]

    d) **Improving medical definitions should not be conditional** upon the likelihood of the policy holder being able to make a claim under the improved definition. It is inappropriate to support a practice that denies people the benefit of better medical understanding simply because of the cost that the advance understanding may impose upon the insurer.[5]

    e) The FSC's member's engaged third parties conduct should be subject to the Code and **the principal insurer be held accountable or make amends for breaches by its engaged third parties**.[6]

[2] See ASIC Regulatory Guide 175 at paragraph 175.46.
[3] See the footnote at the bottom of page 2 referencing clause 2.1(a) and clauses 6.1, 8.1 and 8.24 of the Revised Code.
[4] See clause 2.10(b) of the Revised Code.
[5] See clause 3.3 of the Revised Code.
[6] See clause 2.15 of the Revised Code.

f) Commencing legal proceedings is a legally and procedurally fair right of all the public to seek redress for perceived wrongs and **taking legal action against an insurer should not disenfranchise the policy holder from the Code protections**.[7]

g) The Code undertakings when replacing policies should require life insurer staff to **apply those obligations to 'replacing in' situations as well as 'replacing out'**.[8]

h) Consumers' right to information about themselves and their family's protection (i.e. the life insurance policies) **should not be conditional upon whether the release of information could be prejudicial to the insurer**. This is an inconsistent standard when you consider that an insured party (or applicant) is required to be frank and forthright in their disclosures to an insurer throughout the entire period of being insured.[9]

These qualifications and exemptions appear to be designed to protect the interests of the insurers and their related parties. This does not instil a sense of confidence that this Code is designed to restore confidence, trust and the social license of the life insurance industry as inferred in clause 1.4(d) of the Revised Code. The Code should protect consumers' interests and avoid being a complicated legal document that the insurers can argue is only applicable in a restricted manner.

8. **Further attempts to water down the Code protections should also be resisted**, including:

a) The legal status of the Code will ultimately be determined by the Financial Ombudsman Service (**FOS**), the courts and the Competition and Consumer Tribunal – not the FSC or the Life Code Compliance Committee (**Life CCC**). Accordingly, clause 2.15 should be reflective of FOS's approach that Industry Codes reflect good industry practice and section 51ACB of the *Competition and Consumer Act 2010* – which clearly states that "*A corporation must not, in trade or commerce, contravene an applicable industry code*". The **Code should create a legally and socially binding obligation upon all participants in an industry to comply with the Code requirements**, not just to apply to those that the FSC determines it should apply to.

b) **Constituting the Life CCC with only three people is not sufficient protection to enforce the Code**. The current proposal for the Life CCC to be appointed by the FSC and reportable is not an arms' length relationship. The FSC has not publicly sanctioned its members in the past for recently reported misconduct and the proposed enforcement structure of the Code appears to continue that window-dressing approach to poor behaviour. It is questionable whether the public have faith in the FSC to develop a transparent and robust Code that adequately protects their families from further misconduct if the FSC also appoints the judge and jury (being the Life CCC).

9. **Insurers must genuinely commit to consumer education, especially in relation to life insurance concepts**. This is critically important and whilst financial advisers play a role in improving consumers' financial literacy, insurers have a duty to also reduce misunderstanding amongst policy holders. Whilst we acknowledge commitments in the Code to disclose policy terms in plain language, there is no requirement to not structure a policy design in a complex manner. Consumer education commitments

[7] See clause 2.20 of the Revised Code.
[8] See clause 4.8 of the Revised Code.
[9] See clause 14.5(c) of the Revised Code.

should extend to initiatives outside of policy wordings, for example, an industry standard two-page policy summary could accompany every policy clarifying key concepts of the cover provided, key risks and benefits.

Many current policies start with a plainly stated rule or expectation which is then watered down with layers of exclusions, exceptions and conditions. Policy documents also commonly have several pages of disclaimers and qualifications that at worst obfuscate the true nature of the policy and at best create misunderstanding and this Code continues that practice.[10] **If what the insurer offers or agrees to cannot be stated simply due to the design of the product, then design a simplified product**. Likewise, if the Code cannot state simply what insurers commit to, then the Code should be developed by an independent party.

10. **"Pressure selling" should be clearly and unambiguously defined**[11] to ensure that all insurer sales and business distribution staff clearly understand which practices will not be accepted. Ensuring that pressure selling applies to business distribution staff and wholesale channels will ensure that the policies that flow onto the end consumer have greater integrity.

