ASIC
Australian Securities & Investments Commission

When the price is not right: Making good on insurance pricing promises

Report 765 | June 2023

About this report

This report explains how failures by general insurers to manage non-financial risk have led to significant consumer harm. It also flags significant conduct issues being addressed by ASIC. The report outlines pricing failures identified by general insurers after an ASIC-initiated review of their pricing practices, and the improvements required to fix them. It confirms the standards general insurers need to meet in designing and promoting pricing promises to ensure consumers get the full benefit of any discounts promised.

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Disclaimer

This report does not constitute legal advice. We encourage you to seek your own professional advice to find out how the Corporations Act and other applicable laws apply to you, as it is your responsibility to determine your obligations. Examples in this report are purely for illustration; they are not exhaustive and are not intended to impose or imply particular rules or requirements.

Executive summary

Pricing misconduct occurs if pricing promises are made to consumers and then insurers fail to deliver on the promises in full. This conduct can amount to a contravention of the laws administered by ASIC.

A **pricing promise** is a representation by an insurer to provide a price-related offer (e.g. a discount), a benefit (e.g. gift card, loyalty scheme points or cashback offer), or a reward, including a statement that consumers will save money by taking certain action. This includes multi-policy discounts, no claims discounts and loyalty discounts.

General insurers may use a pricing promise to, among other things:

- attract new customers to purchase insurance policies
- encourage customers to stay with their insurer, and
- incentivise customers to purchase more policies with that insurer.

Ensuring that consumers are charged correct premiums and receive the full benefit of discounts, benefits or rewards promised is not only required by the law; it is the foundation of consumer trust and an efficient and competitive insurance marketplace. If pricing promises are not delivered in full, consumers will be overcharged for their policies or not receive all of the benefits. It can also exacerbate current pressures on access and affordability of general insurance for Australian households.

Consumers who believe they are receiving something of value from their existing policies can also be discouraged from shopping around, even if a pricing promise is not delivered in full (because the consumer may be unaware of this). An insurer may gain an unfair advantage over another by promising a discount to retain customers, then failing to deliver it in full.

Responding to failures by providers of general insurance to deliver on their pricing promises is one of ASIC's enforcement priorities for 2023.

The risks of pricing misconduct and resulting consumer harm have been known by general insurers for some years. The findings of this report reveal the cumulative consumer harm and remediation cost of general insurer inaction before ASIC's further intervention in 2021.

ASIC put general insurers on notice of these risks with a public announcement in 2013, the publication of a report in 2015, and a further public reminder in 2017. These represent missed opportunities for general insurers to comprehensively review their pricing promises and promptly rectify any shortfalls. Notably, ASIC observed significant pricing misconduct, as evidenced by increasing breach reports between 2018 and 2021, and decided a direction to undertake pricing reviews was needed.

The pricing reviews

On 15 October 2021, ASIC called on all general insurers to review their pricing practices, systems and controls to ensure consumers received the full discounts they were promised.

We subsequently wrote to 11 insurers (the participating general insurers listed in **Table 1** on page 5, collectively representing 68% of the general insurance market in Australia) requiring them to comprehensively review any inconsistency, or potential inconsistency, between the pricing promises made to consumers and the promises delivered—and find, fix, repay and report—any pricing failures.

The reviews by the 11 participating general insurers identified significant failures to deliver on the price discounts, benefits or rewards promised, as illustrated in **Figure 1** on page 4. Not receiving the discounts promised meant that more than 5.6 million consumers were overcharged more than an estimated $815 million across more than 6.5 million insurance policies.

The reviews demonstrated to ASIC that:

- not all the participating general insurers have had adequate product governance, systems, processes and controls in place to deliver on their pricing promises
- there has been an ongoing underinvestment in systems, processes and data, and
- the risks of pricing misconduct have been exacerbated by too much complexity in promise design and delivery.

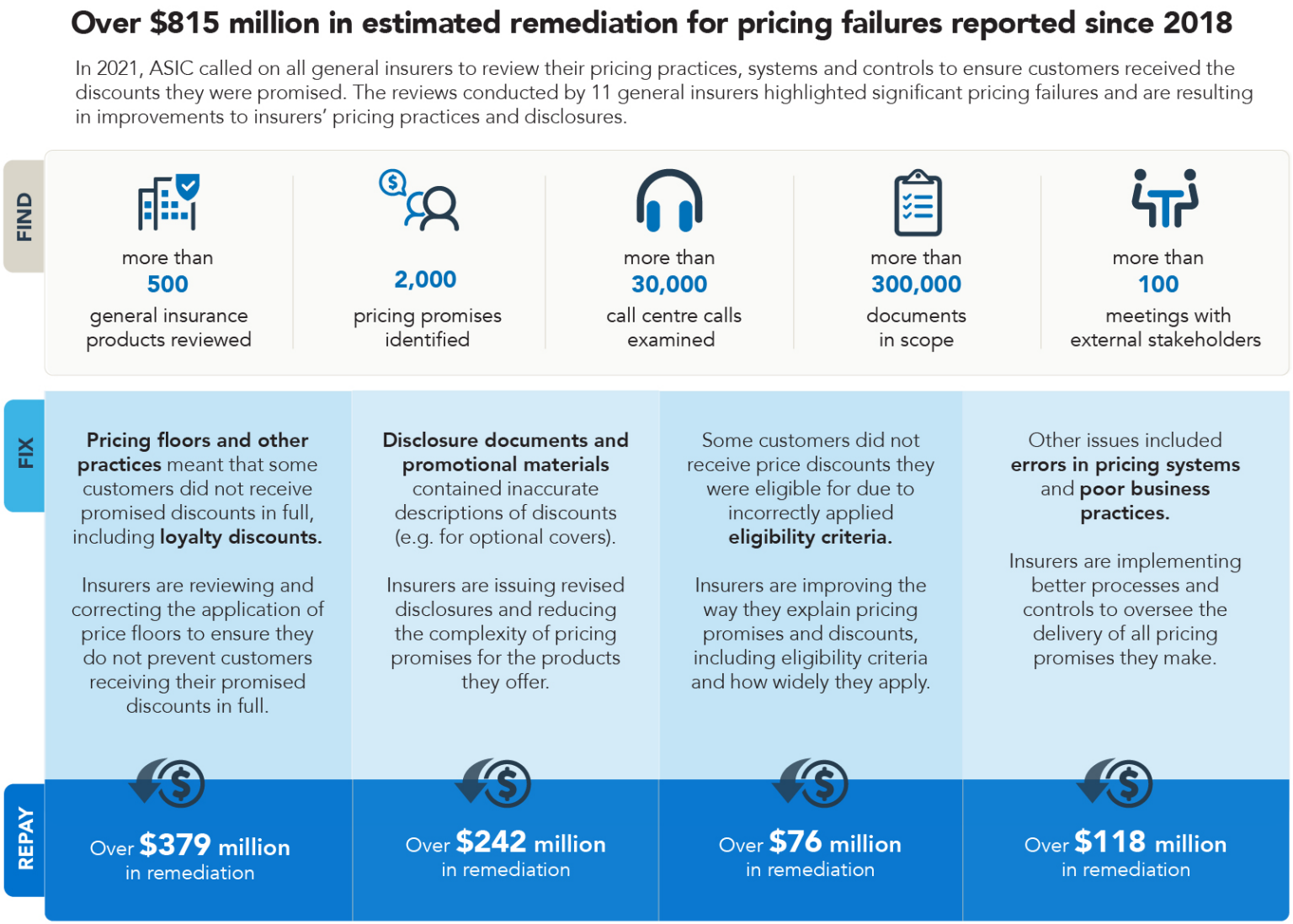
ASIC's work has resulted in the following outcomes:

- ASIC has taken civil penalty proceedings against Insurance Australia Limited (IAL) and RACQ Insurance Limited for allegedly failing to honour discount promises or misleading consumers.
- We have also commenced other investigations into general insurers involving suspected failures to deliver on price discounts promised.
- General insurers are remediating over $815 million to more than 5.6 million consumers, involving over 6.5 million policies: see **Table 1**. This is for pricing failures reported to ASIC since 1 January 2018.
- General insurers are fixing the identified pricing failures and improving systems, controls, processes, and product governance to ensure they honour their promises to consumers. Some insurers have issued revised disclosure documents, several are reviewing existing products and discounts to simplify them, and others are undertaking risk transformation plans to better manage their non-financial risk.

