Joint Consumer Submission to the

Insurance Council of Australia

General Insurance Code of Practice 2017 Review: Interim Report

January 2018

This submission was supported by funding from the Consumers' Federation of Australia

About Consumer' Federation Australia

The Consumers' Federation of Australia is the peak body for consumer organisations in Australia. CFA represents a diverse range of consumer organisations, including most major national consumer organisations.

Community Legal Centres Queensland

Community Legal Centres Queensland is the peak body for Queensland's community legal centres, and works with those centres towards a fair and just Queensland. CLCs Queensland helps community legal centres so they can provide effective, high quality services to their communities. CLCs Queensland helps the network of community legal centres keep informed, united and relevant. CLCs Queensland helps disadvantaged and vulnerable people in the community to understand their legal and human rights, access legal help, and be heard and respected. www.communitylegalqld.org.au

About Consumer Action Law Centre

Consumer Action is an independent, not-for-profit, campaign-focused casework and policy organisation. Consumer Action offers free legal advice, pursues consumer litigation and provides financial counselling to vulnerable and disadvantaged consumers across Victoria. Consumer Action is also a nationally-recognised and influential policy and research body, pursuing a law reform agenda across a range of important consumer issues at a governmental level, in the media, and in the community directly.

About Consumer Credit Law Centre South Australia

The Consumer Credit Law Centre South Australia (CCLCSA) was established in 2014 to provide free legal advice, as well as legal representation and financial counselling to consumers in South Australia in the areas of credit banking and finance. The Centre also provides legal education and advocacy in the areas of credit, banking and financial services. The CCLCSA is managed by Uniting Communities who also provide an extensive range of financial counselling and community legal services as well as a range of services to low income and disadvantaged people including mental health, drug and alcohol and disability services.

About Consumer Credit Legal Service (WA) Inc

Consumer Credit Legal Service (WA) Inc. (CCLSWA) is a not-for-profit charitable organisation which provides legal advice and representation to consumers in WA in the areas of credit, banking and finance, and consumer law. CCLSWA also takes an active role in community legal education, law reform and policy issues affecting consumers. In the 2016 / 2017 financial year, CCLSWA provided advice and representation to 1088 new clients.

About Economic Abuse Reference Group

The Economic Abuse Reference Group is an informal group of community organisations which influences government and industry responses to the financial impact of family violence. Our members include family violence services, community legal services and financial counselling services

About Financial Counselling Australia

Financial Counselling Australia is the peak body for financial counsellors. Financial counsellors assist people experiencing financial difficulty by providing information, support and advocacy. Working in not-for-profit community organisations, financial counselling services are free, independent and confidential.

About the Financial Rights Legal Centre

The Financial Rights Legal Centre is a community legal centre that specialises in helping consumer's understand and enforce their financial rights, especially low income and otherwise marginalised or vulnerable consumers. We provide free and independent financial counselling, legal advice and representation to individuals about a broad range of financial issues. Financial Rights operates the National Debt Helpline, which helps NSW consumers experiencing financial difficulties. We also operate the Insurance Law Service which provides advice nationally to consumers about insurance claims and debts to insurance companies. Financial Rights took close to 25,000 calls for advice or assistance during the 2016/2017 financial year.

About Good Shepherd Microfinance

Good Shepherd Microfinance offers a suite of people-centred, affordable financial programs to people who are financially excluded. These programs promote economic wellbeing for people with low incomes, especially women and girls, and move clients from financial crisis to resilience and inclusion. Through our Good Insurance program we work with major Australian insurers to co-design product design and distribution initiatives to improve accessibility to general insurance products in the Australian market.

About WEstjustice: the Western Community Legal Centre (WEstjustice)

WEstjustice was formed in July 2015 as a result of a merger between Footscray Community Legal Centre, Western Suburbs Legal Service, and the Wyndham Legal Service. WEstjustice is a community organisation that provides free legal assistance and financial counselling to people who live, work or study in the Maribyrnong, Wyndham and Hobsons Bay areas. WEstjustice has a particular focus on working with newly arrived communities. More than 53 per cent of our clients over the last five years spoke a language other then English as their first language. Approximately one quarter of our clients are newly arrived, having arrived in Australia in the last five years. Furthermore, our refugee service in Footscray alone has seen approximately 700 clients in the part five years.

Executive Summary

Consumer Representatives commend the ICA for the breadth and range of issues that have been raised and sought to be addressed in its Interim Report. It is to the ICA's credit that the Interim Report has attempted to capture and address a large number of consumer concerns with the general insurance industry.

Consumer Representatives support the vast majority of the priority proposals and discussion point proposals. We believe that the ICA has appropriately captured the large range of consumer concerns that were raised in the initial consultation and agree with the ICA's eight priority areas, in summary:

- strengthening standards for vulnerable consumers including standards addressing issues in mental health, family violence and financial hardship ;
- providing guidance on best practice disclosure, and product design and distribution principles including specific guidance for add-on insurance products;
- strengthening standards relating to third-party distributors and service suppliers;
- including mandatory standards for investigations; and,
- meeting the requirements for ASIC approval.

In addition to these we believe that the complaints and disputes process, pressure selling and claims should also be prioritised.

Consumer Representatives have identified a number of areas that the eight priority proposals (and complaints, disputes, pressure selling and claims proposals) do not address. We put forward a significant number of recommendations to improve upon these. If these recommendations are taken up by the ICA and general insurers, we believe that the General Insurance Code of Practice (**the Code**) could move closer to being the set of best practice standards that the community, regulators and government expect the Code to be.

There are a small number of proposals that cause Consumer Representatives some concern and we recommend that the ICA and general insurers reconsider these. These include the proposals with respect to the multi-tier complaints process and the Compliance Governance Committee. We are particularly concerned with the Code Governance Committee (**CGC**) proposals (at Discussion Point 8.1, 8.3 and 8.4) which seem designed to weaken the power of the industry's independent monitoring body. This is not a good look at a time when there has been almost endless general insurance scandals, inquiries and now a royal commission into misconduct and behaviour that fails to meet community standards.

In addition to this the ICA makes a series of proposals under the Additional Code Review themes. These should all be implemented (with adjustments and changes as recommended in this submission). These should not be held off because they are lower priority. They should be addressed and dealt with now otherwise they may never be addressed, as other more urgent, higher priority issues may arise in the meantime.

There needs to be a consolidation and simplification of the variety of standards and commitments being agreed to under the Code. There are varying levels of commitments being proposed in the Interim Report for the Code of Practice. They include: actual code commitments; principles to inform best practice (for example, mental health, product disclosure); guidance documents (family violence, product design and distribution), and mandatory standards. Add to this the industry's continued opposition to including Code commitments in individual contracts, and there remains significant complexity and confusion for consumers, regulators, external dispute resolution (**EDR**) services and industry as to what is being committed to under the Code. All of this serves to undermine the impact of having a self-regulatory Code. We believe that all new proposals be mandatory, otherwise there is little point to a self-regulatory Code.

While text is proposed under some of the proposals, we believe the Interim Report should have included proposed text for amending the Code in all the proposals. Given concern has been expressed with respect to the length of time it takes to review the Code, we believe that including proposed text would have saved a lot of time, as consumers, industry and government will now have to wait for another round of proposals, and drafting to provide comment. This will inevitably lead to significant delays for implementing much needed, long overdue reform.

List of Recommendations

Proposal 1: The Code should strengthen standards relating to vulnerable consumers

Proposal (1A) Including a new Code section on vulnerable consumers

---

1. Consumer Representatives support the inclusion of a new section on vulnerable consumers including a statement acknowledging the diverse needs of vulnerable people and committing to supporting the particular needs of customers where these are identified.

2. Consumer Representatives support a commitment under the Code by insurers to accommodate vulnerable consumers' requirements for formal or informal assistance from a third party.

a. Staff training

3. Insurers should commit to training *all* staff to identify and appropriately engage with vulnerable consumers and different staff cohorts (such as public facing, front line staff) receive more specific and in depth training, according to their role.

b. Improving insurance access

4. Insurers can and should commit to more flexible payment arrangements under the Code including, where appropriate, Centrepay deductions and fortnightly payment options.

c. Identification requirements

5. The Code should commit insurers to providing assistance to those who have trouble meeting identification requirements. This should include the development of a common form for the industry to use allowing people in remote communities to be identified by community elders and others. The form would be based on the template developed by AUSTRAC.

d. Use of Interpreters

6. The Code should include commitments to provide people with access to interpreters on the basis of the best practice standards developed by the Commonwealth Ombudsman. As a part of these best practice standards, family and friends should not be allowed to be used as interpreters and insurers should always provide access to an independent interpreter when needed.

Proposal (1B) Providing Code guidance on best practice mental health principles

---

a. Principles to inform best practice

7. Consumer Representatives support the introduction of a set of mental health principles to inform best practice, and commend the ICA and general insurers for proposing to take this important step. We believe these principles should form a mandatory part of the Code, rather than act as a guide.

8. The mental health principles to inform best practice should be amended as follows:

    a) The wording of 2.1 should either remove the first sentence or be amend to state the following:

    Premiums for covers related to mental health illness will be influenced by an insurer's risk appetite, based upon actuarial or statistical data that is reasonable to rely on, as per section 46 of the Disability Discrimination Act 1992.

    b) the wording of 2.2 should be amended to ensure that the "increased associated morbidity, mortality and other risks" be explicitly based on actuarial or statistical data on which it is reasonable to rely, as per section 46 of the *DDA*;

    c) general insurers must commit to a prohibition on broad mental health exclusions without any reliable evidence base or actuarial data, with narrower exclusions only introduced where actuarial or statistical data on which it is reasonable to rely exists;

    d) the wording of 4.2 should commit insurers to ensuring that quantifying loading should be based on actuarial or statistical data on which it is reasonable to rely as per section 46 of the *DDA* rather than "reasonable data or opinions.";

    e) commitments under 3.2 and 5 should be extended from staff to all representatives and service suppliers;

    f) 3.3 should be strengthened to ensure that all other alternative methods of verifying information will be sought before undertaking any more intrusive methods of investigation, as committed to under section 4.1 of the draft investigator standards. A cross reference to the entirety of section 4 of the investigator standards should be included.

    g) the Code should commit insurers to keeping accurate records of the actuarial or statistical data that they rely upon when making decisions relating to mental health.

b. Discrimination

9. The Code should include specific commitments with respect to the insurance industry's engagement with people with mental health problems including:

    a) making explicit reference to Guidelines for providers of insurance and superannuation under the *Disability Discrimination Act 1992* (Cth) (revised 2016);

    b) decisions will be based upon actuarial or statistical data on which it is reasonable to rely;

c) in the case where no such actuarial or statistical data is available and cannot reasonably be obtained the discrimination is reasonable having regard to relevant factors;

d) underwriting decisions will be regularly reviewed to ensure decision making is not relying on out-of-date information.

e) Factors taken into account when considering the risk of someone's mental health condition and there is no actuarial or statistical data available include:

   i. medical opinions

   ii. information which is relevant to the particular individual seeking insurance cover, including:

      - the type of disability the person has
      - the severity of the disability
      - the function impact of the disability
      - treatment plans
      - the person's employment records

   iii. the practice of others in the insurance industry

   iv. actuarial advice

f) Before refusing to provide cover on the basis of a mental health exclusion insurers will:

   i. provide the opportunity to the applicant to either provide further information, including supporting medical documents;

   ii. consider whether alternatives such as providing a policy with an appropriate exclusion clause, restricting the cover or imposing an additional premium would effectively manage any additional risk;

   iii. Insurers will not automatically decline an application for insurance that reveal a mental health condition or symptoms of a mental health condition; and

   iv. insurers will refer applications for insurance that reveal a mental health condition or symptoms of a mental health condition to an appropriately qualified underwriter.

g) When non-standard terms or higher premiums are applied, insurers will include:

   i. advice about how long the non-standard terms or higher premiums would apply;

   ii. any criteria that would need to be satisfied to have the policy 'standardised'; and

   iii. the process for removing or amending the non-standard terms or higher premiums.

h) Insurers will develop a disability action plan (under Part 3 of the *DDA*) and have these published on the Australian Human Rights website.

c. Provision of Data

10. Insurers should provide copies of the mental health actuarial and statistical data that they have relied on to make decisions in relation to an offer of insurance to a consumer or claims made by consumers on their policies within a reasonable time frame upon request.

11. Only where the actual actuarial and statistical data which insurers have relied on are not able to be provided because the material is considered to be commercial-in-confidence, should insurers provide a detailed summary. This summary should specify the type of data that they have relied on, and the relevance of that data to the decision to:

    a) decline insurance coverage to the applicant;

    b) offer coverage on non-standard terms; or

    c) deny a claim.

12. Insurers should detail this right to request this data in the PDS and other relevant communications.

Proposal (1C) Providing Code guidance on recognising and responding to instances of family violence

---

13. Consumer Representatives welcome the development of a draft Family violence guidance document and commend the ICA for taking a positive step forward on this important issue.

14. The Family Violence Guidance Document should state

    "if family violence may be a factor…"

    to acknowledge that it is often very difficult to identify family violence and victims may not raise it.

15. In the Summary section, the following should be included:

    "assistance to staff to identify, and avoid harm, to victims at point-of-sale of policies".

16. To capture the full nature of family violence, the definition of family violence should include the following:

    "Family violence laws in most states and territories recognise economic abuse as a form of family violence."

17. In order that *all* employees and authorised representatives receive family violence training, the Requirements for family violence policy should state:

"The relevant requirements in the Code are to have systems, processes and appropriate training in place to identify and support customers, staff and authorised representatives who require additional assistance."

18. To recognise that there will be victims and perpetrators of family violence amongst the insurer's employees the last dot point under staff training should state:

    "discloses the existence (past or present) of family violence, an intervention order or equivalent"

19. In the section "Protecting private and confidential information" it should state that the safety of the customer, and others, is of paramount importance.

20. A system which flags accounts where there is possible family violence should be committed to, similar to recording the need for an interpreter, proposed in the claims investigations standards.

21. Customer should be able to set the ID requirement as using the address as a form of ID may not suit some customers because of safety concerns.

22. The words 'or potential customers' should be included in the sentence: "Both may be customers, or potential customers, or they may be members of staff."

23. The words "Anyone interviewing or investigating someone involved in a claim who is affected…" should be amended to state "may be affected…"

24. After the words "this can be a particularly complex area in cases of family violence" we recommend adding "and/or where family law property disputes are involved."

25. We prefer the phrase "experiencing financial hardship" rather than "suffering from financial hardship".

26. In relation to referring to external agencies, we recommend basing this on the EARG Good Practice Guide regarding referral options for staff.

27. Insurers should commit to providing a single entry point so that callers can reach the right person with adequate authority and experience to make a flexible decision and ensure the customer's safety.

28. Insurers need to acknowledge the need to deal with the unfair outcome of *Matthew's* case and the perverse situations that arise through telephone underwriting.

Proposal (1D) Including stronger Code standards on Financial Hardship

a. Awareness and identification

29. The Code should include commitments to train insurers and service suppliers on their obligations with regard to consumers in financial hardship.

30. The Code should include information about the financial hardship process in debt recovery letters. This should include information on the Internal Disputes Resolution process and contact details.

31. When an insurer is contacted directly by a consumer in hardship, insurers should, in principle, contact representatives where there is an authority on file. There should be some flexibility built in to ensure that consumers are protected in difficult or sensitive situations such as where family violence is suspected or known, or a debt management firm is involved.

b. Timeframes

32. In assessing applications for financial hardship it is appropriate and reasonable to meet the timeframes set by the National Credit Code, and should be committed to by insurers under the Code. We recommend one adjustment to this: that consumers or third parties be allowed 45 calendar days to provide information requested, with the ability to extend the timeframe in special circumstances.

c. Payment of excesses

33. The financial hardship section of the Code should make it clear that it applies to situations where a customer cannot pay their excess, by including the phrase "deduction of the excess from the claim payment."

34. Insurers should follow the FOS guidance relating to insurance policy excesses and financial difficulty.

35. The General Insurance Code should commit insurers to informing their policy-holders of the availability of the option to pay the excess in instalments when experiencing financial hardship.

36. The General Insurance Code should also allow access to EDR for uninsured persons who are unable to have their claim processed because of an insured inability to pay their excess.

d. Debt waiver

37. Insurers should commit to providing the ability to pay a debt in instalments when customers *and third parties* are experiencing financial hardship.

38. The Code should include a maximum period for a debt to be repaid in instalments.

39. The debt waivers section of the Code should be expanded to detail factors for insurers to take into account when considering a debt waiver. However the criteria should not be set and flexibility and discretion for insurers maintained.

e. Complaints about financial hardship

40. A complaints handling timeframe of 21 days should be committed to under the Code, in line with the timeframe for credit disputes about hardship in RG 165.

Uninsured third parties

41. The Code needs to be clarified to ensure that uninsured third parties who owe a debt have access both to financial hardship assistance and the complaints process.

42. Consumers in financial hardship should be able to enter into hardship arrangements if they cannot afford to meet regular premium payments. Consideration needs to be given to the following options:

    a. changing the coverage or amount covered for, in an appropriate and ethical manner;

    b. reducing or stopping payments for a short period with consequences for coverage;

    c. part payment of a premium with the remainder of the premium and the usual premium to be paid next month;

    d. delay payment of a premium with a double premium to be paid the next month;

    e. part payment of premiums for a few months then full payment of the outstanding value of the insurance premium in full.

43. All notices of cancellation for non-payment of instalments should mention the availability of hardship arrangements.
44. The Code should also apply to small businesses by extending the application of sections 4,6,7,9 and 10.

Proposal 2 The Code should provide guidance on best practice disclosure principles

a. Best practice principles

45. The Product Disclosure Best Practice Principles should incorporate the following:

    a) Disclosure in itself cannot address all problems of information asymmetry.

    b) Disclosure should be continuously improved through a commitment to consumer-testing.

    c) Disclosure should promote consumer understanding of any deviation from standards cover.

    d) Best Practices Principles should include more practical examples of best practice disclosure.

    e) There should be a standard PDS format and structure.

    f) The Principles should include the promotion of good website design to enable easier access to PDS's and KFS's.

    g) Best practice disclosure principles should be extended beyond the key features of a policy and should apply to other areas including consents (such as the proposed uses of a consumer's data)

    h) Disclosure should promote consumer understanding of any deviation from standards cover.

i) A commitment to KFSs by industry can improve the role they can play in disclosure.

j) If automatic renewals are to remains, Best Practice Principles applying to their disclosure should be included in the document.

k) Opt-out mechanisms should be prohibited and the sector should commit to only using opt-in mechanisms.

l) Advertising should be understood as a form of disclosure with a high risk of misleading consumers into misunderstanding the nature of an insurance product and its substance.

m) A commitment to introduce standard definitions will go a long way to improve disclosure and consumer understanding of insurance products.

n) Insurers should disclose the previous year's premium on the annual renewal notice.

o) Insurers should provide component pricing of premiums.

p) Insurers should provide links to identify natural disaster, risk and hazard mapping and modelling for consumers to understand the risks that apply to their own home.

q) Disclosure principles should be developed to better inform consumers with respect to mental health clauses.

r) Insurers should commit to surveying their customers to identify levels of understanding and comprehension of the policies they hold.

s) Disclosure should aim to inform not just about the policy's key exclusions and limits but should also highlight the aspects that are least expected or would be considered a surprise.

b. Plain language

46. The Code should commit insurers to the use of plain language in all communications. This principle should also be incorporated in the Product Disclosure Best Practice Principles document.

c. Sum insured calculators/rebuilding costs

47. A requirement should be included under the Code for insurers to provide access to an accurate and informative sum insured calculator as part of the home building insurance application process.

48. Insurers should commit to regular reviews and auditing of the sum insured calculators and where an error is identified with a calculator that the insurer commits to correcting the calculator and informing any affected consumers.

49. If a sum calculator is used in the sales process, this information should be recorded and kept on a policyholder's file.

Proposal 3: The Code should include product design and distribution principles and provide guidance to insurers

Product design

50. The Product Design Principles and considerations document should be amended as follows:

    a) minimum timeframes for review should be set, with clear about triggers for different types of insurance product.

    b) In order to make it clear to consumers whether they fall within or outside of any identified target market for a particular product, target market information should be prominently included in PDSs, advertising and other promotional material.

    c) the guidance should include a list of factors that would ordinarily be considered when assessing the characteristics of a target market/consumer, including:

        i. proximity to retirement and employment status;

        ii. financial situation (including tax situation, income and assets);

        iii. financial literacy and financial capability/experience;

        iv. access to financial information;

        v. risk profile (including capacity and willingness to bear loss); and

        vi. factors requiring consumers in the target market to benefit from the significant features of the product, such as family structure, age, and asset ownership.

    d) Product Design Principle 2 should state

        Cover should be designed to meet a genuine need and offer a tangible benefit from the significant features of the product *at reasonable value.*

    e) The guidance should then identify those significant features to assist consumers based on the suggestion put forward in the Joint Consumer Submission to the Design and Distribution Obligations and Product Intervention Power – Proposals Paper.

Product distribution

---

a. Product distribution principles

51. The Product Distribution Principles and considerations document should be amended so that insurers commit to undertaking thorough due diligence when selecting distributors including an assessment of the distributor's:

    i. staff expertise and experience

    ii. key person competencies

iii. compliance arrangements (including licensing arrangements)

iv. history of compliance problems or regulator action

v. marketing strategies

vi. other products being distributed

vii. reputation

52. The General Insurance Code should include specific mandatory requirements with respect to sales and distribution practices modelled on Section 4 of the Life Insurance Code, as appropriate.

b. Consumer redress

53. Consumer Representatives recommend the General Insurance Code mirror Life Insurance Code clause 4.9 to ensure that

a) insurers investigate concerns raised with sales practices of staff, authorised representatives and other distributors,

b) appropriate remedies are discussed with effected consumers including

i. Reasonable compensation, where appropriate and

ii. Fines to encourage compliance;

c) if a consumer is not satisfied with a proposed remedy, it will be reviewed and the consumer told how to make a complaint, and

d) sales practice issues are corrected through education and training.

Proposal 4: The Code should provide product design and distribution guidance specific to add-on insurance products

a. Product design, distribution and sales practices

54. The Code should include specific commitments relating to the design, sale and distribution of add-on products mirroring clause 4.7 of the Life Insurance Code.

55. In addition to this the Code should commit insurers to

a) not sell single premium policies, as recommended by ASIC

b) Any consumer communication developed must include information relating to:

i. the key features of the product including premiums, exclusions, conditions and benefits (including maximum benefits)

ii. the cost of the product;

iii. how long the consumer is insured;

iv. the key benefit monetary limits;

v. the date your insurance ends;

vi. claims data including claims ratios;

vii. sufficient information for the consumer to identify whether the product is suitable to the consumer's needs.

c) digital consumer communication should be active/interactive and not passive and include a series of 'filter' or 'knock out' questions, before the purchase of the product so that a customer is alerted to key policy exclusions such as age, residency and employment status to ensure that those not in the target market are excluded;

d) establish a consistent public reporting regime requiring insurers to fully and transparently publicise their claims pay-out ratios, as well as claims handling timeframes and dispute levels across all policy types. Data should be made available on an industry and individual insurer basis.

56. The Code should include specific commitments with respect to a deferred sales model.

57. The Code should include minimum standards for distributors that outline when insurers will *not* distribute through a particular bank, car dealer or other third party.

58. The Code should commit to product design principles to ensure that add-on products:

a) do not provide negative or low value;

b) do not include unreasonable or unexpected clauses that are detrimental to the customer, such as exclusions

c) are not significantly more expensive because they are sold through a particular channel (for example, where term life insurance was found to be 18 times as much when bought through car yard as opposed to online)

b. Deferred sales model

59. The Code should include specific commitments with respect to a deferred sales model that mirrors the deferred sale model settled on by ASIC for regulation and extends it out to cover all other add-on insurance products and distribution channels.

Proposal 5: The Code should strengthen standards relating to third party distributors

60. Clause 5.5 of the Code should be removed and all Authorised Financial Services Licensees acting on an insurer's behalf should be subject to the Code.

61. The Code should include strengthened standards relating to sales practices such as pressure sales and other unacceptable sales practices that do not meet community standards.

62. If this is not possible through a Code, then industry should support regulatory intervention. In the interim the current Code (a) to (e) should be expanded to include consequences for the service provider for a breach of the Code including:

    a) naming of the distributor;

    b) reporting the conduct to ASIC

    c) termination of the contract;

    d) undertaking remediation programs for affected consumers in the event a breach.

63. All third parties should adhere to the relevant sections of the General Insurance Code and be appropriately monitored.

Proposal 6 The Code should strengthen standards relating to Service Suppliers

64. Consumer Representatives support the inclusion of strengthened standards relating to Service suppliers including:

    a) Insurers are responsible for the conduct of their service suppliers and their approved subcontractors

    b) Insurers must have measures in place to ensure that due skill and care is taken in choosing suitable service suppliers

    c) Service suppliers should notify the insurer of a customer complaint by the next business day.

    d) Insurers will appropriately address any actions by service suppliers that breach the Code, Service Level Agreements or license obligations.

65. General insurers must however commit to further standards as recommended by the CGC under Recommendations 5 and 7 of the 2017 Own Motion Inquiry on Investigations of Claims and Outsourced Service, namely:

    Code subscribers should ensure that:

    a) the service supplier's arrangements with a subcontractor or agent are in writing and reflect the Code standards that apply to the services provided by the subcontractor or agent

    b) the service supplier's arrangements require the subcontractor or agent to report to the service supplier complaints about them or the matters they are dealing with, by the next business day, and

    c) the service supplier does not engage the services of an agent or subcontractor in the investigation of a 'sensitive claim' – for instance, where the claim includes death or serious injury. If this is not practical, the Code Subscriber should increase its oversight of such matters.

d) contracts with services suppliers must include a requirement to develop their own systems and processes to ensure compliance with applicable Code obligations. This includes prompt reporting of actual or possible Code breaches and corrective actions.

e) external investigators are required to obtain their express and written authority before putting a fraud allegation to a claimant. This requirement should be included in Code Subscribers' contracts with external investigators and in their written instructions to external investigators.

66. Insurers should commit to requiring that all service suppliers and their subcontractors and agents are trained on the requirements of the Code – in addition to their being appropriately skilled and qualified to carry out their duties and remain up-to-date with industry developments.

67. External Experts should be subject to the appropriate sections of the General Insurance Code, in the same way external experts are included under the Life Insurance Code. If concerns remain with the independence of external experts, a statement could be included to the effect that the Code applies to external experts unless it conflicts with the external expert's professional responsibilities and/or obligations.

68. Alternatively, the Code could include specific commitments that require different external experts to meet the equivalent of their profession's Australian Medical Association's Ethical Guidelines on Independent Medical Assessment. If such guidelines do not exist, the Code should bind external experts unless it conflicts with their professional responsibilities and/or obligations.

Proposal 7: The Code should include mandatory standards for Investigations

69. The Claims Investigations Standards should include the following regarding transparency about why a claim is being investigated and what to expect:

    i. consumers should be informed by telephone that their claim will be investigated and why, and that, if appropriate, an external investigator will interview them;

    ii. staff are provided with clear guidance on the content of such conversations.

    iii. confirm that an investigation will occur and why in writing (letter or email), including information about the following:

        i. the purpose of the investigation, what to expect and that the consumer should not draw an adverse inference from this decision;

        ii. the consumer's primary contact during an investigation, the role and responsibilities of the claims consultant and the external investigator;

        iii. the external investigator's contact details, when to expect to hear from them and what to do if they are not contacted within that timeframe;

        iv. the consumer's rights and responsibilities during the investigation and interview, including who they can contact if they have any questions about the

investigation or process including or if they are unhappy with the external investigator's conduct, how their personal information will be handled and their rights after a claim decision has been made;

v. the timeframe for making a claim decision after completing the investigation and information gathering, information about the complaints process and other resources to assist the consumer during the investigation such as the Financial Ombudsman Service Australia (FOS) and key consumer advocates.

70. The Claims Investigations Standards should include the following regarding interviews:

i. interview subjects are advised in writing;

ii. investigators provide a business card and license details where available;

iii. interview subjects should be provided with information about the roles and responsibilities of the and the external investigator

iv. transcripts are provided automatically, without somebody having to request one;

v. interview subjects should also be offered breaks at least every half an hour, and the request for a break should be adopted in the record of interview

vi. section 3(l) should be amended to ensure that:

i. if more time is needed for an interview beyond two hours, the interview should be suspended and arrangements made to continue at a later date, subject to the Code Subscriber authorising the continuation of the interview and the consumer's consent.

ii. if an interviewee decides that they prefer to continue with the interview beyond two hours, then it should be clearly explained that the interviewee may continue the interview at a later date

iii. the interviewee's acknowledgement and their agreement to continue the interview in these circumstances should be recorded in writing and by audio recording.

vii. ask interviewees (consumers) to complete an interview consent form which also asks whether they need an interpreter or support person

viii. assess whether consumers have special needs and provide additional support to such consumers before authorising an Employee or external investigator to interview them

ix. ensure that their Employees or their external investigators never deny a consumer's reasonable request for a support person

x. ensure that Employees are appropriately trained to identify such consumers and their support needs and that interviews should only be conducted by Employees who have appropriate training or experience

xi. provide external investigators with, or require them to receive, appropriate training to assist in identifying and supporting consumers with special needs

xii. specify in contracts with external investigators that consumers are entitled to have a representative or support person with them during an interview

xiii. if an agreement about support cannot be reached, require external investigators to contact the insurer

xiv. specify in contracts with external investigators their expectations and requirements, or provide guidelines, about consumers with special needs.

71. With respect to interviewing minors specifically, the standard should include the following:

a. ensure that a senior staff member with appropriate experience and training determines whether it is necessary to interview a minor – this includes assessing whether the minor is capable of distinguishing a truth from a lie

b. instructions to an external investigator must clearly set out the scope of the interview and ensure that the external investigator will obtain prior written approval to expand the scope of the interview

c. a request to expand the scope of an interview must also be assessed by a senior staff member with appropriate experience and training

d. if in the course of an investigation the external investigator determines that it is necessary to interview a minor, require the external investigator to obtain prior written approval – such a request should be assessed as described above

e. if the external investigator is required to determine whether the minor has the capacity to distinguish a truth from a lie, provide clear guidance to the external investigator on how to determine this – this assessment should be recorded.

f. the draft standard needs to clarify that the "responsible adult" referred to a (3)(h)(iii) can be a parent or guardian.

72. The Claims Investigations Standards should include the following standards regarding surveillance:

i. surveillance will be discontinued when there is evidence that it is negatively impacting upon a person's recovery;

ii. "independent medical examiner" needs to be defined along the same lines as the Life Insurance Code. Alternatively a different form of words could be included to ensure that surveillance will be discontinued where robust medical evidence is provided by the insured or is known to the insurer;

iii. surveillance will not be conducted on business premises unless a reasonable person would believe that those business premises were open for persons to enter without necessarily expecting them to enter into any form of transaction;

iv. an investigator must make and keep written contemporaneous records of all investigation activities to be retained for 7 years. Contemporaneous notes should include details of: conversations held in person; telephone conversations; unanswered telephone calls, including messages left; letters/faxes/emails sent; travel; details of any statement obtained; any electronic checks, including government and social media sites (e.g. internet/land titles/Facebook/Business Affairs);

v. the investigator must not seek or accept from, or offer to, any person any gifts, benefits or rewards in connection with an investigation, other than modest hospitality such as light refreshments;

vi. interview subjects be provided with reasons for providing an authority to access information from a third party.

73. The Claims Investigations Standards must include cross references to the Family Violence Guidelines and the Mental Health Best Practice Principles.

74. External investigators should be required to obtain their express and written authority before putting a fraud allegation to a claimant. This requirement should be included in Code Subscribers' contracts with external investigators and in their written instructions to external investigators.

75. Code Subscribers should provide guidance to external investigators on arrangements for interviews, which must have regard to the interviewee's circumstances as well as the likely length of the interview.