11. Through the LIF legislation, insurers have imposed a requirement upon financial advisers to repay commissions received if a policy cancels in the first two years. As only a small set of situations will not trigger such a clawback of commission, **all life insurers should commit to <u>not</u> increase premiums during the clawback period except for CPI increases in the sum insured**. Without this commitment, insurers can continue the current practice of raising premiums soon after implementation of a policy without regard to the consequences for the policy holder.

12. **Policy holder investigations to be standardised according to community expectations of privacy and responsible use of intrusive means**. The surveillance and private investigator clauses of the Code start by saying insurers *may* use them and then goes on to outline how surveillance and investors must conduct themselves. There is nothing in these clauses that is not already reflected in the law.

    The AFA considers that to restore consumers' trust in insurers, there needs to be a threshold standard about *when and in which situations* surveillance and private investigators will be used. **Without a clear standard that puts the community's interest and right to privacy first, the FSC members' claims departments will continue to waste funds on surveillance and private investigators in every case of suspected fraud in vain attempts to catch or entrap insured parties**. The reasons why we say 'vain' and 'a waste of funds' are because:

    a) **Not a single FOS determination has relied upon surveillance evidence or private investigator evidence to find fraud** in a life insurance determination that was not evidenced by other less intrusive means.

[10] See for example the way that several clauses of the Revised Code are constructed with double negatives. Clause 8.19 of says: *Where you are receiving an income-related benefit, **we will not stop payments during a non-disclosure investigation unless** we reasonably believe that we have evidence that will lead to your claim being declined or your Life Insurance Policy being avoided*. This could be better stated as: …we will stop payments where we have evidence….

[11] Referred to in clauses 4.3 and 4.6 of the Code.

b) The surveillance footage rarely – if ever – redacts the identities of other people captured in the footage, which is **a particularly repugnant practice when children are reflected in the footage**.

c) Further, there appears to be a practice of disregarding the effect of using surveillance and private investigators on the wellbeing and recovery of people suffering from mental illness. **We question how can video footage demonstrate or a private investigator's observations highlight what is happening inside someone's mind.**

To restore confidence and trust, the Code must contain a threshold standard to be met *before* an insurer *can* use surveillance or private investigators, especially where the claimant has children or has lodged a mental illness claim. This threshold must be a high threshold given the lack of benefit to date in using surveillance and private investigators and it must be more than a mere suspicion of fraud. This is because it appears to the AFA, our Members and many members of the public that insurance claims departments (including general insurers) are increasingly beginning from a position of suspicion in any claim.

The AFA acknowledges that fraudulent claims have an effect upon the cost of premiums for all existing and future policy holders. However, there is also a financial cost when surveillance and private investigators are used and **there is both a financial and non-financial cost to the community and insurers' payout levels when inappropriate conduct by insurers and their agents exacerbates a person's mental health conditions**.

The community expects insurers to act responsibly when discharging of their duties. The AFA considers that not only should the potential benefit of using surveillance and private investigators be weighed against these competing costs, **there must be a cultural shift in claims departments to use intrusive options *only* as a last resort when less intrusive means will not provide the evidence being sought**.

13. The AFA also considers that **there must be a threshold standard for the use of daily activity diaries**. We question how a daily activity diary completed by a person claiming to be mentally unwell can be beneficial to understanding their claim. There must be a consideration – and in fact, it must be a health professionals' consideration – of how such an intricate examination of the person's activities may affect their condition before that introspective task is required of a claimant. Insurers must remember that nobody wants the stigma of being mentally unwell.

The use of daily activity diaries is an increasingly common practice used by claims departments for anyone who is on an income stream benefit for any longer than three months. It appears that the purpose is to obtain information that can be used against claimants to justify bringing them off claim. **When people are asked to report everything they do in a given day, they naturally think that they are not trusted** because even parolees who have actually been found guilty of criminal activity in an independent court of law do not have that level of scrutiny into their daily movements. Although fraud does unfortunately take place, it is and should be approached as the exception to the rule and the legitimate suspicion of fraud is not a reason to impose greater scrutiny than the community expects of convicted offenders.

To mitigate against daily activity diaries being abused in future, the Code should set a high threshold standard where:

a) the purpose of requiring a daily activity diary must be set out,

b) the purpose must have a constructive effect, such as setting out how the information to be captured will help understand how a person's rehabilitation can be improved,

c) the net benefit of using a diary must outweigh the financial and non-financial cost – including potential psychological effects on the person,

d) alternative strategies that could be employed must be set out and explained why they are not preferred,

e) advice sought from the claimant's treating medical practitioner as to how the diary will assist in their recovery, and

f) all of this information should then be communicated to the claimant to help them understand why they are being requested to record their daily movements.