The pricing reviews have provided valuable insights into the systems, processes and governance within insurers for delivering on their promises, as well as a roadmap for the improvements required. It is now up to the boards to take responsibility for ensuring that:

- trust is rebuilt in the general insurance industry
- the improvements are implemented and working effectively, and
- remediation programs are comprehensive and completed in a timely way.

Figure 1: Significant pricing failures identified in the reviews



Note: See pages 2–8 of this report for a description of the outcomes in this figure (accessible version).

Table 1: Estimated remediation by participating general insurers for pricing failures identified and reported to ASIC since 1 January 2018

Name of general insurer (11)	Brands reviewed (50)	Estimated remediation	Estimated number of policies
Insurance Australia Group Limited (IAG), comprising: • Insurance Australia Limited (IAL), and • Insurance Manufacturers of Australia Pty Ltd (IMA)	Brands included: • for IAL—NRMA, CGU, Coles, IAL, LSV, SGIO, SGIC, Swann, WFI • for IMA—RACV	$447.2 million	4,254,000
RACQ Insurance Limited	RACQ, Carpeesh, Famous, Honey, Hug, RACWA	$222.0 million	759,000
QBE Insurance (Australia) Limited	QBE, Chu, MBInsurance, Victor	$90.4 million	746,000
AAI Limited	AAMI, APIA, CIL, Shannons, Suncorp	$19.6 million	165,000
Allianz Australia General Insurance Limited (previously Westpac General Insurance Limited) (see Note 2)	Westpac, BankSA, Bank of Melbourne, RAMS, St George	$13.2 million	130,000
The Hollard Insurance Company Pty Ltd	Woolworths, Arcadia, Fast Cover, Velosure, Real, Kogan, Medibank	$9.4 million	256,000
Youi Pty Ltd	Youi, Domain Insure, BZI	$4.6 million	86,000
Allianz Australia Insurance Limited	Allianz, Club Marine, TIO	$4.4 million	36,000
Auto & General Insurance Company Ltd	Budget Direct, ING Direct, Lady Driver, Qantas Insurance, Virgin Insurance	$3.9 million	92,000
Hollard Insurance Partners Limited (previously Commonwealth Insurance Limited) (see Note 3)	CommInsure, Bankwest	$0.9 million	14,000
Total		**$815.6 million**	**6,538,000+ policies**

Note 1: The 11 participating general insurers collectively represent 68% of the general insurance market in Australia, based on annual gross written premiums: see the Australian Prudential Regulation Authority (APRA), Quarterly general insurance institution-level statistics database, September 2017 to March 2023 (issued 25 May 2023).

Note 2: Westpac General Insurance Limited was acquired by Allianz on 1 July 2021 and renamed Allianz Australia General Insurance Limited.

Note 3: Commonwealth Insurance Limited was acquired by Hollard Holdings Australia Pty Ltd on 30 September 2022 and renamed Hollard Insurance Partners Limited.

Note 4: These estimates include interest, fees and taxes. Some general insurers have completed remediation programs. Other general insurers are still investigating the root cause of suspected breaches and we expect the final remediation figures to change.

Key requirements

While not exhaustive, ASIC expects general insurers will meet the following key requirements, which act as a foundation to comply with their legal obligations and reduce the risk of consumer harm. ASIC will consider action where there are contraventions of the law.

General insurers should be mindful of their legal obligations:

Corporations Act, s912A | **ASIC Act, consumer protection provisions** | **Insurance Contracts Act, s13**

Product governance

General insurers must have robust and effective product governance practices in place over the design and delivery of pricing promises. This should include the use of a centralised repository of pricing promises, and a regular review of products, to ensure that the pricing promises meet consumer expectations.

General insurers should take a proactive approach to risk, including thoroughly investigating reportable situations to identify the 'root cause' and other areas of concern highlighted across the industry.

Design and delivery of pricing promises

General insurers should use clear and concise language in promotional materials, so that consumers clearly understand the nature of the promise and the eligibility criteria that apply.

Consumers should not be required to prove their eligibility for a pricing promise where insurers already hold the required information.

General insurers should err on the side of disclosing more, not less, about any factors that affect the insurance premium, to ensure the disclosure is complete, promotes an understanding of the product and how it is priced, and meets community expectations.

General insurers should ensure that disclosures on price floors are well understood by consumers and that any representations made are consistent with how the consumer's premium is calculated. Pricing algorithms should be reviewed regularly to ensure they are operating as expected.

General insurers should implement measures to reduce the risk of pricing failures arising from range discount representations.

Loyalty promises

General insurers must ensure representations made in renewal communications are not false or misleading. Consumers should not be promised they are being rewarded for loyalty unless this is objectively true.

General insurers must ensure any statement or representation that offers consumers a competitive price is not false or misleading.

Monitoring and supervision

General insurers must adequately invest in and have systems, processes and data commensurate with the necessary complexity of the products sold and the promises made to consumers, including pricing promises.

General insurers should collect and regularly review policy-level data on pricing and use this data to test their compliance.

General insurers must have adequate oversight of third-party distributors to ensure consumers are receiving the full discounts promised. This includes monitoring, and supervision, supported by regular sharing of data and information.

Note: General insurers must ensure they provide financial services efficiently, honestly and fairly to comply with their general obligations under s912A of the *Corporations Act 2001* (Corporations Act). They must also comply with the consumer protection provisions of the *Australian Securities and Investments Commission Act 2001* (ASIC Act), including the requirement not to make false or misleading representations, and the statutory obligation to act with utmost good faith contained in s13 of the *Insurance Contracts Act 1984* (Insurance Contracts Act)

The use of pricing promises by general insurers

What harm is ASIC addressing?

Pricing misconduct occurs where pricing promises are made by insurers to consumers, such as price discounts, benefits, or loyalty representations, and insurers fail to deliver on the promises in full. This conduct may amount to a contravention of the laws which ASIC administers, including:

- the general obligations of Australian financial services (AFS) licensees to do all things necessary to ensure that the financial services covered by the licence are provided efficiently, honestly and fairly
- the consumer protection provisions of the ASIC Act, including prohibitions against false or misleading representations or misleading or deceptive conduct, and
- the statutory obligation to act with utmost good faith contained in s13 of the Insurance Contracts Act.

ASIC's previous work to highlight issues of concern

On 27 June 2013, ASIC publicly announced that the general insurance business of Suncorp Group was implementing improvements to its compliance systems following a failure to provide promoted discounts to:

- eligible multi-policy general insurance customers
- some senior card holders on their home and contents policies, and
- some customers who purchased contents insurance online with a portable cover option.

Note: See Media Release (13-155MR) *Suncorp Groups Life and General Insurance businesses to improve compliance systems following independent expert review* (27 June 2013).

In February 2015, ASIC issued Report 424 *Review of no-claims discount schemes* (REP 424), which found that no-claims discount schemes for motor vehicle insurance policies did not operate in the way that consumers might reasonably expect. In particular, we found that many insurers applied minimum premiums, which had the potential to undermine and limit the full no-claims discount entitlement for consumers.

Although ASIC highlighted risks of pricing misconduct in 2013 and 2015—with a further public reminder to general insurers in February 2017—between 2018 and 2021, general insurers continued to report a significant number of breaches or potential breaches. While we conducted several surveillances and investigations of general insurers during this time, the ongoing and systemic nature of the misconduct we identified led to ASIC taking further industry-wide action.

Note: See *Regulatory update to the general insurance industry*, speech by ASIC Chairman Greg Medcraft, 2017 Insurance Council of Australia (ICA) Annual Forum (17 February 2017).

What did ASIC do to address the harm?

In October 2021, ASIC commenced civil penalty proceedings against IAL and called on all general insurers to comprehensively review their pricing practices, systems and controls to ensure consumers received the full discounts they were promised.

Note: See Media Release (21-270MR) *ASIC launches Federal Court action and calls on general insurers to review pricing practices* (15 October 2021).

