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Insurance • Commercial • Banking

Life Insurance Bulletin: Spring Edition

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OCTOBER 2021

Note from the Editor

October was a historic month in life and for life insurance.

An unmatched number of impactful reforms for the life insurance industry commenced in the first week of October, including new breach reporting requirements, design and distribution obligations and the duty to take reasonable care not to make a misrepresentation.

The ability of the industry through lockdowns to prepare for and meet the breadth of reforms is a testament to the resilience of the industry.

Of course, the changes don't stop with the October reforms. Further UCT and code changes are on the horizon and we preview these in this Bulletin, as well as discussing the regulatory guidance on the new breach reporting requirements.

As it happens, October also saw what appears to be the first court judgment relating to PYS notices and lost insurance cover due to inactivity under the PYS reforms. We discuss the ramifications of this noteworthy SADC decision for trustees and insurers. Interestingly, an underlying theme of this judgment was the value of life insurance contributing to a finding that the customer would have maintained cover if they had received notice that their cover was about to end due to inactivity. A further reminder that reforms which extinguished cover for certain cohorts may not have been the optimal way of protecting customers.

TPD definitions, claims processes and data continue to be areas of regulatory focus and we break down for you ASIC's Report 696 '*TPD Insurance: Progress made but gaps remain*'.

We also analyse some interesting AFCA determinations relating to an insurer's right to vary premiums and inappropriate life insurance financial advice.

A reminder that our next Life Matters webinar is on Thursday 4 November 2021 at 1pm. Turks life experts, Sofia Papachristos and Matt Corkhill, have prepared a great presentation on **LICOP 2.0 - The 5 key things you need to know**. If you would like to register, please email us and we will organise your registration.

We do hope you enjoy the read, perhaps at your favourite cafe!

As always, please reach out to a Turks life expert if you have any questions.

Hope to catch up with you all soon.

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LIFE AND SUPERANNUATION CASES

Court finds trustee, and not insurer, liable for life insurance cover that had ceased under the PYS changes

***Steer v AMP Life Limited & AMP Superannuation Ltd* (SADC 2021)**

Link to decision

Key Takeaways

There had always been concern that the harsher impacts of the Protect Your Super (**PYS**) legislation, which could lead to lost cover at times when an insured member needs the cover the most, may ultimately be borne out in more disputes.

The recent judgment in *Steer* therefore takes on natural significance as appearing to be the first judgment to consider PYS insurance obligations and the consequences of a member not being afforded an opportunity to maintain cover in the context of relevant legislative obligations.

The judgment makes clear that the courts will closely scrutinise whether a member was provided with an opportunity to maintain cover in PYS inactivity cases and indicates that trustees will be liable for the lost cover where a court considers that an insured member was not given the opportunity to maintain cover prior to it ceasing for inactivity. It is also apparent from *Steer* that a court will often make an assumption that an insured member would have elected to continue their cover had they been given the opportunity, which, of course, may not always reflect the practical reality of how members respond to PYS notifications.

Brief Facts

The Applicant in this claim was the executor of the estate of the Deceased member. The Deceased had been insured for death cover in the sum of $259,720.90 under a group insurance policy issued by the insurer to the trustee.

Between 2014 to 2019 the Deceased's life insurance benefits were maintained and premiums were deducted from her superannuation account by the trustee and paid to the insurer.

In March 2019, the PYS changes were introduced under the *Treasury Laws Amendment Act* (*Protecting Your Superannuation Package*) 2019 (**PYS changes**). The PYS changes meant that on and after 1 July 2019, trustees must stop providing insurance under a product to any member whose account has been inactive for a continuous period of 16 months or more and who has not opted-in to the cover. This requirement is reflected in s68AAA of the *Superannuation Industry (Supervision) Act 1993* (**the SIS Act**). Section 68AAA(2) provides that a trustee must ensure that the inactive member may elect in writing that the benefit is to be provided.

There were also requirements in the transitional provisions which required a trustee, in respect of inactive accounts, to send a notice in writing to such members before 1 May 2019. This notice was to state that on and after 1 July 2019 a benefit will not be provided to the member by taking out or maintaining insurance if the account was inactive and the member had not elected that the benefit will be provided even though the account was inactive.

The Deceased's account was inactive at all relevant times in 2019 within the meaning of s68AAA of the SIS Act as it had been inactive since 2014.

The trustee sent emails to the Deceased on 18 April 2019 and 4 June 2019 in which it advised the Deceased about the PYS changes and her right to make an election to maintain her life insurance cover.

A third email was sent to the Deceased dated 7 July 2019 and advised her that her cover had been cancelled on the basis the trustee was not able to provide life insurance benefits to her after 1 July 2019.

All of the above emails were sent to an email address of the Deceased at her previous employer, which the Deceased had not accessed since 2014. The Deceased therefore did not receive the emails.

The trustee had sent the Deceased her annual statements for years prior by post. At no time had the Deceased communicated with the trustee by email. There was no evidence as to how the trustee came to use the email address in terms of the PYS notices.

The Deceased died on 16 October 2019. Shortly before her death, the trustee sent her a letter on 10 October 2019 advising that it had not received an election from her and would contact her before cancelling the life insurance cover (although the cover had in fact been cancelled effective 1 July).

The Applicant, as executor for the estate, lodged a death claim on the policy but the insurer refused the claim on the ground the cover had been cancelled prior to the death of the Deceased.

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The Applicant took action against both the trustee and the insurer contending, among other things, that the trustee or insurer were liable for the death benefit despite cover having ended because the deceased was not provided an opportunity to maintain cover before it ceased in breach of various obligations owed by the trustee and insurer.

Judgment

The central issue in the case was whether the Deceased had effectively been notified of the effect of the PYS changes and given the right of election to maintain cover in accordance with the SIS Act and the transitional provisions.

The trustee argued that it complied with the notification requirements because it sent the disputed emails to the Deceased. The trustee relied upon s9 of the *Electronic Transactions Act 1999* (Cth) (**ETA**) which provides that where a person is required to give information in writing, that requirement is satisfied when the person gives the information by means of an electronic communication if the person to whom the information is required to be given consents to the information being given by way of electronic communication.

His Honour dismissed the trustee's arguments that consent to receive communications via the Deceased's former email address could be inferred noting that the change to electronic communications with the Deceased represented a change to the pre-existing form of communication between the parties and there was no evidence of the Deceased consenting to receive communications electronically.