Without appropriate checks and balances to mitigate against their continued abuse, daily activity diaries will continue to be used for improper purposes and create perceptions of mistrust amongst policy holders and their communities. The practice needs to be urgently reviewed and regulated according to decent standards of community expectations.

14. Whilst improvements have been made in the revised Code around how the agents of insurers and the other third parties engaged by insurers conduct themselves, more can be done to enforce compliance with timeframes and their standards of conduct. We consider that insurers should commit to at least to **ensure the policy holder is not unfairly disadvantaged by another party's breach**.[12]

15. **Until unfair contract terms are extended statutorily to insurance contracts, the Code should reflect the same principle** that a term in a life insurance policy will be considered unfair if:

a) it would cause a significant imbalance in the parties' rights and obligations arising under the contract; and

b) it is not reasonably necessary in order to protect the legitimate interests of the party who would be advantaged by the term; and

c) it would cause detriment (whether financial or otherwise) to a party if it were to be applied or relied on.

Insurers have the ability to vary insurance contracts but so too does FOS. Reflecting the unfair contract terms regime in the Code will allow FOS to consider the fairness or otherwise of insurance contract terms and provide fair remedies to insured parties where the insurer has over-extended what is necessary to legitimately protect its interests.

[12] Clause 5.8 of the Code only requires insurers to inform a policy holder if a third party breaches a timeframe to provide a report. There is no enforcement or consequences in this undertaking. One option could be to commence interim benefit payments until the report is provided to ensure that the policy holder is not unfairly disadvantaged by things beyond their ability to control.

The differential cost of policy premiums for individual policies is not a justification anymore for not subjecting standard form policy series contracts – especially group insurance and default superannuation held insurance – to this important consumer protection measure. Should the FSC's members elect to not subscribe to this, **the AFA calls upon the FSC to publicly explain why its members should not be subject to the same consumer protection laws that apply to all other consumer goods and services**.

16. **Where an insurer wishes to cancel an insurance policy or part of a policy, the insurer must first make genuine attempts to contact the policy holder themselves to provide notice of cancellation and opportunity to remedy the default**. The AFA considers that due to the potential disadvantage and detrimental effect of a person becoming uninsured and being forced to go through underwriting to reinstate a cancelled policy, it is incumbent upon the insurer to set a higher communication standard than the current clauses 2.11 and 2.12 which permit an insurer to discharge its duties by communicating with any one of the life insured, the policy-owner, a third party beneficiary or a representative.

    Whilst we appreciate that many insurers have existing written policies for cancellation of policies, there appears to be an inconsistent standard across insurers and a misunderstanding of the legal requirements – with several instances of reliance upon section 210 of the *Life Insurance Contracts Act 1995* being used for cancelling a policy for reasons other than non-payment of premiums, amongst other misunderstandings.

17. As FOS will do what it considers to be fair in the circumstance after considering the law and applicable industry practices, the AFA also considers that **it would be good industry practice for insurers to standardise the grace periods for cancellation of policies due to non-payment of premiums**.

18. As there is some legal uncertainty around unbundling of contracts since the introduction of section 27A of the *Insurance Contracts Act 1984* – especially where non-disclosure or misrepresentation has not been proven – the AFA considers that **the Code should set clear standards that take out the ambiguity in the law** and cover the grey areas of breach. This should include clarification that underwriting opinion is necessary to avoid or vary only that portion of the policy that is being sought to be unbundled. Without this guidance, FSC members will continue to misunderstand the unbundling rules, which not only has a detrimental effect upon claimants but also presents an unnecessary cost to insurers and can lead to disputes being lodged with FOS. Both of these consequential outcomes have an avoidable flow on effect on the premiums of all other policyholders, which the AFA considers should be a paramount consideration of insurers.

19. The AFA also considers that where a policy holder makes a claim under a policy and they hold cover under other policies, the insurers should always consider whether the person may be covered under all other policies they may be entitled to a benefit under. Whilst this is the approach of the better insurers in the market, not all insurers will take this approach. This can be due to several reasons ranging from that the various arms of insurance companies do not communicate effectively with each other to a view that it is the insured's obligation to know what they are covered for and with whom.

    The 'we will not argue their case for them because it might be prejudicial to us' is particularly deplorable when dealing with people who are in vulnerable states. Life insurance is only called upon when people become injured, sick or die. In all those circumstances, the claimants are in vulnerable

states and the standard of care owed to them rises in other legal relationships. It should be standard for life insurers to presume that a policy claimant is vulnerable until otherwise shown, regardless of whether the injury or sickness was an accident or not which appears to elicit greater empathy amongst claims assessors than non-accidental situations (such as gradual decline).