We subsequently wrote to 11 general insurers with an expectation that they conduct a review to confirm whether all discounts or price rewards the insurer had promised on all retail general insurance

products over the last five years had been fully delivered to all relevant consumers. We also provided a copy of ASIC's letter of expectations to the ICA for distribution to all its members, given ASIC's call to action that all general insurers conduct a review.

General insurers followed a structured process in their reviews:

- **Find:** Identify any differences between the prices promised to consumers and what those consumers were charged.
- **Fix:** Rectify the 'root cause' of the issue and fix relevant systems, processes, controls and governance practices.
- **Repay:** Remediate affected consumers.
- **Report:** Comply with breach reporting obligations to report significant or likely significant breaches to ASIC.

As a result of this process, the participating general insurers:

- reviewed more than **500 general insurance products**
- identified and tested the delivery of **2,000 pricing promises**
- examined **more than 30,000 calls in their call centres**, and
- identified and examined **more than 300,000 documents** relevant to pricing promises.

Since October 2021, more than 600 reportable situations have been notified to ASIC involving potential or suspected pricing failures, resulting in significant overcharging of premiums.

At the conclusion of their reviews, the participating general insurers provided ASIC with a report on the findings of their review.

What was the accountability for the conduct of the review?

ASIC required each participating general insurer to allocate oversight of their pricing review to an appropriate senior executive. We also required the senior executive to provide ASIC with written confirmation that, in their opinion, the review had been completed in a satisfactory manner.

We expect the responsible senior executives to continue their oversight of the remaining program of work until completion—both the consumer remediation program and the fixes to systems, controls, processes and product governance.

The senior executive is also required to provide a further attestation to confirm that the fix, repay and report phases have been satisfactorily completed.

We also expect the boards of the general insurers to be satisfied that the fix, repay and report phases of the review have been implemented in a complete and robust manner.

Effective product governance over pricing promises

General insurers need robust product governance processes to support the delivery of pricing promises to consumers. Effective product governance should be implemented across the product life cycle and should be supported by robust controls.

We attribute the weaknesses in product governance evidenced by the reviews to four main issues:

- a lack of a centralised repository of pricing promises
- poorly designed and administered processes
- siloed decision making, and
- inadequate product and pricing reviews.

No centralised repository of pricing promises

The participating general insurers sought to identify their pricing promises by reviewing marketing materials, disclosure documents, websites, marketing collateral, and correspondence with consumers. However, some general insurers lacked a centralised repository of all past and present pricing promises, and reported challenges in identifying pricing promises made to consumers.

This meant that insurers had to search the documents and marketing collateral to locate relevant promises. Some reviews involved using technology solutions to search the documents for relevant terms or phrases; other searches were conducted manually.

Keeping track of pricing promises

Due to the lack of a centralised repository of pricing promises, general insurers encountered various difficulties, including the following:

- Delays were experienced in undertaking the review due to the time taken to locate and extract documents from multiple sources. In some cases, documents were identified and reviewed only to find that they were never put to market and made available to consumers.
- Documents held by third-party distributors were subject to additional hurdles before review by insurers, such as privacy considerations and differing data and records management practices.

In the process of searching the disclosure documents and marketing collateral, general insurers identified some promises that were:

- inconsistent with pricing promises made through other channels (e.g. call centres)
- inconsistent with the insurer's practices for actually delivering the discount
- intended by the insurer to be limited to a time-specific promotion, rather than in perpetuity, or
- never intended by the insurer to be made in the first place.

Recognising pricing promises is just the starting point

Effective delivery of pricing promises is not possible if general insurers do not have robust product governance processes in place to track all pricing promises made to consumers. These processes support informed pricing decisions, and the monitoring and oversight of promises.

We expect general insurers to properly define a pricing promise and track all pricing promises to delivery through a centralised repository of past and present pricing promises. The repository could store eligibility details, internal approvals, and marketing materials for each pricing promise.

While promises may have been tracked through information sharing between business units, this was open to errors. Centralised record keeping within the insurer is also necessary where pricing promises are delivered by third-party distributors.

Poorly designed and administered processes

Some general insurers reported deficiencies in the design of their product governance processes, which contributed to pricing promises not being delivered to consumers. These deficiencies included insurers not clearly assigning responsibilities to business units and having inadequate documentation for even the most basic of procedures, such as approving marketing materials for a pricing promise.

Other governance processes were adequately designed, but compliance with these processes did not always occur or could not be evidenced. Governance processes for pricing promises administered by third-party distributors were particularly underdeveloped.

Promise design should be supported by robust testing before the business process or marketing campaign is implemented, to ensure it works effectively and pricing promises can be delivered consistently.

Siloed decision making and inadequate dialogue

We observed deficiencies in product governance processes and systems that contributed to pricing decisions being made in a siloed manner, as indicated by the following issues:

- Some insurers could not verify that pricing decisions were being reviewed and approved by relevant staff members or business units, as required by governance processes.
- Some insurers could not evidence a structured consultation process for pricing decisions, which meant they relied on individual staff members or business units to identify and escalate issues.

Siloed decision making and inadequate communication increases the risk of pricing promises not being delivered to consumers. A lack of coordination between business units means decisions are not fully informed and issues are less likely to be detected in a timely manner. The following example highlights the impact of inadequate controls and communication on marketing materials with pricing promises.

Example: Inadequate controls for marketing materials

One review identified shortcomings in an insurer's controls which required the internal legal team to review and approve marketing materials with pricing promises. As this requirement was not clearly documented, business teams only engaged the legal team when there were issues to escalate. The legal team's review and approval of materials could not always be evidenced due to a reliance on emails to communicate decisions rather than a centralised decision register.

Inadequate product reviews

There was evidence that previous product and pricing reviews and incident investigations had not been thorough enough to detect ongoing problems, even when there were known pricing risks.

For example, some Product Disclosure Statements (PDSs) referred to a discount the insurer never intended to provide. These issues were not detected despite the disclosure documents being reviewed and updated—often multiple times over many years.

Delays in identifying and responding to suspected pricing failures

ASIC has been monitoring reportable situations closely while engaging with general insurers about their review findings and plans to respond to the issues identified. Since October 2021, the participating general insurers have notified ASIC of more than 600 reportable situations involving potential or suspected pricing failures.

Our analysis of these reportable situations shows the median time taken to identify a breach was 52 days, with 35 breaches ongoing for more than five years before being identified: see **Table 2**. Further pricing breaches identified during the period 1 January 2018 to October 2021 were ongoing for, in some cases, more than five years, or in other cases, more than 10 years before being identified.

The significant amount of time taken for general insurers to identify pricing failures, and to investigate and identify the 'root cause' of the failure, highlights significant concerns with the insurers' ability to manage their non-financial risks.

If general insurers had identified the pricing failures much earlier, and investigated and identified the root cause in a thorough and timely manner, ASIC's intervention may not have been required and consumer harm and remediation costs would not have exceeded $815 million and extended to millions of consumers.

Table 2: Time taken to identify a breach

Time taken	Number of reports	Percentage of reports
7 days or fewer	12	2.8%
8–30 days	97	22.9%
31–90 days	172	40.7%
91–180 days	59	13.9%
181–365 days	20	4.7%
A year or more	63	14.9%

Note 1: Based on reportable situations notified to ASIC by participating general insurers involving suspected pricing failures during the period October 2021 to April 2023.

Note 2: This figure excludes 181 reports where the date of first instance or identification of the breach was not provided.

The reviews highlighted a small number of cases where, at an earlier date, insurers identified pricing failures that were likely occurring but decided to take no or minimal action at that time, including not remediating consumers. Again, this meant potential pricing failures were not thoroughly investigated or adequately addressed.

Fewer breaches, faster detection

The review process aimed to identify historical and ongoing issues and bring them into the open so they could be adequately addressed. Over the medium-to-long term, we would expect to see fewer pricing breaches occurring as more effective delivery systems are deployed, and improved detective and preventative controls are implemented.

However, we expect to continue to see some pricing breaches, as there will always be small errors. The key metrics to demonstrate change will be how long the breach has been ongoing and the level of resulting consumer remediation.

A proactive approach to risk

Since 2020, general insurers should have increased their focus on the management of non-financial risk, particularly after industry test cases on COVID-19 related business interruption insurance.

Note: For more information, see APRA, Letter to general insurers (19 July 2021) and findings from the Insurance risk self-assessment thematic review (26 October 2022).