76. The Claims Investigations Standards should include the following regarding quality assurance program requirements:

a) the review of recordings, statements, affidavits and/or transcripts of interviews should also refer to running sheets and notes, and should be reviewed for procedural fairness. This should be explicitly referred to in the standard.

b) measures to monitor interview duration and compliance with the Code through:

i. regular reviews of current and closed claim files, including denied claims

ii. for Employees who conduct telephone interviews – call audit reviews and review interview transcripts or recordings

iii. audit external investigator running sheets, interview transcripts or recordings to check the duration of interviews

iv. review of complaints about interviews, including disputes referred to FOS.

77. With respect to privacy and authorities Code subscribers should include the following:

a) ensure that requests for additional information or documents are reasonable and relevant to the claim under investigation

b) require external investigators to record requests to individuals for written authorisation to access personal information held by other parties and surrender to Code Subscribers the original signed authorities at the conclusion of their investigation

c) clearly limit the purpose of the authority to the investigation of the claim in question

d) define the scope of the authority in terms of the type of information that is being requested and the period covering the request – in other words the authority should not be couched in blanket terms or for an indefinite period

78. The Claims Investigations Standards must be mandatory.

Proposal 8 The revised Code should meet the requirements for ASIC approval

79. The revised Code should meet the requirements for ASIC approval and the ICA should seek that approval. In order to do so, insurers should commit to incorporating the Code into individual contracts with consumers.

80. General insurers should empower the CGC to report systemic code breaches and serious misconduct to ASIC.

81. The ICA and general insurers should meet all of the minimum standards set by ASIC RG183 including the requirement to an independent review at intervals of no more than three years, the start of which commences three years after the Code is approved.

82. Code sanctions should mirror those recommended by ASIC RG 183:

a) Compensation for any direct financial loss or damage caused to an individual

b) Binding non-monetary orders obliging the subscriber to take (or not take) a particular course of action to resolve the breach

c) Formal warnings

d) Public naming of the non-complying organisations

e) Corrective advertising orders

f) Fines

g) Suspension or expulsion from the ICA

h) Suspension or termination of Code subscription

i. Claims

a. Making a claim

---

83. The Code should include commitments to

a) provide a claimant with contact details they can use to get information about the claim

b) explain to the claimant why particular information is being requested

c) where possible, request all required information early and in one request, rather than in multiple information requests

84. In addition to these general insurers should, at the time of making a claim or soon after, commit to explaining the cover that the claimant holds, explain the claims process and any waiting periods, excesses or other relevant information.

85. Commitments to improved communications practices more broadly should be made including an equivalent set of commitments to Section 6.3 of the Life Insurance Code.

b. Withdrawn claims

86. The Code should commit insurers to neither discouraging a claim nor encouraging a withdrawal.

87. As a part of this commitment general insurers must not state that there is no difference if a claim is made or not.

88. The Code should require that when a claim is withdrawn, insurers should endeavour to record the reasons for this (if known) and ensure the customer is aware that they can make a complaint if they wish. This should be done so in a consistent manner, and should make this information available to the CGC as a part of their ongoing monitoring.

c. Claims decisions

89. Regular updates should given to a claimant every 10 business days (via text, email or phone, *where possible*), with responses to routine queries given within five business days.

90. A mandatory notification to consumer of their right to seek IDR and EDR within two months of a claim being lodged if the insurer has not made a decision on the claim.

d. Claims denials and partial denials

---

91. Consumer Representatives support written confirmation being provided for partially accepted claims detailing:

a) which aspects of the claim have not been accepted and the reasons for this;

b) the consumer's right to access information relied on to make the decision;

c) information about the insurer's complaints process.

92. The language of clause 7.19 should be amended to ensure that all of the information provided when a claim is denied is required to be in writing, not just the reasons for the denial.

93. The Code should require insurers record the reasons for claim denials.

94. Insurers should commit to improving the insurance reporting system and include commitments under the Code outlining consumer rights and insurer responsibilities in using insurance reports.

95. The commitment to notify a claimant about their entitlement to have their claim reviewed within 12 months should be amended so that this be done so in writing.

96. Clause 9.3 should be expanded to cover all claimants resulting from a catastrophe.

e. External Expert reports

97. Insurers should make a commitment under the Code to the effect that if an expert report cannot be provided within 12 weeks of the date of their engagement, general insurers will inform the claimant every 10 days of the status of the report and, if after a further 30 days the report has not been provided, the policy holder will be provided with details of the Complaints process. In order to address insurer concerns, this should include an exceptional circumstances clause.

f. Home building and vehicle repairs

98. Where an insurer engages someone to carry out work on a customer's building, contents or motor vehicle, the Code should require the insurer to provide the customer with a summary of the scope of that work.

99. The Code should require that, where a repairer, organised by the insurer, has done a faulty or poor repair of a vehicle or building, and this requires the use of a hire car or accommodation over and above what is in a customer's insurance cover, the insurer will arrange these for the customer and cover any costs for the arrangements.

g. Total loss claims protocol

100. Consumer Representatives support Legal Aid NSW's position that where a customer has suffered a total loss in relation to a contents claim, unless exceptions apply, insurers should not require the insured to complete a list of their contents and provide evidence. The agreed sum should be paid. Exceptions may include situations where there is a reasonable basis for suspicion of fraud, or where there is a reasonable basis for forming a belief that the actual loss is less than the agreed sum.

101. As an alternative the Code could include a Total Loss Protocol that conforms to the following:

a) Where a claimant has suffered a total loss, the assumption should be that the claimant be paid the "average sum insured" amount without having to quantify the loss nor provide an inventory assessment and evidence of value.

b) If the sum insured of a particular property is below this average, they should be paid this sum insured amount as per their policy.

c) If the sum insured is however higher than the average, then the insurer and its service suppliers should pay the average sum insured and help them assess their loss, and any inventory assessment required will only have to be provided up to the limit or sub-limit of the cover. Insurers would need to make it clear that this payment is not "in full and final settlement" and that the policyholder is entitled to pursue the difference

d) In addition to this, insurers need to commit to ensuring that people do not significantly over-insure their home and contents in the first place by supporting the recommendations above at Question 2.2

e) insurers need to be clearer with policyholders with respect to what the policyholder needs to maintain in order to provide the necessary evidence for a claim, and that these requirements be highlighted in the Policy certificate or embedded in the sales process and not buried in fine print, terms and conditions.

h. Uninsured third- party claims

102. The Code should clarify the rights of an uninsured third party driver making a claim with an at-fault driver's insurer, by including:

a) principles for claims handling;

b) an explanation of the claims process;

c) access to the insurer's complaints process;

d) access to EDR for a claim up to $15,000.

103. A claim should be considered valid once lodged, irrespective of whether the excess has been paid.

i. Debt Recovery

104. The Code should require insurers and third party suppliers, such as debt collectors, treat individuals from whom they are seeking recovery of a debt in an honest, fair, transparent and timely manner

105. The Code should require the insurer to provide sufficient information in writing for the individual to determine that the amount being recovered is fair and reasonable, including:

a) details of the damage and the claim

b) the repair estimate or completed repairs

c) evidence relied on for making an assessment of liability.

106. Insurers should commit to informing third parties of their right to question the sum that the insurer is seeking to recover.

j. Provision of documents

107. The Code should ensure that insurers provide the following information on request:

a) information and documents relied on to deny a claim;

b) in cases of mental health claims, actuarial and statistical data that they have relied on, and in the case where the material is considered to be commercial-in-confidence, a detailed summary of such data;

c) copies of the PDS and insurance certificate

d) copies of any expert or assessment reports commissioned during the course of the claim copies of any recordings or available transcripts of the sale of insurance and disputed interactions with the policyholder

108. Insurers should commit to providing this information free of charge.

ii. Automatic Renewals

109. At a minimum, automatic renewal disclosure should meet the following basic standards:

a) they are not a standard term;

b) expressed in reasonably plain language;

c) legible;

d) presented clearly; and

e) readily available to any party affected by the term.

110. Furthermore, the Code should ensure that automatic renewal is only used where:

a) the term is transparent or effectively disclosed to the policyholder or potential policyholder;

b) sufficient notice is given that a contract is about to renew;

c) a long window of opportunity is provided to opt out of the term;

d) no additional fees will be incurred if they cancel after the contract is automatically renewed.

111. An extended opt out period should be required by the Code in which insurers commit to giving the consumer a full refund of any premiums paid after the date of automatic renewal.

iii. Cancellation of policy

112. Any notice of cancellation for non-payment of instalments should mention the availability of hardship arrangements.

113. The cancellation procedures in the Code should be amended to provide notice in writing at least 14 days before cancellation through two different channels of communication (SMS, email, post).

114. Insurers should be required to always give the second notice of cancellation within 14 days after the policy has been cancelled.

iv. Complaints and disputes

a. Multi-tier complaints process

---

115. .The Code should implement a single complaints process, with appropriate frontline triage, and a timeframe of 15 business days.

b. Customer representatives

116. The Code should require insurers and service suppliers contact a customer through their representative when this has been requested by the customer.

v. Advertising and marketing

117. The Code should require commitments from insurers under the Code to:

a) consider the target audience for the advertisement or marketing communication and whether it provides adequate information for that audience;

b) ensure statements in advertisements or marketing communications are consistent with the features of the relevant policy and the disclosures in any corresponding PDS;

c) ensure that any images used do not contradict, detract from or reduce the prominence of any statements used;

d) if price or premium are referred to, ensure that these are consistent with the price or premium likely to be offered to the target audience for the advertisement or marketing communication;

e) make clear if a benefit depends on a certain set of circumstances;

f) ensure any use of phrases such as “free” or “guaranteed” are not likely to mislead

g) ensure that advertising does not solely focus on premium savings and provides balanced information regarding the loss of cover for lower premiums; and

h) comply with the ASIC’s guidance for advertising financial products and services and guidance regarding unsolicited sales.

vi. Pressure selling

118. The Code should prohibit pressure selling and other unacceptable sales practices for all employees, authorised representatives and Authorised Financial Services Licensees acting on your behalf.

119. The Code should match the standards set by the Life Insurance Code at clause 4.3 and be designed to prevent the practices described in ASIC's 2011 Report 256 and 470.

vii. Customer communications

a. When insurance is not offered

---

120. Clause 4.8(b) should be amended to include the statement:

> "we will inform you of your right to ask for the information that we have relied on in assessing your application and, if you request it, we will supply it in accordance with Section 14 of this Code."

b. Verification of a customer's disclosure

---

121. Commitments with respect to an improved Insurance Reporting regime should be included in the Code.

122. In the light of a new consumer data right, the ICA should reconsider their approach to the verification of a customer's disclosure.

123. The Code should require that a customer is contacted by an insurer as soon as an insurer becomes aware of an issue with their disclosure.

c. Policies with no-claim discounts (NCDs)

---

124. Implement the ASIC recommendations in Report 424 by requiring that:

a) Where insurers retain the traditional NCD pricing model, insurers should clearly disclose the effect of a claim on a policyholder's NCD rating and underlying premium. Where relevant, insurers should clearly disclose whether claims can affect the underlying premium independently of any effect on the NCD rating.

b) Where insurers retain the traditional NCD pricing model, policyholders should be made aware of the cost and value of purchasing ratings protection. Disclosure of the automatic inclusion of optional extras, such as ratings protection, on policies at renewal should be prominent.

c) Insurers should review and, where appropriate, improve disclosure and/or make available additional information on the operation of NCD schemes, where such schemes are retained.

d) Disclosure should be appropriately balanced so that consumers are not discouraged from making valid claims under their policies.

e) Insurers should disclose to consumers the existence of minimum premiums. Where the minimum premium is sufficiently high to have the potential to affect a policyholder's ability to realise their full discount and other promotional entitlements, that risk should be disclosed.

f) Insurers should ensure that promotional messages on the benefits of NCD schemes, where such schemes are retained, are carefully balanced against the actual features, risks and practical operation of the NCD scheme.

viii. Monitoring, enforcement and sanctions

a. Reporting of Code breaches

---

125. Clause 13.1 should be redrafted to read "Anyone can report alleged breaches of this Code to the CGC."

b. Interpretation of Code standards and process for appeal

---

126. Consumer Representatives strongly oppose the ICA's suggestion that provisions such as honest, fair and timely should operate only in relation to the standards set in each section and believe that clauses 4.4, 6.2, 7.2, and 10.4 be amended to remove the words "…in accordance with this section…", so that it is clear that each of these subsections operates as stand-alone provisions.

127. Consumer Representatives support the regular publishing of CGC decisions and identifying all insurers to incentivise compliance with the Code.

128. Consumer Representatives strongly oppose any move to introduce an appeal process.

129. Consumer Representatives oppose any moves for industry to make collective submissions to the CGC on Code interpretation

c. Reporting of Significant Breaches

---

130. Consumer Representatives strongly oppose the removal of the words "likely breach" from the definition of "Significant Breach."

d. Relationship between Code breaches and EDR

---

131. Consumer Representatives do not support the introduction of a rule to limit the power of the CGC for it to wait for the outcome of an EDR dispute before investigating an alleged breach of the Code.

ix. Promotion of the Code

132. Consumer Representatives believe that the powers and responsibilities of the CGC should be extended to include reporting systemic Code breaches and serious misconduct to ASIC, consistent with the requirements in RG 183.78(f).

133. Consumer Representatives also believe that some form of external or independent monitoring or auditing from time to time is more than appropriate.

134. Consumer Representatives recommend the ICA update the Code website and include the following elements:

a) promotion of the CGC and its role and areas of focus;

b) de-identified decisions of the CGC;

c) guidance to insurers through the use of scenarios and FAQs;

d) online annotations, explanations and examples to aid consumer understanding of the Code;

e) a bold and prominent "Report a Breach" button on the website front page and Governance and Monitoring Page. There should then be a subsequent filtering and step by step reporting process.

135. We also recommend a standalone CGC page similar to the CCMC, or a more prominent page link on the Code page.

136. A customer charter has some potential but is not a priority for Consumer Representatives

x. Extending the scope of the Code

a. Corporate culture

---

137. The Code should contain specific provisions relating to corporate culture.

b. Residential strata

---

138. The Code should extend the definition of retail insurance to include residential strata.

c. Extension of code to business insurance

---

139. The Code should be extended to cover wholesale insurance or a separate Code for wholesale insurance should be developed.

d. Application and guidance on the law

---

140. Consumer Representatives agree that the Code should refer to and add to current legal obligations.

xi. Emerging technologies

141. The ICA should report and consult on how the next iteration of the Code should respond to the needs created by emerging technologies.

x. What the Code does not cover

142. The following areas should be addressed in this Code Review:

a) written-off vehicles;

b) renewal notices;

c) key fact sheets including for motor vehicles;

d) customer communication during the complaints process – via the introduction of a one tier process;

e) disclosure of component pricing;

f) provision of data/access to information; and

g) governance of the Code.

143. The following areas should continue to be pursued outside of the Code Review process:

a) unfair contract terms (with a commitment to review policies with a view to removing unfair terms);

b) addressing affordability and under-insurance (beyond those proposals already put forward in this review);

c) standardisation and comparability of cover (beyond those proposals already put forward in this review).

Proposal 1: The Code should strengthen standards relating to vulnerable consumers

Proposal (1A) Including a new Code section on vulnerable consumers

1: The ICA suggests that the Code could include a new section on vulnerable consumers. The section would begin with a statement acknowledging the diverse needs of vulnerable people and committing to supporting the particular needs of customers where these are identified. Please identify any concerns or suggestions for improvements with this approach.

Consumer Representatives commend the Insurance Council of Australia (**ICA**) for proposing a new section on vulnerable customers. It is important to recognise the varied and specific needs of different sections of the community that have unique difficulties in engaging with the insurance sector.

We recommend that the ICA not reinvent the wheel and base any statement acknowledging the diverse needs of vulnerable people on other similar statements found in other codes of practice in Australia and internationally, in particular, those statements found in the Financial Services Council's (**FSC**) Life Insurance Code,[1] the Australian Bankers Association (**ABA**) Code of Banking Practice (2012)[2] and new commitments found in the soon to be released 2018 Banking Code of Practice, and the UK's Association of British Insurers (**ABI**) and British Insurance Broker Association (**BIBA**) Code of Good Practice.[3]

While a statement of acknowledgement is important and worthwhile, it is also critical to back up this statement with specific, concrete commitments from insurers that will achieve real world improvements and outcomes for vulnerable insurance customers.

Recommendation

144. **Consumer Representatives support the inclusion of a new section on vulnerable consumers including a statement acknowledging the diverse needs of vulnerable people and committing to supporting the particular needs of customers where these are identified.**

[1] Section 7.1 FSC, Life Insurance Code of Practice.

[2] Sections 7 and 8, ABA Code of Banking Practice.

[3] Sections 12-20. ABI and BIBA Code of Good Practice (UK).

1.1: It seems reasonable that the Code should require insurers to accommodate vulnerable consumers' requirements for formal or informal assistance from third parties. Please detail any concerns with this suggestion.

Consumer Representatives strongly support a commitment under the Code by insurers to accommodate vulnerable consumers' requirements assistance by a third party. This should include a positive commitment to ensure that processes insurers put in place to recognise the authority of a third party to act on behalf of a consumer should not be an impediment to fair and practical support for consumers.

Recommendation

145. **Consumer Representatives support a commitment under the Code by insurers to accommodate vulnerable consumers' requirements for formal or informal assistance from a third party.**

a. Staff training

1.2: The ICA suggests that the Code should require staff to be trained to identify and engage appropriately with vulnerable consumers, and to escalate requirements for additional support. Are there any implementation factors that need to be considered?

Consumer Representatives support insurers committing to training staff in order to identify and appropriately engage with vulnerable consumers.

We however recommend that it be made clear that *all* staff should receive this training and that different staff cohorts (such as public facing, front line staff) receive specific training, according to their role.

It is critical that, for example, managers receive similar training to public facing staff to enable them to support their staff in appropriately dealing with vulnerable consumers. It is important too that senior executives and the leadership group also receive this training in order that they consider the needs of vulnerable people in their decision-making process and development of corporate strategic direction.

Training all staff, at all levels of the organisation, to identify and engage with vulnerable consumers will promote a positive culture of recognition and acknowledgement of the issues faced by millions of Australians. If training is merely confined to particular identified cohorts, frontline staff may be disempowered by decision-makers who do not understand the issues at play, senior leadership may not consider the needs of vulnerable people in their corporate planning and vulnerable consumers may find themselves right back where they are now – disempowered by a system that is inflexible and unresponsive to their unique issues.

Recommendation

146. Insurers should commit to training *all* staff to identify and appropriately engage with vulnerable consumers and different staff cohorts (such as public facing, front line staff) receive more specific and in depth training, according to their role.

b. Improving insurance access

1.3: The ICA suggests that the Code should not prescribe specific products or payment arrangements, such as through Centrepay. However, Proposal 3 sets out product design principles for the Code. How could these principles improve product design for vulnerable consumers?

Consumer Representatives believe that general insurers can and should commit to more flexible payment arrangements.

The case for inaction put forward in the Interim Report is not strong.

With respect to payments via Centrepay, the Interim Report states that:

> *Insurers that offer payment through Centrepay have advised that it can be an administratively burdensome process.*[4]

Consumer Representatives acknowledge that offering payment via Centrepay requires additional administration. That does not mean it should be abandoned.

Working with and assisting vulnerable consumers may take extra work, outside of the usual routine that is built around the median consumer. Centrepay has the advantage of assisting people in low-income households to budget, and to avoid late payments and the risk of policies lapsing or being cancelled. Simply because it can be administratively burdensome should not preclude insurance companies doing so if it necessarily excludes or negatively impacts a significant cohort of vulnerable consumers. This is at odds with the commitment by the industry to do a better job when it comes to assisting people who are vulnerable.

The Interim Report also states that Centrepay payments "may not be appropriate for all products."[5] Consumer Representatives acknowledge this is the case but again this should not preclude insurers from providing this option where it *is* appropriate. While we accept that certain insurance products like gap insurance, extended warranty or tyre and rim insurances should not be subject to a Centrepay payment option, other, more essential insurance products such as home building insurance that may be more appropriate to be paid via Centrepay. This will make these products easier to obtain for people on low income.

[4] p. 6, ICA, *Interim Report: Review of the General Insurance Code of Practice*, November 2017

[5] p. 6, ICA, *Interim Report: Review of the General Insurance Code of Practice*, November 2017

We also do not accept that Centrepay is administratively burdensome because insurers' systems are not currently set up to administer fortnightly payments where requested. Insurers need to acknowledge that historical arrangements for monthly payment plans are out of step with modern practices and technologies are now available that allow for fortnightly payments, if requested. If insurers can introduce and implement telematics technologies recording and analysing every minute detail of policyholder's driving performance and fitness level, develop multiple consumer-facing apps and use the power of big data to influence their underwriting, product development and innovation, insurers can easily introduce a fortnightly payment system, to provide much needed choice to consumers.

Recommendation

147. Insurers can and should commit to more flexible payment arrangements under the Code including, where appropriate, Centrepay deductions and fortnightly payment options.

c. Identification requirements

1.4: The ICA suggests that the Code should require assistance to be provided to those who have trouble meeting identification requirements. Please identify any concerns you may have with this approach.

Consumers Representatives support the proposal to provide assistance to those who have trouble meeting identification requirements.

This issue particularly impacts regional and remote Indigenous Australians who are unable to obtain identification for a variety of reasons, including:

- the name many people commonly use is different to that which appears on their birth certificate;
- names may have been poorly recorded or spelt incorrectly on birth certificates;
- others use their traditional name, their English name and a commonly used nickname in different circumstances.

This leads to many people being unable to obtain drivers licences or any other form of identification used to obtain basic financial services including insurance. They are essentially prevented from accessing the financial tools which are taken for granted by most other Australians.

Consumer Representatives note that the FSC Life Insurance Code includes the following commitment which should be used as the basis upon which general insurers should develop their own:

> *7.4 We recognise that some groups of consumers (for example, people from Indigenous communities or those from non-English speaking backgrounds) may require support in meeting identification requirements when buying insurance or making a claim or Complaint.*

The insurance industry could also commit to adopting the approach the Australian Transaction Reports and Analysis Centre (**AUSTRAC**) is taking in relation to the requirements for identification for Indigenous people living in remote communities. The AUSTRAC guidance allows identify to be verified by a referee, such as a community elder. AUSTRAC has developed a template common identification form.[6] The insurance industry could adapt this form for its own purposes.

Recommendation

148. **The Code should commit insurers to providing assistance to those who have trouble meeting identification requirements. This should include the development of a common form for the industry to use allowing people in remote communities to be identified by community elders and others. The form would be based on the template developed by AUSTRAC.**

d. Use of Interpreters

1.5: Noting the Commonwealth Ombudsman best-practice principles, and the point raised by some insurers, would the following principles satisfactorily reflect best practice standards for the use of interpreters?

a) Insurers must provide access to an interpreter, either when one is requested by the customer or when a staff member needs one to communicate effectively with a customer (whether formally or informally).

b) Staff must make a record of a customer's interpretation needs and plan ahead to meet these needs. Where an interpreter is offered but declined, staff must also record this.

c) Insurers must provide a direct link on their website to information on interpretation services and any other relevant information for non- English speakers. This includes any product information that insurers have translated into other languages.

Do you have any concerns with this approach or suggestions for improvement?

Consumer Representatives support the inclusion of commitments to provide people with access to interpreters in the Code on the basis of best practice standards outlined by the

[6] See http://www.austrac.gov.au/aboriginal-andor-torres-strait-islander-people#witness

Commonwealth Ombudsman. This is particularly important in the realm of investigations but should be provided in all circumstances.

We note that the Commonwealth Ombudsman Best Practice Principles say that the use of friends and family members as interpreters should be avoided. Consumer Representatives have seen in our work that friends and family members of consumers being used as interpreters can sometimes result in misinformation about insurance products and can encourage non-disclosure of certain information when signing up for insurance products (be it on purpose or inadvertently). We recommend that family and friends should not be allowed to be used as interpreters and insurers should always provide access to an independent interpreter when needed.

Recommendation

149. The Code should include commitments to provide people with access to interpreters on the basis of the best practice standards developed by the Commonwealth Ombudsman. As a part of these best practice standards, family and friends should not be allowed to be used as interpreters and insurers should always provide access to an independent interpreter when needed.

Proposal (1B) Providing Code guidance on best practice mental health principles

a. Principles to inform best practice

1.6: The ICA proposes that the mental health best-practice principles (detailed in Appendix 1) should be developed into an ICA guidance document. Do the principles adequately respond to the issues raised by stakeholders? Are there any matters that have not been addressed?

Consumer Representatives support the introduction of a set of mental health principles to inform best practice, and commend the ICA and general insurers for proposing this important step.

As stated in the preamble to the principles, around 45 per cent of Australian will have a mental illness at some time in their life with a 12 month's prevalence over 20 per cent. These Australians experience significant challenges in engaging with the general insurance industry and face discrimination at a number of points in the insurance process.

The key issues that have caused concern for consumers and consumer representatives for some time are as follows:

- Insurers include blanket mental health exclusions in their policies and rely on those exclusions to refuse to pay a claim in circumstances where the applicant for insurance had no history of a past or current mental health condition when applying for insurance but developed a mental health condition after purchasing the policy.
- When an applicant for insurance discloses a past or current mental health condition when applying for insurance, the insurer:
    - refuses to offer insurance; or
    - offers insurance with a broad mental health exclusion, in circumstances where a more limited mental health exclusion would have been reasonable; or
    - offers insurance without a mental health exclusion but with an unreasonably high premium.

Consumer Representatives believe that the principles outlined in Appendix 1 are a good first step and we encourage the ICA and general insurers to improve the current draft based on the following observations.

Mandatory nature

The ICA has proposed that the best practice mental health principles be established as a guidance. Consumer Representatives believe that these Best Practice Principles should make up a part of the actual Code and be mandatory. It is unclear why these Best Practice Principles cannot act as mandatory standards much like those being proposed for investigations.

Setting Premiums

Best Practice Principle 2.1 states that:

> *Premiums for covers related to mental health illness will be influenced by an insurer's risk appetite.*

While it goes without saying that all insurance products offered by insurers will be *influenced* by an insurer's appetite for risk, it is critical that this risk profile be based upon proper assessments of this risk, that is, in the case of mental health, actuarial or statistical data that is reasonable to rely on, as per section 46 of the *Disability Discrimination Act 1992*. (***DDA***). The goal should be that every insurer be in the market of providing cover relating to mental health and that as the second sentence of 2.1 states insurers should seek to cover and manage risk through pricing, exclusions, limits and caps rather than not provide cover at all. A risk appetite of zero is not warranted where actuarial and statistical data is available.

We recommend that this sentence either be removed or amended to explicitly state the following:

> *Premiums for covers related to mental health illness will be influenced by an insurer's risk appetite, based upon actuarial or statistical data that is reasonable to rely on, as per section 46 of the Disability Discrimination Act 1992.*

It is important to reference the *DDA* here to remind insurers of their precise obligations in this regard.

We note that Best Practice Principle 2.2 states:

> *When setting premiums for covers related to mental health illness, the pricing of the offered products should reflect the increased associated morbidity, mortality and other risks.*

We believe that this wording should be amended to ensure that the "increased associated morbidity, mortality and other risks" be explicitly based on actuarial or statistical data on which it is reasonable to rely, as per section 46 of the *DDA*.

Blanket exclusions

Best Practice Principle 2.3 states:

> *Insurers should aim to apply narrower exclusions as data becomes more available over time to reflect a better understanding of mental illness. Where possible, insurers should move away from the application of blanket-based exclusions.*

We do not believe that moving away from the application of blanket-based exclusions is enough and that general insurers must commit to a prohibition on any exclusions which have no reliable evidence base or actuarial data.

The Financial Ombudsman Service (**FOS**) in March 2017 (Case No. 428128) found that it was not reasonable for an insurer to include a broad mental health exclusion because:

a) the insurer was unable to provide its own actuarial data specific to the applicant's risk category;

b) the general statistical data submitted did not refer to or assess the risk undertaken by the insurer associated with first presentation mental illness;

c) the insurer was unable to present any data it relied upon when it first introduced the exclusion to the policy; and

d) the data provided was not accompanied by any evidence that the insurer actually relied upon it to introduce and maintain the exclusion.

Narrowing a broad exclusion over time as more data comes available is the wrong approach; it is not consistent with the FOS decision or discrimination law.[7] Where there is no reliable evidence base, or actuarial data, broad exclusions should be removed altogether, with narrower exclusions only introduced where actuarial or statistical data exists.

Given many insurers may not have:

- the statistical or actuarial data to support their decision to include a broad exclusion in their policy; or
- the statistical or actuarial data upon which they rely may be out-of-date, general in nature and not directly applicable to the person or insurance product involved, based on an insufficient sample size or not directed towards insurance risk or incidence data,

we believe it is prudent to take the approach we recommend above.

We note that at 1B (d) of the Interim Report that the ICA states:

> *The ICA considers that the ultimate position when taking into account mental health in underwriting is for an exclusion to be sufficiently granular. This will ensure that the exclusion reflects the actual risk represented by the particular condition.*

We agree with this, however note that the Best Practice Principles allow insurers to maintain their broad exclusions without necessarily having sufficient granularity.

We note too that:

> *The ICA is currently evaluating whether an ICA-led program of data collection and analysis for mental health claims in travel insurance is necessary in order to facilitate improved access for people with a mental illness. Whether undertaken individually by members, or collectively by the ICA, as data becomes available over time, insurers will be in a position to provide narrower exclusions.*

This again has it backwards. While gathering actual data is important, it is implicit in the exercise to collect and analyse data that there is not the sufficient data to support a broad exclusion. Allowing their continued presence in policies is therefore untenable.

Loadings

We note that Best Practice Principle 4.2 states that:

> *Where loadings are applied to insurance products and services, these should be quantified based on reasonable data or opinions.*

[7] *QBE Travel Insurance v Bassanelli* [2004] FCA 396; *Ingram v QBE Insurance (Australia) Ltd (Human Rights)* [2015] VCAT 193,

Rather than reasonable "data or opinions" this should read actuarial or statistical data on which it is reasonable to rely as per section 46 of the *DDA*. While this may be an attempt at plain English or legal interpretation it is preferable that the actual words of the *DDA* be used.

We also note that this section does not address the issue of caps and should.

Insurers, staff and other representatives

Consumer representatives support the inclusion of Best Practice Principle 3.2 which states:

> *Insurers should adopt a respectful and positive approach towards consumers with mental illness in their sales and claims processes. Insurers should develop and implement policies and procedures that support this approach.*

We believe that this however needs to be broadened to include not just the insurers but their authorised representatives and agents. Given the proposed inclusion of mandatory investigation standards and other standards relating to vulnerability more generally, the Best Practice Principles should cross reference the investigator standards and the standards applying to authorised representatives and other service suppliers. This is important as investigators have ignored mental health issues in their engagement with customers in the past.

We would also recommend that Best Practice Principle 5 should apply not just to staff but to their authorised representatives and agents.

Least intrusive methods of investigation

Best Practice Principle 3.3 states that:

> *Claims involving mental illness should be processed sensitively, and where possible, using the least intrusive methods of investigation*

While Consumer Representatives support the inclusion of this principle we believe that it should be strengthened to ensure that all other alternative methods of verifying information will be sought before undertaking any more intrusive methods of investigation, as committed to under section 4.1 of the draft investigator standards. A cross reference to the entirety of section 4 of the investigator standards may be required.

Refusal of cover

We note that the significant issue of refusal of cover in the first instance is not covered in the guidelines. This is disappointing and must be addressed. Consumer Representatives make recommendations on this point in the following section (Question 1.7).

Recording data

It is important that the Principles state something with respect to best practice record keeping. The decisions made with respect to mental health provisions and the actuarial and statistical data relied upon to design them are necessary to be able to be examined and justified. Recording this information is important for insurers to back their case, consumers to understand the insurer's approach and regulators to examine whether the design process and data gathering was undertaken and used in an appropriate manner. We therefore recommend that the Code should commit insurers to keeping accurate records of the actuarial or statistical data that they rely upon when making decisions relating to mental health.