The Court found that by not giving that notice to the Deceased and by subsequently cancelling the life insurance benefit, the trustee had:

> *'breached its duty to act in the best interests of the Deceased... In effect, [the trustee] has taken away a benefit of the Deceased without providing notice to the Deceased.'*

His Honour further held that the trustee breached its duty to act in the best interests of the Deceased by failing to comply with s68AAA of the SIS Act. His Honour found that s68AAA imposes an obligation on the trustee to ensure that the member is given an election and:

> *It can only ensure that a member is given an election if the member receives notification of the right to make an election. If the member does not receive notice, they cannot make an election. In the present case, I have found that the Deceased did not receive the disputed emails that were sent to the WEA email address. It follows that [the trustee] has not ensured that the Deceased has had an election...Clearly, it was in the best interests of the Deceased that she be given an election to continue to receive the benefit.*

Interestingly, His Honour also commented that the ETA does not apply to s68AAA of the SIS Act, but did apply to the transitional provisions, though in the end that finding does not appear to be critical to his conclusion.

Whilst His Honour found that the trustee had breached the best interests duty, he dismissed all allegations against the insurer as well as the other allegations made against the trustee.

> ***His Honour dismissed the trustee's arguments that consent to receive communications via the Deceased's former email address could be inferred noting that the change to electronic communications with the Deceased represented a change to the pre-existing form of communication between the parties and there was no evidence of the Deceased consenting to receive communications electronically.***

These other findings are worthy of comment and include:

- *Misleading and deceptive conduct* - Whilst the sending of the 10 October letter was misleading because it indicated that the Deceased still had cover, His Honour found that the letter did not cause any loss to the Deceased because it was never received (the Deceased having been in hospital and subsequently passing away on 16 October).
- *The insurer breached cancellation requirements* - His Honour considered that the Applicant's claim that the insurer did not comply with the cancellation procedures in either s210 of the *Life Insurance Act 1995* (Cth) or s59(3) of the *Insurance Contracts Act 1984* (Cth) was flawed because the insurer did not cancel the cover, rather, '*life insurance benefits were cancelled or surrendered by [the trustee]*'. Of course, such a finding reflects that cover ending due to '*inactivity*' is essentially an end of cover event and not a cancellation of any underlying policy.
- *Duty of utmost good faith* - The insurer was found not to have breached this duty in: providing notification to the Deceased about PYS changes (as this obligation rested with the trustee); not considering whether it was justified in cancelling the policy (as it was the trustee who undertook that act), and refusing to pay the claim (as cover had ended).

  His Honour also dismissed an argument that the trustee owed a duty of utmost good faith, finding that the contract was clearly between the insurer and the trustee and there was no contract of insurance between the trustee and the Deceased.
- *Unconscionability* – The Court found no evidence of any behaviour of the trustee meeting the test of

unconscionability. His Honour noted that merely sending the emails of notification to the wrong address is not of itself unconscionable.

Having found the trustee and not the insurer liable, there was a live issue as to how damages should be assessed.

Assessment of Damages

His Honour found that the breach of duty by the trustee caused the Deceased to lose the opportunity to elect to continue to maintain her death cover. Given it was a breach of a duty involving the loss of opportunity, His Honour held that the value of the lost opportunity must be determined.

The value of the lost opportunity was determined to be the whole life cover sum insured of $259,720.97 on the basis His Honour considered the Deceased would have elected to maintain cover had she been given the opportunity.

Some of the factors which His Honour felt supported the conclusion that the Deceased would have elected to maintain her life cover included:

1. The Deceased continued to pay premiums right up to the end of June 2019 (His Honour acknowledged that such premiums were deducted automatically from her account, the member statement showed the premiums deducted).
2. The election itself would have cost the Deceased nothing.
3. Her health was deteriorating so it would be illogical to allow the cover to lapse having maintained it for a long time.
4. The cost of premiums was insignificant to the amount in the account balance.
5. The Deceased had previously claimed a TPD benefit and knew the value of insurance.

Implications

Despite the decision in Steer being a decision of the SADC, the case is significant in representing the first decision to consider the PYS insurance obligations of a trustee and demonstrates how closely the courts will consider PYS communications to members. The scrutiny will encompass both the content of the notification and where it was sent.

The Court also confirmed that it will ultimately be the trustee and not the insurer responsible for insurance cover that ceases due to 'inactivity' in accordance with s68AAA of the SIS Act where an insured member was not given an adequate opportunity to opt in to maintaining cover despite being inactive.

Trustees should continue to ensure they have a robust process for PYS/PMIF notifications which ensure that a member is allowed the opportunity to elect to maintain cover prior to that cover ending due to a PYS or PMIF end of cover event, including that the notification is sent in a way that meets the SIS Act requirements.

Finally, it is clear that, despite a member's periods of inactivity, a court will lean towards a finding that a member would have maintained their cover if provided with the opportunity, especially when faced with an insured event that occurs soon after cover ceases. This makes it even more critical for a trustee to establish that the PYS notifications and the opportunity to maintain cover were provided in a way that meets the s68AAA requirements.

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PRODUCT / REGULATORY

The LICOP 2.0... the wait is almost over

Key Takeaways

Readers will recall our Winter 2020 issue of the Life Insurance Bulletin which provided a recap of the Life Insurance Code of Practice (**LICOP**); where things had been and where things were headed. We made note of the looming legislative changes seeking to implement, among other things, the enforceability of industry codes such as the LICOP and otherwise touched on the implications for the life insurance industry at large and what may come of the LICOP going forward.

The FSC released an updated draft LICOP 2.0 which seeks to give effect to the consultation process and stakeholder engagement process undertaken throughout 2020. As noted by the FSC in its report, the aim of this revised LICOP 2.0 is to '*ensure that the Code is as easy to read, and as easy to navigate for everyday Australians as possible.*'[1] Furthermore, to broaden its scope so as '*to provide further support to those who are vulnerable, include additional protections for consumers, ensure a consistent approach when communicating with consumers and to provide increased powers to the LCCC.*'[2]

The updated draft LICOP 2.0, released by the FSC on 18 August 2021, has been the subject of a second round of public consultation (which concluded on 29 September 2021) after which it is intended that the LICOP 2.0 will be submitted for registration under ASIC's new enforceable code regime. This article considers key changes contained within the LICOP 2.0 and implications for life insurers.