From the reviews we noted that even when some general insurers had made public announcements about significant remediation after a failure to honour pricing discounts, other general insurers had not proactively investigated whether similar issues were occurring in their businesses. This indicated a lack of responsiveness to the publicly identified pricing failures across general insurers.

In ASIC's view, better management of non-financial risk involves general insurers responding to these developments in real time by taking note of announcements and reviewing whether the issues identified are occurring in their own business.

How are general insurers responding?

All participating general insurers have implemented or are in the process of implementing a centralised pricing promise repository, to support a more effective control environment.

Most participating general insurers are revising their product governance processes and enhancing record keeping requirements.

Several participating general insurers are making, or have already made, improvements such as clearer documentation of procedures and dedicated roles assigned for reviewing and approving pricing promises. These improvements will help ensure that decisions are properly informed and recorded.

Effective product governance over pricing promises: Key points

Effective governance over pricing promises should involve:

- a documented process for each stage of the pricing promise life cycle (e.g. design, approval, delivery, monitoring and closure)
- a process for assigning responsibilities to internal business units, with clearly defined reporting lines and decision makers
- 'user acceptance testing' and post-implementation reviews
- clear sign-off processes to ensure pricing changes are aligned with promises made in marketing and disclosure materials, and
- regular information sharing between business units and centralised record keeping to track pricing promises.

Product and pricing reviews and incident investigations should be thorough enough to identify the root cause of key issues. Improved governance of pricing promises should extend to older products.

Designing pricing promises

Consumers expect insurers to keep their promises in full, including pricing promises, otherwise insurers run the risk of making misleading representations to consumers and contravening the law. General insurers need to take a consumer-centric approach and should only make promises that they are confident they can deliver in full.

We found that it was difficult for general insurers to fully deliver on pricing promises because they:

- offer many different pricing promises with little consistency across the design of the promises
- use complex pricing practices with greater potential for error
- often do not use existing data to identify eligible consumers
- often require consumers to take action such as reconfirming their eligibility for a discount or price benefit, and
- often rely on systems requiring manual overrides by staff to fulfill promises (see pages 24–25 of this report).

Lots of promises and little consistency

The participating general insurers tested 2,000 pricing promises, across 50 brands and 500 general insurance products.

However, because many used sampling techniques, this does not reflect the total number of pricing promises issued for all the business underwritten by the participating general insurers during the five-year period of the reviews.

The promises made to consumers also differed based on the distributors and brands through which the policy was sold. For example, customers of one general insurer received reward points if they bought a policy through an authorised representative, but received a discount if they bought an equivalent policy directly from the insurer.

Insurers had different eligibility requirements for their pricing promises and there were no consistent definitions for some discounts.

In-kind promises

During the reviews we found that in-kind promises included money or cash equivalents, such as cash-back offers, gift cards, reward points or promotional offers (e.g. discounted groceries or competitions). We encouraged general insurers to review whether 'in-kind' promises were delivered, which we defined as promises for a benefit rather than a premium discount.

In-kind promises are often administered by third-party distributors. We observed that all the risks and findings that applied to traditional pricing promises also applied to in-kind promises, particularly those involving third-party distributors.

In-kind promises must be treated like any other kind of pricing promise—as one that must be capable of full, complete and verifiable delivery to consumers as promised. Where it is found that in-kind promises have not been delivered in full, consumers should be remediated.

Complexity leads to a greater chance of errors

General insurers have complex pricing practices, which can include the use of:

- pricing floors such as 'cups' and 'minimum premiums'
- differential pricing for new and existing consumers with similar risks, and
- randomised factors in the premium calculation intended to prevent third parties from 'scraping' online quoting systems.

General insurers introduce further complexity into their pricing process by having multiple systems for different products or imposing different eligibility criteria (or gate openers) for pricing promises.

We observed that much of the complexity was unnecessary and that these practices generally increased the risk of pricing failures and subsequent loss to consumers, particularly the application of price floors as discussed on page 17 of this report.

Consumer understanding and expectations

At times, we observed a disconnect between how a price promise was promoted in advertising and disclosure documents and how it was delivered by insurers, which may not meet community expectations.

When designing pricing promises and promotional material, general insurers should consider and take into account how consumers may understand the promise to operate. The reviews identified that the advertising and disclosure documents for some multi-policy discounts were often unclear. As a result, it may be difficult for a consumer to clearly understand how the discount operated.

Examples we noted include the following:

- Some insurers limited the multi-policy discount to certain products, and it was sometimes unclear in the advertising or disclosure documents which policies could receive the discount.
- Some insurers placed the onus on the consumer to ask whether the multi-policy discount 'may apply to other insurances' and required them to contact with the insurer for more information.
- Some advertising and disclosure documents did not contain a clear and complete explanation of the qualifications and exclusions that were intended to apply to the discount.

Dollar disclosure

Unclear advertising of discounts, or the eligibility for those discounts, can lead consumers into signing up for policies that do not deliver on their pricing expectations. General insurers must take care to ensure that the advertising of discounts is sufficiently simple and capable of being understood by the audience likely to see it: see Regulatory Guide 234 *Advertising financial products and services (including credit): Good practice guidance* (RG 234) at RG 234.116.

The 'dollar disclosure provisions' in the Corporations Act require various costs (including premiums) to be disclosed as Australian dollar amounts in PDSs issued by general insurers, except when ASIC has granted relief or as otherwise provided for in the *Corporations Regulations 2001* (Corporations Regulations).

ASIC has granted relief from the dollar disclosure provisions in certain situations: see *ASIC Corporations (Disclosure in Dollars) Instrument 2016/767*. If an insurer relies on this relief, they must include in the PDS a description of any significant factors that will affect the insurance premium *and* an explanation of the impact of those factors on the

premium: see Regulatory Guide 182 *Dollar disclosure* (RG 182) at RG 182.38–RG 182.40. ASIC's relief does not alter the substantive obligation to disclose the required information, only whether the information must be presented in Australian dollars.

A 'tailored' dollar disclosure regime in the Corporations Regulations also applies to general insurance products. When the dollar value of a significant cost (including premiums) can only be determined after the insurer assesses the risk of the consumer, the information can be stated in the PDS as a range of amounts in dollars, as a percentage, or as a description. However, the consumer must then be given a document stating the dollar amount of the insurance premium not later than five business days after the insurer has issued the general insurance product: see RG 182.15–RG 182.16.

The dollar disclosure provisions are designed to help consumers better understand information about costs (including premiums), together with fees, charges and benefits, by expressly requiring that information to be presented in Australian dollar amounts.

The tailored regime and ASIC relief, despite altering the operation of the dollar disclosure provisions, still contemplate general insurers providing consumers with adequate information about how insurance premiums are determined. The complexity in insurers' pricing practices that we observed in the reviews further highlights the importance of insurers providing a greater level of disclosure about the factors used to determine insurance premiums: see Regulatory Guide 168 *Disclosure: Product Disclosure Statements (and other disclosure obligations)* (RG 168) at RG 168.82.

Consumer onus and eligibility

Some pricing promises are targeted at specific groups of consumers where the insurer needs information from the consumer to demonstrate eligibility.

For example, in the case of an 'Over 55' consumer discount, the insurer requires information about the consumer's age. For a discount targeted at consumers who have fitted an electronic safety device to their vehicle, the insurer requires details of the enhancement.

We observed that the burden is often too much on the consumer to demonstrate eligibility, as highlighted by the following four scenarios:

- ***The consumer must request the discount because the insurer does not otherwise hold required information on the consumer's eligibility***. For example, the consumer may have to enter a promotional code or refer to a public-facing advertisement.
- ***The consumer must request the discount despite the general insurer being aware of their eligibility.*** In some cases, the insurer has data confirming a consumer's eligibility for a discount, but does not use it. For example, a consumer may need to contact the insurer each year to reconfirm their age, even though general insurers should have age-based information for risk calculations.
- ***The consumer must continually prove eligibility for a discount on renewal.*** For example, the insurer may require employees to submit a request for an employee discount, even though they have information identifying their employees. During the review period, eight of the participating general insurers identified that employees or associates had not received discounts that they were likely entitled to.
- ***Minimal information is provided about a discount.*** For example, the insurer may advertise a discount and rely on the consumer to prove eligibility but provide little information about how to access it.

