Submission by the Financial Rights Legal Centre

on behalf of the Consumer Federation of Australia

Independent Review: Initial Consultation Paper, April 2024

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Financial Rights Legal Centre has drafted this submission on behalf of the Consumers Federation of Australia. The following organisations have contributed and are signatories to this submission:

- Australian Consumers Insurance Lobby
- The Australian Research Centre in Sex, Health and Society
- Consumer Action Law Centre
- Council of the Aging
- Eros Association
- Financial Rights Legal Centre
- Financial Counselling Australia
- Mortgage Stress Victoria
- Owners Corporation Network
- Mob Strong Debt Help
- South Australian Financial Counsellors Association
- Westjustice

Overview and summary

Since the last review of the General Insurance Code (**the Code**) in 2018, there have been 17 extreme weather event catastrophes and a pandemic all of which have tested the sector and found it to be wanting.[1]

A surfeit of evidence is available in multiple reports with accompanying recommendations delivered during this period on a range of topics from claims handling failures and pricing practices to poor data handling and disclosure practices.[2] All of these demonstrate that the general insurance sector is falling short of community expectations and failing insurance customers – particularly those experiencing vulnerability.

While a range of reforms arising out of the FSRC have been implemented to address some of the problems identified in the legislative framework, they have not addressed many critical, on-the-ground matters that negatively impact consumers in their everyday engagement with insurance.

The insurance sector needs to lift its game and the Code needs to be strengthened.

Strengthening the Code should involve clarifying key principle-based commitments and making these more robust and enforceable. At the same time, the Code should provide more specific detail and prescription to enliven these principles to ensure that consumers and insurers can understand what minimum standards are expected.

Central to improving outcomes for consumers is to build a Code that serves all people including those experiencing vulnerabilities. In this way the Insurance Council of Australia (**ICA**) is correct to identify the catastrophe response, financial hardship and customer vulnerability as three of the key focus areas for this current Code review.

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[1] Cat 195 2019/20 Black Summer Bushfires; Cat 196: SEQ hailstorms (QLD); Cat 201 January Hailstorms (NSW, QLD, ACT, VIC); Cat 202 East coast storms and flooding; Cat 203 COVID pandemic; Cat 204 Halloween Hailstorm; Cat 211 Perth Hill Bushfires; Cat 212 Extreme Weather Event; Cat 213 Cyclone Seroja; Cat 214 Victorian Extreme Weather and Flooding; SE 215: Mansfield Earthquake; Cat 216: SA VIC Severe Storms; Cat 221 SE QLD and NSW Floods; SE 222: NSW Severe Weather; Cat 223: Victorian, NSW and Tasmanian Floods; SE 224: Central West Floods; SE 225: River Murray Floods; SE 231: Newcastle Hailstorm; Cat 232: Tropical Cyclone Jasper; Cat 233 Christmas & New Year Storms: Impacting Queensland, Victoria, and New South Wales; SE241 Valentines' Day storms; SE 242 April Storms

[2] There are at least 30 general insurance specific reports, investigations and submissions listed in the bibliography to this submission.

The problem though is to see these topics as somehow divorced from the entire journey of insurance. Siloing vulnerability to its own discrete area as something to address separately is counter to the tenets of inclusive design – an approach that insurers need to take heed of. Addressing vulnerability means improving and adding to commitments in most of the sections of the Code – including buying and cancelling insurance, claims handling, complaints, access to information, investigations as well as those that apply to internal employees and third parties (including service suppliers and distributors).

Rising the tide for those Australians who find themselves facing any number of difficulties when engaging with insurance will lift all boats. Embedding an inclusive design approach to both the Code, and the commitments within, will ensure that insurer service delivery and product design will better serve the risk mitigation partnership between insurers and their customers, and address many of the problems faced by consumers outlined in this submission.

This submission urges insurers to take on the challenge and make a series of specific commitments to restore trust in a sector that consumers rely heavily on. Insurance is an essential service and insurers need to meet the moment through an improved Code.

Self-regulation is a privilege not a right. If the Code is to maintain its legitimacy in the eyes of consumers, and confidence in the sector is to be improved, general insurers must commit to a significant uplift in the Code.

Key areas to be considered

Financial Hardship

2.1 Does the Code provide adequate protections to ensure customers facing financial difficulties are obtaining suitable and appropriate assistance from insurers? If not, how can it be improved? For example:

(a) Should the Code adopt the expectations identified by ASIC relating to financial hardship? If not, why not?

(b) Should the Code more explicitly address financial hardship in relation to the payment of premiums or distinguish between assistance available to those with short -term financial hardship, compared to those for whom financial hardship is more entrenched. If so, how?

The Code does not provide adequate protections for those experiencing financial hardship.

The Code should adopt the expectations identified by the Australian Securities and Investments Commission (**ASIC**) relating to financial hardship, in line with the expectations of RG 183.

The Code should also address financial hardship in relation to the payment of premiums.

Financial hardship is a major driver of vulnerability, and often correlated with a range of other forms of vulnerability.[3] As such, the financial hardship section of the Code needs to be seen as a part of subscribers' broader commitment to building more inclusive service delivery and product design. The current financial hardship section provides a solid platform upon which to build a more comprehensive approach to supporting those experiencing long- and short-term financial difficulties.

Premium hardship

The lack of availability of premium hardship assistance has long been a c gap in the legislative framework for insurance. The introduction of hardship obligations in the credit space early last decade was a lost opportunity to build hardship principles throughout the financial services sector including in insurance. The insurance sector has subsequently largely

[3] See International Standards Organisation (**ISO**), ISO 22458:2022, Consumer vulnerability — Requirements and guidelines for the design and delivery of inclusive service, April 2022, Table 1

managed to avoid the issue and when it has to deal with it, say in the COVID-19 period, it has failed to do so in a systematic and consistent manner.

The lack of a specific legislative regime to require action on premium hardship makes the Code *the* place to put flesh on the "fairly, honestly and efficiently" bones.

Consumer groups have raised - and had rejected - the issue of premium financial hardship in the previous two Code reviews. For consumers, the consequences of financial hardship impacting upon their ability to hold home, contents, motor vehicle and other general insurances has the potential to have a far greater and more immediate impact on their well-being than their ability to meet repayments under a credit contract – especially when their policy needs to be relied on. Yet they have legislative rights in relation to credit and not insurance. We appreciate that insurer's cannot provide insurance for nothing, but there is a lot of room to provide assistance to prevent the immediate partial or total loss of a major asset, or the disastrous financial fallout from an uninsured motor vehicle accident, due to temporary financial hardship without coming close to providing insurance for free.

Home building and contents, motor vehicle and other key general insurance products provide security and well-being and are therefore essential.

When in 2017 the issue was raised in the last review by the joint consumer submission, the General Insurance Code Governance Committee (**CGC**) and the Law Council the ICA acknowledged the fact that:

> "[e]ntering into a Financial Hardship arrangement where a customer has not paid their premium has been included in a limited way, through the family violence guidance document"[4]

Nevertheless, the ICA rejected the proposal to address premium hardship more broadely on the basis that:

> [e]xtending this further to anyone who identifies themselves as a consumer experiencing vulnerability could be difficult, as it would mean that an insurer is making an assessment about someone's vulnerability as well as their more objective assessment of Financial Hardship.

[4] Page 24, ICA, Review of the General Insurance Code of Practice, June 2018

> Taking into account the high numbers of existing general insurance policies, requiring general insurers to enter into arrangements with customers who request premium holidays or to make up their premium the following month would be administratively burdensome and costly.

This position is no longer tenable. It did not meet community expectations then and it does not meet community expectations now.[5]

Subsequent natural disasters, the impact of COVID-19 and the ongoing cost of living crisis, have exposed the failure of the sector to address this issue sooner.

During the COVID-19 pandemic, many insurers did provide a strong response with respect to premium hardship measures and were largely transparent and proactive in doing so. This demonstrated that appropriate and flexible premium hardship responses are possible when there is genuine financial difficulty, and insurers are motivated to maintain customers.

Unfortunately, some insurers did not provide a strong enough response meaning that there was a lack of consistency. The measures ranged from the vague to piecemeal – ensuring that the support people received varied depending on which insurer they were with. Whether someone experiencing financial hardship was able to be supported in an appropriate manner was therefore wholly dependent on chance and the willingness of individual insurers to provide minimal support, best practice support or somewhere in between.

Financial hardship practices should not be an area of competitive tension, nor one based on the size of the insurer. Financial hardship should be a minimum standard in service provision.

During the COVID-19 crisis, ASIC outlined their expectations of general insurers with respect to "build[ing] a more complete and robust hardship framework into their ongoing business model."[6] These provide a solid framework for minimum standards upon which insurers subscribers can commit.

[5] We note too that the ACCC addressed a further set of insurer objections to providing premium financial assistance, see pages 386-387, ACCC, 2020, Northern Australia Insurance Inquiry – Final Report

[6] See ASIC, ASIC's expectations of general insurers: responding to consumers in financial hardship, 22 April 2021

Further improvements

In addition to introducing the right to premium hardship support, the Code should be improved in line with the expectations of ASIC, CGC[7] and the Australian Competition and Consumer Commission (**ACCC**)[8] with respect to communication practices, the collection and monitoring of financial hardship data, and engagement with customers.

We address further specific improvements in answer to **Questions 2.2 and 2.3** below.

There are also other measures that should be considered to improve insurers approach to affordability and its link to financial hardship: See **Question 4.1** re: Affordability.

Regarding distinguishing between the short term or long-term nature of the financial hardship, the Code should not necessarily do this. Clause 123 already includes a non-exclusive list of the types of assistance that will be available to insureds that applies to all the types of financial hardship that is currently considered under Clause 107. Each circumstance is unique and may require different approaches. It may also be hard to distinguish and add unnecessary complexity.

Ultimately, our organisations recommend that the Code be re-drafted in a way that embeds inclusive design principles such that the services or rights available under the Code are accessible to, and usable by, the greatest number of consumers possible.[9]

Recommendations | Financial Hardship

1. **Part 10 and specifically Clause 107 should be updated to commit insurers to provide financial hardship assistance to those experiencing premium hardship.**
2. **Clause 123 should be updated to include the following additional arrangements that can be considered for hardship support including for premium hardship:**
   - **(a) reviewing payment terms and dates**
   - **(b) providing short-term premium waivers and discounts**
   - **(c) permitting a hold or deferral of premium payments**

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[7] CGC, Thematic Inquiry Information about Financial Hardship support on Insurers' websites, 1 June 2023

[8] See Section 15.6 and recommendation 15.6, ACCC, 2020, Northern Australia Insurance Inquiry – Final Report,

[9] See further discussion on inclusive design and its principles at **Question 2.4**

(d) the option to change premium payments from annual to pay by the month instalments for no additional cost

(e) removing the loading for monthly premiums (if not removed altogether)

(f) waiving cancellation and administration fees for customers who cancel their policies, including refunds on the unused proportions of premiums

(g) providing a review of policy cover or reassessing the consumer's risk profile (e.g. because of changes in circumstances such as driving less or spending more time at home) resulting in reduced premiums

(h) implementing non-insurance initiatives such as access to free counselling, welfare checks and gift vouchers

(i) waiving the excess on the claim in part or in full

(j) allowing the excess to be paid in instalments, and

(k) suspending or waiving third party debt recovery or allowing debts to be paid in instalments.

3. Clause 105 should be strengthened to commit insurers to the following:

(a) Provide proactive, clear, transparent and plain English communication about support options including ensuring that this information is visible, easy to find and prominently displayed not just on websites but in written communications, with links logically named.

(b) Mention the availability of payment assistance and Code commitments on all renewals and notices of cancellation for non-payment of instalments.

(c) Provide contact details on the same page as the information and multiple contact methods to make it as easy as possible for consumers to contact subscribers for Financial Hardship support.

(d) Provide a distinct phone number for financial hardship support.

(e) Place information about financial hardship support alongside other information provided with respect to vulnerability.

(f) Provide details and weblinks of other support services to assist a consumer with contacting those.

(g) Provide financial hardship information in different languages.

(h) Apply the commitments to not just websites – for example, insurer apps need to be mentioned.

4. **Clause 124 should be improved by committing insurers to explain the effect on insurance cover if an option is applied (e.g. any reduction in cover) and any relevant timeframes (e.g. end date of the support option)**

5. **Clause 115 should be updated so that insurers commit to proactively avoid asking for unnecessary documentation.**

6. **Upon receipt of a financial hardship request, insurers should conduct a policy health check including checking:**

   (a) **whether all discounts that a customer may be eligible for have been considered,**

   (b) **whether the calculation of premium arrived at is accurate having mind to the customer's circumstances (i.e., location, risk profile, etc)**

   (c) **whether the customer's sum insured is reasonable,**

   (d) **whether the insurer offers other products that may better meet the customer's needs and budget that the consumer could consider, and**

   (e) **the cost impact of various excess choices made by the customer.** [10]

7. **Regularly collect and monitor data to identify and proactively help consumers in hardship.**

8. **Tell insureds that a claim will not be refused in the event that the insured cannot afford to pay the excess and that a claim will be processed even if the insured cannot afford to pay the excess.**

9. **Proactively contact or engage with consumers before the end of support options to consider the consumer's circumstances and whether any further assistance is needed.**

10. **Proactively engage with consumers before the end of any deferral period, rather than after a payment is missed, to ensure the consumer is aware that premium payments are due.**

11. **Provide refunds where policies are likely to provide no material value (such as where the consumer is unlikely to be able to travel due to a 'do not travel' warning issued by the Australian Government, or because of international border closures for nonessential travel).**

[10] Recommendation 15.3, ACCC, (2020)

12. **Offer to provide refunds in cash and not a credit note. Where a consumer chooses to receive a refund in the form of a credit note they should be valid for a reasonable period of time and provide material value.**

13. **Undertake training and education for staff to implement payment difficulty assistance measures with compassion and consistency.**

2.2 How can the Code and/or its administration encourage greater compliance with financial hardship obligations, particularly where third party debt collectors are involved?

We raise the following four issues to elucidate the issues involved and identify how the Code can ensure greater compliance with financial hardship obligations, particularly where third party debt collectors are involved:

1. Problems identified with collection agent practice.
2. Debt recovery from tenants relating to landlord and home building insurance.
3. Insurers pursuing employees rather than their vicariously liable employers.
4. Inappropriate recovery.