The LICOP 2.0

Consumer Consent

Whilst the LICOP 2.0 has an increased focus on communication and transparency with the customer, the requirement for insurers to obtain customers' consent to access personal information, whether that be for the purposes of underwriting or assessing a claim, is a clear example of the Code's attempt to provide better protections for consumers and instil within the LICOP improved industry practices when it comes to the collection and circulation of personal information.

Importantly for consumers, the LICOP 2.0 will require insurers to inform the customer on each occasion that their consent is to be used to obtain personal information and in order to give effect to this requirement, insurers must utilise modern means of communication and contact the customer by phone, SMS, email or similar to provide, wherever possible, the proper notification in this regard. The LICOP 2.0 states:

> *'Every time you make a new claim, we will ask for your consent for us to collect information about you, such as about your finances, job or health. We may ask you to consent to us requesting information from more than 1 source. We will tell you each time we use your consent by phone, SMS, email or similar when possible, to ensure you know quickly. If you do not agree that we need some of this information, we will review our request.'*

Indeed, the new LICOP 2.0 will demand that insurers employ more stringent policies and procedures to ensure that proper consent is obtained from customers wherever necessary, particularly when personal information of a customer or policy owner is to be obtained or shared. Obtaining consent from the customer will also extend to those circumstances where the customer or life insured is not the policy owner. Under the new LICOP 2.0, insurers will not be able to share the personal information of a customer who is not the policy owner without that customer's consent. This may typically arise in the context of group cover where a superannuation trustee is the policy owner (as opposed to the life insured) or where a retail policy may be issued to one person in respect of the life of another person.

Indeed, the new LICOP 2.0 will demand that insurers employ more stringent policies and procedures to ensure that proper consent is obtained from customers wherever necessary, particularly when personal information of a customer or policy owner is to be obtained or shared.

Duty to take reasonable care

Readers will also be interested to know that the new LICOP 2.0 takes account of the new '*duty to take reasonable care not to make a misrepresentation*' when applying

for a policy of life insurance. LICOP 2.0 will require that insurers adequately explain the duty to all customers and also advise of the possible consequences of not taking reasonable care when completing a proposal or application for a life insurance policy.

Furthermore, and consistent with the aims of the consultation process, insurers must ensure that the questions they ask in any proposal or application are in plain language wherever possible and while customers will not be required to have specialist knowledge to answer the questions posed, customers will be '*expected to have a good understanding of their own health, lifestyle and financial situation.*'

Of course, policies of life insurance are commonly sold over the phone and so the LICOP 2.0 seeks to provide consumers with adequate protections in these circumstances. Specifically, where questions are asked of customers face to face or on the phone, insurers must do so carefully, to help the customer understand what is being asked of them so as to assist the customer to comply with the duty to take reasonable care not to make a misrepresentation. Insurers will also have to repeat a question as many times as the customer reasonably requires, give the customer time to ask questions and ask the customer if they have understood the questions asked of them.

> *'We will give you a record or summary of the answers we use to assess your application no later than 10 Business Days of the cover starting.'*

Importantly for consumers, whenever an insurer determines to avoid a policy or one's cover under a group policy, LICOP 2.0 will require the insurer to issue a '*Show Cause*' letter that includes copies of any information that may be relevant to the decision, explains any remedies and the impact that the decision may have on the cover and otherwise gives the customer a chance to explain and provide any further information or documents for the insurer to consider. Of course, the provision of such '*show cause*' letters are already common place amongst insurers.

Claims & Complaints

Whilst most of the existing timeframes have been maintained in the LICOP 2.0, there is now an additional obligation on life insurers to advise consumers of a decision on the claim within ***5 business days***, once all information needed to make a decision, including the policy owner's response to Procedural Fairness or Show Cause letter has been obtained and once all steps have been taken to finalise the decision. Of course, the new LICOP 2.0 caters for those circumstances beyond the control of the insurer which may impact on meeting the timeframes. Regardless, if there is a delay in the decision making process, insurers will be required to update policy owners on the progress of the claim at least every ***20 business days*** (s5.50 (c)).

In relation to Income Protection claims, the LICOP 2.0 will require that insurers make payment of any income-related benefit by the later of the due date or within 5 business days of when the insurer has completed all reasonable enquiries, has obtained all the information reasonably needed to assess the claim, and has taken all the steps needed. Insurers will otherwise have to notify the policy owner or claimant that their payment will be late within 5 business days of the insurer becoming aware.

The new LICOP 2.0 will reduce the maximum time allowed for insurers to conduct interviews from 2 hours to only 90 minutes and otherwise provide increased protections for claimants throughout this process. Under the new LICOP 2.0, policy owners or claimants will have the right to a support person or interpreter if required and they will otherwise have the ability to determine the gender of the interviewer if that is at all possible. Intermittent breaks will be provided and the interview paused or postponed if it becomes evident that a support person or interpreter is required but for whatever reason, was not arranged.

With respect to complaints handling, the LICOP 2.0 provides for more rigorous time constraints than that seen previously. For example, there is now a requirement for insurers to acknowledge a complaint ***within 24 hours*** of lodgement or otherwise as soon as practicable (s7.2). Further, insurers must provide a written response to the complaint within ***5 business days*** and provide a final written response within ***30 calendar days***, barring any circumstances beyond the insurer's control. If there are such circumstances causing a delay, insurers will be required to tell the policy owner why there is a delay and otherwise keep complainants regularly updated about the progress of the complaint.

Finally, if a complaint relates to a policy of life insurance owned by a superannuation fund trustee, consumers can lodge a complaint with either the life insurer or the trustee. However, it is the trustee who must give the consumer a written response to the complaint ***within 45 days*** of lodging the complaint (s7.16). Notably, this 45 day timeframe is half the time stipulated in the current iteration of the LICOP (90 days).