Recommendations

150. Consumer Representatives support the introduction of a set of mental health principles to inform best practice, and commend the ICA and general insurers for proposing to take this important step. We believe these principles should form a mandatory part of the Code, rather than act as a guide.

151. The mental health principles to inform best practice should be amended as follows:

a) The wording of 2.1 should either remove the first sentence or be amend to state the following:

Premiums for covers related to mental health illness will be influenced by an insurer's risk appetite, based upon actuarial or statistical data that is reasonable to rely on, as per section 46 of the Disability Discrimination Act 1992.

b) the wording of 2.2 should be amended to ensure that the "increased associated morbidity, mortality and other risks" be explicitly based on actuarial or statistical data on which it is reasonable to rely, as per section 46 of the *DDA*;

c) general insurers must commit to a prohibition on broad mental health exclusions without any reliable evidence base or actuarial data, with narrower exclusions only introduced where actuarial or statistical data on which it is reasonable to rely exists;

d) the wording of 4.2 should commit insurers to ensuring that quantifying loading should be based on actuarial or statistical data on which it is reasonable to rely as per section 46 of the *DDA* rather than "reasonable data or opinions.";

e) commitments under 3.2 and 5 should be extended from staff to all representatives and service suppliers;

f) 3.3 should be strengthened to ensure that all other alternative methods of verifying information will be sought before undertaking any more intrusive methods of investigation, as committed to under section 4.1 of the draft investigator standards. A cross reference to the entirety of section 4 of the investigator standards should be included.

g) the Code should commit insurers to keeping accurate records of the actuarial or statistical data that they rely upon when making decisions relating to mental health.

b. Discrimination

1.7: The ICA's view is that the Code should not contain guidelines for complying with the DDA. However, the Code could include a statement explaining how underwriting decisions will be made. For example:

a) **Decisions will be evidenced based;**

b) **Underwriting decisions will be regularly reviewed to ensure decision making is not relying on out-of-date information.**

Is this a suitable alternative? Are there any issues or concerns with this approach?

Consumer Representatives note that the Code should include commitments from general insurers that raise industry standards complementing and moving beyond the basic obligations under legislative requirements. One of those key requirements is insurers' obligations under the *DDA*, whose aim is to promote the rights of people with a disability to participate equally in all areas of life.

The Australian Human Rights Commission has produced a specific guideline for insurers and superannuation companies to assist better understanding of rights and obligations under the DDA.[8] At the very least the Code or the Best Practice Principles should make explicit reference to this document in the Best Practice Principles or the Code.

We believe that the Code should include specific commitments with respect to the insurance industry's engagement with people with mental health problems. We support the Code stating that:

a) decisions will be based upon actuarial or statistical data on which it is reasonable to rely;

b) in the case where no such actuarial or statistical data is available and cannot reasonably be obtained the discrimination is reasonable having regard to relevant factors;

c) underwriting decisions will be regularly reviewed to ensure decision making is not relying on out-of-date information.

This is preferred to the use of the phrase "decision will be evidenced based" as this avoids any concern with respect to legal interpretation and makes clear what is actually expected of insurers under the *DDA*.

Further, we believe that it is entirely appropriate to list out some of the factors that insurers should take into account when considering the risk of someone's mental health condition, where there is no actuarial or statistical data available. As spelt out in the Human Rights Guideline, these include:

[8] Guidelines for providers of insurance and superannuation under the *Disability Discrimination Act 1992* (Cth) (revised 2016) https://www.humanrights.gov.au/sites/default/files/AHRC_DDA_Guidelines_Insurance_Superannuation2016.pdf

- medical opinions
- information which is relevant to the particular individual seeking insurance cover, including:
    - the type of disability the person has
    - the severity of the disability
    - the function impact of the disability
    - treatment plans
    - the person's employment records
- the practice of others in the insurance industry
- actuarial advice

We also believe the Human Rights Guidelines point to very reasonable approaches that could easily be committed to by general insurers under the Code. These include:

- before refusing to provide cover on the basis of a mental health exclusion insurers will:
    - provide the opportunity to the applicant to either provide further information, including supporting medical documents;
    - consider whether alternatives such as providing a policy with an appropriate exclusion clause, restricting the cover or imposing an additional premium would effectively manage any additional risk;
- insurers will not automatically decline an application for insurance that reveal a mental health condition or symptoms of a mental health condition;
- insurers will refer applications for insurance that reveal a mental health condition or symptoms of a mental health condition to an appropriately qualified underwriter;
- when non-standard terms or higher premiums are applied, insurers will include:
    - advice about how long the non-standard terms or higher premiums would apply
    - any criteria that would need to be satisfied to have the policy 'standardised'
    - the process for removing or amending the non-standard terms or higher premiums.
- insurers will develop a disability action plan (under Part 3 of the *DDA*) and have these published on the Australian Human Rights website.

Recommendations

152. The Code should include specific commitments with respect to the insurance industry's engagement with people with mental health problems including:

a) making explicit reference to Guidelines for providers of insurance and superannuation under the *Disability Discrimination Act 1992* (Cth) (revised 2016);

b) decisions will be based upon actuarial or statistical data on which it is reasonable to rely;

c) in the case where no such actuarial or statistical data is available and cannot reasonably be obtained the discrimination is reasonable having regard to relevant factors;

d) underwriting decisions will be regularly reviewed to ensure decision making is not relying on out-of-date information.

e) Factors taken into account when considering the risk of someone's mental health condition and there is no actuarial or statistical data available include:

i. medical opinions

ii. information which is relevant to the particular individual seeking insurance cover, including:

- the type of disability the person has
- the severity of the disability
- the function impact of the disability
- treatment plans
- the person's employment records

iii. the practice of others in the insurance industry

iv. actuarial advice

f) Before refusing to provide cover on the basis of a mental health exclusion insurers will:

i. provide the opportunity to the applicant to either provide further information, including supporting medical documents;

ii. consider whether alternatives such as providing a policy with an appropriate exclusion clause, restricting the cover or imposing an additional premium would effectively manage any additional risk;

iii. Insurers will not automatically decline an application for insurance that reveal a mental health condition or symptoms of a mental health condition; and

iv. insurers will refer applications for insurance that reveal a mental health condition or symptoms of a mental health condition to an appropriately qualified underwriter.

g) When non-standard terms or higher premiums are applied, insurers will include:

i. advice about how long the non-standard terms or higher premiums would apply;

ii. any criteria that would need to be satisfied to have the policy 'standardised'; and

iii. the process for removing or amending the non-standard terms or higher premiums.

h) Insurers will develop a disability action plan (under Part 3 of the *DDA*) and have these published on the Australian Human Rights website.

c. Provision of Data

1.8: Should the Code require insurers to provide, on request, a summary of the type of data or a description of the relevant factors relied upon, and why that data or those factors are relevant, when they rely on the DDA to make a decision about the provision of insurance or about a claim? What are the strengths or weaknesses of this approach?

Consumer Representatives believe that insurers should provide copies of the actuarial and statistical data that they have relied on to make decisions in relation to an offer of insurance to a consumer or claims made by consumers on their policies within a reasonable time frame upon request. Wherever possible, this material should be provided to the applicant with a summary in a readily accessible and plain-language format, making reference to the specific additional risk that the applicant represents.

Only where the actuarial and statistical data which insurers have relied on are not able to be provided because the material is considered to be genuinely commercial-in-confidence, should insurers provide a detailed summary. This summary should specifiy the type of data that they have relied on, and the relevance of that data to the decision to:

i. decline insurance coverage to the applicant;

ii. offer coverage on non-standard terms; or

iii. deny a claim.

The consumer should be advised as to the relevant factors that were considered, why they were considered to be relevant, and how those factors affected the decision.

We would note that it is out view that insurers rarely rely on statistical and actuarial data that is genuinely commercial-in-confidence. Often the data comprises of publicly available medical journal articles of statistical studies which are not readily accessible to consumers. The Code should also make clear that this does not negate the obligation to provide all actuarial and statistical data relied on (including that which is commercial-in-confidence) once a consumer has made a DDA complaint to a state or federal complaints body.

This commitment should be extended to include the right to request this information in the Product Disclosure Statement (**PDS**) and all other relevant consumer communications.

Recommendations

153. Insurers should provide copies of the mental health actuarial and statistical data that they have relied on to make decisions in relation to an offer of insurance to a consumer or claims made by consumers on their policies within a reasonable time frame upon request.

154. Only where the actual actuarial and statistical data which insurers have relied on are not able to be provided because the material is considered to be commercial-in-confidence, should insurers provide a detailed summary. This summary should specify the type of data that they have relied on, and the relevance of that data to the decision to:

a) decline insurance coverage to the applicant;

b) offer coverage on non-standard terms; or

c) deny a claim.

155. Insurers should detail this right to request this data in the PDS and other relevant communications.

Proposal (1C) Providing Code guidance on recognising and responding to instances of family violence

1.9: The ICA proposes that the family violence document attached in Appendix 2 be developed into an ICA guidance document. Does the document adequately respond to the issues raised by stakeholders?

1.10: Does it appropriately capture the areas that an insurer should include in their family violence policy?

Consumer Representatives welcome the development of a draft family violence guidance document and commend the ICA for taking a positive step forward on this important issue. As it stands, the document recognises many of the issues that are relevant to customers experiencing family violence. We particularly support the recognition that family violence issues require flexible decision making and decisions by senior employees.

We note however that a number of the key issues raised in the Economic Abuse Reference Group's (**EARG**) paper on insurance and family violence[9] remain unaddressed, and EARG members look forward to continuing to work on these issues with the ICA.

Our comments for the purposes of this submission are therefore focused on the detail of the proposed guidance.

We note this is a draft document, and that a review of the structure and headings may be required to reduce repetition and make the document clearer.

An issue that is important to understand with respect to family violence is that it is often very difficult to identify and victims may not raise it. This needs to be acknowledged in the document. We recommend that the text should state "if family violence *may* be a factor…" so that staff don't only respond when there is clear evidence of family violence.

In the Summary section, we recommend one additional dot point regarding the matters that should be covered by a policy:

> *"assistance to staff to identify, and avoid harm to, victims at point-of-sale of policies."*

We acknowledge and understand why the draft uses the Family Law definition of family violence, but we recommend that the guidance add

> *"Family violence laws in most states and territories recognise economic abuse as a form of family violence"*

This will emphasise the recognition of economic abuse. The EARG can provide a summary of definitions in all states if this is of assistance.

[9] EARG, Insurance and Family Violence, May 2017, https://eargorgau.files.wordpress.com/2017/04/insurance-and-family-violence.pdf

In relation to training and "equipping appropriate employees," the Guideline needs to ensure that *all* employees and authorised representatives receive family violence training and that certain staff receive family violence training specific to their role. This includes managers receiving training to enable them to support their staff. On this point we recommend that the first sentence under "Requirements for family violence policy" should state:

> *The relevant requirements in the Code are to have systems, processes and appropriate training in place to identify and support customers, **staff and authorised representatives** who require additional assistance.*

It is important that the Guidance recognises that amongst the insurer's employees, there will be victims and perpetrators, of family violence.

The last dot point under Staff training states:

- *discloses the existence of an intervention order or equivalent*

We recommend that this be amended to state:

- *discloses the existence (past or present) of family violence, an intervention order or equivalent*

In the section "Protecting private and confidential information" it should state that the safety of the customer, and others, is of paramount importance. This should also be a key principle that should be included at the beginning of the document – possibly in the Objectives or Summary section.

We believe a system which flags accounts where there is possible family violence could be implemented, similar to recording the need for an interpreter, proposed in the claims investigations standards. Yarra Valley Water has instituted a system and can provide details of their approach and its effectiveness.

We are concerned that using the address as a form of ID may not suit some customers (for example, those in a refuge) and that the customer should be able to set the ID requirement.

Regarding the reference to an online report to a state child protection agency, we assume this is a legal obligation. If so, it may be worth obtaining legal advice, and placing any legal obligations that insurers believe their staff have, into a separate section.

We recommend adding the words 'or potential customers' into the sentence, "Both may be customers, or potential customers, or they may be members of staff".

We assume that the reference to counsellors accompanying claims staff to recovery centres refers to counsellors from external agencies, and that they would be appropriately experienced and qualified to respond to family violence (and other issues).

The guidance states that

> *"Anyone interviewing or investigating someone involved in a claim who is affected…"*

This should say "may be affected…"

After "this can be a particularly complex area in cases of family violence" we recommend adding "and/or where family law property disputes are involved".

Under "Financial Hardship Assistance" we prefer the phrase "experiencing financial hardship" rather than "suffering from financial hardship".

In relation to referring to external agencies, we recommend basing this on the EARG Good Practice Guide regarding referral options for staff.[10] In relation to the list of service providers, we assume this relates to contacts for training or helping policy development. The EARG guide recommends that the list of referral options needs to be concise with a minimum range of referral options, with additional referral options only if staff can differentiate between the services based on the customer's circumstances.

This need should be reflected in the guidance. The EARG states:

> *Unless there are reasons for providing additional options, we recommend that one referral option (possibly with a 'back-up' in case of lack of availability) is provided under each of the five categories:*
>
> 1. *Emergency;*
> 2. *Family violence counselling information and referral;*
> 3. *Financial/debt issues;*
> 4. *Housing; and*
> 5. *Assistance for men (whether the man is a victim or perpetrator).*
>
> *1. Emergency*
>
> *If a person is in immediate danger dial 000*
>
> *2. Family violence support, information and referral*
>
> *We recommend that customers who require this assistance are provided with the number of their state-based service (if available) and the national "RESPECT" number in case they have problems making contact. A state-based service is likely to have closer contacts with local services. The state/territory based services we have listed are also the contact point for referral for emergency accommodation.*
>
> *3. Financial/debt issues*
>
> *People can speak to a free, independent and confidential financial counsellor (either on the phone or face-to-face) by calling the National Debt Helpline on 1800 007 007 from anywhere in Australia. The website www.ndh.org.au has a range of step-by-step and self-help guides.*

[10] EARP, Good practice for industry family violence guidelines – Referral Options, 19 September 2017, https://eargorgau.files.wordpress.com/2017/03/referrals-good-practice-190917.pdf

4. Housing (state-based services)

The state-based support services listed below provide referral to emergency accommodation. Provide details for 1800 RESPECT as a second option (or primary option for Northern Territory residents).

5. Support for men (victims or perpetrators)

Provide the number for the state-based services for Victoria, Tasmania or New South Wales. For other states & territories, provide the national number for No to Violence Men's Referral Service.

Furthermore we feel insurers need single entry points so that callers (customers and their case workers) can reach the right person with adequate authority and experience to make a flexible decision and ensure the customer's safety. Other sectors (e.g. banking and water) are adopting this approach.

Finally there are two outstanding family violence matters that require addressing in either this guideline, the Code or via other means.

The first is the need to deal with the unfair outcome of *Matthew's* case.[11] As was outlined in WestJustice's original submission this case has established a precedent that will lead to unfair outcomes for those subject to family violence. We strongly believe that the general insurance industry must take steps to ensure fair outcomes are prevented in the future.

The second issue that insurers need to deal with is the perverse situations that arise through telephone underwriting. For example, one party can insure a jointly owned property in his/her own name or change a joint policy into his/her name alone, with claims payouts going to only one of the joint-policy holders.

A more stringent process is required around insuring parties on title. The industry needs to acknowledge its role in this problem and be more cautious about only allowing both policy-holders to cancel insurance (and generally requiring consent of all insured parties to cancel joint-policies).

Recommendations

156. Consumer Representatives welcome the development of a draft Family violence guidance document and commend the ICA for taking a positive step forward on this important issue.

157. The Family Violence Guidance Document should state

"if family violence may be a factor…"

[11] *Advance (N.S.W.) Insurance Agencies Pty. Limited v Matthews* (1989) 166 CLR 606

to acknowledge that it is often very difficult to identify family violence and victims may not raise it.

158. In the Summary section, the following should be included:

"assistance to staff to identify, and avoid harm, to victims at point-of-sale of policies".

159. To capture the full nature of family violence, the definition of family violence should include the following:

"Family violence laws in most states and territories recognise economic abuse as a form of family violence."

160. In order that *all* employees and authorised representatives receive family violence training, the Requirements for family violence policy should state:

"The relevant requirements in the Code are to have systems, processes and appropriate training in place to identify and support customers, staff and authorised representatives who require additional assistance."

161. To recognise that there will be victims and perpetrators of family violence amongst the insurer's employees the last dot point under staff training should state:

"discloses the existence (past or present) of family violence, an intervention order or equivalent"

162. In the section "Protecting private and confidential information" it should state that the safety of the customer, and others, is of paramount importance.

163. A system which flags accounts where there is possible family violence should be committed to, similar to recording the need for an interpreter, proposed in the claims investigations standards.

164. Customer should be able to set the ID requirement as using the address as a form of ID may not suit some customers because of safety concerns.

165. The words 'or potential customers' should be included in the sentence: "Both may be customers, or potential customers, or they may be members of staff."

166. The words "Anyone interviewing or investigating someone involved in a claim who is affected…" should be amended to state "may be affected…"

167. After the words "this can be a particularly complex area in cases of family violence" we recommend adding "and/or where family law property disputes are involved."

168. We prefer the phrase "experiencing financial hardship" rather than "suffering from financial hardship".

169. In relation to referring to external agencies, we recommend basing this on the EARG Good Practice Guide regarding referral options for staff.

170. Insurers should commit to providing a single entry point so that callers can reach the right person with adequate authority and experience to make a flexible decision and ensure the customer's safety.

171. Insurers need to acknowledge the need to deal with the unfair outcome of *Matthew's* case and the perverse situations that arise through telephone underwriting.

Proposal (1D) Including stronger Code standards on Financial Hardship

a. Awareness and identification

1.11: The ICA suggests that the Code should require insurers and Service Suppliers to receive training on their obligations with regard to consumers in financial hardship, and to identify signs of financial hardship when engaging with individuals who owe money to an insurer. Are there any implementation factors to consider with this approach?

Consumer Representatives support the inclusion of bolstered financial hardship provisions including requiring insurers and service suppliers to receive training on their obligations with regard to consumers in financial hardship, and to identify signs of financial hardship when engaging with individuals who owe money to an insurer.

Case Study – Jaime's story

In early 2015, a judgment order was obtained against WestJustice's client Jaime in the Magistrates' Court for an alleged debt of $9000 due to water damage to the opposing party's ("the insured") property caused by Jaime. The insured was represented by a law firm. Unbeknownst to us, the law firm was also acting for an insurer. The lawyers' actions, on behalf of the insurer, breached numerous provisions of the Code.

WestJustice first wrote to the lawyers in November 2015 requesting a waiver of the judgment debt on the basis of Jaime's financial and personal hardship. Throughout our negotiations with the lawyers, their breaches of the Code included but were not limited to the following failures to:

- Disclose involvement of an insurer in the matter or that they were acting for an insurer over a two year period, and stating that their client was not an insurer;
- Notify the insurer that we had informed them of our client's financial hardship;
- Provide details of the insurer's financial hardship process;
- Supply application forms for financial hardship assistance and contact details for the National Financial Counselling Hotline;
- Provide an assessment as to whether our client is entitled to assistance for financial hardship and reasons for such a decision;
- Provide information about the insurer's complaints process;
- Work with us to consider an arrangement for hardship assistance for our client;
- Request information that is reasonably necessary to assess the hardship application;

- Hold recovery action in the Court proceedings following our initial request for hardship assistance; and
- Adhere to the Australian Competition and Consumer Commission (**ACCC**) and the Australian Securities and Investments Commission (**ASIC**) Debt Collection Guideline when taking recovery action, as the lawyers contacted our client directly after we had notified them that we were acting.

The extent of the lawyers' misconduct amounted to deliberately misleading us by admitting the insurer was their client only when we pressed them to answer how the insured could legitimately recover twice through the legal proceedings and through the insurance policy. The lawyers failed to address many of the above breaches which we had raised with them, and we then lodged a complaint with the Code Governance Committee. A Partner of the law firm responded by stating in writing that the Code operates as a guideline only and does not confer any enforceable rights on our client, and asked us to withdraw our complaint to the Code Governance Committee in light of this.

Source: WestJustice Legal Centre

Recommendation

172. The Code should include commitments to train insurers and service suppliers on their obligations with regard to consumers in financial hardship.

1.12: Noting that an individual will still have to provide evidence of actual financial hardship, are there any practical implications to consider, if the Code were to require debt recovery letters to include information about the financial hardship process?

Consumer Representatives support the Code committing insurers to include information about the financial hardship process in debt recovery letters. This is a simple, fair and good faith step to take to ensure that those who require assistance are informed of their ability to request assistance. This would be a fulfilment of the recommendation of the 2012 Enright review, and would meet best practice standards found in other sectors such as the energy industry.

We accept that many consumers may not receive such assistance if evidence is not subsequently provided, but at the very least, consumers will be empowered to at least know what steps they can take.

We also recommend that as a part of this information, the Internal Disputes Resolution process and contact details be included.

Recommendation

173. The Code should include information about the financial hardship process in debt recovery letters. This should include information on the Internal Disputes Resolution process and contact details.

1.13: Should an insurer who is contacted directly by a consumer in hardship, who is aware that the consumer has a representative, always be required to notify the representative that such contact has occurred? If there are any privacy implications, please detail them. Are there any alternative solutions?

Consumer Representatives believe that the principle should be that the representative be contacted where there is an authority on file.

There should however be some discretion and flexibility built in to the process. Where there are difficult or sensitive situations such as where an insurer has identified, for example, a breakdown in a relationship, family violence, a family member is a representative, or a debt management firm is involved, appropriate consents should be sought.

Recommendation

174. When an insurer is contacted directly by a consumer in hardship, insurers should, in principle, contact representatives where there is an authority on file. There should be some flexibility built in to ensure that consumers are protected in difficult or sensitive situations such as where family violence is suspected or known, or a debt management firm is involved.

b. Timeframes

1.14: It has been identified that timeframes for assessing hardship requests vary among insurers. If the Code required that financial hardship applications should be processed in line with the National Credit Code, would this be a satisfactory solution? Is there another preferable way to address this matter? The timeframes would require that:

a) **The insurer will assess an application for hardship assistance and**

b) **inform the consumer of its hardship decision within 21 calendar days, or inform them that it needs more information.**

c) **If the insurer needs more information, the consumer has 21 calendar days to provide it.**

d) **Within 21 calendar days of the consumer providing the requested information, the insurer must make its hardship decision and inform the consumer of its decision.**

e) **If the consumer fails to provide the requested information, then the Code Subscriber must make its hardship decision on the information available within 28 calendar days of the date that information was requested, and inform the consumer of the decision.**

Consumer Representatives support clarifying the phrase: "as soon as reasonably practicable." This language has led to significant inconsistencies and not pushed the necessary incentive to make decisions within reasonable timeframes. The timeframes of the National Credit Code are reasonable, well established and appropriate. Consumer Representatives support this inclusion.

We would however propose one adjustment to the timeframe. We would recommend that consumers or third parties should be allowed 45 calendar days to provide information requested, with the ability to extend the timeframe in special circumstances. Consumers get flustered when they are provided with short time frames. This is exacerbated by snail mail post where consumers can receive letters after the deadline, and are delayed further by the time taken to see a financial counsellor.

Recommendation

175. **In assessing applications for financial hardship it is appropriate and reasonable to meet the timeframes set by the National Credit Code, and should be committed to by insurers under the Code. We recommend one adjustment to this: that consumers or third parties be allowed 45 calendar days to provide information requested, with the ability to extend the timeframe in special circumstances.**

1.15: There appears to be sound reasons for the Code to require that consumers requesting financial hardship assistance are only asked to provide information that is genuinely necessary to assess their application. Also any request for information should not unreasonably or unnecessarily delay the assessment of the hardship request. Are there any issues that would have to be resolved in order for this to be implemented?

Consumer Representatives support insurers committing to only asking consumers requesting financial hardship assistance for information that is genuinely necessary to assess their application. A statement in the Code ensuring that any request for information should not unreasonably or unnecessarily delay the assessment of the hardship request is welcome. We believe that the commitment should also ensure that insurers identify what further information is needed as soon as possible and request it.

c. Payment of excesses

1.16: To address the concerns noted above, should the financial hardship section of the Code make it clear that it applies to situations where a customer cannot pay their excess? Also should the options for financial hardship assistance in clause 8.8 include "deduction of the excess from the claim payment"? Are there any practical implications with this approach?

Consumer Representatives believe that the financial hardship section of the Code should make it clear that it applies to situations where a customer cannot pay their excess. The options for financial hardship assistance in clause 8.8 should include "deduction of the excess from the claim payment."

Industry guidelines or advice needs to be given on how to deal with issues surrounding excess and financial hardship. Consumer Representatives continue to see cases where insurers fail to acknowledge financial hardship or assert a right to reject a claim (or refuse to progress a claim) on the basis unpaid excess.

Case Study – Jared's story

Jared was involved in a motor vehicle accident in July 2017 in which he was not at fault and suffered a financial loss of approx. $4000. The other insured party ("the insured") lodged an insurance claim but had not paid their excess of $1,000 with the insurer, which caused significant delay to the matter and hardship.

WestJustice assisted Jared in contacting the insured's broker in early August 2017. The broker's details were provided to Jared by the insured who directed Jared to call the broker. WestJustice were then contacted by the insurer in mid-August 2017 confirming their involvement in the matter. WestJustice made contact with the insurer on a number of occasions seeking an update on the matter however did not receive an adequate response. WestJustice requested that the matter be escalated to the insurer's Internal Dispute Resolution Department for review in November 2017 on the grounds of unreasonable delay pursuant to clause 10.3 of the Code. WestJustice were finally advised by the insurer in November 2017 that the delay was due to the insured not having fulfilled policy conditions by failing to pay their excess of $1,000. Jared was experiencing severe financial hardship and remained uncompensated during this time.

In late November 2017, the insurer agreed to pay Jared however deducted the insured's unpaid excess of $1,000 from the full amount. WestJustice proposed as a term in the agreement that the insurer takes all reasonable steps to recover the outstanding excess payment from the insured including offering a payment plan to the insured and that Jared be paid out further if the amount is recovered. Additionally, Jared reserved his right to pursue the insured for $1,000 if the amount was not recovered by a certain date.

Source: WestJustice Legal Centre

We continue to see policies that specify that the customer may have to pay the excess before the insurer will pay the benefit. For example:

> *Home Building Insurance - How to pay your excess*
>
> *When you make a claim we will choose whether to deduct the applicable excesses from the amount we pay you or direct you to pay the excesses to us or to the appointed repairer or supplier. We may require you to pay the excesses in full before we pay your claim or provide any benefits under your policy. The fact we have asked for payment of your excess does not of itself mean that your claim has or will be accepted by us either in whole or in part.*[12]

Consumer Representatives believe that those who can't pay their excess upfront, in addition to having their excess deducted from their payout, should be provided with an option to pay the excess in affordable instalments.

We note the case of *Calliden Insurance Limited v Chrisholm* [2009] NSWCA 398 confirmed that a failure to pay the excess upfront should not be a bar to claiming under an insurance policy. FOS supports this view:

> *When considering disputes about insurance excess, FOS takes the view that:*
>
> - *an insurer cannot automatically reject a claim because you can't pay the excess if that claim would otherwise be covered by your insurance policy*
> - *your inability to pay the excess does not prevent FOS from considering a dispute about the claim.*[13]

We believe that once an uninsured party claims against the insurer and the insurer knows that the reason their policyholder is not claiming (by asking their policyholder directly) is because they can't pay the excess in one go, then the insurer should inform their policyholder of the availability of the option to pay the excess in instalments. The Code should therefore be amended to reflect this and to allow access to EDR for the uninsured person in this case.

FOS has already stated that "consumers experiencing financial difficulty may be unable to pay a policy excess. This should not mean the claim cannot progress." FOS commented on this problem in its FOS Circular from July 2010.[14]

Recommendation

176. The financial hardship section of the Code should make it clear that it applies to situations where a customer cannot pay their excess, by including the phrase "deduction of the excess from the claim payment."

---

[12] AAMI Home Building Insurance Product Disclosure Statement, dated 1 October 2013, page 44, https://www.aami.com.au/aami/documents/personal/home/pds-building.pdf.

[13] Financial Ombudsman Service Australia, A guide to insurance excesses, https://www.fos.org.au/custom/files/docs/a-guide-to-insurance-excesses.pdf

[14] Financial Ombudsman Service: The Circular - Issue 3 – July 2010 https://www.fos.org.au/custom/files/docs/the_circular_issue_3_july_2010_pdf.pdf

177. Insurers should follow the FOS guidance relating to insurance policy excesses and financial difficulty.

178. The General Insurance Code should commit insurers to informing their policy-holders of the availability of the option to pay the excess in instalments when experiencing financial hardship.

179. The General Insurance Code should also allow access to EDR for uninsured persons who are unable to have their claim processed because of an insured inability to pay their excess.

d. Debt waiver

1.17: If a customer in financial hardship has the ability to pay their debt in instalments, should the Code specify that this option should not be refused by the insurer?

Consumer Representatives strongly support insurers committing to providing the ability to pay a debt in instalments when the consumer (both customer *and* third party) is experiencing financial hardship.

In terms of paying a debt in instalments, the General Insurance Code should include a maximum period for a debt to be repaid, e.g. three to five years. Consumer Representatives have had clients who have been on instalment plans for very long periods of time, well beyond three years – i.e. the period for bankruptcy. It is not in the interests of either party to establish a long-term instalment plan. The costs to the insurer of administering an instalment plan would arguably outweigh the value of the repayment of the debt itself.

Recommendation

180. Insurers should commit to providing the ability to pay a debt in instalments when customers *and third parties* are experiencing financial hardship.

181. The Code should include a maximum period for a debt to be repaid in instalments.

1.18: What would the potential challenges or advantages be if the Code were to specify criteria for debt waiver?

Consumer Representatives support the inclusion of expanded information with respect to debt waivers detailing factors for insurers to take into account when considering a debt waiver. This will promote greater consistency in debt waiver provision yet maintain appropriate flexibility and discretion for insurers. Consumer Representatives would not want the criteria to be "set" as implied by the Interim Report.

Some of the factors that should be referred to include, but not limited to:

- the debtor's sole source of income is Centrelink;

- the debtor has no income;
- the debtor is likely to remain on Centrelink as their sole source of income for the foreseeable future;
- the debtor has no significant assets;
- the debtor is subject to family violence;
- the debtor is experiencing a serious illness or disability;
- other compassionate grounds.

As stated above – this list should neither be definitive nor limited. Consumer Representatives note that the banking industry will be including a reference to debt waivers in the new Banking Code. They have taken an approach allowing the exercise of a discretion on a case by case basis and on compassionate grounds having regard to a series of very broad factors.

Recommendation

182. **The debt waivers section of the Code should be expanded to detail factors for insurers to take into account when considering a debt waiver. However the criteria should not be set and flexibility and discretion for insurers maintained.**

e. Complaints about financial hardship

1.19: Should the financial hardship process include a complaint handling timeframe of 21 days, in line with the timeframe for credit disputes about hardship in RG 165? Would this create any administrative or resourcing issues that would outweigh the benefit to consumers?

Consumer Representatives support the inclusion of a complaints handling timeframe of 21 days, in line with the timeframe for credit disputes about hardship in RG 165. The cohort of consumers applying for financial hardship is likely to be more vulnerable and in need of a faster decision-making process than that currently available under the complaints process.

Recommendation

183. **A complaints handling timeframe of 21 days should be committed to under the Code, in line with the timeframe for credit disputes about hardship in RG 165.**

Uninsured third parties

1.20: There is confusion and varying interpretations about the interaction between section 8 and 10 of the Code. What factors need to be considered in order to clarify the obligations and rights under these sections for uninsured third parties?

Consumer Representatives agree that the Code needs to be clarified to ensure that uninsured third parties who owe a debt have access both to financial hardship assistance (as they currently do under Section 8) but also the Complaints process under Section 10. This may simply require removing the word "only" in the first clause of 8.1 and including an additional clause in Section 10 to clarify that third parties considered under section 8 can also access the complaints section. There may be other, simpler ways to implement this, however Consumer Representatives support the general principle.