Problems identified with collection agent practice

The CGC found concerning conduct by collection agents related to the recovery of money from uninsured consumers who are experiencing financial hardship.[11] Common issues that the CGC saw with collection agents and solicitors included:

- failure to provide information about the insurer's financial hardship process when a consumer advises that they are experiencing financial hardship
- failure to put recovery action on hold when a consumer asks for financial hardship support
- lack of understanding of the financial hardship requirements in the Code
- failure to provide sufficient information about the nature of the claim and the amount of the debt
- failure to comply with the ACCC and ASIC debt collection guideline, including contacting a consumer directly rather than contacting their representative.

[11] CGC, Parts 9 and 10 of the 2020 Code Review of subscribers' implementation of vulnerability and financial hardship obligations, November 2021

There are few mechanisms within the Code to ensure that service suppliers meet the requirements of the Code and insurers are not held accountable for the behaviour of their service suppliers.

For example, Clause 41 can only be enacted if the subscriber:

> "is aware that [the] Service Supplier's performance does not meet the relevant standards of the Code."

There is no mechanism to ensure that insurers *are* aware of a service supplier's performance. There is also no requirement for a post-contractual review to ensure that their service suppliers including collection agents are meeting the requirements of the Code.

The application of the Code to external parties acting on behalf of an insurer, including service suppliers and collection agents, needs to be reconsidered. All external parties acting on behalf of an insurer should be subject to the Code: see **Question 3.3**.

The following case study demonstrates a failure to comply with Clause 133 re: the provision of information by a collection agent.

Case study 1.– Ali's story –Westjustice

Ali (name changed), a recently arrived refugee who speaks limited English, was involved in a minor car accident in which he scraped the side of a stationary vehicle parked next to in a car park. Ali, who was uninsured, was contacted several months later by the insurer of the damaged vehicle. The insurer's debt collection correspondence demanded a payment of more than $12,000 from Ali. Ali was shocked by this figure, as the damage to the other car was only a small scratch. The photographs of the damaged vehicle that the insurer sent to Ali were consistent with the scratch being very small. Ali, who fled an authoritarian regime, was very frightened of the prospect of going to court, which was threatened in the debt collection correspondence. Ali earned only a low wage in unskilled employment and had no capacity to pay the alleged debt.

On Ali's request, the insurer sent Ali documents which the insurer claimed substantiated the $12,000 quantum. The documents consisted of repair receipts from two different mechanics, which listed items replaced and repaired plus labour costs on two different occasions. The 'first' mechanical repair invoice was for a figure of less than $1,500. The second invoice was for a figure of more than $11,000. An invoice for a period of car hire which appeared to correlate to the 'second' repair was also provided.

Westjustice assisted Ali to write to the insurer asking for an explanation as to why the Vehicle had been repaired by two separate mechanics, noting that several items that invoiced for repair were to parts of the vehicle that seemed to be unrelated to the scratched panel, and that there appeared to be duplication in the itemised repairs performed by the 'first' mechanic in the invoice of the 'second' mechanic. Westjustice asked the insurer to specify how it alleged the invoiced repairs related to the damage caused by Ali. The insurer responded to Westjustice by claiming that the existence of the invoices was evidence that the repairs were necessary. The insurer declined to explain how these repairs were alleged to have been required due to Ali's accident.

Westjustice then assisted Ali to engage an independent mechanic to review the repair receipts and provide an opinion on whether the repairs invoiced reasonably arose from Ali's accident. Ali had to pay around $450 for this independent review.

In investigating the matter, the independent expert spoke to the 'second' mechanic, who confirmed that they had been engaged by the insurer to repair damage to the vehicle that had been caused by the 'first' mechanic in its attempted repairs. The independent expert produced a report of their findings, which Westjustice sent to the insurer. Westjustice argued that Ali's liability should be limited to the quote provided by the first mechanic, which had been accepted by the insurer, and that Ali should not be liable for extra repairs that were required because of damage caused by the first mechanic.

On receiving the expert report, the insurer agreed to settle the case for by accepting a sum of less than $2,000: less than 20% of the original quantum sought. Ali agreed to this offer as he wanted the case finished. He had found the matter very stressful and wanted to be sure of avoiding any risk of going to court. Ali was still left out of pocket $450 for the independent expert report he had to commission. The insurer has never explained to Ali or Westjustice why it was that it attempted to recover the cost of repairs conducted by the second mechanic from Ali.

The current obligation under Clause 133 appears confined - on the insurer's reading in the above case - to be an obligation to provide the receipts or invoices when demanding payment from a liable third party and doesn't oblige insurers or their agents to actually scrutinise or verify expenses. A positive obligation to vet alleged damages for reasonableness before alleging liability would avoid scenarios faced by Ali.

See further under: **Questions 3.3 and 3.4.**

Recommendations | Collection Agents

14. **Actively and regularly monitor Service Supplier performance, including specific timeframes.**
15. **Insurers must be held liable under the Code for any and all breaches of the Code by Service Suppliers, as if they were the insurer themselves.**
16. **A positive obligation should be placed upon insurers to vet alleged damages for reasonableness before alleging liability.**
17. **Clause 139 should be updated to commit insurers to require Collection Agents or Solicitors to notify the insurer within a timeframe of two days, otherwise they will be subject to Clause 41 re: dealing with service suppliers.**

Landlord and Home Building insurance – Debt recovery from tenants

Over the past decade our organisations have seen saw a significant number of cases where insurers with claims arising out of landlord or building insurance policies have pursued tenants under right of subrogation for damages arising out of accident claims. We are also aware of people renting holiday homes being pursued by insurers for accidental damage.

Case study 2.–Rosa's story –Westjustice

Rosa came to our Tenancy Legal Clinic seeking advice regarding a debt she was being pursued for by debt collection agency DRA Mercantile (**DRA**) acting on behalf of Chubb Insurance (**Chubb**). DRA was seeking the immediate payment of $3,630 for damage to the property alleged to have been caused by Rosa as the tenant. Rosa had at this point in time vacated this property and was living in a new rental. DRA was sending Rosa letters of demand and calling her regularly seeking payment.

The damage alleged by Chubb resulted from an incident that occurred one year prior to Rosa approaching our service. The property was located on the sixth story of a large apartment tower in the Melbourne CBD. The Rosa lived alone and had been in the property for four years at the time of the incident. The damage occurred when Rosa stepped outside on her balcony at around 10pm on a winter night to get some fresh air before going to bed and closed the glass sliding door behind her. The door had no lockable mechanism from the outside for obvious reasons. The locking latch had been worn loose over time and when Rosa closed the door behind her the latch spring failed and the latch fell and locked the door upon closure. Rosa was trapped on the balcony of her apartment with no way to re-enter.

She called the building manager who advised her he did not have a key to her apartment to enter and let her in. He advised her to call the fire brigade and seek their assistance. On the building manager's advice, Rosa called the fire brigade who attended, along with the building manager, and broke down her front door to gain entry and let Rosa into her apartment from the balcony. In the process her door and doorframe were damaged.

It is noted that section 68 of the *Residential Tenancies Act 1997* (Vic) (**the Act**) requires a rental provider to maintain properties in good repair and section 70 of the Act firmly places the responsibility for doors and locks on the rental provider. After the incident Rosa was told by the building manager, who is an agent of the owners corporation, that the damage was not her responsibility and she would not be required to make recompense for any of the damage caused by the fire brigade in gaining entry. The owners corporation claimed on its policy of insurance with Chubb and Chubb paid for the door and doorframe to be replaced. Chubb Insurance then instructed DRA to pursue Rosa for the cost of rectification.

Rosa sought clarification from the owners corporation about the matter. The owners corporation contacted Chubb, who simply responded:

The circumstances of the claim are as follows: Property damage due to someone being locked out on the balcony and fire bridge forced entry to get him/her out. Had they not locked themselves on the balcony the fire brigade would not have needed to force entry hence the costs would not have been incurred therefore the owners corporation building insurance policy will endeavour to recover against the responsible tenant.

Rosa sought the contact details of Chubb from the owners corporation to discuss the matter, in particular to dispute the notion that she had locked herself on the balcony, which was impossible as the door had no lock from the outside. The owners corporation advised her that Chubb would not speak with her directly and she would need to direct any correspondence to PNO Insurance Brokers. We assisted Rosa in drafting a letter to Chubb via PNO Insurance Brokers pointing out that Chubb was not entitled to pursue Rosa for the damage as it was entirely the fault of the locking mechanism in the door for which the rental provider had an active duty to maintain. We further pointed out that the failure to provide contact details of the insurer and the policy was a breach of the General Insurance Code of Practice 2020. If anyone was responsible for the damage it was the rental provider, and there was absolutely no grounds at law under which Chubb was entitled to pursue Rosa for this damage. We were advised a week later that Chubb had dropped their claim against Rosa.

The whole incident caused a great deal of stress for Rosa and drained resources of us as a community legal service in arguing against the claim, and presumably the resources of Chubb too. It was quite clear that Chubb and its agents took little to no steps to investigate

the true nature of the incident and the cause of the damage before deciding to pursue a vulnerable tenant for the full amount of the claim. This case study illustrates something that we commonly see which is insurance providers pursuing tenants without engaging in an analysis of causation or most importantly whether they have any legal entitlement to pursue the claim at all.

Case study 3.–James's story –Westjustice

James and his family had been renting for a number or years. The whole family went out for dinner one night recently and returned to find the property in flames and the fire brigade in attendance. James was not aware how the fire had started, but luckily the landlord had a policy of insurance with GIO Insurance (GIO). As far as James and his family understood, the damage resulting from the fire would be dealt with and covered by GIO. James was not aware that GIO would have a right of subrogation to pursue him for the costs of the damage.

Approximately two and half years after the incident, James received a letter in the mail from GIO seeking payment for damages of over $300,000 without an explanation as to why James was being held liable. A report on the investigation into the cause of the fire only made possible assumptions as to the source of the ignition and did not conclusively determine the cause. Fault on James' part had not been properly assessed or determined, and there is certainly no malice or intent behind the damage to the property. Understandably, this was incredibly alarming and distressing to James and came as a huge shock.

Since the fire which destroyed the family's possessions, James has been picking up the pieces and building up his financial situation to a point where he and his family are beginning to establish themselves but are by no means well off. James' family of five is wholly financially reliant on him as the sole income earner, and his family has been severely impacted by the COVID-19 pandemic.

James and his family are facing losing out twice - the immediate aftermath of the fire resulted in them having to replace a lifetime of built-up material and irreplaceable belongings such as family photos and mementos and deal with the stress and trauma anyone would experience when their home goes up in flames and they find themselves immediately homeless, and James is now being pursued for the costs of the destroyed property years later. Now he is again facing the implications of an event which caused damage to the rental property he treated and cared for as his own home and which he never intended or hoped would occur. Since receiving the letter from GIO, he is facing the possibility of entering into a payment plan which will not come close to repaying the entire

alleged debt or being forced into bankruptcy. Both options will have long-lasting financial impacts on James and his family but make no economic sense to pursue from GIO's perspective.

Case study 4.–Mohammed's story –Westjustice

Mohammed arrived in Australia in 2018 with his family members. Prior to arriving in Australia, he resided in a refugee camp where he spent most of his adult life. Mohammed and his family, which includes his partner and teenage kids, are all reliant on Centrelink Newstart benefits. No one in the family is able to speak, read or write in English, which has made it difficult for them to find work. Mohammed is extremely grateful to now live in stable and secure housing in comparison to his family's life beforehand. Upon arriving in Australia, his family moved into a rental property and continue to live in the same property now.

On an afternoon in 2019, a fire started in the kitchen of the property. Mohammed was alerted to the fire by one of his children and was able to extinguish the fire before the fire brigade arrived. Due to Mohammed putting the fire out, the damage was mostly contained to the kitchen. On the same day the rental provider was notified, and they lodged a claim with their insurer.

Almost a year after the incident, Mohammad received a letter from the insurer demanding over $30,000 in costs for damage that he allegedly caused to the property. Mohammed had not been contacted by the insurer to discuss his financial circumstances or his liability for the fire before receiving this letter. He was extremely confused and upset by this.

Mohammed had not been in the kitchen on the day of the incident and had nothing to do with the fire. His teenage child was cooking in the kitchen about an hour before the fire started, but in any event the rental provider was not at all bothered. The rental provider stated to Mohammed that accidents happen and allowed Mohammed and his family to continue living in the property they had been such great tenants.

Mohammed contacted Westjustice for assistance. We have had to contact the insurer seeking a waiver of the alleged debt sought on the basis that Mohammed is judgment-proof. However, there is a broader issue that the insurer is recovering against a tenant who was not responsible for the damage, and the damage was caused unintentionally. Further, the rental provider did not want the tenant to be pursued for the costs of the damage.

Case study 5.–Javier's story –Westjustice

Javier was a tenant living at a rental property with his housemate. Javier assembled a new barbecue outside; however the ignition was not working. He lit a piece of paper and his housemate turned on the gas to the barbecue, leading to a minor explosion. At this point, Javier believes that embers may have entered the packaging box for the barbecue. He left the piece of paper on the ground outside after stepping on it to make sure it was no longer alight. His housemate then put the packaging box in the spare bedroom where they kept the rest of their recyclable cardboard boxes. Javier returned inside the property from the backyard 30 to 60 minutes later and noticed light underneath the door of the spare bedroom. He opened the bedroom door and there was a fire alight in the room which caused damage to the property.

Javier did not have contents insurance and therefore has no insurance to cover the costs of the damage at the rented premises.

Javier has since received a letter of demand for $183,527.07 from Vardanega Roberts Solicitors acting for CHU Strata Insurance (**CHU**) as agent and administrator of QBE Insurance (Australia) Limited (**QBE**) purportedly under an owners corporation insurance policy. There was no assessment presented by QBE, CHU or Vardanega Roberts Solicitors regarding the incident or Javier's liability for the damage, nor did any party give a proper explanation as to the reason for the claim particularly in circumstances where there was an absence of any malicious or deliberate damage.

Following a consumer-led campaign in 2021, all landlord insurers across Australia publicly pledged that tenants will no longer be pursued over accidental property damage,[12] in line with the general expectation that landlords are responsible for insuring their investment rental property. There is no requirement in tenancy legislation in any Australian jurisdiction requiring a tenant to separately insure the property of a landlord.

While this pledge was welcomed by consumer groups, there is nothing in writing on insurer websites, policies or in the Code supporting or committing to this public pledge and renters and their advocates are forced to point to public statements in the media when seeking waivers. Absent regulatory or Code expectations, there is a risk of a backslide in the event of leadership or culture changes.