20. Standards of practice be required in the Code to ensure **an efficient underwriting process for policy increases are on par with new business underwriting processes**. These standards should require fair and reasonable conduct of the insurers in exchange for the full and frank disclosure and participation of the insured. This is a key measure that will demonstrate to consumers that insurance is not a lopsided equation that they should begrudge, but instead embrace.

21. A commitment to **upgrade the management of information flow between insurers, licensees and advisers** to support remuneration reforms, client orientation, improved capabilities and improved economics of licensees and advisers.

22. A commitment to **upgrade the management of information flow between insurers and industry software providers** to support efficiency in adviser support of client's insurance arrangements.

23. **Life insurers to share lapse and policy cancellation data with licensees and professional associations on a per adviser basis** to help licensees and associations better advise ASIC and government on replacement business, instead of relying upon the aggregate APRA data to determine the level of lapses, churning and replacement business.

24. To ensure that Life Insurers are able to provide granular data on policy cancellations for the future ASIC Review, clause 14.1 of **the Code should be expanded beyond Privacy Act obligations to also extend to Life Insurers' "other legal obligations"** such as any Regulator-requested information, any contractually agreed to information and information required to be statutorily provided.

25. That **future reviews of the Code be developed in a consultative process** that genuinely embraces the perspectives and experiences of:

    - licensees from across the full spectrum of the market,
    - financial advisers and their professional associations, and
    - consumer feedback and the input of consumer advocacy groups.

26. Contingent to this, **the future ASIC-commissioned Review of LIF must consider the effectiveness of the Code and the effectiveness of the Life CCC and FSC to monitor and enforce the Code, including the levelling of appropriate sanctions where breaches occur**. Should it not be found to be effective, the Government should be invited to introduce a statutory Code scheme just as it has been supported by the profession to do so with the professional standards of financial advisers. Statutory Codes are in existence and operate effectively and with associations' support we consider that they can be effective at regulating conduct in an industry or profession.

27. **Upgrading of medical definitions be independently reviewed every three years to ensure that life insurers comply with their undertaking**. Recent media reports have highlighted practices that question whether this was previously been complied with to the detriment of policy holders and therefore raises concerns that it will not be implemented fairly through internal inertia in future. The AFA recommends that the Australian Medical Association be invited to empanel an independent

medical advisory board to facilitate and oversee the upgrading of medical definitions in life insurance policies, which could extend to other advisory roles such as the appointment or nomination of Chief Medical Officers and underwriting staff within Life Insurers. Collaboration will bring additional expertise and commitment to the table.

28. The Code plays an important role in **encouraging industry best practice amongst insurers** and superannuation trustees on claims management and provides consumers with better access to claims assessors. A real and practical example of how this can be done is where AIA recently embedded a claims assessor within the Sunsuper offices to better facilitate claims lodged on Sunsuper member's policies. This simple yet practical measure appears to be improving the experiences of vulnerable policy holders by giving them direct access to the decision-makers and simplifying the process to access benefits.

    Other areas of practical improvement that the AFA supports include modernising processes around claims management, and underwriting at the time of application to reduce delays at claim time. These options are not currently provided for in the Revised Code. The Consumers' Choice Awards[13] are recognition from policy holders when they receive outstanding service from life insurers. The loyalty and referral benefits that flow from being recognised and appreciated by policy holders should be a greater driver for insurers than the cost reductions that might be achieved through stringent claims management or other poor practices.

29. The AFA would also **support an independent industry-wide tribunal to review complex claims decisions** (unhindered by FOS-like restrictions to jurisdiction) and help the insurers to achieve a more transparent and cost-effective solution to the challenge of complex insurance claims. Recent media reports about claims issues in the industry highlight the importance of ethical, consumer-oriented practices during the time that policyholders are at their most vulnerable. The AFA considers that an independent review process is a step in the right direction.

[13] http://www.consumerschoice.org.au/

Closing remarks

The AFA appreciated the opportunity to provide feedback on the draft Code. As with other stakeholders, we are anxious to see a Code introduced. This Code is not however ready. Even as a starting point, it does not require enough of life insurers to clearly prove a commitment to winning back their social license and community trust. Further, it completely ignores the interaction between insurers, financial advisers and the end client.

This Code has been developed because it was a commitment required from the FSC as one element of the package of reforms contained in the Life Insurance Framework (LIF) negotiated between the Minister, the FSC, AFA and FPA in November 2015.

As such, the Code needs to include commitments to consumers **and** the financial advice profession as 50% or more of Australia's life insurance is arranged through the expert advice and support of financial advisers. The commitments to consumers are as yet insufficient in substance to drive cultural change; and the role of the life insurance advice profession has been ignored.