Recommendation

184. The Code needs to be clarified to ensure that uninsured third parties who owe a debt have access both to financial hardship assistance and the complaints process.

Financial hardship and payment of insurance premiums

Consumer Representatives note that the Interim Report has failed to address an important aspect of the financial hardship standards under the Code – that is, the limitation of these standards to only insureds and third party beneficiaries who either owe money (clause 8.1(a)) or individuals seeking recovery from, for damage or loss cause by them to an Insured or Third Party Beneficiary (clause 8.1(b)). Clause 8.2 excludes the payment of premiums under an insurance policy from the financial hardship standards.

A number of submissions to the initial phase of this review brought up the need to remove clause 8.2, and include commitments to assist policyholders experiencing financial hardship.

Opportunity should be given for consumers in financial hardship with an instalment payment plan to enter into a financial hardship arrangement to avoid cancellation of policy. Equivalent obligations have existed in relation to banking and energy products for some time.

Consumer Representatives also notes that the FSC Life Insurance Code includes a section on premiums and financial hardship:

> *Life Insurance Policy changes and financial hardship*
>
> *6.5 If you wish to change the terms of your Life Insurance Policy, or if you are having trouble meeting your premium payments, we will tell you about the options that may be available to you, such as:*
>
> > *a) changing your benefit structure or how much you are insured for;*
> >
> > *b) reducing your benefits and/or removing or altering benefit options in order to reduce your premium; or*

c) stopping your payments for a short period. You would not be able to make a claim for any event that occurs or condition that is diagnosed or first becomes apparent during this period, but your Life Insurance Policy would not be cancelled, in accordance with our hardship procedures.

6.6 If you ask us to consider an arrangement on the basis of financial hardship, you may be required to provide reasonable evidence of your hardship, such as:

a) for Centrelink clients, your Centrelink statements;

b) financial documents including bank statements; or

c) a statement of termination from your employment.

Consumer Representatives believe that the General Insurance Code should include an equivalent section catering to the unique issues faced by general insurance consumers. Consideration needs to be given to the following options:

- changing the coverage or amount covered for, in an appropriate and ethical manner;
- reducing or stopping payments for a short period with consequences for coverage;
- part payment of a premium with the remainder of the premium and the usual premium to be paid next month;
- delay payment of a premium with a double premium to be paid the next month;
- part payment of premiums for a few months then full payment of the outstanding value of the insurance premium in full;
- notices about non-payment should invite the consumer to call the insurer to discuss their options if payment is not possible in the period required.

Recommendations

185. Consumers in financial hardship should be able to enter into hardship arrangements if they cannot afford to meet regular premium payments. Consideration needs to be given to the following options:

f. changing the coverage or amount covered for, in an appropriate and ethical manner;

g. reducing or stopping payments for a short period with consequences for coverage;

h. part payment of a premium with the remainder of the premium and the usual premium to be paid next month;

i. delay payment of a premium with a double premium to be paid the next month;

j. part payment of premiums for a few months then full payment of the outstanding value of the insurance premium in full.

186. All notices of cancellation for non-payment of instalments should mention the availability of hardship arrangements.

1.21: Are there any practical implications with expanding access to an insurer's internal complaints process for those who have a financial hardship complaint that relates to wholesale insurance?

Consumer Representatives agree with the CGC that access to the insurer's complaints process should not be limited to complaints about retail insurance only. The Code should also apply to small businesses by extending the application of sections 4,6,7,9 and 10.

While we do not represent small businesses, we note that the FOS Terms of Reference include small business and the rules for the new Australian Financial Complaints Authority (**AFCA**) will also. We would also note that the soon to be released ABA Banking Code covers small businesses.

Recommendation

187. The Code should also apply to small businesses by extending the application of sections 4,6,7,9 and 10.

Proposal 2 The Code should provide guidance on best practice disclosure principles

a. Best practice principles

2: Do the best practice principles detailed in Appendix 3 adequately address key concerns related to disclosure? Please identify any areas that have not been addressed.

Consumer Representatives support the development and introduction of Best Practice Principles that strive for continuous improvement in the sector. In doing so, we also note that disclosure has been widely acknowledged to be a flawed form of consumer protection.[15]

In finalising a best practice disclosure document we would make the following comments and observations, grouped under three headings:

General approach to a best practice principle document

- **Disclosure in itself cannot address all problems of information asymmetry.** The principles should acknowledge the limits of disclosure and that disclosure does not and can not solve all the problems faced by consumers in understanding and comprehending insurance policies.
- **Disclosure should be continuously improved through a commitment to consumer-testing.** Consumer testing of disclosure documents including innovative forms of disclosure should become an inherent part of the product development process.
- **Best Practices principles should include more practical examples of best practice disclosure.** This should include:
    - providing guidance regarding the use of plain English (or plain language communications) such as avoiding the use of confusing terms such as "premium";
    - the use and improvement of key fact sheets (**KFSs**) with consumer testing;
    - the inclusion of worked examples of specific clauses to demonstrate how they work in practice;
    - interactive elements such as filter questions and quick comprehension questions to improve customer understanding and decision-making; and
    - encouraging the use of infographics in communications.
- **There should be a standard PDS format and structure**. Insurers should agree on the development of a standard content order and standard headings in PDSs, which should

[15] The Financial System Inquiry (FSI) found that while disclosure 'plays an important part in establishing the contract between issuers and consumers', mandated disclosure, in itself, 'is not sufficient to allow consumers to make informed financial decisions'. Financial System Inquiry, Final Report, November 2014, p. 193

be enshrined in the Code or the Best Practice Principles. This will assist consumers with comparability of different policies**.** The comparability problem was a driving force behind the recent Senate Inquiry into General Insurance, resulting in a number of key findings to address the issue.

- **The principles should include the promotion of good website design to enable easier access to PDS's and KFS's.** Best practice disclosure principles should address the lack of consistency for websites. Finding and comparing PDS's and KFS's on insurer websites is difficult with significant variation from insurer to insurer.
- **Best practice disclosure principles should be extended beyond the key features of a policy and should apply to other areas including consents (such as the proposed uses of a consumer's data).** Unbundling these consents in order for consumers to understand what they have agreed to should be an aim of the sector.

Improving current disclosure practices

- **Disclosure should promote consumer understanding of any deviation from standards cover.** The principles should state a recommitment to the spirit of the Insurance Contract's Act's standard cover regime. We note that there is soon to be a Treasury review of standard cover.[16] The industry needs to be prepared for a more 'active' and potentially effective standard cover scheme. As noted in the Interim Report there is a standard cover regime in the *Insurance Contracts Regulations 1985*, of which there is little awareness.[17] The Best Practice Principles should address this by promoting the use of the PDS to detail and highlight any deviations from standard cover. Policies, PDS's, KFS's and comparison websites should clearly show where one policy provides less than standard cover or more than standard cover. We believe that any deviation should be expressed as a "warning" for example, "Warning you might not be fully covered." Standard cover should operate as a minimum standard or benchmark with the only variation being additional benefits. These changes can benefit the insurer-customer relationship through increased trust and confidence.
- **A commitment to KFSs by industry can improve the role they can play in disclosure.** The Best Practice Principles should include reference to KFSs and their role. Insurers should commit to testing and improving the wording and distribution of the KFS with appropriate legislative change where required. We note too that the Government has

[16] Australian Government response to the Senate Economics References Committee report: Australia's general insurance industry: sapping consumers of the will to compare, December 2017 https://static.treasury.gov.au/uploads/sites/1/2017/12/p2017-t248756.pdf

[17] We note that these is few if any mentions of standard cover on the ICA's Understand Insurance website www.understandinsurance.com.au or ASIC's MoneySmart website

announced a Treasury Review into KFSs[18] and that the recent Senate Report found that they may be ineffective and misleading.[19]

- **If automatic renewals are to remain, Best Practice Principles should cover their disclosure.** If automatic renewals are not to be banned, there should be Best Practice Principles developed and included.
- **Opt-out mechanisms should be prohibited and the sector should commit to only using opt-in mechanisms.** Cognitive and physical laziness leads to consumers simply accepting defaults set by an insurer with its own commercial agenda rather than taking active steps to state a preference. Questions should be framed in such a way to encourage actual choices.
- **Advertising should be understood as a form of disclosure with a high risk of misleading consumers into misunderstanding the nature of an insurance product and its substance.** While Consumer Representatives argue below, for the need for stronger Code commitments with respect to advertising, we believe there is also an opportunity for insurers to address a number of concerns in the Best Practice Principles, and should be a particular focus for improvement.

A commitment to innovative approaches to disclosure

- **A commitment to introduce standard definitions will go a long way to improve disclosure and consumer understanding of insurance products**. The industry should adopt common definitions to facilitate consumer understanding. Legal advice may need to be obtained regarding the impact of standardising terms, as standard definitions may require ACCC approval, but this should not stop insurers from taking this critical step. We again note that the Government has directed Treasury to assess the development of standard definitions of key terms.[20] Insurers should lead the way, in consultation with consumer representatives, in developing standard definitions.
- **Insurers should disclose the previous year's premium on the annual renewal notice.** Consumer Representatives note that at 3.9 the clause states that insurers should disclose the previous year's premium at renewal but does not state exactly how this should be done. It should be stated on the annual renewal notice and it should be next to this year's premium in order to make it easier for people to understand. The information should include:
    - the price of the new policy if the consumer renews;

[18] Australian Government response to the Senate Economics References Committee report: Australia's general insurance industry: sapping consumers of the will to compare, December 2017 https://static.treasury.gov.au/uploads/sites/1/2017/12/p2017-t248756.pdf

[19] Senate Economic References Committee, Australia's general insurance industry: sapping consumers of the will to compare, August 2017, https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Economics/Generalinsurance/Report

[20] Australian Government response to the Senate Economics References Committee report: Australia's general insurance industry: sapping consumers of the will to compare, December 2017 https://static.treasury.gov.au/uploads/sites/1/2017/12/p2017-t248756.pdf

- any difference between the new price and the old price; and
- the reasons for any change.

We note again that Treasury will be examining this issue as per the Australian Government response to the recent Senate Inquiry into General Insurance.

- **Insurers should provide component pricing of premiums.** This would communicate to a consumer the risk, and the potential benefits of changing behaviour to mitigate that risk. We recognise that such a proposal will face objections on the basis that pricing information is "commercially sensitive" however we do not believe that this is insurmountable as there are simple and creative ways to ensure such information is sufficiently obscured without denying policyholders the right to basic information about their insurance. This issue too will be reviewed by Treasury as per the Australian Government response to the recent Senate Inquiry into General Insurance.
- **Insurers should provide links to identify natural disaster, risk and hazard mapping and modelling for consumers to understand the risks that apply to their own home.** This would be in addition to the suggestions under section 3 for sum insured calculators and other calculator tools. To assist homeowners even further, information could be provided directly below the chart detailing practical tips on how a homeowner could mitigate cyclone risk and lower their premiums.
- **Disclosure principles should be developed to better inform consumers with respect to mental health clauses.** In order to promote Best Practice Principles in mental health, there should be guidance provided to help insurers appropriately inform consumers of a product's approach to mental health. This could include guidance to appropriately highlight mental health exclusions, pricing structures, limits or caps, and that these are brought to the attention of an applicant, where relevant.
- **Insurers should commit to surveying their customers to identify levels of understanding and comprehension of the policies they hold.** This should be conducted post-purchase and at a time further into the ownership of a policy.
- **Disclosure should aim to inform consumers not just about the policy's key exclusions and limits but should also highlight the aspects that are least expected or would be considered a surprise.** Most PDS's are long and "hide" important terms and conditions – be it incidentally or deliberately. As an addendum to highlighting the deviations from standard cover, the "least expected" terms and conditions should be highlighted up front.

Recommendations

188. The Product Disclosure Best Practice Principles should incorporate the following:

a) Disclosure in itself cannot address all problems of information asymmetry.

b) Disclosure should be continuously improved through a commitment to consumer-testing.

c) Disclosure should promote consumer understanding of any deviation from standards cover.

d) Best Practices Principles should include more practical examples of best practice disclosure.

e) There should be a standard PDS format and structure.

f) The Principles should include the promotion of good website design to enable easier access to PDS's and KFS's.

g) Best practice disclosure principles should be extended beyond the key features of a policy and should apply to other areas including consents (such as the proposed uses of a consumer's data)

h) Disclosure should promote consumer understanding of any deviation from standards cover.

i) A commitment to KFSs by industry can improve the role they can play in disclosure.

j) If automatic renewals are to remains, Best Practice Principles applying to their disclosure should be included in the document.

k) Opt-out mechanisms should be prohibited and the sector should commit to only using opt-in mechanisms.

l) Advertising should be understood as a form of disclosure with a high risk of misleading consumers into misunderstanding the nature of an insurance product and its substance.

m) A commitment to introduce standard definitions will go a long way to improve disclosure and consumer understanding of insurance products.

n) Insurers should disclose the previous year's premium on the annual renewal notice.

o) Insurers should provide component pricing of premiums.

p) Insurers should provide links to identify natural disaster, risk and hazard mapping and modelling for consumers to understand the risks that apply to their own home.

q) Disclosure principles should be developed to better inform consumers with respect to mental health clauses.

r) Insurers should commit to surveying their customers to identify levels of understanding and comprehension of the policies they hold.

s) Disclosure should aim to inform not just about the policy's key exclusions and limits but should also highlight the aspects that are least expected or would be considered a surprise.

b. Plain language

2.1: Would a new Code requirement that key information must be provided in plain language, and be consumer tested to ensure it is clear and informative enough for a consumer to reasonably assess the suitability of the policy for them, be a sufficient strengthening of the plain language provision? Please advise if you consider an alternative approach more appropriate.

Consumer Representatives support the use of plain language in all disclosure, sales and policy information. We note that the Life Insurance Code make the use of plain language a key Code promise[21] and incorporates the principle throughout the Code to ensure that this is the case. Consumer testing of this plain language is also embedded within the Life Code and should be incorporated in the General Insurance Code too.

We would also note that plain language is not referenced in the best practice disclosure principles document. We believe this should be addressed. As we have argued above, the best practices principles should also include more practical examples of best practice disclosure including:

- providing guidance regarding the use of plain English (or plain language communications) such as avoiding the use of confusing terms such as "premium";
- the use and improvement of key factsheets with consumer testing;
- the inclusion of worked examples of specific clauses to demonstrate how they work in practice; and
- encouraging the use of infographics in communications.

Recommendation

189. The Code should commit insurers to the use of plain language in all communications. This principle should also be incorporated in the Product Disclosure Best Practice Principles document.

[21] "1. We will be honest, fair, respectful, transparent, timely, and where possible we will use plain language in our communications with you."

c. Sum insured calculators/rebuilding costs

2.2: In order to improve the guidance provided to consumers on selecting a sum insured amount, the ICA suggests that Code could require insurers to provide access to an accurate and informative sum insured calculator as part of the home building insurance application process. Would this adequately address the issues raised above and are there any additional factors to consider with this suggestion?

Consumer Representatives support including a requirement under the Code for insurers to provide access to an accurate and informative sum insured calculator as part of the home building insurance application process.

Consumer Representatives wish to emphasise the need for accuracy in these calculators and that insurers should commit to regular reviews and auditing of the sum insured calculators and where an error is identified with a calculator that the insurer commits to correcting the calculator and any affected consumers.

One significant issue that is a headache for consumers in the use of sum insured calculators is the fact that the calculators do not provide an audit trail. Consumers regularly report that they cannot recall if they put in the incorrect information into the calculator (generating the wrong figure) or if a calculator provided them with an incorrect figure on correct information. To our knowledge currently calculators on insurers' websites or third party websites, generally do not allow for any recording of the information submitted or resulting, due to the perceived risk of the liability. If an insurer has a calculator to be used by a consumer to determine their sum insured it should be entrenched into the sales process and the insurer should take some responsibility for any errors if an error is identified in the calculator (for example, outdated building estimates). If a sum calculator is used in the sales process, this information should be recorded and kept on a policyholder's file.

Recommendations

190. A requirement should be included under the Code for insurers to provide access to an accurate and informative sum insured calculator as part of the home building insurance application process.

191. Insurers should commit to regular reviews and auditing of the sum insured calculators and where an error is identified with a calculator that the insurer commits to correcting the calculator and informing any affected consumers.

192. If a sum calculator is used in the sales process, this information should be recorded and kept on a policyholder's file.

Proposal 3: The Code should include product design and distribution principles and provide guidance to insurers

Product design

3: Would the inclusion of the following principles in the Code be an effective means of improving product suitability? Are there any other principles to add?

a) **Cover must be designed with a clear target market in mind. Equally, it should be clear to insurers and distributors which consumers are not part of the target market.**

b) **Cover must be designed to meet a genuine need and offer a tangible benefit at reasonable value. This applies to additional as well as core benefits.**

c) **Insurers must not design products that offer (or are capable of offering) negative or very low value.**

d) **The product and its features and exclusions must be capable of being communicated to and understood by the target market.**

e) **When designing products for bundling, insurers must consider how this impacts on the target and non-target market and product value.**

f) **Insurers must regularly review product performance and act promptly on any identified concerns.**

3.1: Do the product design considerations attached in Appendix 4 adequately respond to stakeholder concerns? Can the principles be applied to all general insurance products and does the material provide sufficient detail as to how the principles are to be applied?

Consumer Representatives support the inclusion of the product design principles outlined above to be included in the Code. We make the following comments on the material provided:

Firstly, the number one aim of design and distribution principles should be better consumer outcomes, that is, insurers should design products that respond to a need in the market, are good-value and are suitable for a target market, and ensure they use distribution channels that will reach those people. The document should make a broad statement in this regard.

Given there is now draft legislation on design and distribution obligations, we believe the Code should focus on some practical guidance or more concrete obligations about how insurers are to comply with the new requirements.

For example, the legislation refers to target market determinations setting out periods and/or triggers for review. The Code could add to this by setting minimum timeframes for review, or be clear about triggers for different types of insurance products.

Similarly, the legislation refers to products "generally meeting needs of customers in the relevant target market". The Code could build on this, to ensure products are suitable for a class of customers.

With respect to the target market, it should be made clear to *consumers* whether they fall within or outside of any identified target market for a particular product. The Australian Government's Proposals Paper[22] is largely silent on the information required to be given by issuers and distributors to the consumer about the target and non-target markets of products. We note that the proposed guidance comes close to addressing this point under Section 5 where it details some additional steps that could be taken to ensure that a product and its features and exclusions be capable of being communicated to and understood by the target market.

We do not think this is clear enough nor practical enough to ensure consumers are informed as to whether they fall within or outside the identified target market.

We recommend that target market information should be prominently included in PDSs, advertising and other promotional material. Most consumers would be helped by seeing a description of the types of consumers that the issuer considers would be suited to the product and (perhaps more so) a list of consumers who would not be suited to a product.

We recommend that the guidance include a list of factors that would ordinarily be considered when assessing the characteristics of a target market/consumer. These include a consumer's:

- proximity to retirement and employment status;
- financial situation (including tax situation, income and assets);
- financial literacy and financial capability/experience;
- access to financial information;
- risk profile (including capacity and willingness to bear loss);
- health status and history; and
- factors making it likely that consumers in the target market would benefit from the significant features of the product, such as family structure, age, and asset ownership.

Consumer Representatives note that Product Design Principle 2 states that

> *Cover should be designed to meet a genuine need and offer a tangible benefit at reasonable value.*

We support this principle however note that the Treasury Proposal refers to whether consumers in a target market would "derive benefit from the significant features of the

[22] Treasury, Design and Distribution Obligations and Product Intervention Power, Proposals Paper, December 2016 https://static.treasury.gov.au/uploads/sites/1/2017/06/C2016-054_Design-and-distribution-obligations.pdf

product."[23] This is an important distinction as there may be a tangible benefit derived from a product but this benefit may be a minor one derived from an incidental feature of the product rather than a significant feature. We believe that the phrase "significant features of the product" should be included.

The guidance should then identify those significant features to assist insurers. For further detail on suggest[24]ions for those significant features see the Joint Consumer Submission to the Design and Distribution Obligations and Product Intervention Power – Proposals Paper.

Recommendations

193. **The Product Design Principles and considerations document should be amended as follows:**

a) **minimum timeframes for review should be set, with clear about triggers for different types of insurance product.**

b) **In order to make it clear to consumers whether they fall within or outside of any identified target market for a particular product, target market information should be prominently included in PDSs, advertising and other promotional material.**

c) **the guidance should include a list of factors that would ordinarily be considered when assessing the characteristics of a target market/consumer, including:**

i. **proximity to retirement and employment status;**

ii. **financial situation (including tax situation, income and assets);**

iii. **financial literacy and financial capability/experience;**

iv. **access to financial information;**

v. **risk profile (including capacity and willingness to bear loss); and**

vi. **factors requiring consumers in the target market to benefit from the significant features of the product, such as family structure, age, and asset ownership.**

d) **Product Design Principle 2 should state**

Cover should be designed to meet a genuine need and offer a tangible benefit **from the significant features of the product** ***at reasonable value.***

[23] p. 19 Treasury, Design and Distribution Obligations and Product Intervention Power, Proposals Paper, December 2016 https://static.treasury.gov.au/uploads/sites/1/2017/06/C2016-054_Design-and-distribution-obligations.pdf

[24] pp. 35-37 http://financialrights.org.au/wp-content/uploads/2017/03/Joint-Consumer-Submission-DADOs-and-PIPs-15032017.pdf

e) The guidance should then identify those significant features to assist consumers based on the suggestion put forward in the Joint Consumer Submission to the Design and Distribution Obligations and Product Intervention Power – Proposals Paper.

Product distribution

a. Product distribution principles

3.2: Would the inclusion of the following principles in the Code effectively help consumers to purchase insurance that is suitable for them? Are there any other principles to add?

Insurers must have reasonable controls in place to ensure that:

a) **the product reaches the target market for whom it is intended b) the product does not reach those outside the target market**

b) **the product does not offer low or negative value.**

c) **they set clear expectations about what constitutes good sales practices, and equally what conduct is not acceptable**

d) **they must provide the necessary training and information to their distributors to enable them to sell the product in line with their stated policies**

e) **they regularly review distribution and promptly address any identified concerns**

3.3: Do the distribution considerations attached in Appendix 4 adequately respond to stakeholder concerns? Can the principles be applied to all general insurance products covered by the Code and does the material provide sufficient detail as to how the principles are to be applied?

As with the product design principles we similarly support the inclusion of the product distribution principles outlined above. We again wish to make some comments on the material provided.

With respect to distribution channels, insurers should commit to undertaking thorough due diligence when selecting distributors. We recommend that due diligence checks would include an assessment of the distributor's:

- staff expertise and experience;
- key person competencies;
- compliance arrangements (including licensing arrangements);
- history of compliance problems or regulator action;

- marketing strategies;
- other products being distributed;
- reputation.

Consumer Representatives note that it is unclear from the Interim Report whether the product distribution principles will be included in the actual Code itself or simply form a part of the guidance document attached to the Code. The Life Insurance Code includes actual commitments in the Code under Section 4 rather than mere guidance.

We expect that the General Insurance Code will include similar specific mandatory requirements with respect to distribution, in addition to guidance.

Recommendations

194. The Product Distribution Principles and considerations document should be amended so that insurers commit to undertaking thorough due diligence when selecting distributors including an assessment of the distributor's:

i. staff expertise and experience

ii. key person competencies

iii. compliance arrangements (including licensing arrangements)

iv. history of compliance problems or regulator action

v. marketing strategies

vi. other products being distributed

vii. reputation

195. The General Insurance Code should include specific mandatory requirements with respect to sales and distribution practices modelled on Section 4 of the Life Insurance Code, as appropriate.

b. Consumer redress

3.4: Are there any issues that would have to be considered if the Code were to include options for consumer redress in circumstances where an insurer identifies issues with the distribution of its products? Examples could include:

a) cancelling the cover

b) arranging a refund of premiums and interest

c) arranging more suitable cover

d) honouring a claim

Consumer and industry experience in the add-on market has shown that consumer redress is crucial to rebuild trust in the insurer-consumer relationship. With over $132 million in remediation to date in this space alone, it is critical that the Code include options for consumer redress.

A Key Code Promise under the Life Insurance Code is that:

> *If we discover that an inappropriate sale has occurred, we will discuss a remedy with you, such as a refund or a replacement policy*

The Life Insurance Code then provides the following commitment at 4.9.

> *We will investigate concerns raised or identified with the sales practices of our staff and our Authorised Representatives. If as a result we identify that one of our Life Insurance Policies has been sold inappropriately:*
>
> *a) we will contact you to discuss an appropriate remedy. Appropriate remedies will vary depending on the circumstances, and may include:*
>
> *i. cancelling the cover;*
>
> *ii. arranging a refund of premiums paid;*
>
> *iii. payment of interest on the refunded premium;*
>
> *iv. adjusting the cover or arranging for more suitable cover;*
>
> *v. correcting incorrect information; or*
>
> vi. *honouring a claim;*
>
> *b) if you are not satisfied with our proposed remedy, we will review this and tell you how to make a Complaint; and*
>
> *c) we will correct any identified sales practice issues including through further education and training.*

Consumer Representatives recommend the General Insurance Code mirror these clauses. We note that the example remedies provided in the Interim Report do not refer to

1. payment of interest on the refunded premium
2. adjusting the cover
3. correcting incorrect information

The Code should include these.

A further two remedies should also be included:

1. reasonable compensation, where appropriate and
2. fines to encourage compliance

Recommendations

196. Consumer Representatives recommend the General Insurance Code mirror Life Insurance Code clause 4.9 to ensure that

a) insurers investigate concerns raised with sales practices of staff, authorised representatives and other distributors,

b) appropriate remedies are discussed with effected consumers including

i. Reasonable compensation, where appropriate and

ii. Fines to encourage compliance;

c) if a consumer is not satisfied with a proposed remedy, it will be reviewed and the consumer told how to make a complaint, and

d) sales practice issues are corrected through education and training.

Proposal 4: The Code should provide product design and distribution guidance specific to add-on insurance products

a. Product design, distribution and sales practices

4: Would it be appropriate to develop product-specific guidance in the Code around product design and distribution for add-on insurance products? Are the product-specific considerations relevant to add-on products in Appendix 4 adequate, or is further detail needed?

The problems with add-on insurance are well-documented in ASIC and ACCC Reports[25] along with the almost countless case studies provided by our organisations over the years via our casework and the stories told via Consumer Action's DemandARefund.com website. These have made it abundantly clear that the add-on insurance market via caryard sales is failing consumers, producing significant harm and in dire need for oversight and reform. Insurers need to recognise the need for improved disclosure and sales practices in this market.

Insurers should work with Consumer representatives to develop effective changes to add-on insurance product design and distribution. Consumer Representatives recommend including specific commitments relating to the design, sale and distribution of add-on products as the FSC has done under clause 4.7 of the Life Insurance Code. These issues should not be simply addressed in a guidance document. These commitments include:

a) requiring informed consent from a purchaser;

b) obtaining evidence of the informed consent;

c) providing specific information prior to purchase:

- that the purchase is optional;
- a clear explanation of the eligibility criteria and main exclusions;

d) providing clear information on how premiums are structured;

e) if the option of paying the premium through the loan is offered, a non-financed payment will also be offered;

[25] Report 470 Buying add-on insurance in car yards: Why it can be hard to say no (REP 470) http://asic.gov.au/regulatory-resources/find-a-document/reports/rep-470-buying-add-on-insurance-in-car-yards-why-it-can-be-hard-to-say-no/ Report 471 The sale of life insurance through car dealers: Taking consumers for a ride (REP 471) http://asic.gov.au/regulatory-resources/find-a-document/reports/rep-471-the-sale-of-life-insurance-through-car-dealers-taking-consumers-for-a-ride/; and Report 492 A market that is failing consumers: The sale of add-on insurance through car dealers (REP 492) http://asic.gov.au/regulatory-resources/find-a-document/reports/rep-492-a-market-that-is-failing-consumers-the-sale-of-add-on-insurance-through-car-dealers/; ACCC, ACCC denies authorisation for insurance companies to jointly set a cap on sales commission, 9 March 2017, https://www.accc.gov.au/media-release/accc-denies-authorisation-for-insurance-companies-to-jointly-set-a-cap-on-sales-commissions

f) informing the purchaser of the interest to be paid on a premium if the premium is fully funded by a loan, with loan repayment information provided with and without premium for comparison;

g) minimum cooling-off period of 30 days;

h) providing an annual notice in writing including the period of cover, the types of cover and contact details for making a claim.

In addition to these, Consumer Representatives recommend the following

a) Insurers commit to not selling single financed premium policies, as recommended by ASIC. This is a particular focus for ASIC and insurers should respond accordingly. [26]

b) Disclose any incentives to the customer which they may receive if they take out the add-on insurance.

c) Any consumer communication developed must include information relating to:

- the key features of the product including premiums, exclusions, conditions and benefits (including maximum benefits)
- the cost of the product;
- how long the consumer is insured;
- the key benefit monetary limits;
- the date your insurance ends;
- claims data including claims ratios;
- sufficient information for the consumer to identify whether the product is suitable to the consumer's needs.

d) Digital consumer communication should be active/interactive and not passive and include a series of 'filter', 'knock out' and comprehension questions, before the purchase of the product so that a customer is alerted to key policy exclusions such as age, residency and employment status to ensure that those not in the target market are excluded;

e) The Code should establish a consistent public reporting regime requiring insurers to fully and transparently publicise their claims pay-out ratios, as occurs in the UK, as well as claims handling timeframes and dispute levels across all policy types. Data should be made available on an industry and individual insurer basis.

f) The Code should include specific commitments with respect to a deferred sales model (see below).

g) The Code should include minimum standards for distributors that outline when insurers will *not* distribute through a particular bank, car dealer or other third party.

h) The Code should commit to product design principles to ensure that add-on products:

- do not provide negative or low value;

[26] p. 10 *ASIC Report 492 A Market that is failing consumers: The sale of add-on insurance through car dealers* *http://download.asic.gov.au/media/4042960/rep-492-published-12-september-2016-a.pdf*

- do not include unreasonable or unexpected clauses that are detrimental to the customer, such as exclusions
- are not significantly more expensive because they are sold through a particular channel (for example, where term life insurance was found to be 18 times as much when bought through car yard as opposed to online).[27]

Recommendations

197. The Code should include specific commitments relating to the design, sale and distribution of add-on products mirroring clause 4.7 of the Life Insurance Code.

198. In addition to this the Code should commit insurers to

a) not sell single premium policies, as recommended by ASIC

b) Any consumer communication developed must include information relating to:

i. the key features of the product including premiums, exclusions, conditions and benefits (including maximum benefits)

ii. the cost of the product;

iii. how long the consumer is insured;

iv. the key benefit monetary limits;

v. the date your insurance ends;

vi. claims data including claims ratios;

vii. sufficient information for the consumer to identify whether the product is suitable to the consumer's needs.

c) digital consumer communication should be active/interactive and not passive and include a series of 'filter' or 'knock out' questions, before the purchase of the product so that a customer is alerted to key policy exclusions such as age, residency and employment status to ensure that those not in the target market are excluded;

d) establish a consistent public reporting regime requiring insurers to fully and transparently publicise their claims pay-out ratios, as well as claims handling timeframes and dispute levels across all policy types. Data should be made available on an industry and individual insurer basis.

199. The Code should include specific commitments with respect to a deferred sales model.

[27] p. 4, ASIC Report 471: The sale of life insurance through car dealers: Taking consumers for a ride, February 2016 http://download.asic.gov.au/media/3549384/rep471-published-29-february-2016.pdf

200. The Code should include minimum standards for distributors that outline when insurers will *not* distribute through a particular bank, car dealer or other third party.

201. The Code should commit to product design principles to ensure that add-on products:

a) do not provide negative or low value;

b) do not include unreasonable or unexpected clauses that are detrimental to the customer, such as exclusions

c) are not significantly more expensive because they are sold through a particular channel (for example, where term life insurance was found to be 18 times as much when bought through car yard as opposed to online)

b. Deferred sales model

4.1: What role, if any, should the Code play in the implementation of a deferred sales model for add-on products sold through the motor dealer channel?