[12] Insurers pledge to stop billing tenants for accidental property damage in 'huge win for renters' - ABC News, 1 December 2021 and 'Huge win for renters': landlord insurers change policies following CHOICE campaign, 30 November 2021

It is therefore appropriate that insurers make a commitment under the Code to not pursue tenants under right of subrogation for damages arising out of accident claims.

We are also aware of cases – arising *after* the agreement not to pursue tenants was announced - where insurers have split hairs over semantics where renters have not been pursued for damages paid out under landlord insurance but have been pursued for damages under owners' corporation insurance.

The same commitment should apply to owners' corporation/strata insurers pursuing renters for accidental/unintentional damage to common property.

Recommendations | Pursuing Tenants

18. **Insurers should not pursue tenants under right of subrogation for damages arising out of accident claims including damage to common property under strata insurance**

Insurers pursuing employees rather than their vicariously liable employers

Following a motor vehicle accident where an employee has driven in the course of their employment and is at-fault for the accident, the not-at-fault driver's insurer pursues the *employee* for the costs of their damage despite the employee providing proof that they should be protected by vicarious liability.

An employee is not liable for damage caused in the course of employment. The High Court of Australia case of *Hollis v Vabu Pty Ltd* (2001) 207 CLR 21 stands for the proposition that an employer is vicariously liable for the tortious acts of an employee.

This is an important principle, but its application continues to be an issue. Westjustice for example has seen employers who have sham-contracted or otherwise employed people on undocumented arrangements to perform work, and then deny employing the person, or that the crash arose during the employment. Insurers then simply revert to the employee as the liable party.

There are currently no clear rules or guidelines around what forms of proof of driving in the course of employment are acceptable to an insurer for them to stop pursuing the employee.

There needs to be a commitment from insurers in the Code which outlines the minimum proof required to satisfy insurers that an employee is covered by vicarious liability on the part of their employer. When such proof is provided, the insurer must agree to pursue the employer only.

Further, if such proof is not provided by the employee, it must be expressly stated that this does not mean that vicariously liability may not still apply, and that the commitment or clause is not intended for insurers to confirm that vicarious liability does not apply. Where an employee states they were driving in the course of employment but with an absence of proof, the insurer must exhaust all attempts to pursue the employer first before contacting the employee.

An example of minimum proof could be one or a combination of the following: pay slip, bank statement, employment contract, letter confirming employment, timesheet, roster of shifts, etc.

Recommendations | Pursuing Employees

19. **Outline the minimum proof required to satisfy insurers that an employee is covered by vicarious liability on the part of their employer. When such proof is provided, the insurer must agree to pursue the employer only.**
20. **If such proof is not provided by the employee, it must be expressly stated that this does not mean that vicariously liability may not still apply, and that the commitment or clause is not intended for insurers to confirm that vicarious liability does not apply. Where an employee states they were driving in the course of employment but with an absence of proof, the insurer must exhaust all attempts to pursue the employer first before contacting the employee.**

Inappropriate recovery

Our sector continues to see examples of inappropriate and poor recovery practices from insurers. For example:

Case study 6.–Sally's story –Consumer Action - 557238

Sally called Consumer Action in distress in mid-April 2024. Sally works limited hours and receives a carer's payment for her preteen son, who is an NDIS participant.

A week earlier, she and her family had been staying at a caravan park. Her son was playing with a go-kart provided by the park and had allegedly scratched another guest's car.

Within a few days, Sally says the insurer of the car owner contacted her seeking $6,000 for repairs, to be paid in full. Sally says she was told they had to replace the whole panel of the car because it was a new car, and the actual cost might be higher – they couldn't tell her the actual cost until after the car was repaired. Sally couldn't afford to pay that amount and was in shock that an insurer was pursuing her for minor damage allegedly caused by a child. It was also stressful to hear that even if she could pay the $6,000 upfront, she might be asked to pay even more.

Consumer Action assisted Sally to identify that not only did her home and contents cover include liability cover outside of the home for accidents involving bikes and carts, but her policy was with the same insurer as the car owner. Effectively, the insurer would have ended up recovering the cost against themselves. After advocating on Sally's behalf to the insurer, the recovery action was dropped.

Our organisations have serious concerns about the attempt to recover a significant amount of money for damage allegedly caused by a young boy, where the caravan park or car owner may also have been culpable, and where the recovering insurer made no attempt to help Sally identify that she had liability cover with them.

Recommendations | Inappropriate Recovery

21. **Insurers should be being fair, transparent, and ethical in all recovery practices, and do not attempt to recover from someone if there are no strong prospects of success.**
22. **Before attempting to recover a debt, insurers should check to see if that person is insured with them for their liability.**
23. **Distinct from the obligation to put recovery on hold while assessing for financial hardship, insurers only commence recovery where there is a reasonable basis to do so.**

2.3 Are other mechanisms more appropriate than the Code to address issues related to the assistance insurers provide customers facing financial hardship, and if so, what and why?

We provide the following potential legislative reforms *in addition* to those outlined above that could be considered in further addressing issues of financial hardship and debt collection.

- Amend the *Insurance Contracts Act,* in line with sections 268 to 270 of the *Property Law Act 2007 (NZ*), to:
    - clarify that an insurer is not entitled to pursue a renter for damage to property unless it was caused intentionally,
    - codify the right for renters to be treated as third party beneficiaries under either a landlord or owners corporation insurance policy.
- Introduce protections for renters similar to the protections for family members or employees under sections 65 and 66 the *Insurance Contracts Act 1984*.
- Codify the right of subrogation in a plain English way so that consumers, insurers and their representatives understand it and so that there is no confusion as to who has the right of subrogation (i.e. insurers only and not their representatives – in the past we have seen brokers or agents of insurers, such as owners corporation insurers, fail to mention the insurer they are representing and make claims that they are the party who has actually suffered the loss and are entitled to pursue our third-party client for the loss).
- Codify the principle of vicarious liability, so that insurers do not pursue third-party employees for damage caused in the course of their employment when it is their employer who is vicariously liable.

Customer Vulnerability

2.4 Is the Code in line with community expectations regarding customer vulnerability? If not, how can it be improved? If not, how can it be improved? For example:

(a) Should the Code promote inclusive product and service design to better address customer vulnerability? If so, how?

The Code is not in line with community expectations regarding customer vulnerability.

ASIC and CGC reports, as well as reports and consultation submissions from CHOICE, Financial Rights and other organisations have demonstrated key failures in general insurers engagement with the concept of vulnerability.[13] We also provide specific examples of these failures in the answer to **Question 2.4(b)**.

In the absence of prescription or any real direction on how to take the "extra care" required under the Code, insurers are failing to identify how best to approach the issue of vulnerability and support positive consumer outcomes for those with extra needs. To help insurers improve their support for those who need extra care, the Code needs to be improved to:

- maintain and update a broad principles-based approach,
- supplemented by further specific commitments to enliven these principles and provide insurers and consumers more certainty, and
- embed these commitments throughout the Code (in line with inclusive design principles) to ensure that the notion of vulnerability is not siloed but considered at every step of the insurance journey.

A principles-based approach…

The Code has, to date, largely taken a principles-based approach to vulnerability by committing to "taking extra care" with people experiencing vulnerability.[14] It then lists

[13] CGC, General Insurance Industry Data and Compliance Report 2022–23, May 2024, ASIC, ASIC's expectations of general insurers: Insurance claims and severe weather events, 7 November 2022; Joint consumer submission to the Parliamentary Inquiry into insurers' responses to 2022 major floods, November 2023; ASIC, Navigating the storm: ASIC's review of home insurance claims Report 768, August 2023; CHOICE et al, Weathering the Storm: Insurance in a changing climate, August 2023; CGC, Parts 9 and 10 of the 2020 Code Review of subscribers' implementation of vulnerability and financial hardship obligations, November 2021, Financial Rights, Exposed: Insurance problems after extreme weather events, July 2021

[14] Clause 91

examples of factors that may contribute to vulnerability at Clause 92. This is supplemented with a handful of specific commitments for customers and some broad commitments to training and providing "support measures."[15]

A principles-based approach is important to ensure flexibility and to acknowledge that unique circumstances may require unique responses. We continue to support such a commitment. However, given the failure of insurers to meet community expectations in taking the extra care needed, this should be supplemented with further detail and prescription.

This additional prescription will be a focus of this submission. However, it is also useful to re-examine whether the broad principles at Clauses 91 and 92 continue to meet the moment.

Firstly, Clause 91 should be reconsidered in the light of the development of the international consumer vulnerability standard.[16]. This new standard provides both broad principles and specific detail that can be easily tailored to the insurance sector and taken on as the key "how to" guide to design fair, flexible and inclusive services, and product design. Including a commitment to meeting the requirements of ISO 22458 would be the simplest way to broaden the principles-based approach to vulnerability. The Code should embed ISO 22458 key concepts into its drafting.

Central to the ISO standard is a call for firms to provide a "clear commitment to improving outcomes for consumers in vulnerable situations and minimising the risk of consumer harm."[17] This is more of a proactive, outcomes-focussed approach to service delivery and product design, which should be used as the basis for a renewed and re-drafted commitment at Clause 91.

Further, the principles identified in the standard including accountability, empathy, empowerment, fairness, flexibility, inclusivity, privacy, innovation, and transparency, should also be included and referenced in the Code.

To ensure that a more proactive, outcomes-focussed approach is taken by subscribers, insurers should also specifically commit to applying inclusive design principles when developing service delivery processes and designing products. This means not starting "from an imaginary 'average user'" of a target market but designing services and products for

[15] For example, Clauses 101-103 re: Interpreters.
[16] ISO 22458:2022
[17] Para 4.1, ISO 22458:2022

people "who have additional or out-of-the-ordinary experiences and needs".[18] By designing for those with additional needs insurance sales, underwriting, claims handling the entire insurance journey - becomes more inclusive and benefits all other insureds at the same time. It also necessitates including a wide range of people throughout the service and product design process, particularly those with additional needs – and requires a "humble and open-minded" mindset.[19]

The approach to listing vulnerabilities at Clause 92 should also be expanded to capture a broader understanding of the concept and touch upon notions of situational vulnerability as well as the key drivers of vulnerability.

The Financial Conduct Authority, UK (**UK FCA**) approach, for example, identifies 4 key characteristics that drive an increased risk of vulnerability that could provide some initial guidance to developing an appropriate approach in the Code.[20] These characteristics are:

1. Health conditions or illnesses
2. Life events such as bereavement, job loss, relationship shocks and natural disaster
3. Resilience – ability to withstand financial or emotional shocks
4. Capability – knowledge of financial matters or low confidence in managing financial matters[21]

The ISO standard identifies a similar set of risk factors including:

- Personal characteristics, e.g. age, culture, geographic location
- Health and abilities e.g. mental health, cognitive ability, addiction
- Access and skills, e.g. language, literacy
- Life events e.g. income shock, abuse
- External conditions, e.g. environment and natural disasters

It is also worth considering the effects of historical and inter-generational trauma inflicted by government and corporate entities in their dealings with certain groups, including First nations people and refugees: see **Ali's story** below.

[18] Page 15, Fair by Design, Inclusive Design in Essential Services A practical guide for firms and suppliers, (2021)
[19] As above
[20] Financial Conduct Authority, UK, FG21/1 Guidance for firms on the fair treatment of vulnerable customers, February 2021,
[21] Paras 2.4-2.12, FCA UK (2021)

The range of vulnerabilities listed at Clause 92 should therefore be expanded to better reflect the above notions.

The list should also be updated to capture factors that have specifically been raised with insurers including, for example, LGBTQIA+ issues.[22]

Other factors currently listed need to be updated to capture broader notions of vulnerability to ensure that they are not artificially being used to exclude consideration of specific factors. These include:

- "family violence" should be updated to capture family *and domestic* violence, financial abuse and elder abuse.
- "financial distress" should be updated to simply say financial hardship. Financial hardship is a major risk factor for vulnerability and should be acknowledged as such.

Increase in specific commitments in the Code

The principles-based approach outlined above needs to be supplemented with specific commitments to enhance the broader commitment, providing greater direction to insurers to improve outcomes for their customers and assist insureds to understand the minimum standards they can expect from an insurer – as opposed to having to argue for vague notions of "extra care."

More explicit commitments should, for example, be made under Part 9 regarding:

- *specific forms of training*

  The Code should detail a non-exclusive list of key forms of training that should be provided to all relevant internal and external/outsourced staff (including management) including:
  - vulnerability training[23]
  - trauma informed practice training
  - LGBTIQA+ awareness and inclusion training
  - Aboriginal and Torres Strait Islander cultural training
  - empathy and/or emotional Intelligence training
  - working with interpreters training, and

[22] see further information below at Question 2.4(b))
[23] In line with the expectations of 6.2.3.1 of ISO 22458:2022

- training and education for staff to implement payment difficulty assistance measures with compassion and consistency.

- *a more proactive approach to assisting those experiencing vulnerability*

  This should include commitments to shift the onus away from customers having to tell the insurer that they are vulnerable – something that they are in many cases unlikely to do – towards practices that proactively capture and identify customer vulnerabilities. This includes:

  - training to elicit information in a supportive and compassionate way, in line with the requirements of the Privacy Act[24]
  - creating mechanisms and opportunities built into communications channels to share relevant information[25]
  - collecting, recording, flagging, and sharing information with consent – including for example Aboriginal and Torres Strait Islander status,[26] and
  - using data analysis to identify potential customers who may need assistance.

- *specific forms of vulnerability and situations*

  Part 9 of the Code should be expanded to provide specific commitments to address specific issues facing cohorts subject to risks. This includes new and enlarged sections detailing commitments with respect to those factors listed at Clause 92. (See below at **Question 2.4(b)**)

More explicit commitments with respect to vulnerability should also be applied throughout the Code and not only be siloed in a distinct vulnerability section.

Embed the notion of vulnerability in the commitments made throughout the Code

Vulnerability should not be seen as this "thing" to address, separate to the functions and life cycle of insurance. Nor should it be kept separate to the other commitments made in the Code. In this sense, the principles of inclusive design should be applied to the Code itself and the commitments within.

[24] See 7.4.2 of ISO 22458:2022
[25] See 7.4.3 of ISO 22458:2022
[26] See 7.5 of ISO 22458:2022

Reviewing the drafting of the Code with an inclusive design approach can assist in helping insurers understand that designing service delivery and products with an inclusive lens can lead to significant improvements for all consumers.