As a result of placing too much onus on the consumer, insurers were often not able to identify consumers eligible for discounts.

How are general insurers responding?

General insurers are revising their pricing promises and:

- simplifying their discount offers and updating consumer eligibility information, making it easier to deliver on their promises
- reviewing the systems and processes used to administer pricing promises for anomalies, and
- reviewing and revising their promotional material and disclosure documents with the aim to provide greater transparency to consumers on how insurers determine offer eligibility and deliver on pricing promises.

In response to findings from the reviews, the participating general insurers have also:

- updated more than **530 web pages** or other promotional material to reduce complexity and clarify their insurance offerings and promotions, and
- revised or reissued **115 PDSs, policy documents or other disclosure documents**.

Greater transparency in the future is important to ensure that a consumer clearly understands the pricing promise, and consumer eligibility, so that an insurer can be held to account to keep their promises or remediate a consumer if things go wrong.

Designing pricing promises: Key points

General insurers should put consumers first when designing pricing promises and:

- ensure that they only make promises that they are confident in being able to deliver in full
- ensure consistency with community understanding and expectations of how promises and discounts will work, and
- consider the relative difficulty for consumers in establishing their eligibility for discounts or offers.

Consumers should not be required to prove their eligibility for a pricing promise where insurers already hold the required information. Where possible, insurers should proactively use data they already have to determine eligibility for pricing promises and calculate premiums. This will avoid situations where a consumer purchases a product on the understanding that they are eligible for, and will receive, a discount, but the discount is not applied.

General insurers should err on the side of disclosing more, not less, about any factors that affect the insurance premium, to ensure the disclosure is complete, promotes an understanding of the product and how it is priced, and meets community expectations that are well informed and current.

Delivering on pricing promises

Effective promise delivery means being able to provide consumers with the promised price or benefit in a consistent and verifiable way. General insurers need to have structured processes to ensure that promises are delivered; this includes effective implementation of pricing discounts so they are calculated reliably and accurately.

Application of price floors

It is common for general insurers to use pricing constraints such as cupping (or collaring), capping or minimum premiums to manage variations in premiums when consumers renew policies.

Cupping (or collaring) **and capping** involve applying a price floor or a price ceiling to year-on-year premiums for renewing consumers. Cupping (or collaring) is used to limit large price *decreases*, whereas capping will limit large price *increases* to smooth any large price variances for the consumer. This may also allow the insurer to retain market share.

In contrast, a **minimum premium** only involves the application of a price floor. A minimum premium may be applied at renewal to prevent a consumer's premium dropping too low or to ensure there is a certain profitability level for the insurer.

Note: In 2020, the Australian Competition and Consumer Commission (ACCC) published its final report as part of the Northern Australia insurance inquiry. The report contains a detailed explanation of how insurers generally set premiums: see Chapters 4, 5 and 10.

Price floors can interfere with pricing promises

A pricing failure can occur when a price floor prevents a consumer from being provided with the full discount that has been promised.

In February 2015, ASIC found that many insurers applied minimum premiums, which had the potential to undermine and limit the full no-claims discount entitlement for their consumers: see REP 424.

Despite earlier calling out the risk of consumer harm arising from these practices, **six of the participating general insurers** in their reviews identified that the application of price floors in their business had resulted in promised discounts not being delivered in full. In October 2021, ASIC commenced civil penalty proceedings against IAL alleging that price floors (specifically a cupping mechanism that was historically applied to certain renewing premiums) had resulted in certain promised discounts not being honoured in full: see 21-270MR.

Remediation due to the misapplication of price floors is estimated to be **more than $379 million,** or close to half of the over $815 million expected to be paid to consumers by general insurers for the failure to deliver their pricing promises in full.

We observed that this generally occurred for the following reasons:

- ***Incorrect order of pricing algorithm***: To ensure consumers receive promised discounts, pricing algorithms should be structured so that the discount is calculated *after* the price floor has been applied. Instead, we found that pricing algorithms were structured so that the discount was applied *before* the price floor. If the price floor was triggered, the consumer may not have

received the full promised discount, resulting in consumer harm, as shown in the example below.

- ***Poor disclosure***: In some cases, insurers failed to disclose that a discount could be limited by the imposition of a price floor.

These are relatively straightforward risks that general insurers should have been able to identify through good product governance.

Example: Incorrect order of pricing algorithm

To demonstrate the impact of an incorrect order of a pricing algorithm we use a simplified, hypothetical example. In this example the pre-discount premium is $100 and the general insurer has advertised a 10% discount while applying a $95 price floor.

Discount applied before price floor	Discount applied after price floor
Pre-discount premium = $100 *10% discount applied* Post-discount premium = $90 Price floor triggered as post-discount premium is under $95 Premiums charged = $95 The consumer does not receive the 10% discount as promised.	Pre-discount premium = $100 Price floor not triggered as pre-discount premium is over $95 *10% discount applied* Post-discount premium = $90 Premium charged = $90 The consumer receives the full 10% discount as promised.

Note: This example is for illustrative purposes only.

Disclosure is not a complete solution

Taking a broader view, it is important to acknowledge that:

- price floors can have the effect of reducing the value of a pricing promise the consumer **thinks they are getting**
- consumers often **don't know this is happening**, and
- consumers often **don't understand** the disclosure and industry terms such as 'cupping', 'collaring' or 'minimum premiums'.

ASIC considers that the use of opaque disclaimers such as 'minimum premiums may apply', which are often hidden at the bottom of a web page or in a lengthy PDS, does not solve these issues. Disclaimers and qualifications should have sufficient prominence to effectively convey key information so as to not be misleading or deceptive. The limited effectiveness of disclaimers and warnings was highlighted in Report 632 *Disclosure: Why it shouldn't be the default* (REP 632).

Disclosure of the existence of pricing floors should not be considered a panacea for all accompanying price representations. It should not be used to mitigate risk in the event of future pricing failures.

Delivering on pricing promises: Key points

General insurers should regularly examine their promotional material and disclosure documents to ensure that the disclosure on price floors is clearly understood by consumers and that any representations made are consistent with how the consumer's premium is calculated.

General insurers should consider how disclosure of the existence of price floors can influence consumers' behaviour, and improve transparency and engagement accordingly.

General insurers should regularly review their pricing algorithms to ensure that they are operating as expected and not contravening the law.

Range discount representations

Explicit discounts and price offers, whether in dollars or percentages, are not always expressed in fixed terms (e.g. 'save up to $200' or 'up to 10% off'). The reviews identified cases where general insurers had advertised discounts expressed as a range of outcomes rather than fixed terms, and then not fully delivered on those promises.

RG 234 contains guidance to help insurers when they consider designing pricing promises and making range discount representations, to avoid making false or misleading representations to consumers and contravening the law. The guidance includes the following example:

> *ASIC does not consider [financial firms] can rely on a statement such as 'up to X%' to describe the discount if in fact it is only available in limited circumstances and this is not prominently disclosed. The use of qualifying phrases such as 'up to' or 'from' should generally be approached with caution because the overall impression created by an advertisement may still be that the maximum benefit is more widely or readily available than is in fact the case*. (RG 234.47)

Harm arising from range discount representations

The reviews identified specific issues with range discount representations and promise delivery, which contributed to consumer harm:

- ***Consumers did not always get what was promised***. In some cases, the maximum discount offered was either mathematically impossible or practically unattainable for most consumers. Sometimes this was due to interaction with other pricing failures.
- ***Discounts were calculated incorrectly***. This could be, for example, because of interacting discounts where one was expressed as a fixed dollar amount and a second as a variable percentage.
- ***Some insurers lacked criteria for delivering range discounts to eligible consumers***. Several insurers are introducing new or more transparent criteria as well as improving their product governance, oversight and controls around the use of fixed versus variable discounts.
- ***Advertising and design of promises were opaque***. For example, a consumer may not know the exact discount they are owed within a range. Some range discounts were applied with minimal reference to the factors underpinning the offer.
- ***Discounts were not based on the whole premium***. In some cases, the discount applied to only part of the premium (or even part of the *technical premium*). This fact was not always prominently advertised. General insurers should ensure that consumers understand industry terms for components of the price of the product, such as 'technical premium', if they intend to use them.