Consumer Representatives strongly support the introduction of a deferred sales model and believe that this should be implemented through regulation as currently proposed by ASIC with respect to the sale of add-on in car yards.

However we note that the deferred sales model is currently limited to sale of add-on and warranties in car yards and no other distribution channels.

We therefore recommend that the deferred sale model settled on by ASIC for regulation be mirrored in the Code and extended to cover all other add-on insurance products and distribution channels.

We also believe that there will be a significant role for the Code to address other issues with respect to the sale of add-on insurance as outlined above, including "common standards around consumer communication."

Consumer Representatives will make a supplementary submission after the ASIC model is finalised and released.

Recommendations

202. The Code should include specific commitments with respect to a deferred sales model that mirrors the deferred sale model settled on by ASIC for regulation and extends it out to cover all other add-on insurance products and distribution channels.

Proposal 5: The Code should strengthen standards relating to third party distributors

5: The ICA has identified obstacles with requiring all entities, engaged in an activity covered by the Code, to subscribe to the Code directly. We suggest that as an alternative, the Code should require that when an insurer enters into a formal agreement with a third party to sell its product, the agreement should include the following:

a) **Sales to be conducted in an efficient, honest, fair and transparent manner**
b) **All salespeople to be appropriately trained and educated, their conduct monitored by their employer and problems with conduct addressed**
c) **Insurers to notify their distributors of the identified target and non-target market for the product**
d) **Pressure selling is not permitted**
e) **Distributors to notify insurers of any complaints and tell customers the identity of the relevant insurer**

Is this a suitable option for strengthening the standards relating to Service Suppliers? Please identify any concerns with this approach.

Consumer Representatives believe that clause 5.5 should be removed and all Authorised Financial Services Licensees acting on an insurer's behalf be subject to the Code by including them under Subsections 5.1 and 5.2 and Section 4. In addition, the Code should include strengthened standards relating to sales practices such as pressure sales and other unacceptable sales practices that do not meet community standards.

The problems of add-on insurance and exploitative sales practices are well-documented and long standing. It is time that general insurers take responsibility and take action to ensure that the poor consumer outcomes that we've seen in the past are stamped out.

Consumer Representatives strongly support implementing the ASIC Enforcement Review Taskforce option that entities engaging in activities covered by an approved code should be required to subscribe to that Code (by a condition on their AFSL or some similar mechanism).

Consumer Representatives are unconvinced by the Interim Reports arguments about Code Subscribers inability to monitor third parties. As Treasury has stated (and quoted in the Interim Report):

> *"product issuers cannot be wilfully blind if distributors are acting in a manner that is inconsistent with their expectations."*

Consumer Representatives do not support general insurers entering into formal agreements with only a limited set of requirements as outlined above from (a) to (e). If an insurer can negotiate a formal agreement to include a limited set of requirements, they can negotiate a formal agreement that brings the third party in line with all the relevant commitments under

the Code. We believe that any exercise to negotiate agreements with third parties to sell products to include commitments to act as outlined from (a) to (e) above will be just as "challenging" and will require "extensive engagement" as ensuring that third parties meet all relevant Code requirements. Insurers could just as easily expand this (a) to (e) list to cover every commitment under the Code relevant to their work.

Given the above, it is clearly simpler to remove clause 5.5 and include them under Sections 4 and 5 along with Employees and Authorised Representatives

Having two sets of standards working in parallel - one set for authorised representatives and employees and another set for third parties - with different monitoring standards will just add to the complexity and costs for general insurers and will only serve to further confuse consumers and undermine confidence in the sector.

If there are lower standards placed upon one cohort of third party distributors versus authorised representatives as currently is the case, there will remain a perverse incentive to enter into agreements with these third parties, and not clean up their act.

The simplest and cleanest approach would be to include a series of commitments under the Code that will strengthen standards for sales practices for employees, authorised representatives *and* third parties (being authorised financial services licensees) acting on insurer's behalf. This will also ensure that any distribution principles as foreseen by proposal 3 will also apply to third party distributors.

Finally we note too that life insurers have bound their Independent Service Providers to the standards of their Code under clause 10.2 of the Life Insurance Code.

General insurers, who genuinely care about their reputation, want to raise sales standards and improve consumer confidence and trust in the industry should not accept different, historically poor, standards from the authorised Australian Financial Service Licensees that they work with. These arrangements have led to serious reputational damage to their industry and fixing this must be a priority of this review.

If this is not possible through a Code, then industry should consider supporting regulatory intervention.

In the interim the current Code (a) to (e) should be expanded to include consequences for the service provider for a breach of the Code including:

- naming of the distributor;
- reporting the conduct to ASIC
- termination of the contract;
- undertaking remediation programs for affected consumers in the event a breach.

Recommendations

203. Clause 5.5 of the Code should be removed and all Authorised Financial Services Licensees acting on an insurer's behalf should be subject to the Code.

204. The Code should include strengthened standards relating to sales practices such as pressure sales and other unacceptable sales practices that do not meet community standards.

205. If this is not possible through a Code, then industry should support regulatory intervention. In the interim the current Code (a) to (e) should be expanded to include consequences for the distributor for a breach of the Code including:

a) naming of the distributor;

b) reporting the conduct to ASIC

c) termination of the contract;

d) undertaking remediation programs for affected consumers in the event a breach.

5.1: Industry has noted the operational challenges of requiring insurers to monitor the sales practices of third parties. Is there an alternative approach that would allow for the effective monitoring of outsourced third parties?

Consumer Representatives note that under the AFSL regime, insurers can outsource functions, but not their responsibilities as a licensee. This means that insurers must monitor the ongoing performance of service providers.[28]

General Insurers should not shirk their responsibilities to ensure that their distributors meet the standards set by the Code.

Recommendation

206. All third party distributors should adhere to the relevant sections of the General Insurance Code and be appropriately monitored.

[28] RG 104.33

Proposal 6 The Code should strengthen standards relating to Service Suppliers

6: Would making the following requirements explicit help to strengthen insurers' responsibility for the conduct of their Service Suppliers:

a) **Insurers are responsible for the conduct of their Service Suppliers and their approved subcontractors**

b) **Insurers must have measures in place to ensure that due skill and care is taken in choosing suitable Service Suppliers**

c) **Service Suppliers should notify the insurer of a customer complaint by the next business day.**

d) **Insurers will appropriately address any actions by Service Suppliers that breach the Code, Service Level Agreements or licence obligations.**

Are there any further provisions to be considered?

The CGC made a series of recommendations with respect to service suppliers in its 2017 Own Motion Inquiry on Investigations of Claims and Outsourced Service.[29] Recommendation 7 stated that:

> *Code subscribers who have authorised a Service Supplier to use subcontractors or agents should ensure that*
>
> - *the Service Supplier's arrangements with a subcontractor or agent are in writing and reflect the Code standards that apply to the services provided by the subcontractor or agent*
> - *the Service Supplier's arrangements require the subcontractor or agent to report to the Service Supplier complaints about them or the matters they are dealing with, by the next business day*
> - *the Code Subscriber's contract with the Service Supplier requires it to report to the Code Subscriber complaints about its subcontractor or agent, by the next business day*
> - *the Service Supplier does not engage the services of an agent or subcontractor in the investigation of a 'sensitive claim' – for instance, where the claim includes death or serious injury. If this is not practical, the Code Subscriber should increase its oversight of such matters.*

We note that the ICA is however proposing the following requirements:

[29] https://www.fos.org.au/custom/files/docs/gicgc-omi-on-investigation-of-claims-outsourced-services-may-2017.pdf

a) Insurers are responsible for the conduct of their service suppliers and their approved subcontractors

b) Insurers must have measures in place to ensure that due skill and care is taken in choosing suitable service suppliers

c) Service suppliers should notify the insurer of a customer complaint by the next business day.

d) Insurers will appropriately address any actions by service suppliers that breach the Code, Service Level Agreements or licence obligations.

While Consumer Representatives support the addition of all four of these requirements, they do not cover all of the specific recommendations made by the CGC.

Namely, the proposed requirements do not require that the service supplier's arrangements with a subcontractor or agent be in writing and reflect the Code standards that apply to the services provided by the subcontractor or agent. Nor do they require that the service supplier not engage the services of an agent or subcontractor in the investigation of a 'sensitive claim'.

Furthermore the proposed new requirement only requires service suppliers to notify the insurer of a customer complaint by the next business day. It does not explicitly require the Service supplier to require the subcontractor or agent to report to the service supplier about any matters the agent is dealing with related to the complaint by the next business day.

While the proposals being put forward are important, we do not believe that they go far enough and should explicitly address all elements of recommendation 7 of the CGC in its Own Motion Inquiry.

The CGC made a number of further recommendations with respect to service suppliers that Consumer Representatives believe need to be address in a new Code: Recommendation 5 stated that:

> *Code Subscribers should include in contracts with Services Suppliers a requirement to develop their own systems and processes to ensure compliance with applicable Code obligations. This includes prompt reporting of actual or possible Code breaches and corrective actions.*

This has not been addressed in the proposed new requirements. It is crucial that insurers commit to being responsible for the conduct of their service suppliers and their approved subcontractors, and they commit to developing specific monitoring and reporting systems. With these commitments, insurers will be more empowered to identify issues and breaches earlier and in a more systematic manner. Finally the Code should commit to the training of all service suppliers in the General Insurance Code standards.

Recommendations

207. Consumer Representatives support the inclusion of strengthened standards relating to Service suppliers including:

a) **Insurers are responsible for the conduct of their service suppliers and their approved subcontractors**

b) **Insurers must have measures in place to ensure that due skill and care is taken in choosing suitable service suppliers**

c) **Service suppliers should notify the insurer of a customer complaint by the next business day.**

d) **Insurers will appropriately address any actions by service suppliers that breach the Code, Service Level Agreements or license obligations.**

208. **General insurers must however commit to further standards as recommended by the CGC under Recommendations 5 and 7 of the 2017 Own Motion Inquiry on Investigations of Claims and Outsourced Service, namely:**

Code subscribers should ensure that:

a) **the service supplier's arrangements with a subcontractor or agent are in writing and reflect the Code standards that apply to the services provided by the subcontractor or agent**

b) **the service supplier's arrangements require the subcontractor or agent to report to the service supplier complaints about them or the matters they are dealing with, by the next business day, and**

c) **the service supplier does not engage the services of an agent or subcontractor in the investigation of a 'sensitive claim' – for instance, where the claim includes death or serious injury. If this is not practical, the Code Subscriber should increase its oversight of such matters.**

d) **contracts with services suppliers must include a requirement to develop their own systems and processes to ensure compliance with applicable Code obligations. This includes prompt reporting of actual or possible Code breaches and corrective actions.**

e) **external investigators are required to obtain their express and written authority before putting a fraud allegation to a claimant. This requirement should be included in Code Subscribers' contracts with external investigators and in their written instructions to external investigators.**

6.1: Are there any issues to consider if the Code were to require insurers to ensure that Service Suppliers are appropriately skilled and qualified to carry out their duties and remain up-to-date with industry developments as well as the requirements of the Code?

Consumer Representatives strongly support including a requirement that all service suppliers and their subcontractors and agents are trained on the requirements of the Code – in addition to their being appropriately skilled and qualified to carry out their duties and remain up-to-date with industry developments.

Recommendation

209. Insurers should commit to requiring that all service suppliers and their subcontractors and agents are trained on the requirements of the Code – in addition to their being appropriately skilled and qualified to carry out their duties and remain up-to-date with industry developments.

6.2: The ICA does not believe that the definition of Service Suppliers should be expanded to include External Experts. Do you agree with the concerns we have raised with this proposal? How can the standards of External Experts be improved without compromising their independence?

Consumer Representatives do not accept that external experts' independence would be compromised through "the imposition of insurer oversight and expectations" as asserted in the Interim Report.

The commitments under the General Insurance Code that would be extended via the service supplier standards are simply:

- ensuring that they will act in honest, efficient, fair and transparent manner;
- that they will be qualified,
- hold a licence if required,
- obtain approval if subcontracting;
- inform people of the service they have been authorised to provide and
- notify the insurer of any complaints.

None of these requirements in any way compromise the independence of an external expert. External experts should be expected to meet these fairly basic standards. If not then there is a serious problem.

We note that the FSC includes an entire section of their Life Insurance Code to setting standards for *Independent* Service Providers which includes Independent Medical Examiners. Life insurers commit to, amongst many requirements under section 10 that, they will require them to comply with the Australian Medical Association's Ethical Guidelines on Independent Medical Assessment or an equivalent international guideline for providers overseas.[30]

None of these requirements have compromised the independence of these external experts and in fact serve to bolster their independence in the eyes of consumers.

If the ICA remains concerned with this issue, a statement could be included to the effect that the Code applies to external experts (just as they do to service suppliers) unless it would conflict with the external expert's professional responsibilities and/or obligations.

[30] Life Insurance Code of Practice clause 10.5

Alternatively, the Code could include specific commitments that require different external experts to meet the equivalent of their profession's Australian Medical Association's Ethical Guidelines on Independent Medical Assessment. If equivalent guidelines do not exist, then it is more than appropriate to include these external experts under the General Insurance Code in order to raise their standards. The ICA should also commit to working with these sectors to develop their own ethical guidelines to establish independence. Otherwise it is this ongoing lack of ethical guidelines for independent assessment by external experts that will continue to compromise their independence rather than any inclusion under the General Insurance Code.

Recommendations

210. External Experts should be subject to the appropriate sections of the General Insurance Code, in the same way external experts are included under the Life Insurance Code. If concerns remain with the independence of external experts, a statement could be included to the effect that the Code applies to external experts unless it conflicts with the external expert's professional responsibilities and/or obligations.

211. Alternatively, the Code could include specific commitments that require different external experts to meet the equivalent of their profession's Australian Medical Association's Ethical Guidelines on Independent Medical Assessment. If such guidelines do not exist, the Code should bind external experts unless it conflicts with their professional responsibilities and/or obligations.

Proposal 7: The Code should include mandatory standards for Investigations

7: Do the investigation and interview standards attached in Appendix 5 adequately respond to stakeholder concerns regarding investigations? Please advise if any areas have not been covered.

7.1: Are there any practical implications if these standards were to be included in the Code as mandatory?

7.2: Are there any other practical issues with these requirements?

Consumer Representatives strongly support proposal 7 that the Code include mandatory standards for investigations and commend the ICA and insurers for taking this important step.

As has been extensively documented in Financial Rights' 2016 report *Guilty Until Proven Innocent: Insurance Investigations in Australia* and the 2017 CGC *Own Motion Inquiry on the use of investigators and outsourced providers*, consumers have serious concerns regarding investigation practices.

Overall, the standards as drafted are fairly comprehensive and address many of the central concerns raised by consumers.

Our following comments are focussed on areas that have not been covered.

Areas not covered - transparency about why a claim is being investigated and what to expect

There are no standards drafted for informing a consumer that their claim is being investigated in the first place. There is a proposed requirement to inform somebody that a formal interview will be carried out, but there may be the case where an investigation takes place without an interview, or the interview comes at the end of a lengthy and invasive investigation. Either way, the standards should include the recommendation by the CGC in its Own Motion Inquiry that Code Subscribers should:

- *initially inform a consumer by telephone that their claim will be investigated and why, and, if relevant, that an external Investigator will interview them*
- *provide staff with clear guidance on the content of such conversations, and*
- *confirm that an investigation will occur and why in writing (letter or email), including information about the following:*
    - *the purpose of the investigation, what to expect and that the consumer should not draw an adverse inference from this decision;*
    - *the consumer's primary contact during an investigation, the role and responsibilities of the claims consultant and the external Investigator;*
    - *the external Investigator's contact details, when to expect to hear from them and what to do if they are not contacted within that timeframe;*
    - *the consumer's rights and responsibilities during the investigation and interview, including who they can contact if they have any questions about the*

investigation or process including or if they are unhappy with the external Investigator's conduct, how their personal information will be handled and their rights after a claim decision has been made;

- *the timeframe for making a claim decision after completing the investigation and information gathering, information about the complaints process and other resources to assist the consumer during the investigation such as the Financial Ombudsman Service Australia (FOS) and key consumer advocates.*

This could be partly resolved by amending the proposed section 3 from "where we require formal interviews" to "where we initiate an investigation," whereby capturing all situations. The subclauses should then address the recommendations above.

Areas not covered regarding interviews

With respect to the proposed requirements for formal interview we make the following recommended amendments.

Where a formal interview is requested, the standards state that the interview subject will be advised of particularly information (section 3(a)). Consumer Representatives recommend that this be done in writing (hard or soft copy). Providing this in writing will give people the chance to refer back to this as they process the fact that they are being interviewed. Being asked to a formal interview can be a stressful experience for many people who have never been subject to an investigation. Providing this information in writing will give people the chance to read over the information a number of times with less likelihood of misinterpretations and subsequent increase in stress.

Further, where a formal interview is requested, investigators should – in addition to the material already listed at 3(a)(i)-(v) – provide a business card and license details, where available. Interviewees should also be provided with information about the roles and responsibilities of the external investigator.

We note that clause (l) states that:

> *a transcript of the interview (or a digital copy of the recorded interview) can be provided to you if requested*

The Life Insurance Code includes a similar clause however it states that:

> *a transcript of the interview (or copy of the recorded interview if requested) will be provided to you for confirmation.*

The latter LICOP clause implies that a transcript will be provided in all interviews, the draft Code clause is only provided if requested. We believe that if life insurers can provide a transcript automatically, so can general insurers.

The draft standard proposes to include the following:

> *(k) you can request breaks during the interview if you require and you can stop the interview early and reschedule if you need;*

While we support this inclusion we think interview subjects should also be offered breaks at least every half an hour, and the request for a break should be adopted in the record of interview, as per Recommendation 16 of the CGC Own Motion Inquiry.

The draft standard also proposes to include the following:

> *(l) interviews will be conducted respectfully and take a maximum time of two hours, unless you agree to an extension. Further interviews will be organised if it is reasonably required;*

This doesn't quite capture the recommendation of the CGC which states at Recommendation 16 that

> *if more time is needed, the interview should be suspended and arrangements made to continue at a later date, subject to the Code Subscriber authorising the continuation of the interview and the consumer's consent.*
>
> *if an interviewee decides that they prefer to continue with the interview beyond two hours, then it should be clearly explained that the interviewee may continue the interview at a later date*
>
> *the interviewee's acknowledgement and their agreement to continue the interview in these circumstances should be recorded in writing and by audio recording.*

We believe this approach is more responsible and the standard should be amended to reflect this.

While Consumer Representatives acknowledge that the draft standards include specific clauses to support people with special needs[31] these need to be bolstered with a series of commitments as recommended by the CGC:

> *Recommendation 17 – Interviewing consumers with special needs*
>
> *Code Subscribers should:*
>
> - *ask interviewees (consumers) to complete an interview consent form which also asks whether they need an interpreter or support person*
> - *assess whether consumers have special needs and provide additional support to such consumers before authorising an Employee or external Investigator to interview them*
> - *ensure that their Employees or their external Investigators never deny a consumer's reasonable request for a support person*
> - *ensure that Employees are appropriately trained to identify such consumers and their support needs and that interviews should only be conducted by Employees who have appropriate training or experience*
> - *provide external Investigators with, or require them to receive, appropriate training to assist in identifying and supporting consumers with special needs*
> - *specify in contracts with external Investigators that consumers are entitled to have a representative or support person with them during an interview*
> - *if an agreement about support cannot be reached, require external Investigators to contact them*

[31] including clause 3(a)(v) re: support persons, 3(c) re: interpreters, clause (d) re: family violence, clause (e) re: the use of same sex interviewers and (h) re: interviewing minors,

- *specify in contracts with external Investigators their expectations and requirements, or provide guidelines, about consumers with special needs.*

With respect to interviewing minors, we note the ICA has again only included some of the requirements recommended by the CGC Own Motion Inquiry. The missing recommended requirements are:

- *ensure that a senior staff member with appropriate experience and training determines whether it is necessary to interview a minor – this includes assessing whether the minor is capable of distinguishing a truth from a lie*
- *instructions to an external Investigator must clearly set out the scope of the interview and ensure that the external Investigator will obtain prior written approval to expand the scope of the interview*
- *a request to expand the scope of an interview must also be assessed by a senior staff member with appropriate experience and training*
- *if in the course of an investigation the external Investigator determines that it is necessary to interview a minor, require the external Investigator to obtain prior written approval – such a request should be assessed as described above*
- *if the external Investigator is required to determine whether the minor has the capacity to distinguish a truth from a lie, provide clear guidance to the external Investigator on how to determine this – this assessment should be recorded.*

We recommend that these all be included in the standard.

Furthermore the draft standard needs to clarify that the "responsible adult" referred to a (3)(h)(iii) can be a parent or guardian.

Areas not covered - Surveillance

Clause 4(e) states that

> *we will discontinue surveillance where there is evidence from an independent medical examiner that it is negatively impacting a pre-existing mental health condition;*

The equivalent section of the Life Insurance Code states that:

> *We will discontinue surveillance where there is evidence from an independent medical examiner that it is negatively impacting your recovery.*

The latter Life Code clause is broader than the draft general insurance clause. While it is clearly aimed at mental health issues, there may be other scenarios where surveillance could impact negatively upon somebody's health.

Consumer Representatives also note that "independent medical examiner" has a specific meaning under the Life Insurance Code which has many commitments that define and apply the concept. If "independent medical examiner" is to be used in this circumstance it will need to be defined. The General Insurance Code may need to provide further details as to how an independent medical examination may be sought and realised. Alternatively a different form of words could be included to capture the intent of the clause, that is, surveillance will be discontinued where robust medical evidence is provided by the insured or is known to the

insurer. Some scalability should be built in, such as where evidence provided by the claimant is not convincing that a second opinion or independent third-party opinion is provided.

Consideration also should be given to needs to be given to including the following additional standards:

- surveillance will not be conducted on business premises unless a reasonable person would believe that those business premises were open for persons to enter without necessarily expecting them to enter into any form of transaction;
- an investigator must make and keep written contemporaneous records of all investigation activities to be retained for 7 years. Contemporaneous notes should include details of: conversations held in person; telephone conversations; unanswered telephone calls, including messages left; letters/faxes/emails sent; travel; details of any statement obtained; any electronic checks, including government and social media sites (e.g. internet/land titles/Facebook/Business Affairs). We note that the standards refer to requiring "records of all investigation activities are kept in accordance with the requirements of the *Privacy Act 1986*. However we believe that this should be expanded to the above.
- the investigator must not seek or accept from, or offer to, any person any gifts, benefits or rewards in connection with an investigation, other than modest hospitality such as light refreshments.

While this may be similar to a prohibition on inducements, it is not necessarily the same and should be delineated.

Consumer Representatives note that the above recommendations are included in the *WorkSafe Victoria Code of Practice for Private Investigators*, July 2016[32] which we would consider to be Australia's best practice code in this field. We would encourage the ICA to meet this standard to in order to reach best practice.

We strongly recommend that the Claims Investigations Standards include cross references to the Family Violence Guidelines and the Mental Health Best Practice Principles. The complex sets of issues being addressed in these two guidelines specifically are exacerbated in an investigation context and it is critical that external investigators (and consumers) are made aware of and adhere to these separate guidelines.

With respect to the interview request form, it includes an authority to access information from third parties including "type of information to be requested." We would recommend that reasons why should also be included here. Just as the interview subject will be given "the purpose of the interview" as a part of their own interview request (under section 3(a)(i)), similarly it is good practice to provide the purpose for why the investigator is seeking to access information from a third party.

Finally, it is critical to include the following recommendations of the CGC's 2017 Own Motion Inquiry, that is:

[32] https://www.worksafe.vic.gov.au/__data/assets/pdf_file/0019/207721/ISBN-Code-of-practise-for-private-investigators-2016-07.pdf

Recommendation 3 – External Investigators to obtain authority before alleging fraud

Code Subscribers should require external Investigators to obtain their express and written authority before putting a fraud allegation to a claimant. This requirement should be included in Code Subscribers' contracts with external Investigators and in their written instructions to external Investigators.

Recommendation 12 – Informing Code Subscribers about interview arrangements Code Subscribers should … provide guidance to external Investigators on arrangements for interviews, which must have regard to the interviewee's circumstances as well as the likely length of the interview.

Areas not covered - Monitoring

With respect to the quality assurance program requirements proposed at 1(c), the review of recordings, statements, affidavits and/or transcripts of interviews should also refer to running sheets and notes, and should be reviewed for procedural fairness. This should be explicitly referred to in the standard.

Given the concerns with respect to interview duration, Code subscribers should commit to monitor this specifically as recommended by the CGC:

Recommendation 15 – Monitoring interview duration

Code Subscribers should include in quality assurance programs measures to monitor interview duration and compliance with the Code through:

- *regular reviews of current and closed claim files, including denied claims*
- *for Employees who conduct telephone interviews – call audit reviews and review interview transcripts or recordings*
- *audit external Investigator running sheets, interview transcripts or recordings to check the duration of interviews*
- *review of complaints about interviews, including disputes referred to FOS.*

Areas not covered - Privacy

We acknowledge that the interview consent form will include:

- information regarding the scope of authority,
- type of information to be requested,
- period of information requested,
- impact on the claim if the information is not provided, and
- date of issue and expiry of authority.

However there are no commitments to confine or limit the scope of authorities, nor any commitments to monitor these authorities. We recommend the standard addresses CGC's Recommendation 21:

Recommendation 21 – Scope of signed authorities for information held by third parties

Code Subscribers should:

- *ensure that requests for additional information or documents are reasonable and relevant to the claim under investigation*
- *require external Investigators to record requests to individuals for written authorisation to access personal information held by other parties and surrender to Code Subscribers the original signed authorities at the conclusion of their investigation*
- *clearly limit the purpose of the authority to the investigation of the claim in question*
- *define the scope of the authority in terms of the type of information that is being requested and the period covering the request – in other words the authority should not be couched in blanket terms or for an indefinite period*

Form of the Claims investigations standards

We note the argument in the Interim Report[33] that because investigated claims make up a small proportion of claims, including the investigations section in the main Code document may lead consumers to believe investigations are much more prevalent than they are.

This argument does not really hold any water as there are a number of sections of the Code that will only apply to a minority of policyholders.

We note too that the investigations and surveillance commitments under the Life Insurance Code are included in the main document and are not an appendix, and that the FSC did not have similar concerns.

Having said that though, as long as the standards are mandatory, Consumer Representatives are not necessarily wedded to the form, beyond our concern with the large variety of commitment and standards mentioned in the Executive Summary.

Recommendations

212. The Claims Investigations Standards should include the following regarding transparency about why a claim is being investigated and what to expect:

i. consumers should be informed by telephone that their claim will be investigated and why, and that, if appropriate, an external investigator will interview them;

ii. staff are provided with clear guidance on the content of such conversations.

iii. confirm that an investigation will occur and why in writing (letter or email), including information about the following:

vi. the purpose of the investigation, what to expect and that the consumer should not draw an adverse inference from this decision;

vii. the consumer's primary contact during an investigation, the role and responsibilities of the claims consultant and the external investigator;

[33] p. 28

viii. the external investigator's contact details, when to expect to hear from them and what to do if they are not contacted within that timeframe;

ix. the consumer's rights and responsibilities during the investigation and interview, including who they can contact if they have any questions about the investigation or process including or if they are unhappy with the external investigator's conduct, how their personal information will be handled and their rights after a claim decision has been made;

x. the timeframe for making a claim decision after completing the investigation and information gathering, information about the complaints process and other resources to assist the consumer during the investigation such as the Financial Ombudsman Service Australia (FOS) and key consumer advocates.

213. The Claims Investigations Standards should include the following regarding interviews:

i. interview subjects are advised in writing;

ii. investigators provide a business card and license details where available;

iii. interview subjects should be provided with information about the roles and responsibilities of the and the external investigator

iv. transcripts are provided automatically, without somebody having to request one;

v. interview subjects should also be offered breaks at least every half an hour, and the request for a break should be adopted in the record of interview

vi. section 3(l) should be amended to ensure that:

iv. if more time is needed for an interview beyond two hours, the interview should be suspended and arrangements made to continue at a later date, subject to the Code Subscriber authorising the continuation of the interview and the consumer's consent.

v. if an interviewee decides that they prefer to continue with the interview beyond two hours, then it should be clearly explained that the interviewee may continue the interview at a later date

vi. the interviewee's acknowledgement and their agreement to continue the interview in these circumstances should be recorded in writing and by audio recording.

vii. ask interviewees (consumers) to complete an interview consent form which also asks whether they need an interpreter or support person

viii. assess whether consumers have special needs and provide additional support to such consumers before authorising an Employee or external investigator to interview them

ix. ensure that their Employees or their external investigators never deny a consumer's reasonable request for a support person

x. ensure that Employees are appropriately trained to identify such consumers and their support needs and that interviews should only be conducted by Employees who have appropriate training or experience

xi. provide external investigators with, or require them to receive, appropriate training to assist in identifying and supporting consumers with special needs

xii. specify in contracts with external investigators that consumers are entitled to have a representative or support person with them during an interview

xiii. if an agreement about support cannot be reached, require external investigators to contact the insurer

xiv. specify in contracts with external investigators their expectations and requirements, or provide guidelines, about consumers with special needs.

214. With respect to interviewing minors specifically, the standard should include the following:

g. ensure that a senior staff member with appropriate experience and training determines whether it is necessary to interview a minor – this includes assessing whether the minor is capable of distinguishing a truth from a lie

h. instructions to an external investigator must clearly set out the scope of the interview and ensure that the external investigator will obtain prior written approval to expand the scope of the interview

i. a request to expand the scope of an interview must also be assessed by a senior staff member with appropriate experience and training

j. if in the course of an investigation the external investigator determines that it is necessary to interview a minor, require the external investigator to obtain prior written approval – such a request should be assessed as described above

k. if the external investigator is required to determine whether the minor has the capacity to distinguish a truth from a lie, provide clear guidance to the external investigator on how to determine this – this assessment should be recorded.

l. the draft standard needs to clarify that the "responsible adult" referred to a (3)(h)(iii) can be a parent or guardian.

215. The Claims Investigations Standards should include the following standards regarding surveillance:

i. surveillance will be discontinued when there is evidence that it is negatively impacting upon a person's recovery;

ii. "independent medical examiner" needs to be defined along the same lines as the Life Insurance Code. Alternatively a different form of words could be included to ensure that surveillance will be discontinued where robust medical evidence is provided by the insured or is known to the insurer;

iii. surveillance will not be conducted on business premises unless a reasonable person would believe that those business premises were open for persons to enter without necessarily expecting them to enter into any form of transaction;

iv. an investigator must make and keep written contemporaneous records of all investigation activities to be retained for 7 years. Contemporaneous notes should include details of: conversations held in person; telephone conversations; unanswered telephone calls, including messages left; letters/faxes/emails sent; travel; details of any statement obtained; any electronic checks, including government and social media sites (e.g. internet/land titles/Facebook/Business Affairs);

v. the investigator must not seek or accept from, or offer to, any person any gifts, benefits or rewards in connection with an investigation, other than modest hospitality such as light refreshments;

vi. interview subjects be provided with reasons for providing an authority to access information from a third party.

216. The Claims Investigations Standards must include cross references to the Family Violence Guidelines and the Mental Health Best Practice Principles.

217. External investigators should be required to obtain their express and written authority before putting a fraud allegation to a claimant. This requirement should be included in Code Subscribers' contracts with external investigators and in their written instructions to external investigators.

218. Code Subscribers should provide guidance to external investigators on arrangements for interviews, which must have regard to the interviewee's circumstances as well as the likely length of the interview.

219. The Claims Investigations Standards should include the following regarding quality assurance program requirements:

a) the review of recordings, statements, affidavits and/or transcripts of interviews should also refer to running sheets and notes, and should be reviewed for procedural fairness. This should be explicitly referred to in the standard.

b) measures to monitor interview duration and compliance with the Code through:

i. regular reviews of current and closed claim files, including denied claims

ii. for Employees who conduct telephone interviews – call audit reviews and review interview transcripts or recordings

iii. audit external investigator running sheets, interview transcripts or recordings to check the duration of interviews

iv. review of complaints about interviews, including disputes referred to FOS.