While some commitments to address specific risk factors as outlined above will need particularly focussed commitments, others can be built into other sections of the Code. The investigators section already does so. This approach needs to be expanded to other sections of the Code (including "Financial Hardship", "Making a Claim", "Complaints", "Your Access to Information") and current commitments should be improved. Three examples are:

- c. Seen through this lens Clause 133 re: collection agent communications would be updated to ensure that consumers are able to have their communication preference met. .
- Commit to providing all communications in plain English to assist in understanding how insurance products work, understanding one's rights and obligation under an insurance contract and improving engagement with the claims, complaints and other insurance processes. This would go a long way addressing issues raised with respect to financial literacy, First Nations people customers, financial difficulties and other intersecting vulnerabilities.
- Part 6 should be expanded its range of commitments re: buying insurance to address key issues of affordability and remove the poverty premium built into insurance pricing and product design. This will address a range of experiences and needs.
- Clause 209 re: requesting investigators of the same gender should be updated to remove the proviso "We may not be able to do this if it is not reasonably practical for us to do so." This could have negative impacts upon those experiencing gender-based violence, or those from particular cultural backgrounds. It should be a policy of insurers to ensure that a diversity of genders is made available otherwise. If they are not, then this is an internal issue of panel selections.

Recommendations | Vulnerability

24. **Insurers' approach to vulnerability should be improved by updating the broad, principles-based approach to vulnerability the Code has taken, supplemented with more specific commitments to enliven these principles, and embedding these commitments throughout the Code in line with inclusive design principles.**
25. **Insurers should commit to meeting the requirements of ISO 22458 under the Code.**
26. **Clause 91 of the Code should be re-drafted to embed a proactive, outcomes-focussed approach to service delivery and product design.**

27. **The Code should commit subscribers to apply inclusive design principles when developing service delivery processes and designing products.**

28. **Clause 92 should be expanded to capture a broader understanding of the concept and touch upon notions of situational vulnerability as well as the drivers of vulnerability.**

29. **Part 9 should be expanded to include:**

    a. **specific forms of training that should be provided**

    b. **a more proactive approach to assisting those experiencing vulnerability, and**

    c. **commitments to address specific factors.**

30. **Inclusive design principles should be applied to the Code itself to ensure that all commitments under the Code are designed with those with additional needs in mind.**

(b) Are there other types of vulnerability or disadvantage that need to be more explicitly addressed by the Code?

In line with the above, Part 9 should be updated to include an expanded set of commitments specifically addressing risk factors raised in Clause 92. This includes additional factors outlined below. We address key issues identified in the consultation paper including:

- Family Violence including women's financial safety
- First Nations customers
- Mental Health
- LGBTIA+
- Blood-borne viruses
- Sex work and adult industry businesses
- Customer personal insolvency.

We also provide comments on factors such as age, language barrier and cognitive ability as examples of how insurers can make specific commitments on specific vulnerability factors to enliven the broader principles at Clauses 91 and 81.

Family violence including women's financial safety

The impacts of family and domestic violence including financial abuse are at the heart of an important national conversation. We note that the Parliamentary Joint Committee on Corporations and Financial Services has commenced an inquiry into financial services regulatory framework in relation to financial abuse, which many of our organisations will contribute.[27]

Further work needs to be done to strengthen insurers' approach to this issue.

We have noted above that Clause 91 should be updated to broaden the concept of family violence to capture family *and domestic* violence, financial abuse, and elder abuse.

Further, we note that the commitments made on family and domestic violence are currently limited and minimal. Clause 95 commits subscribers to:

(a) have a publicly available policy about how the subscriber will support consumers affected by family violence.

(b) that this policy will be published on the subscriber's website.

The CGC released research[28] into whether examined whether subscribers met these basic commitments. 2021 research from Financial Rights subsequently examined whether subscribers met not just the letter of the commitment but the spirit of the commitment – i.e. the quality of the policies developed and what protections and commitments were being made to customers who may be subject to family violence.[29] This research found that a little over half the subscribers had policies that addressed only half of the requirements under the 11 areas listed in the ICA's Guide to helping customers affected by family violence to be included in a family violence policy.[30]

The key recommendation of this research was that key elements of the Family Violence Guide should be included in the General Insurance Code in such a way that empowers the CGC to assess subscribers meeting the content expectations of a family violence policy and compliance with their commitments made under those policies.

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[27] Parliamentary Joint Committee on Corporations and Financial Services, Financial Services Regulatory Framework in Relation to Financial Abuse, 2024

[28] CGC, Assessment of compliance with new provision on family violence policies, March 2021

[29] Financial Rights, Family Violence and General Insurance: Desktop audit of family violence policies, August 2021

[30] Financial Rights is undertaking an update of this research to examine whether insurer subscribers have improved their approach to their family violence policies. This should be available to the reviewers to consider in June.

Further, the report recommended that insurers commit to implementing the best practices identified in the research such as:

- including a large button to navigate quickly to another website for safety reasons
- flagging, with consent, those customers impacted by family and domestic violence and financial abuse to avoid repeating stories and to ensure only authorized employees have access to the information
- ensure communication preferences (including gender preferences) are considered
- assure customers that their family violence situation will not hurt their claim etc.

The recent Design to Disrupt report also tackles the issue of family and domestic violence and financial abuse through the product design and distribution lens.[31] The recommendations of this report should also be considered for inclusion as Code commitments, where possible. For example:

- Committing to treating joint insurance policies as composite when advised of separation or divorce.
- Adopting a 'conduct of others' clause as a standard policy term to enable discretion where the 'malicious damage' exclusion disadvantages a victim-survivor. An 'innocent' co-insured should not be penalised where it was unreasonable for them to know the other party had failed to disclose relevant information to the insurer.
- Conducting risk assessments for each product during the development or review process examines the potential harm to a customer experiencing domestic and financial abuse and introduce relevant controls and mitigants.
- Committing to standardised data collection to record and report cases of insurance abuse in the context of intimate partner violence.
- Updating design and distribution policies with an anti-discrimination lens.
- Not requiring notification or consent to the other joint policyholder when assessing financial hardship of a victim-survivor.
- Fast tracking hardship request and support.
- Not notifying claims (or seeking consent on a claim) from a co-policyholder where family violence is involved.

[31] Catherine Fitzpatrick, Designed to Disrupt, Reimagining general insurance products to improve financial safety, March 2024

- Including a term in insurers' terms and conditions that make financial abuse an unacceptable customer behaviour, with consequences for those who misuse insurance products or services.

Recommendations | Family Violence and Financial Abuse

31. The Code should expand upon the limited commitment at Clause 95 to:

a. incorporate the substantive requirements for family violence policies at Clause 17 of the ICA's Guide to helping customers affected by family violence to be included in a family violence policy.

b. implement best practices including

i. large button to navigate quickly to another website for safety reasons

ii. flagging (with consent) those customers impacted by family and domestic violence

iii. ensuring communication preferences (including gender preferences) are considered, and

iv. assuring customers that their family violence situation will not hurt their claim.

c. address issues of product design in the Code including treating joint policies as composite where appropriate and adopting a 'conduct of others' clause which enables discretion where the 'malicious damage' exclusion disadvantages a victim-survivor.

First Nations customers

We understand that the ICA has established an Indigenous Advisory Committee and produced its first Reflect Reconciliation Action Plan. We congratulate the ICA for taking these important first steps. We note that a handful of insurer members have also begun their reconciliation action plan journey, including QBE insurance, Hollard and IAG.

We commend these and recommend all subscribers take this important step to drive better consumer outcomes for First Nations peoples and communities.

We note too that ASIC has developed an Indigenous Financial Services Framework and that central to this is promoting the ongoing involvement and support of the financial services industry, including facilitating tailored industry workshops. These workshops are open to all industry sectors to discuss specific opportunities for driving positive outcomes and addressing systemic challenges for First Nations consumers. We recommend that Code subscribers proactively engage with these workshops.[32]

We also believe that insurers can make further specific commitments to First Nations people via the Code. Insurance is a complex product that is poorly understood by the average consumer, and the Code is remarkedly silent on dealing specifically with the needs and requirements of First Nations consumers.

The only specific commitment made regarding First Nations customers to enliven the acknowledgement under Clause 92 is at Clause 100 re: identification. More can be done on this point alone, specifically by following the AUSTRAC's guidance on identification and verification of Aboriginal and Torres Strait Islander customers.[33]

The draft ABA Code commits subscriber banks to take steps to make their services more accessible including telling customers about any accounts and services that are relevant to them and assist those in remote communities to access and undertake their banking. There is significant scope to do the same under the General Insurance Code.[34]

First Nations people are often only first- or second-generation money earners and are new to asset owning, asset building and asset protection – they are a communal culture. Because of this, there is a significant gap in knowledge in understanding how insurance works.

For example, some First Nations people see insurance as a savings fund that you can take money out of when needed, rather than a premium paid that no longer belongs to the insured.

This financial literacy gap needs to be considered in the product design and service delivery of insurance, including specifically by examining the appropriateness of each insurance product developed and by developing plain English information and product disclosure statements.

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[32] ASIC's *Better Banking for Indigenous Consumers Project* reviewed TMDs and found that many Indigenous consumers identified in the data were in inappropriate accounts. Insurers can learn from this approach.

[33] This would align with 6.14 of the Life Insurance Code.

[34] See ASIC CP 373 Proposed changes to the Banking Code of Practice, November 2023

Adequate protections are needed to for all consumers of insurance – and by extension First Nations consumers – to address the difficulties of understanding insurance products, express, and communicate their concerns or complaints, or comprehend their policy rights.

To truly close the gap, insurers must understand that there is a gap in the first place and address it at each step of engagement. Doing so will increase First Nations understanding and knowledge of insurance, so they can benefit from the product and protect their assets. Insurers can also play a part in Closing the Gap.[35]

Insurers should engage First Nations specialist teams to advise on how to explain the complex terms of insurance through different means (for example, via the use of multimedia) how to avoid gratuitous concurrence in communications, encourage contact with specialist First Nations teams and have an equitable cooling off period if the product would not meet the consumer's needs.

First Nations consumers may also not be fully aware of their rights and obligations under the insurance contract and be prejudiced by this. A good example of this would be the duty of disclosure where the disclosure questions might be difficult to understand or even feel ashamed to disclose. The insurer has a right to open an investigation and the insured has a duty to cooperate. However, for someone with a history of current or intergenerational trauma, including with authorities, engaging with an insurance investigation could be a very triggering event and can result in the consumer not wanting to engage with the insurer, ending their claim under duty of utmost good faith. It should explicitly be explained to all customers that an investigation is not a criminal process, but an inquiry the company needs to undertake to substantiate a claim.

Inappropriate insurance sales to First Nations consumers have been notorious. While this has mostly arisen in the in funeral and life insurance space (e.g. Youpla) we have seen it arise in motor vehicle sales and add-on consumer credit and gap Insurances. It is worth considering whether the Consumer Credit Insurance section of Part 6 needs to include specific commitments to addressing issues arising out of the sale of lemon cars in regional areas.

First Nations people in regional and remote communities face particularly unique issues.[36] It means problems with digital connectivity. It can mean low access to devices and the internet. It can mean generally having to deal with a poor communications environment and digital

[35] Particularly Target 17 re: people having access to information and services enabling participation in informed decision-making regarding their own lives. See Closing the Gap Targets and Outcomes

[36] Note that while it is clearly the case that not all Aboriginal and Torres Strait Islander people are vulnerable, it is equally true that not all vulnerable Aboriginal and Torres Strait Islander people are remote. 37.1 per cent of First Nations people lived in capital city areas, while the remaining 62.9 per cent lived outside of capital cities.

divide. This can lead to difficulties in the claims process with the need to upload and send multiple documents and photos via dedicated insurance portals. This assumes that everyone has access to a digital device and the internet and know how to use it.[37] The most recent Australian Digital Inclusion Index released in July 2023, found that there was an overall Index Score of 73.4 for non-First Nations Australians but only 65.9 for First Nations Australians, reflecting a national gap of 7.5 points for First Nations people.

First Nations households may also share one device, meaning the customer has limited opportunities to make calls and use website portals. When a First Nations person needs to rely on other people to access a device to navigate technology, there is an increased risk of financial abuse – particularly if they are entitled to a payout.

Living in regional or remote areas also means long distances, which has an impact on engagement with insurance products.

High towing costs, for example, exacerbate issues with vehicles and insurance. This is particularly the case with lemon cars sold where some dealerships prey on First Nations consumers – upselling them to inappropriate and expensive vehicles and adding junk warranties and insurance products to already unsuitable loans.[38]

Many people in remote and regional areas may find it difficult, if not impossible to reach preferred insurer repairers that may be many hundreds of kilometres away.

Being reliant on a car in a regional area is also not factored in by insurers in their product design and claims handling processes.

Case study 7.– Claudia's story – Financial Rights - C248761

Claudia is a First Nations woman with a mental health disability and living in regional Queensland. Claudia needs a car to go to work as there is no public transport. Claudia's car was stolen and recovered by police 2 days later but with damages. The insurer received the claim in early December, the car was released from police hold a short time afterwards, with the subsequent repair assessment completed in January. However, the parts for repair will not be available until May.

[37] Measuring Australia's Digital Divide. Australian Digital Inclusion Index 2023

[38] See Maree's story in Submission by Mob Strong Debt Help, Standing Committee on Indigenous Affairs, Inquiry into how the corporate sector establishes models of best practice to foster better engagement with Aboriginal and Torres Strait Islander consumers, December 2021

Claudia has a hire car provision in her policy, but this is only for 14 days. After this, she is not entitled to car hire and cannot afford another car hire while the insurer will take close to 6 months to complete the repairs. Claudia believes that the car damage assessment was not done properly, and the insurer was trying to avoid a car write off. However, she cannot afford a second opinion to review the report and has not had any possession of the vehicle to arrange this inspection.

Case study 8.– Eloise's story – Financial Rights - S306985

Eloise is a First Nations, aged pensioner living with her husband in regional NSW. Two years ago, a storm damaged her property, and she made a claim on her insurance. Her insurer arranged for a make safe for the roof but took two years to come back with a written decision to decline the claim. The reason for the decline was that the roof tiles seemed too old and needed to be replaced. Eloise was not sure if there was a written expert report that came with the decision but that was all the insurer explained to her. Eloise had been with the insurer for over 10 years and was not aware of anything wrong with the tiles but is not physically able to check the roof because of her advanced age. She cannot afford another expert to review the insurers decision, or the roof and it would take months to find an available expert hundreds of kilometres away.