This Code needs substantial improvements before it can achieve the intent with which it was promised.

If you require clarification of anything in this submission, please contact us on 02 9267 4003.

Yours sincerely,

Brad Fox
Chief Executive Officer
Association of Financial Advisers Ltd

Encl.

Appendix – Examples of feedback from AFA members on the draft FSC Code of Practice

Below is a sample of correspondence from AFA Members to help bring contextual understanding of key concerns – especially from highly experienced life insurance advisers.

"Regarding insurance companies stopping a book/product line and starting a new product line - this has been very detrimental to consumers in the past. Policy holders with old policies in a book that is not accepting new policies end up paying over the top premiums, as healthy members leave the book for better value policies forcing the price up for the unhealthy members stuck in that product. When insurers change reinsurers and treaties they should transfer all consumers (sick and healthy) to the new treaty on offer / into the new product, rather than leaving the smaller book of consumers with higher prices."

"The Life insurance code of conduct draft dated 10/08/16 has several notable deficiencies and should be rewritten to address the numerous issues that continue to influence the behavior of insurance companies to the detriment of consumers. The draft as it stands today offers little more than the standard legal protections offered to consumers and outside of timeframe for a response to claims can be summed up as "insurers will comply with existing law and continue to do business as they do now".

Consumers, advisers and regulators continue to push for more transparent business process, disintermediation and access to quality advice. The Code of conduct should support this transition while eradicating the behaviour that has continually eroded the profitability and sustainability of insurance companies.

A more transparent price model demands better service, improved communication and better technology. A code of conduct should address service standards and communication requirements by outlining commitments that the industry can be held to account and real penalties for failure.

Advice remains and will remain crucial to the process of buying insurance. Many insurers statistics will show that advised clients buy more cover and hold it longer than direct products. Advice will continue to have a place in the future, perhaps more with respect to the structure and selection of insurance than its application.

Consumers have also proven significantly more likely to litigate for an outcome in the last 15 years. Insurers have seen a dramatic increase in TPD claims and legal firms advertising their services to pursue insurers over claims management on a no win no fee basis. This trend hurts consumer confidence. The $20,000+ legal fees to secure a claim is a poor outcome for the client and an indictment on the insurer.

Successive governments have also begun to rise to the challenge of overly complex contracts. Unfair contracts acts have been enacted to protect consumers from difficult to understand, overly long and unfair terms.

Insurance companies offering restricted and costly products with significant exclusions offer lawyers and governments another opportunity to cast the industry in a poor light and again, a code of conduct should address the marketing of these products. This is especially confusing for consumers when the same insurer offers both a direct and advised product. The direct product is often significantly inferior AND more expensive than the advised solution and the client without taking the time to read the product statement would have no idea of the implications of their purchase until claims time.

Below is a dot point summary of terms that should be added to the code of conduct. There is little to comment with respect to the current terms as they amount to little more than restating standard consumer protections and current policy.

Recommended terms or concepts for inclusion:

- *Products should have a basic rating: Bronze/Silver/Gold*
    - *Gold: advised/retail insurance contracts*

- *Silver: Group scheme policies where the terms can be altered by the policy owner (typically a super fund), where the only ownership option is superannuation.*
- *Bronze: direct policies with standard exclusions (eg mental health and pastime exclusions)*

Suggestion: ALL PDS's must mark the rating on the front page and explain this rating with standard text on the first page.

Why? *Clients have no idea what they are buying and would reasonably assume that "Income protection" offered via a television advert is similar to "income protection" recommended by a financial adviser. However, the television or brand offered product could exclude all mental health related claims (a significant portion of claims typically) and exclude any dangerous past times (which may be covered if disclosed with a proper policy). The product disclosure statement does state this information clearly however it's very common for an insurer to offer both a direct, inferior policy and an advised superior policy. The client has no idea of the vast differences between the two and can't easily identify which one is good and which is not as good.*

- *A schedule of minimum service standards:*
  - *The code does not need to state SLA's (service level agreements) however insurers must publish and make public their service level agreements with advisers and consumers then adherer to them. Where they exceed their SLA they must also note the action they will take to escalate and extreme circumstances, compensate.*

Why? *For many years' insurers have delivered an inefficient, manual and error prone service to the market. This has been accepted as part and parcel of the variable reward that is commissions. The insurer has little reason to address the issue as agents or advisers will often point our errors and work with insurers to rectify them. The push to a reduced payment and increased risk of "claw back" (the reversal of a commission payment if a client cancels the policy) means that more advisers will move to a fee for service arrangement. This comes with its own challenges. The cost of executing advice is significantly higher than consumers tell us they will pay for the service. Improving service standards and lowering the cost of advice starts with clear service standards and a financial incentive to drive insurers to reduce error rates and improve turnaround times.*