220. With respect to privacy and authorities Code subscribers should include the following:

a) ensure that requests for additional information or documents are reasonable and relevant to the claim under investigation

b) require external investigators to record requests to individuals for written authorisation to access personal information held by other parties and surrender to

Code Subscribers the original signed authorities at the conclusion of their investigation

c) clearly limit the purpose of the authority to the investigation of the claim in question

d) define the scope of the authority in terms of the type of information that is being requested and the period covering the request – in other words the authority should not be couched in blanket terms or for an indefinite period

221. The Claims Investigations Standards must be mandatory.

Proposal 8 The revised Code should meet the requirements for ASIC approval

8: What issues should be taken into account if the Code were to make it explicitly clear that Code standards are enforceable through the Code Subscribers' EDR scheme?

Consumer Representatives believe that the ICA should reconsider its view that it would not support ASIC approval if it required the Code to be incorporated into individual contracts with consumers.

Consumer Representatives note the inclusion of clauses 41 and 12.3 ABA Code of Banking Practice.[34] The Banking Code has for many years formed a part of the individual contracts with the banking customer with minimal litigation with respect to code breaches.[35] The next iteration of the Code – the Banking Code of Practice – will also retain the exact same commitment.

The Customer Owned Banking Code of Practice is also incorporated into customer contracts.

We note that the ICA argues that:

> *"the benefit of keeping the Code standards part of a standalone self regulatory model is that it allows the Code to contain principles and flexibility….[and] that flexibility could well end up being stripped out and the Code reduced to base-level, prescriptive service standards If the Code were to become a brief, base level. If the Code were to become a brief, base level document, it would weaken its ability to respond to emerging issues and to deliver evolving and improved outcomes for consumers."*[36]

This argument is mistaken. The Interim Report provides no evidence to support this assertion. We note that there is in fact only clear evidence to the contrary. The next iteration of the Code of Banking Practice is currently being finalised and is about to be released. Far from reducing the Code to "base level prescriptive service standards" the new Code will include a wide range of strengthened and additional service commitments from signatory banks all of which will form part of the contract with individual customers. Far from weakening its ability to respond to emerging issues and delivering evolving and improved outcomes for consumers, it has strengthened this ability.

The ICA has stated that it will consider any developments in operational details of the AFCA and the current ASIC Enforcement Review on industry codes in the financial sector, in the

---

[34] *41.1. On and after the 2013 transition date we will be bound by this Code in respect of: (a) any banking service that we commence to provide to you; and (b) any Guarantee (as described in clause 31) we obtain from you, on or after that date.*

12.3 Any written terms and conditions will include a statement to the effect that the relevant provisions of this Code apply to the banking service but need not set out those provisions.

[35] *Doggett v Commonwealth Bank of Australia* [2015] VSCA 351; *National Australia Bank Ltd v Rice* [2015] VSC 10, *Commonwealth Bank of Australia v Wood* [2016] VSC 264,

[36] ICA Interim Report (2017) p. 30

Code Review Final Report, particularly with respect to enforceability issues. As a part of the ICA's deliberations, Consumer Representatives strongly recommend also examining the developments in the Code of Banking Practice and speaking with the ABA in this regard. We expect that these developments will reassure the ICA and its membership of any concerns insurers have with respect to incorporating the Code into individual contracts.

Furthermore, Consumer Representatives wish to direct the ICA back to the Final Report of the Independent Review of the General Insurance Code of Practice 2012-13.[37] In this report Ian Enright thoroughly canvassed the issue of whether the Code was legally enforceable. Enright notes that the Code was not explicitly enforceable:

> *The Code is clearly not currently enforceable as a term of an insurance covered by the Code. There are no express words that make it a term of a Code Insurance and many of the Code standards as currently drafted would not be amenable to being a term of a contract. In general terms it is doubtful that the Code would be an implied term of a Code Insurance although a specific circumstance might evidence the facts which would make it an implied term. The terms of the Code, section 1.12[38] would also militate against the conclusion that the Code was enforceable as a term of a Code insurance.[39]*

Enright however moved on to argue that in relation to "utmost good faith" there "are ways in which the Code is now legally enforceable":

> *Firstly, a Code corrective action and a sanction under section 7 are contractually binding on a Code Participant and if the Code Participant does not comply with the sanction then an appropriate legal contractual remedy would be available to FOS Code or the CCC. Secondly, the Code is clearly enforceable in the sense that it is a factor in assessing whether an insurance operation is involved in unconscionable conduct under the ASIC Act, section 12CC(1)(h) and (3). Thirdly, there may be circumstances in which a Customer can establish that the Code was a representation by the Code Participant that it would comply with the Code standards and the customer relied on that representation in order to enter into a Code Insurance. Fourthly, although there is no relevant judicial authority of which I am aware, a court would have regard to the Code when deciding whether or not an insurer's conduct had been reasonable in the context of an award of interest under the insurance policy and the IC Act, section 57: if the Code Participant had delayed in breach of a Code standard, that would be a factor in assessing whether the insurer's conduct was unreasonable under the IC Act. Fifthly, and of critical importance, a court would have regard to the Code in appropriate circumstances in a claim by a customer that an insurer had breached its duty of utmost good faith under the IC Act, section 13; if the Code Participant had acted in breach of a Code*

---

[37] Ian Enright, General Insurance Code of Practice 2012-13, Independent Review Final Report http://www.insurancecouncil.com.au/assets/report/GI%20COP%20Independent%20Review%20Final%20Report%202012-13.pdf

[38] The 2009 section 1.12 stated *"This Code does not provide to you or anyone else any legal entitlement or right of action against us, other than that you may: (a) Ask us to address a matter; (b) Report your concerns to FOS; and/or (c) Access our complaints handling procedures (see section 6)."* The equivalent section under the 2014 Code of Practice is section 1.5.

[39] Enright (2013) Para 9.117, p. 101.

> *standard, that would be a factor for a court in assessing whether the insurer's conduct was in utmost good faith under the IC Act.*[40]

Enright makes three conclusions from this analysis

> *The first is that the current Code is legally enforceable in a variety of situations and with a variety of remedies for the customer. The second is that the Code, section 1.12 is wrong and must be amended. The third is that a proposal to make the Code legally enforceable as a term of a Retail Code Insurance merely makes express what is now implied and merely makes explicit what is now implicit. In particular, the Code has, since its inception, emphasised that the relation between the insurer and the insured is based on utmost good faith. The insurance industry should have no difficulty in being held to account for not acting in the utmost good faith.*[41] *(emphasis added)*

Enright went on to recommend that the Claims Service Levels of the Code should be a term of each insurance contract and therefore be legal enforceable. This was ultimately dismissed by the ICA, despite initial assertions at the time, and regrettably remains the ICA's position.

Given the fact that the Code is already legally enforceable in an implied sense, the ICA needs to cease the legal charade and join other financial service providers in taking explicit responsibility for failures to meet basic agreed standards and the insurer's duty of utmost good faith.

Recommendation

222. The revised Code should meet the requirements for ASIC approval and the ICA should seek that approval. In order to do so, insurers should commit to incorporating the Code into individual contracts with consumers.

8.1: Are there any factors to consider if the Code required the CGC to report systemic code breaches and serious misconduct to ASIC?

Consumer Representatives strongly support the Code committing the CGC to report systemic code breaches and serious misconduct to ASIC.

Recommendation

223. General insurers should empower the CGC to report systemic code breaches and serious misconduct to ASIC.

[40] Enright (2013) para 9.121, p. 102

[41] Enright (2013) para 9.123, p. 102-3

8.2: Noting the issues raised above, in order to meet the requirements for ASIC approval, would it be satisfactory if the Code required an independent review no later than three years after the adoption date of any previous changes to the Code? Are there any alternative approaches to consider?

Consumer Representatives believe the ICA should meet all of the minimum standards set by ASIC RG183 including the requirement to an independent review at intervals of no more than three years.

Consumer Representatives would note the following issues:

In requiring that a Code must be independently reviewed at intervals of no more than three years, RG183.84 states that ASIC will discuss a timeline for review and implementation at the "start of the review process, which commences three years after the code was approved [by ASIC]."

The previous Independent review lasted from May 2012 to August 2013 (15 months). The implementation period lasted a further 21 months including 6 months to agree upon the changes – watered down from the Enright recommendations - 5 months to introduce the Code, and 12 further months to transition. At a minimum the 5 month introduction seems to be a waste of time.

If, as ASIC RG183 suggests, this current Review had begun three years after Code approval – which presuming the ICA had worked with ASIC in the lead up to ICA signing off on the Code would have made the date February 2014 – a review would have had to have begun in February 2017. This current Code Review began in February 2017. This suggests it is not too hard to meet a three year time frame.

The ICA proposal however will inevitably lengthen the review and implementation process out significantly if it is three years after adoption. If this proposal had been in place now, the current Code would not begin a review until June 2018.

If the ICA were to repeat the three year process of review and implementation – a new Code would have not been introduced until June 2021. Given the need and urgency to improve standards a six year turnaround with a three year review and implementation period seems particularly unreasonable.

Consumer Representatives agree though that there is obvious value in allowing the Code to be given time to actually work before reviewing it. It makes little sense to review a Code just as it had been introduced. However, this was simply the case last time because of an exceedingly lengthy three year review and implementation process. This merely suggests a failure in the review and implementation process, rather than a problem with the timeframes. If an independent review was provided with the resources it required to review the Code efficiently and thoroughly, then it is likely that the review time could be cut down to a more realistic timeframe.

Furthermore, industry should commit to working with the outcome of independent reviews more by supporting and effecting real changes addressing ongoing consumer concerns raised in these reviews. There is a tendency in industry to reflexively defend existing practice for no

other reason other than consumer friendly changes will involve extra costs. Cultivating an industry culture of improved customer service delivery via a Code, will be a win for all involved.

Recommendation

224. The ICA and general insurers should meet all of the minimum standards set by ASIC RG183 including the requirement to an independent review at intervals of no more than three years, the start of which commences three years after the Code is approved.

8.3: Given the apparent lack of clarity around the operation of the remedies and sanctions in the Code, would this be addressed if the available Code sanctions mirrored those recommended by ASIC RG 183:

a) **Compensation for any direct financial loss or damage caused to an individual**
b) **Binding non-monetary orders obliging the subscriber to take (or not take) a particular course of action to resolve the breach**
c) **Formal warnings**
d) **Public naming of the non-complying organisations**
e) **Corrective advertising orders**
f) **Fines**
g) **Suspension or expulsion from the ICA**
h) **Suspension or termination of Code subscription**

Are there any other factors that need to be considered with this approach?

Consumer Representatives commend the ICA for suggesting the CGC be provided with a full toolbox to sanction a member for a Code breach. To be clear, Consumer Representatives do not expect any or all sanctions to be used in every case. We simply argue that the CGC be provided with all appropriate tools available to ensure that a Code Subscriber is appropriately sanctioned, processes improved and there are better outcomes for consumers moving in to the future.

Consumer Representatives strongly support the inclusions of fines as an appropriate Code sanction. We note that the Insurance Council of New Zealand includes fines in their Fair Insurance Code.[42] It should be designed to avoid moral hazards, where the CGC could impose the fine, and use the money to support its work. To avoid this, ICA could consider a process being established similar to ASIC's enforceable undertakings, and ensuring any fines be used to provide specific rectification or redress for a class of harmed consumers or support better consumer outcomes in that class moving into the future.

[42] Insurance Council of New Zealand Fair Insurance Code 2016, https://www.icnz.org.nz/fileadmin/Assets/PDFs/Publications/Fair-Insurance-Code-2016.pdf

Recommendation

225. Code sanctions should mirror those recommended by ASIC RG 183:

a) Compensation for any direct financial loss or damage caused to an individual

b) Binding non-monetary orders obliging the subscriber to take (or not take) a particular course of action to resolve the breach

c) Formal warnings

d) Public naming of the non-complying organisations

e) Corrective advertising orders

f) Fines

g) Suspension or expulsion from the ICA

h) Suspension or termination of Code subscription

i. Claims

a. Making a claim

Discussion Point 1: What issues should be taken into account if the Code were to require the following:

a) **provide a claimant with contact details they can use to get information about the claim**

b) **explain to the claimant why particular information is being requested**

c) **where possible, request all required information early and in one request, rather than in multiple information requests?**

Consumer Representatives support the inclusion of these commitments and provides the following comments.

b) explain to the claimant why particular information is being requested;

A common frustration faced by policyholders is not knowing why certain pieces of information are being requested. While it may be obvious to a lawyer or insurer why the information is being requested, it is not always immediately obvious to somebody who has not engaged with the claims process previously. This can lead to misunderstandings, defensiveness and confusion. This is heightened during an era where people are increasingly aware and concerned about their privacy, particularly privacy around sensitive information including financial data.

By providing basic reasons why a document is required, this will both assure a claimant and empower them to better understand the insurance claims process. It also removes one small but important piece of information asymmetry. We also believe that given most information requests fall into a set number of categories (e.g., bank records, phone records etc.) it will require little work on the part of insurers to establish common reasons for requesting information.

c) where possible, request all required information early and in one request, rather than in multiple information requests.

This is an important point. Solicitors at the Insurance Law Service regularly hear complaints from policyholders regarding the drip feeding of requests for information and documentation. This is usually frustrating and disruptive. Many policyholders are going through particularly stressful periods of their life, of which dealing with multiple insurer requests for information simply adds to that stress. This stress is heightened if the situation is that an insurer is conducting an investigation. Drip-feeding of information requests also fundamentally adds to delays in processing of claims – another key source of frustration for claimants. It also provides the impression – rightly or wrongly – that the insurer is deliberately delaying the process.

In addition to these three commitments we would recommend that general insurers commit to improved communications more generally.

As the life insurers have done under the Life Insurance Code, we believe general insurers should in addition to the above commit to explaining the cover that the claimant holds, the claims process and any waiting periods, excesses or other relevant information, once the insurer has been notified of a claim:

> *8.3 Within ten business days of being notified about your claim, we will explain to you your cover and the claim process, including why we request certain information from you and any waiting period before payments will be made. We will give you contact details that you can use to get information about your claim. (our emphasis)*

Furthermore, we recommend broadening these commitments to improving communications practices more generally, not just during the claims process. We note for example that the Life Insurance Code commits to providing annual notice which will include amongst a number of things, "information about how to contact us to discuss options if you want to change the terms of your Life Insurance Policy." We recommend the General Insurance Code include an equivalent set of commitments.

Recommendations

226. The Code should include commitments to

- **a) provide a claimant with contact details they can use to get information about the claim**
- **b) explain to the claimant why particular information is being requested**
- **c) where possible, request all required information early and in one request, rather than in multiple information requests**

227. In addition to these general insurers should, at the time of making a claim or soon after, commit to explaining the cover that the claimant holds, explain the claims process and any waiting periods, excesses or other relevant information.

228. Commitments to improved communications practices more broadly should be made including an equivalent set of commitments to Section 6.3 of the Life Insurance Code.

b. Withdrawn claims

Discussion Point 1.1: Some stakeholders have suggested that the Code should make it clear that insurers will neither discourage a claim nor encourage a withdrawal. Is this a sensible Code requirement or are there any problems with this approach?

Consumer Representatives support extending the current commitment under clause 7.8 of the Code to include not encouraging a withdrawal. This latter issue is a common occurrence and is not currently captured by the Code.

We would also wish to ensure that this does not result in people being misled as to consequences of making a claim. Consumer Representatives hear from people who are making a motor vehicle claim where they are inquiring about whether to make a claim on their own policy (as opposed to claiming against the insured at fault driver) and they have been told by insurers that "it makes no difference". This statement is wrong. There are significant consequences for people involved in motor vehicle accidents, where there is a possibility that their vehicle may be added to the written off vehicle register if they claim, the deduction of premiums and being subject to the terms of their insurance policy including no choice as to repairer or needing to recover other costs separately from the third party insurer such as car hire. Whilst we do not want insurers to discourage claims being made, accurate information as to the consequences of a claim must be clearly communicated to the person.

Recommendations

229. **The Code should commit insurers to neither discouraging a claim nor encouraging a withdrawal.**

230. **As a part of this commitment general insurers must not state that there is no difference if a claim is made or not.**

Discussion Point 1.2: There is strong support for better data collection of withdrawn claims. The ICA notes that this could involve extensive system changes for some insurers. Taking this into consideration, would an appropriate middle ground be for the Code to require that when a claim is withdrawn, insurers should endeavour to record the reasons for this (if known) and ensure the customer is aware that they can make a complaint if they wish? Please identify any concerns with this approach or alternative options.

Consumer Representatives note that Australian Prudential Regulation Authority (**APRA**) and ASIC are currently in the process of introducing a transparent public reporting regime for life insurance claims information. This arose out of an ASIC review to identify systemic concerns with claims handling across the life insurance industry resulting in *Report 498 Life Insurance*

claims: An industry review[43]. One key finding of this report was that there was "a clear need for better quality, more consistent and more transparent data about insurance claims.'[44]

As a part of this public reporting regime the APRA and ASIC are seeking information on withdrawals.[45] The rationale for this is that the data will be used to assess claims outcomes.

We believe it is only a matter of time until the public reporting regime will be extended to cover general insurers. We therefore believe it is incumbent upon general insurers to improve their systems to fully capture information regarding withdrawals sooner rather than later.

With respect to the proposal, Consumer Representatives strongly support requiring that when a claim is withdrawn, insurers should endeavour to record the reasons for this (if known) and ensure the customer is aware that they can make a complaint if they wish. This should be done so in a consistent manner, and should make this information available to the CGC as a part of their ongoing monitoring.

Recommendations

231. The Code should require that when a claim is withdrawn, insurers should endeavour to record the reasons for this (if known) and ensure the customer is aware that they can make a complaint if they wish. This should be done so in a consistent manner, and should make this information available to the CGC as a part of their ongoing monitoring.

c. Claims decisions

Discussion Point 1.3: What factors should be taken into account if the Code were to require regular updates to be given to a claimant every 10 business days (which can be provided via text, email or mobile phone), with responses to routine queries given within five business days?

Consumer Representatives support Legal Aid NSW's original submission that there shall be a mandatory notification to a consumer of their right to seek internal dispute resolution (**IDR**) and EDR within two months of a claim being lodged if the insurer has not made a decision on the claim.

[43] http://asic.gov.au/regulatory-resources/find-a-document/reports/rep-498-life-insurance-claims-an-industry-review/

[44] Report 498, paragraph 43.

[45] APRA, Discussion Paper: Towards a transparent public reporting regime for life insurance claims information, p. 25 http://www.apra.gov.au/lifs/Documents/Life%20claims%20data%20collection%20discussion%20paper%20final.pdf

Consumer Representatives submit that if insurers truly seek to decide claims as early as possible rather than waiting until the deadline, then a two month timeframe for deciding a claim with the usual exceptional circumstances clause is reasonable. If a claim is required to be decided in four months and that this is the exception, then it makes sense to commit to a 2 month timeframe with a notification to consumers of their right to seek IDR and EDR. Insurers will still be able to extend this period to 4 months or further under the exceptional circumstances clause.

Consumer Representatives strongly support the proposal that regular updates be given to a claimant every 10 business days (which can be provided via text, email or phone), with responses to routine queries given within five business days.

We would note that there remains significant numbers of Australians who do have access to the internet: 1.3 million households as of 2015. Many of these people are disadvantaged, lack confidence or knowledge to access the internet or unable to afford access. We believe that as suggested by the Interim Report that sending these updates to text, email or mobile phone should be limited to those circumstances that this is in fact possible. While the grand majority of Australians will be more than OK with text, email or mobile phone, the Code should provide some leeway for people who may not be able to be reached by these means.

Recommendations

232. Regular updates should given to a claimant every 10 business days (via text, email or phone, *where possible*), with responses to routine queries given within five business days.

233. A mandatory notification to consumer of their right to seek IDR and EDR within two months of a claim being lodged if the insurer has not made a decision on the claim.

d. Claims denials and partial denials

Discussion Point 1.4: Are there any matters that would have to be resolved if the Code were to require that, where a claim is partially accepted, this should be confirmed in writing? The written confirmation could include:

a) **which aspects of the claim have not been accepted and the reasons for this**
b) **the consumer's right to access information relied on to make the decision**
c) **information about the insurer's complaints process**

Consumer Representatives support this proposal.

Recommendation

234. Consumer Representatives support written confirmation being provided for partially accepted claims detailing:

a) which aspects of the claim have not been accepted and the reasons for this;

b) the consumer's right to access information relied on to make the decision;

c) information about the insurer's complaints process.

Discussion Point 1.5: Would a satisfactory Code improvement be for clause 7.19 to make it clear that all of the information provided when a claim is denied is required to be in writing, not just the reasons for the denial in (a)? Is there an alternative approach?

Consumer Representatives support this proposal.

Recommendation

235. The language of clause 7.19 should be amended to ensure that all of the information provided when a claim is denied is required to be in writing, not just the reasons for the denial.

Discussion Point 1.6: Are there any issues to be considered if the Code required insurers to record the reasons for claim denials?

Consumer Representatives support recording the reasons for claims denials. This is important for identifying and understanding systemic issues that may arise.

The only issue that has been identified by Consumer Representatives is the flow on impact on to a consumer's insurance report, particularly when the denial includes an accusation of fraud. We remain concerned that the insurance reporting system has little oversight, used inconsistently, is haphazard and largely unreliable. There remain many opportunities for misreporting and abuse without adequate rules and oversight. We believe that in addition to better recording of claims denials, that insurers should commit to improving the insurance reporting system and include commitments under the Code outlining consumer rights and insurer responsibilities in using insurance reports.

Recommendations

236. The Code should require insurers record the reasons for claim denials.

237. Insurers should commit to improving the insurance reporting system and include commitments under the Code outlining consumer rights and insurer responsibilities in using insurance reports.

Discussion Point 1.7: What factors should be taken into account if clause 9.3 of the Code were amended so that, after a catastrophe, there was an obligation to notify a claimant, in writing, about their entitlement to have their claim reviewed within 12 months?

The commitment under the existing clause 9.3 already states that insurers will notify the claimant about their entitlement in the situation. As we understand the proposal, insurers will now be required to do so in writing. Consumer Representatives support this proposal.

We also note that the current clause is limited to people who have had property claim resulting from a catastrophe finalised within one month after the event causing the loss. We believe that this should be expanded to all claims resulting from a catastrophe.

Recommendations

238. The commitment to notify a claimant about their entitlement to have their claim reviewed within 12 months should be amended so that this be done so in writing.

239. Clause 9.3 should be expanded to cover all claimants resulting from a catastrophe.

e. External Expert reports

Discussion Point 1.8: We have noted a number of issues with providing a policyholder with the details of the complaints process when an external report is not received within 30 days. Do you agree with our concerns? If not, is there an alternative solution that could be considered?

Consumer Representatives note that there are circumstances where an expert report may not be reasonably be received within 30 days including as detailed in the Interim Report, in the aftermath of a catastrophe is one of those circumstances.

However, this one example should not be used as excuse to not commit to hard timeframes to inform a claimant about what is happening to their external expert report. Claimants remain in a situation where they are not regularly informed of a key part of their claim and will continue to feel powerless, particularly following a catastrophe. If, as the Interim Report suggests, there "are a limited number of experts who can be engaged to produce a large number of reports" insurers should commit to telling the claimant this, and commit to updating them on a regular

basis so that they are fully informed of the situation and do not languish in a no man's land. We see no harm in insurers committing to hard timeframes to keep claimants informed.

We would also submit that there are a number of other circumstances where claims are not being processed within 12 weeks and continue to languish because of delays in receiving an external report. Without a regular update of what is occurring with an external report or no hard end date, this leads to significant stress for the policyholder from delays, and can lead to withdrawals based on nothing but pure frustration.

Consumer Representatives see no problem with making a commitment that if an expert report cannot be provided within 12 weeks of the date of their engagement, general insurers will inform the claimant every 10 days of the status of the report and, if after 30 days the report has not been provided, the policy holder will be provided with details of the Complaints process. That is:

- Insurers will ask external experts to provide an external report within 12 weeks.
- If they don't, the insurer will inform the consumer and keep them informed every 10 business days.
- After 30 days (that is, 3 lots of 10 business day cycles), the insurer will provide the policyholder with the details of the complaints process, to complain about the delay.

There will of course be exceptional circumstances where an expert report simply cannot be provided in that time, such as a catastrophe, but an insurer should not be able to delay the finalisation of a claim, because of issues that are in no way exceptional.

Recommendation

240. Insurers should make a commitment under the Code to the effect that if an expert report cannot be provided within 12 weeks of the date of their engagement, general insurers will inform the claimant every 10 days of the status of the report and, if after a further 30 days the report has not been provided, the policy holder will be provided with details of the Complaints process. In order to address insurer concerns, this should include an exceptional circumstances clause.

f. Home building and vehicle repairs

Discussion Point 1.9: What would be the advantages or disadvantages if the Code were to require that, where an insurer engages someone to carry out repairs on a customer's building, contents or motor vehicle, a written summary of the scope of the work is to be provided to the customer?

Discussion Point 1.10: Are there any issues that need to be taken into account if the Code were to require that, where a repairer, organised by the insurer, has done a faulty or poor repair of a vehicle or building, and this requires the use of a hire car or accommodation over and above what is in a customer's insurance cover, the insurer will arrange these for the customer and cover any costs for the arrangements?

Consumer Representatives agree that customers should be given a summary of the scope of work to be carried out by someone engaged by the insurer to undertake repairs to the customer's building, contents or motor vehicle. This is important information for a customer to retain, and it may avoid disputes during and after the work. With the growing complexity of motor vehicle design, people lack an understanding of the cost or methods of repair. This can be difficult for people who are concerned with the safety of the vehicle. Insurers need to be more transparent as to the repair process and methodology. In doing so insurers will raise levels trust in the repair process amongst consumers.

Consumer Representatives supports the Code requiring that, where a repairer, organised by the insurer, has done a faulty or poor repair of a vehicle or building, and this requires the use of a hire car or accommodation over and above what is in a customer's insurance cover, the insurer will arrange these for the customer and cover any costs for the arrangements. This is because it will incentivise the industry to used skilled tradespeople, lift standards in the industry in the process and ensuring more satisfied customers as the job will more likely be done correctly the first time.

Clearly the key concern from general insurers will be increased costs, however with the incentives in place, it will over time, more than likely stabilise as standards are improved.

Recommendation

241. **Where an insurer engages someone to carry out work on a customer's building, contents or motor vehicle, the Code should require the insurer to provide the customer with a summary of the scope of that work.**

242. **The Code should require that, where a repairer, organised by the insurer, has done a faulty or poor repair of a vehicle or building, and this requires the use of a hire car or accommodation over and above what is in a customer's insurance cover, the insurer will arrange these for the customer and cover any costs for the arrangements.**

g. Total loss claims protocol

Discussion Point 1.11: Given the concerns noted above, would it be a suitable improvement if the Code required that, when a claimant's loss is equal to or greater than the full sum insured, or a sub-limit within this, the insurer and its Service Suppliers will help them to assess their loss, and any inventory assessment required will only have to be provided up to the limit or sub-limit of the cover? What are the advantages or disadvantages with this approach?

Consumer Representatives believe that a Total Loss Claims Protocol put forward by Legal Aid NSW remains an important idea that should be encouraged and supported by the sector.

We do not support the Interim Report proposal requiring that, when a claimant's loss is equal to or greater than the full sum insured, or a sub-limit within this, the insurer and its service suppliers will help them to assess their loss, and any inventory assessment required will only have to be provided up to the limit or sub-limit of the cover.

While Consumer Representatives understand that insurance is a shared risk and there is an obligation on customers to assist in reasonably quantifying the loss suffered, providing a detailed inventory with evidence of value after a total loss event is one of the most difficult, if not impossible processes to undergo. Insurers need to take a more understanding, empathetic and sensitive approach and support the development of a Total Loss Claims Protocol that ensures that puts the interests of devastated people first.

Consumer Representatives support Legal Aid NSW's position that where a customer has suffered a total loss in relation to a contents claim, unless exceptions apply, insurers should not require the insured to complete a list of their contents and provide evidence. The agreed sum should be paid. Exceptions may include situations where there is a reasonable basis for suspicion of fraud, or where there is a reasonable basis for forming a belief that the actual loss is less than the agreed sum.

As an alternative approach, Consumer Representatives put forward the following suggestion:

- Where a claimant has suffered a total loss, the assumption should be that the claimant can recover for losses up to "average sum insured"[46] amount without having to quantify the loss or provide an inventory assessment and evidence of value.
- If the sum insured of a particular property is below this average, (i.e. underinsured) they should be paid the sum insured amount as per their policy without requiring an inventory.
- If the sum insured is however higher than the average, then the insurer and its service suppliers should pay the average sum insured immediately and help them assess their loss, and any inventory assessment required will only have to be provided up to the

[46] Re: average sum insured, we would expect insurers in designing products and calculators have some information about what an average household contents with various factors such as number of household occupants, rooms, and location for example as used in calculators.

limit or sub-limit of the cover. This would be an appropriate acknowledgement that there is some obligation on the customer who on paper seems insured over what is ascertained as the average to reasonably quantify the loss. There is a risk an insured may just accept this without dispute to their detriment. It must be made clear by the insurer that this payment is not "in full and final settlement" and that they are entitled to pursue the difference. This is in line with current best practice to pay the undisputed amount in a claim.

- In addition to this, insurers need to commit to ensuring that people do not significantly over-insure their home and contents in the first place. Insurers therefore need to provide accurate sum insured calculators as we recommend above under Question 2.2.
- Secondly, insurers need to be clearer with policyholders with respect to what the policyholder needs to maintain in order to provide the necessary evidence for a claim, and that these requirements be highlighted in the Policy certificate or embedded in the sales process and not buried in fine print, terms and conditions.

Recommendation

243. Consumer Representatives support Legal Aid NSW's position that where a customer has suffered a total loss in relation to a contents claim, unless exceptions apply, insurers should not require the insured to complete a list of their contents and provide evidence. The agreed sum should be paid. Exceptions may include situations where there is a reasonable basis for suspicion of fraud, or where there is a reasonable basis for forming a belief that the actual loss is less than the agreed sum.

244. As an alternative the Code could include a Total Loss Protocol that conforms to the following:

a) Where a claimant has suffered a total loss, the assumption should be that the claimant be paid the "average sum insured" amount without having to quantify the loss nor provide an inventory assessment and evidence of value.

b) If the sum insured of a particular property is below this average, they should be paid this sum insured amount as per their policy.

c) If the sum insured is however higher than the average, then the insurer and its service suppliers should pay the average sum insured and help them assess their loss, and any inventory assessment required will only have to be provided up to the limit or sub-limit of the cover. Insurers would need to make it clear that this payment is not "in full and final settlement" and that the policyholder is entitled to pursue the difference

d) In addition to this, insurers need to commit to ensuring that people do not significantly over-insure their home and contents in the first place by supporting the recommendations above at Question 2.2

e) insurers need to be clearer with policyholders with respect to what the policyholder needs to maintain in order to provide the necessary evidence for a claim, and that

these requirements be highlighted in the Policy certificate or embedded in the sales process and not buried in fine print, terms and conditions.

h. Uninsured third- party claims

Discussion Point 1.12: The Code could clarify the rights of an uninsured third-party driver making a claim with an at-fault driver's insurer, by including:

a) **principles for claims handling**

b) **an explanation of the claims process**

c) **access to the insurer's complaints process for a claim up to $5000**

d) **access to EDR for a claim up to $5000**

Would this be a satisfactory solution or is there a more appropriate alternative?

Consumer Representatives support clarifying the rights of an uninsured third party driver making a claim with an at-fault driver's insurer, by including:

a) principles for claims handling;

b) an explanation of the claims process;

c) access to the insurer's complaints process;

d) access to EDR for a claim up to $15,000.

This will likely make claims handling more efficient and reduce claims in FOS and court, reduce involvement of "demurrage" or claims handling firms and improve consumer attitudes towards insurers.