Vulnerable Persons

The LICOP 2.0 will also further support customers experiencing vulnerability and financial hardship. This is another key pillar of the new LICOP 2.0. Under this new section, consumers are advised that if they need extra support due to vulnerability, the insurer will work with them to find a suitable, sensitive and compassionate option where possible. Insurers will do this as early as practical. Customers will otherwise be encouraged to inform insurers about any vulnerability they may have and if they need

extra support, the insurer can arrange support or help to access its services. This includes engaging extra support such as a lawyer, consumer representative, interpreter or friend. Insurers will be required to recognise the customers' needs in this regard and allow it in all reasonable ways. Insurers must ensure that its processes are flexible enough to recognise the authority of the customer's support person where possible.

This means of course that insurers will have to have in place internal policies and role-appropriate training to help its employees identify and understand if customer's are vulnerable, consider the customers unique needs or vulnerability, decide how to help the customer engage with the process and to what extent, and engage with the customer with empathy, compassion and respect. Finally, the LICOP 2.0 will require insurers to recognise that people living in remote and regional communities may have trouble meeting the timeframes set to provide documents or to take part in claims assessments. Accordingly, insurers will have to take this into consideration during the underwriting and claims processes.

Anti-Discrimination

The LICOP 2.0 has removed the reference that decisions on applications will comply with the requirements of anti-discrimination law. Naturally, such an obligation arises pursuant to the Commonwealth and various state anti-discrimination regimes so is unnecessary to restate in the code.

However, the current code did include references to other evidentiary matters in the context of decisions on applications, which did not necessarily mirror the anti-discrimination law requirements. To this extent, the removal of that wording would appear to result in the LICOP 2.0 being more closely aligned to anti-discrimination legislation.

Implications

The LICOP 2.0 sets clear obligations for insurers and underscores the industry's commitment to openness, fairness and honesty in all dealings with customers. It includes a range of customer centric provisions, including stronger protections for customers with a greater level of transparency in the underwriting, claims and complaints process as well as support for those experiencing vulnerability and financial hardship.

The enhanced customer protections place greater emphasis on life insurers making early decisions on the evidence required to assess a claim.

The LICOP 2.0 is likely to be a barometer for expected standards of life insurers in a range of disputes, which enhances the importance of complying with such standards. Of course, LICOP 2.0 will also take on additional prominence when certain provision within it are deemed enforceable code provisions.

[1]https://www.fsc.org.au/policy/life-insurance/code-of-practice/code-2-0

[2]Ibid.

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PRODUCT / REGULATORY

ASIC identifies areas of focus in relation to TPD Insurance

Key Takeaways

On 2 August 2021, ASIC released Report 696 '*TPD insurance: Progress made but gaps remain*'.

As the title suggests, this is a report card on the progress made by life insurers in addressing the industry wide issues identified in ASIC's report 633 '*Holes in the safety net: A review of TPD insurance claims*' (**REP 633**). Please see this link for the article we published on ASIC Report 663 on TPD - Analysis and Implications.

Whilst ASIC acknowledges the significant steps taken by most life insurers to assess and improve their practices in light of the issues identified by ASIC in REP 633, the report also identifies areas where ASIC considers further action is required. These areas range from product design and data capability to claims handling practices. In this way, ASIC Report 696 provides important insights into areas of TPD cover for both insurers and trustees that will likely be the subject of enhanced regulatory scrutiny.

Background

In REP 633, ASIC identified four industry-wide issues:

1. Poor consumer outcomes from the '*activities of daily*' (ADL) disability test.
2. Frictions in the claims handling process, contributing to withdrawn claims.
3. Consumer harm arising from life insurers having inadequate data to monitor product performance and consumer outcomes.
4. Higher-than-predicted declined claim rates for claims with certain features.

ASIC Report 696 provides an update on insurers' progress to address these issues.

TPD Definitions – ADL Test

ASIC noted that insurers had taken some of the following steps to address restrictive TPD definitions including:

- Providing options to their trustees for changing onerous ADL definitions in group policies.
- Broadening the eligibility criteria to assess consumers under an '*any*' or '*own*' occupation definition, rather than an ADL definition. ASIC notes that this should help lead to fewer consumers being funneled into restrictive definitions.
- Including mental health criteria in TPD definitions. ASIC commented that such a change should produce fairer outcomes for consumers with mental health claims.

Importantly, ASIC acknowledged most insurers had developed ways to measure customer experience, complaints, claims outcomes, claims loss ratios and lapse rates in order to better assess the value of their TPD products to customers.

Going forward however, ASIC made its expectations clear that:

- Insurers should continue to review restrictive TPD definitions and consider their removal or consider product redesign having regard to design and distribution obligations in effect from 5 October 2021. This includes engaging with trustees on TPD definitions as early as possible before renewals.
- Insurers should continue to improve the design of their products to meet consumer needs.
- For group insurance, trustees should continue to review whether their insurance strategies and offerings are meeting members' needs and providing value for money.
- For group insurance, trustees should proactively consider how they can refine the design and pricing of default cover working closely with insurers.

Claims Handling Practices

ASIC observed that most insurers had made efforts to identify claims friction points and improve claims handling practices. ASIC commented on the following enhancements made to claims handling practices:

- enhanced written and verbal communication with customers – with most insurers, for example, now offering customers alternative claims lodgement (such as paper, online and '*tele-claims*');

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- a shift towards minimal use of physical surveillance (ASIC again commented that physical surveillance '*would rarely, if ever, provide evidence of a consumer's mental health status and may exacerbate an existing mental illness*');
- enhanced controls for requesting medical information and investigating potential non-disclosure; and
- improvements to the format and/or content of claim forms and reduction in the length of some claim forms (as discussed below, ASIC also raised concerns regarding some claim forms still requesting more information than is needed).

ASIC also identified areas of claims handling which they considered require improvement and review. These included:

- streamlining tele-claim lodgement processes;
- focusing on the length and content of the claim form to lower hurdles for consumers;
- keeping more accurate records of withdrawn claims relative to a particular claim event; and
- continuing to enhance communications on the type of TPD cover an insured member may be eligible for in various circumstances.

In addition, the report referenced the need for insurers to comply with the new claims handling obligations coming into effect from 1 January 2022. This of course includes the overarching obligation to act efficiently, honestly and fairly in claims handling.

Interestingly, ASIC also referenced that trustees, in light of their obligations, should proactively address hurdles that members face when making a claim.

ASIC also flagged it will consider targeted surveillance of insurers if the consumer harms highlighted in the report are not addressed.