- *Acceptance of electronic signatures and record keeping*
  - *Beyond the application insurers must accept valid electronic signatures for all aspects of client or adviser authorization in line with the Electronic Communication Act of* ***1999****.*

Why? *While many insurers accept electronic applications very few accept electronic authorizations for policy alterations or amendments. Despite the federal governments introduction of the accepted method for digital signatures 16 years ago, many insurers and super funds will not accept a digital signature. There are numerous productivity gains to be enjoyed by all parties. This is especially important for rural clients where the physical signing of documents involves printing, signing and scanning or personally picking up documents to obtain originals.*

- *Standardize the recording of Lapses (cancellation of policy)*
  - *Insurers must record lapse as either:*
    - *Adviser directed – replacing cover.*
    - *Adviser directed – cover no longer required*
    - *Client directed – replacing cover*
    - *Client directed – cancelling due to escalating cost*
    - *Client directed – cancelled due to change in circumstances*
    - *Client directed – cancelling no reason disclosed.*

- *Insurers are free to record information beyond this but they must at least record this together with the policy type (advised/not advised), age, dob and levels of cover held.*

Why? *When ASIC asked the insurers for lapse records it became clear that there is no standard definition of lapse nor any accepted codification of lapses. Despite this lack of clarity, insurers stated that adviser "churn" (the active movement of policies from insurer to insure for the benefit of the adviser) was a major cause of policy cancellation. Insurers should standardize minimal recording methods to ensure the industry captures better data and can deliver superior insights to the regulator, consumers and advisers.*

- *Ban concessions designed to facilitate the replacement of cover*

  - *Remove short form "take over terms" and other documents or processes designed to facilitate the easy replacement or transfer of a policy except when the client is transferring default cover as part of a group super scheme.*

Why? *Insurers cite churn or the replacement of insurance products as having negatively impacted on the profitability of the industry. They have also cited an investigation by ASIC into churn stating that payments received by advisers correlated with advisers replacing business. Insurers hold a duplicitous position by both publicly decrying churn and then facilitating it by offering forms and terms that allow an adviser to more easily replace cover if it has been held for less than 5 years. The removal of these forms brings them into line with their public message recommending that clients keep their policy for the long term.*

- *Ban inducements or special terms to advisers designed to facilitate a volume transfer of clients.*

Why? *Similar to the point above it is duplicitous to denounce "churn" or the movement of a policy from one insurer to the next while also offering inducement or special terms for such behavior.*

- *Provide 6 months' notice minimum for any rate changes to retail/advised products.*

Why? *For advised clients it is primarily the financial adviser that deals with enquiries relating to price changes. The most common enquiry – "can you find me a cheaper provider". By committing to provide a reasonable notice advisers can begin to warn their clients of likely price changes and to provide commentary about why this might be the case. This can reduce bill shock and help people retain their policy.*

- *Insurers must report on the profitability and financial position of their business to the adviser network annually.*

Why? *The profitability of insurance companies is, similar to banks – of mutual concern to advisers, clients and insurers. Profitable insurers can provide stable and sustainable premium rates to clients over the long term, ensuring that they hold cover until they have built sufficient assets to replace the need for insurance. With opaque financial reporting for the unlisted insurers it is difficult to understand their position and therefore the sustainability of their premiums. This is an important consideration when selecting an insurer as most advisers will place a policy on the basis that the client can remain there for their working life.*

- *Clients should be able to access ALL information collected about them at all times.*

Why? *Many insurers will only send results of medical reports to the client's doctor. Where the client has complex needs it may be required that their medical information is provided to multiple insurers or that the client simply wants a copy of their doctor's notes. Insurers should not restrict access to the clients own data and should instead always pass it back to the client.*

- *Insurers and their distribution staff should have the obligation to report poor, unethical or unlawful behavior to an adviser's licensee, professional body, regulator or all three depending on severity.*

Why? *It is constantly remarked by those working for insurers that they know who the "trouble makers" are. They are aware of poor behavior and yet there is no agreement or requirement for them to report this behavior. Licensees are required to report breaches to ASIC as are advisers however product providers have no such obligation. The code of conduct should require that Insurers who witness someone doing the wrong thing must say something.*

Notes relating to specific sections of the Code.

- *There are no defined penalties (section 13) for breaching the code beyond publication of non-compliance and to fix the problem or receive a formal warning. With what consequence are any of these sanctions?*
- *Objective of the code: - an objective of the code should include financial advisers – eg to collaborate etc.*

Industry should adopt a simple rating system for product offers: 3.1C and d

3.3 – fine with this. Insurers should retain the right to close policy series to ensure product innovation and allow insurers to back away from overly generous terms by closing a product.