The muddled purpose of range discount representations

The issues listed above were compounded by the muddled purpose of these representations, encompassed by two underlying themes. First, insurers had **different perspectives on how range discount representations would operate**, revealed in the following ways:

- Some insurers took the view that range discounts were calculated and provided at their discretion.
- Some insurers took the view that these offers provided flexibility to apply the discounts to relevant components of the insurance, rather than the total premium.
- One insurer advised that discounts were deliberately expressed as a range in advertising to allow for different results to be calculated by the pricing engine.

Second, there was often insufficient consideration of how **an offer expressed as a range or variable amount would be fully delivered.** In ASIC's view, the following key questions should be considered during the product life cycle to ensure the pricing promise is delivered:

- Are consumers getting what has been promised?
- How does a consumer access the 'X% off'?
- What is the 'X% off' based on?
- What qualifications apply?
- What other key information does a reasonable member of the audience require to understand the offer?

The pricing failures identified through the reviews generally demonstrated insufficient consideration of at least one of these key questions.

How are general insurers responding?

General insurers are responding by:

- updating their disclosure about the existence or application of minimum premiums (or other kinds of price floors)
- changing their pricing algorithms to ensure that discounts are no longer reduced by minimum premiums
- reviewing 'up to' discounts, the appropriateness of campaign language and the effectiveness of disclosure (where necessary frameworks to deliver these discounts are being revised), and
- updating systems and policy documentation to align the explanation of discounts with the pricing mechanisms used.

Delivering on pricing promises: Key points

General insurers should review their representations to ensure consumers clearly understand what is being offered and how widely or readily available the offer is. Where a discount is not based on the whole premium, insurers should consider whether the offer can be redesigned to make them clearer to consumers.

Range discounts should be applied based on an objective formula, rather than on an arbitrary or discretionary basis. Insurers should ensure that where discounts are expressed as a range, the maximum level is attainable by a reasonable number of consumers.

To reduce the risk of pricing failures arising from range discount representations, general insurers should put in place:

- internal criteria setting out what discount within a range consumers can expect to receive
- processes for validation demonstrating the maximum level of the discount that is attainable and being delivered
- processes and product governance around how discounts expressed as a range will be delivered to consumers that is efficient, honest and fair, and
- monitoring to ensure that discounts are delivered in a manner that is consistent with the internal criteria.

When remediating consumers for range discounts, insurers must place the consumer in the position they would otherwise have been in but for the breach. If a consumer satisfies the internal criteria for a specific discount within a range, the refund should be calculated based on that discount. If there were no criteria, the insurer should determine a reasonable basis for any remediation.

Honouring loyalty promises

The ability of a general insurer to secure a consumer's renewal business is a key component of profitability for most lines of personal insurance.

Loyalty discounts can be based on several factors, such as the length of the consumer's relationship with the insurer and the number of policies held. These discounts can be quite formulaic and explicit by promising set discounts based on certain criteria. Loyalty discounts may discourage consumers from switching providers because these discounts:

- tend to offer more generous benefits the longer the consumer stays with the insurer
- typically are not transferrable to another insurer, and
- capitalise on existing inertia for consumers to stay with their existing insurer rather than shop around.

From the reviews, we observed that loyalty discounts were offered by several insurers, although there was no consistent approach to loyalty promises.

Some insurers found that their loyalty discount promises were affected by pricing failures noted elsewhere in this report, such as the application of price floors that were not disclosed to customers, resulting in a need to remediate consumers. One such example was the subject of ASIC's court action against IAL: see 21-270MR.

The 'value' of loyalty promises: A moving target

We are concerned that some general insurers may be making positive representations about rewarding loyal consumers (e.g. for years of tenure) that could be inconsistent with how the pricing engine is calculating the premium for the consumer.

In ASIC's view, loyalty representations made by general insurers may be misleading if consumers do not get the full benefit of the promised discounts. This may occur if:

- any loyalty discount or benefit promised is reduced or offset by the application of a 'loyalty tax', or
- general insurers promise a loyalty discount but do not fully disclose what factors may affect the discount.

'Loyalty taxes' involve a general insurer considering a renewing consumer's price elasticity (i.e. whether they are more or less likely to shop around for a better insurance premium) and then charging renewing consumers who are less likely to shop around a higher premium than other consumers (with similar actuarial risk profiles for the same risk). This practice may also take into account other attributes that may affect whether the consumer is likely to shop around (e.g. postcode or income).

Some overseas regulators, such as the Financial Conduct Authority (FCA) in the United Kingdom and the Central Bank of Ireland, have introduced rules to ban a loyalty tax known as 'price walking', which the FCA defined as 'gradually increasing the price to consumers who renew with [the insurers] year on year'.

How can loyalty promises be misleading?

General insurers should ensure they are not making misleading representations that consumers are being rewarded for loyalty, or are being 'looked after', or are receiving something of value by remaining with the insurer if that is not the case.

There needs to be an objective basis for making representations that consumers are being rewarded for loyalty to ensure these representations are not false or misleading.

Any loyalty benefit is reduced by the application of a loyalty tax

In 2020 the ACCC published its final report from the Northern Australia insurance inquiry.

Two observations in this report are worth highlighting:

- In 2018, Australian consumers renewing their combined home and contents insurance paid on average between 7 and 24% more than new customers.
- In contrast, the maximum loyalty discount offered to consumers by the main insurers in Northern Australia in 2017–18 was 17.5%.

Note: See ACCC, *Northern Australia insurance inquiry* final report at p. 86 and p. 247.

This research highlighted that some consumers who remained loyal to a single insurer paid higher premiums than new customers despite the use of loyalty discounts, and that the value of any loyalty discount offered by an insurer to these consumers may be reduced due to the higher premiums charged to the renewing customer. While the ACCC also observed the difference may be decreasing over time, with increasing use of more sophisticated pricing techniques, we believe it is important for insurers to consider whether this is occurring in their business.

Example: What does this mean for consumers?

Jessie has had home, contents and comprehensive car insurance with Insurer ABC for 20 years. Insurer ABC has promised Jessie a discount of 15% off her premium for the number of years she has held a policy and the number of policies held.

However, Insurer ABC is also charging Jessie a loyalty tax by charging her 20% more on insurance renewal than it would for a new customer with the same risk profile.

Note: This example is for illustrative purposes only.

How do loyalty taxes interact with the use of big data?

ASIC is concerned that loyalty promises and representations don't always fully disclose or capture the nuance of:

- how general insurers actually set their premiums, including what data may be used, and
- how this may affect the loyalty benefit consumers are promised.

As general insurers continue to develop their use of price optimisation and big data to set premiums for consumers, there is a need to consider whether these techniques may be incompatible with loyalty promises.

For example, insurers may make a promise to reward loyal consumers but at the same time use big data to identify price inelastic consumers and allocate larger price increases to those consumers. This would not meet community expectations as consumers who are more 'loyal' or do not shop around may receive larger price increases that are inconsistent with the loyalty promise.

Loyalty representations through 'soft' promises

In the United Kingdom, the FCA has previously fined a group of companies including Lloyds Bank General Insurance Limited more than £90 million for failing to ensure that language contained in renewal communications was clear, fair and not misleading.

Note: See FCA, *FCA fines LBGI £90 million for failures in communications for home insurance renewals between 2009 and 2017*, media release (8 July 2021).

As part of their reviews, we asked general insurers to consider whether the use of differential pricing between renewing and new business customers affected whether consumers received any 'loyalty' discounts or rewards.

We also asked insurers to identify whether disclosure documents and marketing collateral contained any unsubstantiated statements or language that could cause cost-conscious consumers to believe that they were receiving a reward for loyalty, or something of value, for remaining with their insurer. Examples of these 'soft' or 'micro' promises include insurers promising to provide consumers with a 'competitive price' or to simply 'reward consumers for [your] loyalty'.

Insurers were asked to identify whether any consumer promises, particularly 'soft' promises, were being made in call centres as we considered this to be a high-risk environment for this type of language.

Summary of the call centre reviews

In total, general insurers reviewed **more than 30,000 call centre calls**. The call centre reviews were generally positive about the effectiveness of the insurers' existing quality assurance processes in identifying deviation from approved scripts.