Insurer Data and Data Usability

The report identified data capability to be the area in most need of improvement. Whilst insurers have generally worked to strengthen their data capabilities, ASIC found there remain gaps in the data needed to properly monitor consumer outcomes. The top three data gaps identified include:

1. key claim events;
2. group data from trustees and intermediaries; and
3. claims experience of consumers assessed under each TPD definition.

The common theme to emerge from the data gap analysis is that captured data is not in ASIC's view stored by insurers in a consistent, searchable or reportable format.

ASIC's key message was that insurers need to uplift their data capability '*because poor data capability creates key conduct, compliance and governance risks, which can lead to financial risk.*'

Moving forward, ASIC has set out clear expectations for improvement by insurers in data capability, including:

- Continuing to invest in systems to capture, store and retrieve data, particularly in relation to key claim events (e.g. IMEs) and policy-level data.
- Maintaining searchable and reportable data to proactively identify trends and manage consumer harm.
- Using data to drive a consumer centric approach to designing, marketing and distributing sustainable products.

ASIC found that trustees also need to enhance their data capability for insurance in superannuation in line with the findings in Report 675 '*Default insurance in superannuation: Member value for money*', which we discussed here.

> ***ASIC's key message was that insurers need to uplift their data capability 'because poor data capability creates key conduct, compliance and governance risks, which can lead to financial risk.***

Implications

ASIC Report 696 identifies a number of ways in which life insurers have addressed key issues identified in REP 633.

Nonetheless, ASIC Report 696 also identifies areas within TPD product design, claims handling and, in particular, data capability where ASIC expects insurers to take steps. Significantly, whilst ASIC Report 696 is focused on findings from ASIC's work with insurers, the report also emphasises the key role trustees have to play in group TPD insurance and the areas where ASIC expects trustees to better monitor member outcomes in relation to TPD insurance.

As such, ASIC Report 696 provides a useful roadmap of areas of product design and claims handling that are likely to attract more regulatory scrutiny. These areas include the design and pricing of default insurance and the data analysis that sits behind this, restrictive TPD definitions, communicating on different TPD definitions, surveillance, reducing hurdles that members face when making a claim and non-disclosure investigations.

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PRODUCT / REGULATORY

Proposed enhancements to the Unfair Contract Terms Regime: What you need to know

Key Takeaways

The exposure draft legislation relating to enhancements to the unfair contract terms (**UCT**) regime has been released and contains a number of significant amendments to the UCT legislation which will have important consequences for the operation of the UCT regime in life insurance.

The consultation period for the exposure draft legislation *Treasury Laws Amendment (Measures for a later sitting) Bill 2021: Unfair contract terms reforms* (**the Bill**) and explanatory materials closed on 20 September 2021.

The changes introduced by the Bill (many of which had been flagged in previous consultations) include giving courts the power to impose a civil liability, providing more flexible remedies to a court when it declares a contract term '*unfair*' and clarifying the court's power to make orders that apply to other standard form contracts that contain an unfair contract term that is the same or substantially similar to a term the court has declared to be an unfair contract term.

The Proposed Changes

The Bill proposes changes to critical components of the UCT regime including the powers of the court, the classes of contracts covered by the regime and changes to definitions and exemptions. These changes are summarised below.

Powers of the courts

The Bill augments the court's powers under the UCT regime by:

- Providing courts with the power to impose a pecuniary penalty for a contravention of the UCT provisions in addition to the current ability to declare a term unfair.
- Providing more flexible remedies to a court when it declares a contract term unfair by giving courts the power to determine an appropriate remedy, rather than the term being automatically void (though the Bill retains the automatic voiding provisions present in the existing law).

  The extra flexibility may be important in the insurance context where declaring a term unfair, may, depending on the particular term, not provide a workable solution if, for example, the term declared unfair is the term under which a customer is claiming a benefit (such as a particular definition of TPD).
- Creating a new rebuttable presumption that terms found to be unfair that are subsequently included in relevant contracts in similar circumstances, are unfair. The presumption applies where the term is proposed by the same person who proposed the original unfair term or where the term is part of a contract that is in the same industry as the contract that contained the original unfair term.

  It follows that the declaration that a term is unfair in particular proceedings will have ramifications for the broader industry depending on how commonplace such a term is. Of course, the presumption that a term in a contract is unfair based on a previous court ruling can be rebutted in subsequent proceedings if there is evidence that the term is not unfair in the particular context of a different case.
- Clarifying the court's power to issue injunctions with respect to existing or future consumer or small business standard form contracts containing a term that is the same or is substantially the same as a term the court has declared to be an unfair contract term.

Class of contracts covered by UCT regime

The Bill expands the classes of contracts covered under the UCT regime by:

- Removing the upfront contract value thresholds for the definition of small business contract. The net effect is that provided a contract meets the other criteria of small business contract (as amended by the Bill as discussed below), the contract entered into by the parties will be covered irrespective of the upfront price payable under the contract.
- Amending the definition of small business contract from less than 20 employees to less than 100 employees or a business that has an annual turnover of less than $10 million for the previous income year.

  Consequently, more businesses will meet the definition of small business contract and importantly, further

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clarity is also provided on how employees are to be counted in determining whether a business falls within the 100 employee threshold. An exemption remains for casual employees not employed on a regular and systematic basis, but there is now also a pro rata assessment for staff employed on a part time basis.

> *Providing more flexible remedies to a court when it declares a contract term unfair by giving courts the power to determine an appropriate remedy, rather than the term being automatically void (though the Bill retains the automatic voiding provisions present in the existing law).*

Other definitions and exemptions

The Bill also introduces other definitional related changes including;

- Setting out matters the court must not consider when determining whether a party was required to accept or reject terms of a contract or whether a party was giving an effective opportunity to negotiate the contract.

  These new matters form part of the provisions about determining whether a contract is a standard form contract. They include that when determining whether a party was able to genuinely negotiate a contract a court is to disregard instances where a party has negotiated minor or insubstantial changes to the terms of a contract. A party's ability to select from a pre-determined range of terms within a contract is also to be disregarded as evidence that an effective opportunity to negotiate is provided to that party.
- Changes that make it even clearer the selection by an insured of certain available features will not change the contract from being a standard form contract. In addition, even contracts which may have a number of amendments requested by an adviser will not necessarily mean the contract is not a standard form contract depending on the nature of the changes made.
- Enabling certain clauses that include 'minimum standards' or other industry-specific requirements contained in relevant Commonwealth, state or territory legislation to be exempt from the protections.