3.4 – The group policy owner MUST notify members of change and confirm this with the insurer.

4.8 – If a client is replacing a policy the insurer or its direct representatives including authorized representative or contact center staff should RECORD this data for industry churn reporting and issue the client with a specific warning e.g.: The replacement of life insurance policies can carry significant risks. You must clearly understand the potential for lost benefits, legal protections or features not offered by your replacement policy. The sales person cannot provide you with a detailed analysis and you should either conduct your own research or seek personal financial advice to compare the contracts before proceeding."

"My biggest concern in relation to the FSCs code of conduct is that Section 3.3 basically counters the benefits of section 3.2

In section 3.2, the FSC proposes that medical definitions be reviewed every 3 years and then these be incorporated into policies, ensuring clients always have the best definitions (I would prefer a shorter period, being a maximum of 2 years). However, Section 3.3 states that where the improvement in definitions will result in greater likelihood of a claim, that the insurer is under no obligation to provide the improved definition to the client.

Given advancements in definitions due to improvements in medical advances would make it easier for clients to claim in just about 100% of cases, the wording of section 3.3 gives insurers the opportunity to not improve their definitions! This is disgraceful. The wording of Section 3.3 is basically a 'get out of jail free' card, meaning insurers can be selective with the improved definitions they pass back to clients. Using the Comminsure heart attack scandal as an example, you may recall that Comminsure (and unfortunately they're not alone) was assessing heart attacks using out-dated methodology. New, medically accepted, diagnostic techniques make it easier for a client to meet the heart attack definition. Using the FSCs logic, an insurer could refuse to incorporate the new diagnostic techniques into their policy as it would lead to an increase in claims, but they could publicly state that they are compliant with the Code of Practice!

Further, all existing insurance customers should benefit from current medically accepted definitions, not just new clients."

"The code will improve clarity and this is a good thing. In parts it reads like a service level agreement rather than a code of practice. This is a little too prescriptive for my liking but if the insurers are willing to agree to it then so be it. Comments as follows

1. Commitment to fairness. There no reference in s1.4 of the code, and its particularly relevant to the claims process.

2. Replacement rules s6.3(c) are weak. The duty of care for an insurer who is replacing a policy needs to be more than just a 1 sentence generic warning. It's not just the advisers' responsibility, if there is one.

3. reference to misleading in s4.1(g): needs to NOT BE misleading, not the weasel words "not likely to mislead".

4. Claims in s8.9 is an improvement, especially s8.9(c) but it doesn't go far enough. Insurers underwrite policies at the time of issue other than AAL policies, even for indemnity policies. Apart from current medical or financial reports to support a claim, insurers should not request extensive medical history going back many years. And yet they do, delaying assessment and payment, apparently finding excuses not to pay claims, and undermining the confidence and contributing to the underinsurance issue.

5. Finally, it is my understanding that personal insurance is not covered by the consumer law rules. So it doesn't have to be fit for purpose and the concept of what a reasonable person would expect simply doesn't exist. Personal insurance is sold to the general public. The same ones who have rights under the consumer law. Easier said than done, but shouldn't we be fixing this?"

"My thoughts are that they have added stuff to this and obviously quite a bit of this relates to the 4 Corners/CommInsure issue.

I still think that the document does not give clients much on top of what they are already entitled to.

I notice that there is an increasing focus upon the Authorised representatives of the life insurers. In reading this I was wondering if it was referring to the ARs of a related AFSL, but the definition is clearly an AR of the life insurer. I am somewhat confused by what they are getting at, since I would have thought that this was uncommon. Does it relate to direct business models?

My detailed feedback is as follows:

- *2.10 – Why have they excluded whole of life policies?*
- *2.15 – I still question why this does not create a legal right between the life insurer and the client.*
- *2.20 – How can they argue that the code does not apply simply because someone commences proceedings. If they believe these principles should apply then they should apply.*
- *3.2 – How is this checked and enforced?*
- *3.3 – refers to automatic updates except where there will be a cost increase. What happens then?*
- *4.3 and 4.4 look very much like they are focussed at direct operations. Will the sales philosophy documents be public documents?*
- *4.5 is one place where the question between ARs of the life insurer or of the group comes into play.*
- *4.3 and 4.6 refer to pressure selling, however I am not sure this has been defined.*
- *4.8 refers to product replacement and their staff explaining the risks. I wonder if this applies equally to replacing in as it does to replacing out.*
- *Section 5.1 specifically comments on how this section does not apply to cover provided without underwriting. This type of insurance is a problem and maybe this is a chance to highlight it.*
- *5.2 - It will be interesting to see how this applies in the context of a claim being underway as opposed to normal course of business.*
- *6.3 should refer to changes to the policy if these have been applied automatically.*