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Other factors that can intersect with the experience of First Nations customers include generational trauma, language, literacy, and financial literacy. While culture is not a vulnerability in itself (in fact quite the opposite) there are cross- cultural differences which mean that Aboriginal and Torres Strait Islanders may find it particularly difficult to navigate some insurance products, services and processes. Cultural differences, including communications styles, can mean that customer needs are not clearly understood.

This is why we recommend Specialist First Nations assistance teams be established to solve problems for customers and resolve disputes on the spot as often as possible. This is something banks have already identified as an approach they are working towards. Banks are also including engaging First Nations team members in strategy and leadership positions to improve First Nations outcomes.

Another issue to consider is whether insurance companies engage First Nations interpreter services when English is not identified as the primary language. While there is a commitment

to providing interpreter services, it is important that that First Nations people who speak English as a second or third language are provided with the language support they need.

Recommendations | First Nations people

32. **Expand Clause 100 to ensure insurers follow the AUSTRAC's guidance on identification and verification of Aboriginal and Torres Strait Islander customers.**
33. **Take additional steps to make insurance more accessible to First Nations communities including telling customers about any products, services or design elements that may be relevant to them and assist those in remote communities to access and undertake their insurance needs.**
34. **Apply a First Nations and remote and regional lens on product design with an eye to develop more culturally appropriate insurance, including flexibility for rental cars and repairs.**
35. **Commit to First Nations cultural training to all employees and external representatives, including customer facing, front line staff.**
36. **Establish and appropriately resource specialist Aboriginal and Torres Strait Islander groups for product design, service delivery, customer phone lines and contacts.**

Mental health

General insurers have acknowledged the interaction of mental health and insurance. The current Code does include mandatory obligations for insurers in relation to customers with a mental health condition.[39] There is also the Guide on Mental Health that highlights best practices insurers "should consider in meeting these Code requirements." However, the Guide "does not bind insurers" nor does it "have legal force."[40]

Whether an insurer meets aspirational best practice standards to meet what consumers regard as minimum standards that should apply equally, is not a best practice approach to supporting those with a mental health condition. It means that, like those subject to premium hardship during COVID-19, whether you receive the assistance you need is wholly dependent on chance and the willingness of individual insurers to provide minimal support, best practice support or somewhere in between.

[39] Clause 104

[40] ICA, Guide on Mental Health, July 2021

This approach is not acceptable. The key best practices in the Guide on Mental Health should be a part of the Code itself and no longer be simply aspirational.

Recommendations | Mental Health

37. **The key best practices in the Guide on Mental Health should be included in an expanded range of commitments at Clause 104 including:**

    a. **proactively providing customers the actuarial or statistical data they rely upon should they deny coverage or only offer cover on non-standard terms due to disability**

    b. **regularly reviewing the data, they rely on to make decisions to discriminate and continually seek better data to enable differentiated underwriting of mental health conditions**

    c. **meeting their communications needs using channels that do not trigger mental health crises**

    d. **provide training and education to staff, particularly service or sales staff, on dealing sensitively with customers with a past or current mental health condition.**

LGBTIQA+

In June 2022, the Victorian Pride Lobby released a report into LGBTIQA+ experiences with insurance providers[41] seeking to understand challenges faced by groups within the LGBTIQA+ community; aspects of the customer journey that may be problematic for LGBTIQA+ customers, and potential barriers to LGBTIQA+ customers accessing or utilising insurance.

The report noted that the Code does not include sexual orientation, gender identity and sex characteristics as factors that cause vulnerability under Clause 92.

The research sought to redress this issue, acknowledging that, when we talk of vulnerability, it is not a person's sexual orientation, gender identity or sex characteristics that is the reason for their disadvantage, but rather the failure of institutions and wider society (including

[41] Victorian Pride Lobby, Worth the Risk LGBTIQA+ experiences with insurance providers, 8 June 2022

financial services like insurers) to ensure that everyone has equal access to services and equal rights when dealing with service-providers.

The report made 24 recommendations to improve LGBTIQA+ inclusion amongst insurance providers. Many of these can and should be met as commitments under the Code. If the reviewer believes it more appropriate to create a standalone Code-related document outlining these issues – then it must be enforceable under the Code and not simply voluntary and aspirational.

Recommendations | LGBTIQA+

38. **Clause 92 should include sexual orientation, gender identity and sex characteristics as factors that can cause vulnerability.**
39. **All insurers should provide publicly available information on whether and how LGBTIQA+ people are covered by their insurance policies, and tailored information for different population groups developed in consultation with peer organisations.**
40. **Insurer communications and marketing material should also include depictions of LGBTIQA+ people and inclusive language.**
41. **Insurers should provide LGBTIQA+ training to staff, particularly service or sales staff, to:**
    a. **help them understand if customers may be LGBTIQA+**
    b. **how best to support LGBTIQA+ customers**
    c. **how to take account of the needs of LGBTIQA+ customers, and**
    d. **how to engage with LGBTIQA+ customers with sensitivity, dignity, respect, and compassion, including identifying additional support for LGBTIQA+ customers.**
42. **Insurers should commit to ensure that:**
    a. **data on sex or gender are only collected where reasonably required in line with Clause 45**
    b. **the reasons for collection of data on sex or gender and privacy protections in place are made clear at the point of collecting the data**
    c. **questions are asked in a gender-neutral manner as far as is practicable**
    d. **titles are only used where required**
    e. **non-binary options for gender and titles are included**

f. **policies are in place directing staff do not default to certain genders or titles based on assumptions about a customer's gender or that of their partner**

g. **processes for changing name, gender and titles are as simple and comprehensive as possible**

h. **dead names and former genders or titles are removed from all records, except where required under law**

i. **all systems are updated when a customer changes their name, gender, or title and**

j. **a customer who is changing their name, gender or title need only speak to one customer service representative.**

Blood-borne viruses

The Victorian Pride Lobby report also found that just 6% of respondents living with HIV feel comfortable disclosing their HIV status or other factors to insurance companies and that 55% of people living with HIV always assumed that they would be excluded from taking out certain insurance policies.

The Institute of Many, a HIV peer organisation, recommends that applicant questionnaires be reviewed for sensitivity and to ensure less intrusive questioning. The Institute of Many also recommends that information on insurance coverage for people living with HIV should be communicated to the community, with consultation with HIV peer organisations prior to ensure appropriate messaging. This is because people living with HIV tend to rely on community networks and organisations to find which insurance companies will cover them.

Travel insurance applicants must disclose their HIV status and should not be excluded from getting insurance on this basis. However, according to the Victorian Pride Lobby report, people living with HIV reported exclusion, having to pay additional premiums for travel insurance, having to submit 'endless [...] medical reports' including assessment forms filled out by doctors, and uncertainty over coverage. This can cause some to not disclose their HIV status.

The Institute of Many recommends that travel insurers remove premium loadings for people living with HIV, particularly if a person's HIV condition is being managed through treatment.

Since the advent of antiretroviral drugs, HIV can be effectively treated, with thousands of Australians receiving this treatment each year.[42]

These issues are not unique to HIV. The Anti-Discrimination Board of New South Wales found that:

> 'people with hepatitis C are being routinely refused insurance or dissuaded from applying for insurance'[43]

and community organisation Hepatitis Victoria advises that:

> 'chronic hepatitis is considered a "risk" to many insurance providers, and you may not be approved for a policy or the costs may be increased.'[44]

Importantly, with the advent of new treatments known as direct-acting antivirals, hepatitis C is now curable, and thousands of Australians have undergone treatment and cleared the virus.[45] Antibodies of the virus remain behind, however, and there is evidence that some – including key professionals – may confuse this as evidence of the virus still being present/active, with potential implications for those so affected.[46] Issues such as these needs to be addressed for people with a history of hepatitis C.

In a 2022 article on insurance discrimination and hepatitis C,[47] Sean Mulcahy et al propose that:

> 'insurers should review their questionnaires around hepatitis C to ensure that the questions they ask are both necessary and posed in sensitive ways that are not stigmatising, for example, by not [...] demanding an unreasonably extensive medical history, or assuming

[42] Pharmaceutical Benefits Scheme, *HIV Antiretroviral Medicines: Utilisation Analysis Using PBS Data* (2021).
[43] Anti-Discrimination Board of New South Wales, *C-Change: Report of the Enquiry into Hepatitis C Related Discrimination* (2011) 80.
[44] 'Stigma and discrimination FAQs', *LiverWELL*.
[45] Kirby Institute *Monitoring Hepatitis C Treatment Uptake in Australia* (2020).
[46] Kate Seear et al, 'Echoes and antibodies: Legal veridiction and the emergence of the perpetual hepatitis C subject' (2023) 32(2) *Social and Legal Studies*.
[47] Sean Mulcahy et al, 'Insurance discrimination and hepatitis C: Recent developments and the need for reforms' (2022) 23 *Insurance Law Journal*.

connections between hepatitis C and liver conditions or intravenous drug use',

as this may encourage non-disclosure.

Recommendations | Blood-borne viruses

43. **Insurers should review applicant questions to ensure that questions asked about blood-borne viruses are necessary and asked in a sensitive manner that is not stigmatising.**
44. **Insurers should provide publicly available information as to whether people living with blood-borne viruses are covered by their insurance policies, developed in consultation with peer organisations to ensure appropriate messaging.**
45. **Insurers should review, with a view to removing, exclusions or premium loadings for people living with blood-borne viruses, particularly in situations where the virus is being managed through treatment.**

Sex work and adult industry businesses

Insurance can be difficult to obtain for sex workers and other adult industry businesses (including retailers and wholesalers of adult goods, sex on premises venues, adult entertainment venues, and media production companies making erotic content).

The Victorian Pride Lobby report found that 83% of respondents who were a current or former sex worker had experienced discrimination or exclusion by an insurance advisor or broker, and over 70% of sex workers experienced intrusive questioning, including questions about sexual history and questions on insurance forms using outdated language like 'prostitute', which may dissuade sex workers from disclosing their occupation in applications and claims.

The report also found that many public liability policies do not cover adult services and some respondents found business insurance to be 'useless' in this regard or reported being knocked back for insurance because of their sex worker status. Some sex industry businesses will require property insurance, including building and contents insurance, but could be discriminated against because of ostensibly moral judgments. Furthermore, a report by Scarlet Alliance, a sex worker peer organisation, found that some individual sex workers were unable to secure home

and contents insurance.[48] A report by Eros Association, the adult industry association, found that insurers can characterise adult goods and services as being of particular risk, in part due to the *Anti-Money Laundering and Counter-Terrorism Financing Act 2006*.[49]

Recommendations | Sex work and adult industry businesses

46. **Insurers should review applicant questionnaires to ensure that questions asked about sex work are asked in a sensitive manner.**

47. **Insurers should provide publicly available information as to whether sex work and adult industry businesses are covered by their insurance policies, and review, with a view to removing, exclusions or premiums that are based purely on the provision of adult goods and services.**

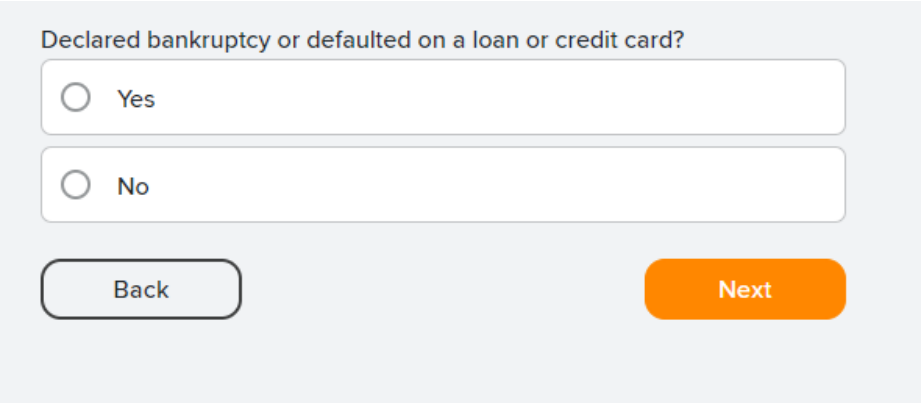
Customer personal insolvency

Consumer groups have identified that there have been, and still remain, insurers who seek financial history information for disclosure and underwriting purposes including where a person is or becomes insolvent, either through bankruptcy or a debt agreement under Part IX of the *Bankruptcy Act 1966*.

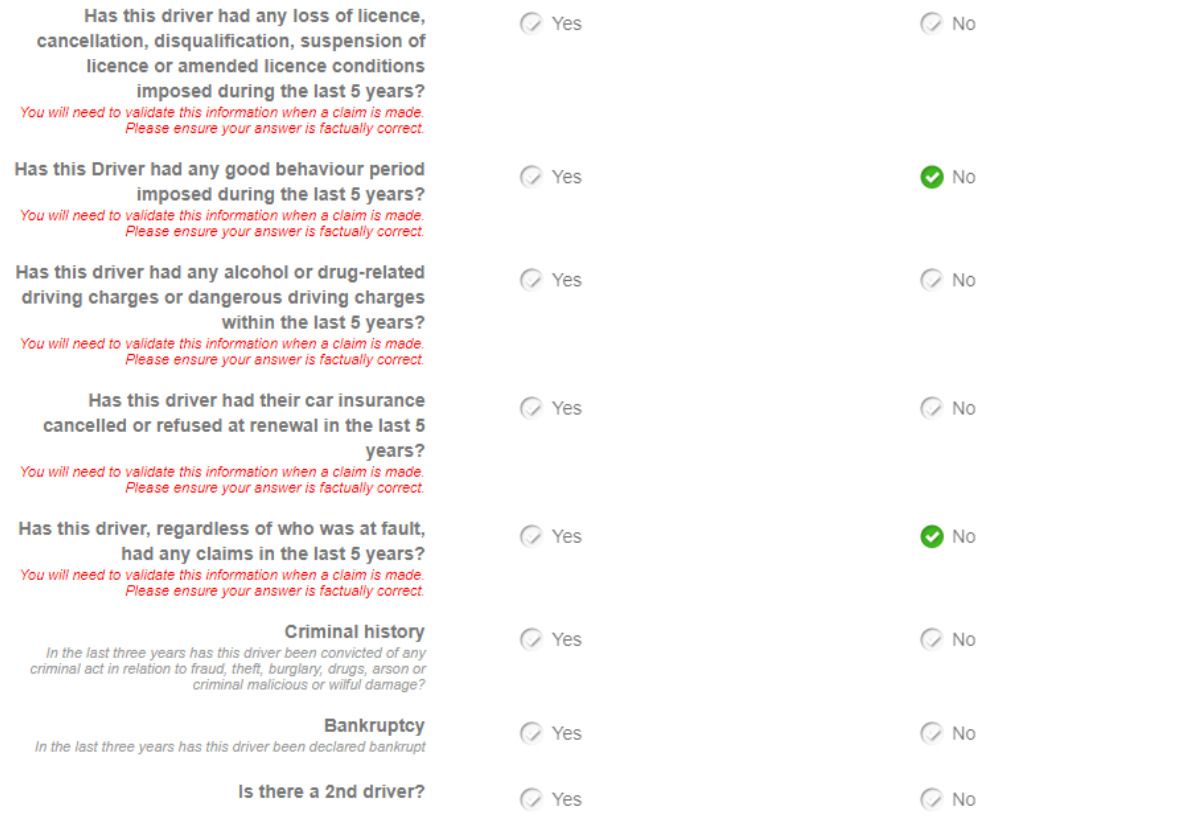
Insurers ask disclosure questions about personal insolvency on policies that have no obvious connection to insolvency, including car, home building and contents, landlord or travel insurance.