With respect to the monetary limit, Consumer Representatives have argued that the current monetary limit of $5,000 is too low given the rising costs of car repair. Uninsured drivers are often a vulnerable group of consumers with many experiencing financial hardship when their car is damaged. They are often attracted to the promise of demurrage firms and if they were treated better by insurers in the initial stages the use of such firms may diminish. The specific limit should be removed for IDR and increased to $15,000 for EDR providing an alternative to court-based dispute resolution which can be costly for both insurers and the uninsured driver.

One issue that remains of concern to Consumer Representatives is the difficulties faced by uninsured parties in dealing with an insured, where the insured has not paid their excess: see Jared's story, above. A valid claim should not include a requirement that the insured has paid the excess. A claim should be considered valid once lodged. If a claim has been lodged, the insurer should have to provide sufficient details as to why a claim is not valid so that the uninsured third party knows the reason.

Recommendations

245. The Code should clarify the rights of an uninsured third party driver making a claim with an at-fault driver's insurer, by including:

a) principles for claims handling;

b) an explanation of the claims process;

c) access to the insurer's complaints process;

d) access to EDR for a claim up to $15,000.

246. A claim should be considered valid once lodged, irrespective of whether the excess has been paid.

i. Debt Recovery

Discussion Point 1.13: Would a Code requirement, that insurers should treat individuals from whom they are seeking recovery of a debt in an honest, fair, transparent and timely manner, be a satisfactory improvement and address stakeholder concerns noted above?

Consumer Representatives support the Code requiring insurers treating individuals from whom they are seeking recovery of a debt in an honest, fair, transparent and timely manner. This Code commitment should extend to third party suppliers i.e. debt collectors.

Recommendation

247. The Code should require insurers and third party suppliers, such as debt collectors, treat individuals from whom they are seeking recovery of a debt in an honest, fair, transparent and timely manner

Discussion Point 1.14: To improve the provision of information to third parties, where an insurer is seeking recovery from an uninsured third party, the Code could require the insurer to provide sufficient information in writing for the individual to determine that the amount being recovered is fair and reasonable, such as:

a) details of the damage and the claim

b) the repair estimate or completed repairs

c) evidence relied on for making an assessment of liability

Would this help to address the concerns raised? Would there be any challenges with implementing this provision?

The Code should require the insurer to provide sufficient information in writing for the individual to determine that the amount being recovered is fair and reasonable, including:

a) details of the damage and the claim

b) the repair estimate or completed repairs

c) evidence relied on for making an assessment of liability

If the debtor is sufficiently impecunious, they may not see the point in challenging a grossly inflated damages claim. It is in the interests of the industry to encourage the debtor to seriously consider the damages claim regardless of whether or not they are going to have to pay it in order to protect the insurance industry against fraud by their third party service providers.

Insurers should also commit to informing third parties of their right to question the sum that the insurer is seeking to recover. Presumably this will be included as part of the information being provided at Discussion Point 1.12, but to remove any doubt this should be affirmed by the ICA.

Recommendations

248. **The Code should require the insurer to provide sufficient information in writing for the individual to determine that the amount being recovered is fair and reasonable, including:**

a) details of the damage and the claim

b) the repair estimate or completed repairs

c) evidence relied on for making an assessment of liability.

249. **Insurers should commit to informing third parties of their right to question the sum that the insurer is seeking to recover.**

j. Provision of documents

Discussion Point 1.15: The Access to Information section of the Code could be updated to clarify that insurers will provide the following information on request (subject to any special circumstances where information cannot be provided under clause 14.4):

a) information and documents relied on to deny a claim

b) copies of the PDS and insurance certificate

c) copies of any expert or assessment reports relied on

d) copies of any recordings or available transcripts of the sale of insurance

Would this be a suitable improvement or are there alternative documents that should be specified?

Consumer Representatives generally support this proposal.

With respect to copies of any recordings or available transcripts – this should not be limited to the sale of the insurance, but include any disputed interactions with the policyholder.

With respect to mental health claims, insurers should, as per the provision of data section above, commit to providing copies of the mental health actuarial and statistical data that they have relied on. Only where the actual actuarial and statistical data which insurers have relied on are not able to be provided because the material is considered to be commercial-in-confidence, should insurers provide a detailed summary that specifies the type of data that we have relied on.

We would further recommend that this information be provided for free.

Recommendations

250. The Code should ensure that insurers provide the following information on request:

a) information and documents relied on to deny a claim;

b) in cases of mental health claims, actuarial and statistical data that they have relied on, and in the case where the material is considered to be commercial-in-confidence, a detailed summary of such data;

c) copies of the PDS and insurance certificate

d) copies of any expert or assessment reports commissioned during the course of the claim copies of any recordings or available transcripts of the sale of insurance and disputed interactions with the policyholder

251. Insurers should commit to providing this information free of charge.

ii. Automatic Renewals

Discussion Point 2: In order to address concerns raised about automatic renewals, would a practical option be for the Code to require insurers to effectively inform consumers about automatic renewal when they first purchase a policy and at renewal time? This would include obtaining a customer's express consent to allow this and providing the ability to opt out. Is this a sensible balance?

Consumer Representatives note that automatic renewal terms are closely scrutinised by regulators as to whether they are unfair.

Automatic rollover terms were recently considered in the ACCC's case against Chrisco Hampers Australia Ltd.[47] In 2015, the Federal Court found that Chrisco included an unfair contract term in its lay-by agreements, which allowed Chrisco to continue to take payments by direct debit after the consumer had fully paid for their lay-by order. Consumers were required to 'opt out' in order to avoid having further payments automatically deducted by Chrisco after their lay-by had been paid for.

While insurers are not currently subject to the unfair contract term regime under the Australian Consumer Law, the regulatory approach to automatic renewals should guide general insurers' approach.

The ACCC have indicated that automatic renewal clauses are concerning when:

- they are not adequately disclosed;
- no notice is provided that a contract is about to renew;
- they can change the cut-off date for cancellation of the renewal; or
- the customer will incur large early termination charges if they cancel after the contract has automatically renewed.

Consumer Representatives note that the UK Financial Conduct Authority (**FCA**) lists automatic renewal of a fixed-length contract where the deadline to cancel is unreasonably short, as an unfair contract term. In Australia, ASIC last year reviewed six insurers' car insurance renewal practices.[48] They found that:

> *"consumers were not always clearly informed by insurers, when first purchasing the policy, that it would automatically renew unless the consumer advised otherwise. In most cases consumers were only informed about the automatic renewal practice in the product*

[47] Australian Competition and Consumer Commission v Chrisco Hampers Australia Limited [2015] FCA 1204 (10 November 2015) http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/cth/FCA/2015/1204.html?stem=0&synonyms=0&query=title(%22015%20FCA%201204%22)

48 ASIC, 15-345MR ASIC drives better disclosure of automatic renewal of car insurance, 19 November 2015 http://asic.gov.au/about-asic/media-centre/find-a-media-release/2015-releases/15-345mr-asic-drives-better-disclosure-of-automatic-renewal-of-car-insurance/

> *disclosure statement (which may not be received by the consumer until after the insurance is purchased) and renewal notice."*

The law does not prevent insurers from automatically renewing insurance policies and in some cases consumers do seek this feature out, however by structuring the sales and disclosure practice in a way that does not fully inform consumers of this renewal practice unreasonably advantages the insurer. Where consumers inadvertently find themselves insured twice, they struggle to obtain a refund for the full premium and are often limited in only recovering 50% of the overpaid premium on the basis the insurer was "on risk".

Consumer Representatives remain concerned that committing to "effectively informing consumers about an automatic renewal" is vague and unclear. Currently, notices are found in the PDS often many pages into the policy. Given what the industry, regulators, academics and consumers know about the failings of disclosure, we would expect the code require insurers to go over and above the current inadequate disclosure of the practice.

Embedding an express consent regime with a mere ability to opt out is particularly problematic and does not meet current community expectations. It places the onus on the consumer to read, act and comprehend the terms and conditions – otherwise they will be charged. This process can be undermined by the design of the automatic renewal information consents, for example, if it is "auto ticked" on an online application or quickly explained over the phone in an application process.

The Australian Consumer Law states that a term is transparent if it is:

- expressed in reasonably plain language;
- legible;
- presented clearly; and
- readily available to any party affected by the term.

ACCC v Chrisco Hampers may provide some additional guidance about what not to do.

Consumer Representatives acknowledge that insurance is not a Chrisco hamper, but provides important protections against risks such liability in car accidents or homes from significant risks. But, a balance does need to be met for all those people who desire automatic renewal as a service compared to those who find themselves insured for years where they have sourced alternative cover or no longer have the insured asset.

Many Consumer Representatives believe the practice of automatic renewal should be banned. By doing so it may have the collateral benefit of engaging a consumer on an annual basis to review their insurance, review price information, cover and risk rather then "setting and forgetting". This however, is balanced against other Consumer Representatives who see some benefit for some cohort of disengaged consumers. The question is striking the right balance and if a ban is not the solution, then a robust process of consent and a robust regime for consumers who have inadvertently renewed and find them double insured that they are refunded premiums where they have received no value or consideration.

What at the very least should be prohibited is that automatic renewal are made a standard term of the policy. Instead automatic renewals should be a specific feature consented to at the point of purchase. The proposal at Discussion Point 2 must be improved in three ways.

Firstly, any automatic renewal information should meet basic standards under the ACL for a transparent term, that is, it is:

- expressed in reasonably plain language;
- legible;
- presented clearly; and
- readily available to any party affected by the term.

Furthermore, the Code should ensure that automatic renewal is only used where:

- the term is transparent or effectively disclosed to the policyholder or potential policyholder at entry into the contract;
- sufficient notice is given that a contract is about to renew, that is in the renewal notice the information is prominent, consumer tested and unambiguous; and
- no additional fees will be incurred if they cancel after the contract is automatically renewed, such as administration costs.

It order to ensure that automatic renewal has been "effectively disclosed" and express consent obtained, it is incumbent upon general insurers to capture the information at consent time as to how consent was obtained and measure the effectiveness, via a survey of their customers, to see if following the sale of the insurance product they understand that they have expressly consented to an automatic renewal. General insurers also should collect data on automatic renewal complaints and provide this to the CGC for public reporting.

Thirdly, refunding of premiums must be more robust and consistent. We support an extended opt out period where insurers will commit to giving a full refund of any premiums paid and not simply refunding 50% of the premiums if the consumer has gotten insurance elsewhere for the same period.

Recommendations

252. At a minimum, automatic renewal disclosure should meet the following basic standards:

a) they are not a standard term;

b) expressed in reasonably plain language;

c) legible;

d) presented clearly; and

e) readily available to any party affected by the term.

253. Furthermore, the Code should ensure that automatic renewal is only used where:

a) the term is transparent or effectively disclosed to the policyholder or potential policyholder;

b) sufficient notice is given that a contract is about to renew;

c) a long window of opportunity is provided to opt out of the term;

d) no additional fees will be incurred if they cancel after the contract is automatically renewed.

254. An extended opt out period should be required by the Code in which insurers commit to giving the consumer a full refund of any premiums paid after the date of automatic renewal.

iii. Cancellation of policy

Discussion Point 3: How can we improve the cancellation procedures in the Code to assist with customer engagement and prevent unnecessary cancellation? Are there any practical implications with changing the cancellation procedures?

Consumer Representatives support the Financial Rights proposal to improve cancellation procedures to ensure consumers are not unnecessarily losing their insurance cover. These are:

- Any notice of cancellation for non-payment of instalments should mention the availability of hardship arrangements.
- The cancellation procedures in the Code should be amended to provide notice in writing at least 14 days before cancellation through two different channels of communication (SMS, email, post).
- Insurers should be required to always give the second notice of cancellation within 14 days after the policy has been cancelled.

With respect to providing notice via two different channels of communication, the Interim Report asks whether consent is required before utilising an additional channel. Consumer Representatives believe that this can be done up front by asking the potential policyholder for an alternative, secondary method of contact, to be used only if required.

We believe a notification that a consumer's policy has been cancelled will be the most effective means of motivating them to take action before an insurable event takes place. This notice should also include information the date of cessation and the options for reinstatement of the cover.

General insurers should also consider moving from monthly to fortnightly payment arrangements as this could reduce the number of cancellations.

Recommendations

255. **Any notice of cancellation for non-payment of instalments should mention the availability of hardship arrangements.**

256. **The cancellation procedures in the Code should be amended to provide notice in writing at least 14 days before cancellation through two different channels of communication (SMS, email, post).**

257. **Insurers should be required to always give the second notice of cancellation within 14 days after the policy has been cancelled.**

iv. Complaints and disputes

a. Multi-tier complaints process

Discussion Point 4: Insurers have suggested that moving to a one-tier complaints process would be difficult to manage. Noting the issues outlined above, are there other suggestions for improving the internal complaints process? Are there any concerns with waiting until after AFCA is established before implementing changes?

Consumer Representatives believe that insurers' dismissal of a one step complaints process is fundamentally against the interests of consumers and against the spirit of IDR requirements.

Our key concerns with two-stage IDR are that:

- it is confusing – many people do not know what stage they're at and what to do at a particular point;
- it deters people from pursuing legitimate complaints – we see people abandon legitimate complaints because the process seems laborious,
- it protracts the time taken up by internal disputes, for both insurers and consumers, particularly for less complex disputes; and
- damages consumer trust, as people feel confused and unheard.

The Interim Report puts forward five arguments against a one stage complaints process:

- *Insurers are of the view that this would be difficult to manage, particularly for large insurers who handle very large numbers of complaints, the bulk of which are resolved without issue.*

It is unclear why a one stage process would be more difficult to handle than a two stage process. The fact that large insurers, with higher profits, economies of scale and greater resources at hand are those claiming they have the most to lose, is unrealistic.

- *Having a two-stage system means that, in the first instance, someone close to the complaint reviews it and does not have to spend a significant amount of time familiarising themselves with the file. Sending a matter straight to an independent team will build time into the initial review as someone will have to review the entire file to assess the complaint.*

Having someone close to the complaint reviewing the complaint is part of the problem and a key concern of consumers with insurer practices. Consumer Representatives point to clause 9.4 of the Life Insurance Code

> *Your Complaint will be handled by someone different from the person or persons whose decision or conduct is the subject of the Complaint*

If life insurers can do this, general insurers can too.

IDR should be independent of the claims department and the initial claims decision maker. Under the 2014 Code there is no explicit requirement that IDR is separate from the claims

department. In fact, Code clause 10.15 envisages that the employee considering the complaint could be the employee whose decision or conduct caused the complaint.

We submit that the General Insurance Code should set out guidelines to ensure an independent internal review as part of the IDR process. These guidelines are necessary as in our experience, customers are very wary of any veneer of independence when referring matters back to an insurer after that insurer has already made a decision against them. However, where an insurer has chosen to deal with a complaint without genuine independent review, this should not be cause to delay the complainant's access to EDR for a further 45 days.

- *Requiring large insurers to have sufficiently large complaint and dispute management departments to deal with all complaints would be a significant financial burden.*

Again the fact that large insurers, with higher profits, economies of scale and greater resources at hand are those with most to lose is difficult to accept. If this is a genuine financial impost on large insurers, it will incentivise further insurers to institute practices that ensure fewer complaints are made.

- *If the Code only included one 45-day timeframe for deciding on a complaint, this would lead to insurers having differing processes and practices, leading to customer uncertainty. Consistency in communication and processes would be preferred.*

There is nothing inherent in a one stage process that will lead to inconsistency that does not already exist in the two stage process. There is already significant inconsistency between insurers that has led to customer uncertainty. One issue is that insurers variously refer to "complaints handling", "complaints and resolutions" when referring to their complaints handling processes. Having a one stage process, known singularly as Internal Dispute Resolution will lead to less complexity, less confusion and will lead to greater consistency.

- *Insurers have also suggested that it would be prudent to wait until the details of AFCA are in place before making any changes to the standard industry complaint process.*

The establishment of the AFCA has little to no impact on the IDR procedures expected of insurers or any other financial service provider. General insurers and the ICA have the power and ability today to simplify the complaints process applying to signatories to the Code and this will not be impacted upon by any decisions with respect to AFCA.

Consumer Representatives reiterate our concerns with the complaints expressed earlier. We do so because we believe strongly that the two stage process is fundamentally flawed.

Consumers have for many years been flummoxed by the complicated two step process, and withdraw their complaint. This complexity we believe only benefits for general insurers rather than providing any ease or assistance for consumers. The two stage IDR process is confusing and adds to frustrations, annoyance and dissatisfaction.

The first stage is a 15 business day period beginning from the date of complaint, where the Code Subscriber will respond in writing with a decision and reasons and provides information on the complainer's right to take the complaint to stage two.

Stage two is another 15 day period but this time it will be reviewed

> *"by an Employee or Employees with the appropriate experience, knowledge and authority, who is/are, to the extent it is practical, different from the person or persons whose decision or conduct is the subject of the Complaint, or who was/were involved in the Stage One decision."*

It is not clear whether an employee with appropriate experience, knowledge or authority has been involved in the first stage of the process. Again, as mentioned above, the fact that it has been reviewed by somebody connected to the complaint in the first place is the problem and very likely in these circumstances to inevitably lead to the second stage.

Both stages allow the Code Subscriber to extend the length of the 15 days on the basis that they do not have all the necessary information or they have not completed the investigation (clauses 10.12, 10.17, 10.18).

The General Insurance Code does impose a 45 calendar day upper limit as mandated.

It also should be noted that there is another 5 business day complaint process that exists under subsection 10.9 of the General Insurance Code that occurs if the Code Subscriber can, resolve the complaint within that time and the complainer has not requested a letter. This is also included in the Life Insurance Code. This is because it is recommended to be included under RG165.91 of the *Licensing: Internal and external dispute resolution Regulatory Guide 165*.[49]

There is no additional stage recommended under ASIC Regulatory Guide 165.

Meeting the 15 day time limit however remains the "largest area of non-compliance" according to the CGC.[50]

Consumer Representatives continue to believe that the Code should be revised to reflect that IDR should be a simple, seamless one stage process for consumers of no more than 45 calendar days, and then access to EDR if the dispute is not resolved. The Code should remove any suggestion (e.g. 10.14) that a consumer must complain again or 'request' that their complaint be moved from one stage to the next.

It makes little difference to Code Subscribers to eliminate Stage Two of the process. The complaints process would be 15 business days (as it is currently) is unless the Code Subscriber does not have all the necessary information or they have not completed the investigation, in which case a new timetable – up to an overall maximum of 45 calendar days – is instituted. The complaint should be dealt with from the beginning by an employee with the appropriate experience, knowledge and authority for that type of complaint, who is different from the person or persons whose conduct is the subject of the Complaint.

To implement this change, insurers could have trained people at the frontline who can quickly triage and issue-spot with complaints. These frontline staff could deal with minor complaints themselves, and direct more complex or serious complaints appropriately and immediately.

This would also ensure that the Code Subscriber does not have to write a letter closing stage one and the consumer does not have to make a new request for a stage two review. Stage two adds little to nothing to the process for the Code Subscriber or consumer. There are no new additional rights for the consumer other than they can at last have the complaint reviewed by

[49] http://download.asic.gov.au/media/3285121/rg165-published-2-july-2015.pdf

[50] p. 40 CGC GI Industry Data Report 2015-16

somebody in authority. If a Code Subscriber needs 30 days as foreseen by the current two stages, they have the ability under the 15 day process to extend it. There is nothing that justifies a first stage. There is nothing in stage one that assists either the Code Subscriber or the consumer.

Recommendations

258. .The Code should implement a single complaints process, with appropriate frontline triage, and a timeframe of 15 business days.

b. Customer representatives

Discussion Point 4.1: Would a satisfactory improvement be for the Code to require that insurers and Service Suppliers contact a customer through their representative when this has been requested by the customer?

Consumer Representatives support requiring insurers and service suppliers contact a customer through their representative when this has been requested by the customer.

Consumer Representatives reiterate that insurers have directly contacted people who are being representing in claims or disputes, instead of contacting their representatives. This can cause significant confusion and stress. It happens despite the fact that the insurer has been informed that they are represented.

Recommendation

259. The Code should require insurers and service suppliers contact a customer through their representative when this has been requested by the customer.

v. Advertising and marketing

Discussion Point 5: Would the following provisions provide adequate restrictions on advertising and marketing?

a) **Consider the target audience for the advertisement or marketing communication and whether it provides adequate information for that audience**

b) **Ensure statements in advertisements or marketing communications are consistent with the features of the relevant policy and the disclosures in any corresponding PDS.**

Are there other factors to consider?

Consumer Representatives support the inclusion of these commitments from insurers under the Code.

Just as life insurers have, we also believe that general insurers can make the following commitments:

- ensure that any images used do not contradict, detract from or reduce the prominence of any statements used;
- if price or premium are referred to, ensure that these are consistent with the price or premium likely to be offered to the target audience for the advertisement or marketing communication;
- make clear if a benefit depends on a certain set of circumstances;
- ensure any use of phrases such as "free" or "guaranteed" are not likely to mislead;
- ensure that advertising does not solely focus on premium savings and provides balanced information regarding the loss of cover for lower premiums;
- comply with the ASIC's guidance for advertising financial products and services and guidance regarding unsolicited sales.

Recommendation

260. The Code should require commitments from insurers under the Code to:

a) consider the target audience for the advertisement or marketing communication and whether it provides adequate information for that audience;

b) ensure statements in advertisements or marketing communications are consistent with the features of the relevant policy and the disclosures in any corresponding PDS;

c) ensure that any images used do not contradict, detract from or reduce the prominence of any statements used;

d) if price or premium are referred to, ensure that these are consistent with the price or premium likely to be offered to the target audience for the advertisement or marketing communication;

e) make clear if a benefit depends on a certain set of circumstances;

f) ensure any use of phrases such as “free” or “guaranteed” are not likely to mislead

g) ensure that advertising does not solely focus on premium savings and provides balanced information regarding the loss of cover for lower premiums; and

h) comply with the ASIC’s guidance for advertising financial products and services and guidance regarding unsolicited sales.

vi. Pressure selling

Discussion Point 6: What issues need to be taken into account if the Code were to explicitly state that pressure selling practices are prohibited?

Consumer Representatives support the Code committing insurers to prohibiting pressure selling and other unacceptable sales practices for all employees, authorised representatives and Authorised Financial Services Licensees acting on your behalf.

Consumer Representatives and regulators have long held concerns with pressure selling tactics, and the problems and poor consumer outcomes are well documented. It is time for the general insurance industry to take action.

Consumer Representatives consider it is very difficult to abolish pressure selling where there are incentives placed on salespeople (employees, authorised reps or third dirties) to make sales or reach targets. The use of commissions and bonuses which is endemic in the Australian finance industry provides a direct incentive for poor sales practices. Consumer Representatives consider the deferred sales mechanism for add-on sales is a particularly useful response to pressure selling in these circumstances, particularly because the consumer did not seek out the product. A useful way to disrupt pressure selling in a commission-sales environment is to provide a "break" so that the consumer is not captured and abused into making a purchase.

The Interim Report states that the ICA proposes that the Code should strengthen standards relating to third-party distributors and welcome feedback on whether the Code should more broadly include standards on pressure selling.

Consumer Representatives strongly support the use of formal agreements with distributors to prohibit pressure selling, however it is our view, as expressed above, that the easiest way to do so would be to subject all third parties who engage in sales to the Code.

It is important that these formal agreements be appropriately monitored as per the requirements of RG 104 to ensure that such practices no longer occur. Ensuring all third parties meet the standards set by the Code will again be the easiest way to do this.

With respect to standards to set in the General Insurance Code – these should at the very least match the standards set by the Life Insurance Code at clause 4.3 which commits insurers to implement sales rules for staff to:

> *conduct sales appropriately and prevent pressure selling or other unacceptable sales practices. These will include:*
>
> *a) how to identify if someone is unlikely to ever be eligible to claim the benefits under a policy;*
>
> *b) having clear rules on when our staff must stop selling if you indicate you do not want a Life Insurance Policy being offered or if it becomes clear that you will be unlikely to ever be eligible to claim the benefits under the policy;*
>
> *c) how to record and keep adequate evidence that you have genuinely consented to purchase the Life Insurance Policy;*

d) the minimum information that must be disclosed to you about the premium, features, benefits, exclusions, limits and cooling-off period of the Life Insurance Policy; and

e) compliance performance measures included in our staff incentive programs including consequences if we identify they have engaged in pressure selling, incentivisation of financial advisers contrary to law or other unacceptable sales practices.

The Code should be amended to include a section on sales practices and advertising. The Code should include a standard that requires a Code Subscriber to clearly document its sales rules to ensure that employees, Authorised Representatives and other third party sellers conduct sales appropriately and do not engage in pressure selling and other unacceptable sales practices.

The commitments should also be designed to ensure that the practices described in ASIC's 2011 Report 256 and 470 are not permitted including:

- persistent pitches
- keeping consumers 'captive';
- using the cooling period as a selling point;
- unfairly highlighting the benefits of insurance over cheaper more responsible alternatives;
- masking the cost of loans
- pre-filling forms; and
- sales scripts not allowing customer to say no.

Recommendations

261. The Code should prohibit pressure selling and other unacceptable sales practices for all employees, authorised representatives and Authorised Financial Services Licensees acting on your behalf.

262. The Code should match the standards set by the Life Insurance Code at clause 4.3 and be designed to prevent the practices described in ASIC's 2011 Report 256 and 470.

vii. Customer communications

a. When insurance is not offered

Discussion Point 7: To address the concerns raised above, is a satisfactory solution for clause 4.8(b) in the current Code to be amended to state "we will inform you of your right to ask for the information that we have relied on in assessing your application and, if you request it, we will supply it in accordance with Section 14 of this Code." Please identify any concerns with this approach.

Consumer Representatives support amending clause 4.8(b) to include the above statement.

Recommendation

263. Clause 4.8(b) should be amended to include the statement:

"we will inform you of your right to ask for the information that we have relied on in assessing your application and, if you request it, we will supply it in accordance with Section 14 of this Code."

b. Verification of a customer's disclosure

Discussion Point 7.1: Given the obstacles noted above regarding verifying disclosure at the point of sale, would a satisfactory alternative be for the Code to require that a customer is contacted as soon as an insurer becomes aware of an issue with their disclosures? What are the advantages and disadvantages of this approach?

Consumer Representatives do not accept that the issues raised by the insurers with respect to verification of customer's disclosure are the insurmountable obstacles that the Interim Report asserts.

The Interim Report states that:

> *A number of insurers have advised that they do not have easy access to this data and that access to consumer information through a third party insurance report service can be ambiguous. For example, withdrawn claims may be shown as declined, which could lead to an insurer believing a customer may have failed to disclose a previously declined claim. Insurers have also noted that it could be costly to have to generate an external insurance report for every sale.*

If this admission is true, the maintenance and development of insurance reports is a serious failure that will further lower consumer confidence and trust. This is clearly a serious issue that needs to be immediately looked at. If general insurers cannot rely on insurance reports for clear information, they should either take immediate action to improve the information being provided or simply close down the entire insurance reports system.

Financial Rights raised a number of concerns with insurance reports in its submission. They recommended that:

> *A guide should be developed by the ICA which is enforceable through the General Insurance Code. The guide would cover consumer rights and insurer responsibilities in using insurance reports.* [51]

Consumer Representatives note that this recommendation and the issues raised by Financial Rights were not mentioned in the Interim Report even in the section titled "What the Code does not cover?"

Given the statement of insurer's lack of faith in the insurance reports system, it is clear that this is an issue that needs to be addressed in this review.

With respect to the statement that "it could be costly to have to generate an external insurance report for every sale" this is a ball that is clearly in the court of insurers. Insurance reference service is operated by a third party, that is obviously a for profit enterprise. This does not necessarily have to be the case, and it is in the power of the holders of the data – i.e. general insurers – to develop a cheaper costing recovery system. Furthermore, the banking sector has been using credit reports and paying for access for years. If banks can afford this it is difficult to see why general insurers can not.

The Interim Report then goes on to state that:

> *In addition to this, insurers have noted that accessing a consumer's driver history and criminal record are not processes that happen in real time, and there are privacy concerns involved that would require the individual's consent. This could cause major delays in the sales process, as it can take significant time to receive this information.*

It is our understanding that consumer driver history can be accessed in real time with consent and already does under, for example data sharing arrangement in CTP in NSW.[52] Obviously privacy concerns should be taken into account and can be dealt with appropriately.

There may be delays elsewhere with other data due to legacy systems, however if there is a will, these systems could be updated.

Policyholders who have not fully disclosed the information that they need to disclose – be it because of a lack of memory, unable to access the appropriate documents or they simply lied, are currently driving around with illusory insurance. It is clear that it is in the interests of insurers not to bring this up with the policyholder given they are receiving premiums,

[51] p136

[52] Regulation 109 of the *Road Transport (Driver Licensing) Regulations 2008* (NSW) also allow RMS to enter into arrangements with CTP insurers to provide for the disclosure to the insurer, with the consent of the driver, as to the number of demerit points issued to a driver.

sometimes for years on end, and able to deny a claim on a matter that could have been easily checked up front.

Given we have the technology, the government is introducing a consumer data right and opening up data more generally, Consumer Representatives call on the ICA to reconsider this issue.

Similar to the Life Code provisions, we believe that the Code should require that a customer is contacted by an insurer as soon as an insurer becomes aware of an issue with their disclosure.

Recommendations

264. Commitments with respect to an improved Insurance Reporting regime should be included in the Code.

265. In the light of a new consumer data right, the ICA should reconsider their approach to the verification of a customer's disclosure.

266. The Code should require that a customer is contacted by an insurer as soon as an insurer becomes aware of an issue with their disclosure.

c. Policies with no-claim discounts (NCDs)

Discussion Point 7.2: Should the Code contain measures aimed at increasing consumer understanding of NCDs or have insurers taken reasonable steps to improve this? If the Code were to include measures, please provide examples.

Consumer Representatives remain concerned with the impact of no claims discounts. In addition to the issues identified by ASIC regarding their confusing, unclear and non-transparent nature, NCDs discourage claims where it is in the legitimate interest of the consumer to claim, and also encourage business models such as the car-napping industry.

We believe that the recommendations of the ASIC review should be included in the Code, under the guidance on best practice disclosure principles at Proposal 2 and in a new section on Advertising. Given the Interim Report states that the "many insurers have implemented ASIC's recommendations in the past two years" it will not be a stretch to incorporate these recommendations. Specifically ASIC recommended the following:

> *Recommendation 1*
>
> *Where insurers retain the traditional NCD pricing model, insurers should clearly disclose the effect of a claim on a policyholder's NCD rating and underlying premium. Where relevant, insurers should clearly disclose whether claims can affect the underlying premium independently of any effect on the NCD rating.*
>
> *Recommendation 2*

Where insurers retain the traditional NCD pricing model, policyholders should be made aware of the cost and value of purchasing ratings protection. Disclosure of the automatic inclusion of optional extras, such as ratings protection, on policies at renewal should be prominent.

Recommendation 3

Insurers should review and, where appropriate, improve disclosure and/or make available additional information on the operation of NCD schemes, where such schemes are retained.

Disclosure should be appropriately balanced so that consumers are not discouraged from making valid claims under their policies

Recommendation 4

Insurers should disclose to consumers the existence of minimum premiums. Where the minimum premium is sufficiently high to have the potential to affect a policyholder's ability to realise their full discount and other promotional entitlements, that risk should be disclosed.