- *8.2 has an interesting reference to insurers trying to maximise the benefits payable. Interesting to see how this plays out.*
- *I think they need to be clearer about when reports are available to the client, such as 8.11(j). What is the point of documenting this if it is not available to anyone.*
- *9.2 – it will be interesting to see exactly what they propose to do with this and the investigation of advice provided by an external adviser.*
- *10.9 c) - I think the words "the investigator does not" is missing from the start of this item.*
- *12.5 – I don't think that a committee of 3 is enough.*
- *13.9 – is this annual report going to be a public document.*
- *13.13(b) seems to be mixed up – determining the sanction based upon the appropriateness of the sanction. Maybe they should add to this list the nature of the breach.*
- *13.14 – these sanctions are really a bit soft.*
- *14.5 on special circumstances – It is a bit hypocritical that they will release information except where it is prejudicial to them. What does commercial-in-confidence mean?*
- *We might like to argue that the definition for Exception Circumstances is too loose.*

I hope that this is useful."

"Are the AFA going to agree to be bound by this code because I would strongly suggest that we do not. This code once again emphasises the FSC's total lack of regard or interest in the adviser community. They and some (or all) of their members believe that the client is theirs. When it is an advised client that is not the case! The client is ours and only has a policy with a particular insurer because that is the insurer we recommended. They need to understand this and respect it. Part of the code needs to state that other than annual statements, outstanding premium notices and policy upgrade information, when a policy has an adviser, NO communication should take place between the insurer and the client."

"*This is a carefully drawn up document excelling at obfuscation with carefully drafted footnotes and an 'elephant in the room' exclusion for superannuation trustees.*

1. ASIC or some independent responsible body with countervailing power needs to determine their Code of Conduct.

2. All Superannuation Trustees must be forced to adopt an ASIC-sanctioned Code of Practice and the Code of Conduct should also apply to all in-force premiums and those consumers on claim.

3. All FSC without exemption should be compelled to accept their responsibility under a Charter of Conduct or be forced by the FSC to resign from the FSC.

4. Curiously the current 4 May 2012 FSC Code of Conduct: Code of Ethics & Code of Conduct states that "This Standard is relevant to all FSC Members" It doesn't bind them but is relevant ???. In 2016 the FSC suggests in their new Code of Conduct that they change this to allow members to be excluded from the Code of Conduct.

5. FSC members have been outed on the ABC and have been party to changing claimability clauses on insurance within super and increase in-force premiums with gay abandon. They have not demonstrated that they are an honourable group that can self-regulate.

6. The FSC set out that the FSC will determine the Life Code Compliance Committee (Life CCC) Charter (which we do not get to see) under which the FSC's judge (the LCCC) will operate, and perhaps the FSC will also selects

the members of the LCCC (its jury). Regrettably we are not told how or by whom the LCC will be appointed, nor how it will be funded.

12.1 The FSC is responsible for the development of the Code, including the Charter of the Life CCC

12.5 The Life CCC is made up of:

a) a consumer representative;
b) an industry representative; and
c) an independent chair.

7. If the FSC gets to choose 50% of the committee ie the industry representative (let alone the consumer representative) it automatically holds too much influence. The LCCC needs to be administered by ASIC.

8. The Draft Code of Conduct document is disingenuous when it adds exclusions such as:

Page 2 Footnote 1. For clarity, superannuation fund trustees who are members of the FSC are not bound by the Code unless they enter into a formal agreement with the FSC and the Life CCC under section 2.1(b).

Page 3 Footnote 2. The Code does not apply to interactions we have with you before we are bound by the Code;

9. Delayed claims should be referred on to the LCCC after the elapsing of a set amount of time for adjudication, resolution of delays and penalties for those responsible for the delays:

5.8 If we ask you to attend an assessment with a Third Party Service Provider, we will ask them to provide their report on the assessment within ten business days. If we request any other reports from Third Party Service Providers that do not require you to attend an assessment, we will ask for the report to be provided to us within four weeks of the date of request. If the Third Party Service Provider fails to meet these timeframes, we will inform you of this, and keep you informed of our progress in obtaining the report.

There is no circuit breaker in the Code to force progressing of a claim and indeed for FSC members to forced to cease prevaricating. Clients want resolution of claims, not information about administrative delays.

If a camel is a horse designed by a committee this Code of Conduct is more like an Okapi."