[48] Scarlet Alliance, *Unjust and Counter-Productive: The Failures of Governments to Protect Sex Workers from Discrimination* (1999) 19. This was also found to be the case in a 2020 survey by Scarlet Alliance on financial discrimination.
[49] Eros Association, *Financial Discrimination Against Adults-Only Businesses* (2017).

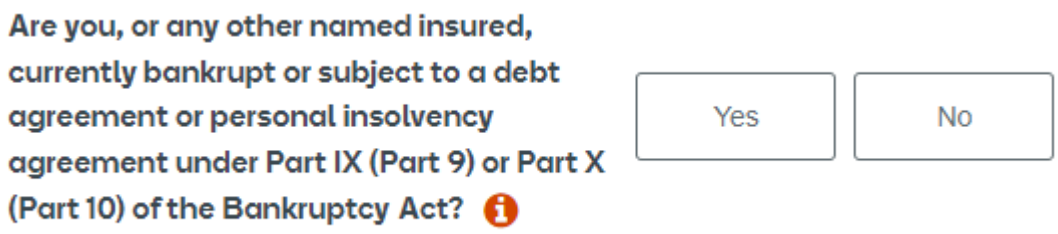
For example, PD insurance asks an applicant if they have declared bankruptcy or defaulted on a loan or credit card.



Carpeesh (RACQ) asks applicants if they have been declared bankrupt in the last three years:



Through the Woolworths brand, Hollard asks applicants if they have bankrupted or entered into a Part IX or X agreement.



Case study 9. Consumer Action – 506492

One caller in early 2021, a rural farmer, was unable to obtain policies for his home and contents, third-party motor vehicle and business public liability insurance because he had recently filed for bankruptcy. He told our financial counsellor that he contacted four different underwriters and was told they couldn't offer him a policy because the bankruptcy made him 'high-risk'. Eventually he found another insurer who was prepared to issue policies for his home, car and business.

It is difficult to understand why these questions are necessary or relevant to the risk. We have, for example, not seen any data to suggest that a person becomes a risker driver as a result of entering personal insolvency. Currently, if an insured does not meet their premium payment requirements, insurers are able to cancel a policy. Financial hardship is not, on the face of it, relevant to the insured events covered by a car or any other insurance policy.

Any higher premium or refusal to provide cover (or subsequent avoidance for non-disclosure) appears based on outdated notions of insolvency. Personal insolvency is no longer considered a moral wrong – it is about providing a 'fresh start' to the debtor and enabling their financial rehabilitation over time. Insurers' approach is counterproductive to these goals if it leaves a person's remaining and future cars, homes and bodies uninsurable. It essentially punishes somebody for being poor.

Once these impacts are disclosed to a potential bankrupt, it may dissuade people from choosing bankruptcy, potentially prolonging their financial difficulty or sending them towards predatory lenders and advisors in lieu of the fresh start they need.

Issues also arise where a customer is denied a claim on the basis of non-disclosure where someone specifically the person not realising that a Part IX Debt Agreement was a form of insolvency under the *Bankruptcy Act*.[50] This has led to a form of illusory insurance where Australians are driving the streets under the belief that they are insured when in reality they are not. This is because they have inadvertently – or in a small number of cases -

[50] See AFCA Determination 535017. See also AFCA Determination 801966

purposefully not provided the full picture of their driving history, insurance history, or any other relevant information to their insurer including in the above cases their insolvency status, at the time they purchased their insurance.

See further discussion under **Question 3.7 – Buying Insurance**

Recommendation | Customer Personal Insolvency

48. **No longer underwrite risks on the basis of insolvency nor ask consumers to disclosure whether they are or have become insolvent under Part IX of the *Bankruptcy Act 1966*.**

Age

Building specific commitments into the Code to support older Australians to enliven the reference to age at Clause 92 is a good example of how the Code should be expanded to address issues of vulnerability.

Insurers know their customer's age. This is basic information collected and included in client management databases. Insurers should ensure that their approach to older Australians shifts.

While many older people are adept at voicing their concerns and in using of variety of technologies, age can be a factor increasing an individual's needs, particularly where it intersects with other factors. Our organisations have seen older Australians mistreated by insurers who failed to make basic links between their customer's age, needs and their service delivery or product design.

Case study 10.–Alice's story –Financial Rights - S305290

Alice is an older Australian and has cancer. Alice had a water leak in a bathroom she doesn't use often. Her insurer has accepted claim but said they can't warrant work due to the age of house and will cash settle. Alice told the Insurance Law Service that due to age and poor health she can't arrange repairs.

Alice was also concerned with the communication practices of her insurer. Alice told the Insurance Law Service that her insurer would leave voicemails before she could get to the

phone and when she rang them back she was told she shouldn't have rung and they will send her an email.

Case study 11.–Gary's story –Financial Rights - S307498

Gary is an elderly pensioner who only has a home phone, with no access to email or post. His patio was damaged after a storm and made a claim on his home insurance. An assessor was sent down without his knowledge. The assessor climbed over a fence to inspect the patio roof for storm damage when Gary wasn't home. When Gary got home, he was shocked to find the assessor in his backyard as he had not provided access.

We also direct the reviewers to **Case Study 5**, Jill's story in the Joint submission to the Flood Inquiry[51] which vividly demonstrates the communication needs of an older Australian and the poor treatment she was subjected to. **Case study 10** of that same submission demonstrates the clash between product design and its impact upon an older Australian.[52]

Recommendations | Age

49. Insurers should commit to proactively approaching older customers to offer and provide specific assistance including:

- **a. checking in on their communication preferences specifically (in line with a general requirement to identify customer communication preferences)**
- **b. checking in on their ability meet the requirements expected to maintain their home and proactively obtaining that assistance or assisting them to obtain that assistance**
- **c. in cases of cash settlement, offer to pay for and arrange a project manager to assist: see further below at Question 3(d).**

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[51] See pages 19-20, Joint consumer submission to the Parliamentary Inquiry into insurers' responses to 2022 major floods, November 2023

[52] As above, pages 23-24.

Language barriers

The need to use interpreters is already recognised under Clauses 101-103 and are positive commitments that address language barriers. Despite this, our organisations have experienced some difficulties in enlivening these commitments. Westjustice, for example found that many essential services, including insurers, "frequently failed to offer, or declined access to, interpreters for our clients".[53]

In the previous review the ICA had the view that

> the industry standard should be that access to an independent interpreter is provided when requested or needed. However, this shouldn't be forced on someone who wishes to use a friend and family member for interpretation support and assistance.

We disagree that this position. Relying on family or friends is problematic particular in circumstances where there may be financial, elder or other abuse taking place. It may also unfairly prejudice a claim. Setting a standard of always providing an independent paid interpreter in all circumstances is the most appropriate approach and should be a minimum standard.

Similar to the issues raised in the First Nations customer section, people from non-English speaking backgrounds or refugee backgrounds are also at risk of unethical conduct relating to car repair services.[54] A big point of tension is services lying (or lying by omission) that they will liaise with insurers and get assignment of rights, extortionate hire car arrangements, etc. The insurance industry needs to be cognisant of this exploitation that can arise because of language barriers by not unfairly denying claims which are affected by this innocent conduct by insured parties.

Recommendations | Language barriers

50. Strengthen Clause 101 to:

a. require insurers to providing interpreter with exceptions only in genuinely exceptional circumstances, and

[53] Tess Matthews and Joseph Nunweek, Don't Settle For Less: The Settlement Justice Partnership and Fairer Outcomes for Refugees in Melbourne's West, Westjustice, July 2023

[54] See pages 59-60, Margo's story, Matthews and Nunweek (2023)

b. **Remove "where practicable" and commit to using an independent interpreter paid for by the insurer in all cases and plan ahead to meet these needs.**[55]

Cognitive ability

Issues with cognitive ability seem to fall between the cracks of a number of factors listed at Clause 92. We think that it is worth including given the range of issues that may be captured and the lack of support our organisations have seen provided to people experiencing a cognitive impairment.

Case study 12.–Louise's story –Financial Rights - S306203

Louise has traumatic brain injury. It affects her concentration and ability to read long documents. She is having lengthy dispute with her insurer over her contents insurance.

Louise was asked to attend an interview. In stressful situations, due to her brain injury, Louise sometimes freezes. Louise asked if she could answer the questions in written form. The insurer refused and then insisted she attend an interview.

Cognitive ability can capture a range of issues and experiences including age, injury, or disorders.

Designing processes for people with learning difficulties and or cognitive impairments through the use of simpler language, alternative text formats and clear page layouts can also improve outcome for all.: See **Question 3.9** re: Use of technology

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Recommendations | Cognitive Ability

51. **Clause 92 include cognitive ability in the list of example factors that increase the risk of vulnerability.**
52. **Commit to an approach to communicating (be it verbal, printed or online) with all customers in ways that are:**

[55] See the precedent set by 6.8 of the now defunct Voluntary Insurance in Superannuation Code of Practice.

a. **clear (i.e. using plain, simple language that is easily understood and avoids jargon)**
b. **accurate (i.e. factual and not intended to mislead**
c. **relevant (i.e. appropriate to the customer's individual circumstances) and**
d. **timely (i.e. provided when it is most useful).**

(c) How could the Code require or encourage better identification of potential vulnerabilities, other than at the point of claim? Should the assumption of vulnerability in the Code be reversed in certain situations such as those involving trauma? If so, how could the Code be amended to achieve this?

Insurers should commit to a more proactive approach and increased specific forms of training in line with the expectations of ISO 22458, as outlined above.

Clause 93 re: encouraging insureds to tell the insurer about their vulnerability is not drafted as a commitment to consumers and needs to be revised. This is because it places the onus on a vulnerable person to self-identify. This is unlikely to occur unless insurers proactively and compassionately engage with their customers to identify this information.

We are aware of at least one insurer who requests that callers tell the insurer about their "vulnerabilities." Such language is unrelatable to most people. Most people are proud and don't necessarily see themselves as "experiencing vulnerability" and so are unlikely to raise the issues that the insurer needs. They are more likely to identify as having "difficulties" or may simply be open to offers of further assistance such as providing implementing preferred communication options.

The Code should include a specific commitment to proactive identification (including through data analysis) and communication with respect to vulnerability. The current banking Code Clause 165 provides a model for this. Insurers hold a significant amount of information on their customers including their age, their location or spoken languages and thus should be aware of customers' extra needs..

In line with privacy law, insurers should commit to taking steps to record, with consent, the appropriate information to help support people experiencing vulnerability, where it will benefit the customer. For example, by ensuring they do not have to repeat their stories and be re-traumatised.

As outlined above, commitments on vulnerability training should also include specific references to forms of training that are well established and can assist in supporting the ability to recognise vulnerabilities.

Recommendations | Identification of Vulnerabilities

53. Re-draft Clause 93 to place the onus on the insurer to:

- **a. proactively work with customers in a compassionate manner to identify whether there are any risk factors that may be impacting their ability to engage with their insurance**
- **b. use data analysis to better identify where a customer has extra needs, contact those customers to discuss their situation and the options available to help them.**

54. Take appropriate steps to record, with consent, personal information to help support people experiencing vulnerability.

(d) How should the Code promote enhanced responses to customers experiencing heightened levels of vulnerability, particularly during a catastrophe?

If the principles-based inclusive design approach as outlined above is incorporated to recognise life events and situational vulnerability then this would be a positive step toward recognising this significant intersection of vulnerabilities that can arise after a catastrophe.

Specific reference should be made to the impact of natural disasters on vulnerability in the list of vulnerabilities at Clause 92, as well as the catastrophe section. This should a commitment to consider the circumstances of compounded trauma or vulnerability.

The catastrophe section then should outline additional commitments regarding improved communications, engagement and service delivery for those experiencing vulnerability post-catastrophe.

By implementing an inclusive approach to designing service delivery, the need to consider whether insurers should treat those people impacted by natural disasters differently to those impacted by a natural disaster but with compounded risk factors and vulnerabilities on top of those impacts, is moot. An inclusive service delivery and product design approach should flexibly empower insurers to treat all those with additional needs in the way they need.

2.5 How can the Code and/or its administration encourage greater compliance with vulnerability obligations?

As outlined above, a principles-based approach needs to be complemented by greater prescription with respect to specific commitments applied throughout the Code. Both insurers and consumers need to know what can be relied on and expected as minimum standards. That is why the Code needs to include more specific, prescriptive commitments rather than aspirational guidelines.

Unenforceable guidance falls into the trap of voluntary "aspiration" and "best practice" rather than establishing minimum standards and promises to consumers.

Any concern about length can be dealt with. Our concern has never been with the length of a code of practice – it has been about the lack of a comprehensive set of protections and ambiguity of commitments.

Further we refer to our recommendation for subscribers to take all reasonable steps to have in place the appropriate systems, processes, and programs to support compliance with the Code: see **Question 5.3.**

2.6 Are other mechanisms more appropriate than the Code to address issues related to the assistance insurers provide vulnerable customers and if so, what and why?