Implications

The UCT regime only recently commenced in terms of insurance contracts. The further changes to the UCT regime proposed in the Bill will strengthen the remedies under and enforcement of the UCT regime.

The net effect of a term being declared '*unfair*' will also now have significant flow on ramifications for the usage of any '*substantially similar*' term by that insurer or within the industry (albeit, in practical terms a term declared unfair in one contract would likely cause a review of any similar term in other policies).

Overall, the proposed enhancements to the UCT regime underscore the importance of insurers continuing to monitor product terms against the '*unfairness*' test in the UCT provisions.

Insurers will also need to identify which contracts that may have previously been exempt, will fall under the new thresholds and ensure those contracts entered into after the Bill starts comply with the UCT test.

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PRODUCT / REGULATORY

New breach reporting obligations: ASIC Guidance

Key Takeaways

In September 2021, ASIC published its new Regulatory Guide 78 – Breach Reporting by AFS Licensees and Credit Licensees (**RG 78**) on the new and revised breach reporting obligations introduced by the *Financial Sector Reform (Hayne Royal Commission Response) Act 2020* (**FSR Act**).

The guidance provides important insights into ASIC's expectations as to how licensees should comply with the enhanced breach reporting requirements, including additional examples to those in draft RG 78 that had been released for consultation.

When do the new breach reporting obligations apply?

The FSR Act amends existing s912D of the *Corporations Act 2001* (Cth) (**the Act**), and introduces new s912DAA, with effect from 1 October 2021.

The new regime requires AFS licensees to report all '*reportable situations*' to ASIC that arise on or after 1 October 2021.

The former breach reporting regime continues to operate on a transitional basis for breaches (or likely breaches) that arise wholly before 1 October 2021, provided the licensee knows of the breach (or likely breach) prior to the commencement of the new regime.

What must be reported to ASIC

New s912DAA of the Act requires AFS licensees report to ASIC all 'reportable situations'.

In RG 78, ASIC refers to four types of '*reportable situations*', namely:

1. breaches or '*likely breaches*' of core obligations that are significant;
2. investigations into breaches or likely breaches of core obligations that are significant;
3. additional reportable situations; and
4. reportable situations about other licensees.

1. Breaches or likely breaches of core obligations that are significant

The first reportable situation is any '*significant*' breach (or likely significant breach) by a licensee or its representative of a licensee's '*core obligations*'.

'*Core obligations*' are those existing obligations under s912D(3) of the Act.

Before being reported to ASIC, a '**determination of significance**' will therefore be required by the licensee in a similar way to that under the previous regime (i.e. having regard to the relevant factors in s912D(5) of the Act which include the number and frequency of similar breaches, the impact of the breach/likely breach on the licensee's ability to provide financial services, and the extent to which the breach indicates the licensee's compliance arrangements are inadequate).

In certain situations, a breach (or likely breach) of a core obligation is a '*deemed significant breach*' that triggers an automatic reporting obligation.[1] These situations include breaches that result or are likely to result in '*material loss or damage*' to customers. The ASIC Guidance identifies that a licensee should consider the financial circumstances of clients (retail and wholesale) affected by a breach in considering whether loss or damage suffered is material.

The ASIC Guidance also provides examples of material loss and damage. An example provided relates to a superannuation fund trustee who identifies issues with its operation and control systems that led to overcharging of member insurance premiums. The trustee establishes that the individual loss to members is low but the breach collectively results in a large cohort of affected members (over 70,000) who suffer a significant collective loss (over $5 million). ASIC outlines that in assessing whether a breach results, or is likely to result, in material loss or damage to a member or members of a superannuation entity, a superannuation fund trustee should take into account the total and aggregated loss or damage to affected members of the entity, even if the individual loss per affected member is small.

2. Investigations into breaches or likely breaches of core obligations that are significant ('Reportable Investigations')

The high water mark under the new regime is that an investigation into a significant breach (or likely significant

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breach) of a core obligation is now reportable if the investigation continues for more than 30 calendar days. The outcome of such an investigation (whether or not a breach is found by the licensee) is also a separate automatic '*reportable investigation*'.

The time at which an investigation commences will therefore be critical for reporting purposes. ASIC makes it clear that it will not be a matter '*of a subjective determination*' by a licensee, but rather will be '*a matter of fact*'.

RG 78 explains that what constitutes a reportable investigation will depend on the specific facts of each case and '*is likely to vary significantly depending on the size of the licensee's business, their internal systems and processes, and the type of breach*'. ASIC adds that what is critical is '*the nature of the activities being conducted not which team is conducting them*', and how a licensee labels the activity in its internal processes will not be relevant to determining a reporting obligation.

Table 6 in RG 78 provides a useful example for life insurers relating to customer complaints (example 6(d)). ASIC also confirms that an investigation does not commence as soon as a customer complaint is received and/or acknowledged by a licensee. However, ASIC points out that when the licensee takes steps towards determining whether a significant breach has occurred, including further information gathering, then an investigation would be considered to have commenced.

> ***The time at which an investigation commences will therefore be critical for reporting purposes. ASIC makes it clear that it will not be a matter 'of a subjective determination' by a licensee but rather will be 'a matter of fact'.***

3. 'Additional reportable situations'

This includes conduct constituting gross negligence or serious fraud.

4. Reportable situations about other licensees

New obligations exist to report another licensee, such as a financial adviser where there are reasonable grounds to believe a '*reportable situation*' has arisen. The ASIC Guidance clarifies that there is no obligation for licensees to '*proactively investigate any possible misconduct of other licensees*', though they '*must not turn a blind eye*' to facts that would reasonably give rise to such concerns.

When and how to report to ASIC

Reports must be lodged with ASIC within 30 calendar days after licensees '*first know that*' (or are '*reckless*' as to whether) there are '*reasonably grounds to believe*' a '*reportable situation*' has arisen.

ASIC clarifies that '*reasonable grounds to believe*' a reportable situation has arisen ensures that the breach-reporting obligation is clearly '*an objective standard*'.

For investigations continuing after 30 days, as discussed above, these will automatically become a '*reportable situation*' on '*Day 31 of the investigation*' and there is a further 30 days to lodge a report with ASIC.