Recommendation 5

Insurers should ensure that promotional messages on the benefits of NCD schemes, where such schemes are retained, are carefully balanced against the actual features, risks and practical operation of the NCD scheme.[53]

Recommendations

267. Implement the ASIC recommendations in Report 424 by requiring that:

a) Where insurers retain the traditional NCD pricing model, insurers should clearly disclose the effect of a claim on a policyholder's NCD rating and underlying premium. Where relevant, insurers should clearly disclose whether claims can affect the underlying premium independently of any effect on the NCD rating.

b) Where insurers retain the traditional NCD pricing model, policyholders should be made aware of the cost and value of purchasing ratings protection. Disclosure of the automatic inclusion of optional extras, such as ratings protection, on policies at renewal should be prominent.

c) Insurers should review and, where appropriate, improve disclosure and/or make available additional information on the operation of NCD schemes, where such schemes are retained.

d) Disclosure should be appropriately balanced so that consumers are not discouraged from making valid claims under their policies.

e) Insurers should disclose to consumers the existence of minimum premiums. Where the minimum premium is sufficiently high to have the potential to affect a

[53] pp. 6 ASIC, *Report 424: Review of no-claims discount schemes* http://download.asic.gov.au/media/3001588/rep424-published-26-february-2015.pdf

policyholder's ability to realise their full discount and other promotional entitlements, that risk should be disclosed.

f) Insurers should ensure that promotional messages on the benefits of NCD schemes, where such schemes are retained, are carefully balanced against the actual features, risks and practical operation of the NCD scheme.

viii. Monitoring, enforcement and sanctions

a. Reporting of Code breaches

Discussion Point 8: Would a redrafting of Clause 13.1 of the Code to read "Anyone can report alleged breaches of this Code to the CGC" sufficiently address the issue noted above? Is an alternative solution needed?

Consumer Representatives strongly support redrafting clause 13.1 to read "Anyone can report alleged breaches of this Code to the CGC."

It may be worth considering including a list of potential complainants including, but not limited to, policyholders, FOS, consumer advocates, legal professionals.

Consumer Representatives would also note that the practicalities of the breach reporting process are such that there is not a high level of awareness on what is involved. Consumer Representatives can report that many solicitors did not realise that there were contact details available on the CGC website. Even when they knew of the CGC webpage's existence they had not seen the email address.

We also believe that very few consumers would know that there is a second step process in lodging a breach report after finalising their dispute. When they do find out this can be frustrating. It is also unclear from the webpage when someone can submit an alleged breach, if they have not first gone through the IDR and subsequent FOS process.

Recommendations

268. Clause 13.1 should be redrafted to read "Anyone can report alleged breaches of this Code to the CGC."

b. Interpretation of Code standards and process for appeal

Discussion Point 8.1: The ICA suggest that provisions such as honest, fair and timely should operate in relation to the standards in each section. Is there a way for these terms to be appropriately defined if this approach is not taken?

Consumer Representatives strongly oppose the ICA's suggestion that provisions such as honest, fair and timely should operate only in relation to the standards set in each section and wholeheartedly agree with the CGC that clauses 4.4, 6.2, 7.2, and 10.4 be amended to remove the words "…in accordance with this section…", so that it is clear that each of these subsections operates as a stand-alone provision.

If efficiency, honesty, fairness and transparency as required in clause 4.4 were limited to only those matters detailed in the 10 sub-clauses of the section it would be a severe restriction of the common sense understanding of these terms.

This interpretation will mean that any significant dishonesty, unfairness, inefficiency from a service supplier that isn't explicitly covered under Section 6 will not be captured by this standard. Given the limited number of requirements placed on service suppliers under this section, for example, it really means that anything not strictly legal and not referred to in the 7 clauses of Section 7 is up for grabs. If the ICA takes this approach, Consumer Representatives would argue that a significant expansion of the Code will be required to capture every dishonest trick, poor practice, sales tactic and inefficiency that takes place in order to capture and fill out the terms.

This proposal is a significant reading down and undermining of the stated intent of the Code (as outlined in Section 2 and Foreword) and insurers requirements under the law: section 912A(1)(a).[54] It is also contrary to the expectations outlined explicitly in ASIC Regulatory Guide 104 which states that:

> *The general obligations are principles-based and designed to apply in a flexible way. For this reason, we do not think we can or should give prescriptive guidance on what you need to do to comply with them. The Corporations Act places responsibility on you to decide how to comply.* [55]

We would also note that the phrase "in accordance with this section" seems to have only been introduced in the most recent version of the Code and does not appear in all previous versions of the Code.

This approach risks exacerbating already high levels of community distrust and lack of confidence. Given the range of misconduct and behavioural issues in the financial services sector which have led to the establishment of the Royal Commission, we believe it is unwise for the ICA to take this short-sighted approach.

Recommendation

269. Consumer Representatives strongly oppose the ICA's suggestion that provisions such as honest, fair and timely should operate only in relation to the standards set in each section and believe that clauses 4.4, 6.2, 7.2, and 10.4 be amended to remove the words "…in accordance with this section…", so that it is clear that each of these subsections operates as stand-alone provisions.

[54] "do all things necessary to ensure that the financial services covered by your licence are provided efficiently, honestly and fairly"

[55] ASIC Regulator Guide 104: Licensing: Meeting the general obligations http://download.asic.gov.au/media/3278615/rg104-published-1-july-2015.pdf RG 104.7

Discussion Point 8.2: What would be the advantages or challenges if the CGC were to regularly publish its decisions on a de-identified basis?

Consumer Representatives note that the CGC already publishes a selection of de- identified breach decision case studies in their Annual Report.

We believe that more transparency is always a good thing and would support the regular publishing of CGC decisions.

Ideally, for greatest transparency, all insurers would be fully identified, as we believe consumers have the right to know which insurance companies are not meeting their requirements. We understand that this would be strongly opposed by insurers because of the reputational damage that it can cause, however this would act as a significant incentive for insurers to meet their Code obligations.

Recommendation

270. Consumer Representatives support the regular publishing of CGC decisions and identifying all insurers to incentivise compliance with the Code.

Discussion Point 8.3: Are there any issues that need to be taken into account if the Code were to require that, where a CGC decision has a significant and/or broad industry impact, there is an ability to appeal? Should the industry be able to provide a collective submission on Code interpretation?

Consumer Representatives strongly oppose any move to introduce an appeals process.

The CGC is the industry's independent monitoring and enforcement body overseeing compliance with the code. The CGC's raison detre (along with all industry Code bodies) is to make independent decisions about code breaches that from time to time will identify systemic issues that need addressing. These decisions by their very nature will impact upon the entire industry. They conduct this role impartially and objectively.

Consumer Representatives note that FOS includes a mechanism to review the approach taken by FOS in determination. This however is only directed at service standards and not the merit of cases. There is also a significant difference between the role of FOS and the role of a Code administrator. FOS is an EDR service that acts as an alternative to court and serves the community to resolve disputes between consumers and financial service providers. The CGC independently administers, monitors and enforces Code standards to which general insurers have agreed. These are two very different roles.

We note too that if an insurer or any individual or entity has a complaint concerning the CGC, this is already dealt with under section 7 – Complaints concerning CGC under the Code Governance Committee Charter[56] which states that:

> *any complaint that the CGC has not acted in accordance with the Code or the Charter received by the CGC or referred to it by the ICA or FOS.*

This is appropriate.

Adding an appeals process would however fundamentally undermine the independence and enforceability of the decisions of the industry's own Code Administrator. They are already the independent umpire. Introducing an appeals process would make a mockery of the governance regime and weaken the independent umpire role of the CGC. This will further erode trust and confidence in a sector whose customer trust and confidence are currently hitting historic low points.

An appeals process is not envisioned or referred to under RG 183. "The success of the code in protecting consumers and raising standards," RG 183.35 states, "depends on ensuring that subscribers comply with the provisions of the code." The Code Administrator is responsible for this. Not a second body. Without this Code Administrator there "may be little incentive for subscribers to continue to comply." Providing an appeals process has the potential to act as a disincentive to comply as it will give a second chance to insurers who are deemed to have breached and an incentive to push the boundaries.

Furthermore it is not clear if an insurer or industry body would appeal to the ICA, FOS, a court or some other independent umpire.

An appeals process is an attack on the very nature of the CGC. An appeals process will fundamentally undermine the ability of the CGC to monitor the code, and will neuter and weakened their duties. The CGC already has an industry representative on the Committee who will take into account the significant and/or broad industry impact of the Committee's decisions.

If the industry has a major concern with the impact of a CGC decision it already has two important redress options. It can change the Code accordingly at the next Code review, or it can appoint a different Industry representative to the Committee.

Recommendation

271. Consumer Representatives strongly oppose any move to introduce an appeal process.

272. Consumer Representatives oppose any moves for industry to make collective submissions to the CGC on Code interpretation

[56] http://codeofpractice.com.au/assets/The%20Code%20Governance%20Committee%20Charter.pdf

c. Reporting of Significant Breaches

Discussion Point 8.4: Would the issue identified above be appropriately resolved if the definition of Significant Breach in the Code was amended to remove the words "likely breach". Do you have any concerns with this proposed change?

Consumer Representatives strongly oppose the removal of the words "likely breach" from the definition of "Significant Breach."

Obligations to notify licensee breaches to ASIC under Section 912D of the *Corporations Act 2001* refer to "licensee breaches, or is likely to breach." ASIC Regulatory Guide 78 also refers to and provides guidance as to what "likely to breach" mean.[57] RG 78.9 states:

> *You are likely to breach an obligation if, and only if, you are no longer able to comply with the obligation*

While these apply to a general insurer's obligations under the AFSL regime, it should also apply to breaches and likely breaches of the Code. To do so would be to significantly narrow the obligations insurers have placed upon themselves.

It makes no sense that a significant breach is limited to actual breach only and not likely breaches. The insurer will have had to have already acted as judge and jury on the matter. The breach would have to be clear and discrete – there can be no grey area whatsoever as the insurer would have to be confident that it was an actual breach.

This will not promote good practice, and there is a higher risk that such practices will continue to be conducted, and consumers will be worse off

Recommendation

273. Consumer Representatives strongly oppose the removal of the words "likely breach" from the definition of "Significant Breach."

[57] ASIC Regulatory Guide 78: Breach reporting by AFS licensees, RG 78.9-78.10
http://download.asic.gov.au/media/1239857/rg78-published-26-february-2014.pdf

d. Relationship between Code breaches and EDR

Discussion Point 8.5: To address the confusion noted above, is an appropriate solution for the monitoring process in the Code to include the following:

a) **The CGC should determine whether a breach allegation has also gone to IDR/EDR, and if the issue is more appropriate for an insurer's complaints process, then it can be referred there.**

b) **If a breach allegation is currently being heard at EDR, then the CGC should await the outcome of this before investigating.**

c) **EDR should provide details of possible Code breaches to the CGC once a determination is made**

Do you have any concerns with this approach or an alternative suggestion?

Consumer Representatives understand that the CGC already determines whether a breach allegation has also gone to IDR/EDR and if the issue is more appropriate for an insurer's complaints process, then if it can be referred there.

We do not support the introduction of a rule to limit the power of the CGC for it to await the outcome of an EDR dispute before investigating an alleged breach of the Code. While Consumer Representatives are aware that this is the case under other Codes, this has not been the case under the CGC and should not change. The CGC should have discretion whether to initiate an investigation in parallel or wait for the EDR outcome. We believe that it is the other codes that are out of step with good practice. This is because EDR and the CGC are dealing with two very different things. FOS is seeking to resolve an individual dispute on the facts. The CGC is examining the conduct and services standards of the code subscriber. These are mutually exclusive tasks that can occur distinctly and in parallel. It would also significantly delay the work of the CGC as it does already in other Codes.

As we understand the current process, FOS does already provide details of possible Code breaches to the CGC. We support this but it should not be tied the final determination. All alleged breaches should be provided to the CGC to consider investigation.

Recommendation

274. **Consumer Representatives do not support the introduction of a rule to limit the power of the CGC for it to wait for the outcome of an EDR dispute before investigating an alleged breach of the Code.**

ix. Promotion of the Code

Discussion Point 9: Would it be beneficial if the Code included more information about the CGC's role and its areas of focus, such as:

a) **to monitor and enforce the Code through investigations and analysis of data and evidence**

b) **to provide leadership to industry and help subscribers understand and comply with their obligations and seek continuous improvement of insurance practices**

c) **to liaise with the ICA**

Is there any other additional information that could assist with improved understanding of the CGC?

Consumer Representatives agree with ASIC that the powers and responsibilities of the CGC should be extended to include reporting systemic Code breaches and serious misconduct to ASIC, consistent with the requirements in RG 183.78(f). This will help to ensure that systemic non-compliance and serious misconduct is identified and reported appropriately.

Consumer Representatives also believe that some form of external or independent monitoring or auditing from time to time is more than appropriate. This is not to usurp the role or independence of the CGC in anyway, simply a good practice additional mode of compliance.

Providing more information about the powers of the CGC in the Code or the website, as suggested by the Interim Report,[58] does not in itself address the issues raised, however including such information on the website is welcomed by Consumer Representatives.

Recommendations

275. **Consumer Representatives believe that the powers and responsibilities of the CGC should be extended to include reporting systemic Code breaches and serious misconduct to ASIC, consistent with the requirements in RG 183.78(f).**

276. **Consumer Representatives also believe that some form of external or independent monitoring or auditing from time to time is more than appropriate.**

Discussion Point 9.1: The Code website could be expanded to include:

a) **promotion of the CGC and its role and areas of focus**

b) **de-identified decisions of the CGC**

[58] at p. 46

c) **guidance to insurers through the use of scenarios and FAQs**

d) **online annotations, explanations and examples to aid consumer understanding of the Code**

Is there any other information that should be included on the Code website?

Consumer Representatives support these features being included on the Code website.

Taking a look at the Code website and Governance and Monitoring webpage we would make the specific observations:

- The Breach Reporting email address is not on the front page – it is hidden on the Code website filed under Governance and Monitoring: http://codeofpractice.com.au/governance-and-monitoring
- If you then go to this page, the email address is not highlighted and is simply a sentence amongst a page of dense text, four paragraphs in.
- Clicking on the link only opens a blank email in which you have to write about your breach. There are no instructions on what to write or what can be reported to the CGC.
- We would note that "Lodging a dispute" with FOS is much clearer in that there is a bold green button on the top right of the front page. Once clicking it there is a step by step process for people, which is clear and logical.
- We would also note that the Code of Banking Practice Code Compliance Management Committee (**CCMC**) has its own separate standalone page with the Code of Banking Practice on the ABA's website. The website includes a separate page on instructions on reporting a concern at http://www.ccmc.org.au/for-consumers-small-business/before-you-report-a-concern/ although this is far from ideal as it is designed in a negative sense – i.e. the page from where you can report a concern is titled "Before you report a concern." This seems to be attempting to prevent large numbers of complaints. This could easily be fixed by taking the same approach as FOS's lodging a complaint which filters people out via their step by step process.

We would recommend that FOS approach be taken by the CGC with a bold and prominent "Report a Breach" button on the Code website front page and Governance and Monitoring Page. There should then be a subsequent filtering and step by step reporting process.

We would also recommend a standalone CGC page similar to the CCMC, or a more prominent page link on the Code page.

Recommendations

277. **Consumer Representatives recommend the ICA update the Code website and include the following elements:**

a) **promotion of the CGC and its role and areas of focus;**

b) **de-identified decisions of the CGC;**

c) **guidance to insurers through the use of scenarios and FAQs;**

d) online annotations, explanations and examples to aid consumer understanding of the Code;

e) a bold and prominent "Report a Breach" button on the website front page and Governance and Monitoring Page. There should then be a subsequent filtering and step by step reporting process.

278. We also recommend a standalone CGC page similar to the CCMC, or a more prominent page link on the Code page.

Discussion Point 9.2: Would a summary of the key consumer commitments in the form of a "customer charter" be useful for consumers? Please advise if a more engaging tool could be adopted or if you have any concerns with this proposal.

A customer charter has some potential but is not a priority for Consumer Representatives. Consumer Representatives would prefer it if general insurers aimed to increase the effectiveness of the Code in addressing specific industry issues and consumer problems not covered by legislation. A customer charter would not be read by consumers (just as the Code is not read by most consumers).

If there are any elements of a customer charter that insurers are keen to include in this, they should be included in the Code.

Recommendation

279. A customer charter has some potential but is not a priority for Consumer Representatives

x. Extending the scope of the Code

a. Corporate culture

Discussion Point 10: The ICA's view is that the Code should not contain a specific provision relating to corporate culture. Please advise any concerns

Consumer Representatives disagree with the ICA's view that the Code should not contain a specific provision relating to corporate culture.

Corporate culture is a central concern of consumers, consumer advocates, government and regulators and is a key reason why the industry has been suffering from a series of never-ending scandals. Any provision developed should be with a view to give effects to the commitments under the code and fostering a culture of customer service rather than one driven by sales and the bottom line.

We do not believe it is hard for insurers to make general commitments in this regard.

Recommendation

280. The Code should contain specific provisions relating to corporate culture.

b. Residential strata

Discussion Point 10.1: Should the definition of Retail Insurance explicitly state that this includes residential strata, excluding mixed-use and high value strata insurance?

Consumer Representatives support the extension of retail insurance to include in its definition residential strata. This is important for some consumers in high risk areas such as North Queensland.

It also reflects the changing profile of Australian home ownership, where an increase in townhouse and apartment complexes has led to historic highs.[59]

Recommendation

[59] Reserve Bank of Australia, Houses and Apartments in Australia, Bulletin, June Quarter 2017 https://www.rba.gov.au/publications/bulletin/2017/jun/pdf/bu-0617-1-houses-and-apartments-in-australia.pdf

281. The Code should extend the definition of retail insurance to include residential strata.

c. Extension of code to business insurance

Discussion Point 10.2: Do you agree with the ICA's view that the current distinction between retail Insurance and wholesale Insurance should remain unchanged? What are the practical implications of extending sections of the Code to wholesale Insurance?

Consumer Representatives note that the ABA is about to introduce a new Banking Code which will include specific section applying to small business. It seems natural that the Code should similarly extend or a separate Code for wholesale insurance should be developed.

Recommendation

282. The Code should be extended to cover wholesale insurance or a separate Code for wholesale insurance should be developed.

d. Application and guidance on the law

Discussion Point 10.3: Do you agree with the ICA's view that the Code should not restate and provide guidelines on existing legal requirements? If not, noting the concerns raised, how can the Code effectively provide guidance on existing legal requirements without cutting across regulatory frameworks?

Consumer Representatives believe that the Code should provide guidance to insurers and refer to current legal obligations under the *Privacy Act*, *DDA* and any other applicable legislative instrument. The Code should not be prevented from restating or referring to a legal obligation when it is committing to an enhanced consumer outcome over and above an existing legislative requirement. The recommendations made above with respect to mental health best practice standards, for example, meet this standard and are not acts of legal interpretation, rather simply commitments to improve consumer outcomes for those with mental health issues.

Consumer Representatives note the proposed inclusion of product design and distribution principles to provide guidance to insurance under Proposal 3 and 4. While we strongly support their inclusion, depending on their implementation by Government, they could in the ICA's

view be "restat[ing] and provide guidelines on existing legal requirements." Their inclusion in the Code is however right and proper and the ICA should not use the "interpreting existing legal requirements" as some excuse not to do so in this case or any other case under the Code.

Recommendation

283. Consumer Representatives agree that the Code should refer to and add to current legal obligations.

xi. Emerging technologies

Discussion Point 11: How can the Code be flexible enough to allow for the use of emerging technologies in insurance sales, customer communication and claims handling?

Consumer Representatives believe that the impact of new technologies on general insurance will bring a significant number of challenges with respect to preventing consumer harm.

In addition to the examples provided in the Interim Report – i.e. robo-advice, robo contact and self managing of claims via apps, there are a raft of other examples:

- the use of connected device data including
    - motor telematics – devices in vehicle recording GPS location data, as well as information from a vehicles engine management system to monitor all aspects of driving style;
    - home telematics – monitoring the use and supply of utilities and security of a home, but also could extend to GoogleNest, Amazon Alexa and Apple HomePod;
    - health monitors – such as wearable fitness devices recording location, movement and other health information;
- the use of other forms of data including:
    - proprietary Data – that is personal data which a company has collected outside the sale of an insurance product including 'lifestyle data' collected from retail loyalty card schemes.
    - data acquired from third parties – for example:
        - credit checks using external agencies;
        - flood mapping data;
        - licence details;
        - insurance reports;
        - no claims discount database;
        - price comparison website quotes and transaction data;
        - aggregated search engine data;
    - social media data – e.g. Twitter, Instagram and Facebook;
- new range of innovative insurance products and InsureTech;
- the rise of peer to peer insurance.

All of these new technologies will lead to potential benefits for consumers and potential harms.

Many of these potential harms have already been identified including:

- risk segmentation and an undermining of the principle of risk pooling;

- price discrimination, increased economic inequality and financial exclusion;
- increased information asymmetry and predatory marketing
- potential exploitation from unscrupulous new InsureTech platforms,
- increased complexity and confusion,
- privacy concerns.

There are other impacts yet to come.

We believe that the ICA needs to get ahead of the game and investigate these issues relating to emerging technologies and provide a report with recommendations for the next iteration of the Code. Digital disruption is happening now and the sector needs to address the opportunities for their businesses but must seriously consider the threats to consumers and potential for poor outcomes.

We believe that while these are critical issues that require research, identification and action, it is important for the sector to first get the basics right with an improved Code based on the proposals that we have supported and amendments as suggested.

Recommendation

284. The ICA should report and consult on how the next iteration of the Code should respond to the needs created by emerging technologies.

x. What the Code does not cover

Discussion Point 12: Do you agree that the areas above are not in the scope of this Code Review? For those areas where non-Code initiatives are underway, are they responding to stakeholder concerns?

Unfair contract terms

Unfair contract terms in insurance this has been a core concern of Consumer Representatives for a very long time. We note too that the Government will be releasing proposals in early 2018 to implement the Australian Consumer law recommendation to apply unfair contract terms to insurance.[60] We welcome this development and emphasise that this problem requires a legislative solution.

We acknowledge that the ICA have recently taken the step to develop a possible approach to applying UCT to insurance contracts, however Consumer Representatives are concerned that this model could carve out a very significant portion of contract terms from the unfair contract terms test and potential review.

We commend the ICA for taking the important step in acknowledging the need for action and taking the steps to at least develop an option to implement UCT protections in general insurance.

Consumer Representatives believe it is appropriate to not address this important issue in the Code but that an appropriate legislated solution be developed that addresses the central concerns of consumers, industry and other stakeholders and is supported by Government.

Addressing affordability and under-insurance

Consumer Representatives agree that issues of affordability and underinsurance a major concern but that the Code should focus on customer service standards. This however should not be read to mean that any proposals in the interim report supported by Consumer Representatives or put forward by Consumer Representatives in this submission that go to directly addressing issues of affordability and under-insurance – such as requiring accurate and informative sum insured calculators – be removed or down-graded as a priority.

[60] Australian Government response to the Senate Economics References Committee report: Australia's general insurance industry: sapping consumers of the will to compare, December 2017 https://static.treasury.gov.au/uploads/sites/1/2017/12/p2017-t248756.pdf

Written-off vehicles

Consumer Representatives disagree with the ICA that standards relating to written-off vehicles not be included in the Code. It is completely appropriate that a customer service standard relating to how insurers approach statutory write-offs be included in the Code.

The Interim Report states that the Code should not intersect with the requirements and process for insurers to put vehicles on the Written-off Vehicle Register (**WOVR**) after an accident. This is inconsistent with the ICA's broad approach to the Code as it intersects with a number of requirements of law and regulation. Indeed the Code is designed to provide industry commitments that extend beyond the law and regulations that currently apply as per RG 183.22 and RG 183.60.

We believe that the ICA and subscribers to the Code should consider basic standards to be included in the Code to address a number of the issues raised by the Financial Rights Legal Centre in their earlier submission to this review. We assert that none of the recommendations interfere with insurer obligations under the law. These include:

- Car owners should be given notice that their vehicle has been assessed by an insurer as a total loss at least 3 business days before the car is reported to a WOVR.
- Notice of a total loss assessment should include information about what kind of write-off the vehicle has been assessed as, whether the vehicle could legally be repaired, what the insurer is intending to do with the vehicle and information about the WOVR.
- Insurers should be more flexible about giving options to car owners that want to organise repairs to their own vehicles even if those repairs are uneconomical.

Renewal notices

We strongly disagree with the ICA that the Code should not be used to prescribe insurer's renewal processes.

We note that the Life Insurance Code prescribes certain information for their annual notices at two points in their Code:

> *6.3 We will provide you with an annual notice in writing each year prior to the anniversary of your Life Insurance Policy. The annual notice will include:*
>
> > *a) the types of cover you are insured for and how much you are insured for;*
> >
> > *b) an explanation for any increase in your premiums in accordance with the terms of your Life Insurance Policy;*
> >
> > *c) information about the risks of cancelling and replacing an existing Life Insurance Policy;*

d) information about how to contact us to discuss options if you want to change the terms of your Life Insurance Policy or are having difficulty meeting your payments; and

e) what to do in the event of a claim.

4.7 If you apply for a consumer credit insurance (CCI) Life Insurance Policy as an add-on to another financial product, either with us directly or through our Authorised Representative, we will:

(g) *provide you with an annual notice in writing each year prior to the anniversary of your Life Insurance Policy. The annual notice will include:*

i. the period of cover;

ii. the types of cover; and

iii. contact details if you have any questions or need to make a claim.

If the FSC feel that is appropriate to prescribe information, there is no excuse for the ICA to not do so. The annual renewal statement is a fundamental document is provided to consumers and it is more than appropriate to include basic customer service standards in the Code with respect to them.

We also do not accept that insurers systems are not currently in a position to provide annual premiums. An annual premium is a fundamental, basic piece of information that insurers hold. It is unacceptable that insurers are using the usual "systems" excuse for a fundamental piece of disclosure information.

If insurers can implement telematics systems recording and analysing every minute detail of policyholder's driving details and fitness, develop multiple apps and engage the power of big data to their underwriting and product development and innovation, insurers can find the power to provide last year's premium to their policyholders.

The Australian Government's has directed Treasury to assess disclosing the previous year's premium on insurance renewal. Introducing a new Code commitment would put insurers ahead of the game.

The Code should require that the renewal notice be accompanied by a copy of the KFS.

Customer communication during the complaints process

Consumer Representatives believe that many of the issues faced by consumers with respect to communications issues during the complaints process and understanding about progress and next steps could be resolved very simply: replace the two step complaints process with a one tier complaints process as we recommend above.

The fact that a flow chart is needed demonstrates very clearly why a one tier process is required.

Standardisation and comparability of cover

We believe that the ICA can make a number of commitments to improve standardisation and comparability of cover under this Code and we have made a number of recommendations above including in the Best Practice Principles for disclosure document:

- a standard PDS structure and format;
- good website design to enable easier access to PDS's and KFS's;
- disclose the previous year's premium on the annual renewal notice;
- provide component pricing of premiums;
- highlight the policy's key exclusions and limits but should also the aspects that are least expected or would be considered a surprise;
- a commitment to introduce standard definitions for the most common terms.

We note that the Australian Government's has directed Treasury to assess the operation of standard cover, particularly the disclosure requirements, and disclosure of prior year premiums and pricing components in renewal notices.

Key Fact Sheets and Key Fact sheets for motor policies

Consumer Representatives believe that general insurers need to work to improve the documents to ensure that they improve comparability and consumer understanding of their products.

While we understand that insurer's are somewhat constrained by regulation with respect to innovation in this area, we assert, again, that the Code can make commitments that move insurers beyond their basic legislated obligations.

Insurers could quite easily make commitments to ensuring that KFS are prominent and easy to find on websites (they are currently not easy to find on many websites), and can commit to developing consumer testing KFS's for motor vehicle policies. Indeed testing innovative forms on KFS's for motor vehicles could provide a significant opportunity to improve upon the mandated form of KFS for home and contents policies.

Disclosure of component pricing

Consumer Representatives strongly disagree with the ICA that disclosure of component pricing should not be addressed under the Code. While there are obvious competition and pricing issues, in no way should these be used as barriers to action. No doubt commercially

sensitive information is a part of the components of a price but these elements are easily obscured using common, well understood statistical and analytical approaches.

We also strongly reject that component pricing may not help consumers to better understand their risks and how they mitigate them. If consumers in Northern Australia understood that a large proportion of their premium and/or premium increase is due to cyclone risk, this is a key piece of information that will lead to behavioural change.

The Australian Government's has directed Treasury to assess explaining premium increases when a request is received from a policyholder. Introducing a new Code commitment would put insurers ahead of the game.

Provision of data/access to information

Consumer Representatives agree with the CGC and ASIC that there is a need for better quality, more consistent and transparent data to identify trends and issues within a product, an insurer or the industry as a whole.

We look forward to the ICA working with the Code Subscribers, CGC, ASIC and the AFCA to improve data.

Consumer Representatives note that APRA and ASIC are currently in the process of introducing a transparent public reporting regime for life insurance claims information. We believe that APRA and ASIC should introduce a similar regime for general insurance.

Governance of the Code

Consumer Representatives believe that while the governance of the Code were not within the scope of this review as announced, we believe that the scope of the Code was too limited in the first place and should have included a complete Independent review of the Code.

We believe that this should be reconsidered by the ICA.

Recommendations

285. The following areas should be addressed in this Code Review:

a) written-off vehicles;

b) renewal notices;

c) key fact sheets including for motor vehicles;

d) customer communication during the complaints process – via the introduction of a one tier process;

e) disclosure of component pricing;

f) provision of data/access to information; and

g) governance of the Code.

286. The following areas should continue to be pursued outside of the Code Review process:

a) unfair contract terms (with a commitment to review policies with a view to removing unfair terms);

b) addressing affordability and under-insurance (beyond those proposals already put forward in this review);

c) standardisation and comparability of cover (beyond those proposals already put forward in this review).

Stakeholder assessment

9: Do the ICA Priority Proposals adequately reflect the priority matters to be addressed by the Code Review?

10: Have the additional Code Review themes been appropriately prioritised for inclusion into a revised Code?

Consumer Representatives believe that the ICA has appropriately captured the large range of consumer concerns that were raised in the initial consultation.

Generally speaking, Consumer Representatives agree with the ICA's priority areas namely that:

1. The Code should strengthen standards relating to vulnerable consumers including:
    - A new Code section on vulnerable consumers
    - The provision of guidance on best practice mental health principles
    - The provision of guidance on recognising and responding to instances of family violence
    - Stronger Code standards on financial hardship
2. The Code should provide guidance on best practice disclosure principles
3. The Code should include product design and distribution principles and provide guidance to insurers
4. The Code should provide product design and distribution guidance specific to add-on insurance products
5. The Code should strengthen standards relating to third-party distributors
6. The Code should strengthen standards relating to service suppliers
7. The Code should include mandatory standards for Investigations
8. The revised Code should meet the requirements for ASIC approval

In addition to these we would add to further themes identified in the "Additional Code Review Themes" that we believe should be priority areas.

The first is the claims area. As evidenced by the vast array of issues relating to the claims process, there is a clear need to act to improve the claims process. The claims process is a source of incredible frustration for consumers, which would be ameliorated to a significant extent if the proposals put forward in the Interim Report (with a few adjustments recommended in this submission) were introduced under the Code.

Second, is the complaints and disputes process. While the Interim Report has rejected recommendations to streamline the process, we urge the ICA and subscribers to reconsider this position as a priority. The complaints and disputes process, like the claims process is a major source of frustration, exacerbated largely by the confusion wrought by, and the complexities found in the two stage process. Insurers have a clear opportunity to improve

confidence in their industry by shifting towards a more consumer-focussed complaint process, and away from a process that merely serves the bureaucratic needs of the organisation and the bottom line.

The third is pressure selling, given the huge weight of evidence of harm and the urgent need to address the issue.

Finally we wish to raise as a final priority area, monitoring, enforcement and sanctions. Not only are enforcement and sanctions critically important for building consumer trust in the effectiveness of a self-regulatory Code, we are seriously concerned that the proposals put forward by the ICA in the Interim Report will significantly undermine the power of the independent CGC.

In addition to this there are a number of proposals made under the Additional Code Review themes. We believe that these should be implemented (with adjustments and changes as recommended in this submission) and should not be held off because they are lower priority. These should not be held off because they are lower priority. They should be addressed and dealt with now, otherwise they may never be addressed, as other more urgent, higher priority issues may arise in the meantime.

Concluding Remarks

Thank you again for the opportunity to comment. If you have any questions or concerns regarding this submission please do not hesitate to contact Drew MacRae, Policy and Advocacy Officer at Financial Rights Legal Centre on (02) 8204 1386 or at drew.macrae@financialrights.org.au .