The Code is the ideal place to address most of the core, on-the-ground, practical issues faced by consumers impacted by difficulties. The above discussion demonstrates many of the specific examples where insurers can set minimum, common sense standards via the Code. However, there are some aspects of the issues that are either more complex, baked into the nature of the general insurance industry and its regulatory framework, or pose competition policy issues. These may need to be addressed at a legislative and regulatory level. They include:

- Standard definitions should be developed to address issues of poor insurance design, for example, including innocent victim's clauses or otherwise remove requirements to inform police in the case of a "malicious act" as "maintenance" "wear and tear" "defect clauses" and "pre-existing clauses". Consumer groups have also argued that all key terms and exclusions (natural hazard or otherwise) prescribed by standard cover should be standardised by government.[56] It should be noted though that there is a precedent to an industry committing to standard definitions in a Code. The Life

[56] Joint Consumer Submission to the Treasury consultation on Standardising natural hazard definitions and reviewing standard cover for insurance, 17 April 2024

Insurance Code includes 3 standard medical definitions regarding cancer, heart attack and stroke.[57] Including standard definitions agreed to by the industry may arguably be a preferable approach if done transparently and inclusively since it would provide greater flexibility to update and include new definitions than a statutory framework would enable.

- All insurers committing to including innocent victim's clauses, could be included in the Code but could also be included in an effective standard cover regime.
- Insurers should not place undue responsibilities on claimants that could compromise their safety. Of particular importance is the requirement in many insurance products to inform police in the case of a "malicious act".

  Financial Rights research found that this can pose a significant risk in cases of domestic violence which has already been recognised as a risk by consumer advocates and some insurers.[58] Instances of domestic violence are not the only circumstances in which informing the police may cause harm. For example, a person exposed to violence may not have previously reported this to the police and may be subjected to providing additional evidence to obtain this exemption. In addition, and articulated by participants in the current research, risks of violence can result from a wide range of potential perpetrators or adversaries and from a range of causes including mental illness. The research also identified additional reasons that might provide a disincentive for people to report an incident to the police. Not least of these is a perception that there is often little the police can do, and that police time is better spent pursuing more "serious cases". The insurance industry needs to consider abandoning this requirement, given the often-undue encumbrance the requirement to report malicious acts to the police can place on claimants, and noting that not all insurers have this requirement. This could be done so under the Code but again could also be addressed under either a standard definition or an effective standard cover regime.
- Improving the ASIC regulatory guidance on design and distribution obligations, through more specific expectations on vulnerability would be of assistance.

[57] See clause 5.67 and the Medical Definitions section of the Life Insurance Code of Practice 2.1.1
[58] Diana M. Grace, Ph.D. and Michael J. Platow, Ph.D., Standardising general insurance definitions March 2022

The Code and the Law

2.7 How effectively does the Code interact with the law and how, and in what areas, could this be improved?

(a) Are paragraphs 18 and 20 of the Code sufficient to manage any conflict or inconsistency between the Code and the law? What changes would you propose to these paragraphs, if any, and why?

We have no strong view regarding Clauses 18 and 20 other than the Code should be a term of the terms and conditions/contract of all relevant insurance products to provide a contractual right to consumers in line with the banking and customer owned banking codes.[59]

(b) Are there any paragraphs of the Code that should be amended or removed due to subsequent regulatory changes? If so, which paragraph and why?

We do not accept that the Code should remove provisions that are seen to be restatements of the law. Removing commitments from the Code means that:

- the CGC would no longer oversee compliance with these areas, making it more difficult for it to identify and highlight systemic and emerging issues
- there will be a reduction in the areas where the CGC can justify specialised investigations and analysis
- consumers will no longer have an easily accessible source of information regarding their rights and will be forced to read through legislation and regulatory guidance documents.

While ASIC would in theory oversee compliance with areas already covered by law, it is unlikely that it would ever conduct the same level of specific compliance work and monitoring that the CGC currently undertakes given the limited resources of the organisation and breadth of regulatory coverage. Further ASIC does not publicly issue annual breach statistics that drill down into the same level of detail as the CGC currently does.

Removing any parts of the Code would be a significant step backwards in the concept of self-regulation.

[59] See **Recommendation 179** below

2.8 How can the Code go beyond the law? And would it be appropriate to do so? For example:

The Code should include commitments that spell out minimum standards that insurers will undertake to meet the requirements of the law. That expectation is spelled out under ASIC RG183 to do so (noting that Codes as a whole, can and should still include commitments that replicate the law.)

(a) Paragraph 21 of the Code and the general obligation of AFS Licensees to provide financial services efficiently, honestly and fairly.

Clause 21 currently extends the commit beyond section 912A of the *Corporations Act* to include concepts of transparency and timeliness.

Clause 22 asserts that the Code sets out how the obligation will be met.

While the Code can provide some guidance as to how this legal obligation is to be fulfilled, it cannot be the sole list of ways that insurers will meet the requirements of Clause 21. There are clearly circumstances that will arise that will require honesty, efficiency, fairness, transparency and timeliness that are not specifically addressed in the Code. It certainly cannot be the sum total of insurer's obligations under section 912A.

Currently Clause 21 would *not* meet the requirements of an enforceable code provision under the extant regime given the broad nature of the terms used. It however is a key commitment and it needs to be able to be enforced.

Given the constraints of the current enforceability regime, it can be made enforceable contractually via the Code being included as a term of the contract.[60]

(b) Paragraphs 28 and 38 of the Code and the general obligation of AFS Licensees to ensure representatives are adequately trained and competent to provide the financial services.

We support further detail being provided here regarding:

- specific forms of training.[61]
- increased commitments regarding monitoring of service suppliers.[62]

[60] See **Recommendation 109**
[61] See **Question 2.4**, as well as **Question 3.4** and **3.5**.
[62] See **Question 3.5**

(c) Paragraph 43 of the Code and design and distribution requirements relating to financial products for retail clients.

The Code must do more to address product design and distribution to provide more "meat on the bones" of the requirements under ASIC RG 274 and in particular RG 274.47 regarding vulnerability.[63] This would be in line with the approach advocated above regarding commitments to meeting the requirements of ISO 22458 and applying inclusive design (above at **Question 2.4**).

Addressing issues of vulnerability, for example, should not be left to commitments regarding service delivery alone. The Code is the appropriate place to make commitments regarding product design and distribution and we have made a number of recommendations in this submission regarding commitments that clarify the requirements under ASIC RG 274.47.[64]

There are additional ways that insurers can expanded upon the commitment under Clause 43.

Having a "publicly available policy on our approach to the development and distribution of our products for appropriate target markets" is on our reading not the same as the requirement to make a "Target Market Determination" (**TMD**) available.[65]

If it is the intention that it is the TMD that needs to be made publicly available, then this needs to be clarified but also supplemented with making publicly available their approach to developing TMDs and meeting the design and distribution obligations.

Further, we have seen examples of insurer advertising that asserts that customers should read the TMDs.[66] This is inappropriate since it undermines the intent of the design and distribution obligations regime to shift responsibility back on to the insurer to design suitable products. It also does not match the requirement under the law. When this was brought up by consumer advocates with the ICA, the response we received was that Section 1018A(1)(ca) of the *Corporations Act* requires insurers to make the statements. On our reading this is incorrect. Section 1018A(1)(ca) requires insurers to:

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[63] ASIC RG 274 Product design and distribution obligations, December 2020

[64] For example, the discussion of product design issues and First Nations communities at **Question 2.4(b)**

[65] See section 994B(2) and (9), Corporations Act.

[66] NRMA has stated in its advertisements "Always read the PDS and TMDs from NRMA Insurance at nrma.com.au." RACV says" Before making decisions please consider your own circumstances and the Product Disclosure Statement and Target Market Determinations."

a. describe the target market for the product in the advertising *or*

b. specify *where the determination is available (our emphasis)*

Section 1018A(1)(ca) does *not* require insurers to include a statement that a consumer consider a TMD or should read a TMD. In fact, Section 1018A explicitly *only* requires that "a person should consider the Product Disclosure Statement in deciding whether to acquire, or to continue to hold, the product".[67] The fact that TMDs are not listed here at subs (e) should clarify the issue.

Ideally the TMD should be *described* in the advertisement as per Section 1018A(1)(ca) – but insurers don't do this. Insurance advertising is largely filled with vague platitudes and unspecific promises to be there when you need them. Since insurers don't usually describe their target market they do have to at least say they have a TMD *available*.

The Code should commit insurers to clarify in their promotional material that consumers are not expected to read the TMD.

Given the rising impact of climate change, insurers should also commit to ensuring that products offered are designed to meet the needs of consumers who live in parts of Australia prone to severe weather events and are fit-for-purpose, providing adequate cover in times of need (including appropriate temporary accommodation benefits and other costs in addition to the sum insured amount, such as for debris removal).[68]

Recommendations | Target Market Determinations

55. Clarify in promotional material that consumers are not expected to read the TMD.

56. ensuring that products offered are designed to meet the needs of consumers who live in parts of Australia prone to severe weather events and are fit-for-purpose.

(d) Paragraph 79 of the Code and the Cash Settlement Fact Sheet.

[67] Section 1018A(1)(e)

[68] See page 2, ASIC Letter of Expectations: Insurance claims and natural disaster events, 17 December 2020

It is worth examining the two different requirements on insurers to provide a Cash Settlement Fact Sheet and "information" under Clause 79 since providing consumers with two different sets of information may lead to confusion.

Having said that simply removing the obligation would not address the issues we have identified elsewhere in this submission.[69] Insurers should make commitments in line with those recommendations to address the gaps and failings of the CSFS and improve consumer outcomes more generally with respect to the cash settlement process.

(e) Part 11 (Complaints) of the Code and enforceable paragraphs of RG 271.

The ABA have taken the step to remove the complaints section of the Banking Code replacing it with a direction for consumers to read RG 271. Consumer advocates have strongly opposed this approach in the Banking Code and would oppose such an approach in the General Insurance Code.

Removing provisions that are replicated in RG 271 reduces the value that referring to the Code offers general insurance customers. The time that consumers are most likely to consult the Code is when they are looking to make a complaint. Removing these provisions from the Code will make guidance on the complaint process more difficult to find.

For customers who do refer to the Code, it is easily searchable. It seems far less likely a consumer seeking to find out about the complaints process is going to seek out an ASIC regulatory guide at the Code's direction to understand the commitments banks make about complaints. ASIC regulatory guides are not drafted in plain English for general consumption, but for regulated industry compliance lawyers to better understand their regulated entities' obligations under the law. We appreciate that there are other ways insurers communicate this information, but it remains important to have in a public document that outlines key commitments insurers made to customers in one readable document, rather than scattered across regulatory guides and the common law.

Removing Part 11 would confuse consumers and make understanding their rights a challenge.

At worst it will work to frustrate consumer attempts to seek the restitution or justice where needed and subsequently act as a barrier to consumers to activate their rights.

The current provisions in Part 11 go beyond the law or clarify the law in some respects. For example, the commitment that the person who handles the complaint will not be the person

[69] See **Question 3.10**

whose decision or conduct is the subject of the complaint (para 144) and the commitment to keep the complainant informed of the progress of the complaint every 10 business days (in para 146) go beyond the legal requirements in RG 271.

There is scope for Part 11 to go even further:

- providing more detail about how insurers will meet the strict requirements of RG 271
- explicitly making more of the guidance (ie the non-enforceable paragraphs in RG 271) in RG 271 binding on insurers, and
- in some respects setting more demanding requirements than those in RG 271.[70]

2.9 In which areas could the Code help Code subscribers meet legal obligations by setting out good practice?

We generally do not support the Code including aspirational elements. A promise is a promise. The Code should set minimum standards to be met by insurers and able to be relied upon by consumers.

[70] See **Questions 3.13 and 3.14**.

Retail Insurance and Wholesale Insurance

2.10 Should the application of the Code to retail and wholesale insurance – and in particular small and medium sized enterprises (SMEs) – be reviewed and if so, how?

SMEs should have access to all the commitments made under the Code.

This can be done by extending the Code to cover wholesale insurance or develop a standalone Code for those wholesale products – as we have argued previously.

Consideration could also given to the CGC position during the last review that the Code should be extended to apply to small business consumers of products that currently fall outside the Code's definition of Retail Insurance, but which are covered by Section E of the Australian Financial Complaints Authority (**AFCA**) Rules, such as "general property", "theft" and "loss of profits/business interruption".[71]

The key reason provided in the last review for not including wholesale insurance was that it would involve additional costs, thereby diverting resources from retail insurance and individual consumers. This can be overcome by providing the CGC with the appropriate resources.

Recommendation | SMEs

57. SMEs should have access to all the commitments made in the Code.

Body Corporates and Strata Insurance

There remains some ambiguity and confusion regarding the applicability of the Code to strata insurance, and in particular the rights afforded owners given they are technically third-party beneficiaries to a strata insurance product. Most insurance-related duties are delegated to the strata manager. They in turn deal with insurance brokers, seeking quotes on behalf of the owners' corporation, providing these to strata committees, before voting and decision-making. Strata managers are not making the decision, but the management of building and insurance is delegated.

[71] AFCA Complaint Resolution Scheme Rules, 7 March 2024

There are a number of complex issues at play. There is significant lack of transparency with opaque or incomplete disclosure to the owners corporation and the owners themselves of strata insurance-related transactions.[72] There are significant and multiple conflicts of interest regarding commissions for strata managers and insurance brokers that are not transparent to owners. And then there are disputes that arise between owners, owners corporations, and insurance companies.

According to the ICA in its Final Report on the previous review:

> In practice, insurers generally treat all residential strata as retail insurance rather than assessing each case on the basis of whether the small business limb of the definition has been met.[73]

However, it chose not to so on the basis that:

> clarifying the definition as proposed in the interim report is likely to cause more confusion. Defining residential strata to exclude mixed use and high value strata insurance would require these exclusions to be defined as well. We note the CGC's submission that they currently treat residential strata as retail insurance for the purposes of the Code, and as such, we do not see any gaps in the application of the Code.
>
> Instead, the ICA recommends more work, through the ICA website, to promote the rights of residential strata consumers under the Code.[74]

We are unaware whether this work was implemented. From a consumer and consumer representative perspective confusion still reigns.

It is important to clarify the status of strata insurance (including mixed use strata insurance) to spell out the rights of owners in engaging with insurers and under the Code.

While there are other consumers that will be defined as third party beneficiaries, owners in owner corporations pay the premium and need to understand their legal position regarding

[72] John Trowbridge, Independent Review of Strata Insurance Practices, Consultation and discussion paper for Phase 1: disclosure, March 2022
[73] See 13.4.1.3, page 79, ICA, (2018)
[74] As above

these insurance products. The Code can assist in promoting this increased disclosure and transparency.