A small number of competitive price representations made by call centres were identified, but usually in isolated instances. Examples included statements such as 'competitive price', 'best price', 'best offer', 'very good cover' and 'invaluable cover'.

Broader pricing failures were also identified in the call centre environment during the reviews. For example, one insurer reported to ASIC that, during a call centre interaction, it identified that some multi-policy discount codes were not being applied to home and contents insurance products from the policy's inception. Further investigations identified a broader problem with an estimated financial impact on consumers of $3.4 million. This insurer is remediating affected consumers.

The participating general insurers are responding to the findings of the call centre reviews as appropriate.

Honouring loyalty promises: Key points

General insurers must ensure that there is a proper basis for any pricing promise language contained in renewal communications and that representations made are not false or misleading.

General insurers must not promise consumers that they are being rewarded for loyalty unless this is objectively true in an overall sense.

General insurers must ensure any statement or representation that offers consumers a competitive price is not false or misleading.

General insurers should monitor consumer interactions through call centres and act where issues with promise delivery arise.

Monitoring pricing promises

The promise life cycle does not end when consumers are provided with a product. It is important for general insurers to have strong internal processes—including quality assurance, controls, monitoring, and oversight—which demonstrate the ongoing delivery of pricing promises to the necessary standards and that insurers are not contravening the law. These processes should also allow for timely rectification of problems that are identified.

Deficiencies in systems, processes and data

The reviews identified specific problems that interfered with the consistent delivery of pricing promises. These problems primarily involved system and data limitations, poor data practices, and inadequate tools for insurers to calculate prices and premiums.

General insurers have been challenged by both ASIC and APRA to invest more in systems (including IT systems), processes and data for a number of years as part of uplifting their risk management practices. ASIC considers that a lack of data and other forms of management information, together with the consolidation of brands in the industry across multiple legacy systems, have contributed to the scale and longevity of the issues that were uncovered in the reviews.

Note 1: See *Legacy, operational risk and the changing consumer*, speech by APRA Executive Member Geoff Summerhayes, Actuaries Summit, Melbourne (22 May 2017) and *APRA Deputy Chair Helen Rowell—Speech to the Insurance Council of Australia's 2022 Annual Conference* (2 November 2022).

Note 2: See also *General insurers: From trust-deficit to trust-dividend*, speech by ASIC Deputy Chair Karen Chester, 2021 Annual Industry Forum of the Insurance Council of Australia (13 October 2021).

System and data limitations

Some general insurers had **errors in their quoting systems**, which were largely attributable to poor testing of pricing algorithms, policy administration systems and related processes. For example, one insurer reported that its pricing systems sometimes applied the incorrect no-claims discount to motor vehicle policies if the 'at-fault' status of a claim changed close to the policy renewal date. Correcting the no-claims discount relied on manual intervention by staff after a customer inquiry. This type of issue was not uncommon.

Some promises involved **legacy systems**, which had a lack of data for testing at a policy level. Policies delivered using these legacy systems were more likely to be affected by issues like the misapplication of price floors applied through cupping, collaring and minimum premiums.

For example, one insurer had difficulty in reconstructing historical policies, resulting in only 60% of home insurance policies from the sample being successfully emulated to match the premium paid. This mismatch was attributed to data quality issues, unclear historical discount rates, or premium overrides and rounding calculations.

Poor data practices

The lack of available data meant that some general insurers had to use risk-based approaches in undertaking the reviews, involving checking systems and processes for systemic issues affecting the delivery of promises. These risk-based approaches were useful for diagnosing when processes had broken down or were not producing consistent outcomes, but they did not deliver the same precision as data-led techniques. There was no alternative, due to the lack of data.

Another factor contributing to insurers failing to deliver pricing promises may have been **poor data management practices**. For example, some insurers relied on third-party distributors to keep data on the application and delivery of pricing promises. The data management practices of these distributors also varied.

Inadequate tools for calculating prices and premiums

The reviews highlighted a lack of adequate tools used by general insurers to recalculate historical premiums, including pricing emulators. Some insurers developed pricing emulators during the review process to test pricing promises delivered using decommissioned pricing systems.

Other problems involved particular price discounts as noted earlier:

- ***Premium overrides*:** This was a standalone issue that insurers had to overcome to recalculate premiums. One insurer found that some discount types were implemented using an override function and were not always itemised. Of 13.5 million overrides recorded in the data used for detailed testing, approximately 12.5 million had no override reason given for the discrepancy so the reviewer could not verify whether those override discount calculations were properly applied. The practice of manually applying premium overrides is prone to human error and can result in inconsistent promise delivery.
- ***Multi-policy discounts:*** These were a particularly challenging promise to deliver consistently using poorly designed systems. One insurer advised it had never offered home and car insurance multi-policy discounts due to known system limitations, to remove the risk of failing to meet this pricing promise.

Sometimes these issues could be quite basic. For example, one insurer reported that some pricing promises were not itemised in premium calculations, causing the systems to fail to correctly apply internal business rules and limiting the application of multiple pricing promises.

Lack of effective monitoring and oversight

From the reviews, we found that in many cases, an effective mechanism for general insurers to track the consistent delivery of promises was not present or possible because the promise design and delivery process was flawed to begin with.

To varying degrees across different general insurers, there was an absence of effective detective and preventative controls to identify pricing failures and stop them from reoccurring. Effective monitoring and oversight was most notably absent from:

- pricing promises delivered via a rebate or premium adjustment
- pricing promises that required customer action to be eligible for the discount, such as installing a safety device to a vehicle
- processes that had the effect of 're-rating' premiums in a way that cancelled out all of part of a discount, and
- products delivered through third-party distributors, including distributors with price-setting discretion and in-kind promises.

Pricing failures caused by cupping, collaring and minimum premiums would have been detected earlier through properly designed and effective monitoring and oversight.

An analogous issue to the kind of pricing failures identified in the reviews is when general insurers charge their customers twice; this may be due to incorrectly issuing consumers with two policies for the same risk as outlined in the following example.

Case study: Duplicate policies and lack of adequate controls

ASIC secured $11 million in remediation after Westpac General Insurance Limited (now Allianz Australia General Insurance Limited) sold duplicate insurance policies to over 7,000 consumers for the same property at the same time, causing consumers to pay for two or more insurance policies where they only required one.

We took action in the Federal Court against this conduct in 2021 where Westpac Banking Corporation (Westpac) was ordered to pay a penalty of $15 million. The court found that Westpac failed to have in place adequate risk management procedures, the objectives of which were to:

- ***detect*** breaches in relation to the issuance of duplicate policies (detective controls)
- ***prevent*** breaches in relation to the issuance of duplicate policies (preventative controls), and
- ***monitor*** the success or otherwise of the detective and preventative controls.

Note: See Media Release (22-097MR) *Westpac penalised $113 million after multiple ASIC legal actions* (22 April 2022).

During the reviews, we were notified about reportable situations by other general insurers who identified similar matters involving duplicate policies for the same risk or charging consumers twice.

Reliance on customer complaints and interactions

Regulatory Guide 271 *Internal dispute resolution* (RG 271) explains that customer complaints are a key risk indicator for systemic issues within a financial firm and financial firms must have robust systems in place to ensure that possible systemic issues are investigated, followed up and reported on. Customer complaints and interactions need to be monitored and the results fed into the product life cycle.

However, customer complaints and interactions are not a substitute for dedicated detective and preventative controls. In relation to pricing, customers may not be in a position to verify whether they have been charged the correct price as they will not be able to investigate what discount or price offer has been applied versus what they are owed. This is further supported by the fact that in some cases, staff discounts were not passed on in full by insurers.

Weaker monitoring and oversight of third-party distributors

Because many breach reports from general insurers involve third-party intermediaries, ASIC asked general insurers to include intermediaries in the scope of their reviews. This included authorised representatives and any distribution arrangements with third parties, including under the insurer's own AFS licence.

The reviews generally showed that insurers tended to have weaker monitoring and oversight of products distributed through third-party arrangements.

Third-party distributors sometimes had a high degree of control over pricing promises. Some had discretion to make decisions and approve prices and promotional offers. During the reviews, some insurers relied on third-party distributors to verify the delivery of pricing promises, investigate findings and remediate consumers. We also noted breakdowns in data sharing between insurers and third-party distributors.