The consequences of not complying with breach reporting obligations are severe and can attract both civil and criminal penalties.

Reportable situations must be reported to ASIC using the prescribed form through the ASIC portal. ASIC will be enabling licensees to report multiple reportable situations in one transaction, provided they can be grouped together on the basis that they relate to '*a single, specific root cause*' (i.e. an underlying cause of the breach).

Implications

The new reporting regime will undoubtedly lead to a larger volume of breach reports to ASIC. Licensees have been preparing for such changes, including ensuring systems are in place for identifying, assessing, recording and reporting reportable situations to ASIC.

A key area of focus will need to be on when the 30 day clock starts to run on an investigation. The ASIC guidance provides commentary and examples that highlight ASIC's expectations that the 30 day timeframe can commence prior to any incident being referred to the legal department. Licensees will need to ensure processes are in place that reflect ASIC's guidance regarding the 30 day period.

[1]See s912D(4) of the *Corporations Act*.

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LIFE AND SUPERANNUATION CASES

VCAT considers the definition of '*domestic partners*'

***D'Arcy v Emergency Services Superannuation Board (Review and Regulation)* (VCAT 2021)**

Link to determination

Key Takeaways

In this decision, the **VCAT** considered whether the applicant and her deceased brother could, at the time of his death, be considered '*domestic partners*' under the *State Superannuation Act 1988* (Vic) (**SS Act**) such that the applicant would qualify for a '*partner pension*'.

The decision examines the interplay and development of legislation addressing domestic partner and independency relationships and in particular the phrase '*living as a couple on a genuine domestic basis*' and concludes that siblings are not capable of being recognised as '*domestic partners*' without a significant shift in the law.

Brief Facts

The deceased was a member of an Emergency Services Scheme (**the Scheme**). This membership allowed his partner to apply for a partner pension under s37(1) of the SS Act.

To be entitled to a partner pension under the SS Act, the person applying must be a '*spouse*' or '*domestic partner*' of the deceased member.

A claim for the partner pension was lodged by the deceased member's sister (**the Applicant**) in November 2019. The Applicant considered that although she and the deceased were related by family and therefore not spouses or in a romantic relationship, for all practical purposes they lived together and shared expenses and therefore the SS Act could entitle her to a partner pension.

The Board of the Scheme determined that the partner pension was not payable to the Applicant on the basis that:

- She did not satisfy the definition of '*partner*' under s3(1) of the SS Act.
- She did not satisfy the definition of '*registered domestic relationship*' under s3(8) of the SS Act.
- She did not satisfy the definition of '*domestic partner*' under s3(8) of the SS Act.
- She did not satisfy the definition of '*living as a couple on a genuine domestic basis*' under s3(8) of the SS Act.
- The Applicant and the deceased member were siblings and a recognised domestic relationship or couple living together on a genuine domestic basis must not be between persons who are related by family.

The Applicant applied to VCAT to review the Board's decision.

VCAT affirmed the Board's decision and found that siblings cannot be considered domestic partners and the Applicant was not entitled to the partner pension of her deceased brother.

Decision

In affirming the Board's decision, VCAT found that:

- The definition of '*domestic partner*' has not been a static one, but rather has been responsive to social change and adaptation in order to reduce discrimination against persons in same-sex relationships.
- When considering the SS Act, the *Relationships Act 2008* (Vic) and the amendments made to the concept of domestic partners by the *Statute Law Amendment (Relationship Act) 2001* (Vic) to the effect that siblings cannot be domestic partners of each other, VCAT noted that there would have had to have been very clear and express language in the statute had such a wide change been intended.
- Although the concept of '*domestic partner*' is not fixed and can be applied to a couple by having regard to all of the circumstances of their relationship and a number of commonly applied factors, siblings cannot be domestic partners of each other.
- The phrase '*living as a couple on a genuine domestic basis*' is not perfect and may not reflect the diversity of relationships which were traditionally defined by reference to romance and intimacy. However, when considering this phrase against common law cases, the phrase was intended and continues to be understood to refer to '*marriage like relationships between two people*'.

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- VCAT disagreed with the Applicant's submission that because the Board had accepted the Applicant and her late brother were in an interdependency relationship, she was entitled to the pension. VCAT noted that even if the concept of an interdependency relationship could be applied to the Applicant, there is no room for it to be considered because under s37 of the SS Act, the benefit in issue – a partner pension – is only payable to a '*domestic partner*' of a member of the Scheme.

> ***The phrase 'living as a couple on a genuine domestic basis' is not perfect and may not reflect the diversity of relationships which were traditionally defined by reference to romance and intimacy. However, when considering this phrase against common law cases, the phrase was intended and continues to be understood to refer to 'marriage like relationships between two people'.***

Implications

The decision of the Tribunal is of clear significance to trustees for its obvious implications for sibling relationships, in an area of the law largely silent prior to this decision. Notably, even in the face of legislative change, siblings are not capable of being recognised as '*domestic partners*' on the current state of the law.

The decision also highlights that while the phrase '*living as a couple on a genuine domestic basis*' does not necessarily reflect the diversity of relationships, the position remains that of requiring something greater than interdependency to be considered '*domestic partners*'.

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LIFE AND SUPERANNUATION CASES

AFCA finds insurer properly exercised its right to significantly increase premium rates

Link to determination

Key Takeaways

AFCA will generally recognise the right of an insurer to increase premium rates, regardless of the nature of the rate increase, if such a right is clearly set out in the policy, the notice period has been complied with and the insurer is able to demonstrate that it has increased premiums in a group (as applicable) and not singled out one particular coverage.

Brief Facts

The complainant held a combined income protection (**IP**) and business expenses (**BE**) policy with the insurer, which commenced on 9 December 1996.

The policy had a stepped premium structure, with premiums increasing each year in line with the complainant's age. The premium also increased as the sums insured increased annually in line with the Consumer Price Index.

The complainant had not taken issue with the premiums payable until December 2020, when the monthly premiums increased from $3,273.378 to $5,815.27. The complainant alleged this increase was unfair because:

- he had not made a claim for the policy benefits for 20 years; and
- the insurer was attempting to force him to cancel the policy as he is now at an age where he might make a claim.

The complainant further submitted that the insurer had not properly exercised its contractual right to increase premiums and claimed that such a right must be exercised reasonably and on proper grounds.