Systems and promise complexity

Looking at the totality of the reviews, and the examples highlighted throughout this report, we observed that the choices made by general insurers in product design and distribution had introduced a significant amount of complexity into their business. This has manifested in pricing failures where product complexity, promise design and the systems that are used to support promise delivery don't always match up—complexity in many cases exceeded the ability to deliver consistently using current systems and processes.

In one example, an insurer examined whether customers had been provided with prices under a certain promotion, only to identify that there was no data showing customer uptake of the promotion. This indicated the insurer's limited capability to monitor and measure the successful delivery of its pricing promises.

During the reviews, some insurers identified poor collaboration between internal teams, which stymied effective oversight. In some cases, the quality assurance framework appeared to have significant flaws. For example, one insurer reported that call centre staff of third-party distributors were conducting their own quality assurance. Other shortcomings included missing or outdated process documentation and inconsistent compliance with controls.

How are general insurers responding?

General insurers are correcting errors in the pricing algorithms that charged consumers the wrong amount and are strengthening their preventative and detective controls. Consolidation of products and reduced complexity will make this task more straightforward.

All participating general insurers are taking measures to improve the monitoring and oversight of pricing promises. Some are increasing resourcing in quality assurance and oversight roles in their business.

General insurers that achieve strong alignment between, on the one hand, design and complexity of pricing promises aimed at providing real value to consumers, and on the other, the state of systems, processes and data, will be best positioned to avoid pricing failures in the future.

Monitoring pricing promises: Key points

General insurers must adequately invest in and have systems, processes and data that are commensurate with the complexity of the products sold and the promises made to consumers, including pricing promises. The systems should not just deliver pricing promises, but also monitor and demonstrate fulfilment—across the product life cycle. Detective and preventative controls should be in place and tested regularly.

We expect general insurers to collect and review policy-level data on pricing, including discounts applied, and use this data to test their compliance and check for any errors. Given the individual nature of discounts, it is unlikely that aggregate data will be sufficient. All general insurers are encouraged to retain and interrogate policy-level data as part of the sound management of compliance risk.

We expect general insurers to have adequate oversight of third-party distributors to ensure that consumers are receiving the full discounts promised. This includes regular monitoring, oversight and supervision by the insurer of the third-party distributor, supported by regular sharing of data and information.

Key terms and related information

Key terms

ACCC	Australian Competition and Consumer Commission
AFS licence	An Australian financial services licence under s913B of the Corporations Act that authorises a person who carries on a financial services business to provide financial services **Note:** This is a definition contained in s761A.
AFS licensee	A person who holds an AFS licence
APRA	Australian Prudential Regulation Authority
ASIC	Australian Securities and Investments Commission
ASIC Act	*Australian Securities and Investments Commission Act 2001*
ASIC relief	Relief granted by ASIC from certain legislative provisions (i.e. by exemption or declaration), using our discretionary powers
authorised representative	A person authorised by an AFS licensee, in accordance with s916A or 916B of the Corporations Act, to provide a financial service or services on behalf of the licensee
breaches	AFS licensees have an obligation to report certain breaches of the law to ASIC **Note:** For more information, see Regulatory Guide 78 *Breach reporting by AFS licensees and credit licensees* (RG 78).
Corporations Act	*Corporations Act 2001*, including regulations made for the purposes of the Act
cupping (or collaring) and capping	Applying a price floor or a price ceiling to year-on-year premiums for renewing consumers. Cupping (or collaring) is used to limit large price *decreases*, whereas capping will limit large price *increases* to smooth any large price variances for the consumer. This may also allow the insurer to retain market share
discount	A reduction applied to the amount a consumer pays for an insurance policy premium
dollar disclosure	Provisions in the Corporations Act that require various costs (including premiums) to be disclosed as Australian dollar amounts in PDSs issued by general insurers, except when ASIC has granted relief or as otherwise provided for in the Corporations Regulations
FCA	Financial Conduct Authority (UK)
general insurer	A licensee who is a 'general insurer' as defined in s11 of the *Insurance Act 1973*
ICA	Insurance Council of Australia
in-kind promises	Promises for a benefit rather than a premium discount. These promises generally involve money and equivalents (e.g. cash-back offers or gift cards, reward points, or promotional offers such as discounted groceries or competitions)

loyalty discount	A discount based on a consumers' relationship with an insurer (e.g. the length of the relationship with the insurer or the number of policies held)
loyalty tax	Involves a general insurer considering a renewing consumer's price elasticity (i.e. whether they are more or less likely to shop around for a better insurance premium) and then charging those renewing consumers who are less likely to 'shop around' a higher premium than other consumers (with similar actuarial risk profiles for the same risk). This practice may also take into account other attributes that affect whether the consumer is likely to shop around (e.g. postcode or income)
multi-policy discount	Discounts applied for having more than one eligible policy with an insurer
no claims discount	Typically involves a discount on an insurance premium based on the policyholder's claims history, specifically the absence of at-fault or unrecoverable claims
non-financial risk	Includes operational risk, compliance risk and conduct risk
participating general insurers	The general insurers listed in **Table 1** that ASIC wrote to individually with an expectation they undertake a review
policyholder	A person who holds an insurance policy with an insurer
premium	The amount of money charged by an insurer for coverage
price floor or minimum premium	A pricing constraint to ensure the premium does not fall below a certain level
price optimisation	Premium adjustments made with reference to particular (usually non-risk related) characteristics of a consumer (e.g. their propensity to shop around) that insurers use to set premiums which they consider will maximise profitability and or customer retention
pricing failures	Where there is an inconsistency between the price the insurer promised or intended to charge, and what was delivered to the customer. This includes a situation where insurers promise price-related offers (e.g. a discount), benefits, rewards or make loyalty representations, and then fail to deliver on them in full
pricing misconduct	Where pricing promises are made by insurers to consumers, such as price discounts, benefits, or loyalty representations, and insurers fail to deliver on the promises in full
pricing promise	A representation by an insurer to provide a price-related offer (e.g. a discount), a benefit (e.g. gift card, loyalty scheme points or cashback offer), or a reward, including a statement that consumers will save money by taking certain action
Product Disclosure Statement (PDS)	A document that must be given to a retail client for the offer or issue of a financial product in accordance with Div 2 of Pt 7.9 of the Corporations Act **Note:** See s761A for the exact definition.

product governance	The processes firms have in place to design, approve, market and manage products through the products' life cycle to ensure they meet legal and regulatory requirements
range discounts	Discounts expressed as a range of outcomes rather than in fixed terms (e.g. 'save up to $200' or 'up to 10% off')
remediation	A process, large or small, to investigate the scope and 'root cause' of the misconduct or other failure and, if appropriate, return consumers who have suffered loss as a result of the misconduct or other failure to the position they would have otherwise been in, as closely as possible
reportable situation	Has the meaning given in s912D of the Corporations Act
technical premium	A calculation by an insurer of the expected cost to supply an insurance product, with a margin added for profit and/or return on capital. Components may include expected claims costs, reinsurance costs, operating costs, commissions, and margins

Related information

Headnotes

Advertising, disclosure, general insurance, non-financial risk, pricing failure, pricing misconduct, pricing promises, product governance

Legislation

ASIC Corporations (Disclosure in Dollars) Instrument 2016/767

Australian Securities and Investments Commission Act 2001

Corporations Act 2001, Div 2 of Pt 7.9, s716A, 912D, 916A, 916B

Corporations Regulations 2001

Insurance Act 1973, s11

Insurance Contracts Act 1984

ASIC documents

RG 78 *Breach reporting by AFS licensees and credit licensees*

RG 168 *Disclosure: Product Disclosure Statements (and other disclosure obligations)*

RG 182 *Dollar disclosure*

RG 234 *Advertising financial products and services (including credit): Good practice guidance*

RG 271 *Internal dispute resolution*

REP 416 *Insuring your home: Consumers' experiences buying home insurance*

REP 424 *Review of no-claims discount schemes*

REP 632 *Disclosure: Why it shouldn't be the default*

13-155MR *Suncorp Groups Life and General Insurance businesses to improve compliance systems following independent expert review*

21-270MR *ASIC launches Federal Court action and calls on general insurers to review pricing practices*

22-097MR *Westpac penalised $113 million after multiple ASIC legal actions*