The insurer submitted a breakdown of the basis for the increase between the 2019 and 2020 policy anniversary notices, which showed the main reason for the premium increase was the insurer's decision to re-rate the policy.

The insurer also pointed to clauses in both the IP and BE policies that set out its rights to increase premiums in the following way:

> ***Increasing your premium***
>
> *We will increase your premium if you or we increase the benefit. Also, as mentioned in clause 22, when we calculate your premium rate, your premium can increase. And, regardless of your premium structure, we can increase your premium if we increase the standard premium table for all contracts like this one. We will give you one month's notice before we do that. There are no guarantees that the premium will remain the same.*

Determination

Firstly, AFCA considered whether it was within its rules to determine a dispute related to premiums.

Of course, AFCA's rules do not allow it to consider a complaint about premiums merely because a complainant is dissatisfied with an increase or is dissatisfied with the level by which it had increased.

However, in this case, the complainant asserted that the insurer had breached a legal obligation in increasing the premiums in the manner it did. Therefore, AFCA determined that it could consider the complaint.

On the more substantive question of whether the insurer had the contractual right to increase premiums in the way it did, AFCA determined:

- The policy provision was clear and unambiguous. It says the insurer can increase the '*standard premium table for all contracts like this one*'. If it does, it must provide one month's notice.
- The policy provision did not place a cap on the amount by which premiums could be increased.
- The insurer was able to demonstrate that it increased premiums for all policies in a group and it did not single out the complainant for the increase.
- The insurer complied with its ongoing disclosure obligations under s1017B of the *Corporations Act 2001* (Cth). Specifically, s1017B(5) which requires the insurer to give 30 days' notice before a change, such as an increase in fees or charges, takes effect.

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Implications

The determination shows that AFCA will uphold an insurer's right to increase premium rates provided relevant legislative (including, of course, the requirements under the *Life Insurance Act 1995* (Cth), albeit not referenced in this AFCA decision) and policy obligations are met.

> *The policy provision was clear and unambiguous. It says the insurer can increase the 'standard premium table for all contracts like this one'. If it does, it must provide one month's notice.*

Interestingly, AFCA's determination refers to APRA's concerns regarding the sustainability of IP insurance. Whilst sustainability of IP cover was not ultimately a factor relied upon by AFCA in finding for the insurer, AFCA's reference to sustainability at the very least indicates that AFCA is prepared to recognise the sustainability context in the context of premium rate increases. Insurers may wish to bear this in mind when facing similar complaints before AFCA.

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LIFE AND SUPERANNUATION CASES

Financial Advice: AFCA determines customer suffered no loss despite inappropriate insurance policy recommendation

Link to determination

Key Takeaways

AFCA's decision in case number 725328 highlights the need for financial advisers to understand potential restrictions on cover in the context of disclosures made by a client during the application process.

The decision is also a timely reminder that on the question of loss in financial advice insurance cases, complainants will have to prove that more appropriate policies were available to them than the cover which they were recommended.

Brief Facts

Ms M obtained Total and Permanent Disablement (**TPD**) and Income Protection (**IP**) insurance through a financial adviser, Mr T (**the adviser**).

The adviser recommended the policies as appropriate for her circumstances. During the course of the application process, Ms M made disclosures of prior mental health treatment. Although then in receipt of that information, and having forwarded the applications to the insurer, the adviser did not make further enquiries as to how the policies would operate to exclude disclosed pre-existing conditions and did not update his advice and recommendations on the appropriateness of the policies.

Ms M made a claim under the IP cover for disability arising from a mental health condition that was declined under the pre-existing conditions exclusion.

Ms M made allegations of misleading advice by the adviser to the effect that the insurer would review her medical history when approving her application for insurance; and her medical history would not impact the cover after the policies were approved. AFCA found that there was nothing to suggest that this advice was given.

However, AFCA also considered whether the adviser had breached the best interest test under s961B of the *Corporations Act 2001* and s916G which requires the resulting financial advice be appropriate to the client.

Determination

Liability

AFCA found the advice provided by the adviser did not consider whether Ms M's disclosures of her previous mental health treatment may impact the appropriateness of the policies, or explain to her how pre-existing conditions clauses in the policies may operate in respect of future claims.

The adviser's obligation to provide appropriate advice in the best interests of Ms M did not end with recommendations he made following the formal Fact Find and written Statement of Advice. Once he came into possession of further relevant information, he had an obligation to investigate whether the policies would be able to provide her desired level of cover considering her disclosures and it was fair to expect him to revise his advice if the investigations revealed the policies did not suit her objectives.

> *AFCA found the advice provided by the adviser did not consider whether Ms M's disclosures of her previous mental health treatment may impact the appropriateness of the policies, or explain to her how pre-existing conditions clauses in the policies may operate in respect of future claims.*

Loss

In considering what remedy may be appropriate for the failure to provide advice in the best interests of his client, AFCA looked at what would have occurred had the adviser considered those matters and given the advice regarding the pre-existing conditions clause.

AFCA emphasised that Ms M bore the onus of proving both the conduct complained of and the loss she suffered. AFCA looked at what the appropriate advice would have been and what Ms M was likely to have done once that advice was received. She had to prove that more appropriate policies of insurance would have been available to her, that the adviser should have advised her to enter into and his failure to do so caused her loss.

AFCA found that Ms M failed to prove there were policies available in 2015 which would have responded in the circumstances. Indeed, AFCA considered that the adviser could have appropriately advised that the '*policies remained appropriate considering her objectives*', and AFCA

found it was reasonable to think that Ms M would have still taken them out. Therefore, the adviser's conduct did not cause her to suffer a loss.

Implications

The determination is a reminder that the obligation to provide appropriate advice does not end with the formal Fact Find and written Statement of Advice and of the importance in the insurance context of assessing the medical history disclosed by a client in terms of the appropriateness of the cover recommended by the adviser.

However, the determination also affirms how AFCA approaches the issue of loss in such financial advice insurance cases and that financial advice insurance cases often turn on whether loss can be established. The issue of proving loss will often require a customer to establish that they would have obtained cover from another insurer at the time of the alleged inappropriate advice, which would have covered them in the way that they claim they should have been covered.

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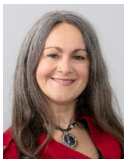

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