It is our view that all strata products should be subject to the Code, owners should be able to engage directly with insurers on these products and that greater transparency should be promoted by subscribers offering these products.

Recommendations | Strata Insurance

58. **Clarify the applicability of the Code to strata insurance and extend all protections to owners.**
59. **Set out the rights of a third party beneficiary owners under strata insurance products in the Code.**

2.11 If there were different application for SMEs, should the Code adopt the AFCA definition of an SME as an organisation with less than 100 employees?

Yes – ensuring that there is one definition of SMEs is important to remove complexity and confusion.

Recommendation | Definition of SMEs

60. **The Code should adopt the AFCA definition of an SME as an organisation with less than 100 employees.**

2.12 Should the Code distinguish between the commitments of insurers for consumers dealing directly with an insurer and those who have an intermediary (including insurance brokers) acting on their behalf? If so, how?

No. Just because a consumer or small business engages an insurance broker does not discount the need for insurers to meet their commitments under the Code, nor does it remove the vulnerabilities that someone may be experiencing.

Other Parts of the Code

Key Obligation – Honest, Efficient, Fair, Timely and Transparent

3.1 Do you have any feedback on the practical operation of the over-arching obligation in paragraph 21, including whether the Code could expand on what 'honest, efficient, fair, transparent, and timely' means, in the context of general insurance?

See comments under **Question 2.8(a)**.

3.2 Do you consider that paragraph 21 is restricted in its operation by paragraph 22, and if so, why? How could this be addressed?

Yes – see response to **Question 2.8(a)**.

Standards for Employees and Distributors

3.3 Do you have any feedback about the practical operation of Part 4 of the Code, including the relevant definitions in Part 16? Does it deal effectively with ensuring that Code subscribers are accountable for the conduct of their employees and distributors?

There is significant complexity and confusion with respect to the application of the Code to a multitude of different internal and external parties. In alphabetical order, the Code refers to:

- Australian Financial Service Licensees
- Collection agents (subset of Service Supplier)
- Distributors
- Employees
- External Experts
- Investigators (a subset of Service Supplier)
- Loss Assessor (a subset of Service Supplier)
- Loss Adjuster (a subset of Service Supplier)
- Service Suppliers
- Solicitors.

Different Code commitments apply in different ways that are not always clear.

It is our view that all internal and external actors - i.e. all of the above list must be equally subject to the Code, where relevant. The Code should be redrafted to provide clarity and simplicity in this regard.

Specific commitments regarding say external reports or the expectations of investigators should apply equally to internal and external parties as if there were no distinction.

Consumers deal with third parties on the basis that they are acting on the insurer's behalf to provide a service. The distinctions between the types of arrangements means nought to someone seeking to have their claim managed and repairs (or other services) deployed.[75]

75 For example, Carrie in **Carrie's story** should be able to expect that all the assessors, claims managers and restorers that she dealt with in having her home restored after a natural disaster, act in accordance with equal standards and that the insurer will deal with any and every problem that arises. See Carrie's story at pages 20-21 and 29-30, Joint Consumer Submission (2023)

Doing so will ensure inclusive design principles embedded in the Code will apply to all insurer and insurer related entities.

Insurers can negotiate formal agreements that bring the third party in line with all the relevant commitments under the Code.

Further detail is required under Clause 30 to outline standards that should apply to a monitoring program including how regularly it should be monitored, how they should be resourced, and how the process can be made more transparent including through the sharing of information with the CGC. There is currently nothing under the Code requiring insurers to meet their policies or monitor whether insurers are meeting their policies - rather the commitment is strictly to have a *policy*. Insurers could read this obligation down in the same way that they have read down the obligation to have a Family Violence Policy.

Insurers should commit to regularly monitoring third party distributors (including through the collection and sharing of data) to ensure that consumers are receiving the full discounts promised.[76]

The level of empathy exhibited during interactions between employees, distributors, service suppliers and consumers, particularly in distressing situations, is vital for fostering positive experiences and minimising disputes. Empathy is essential when consumers face crises such as property losses or accidents. Implementing a standard of empathy within the Code would ensure that all consumer engagements are conducted with genuine compassion, which can transform challenging encounters into supportive and trusting experiences. To operationalise this, the Code should be amended to specifically mandate empathetic communication across all consumer interactions, outlining clear guidelines and setting expectations for how staff should empathetically engage with consumers: See **Question 2.4** and **Recommendation 29.a**.

Further sanctions should be included under Clause 31 to dealing with concerns, such as termination of an agreement.

Recommendations | Third Party Standards

61. Code should be redrafted to reduce confusion over types of internal and external parties and ensure that they are all equally subject to the Code, where relevant.

[76] : p27 ASIC Rep765

62. **Clause 30 should outline specific standards that should apply to a monitoring program including:**

    a. **how regularly it should be monitored,**

    b. **how they should be resourced, and**

    c. **how the process can be made more transparent including through the sharing of information with the CGC**

63. **Insurers should commit to regularly monitoring third party distributors and their pricing practices.**

64. **Insurers should commit to terminating agreements where third parties consistently breach Code commitments.**

3.4 Should the Code be more prescriptive on the training requirements for employees, distributors and service suppliers? If so, how would the Code achieve this given the different and varied roles across the industry?

Yes, it should detail the types of training that should be required including forms of vulnerability training described above at **Question 2.4(a)**.

Implementing mandatory empathy training for all personnel involved in consumer interactions should be considered a foundational requirement, ensuring that all parties are equipped to meet these standards effectively.

Standards for Service Suppliers

3.5 Do you have any feedback about the practical operation of Part 5 of the Code, including the definition of Service Supplier in Part 16? Does it deal effectively with ensuring that Code subscribers are accountable for the conduct of their Service Suppliers?

We reiterate the need to simplify the Code and have it apply to all third parties equally and where relevant.

Insurers should commit to providing comprehensive training to claim consultants, monitor decision making and implement processes that ensure the consultants can identify and escalate expert recommendations that are not well substantiated.

The role of the insurer in managing third party service suppliers needs to be further articulated. Insurers need to commit to monitoring and maintaining adequate oversight of service suppliers, (including External Experts, Loss Assessors, Loss Adjusters and Investigators). This should include a commitment to notify consumers about the order and timing of attendance at their homes: See **Question 3.9.**

Concerns about conflicts of interest among service suppliers are pronounced, particularly due to their financial and operational ties to insurers. Reports of insurers directing assessments towards certain outcomes highlight the potential for biased results that disadvantage consumers. There is a need for greater independence and impartiality in these relationships. Furthermore, in cases of disputes, insurers should be required to cover the cost of a second opinion from an independent supplier, alleviating the financial burden on consumers. Additional transparency is also necessary, with a call for clearer disclosure of the qualifications of individuals conducting assessments and their obligation to serve both insurers and consumers equally. This approach aims to establish fairness and remove any perceived biases in expert assessments, fostering trust in the insurance process.

In line with the need to ensure all third parties providing services on behalf of an insurer, the Code needs clarify or extend the definition to include suppliers. The present version of the Code fails to comprehensively cover all relevant service providers that should be governed by Part 5, specifically excluding storage suppliers, builders and various external experts who contribute professional assessments to claims.

Greater oversight is specifically needed in the realm of subcontracting. We note that Clause 40 requires insurers to approve a service supplier subcontracting a service on their behalf.

However, it makes no statement regarding the bona fides or licensing of these sub-contractors. This needs to be addressed in the Code.

See also Standardising expert reports under **Question 3.11** below.

Recommendations | Service Suppliers

65. **Cover the cost of second opinions from an independent supplier. Alternatively, subscribers should contribute to a fund to support AFCA complainants to obtain independent expert reports.**
66. **Clarify or extend the definition to include all forms of suppliers including storage suppliers etc.**
67. **Extend Clause 40 to ensure insurers obtain and approve the bona fides or licensing of these sub-contractors.**

Buying and Cancelling an Insurance Policy

3.7 Do you have any feedback on the practical operation of Part 6 or 7 of the Code? Do these Parts deal effectively with consumer issues or concerns around purchase, renewal and cancellation processes?

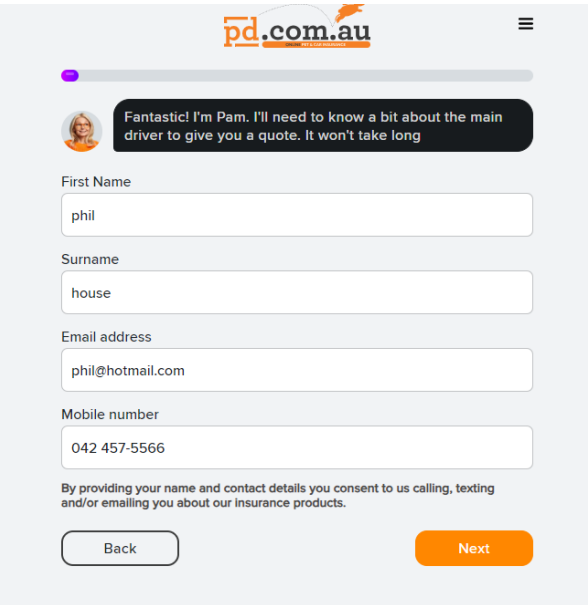
A number of issues have been identified in ASIC, CGC and consumer reports and submissions regarding the selling of insurance. These relate to:

- Pressure selling
- Buying insurance
- Automatic renewals
- Sum insured
- Renewal notices
- Accessing disclosure information

Pressure selling

Our organisations have identified selling techniques that border on pressure selling.

When applying for a quote with PD, to proceed with the quotation process, an applicant is obliged to 'agree' to be contacted by PD Insurance about 'our insurance products' by simply providing details for a quote (as set out below):



We are also aware that when applying for insurance with Youi, an online applicant receives a call from a Youi salesperson within seconds of applying for a quote – usurping the communication choice of applicant and placing them in a more pressured environment.

Both these approaches impact upon the positive and voluntary consent of applicants, are far from fair and transparent and may in fact be forms of "dark patterns" or deceptive design: see **Question 3.9**.

Recommendations | Pressure Selling

68. **Provide further guidance to Clause 44 and 21 to address the usurping of consent in the examples provided above.**

69. **Clarify Clause 44 so that the insurer has responsibility for all instances of pressure-selling.**

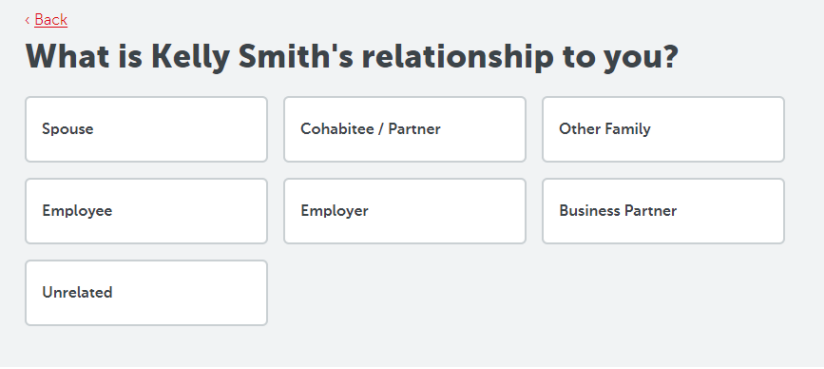
Buying Insurance

We are concerned that during the application process for car insurance, some insurers are asking for information that is irrelevant to their underwriting decisions.

Relationship status

We see instances of insurers asking inappropriate and irrelevant questions about relationship status.

For example, Budget Direct asks if someone (in addition to the applicant) will also be driving the car (or words to that effect). It then goes on to ask more detail about the applicant's relationship status:



It is unclear to us why 'spouse' and 'cohabitee/partner' need to be separately described. That is, why is this distinction relevant under section 45 of the Code. It is also unclear why a person's relationship status is relevant at all where Auto and General has already asked about whether someone else will be driving the car. This is potentially discriminatory.

PD Insurance also makes very specific enquiries about relationship status. Again it is unclear how this is relevant at all. The question requires the user to choose one of the following, even if you respond 'yes' to the question, 'Are you the only person who will be driving all cars on this policy?':

- Married
- Single
- Divorced
- Widowed
- Separated
- De facto relationship

Clause 45 re: buying insurance currently requires insurers to only ask for and rely on information relevant to the underwriting decision. It is unclear how the solicitation of this information is relevant.

We have raised a similar issue with respect to the collection of data re: sex or gender (see **Question 2.4(b) above**)

The examples above may simply be in breach of Clause 45, however it is worth considering whether this clause needs to be updated to commit to regularly reviewing insurer underwriting policies and disclosure questions with a vulnerability lens to identify where they may be asking irrelevant questions such as relationship status, sex or gender. If they are relevant, information should be provided on request to explain, in plain English, how they are relevant.

Financial status

We have already outlined the irrelevant questions asked of applicants regarding their financial status above at **Question 2.4(c)**. Similar to the relationship questions above, it is difficult to see how these questions meet the requirements under Clause 45 of the Code.

Data analysis

We are also concerned about insurers using secondary data analysis and correlation from disclosure information for underwriting purposes[77].

[77] InsuranceNews, Zurich deploys AI to flag mental health factors, 27 May 2024

Recommendations | Inappropriate Disclosure Questions

70. **Re-draft Clause 45 to ensure that a vulnerability perspective is applied to disclosure questions, including whether specifics are required to address current practices regarding relationship status, sex, gender and financial status.**
71. **Re-draft Clause 45 to make sure that insurers will ask for an rely on information and documents only if they are *reasonably* relevant to a decision.**
72. **Extend the scope of Clause 45 to include the setting of premiums.**
73. **Strengthen Clauses 47, 161 and 162 to:**
    a. **automatically provide the information that was relied on, and**
    b. **highlight the use of any secondary data analysis or correlation.**

Automatic renewal

Automatic renewals remain a concern for consumers. While automatic renewal may suit some people, the process doesn't incentivise consumer engagement including with respect to their premium level and their sum insured (see further below in the following section on sum insureds).

The ACCC has stated that

> "[w]hile not necessarily unfair, automatic renewal clauses are concerning when:
>
> they are not adequately disclosed
>
> no notice is provided that a contract is about to renew
>
> the publisher 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.[78]

Further, in line with the increase in consumer concerns with respect to data handling practices, scams and privacy, the approach to consent under the law is changing, and should be applied to automatic renewals.

The Consumer Data Right established the standard that consent be voluntary, express, informed, specific as to purpose, time limited, and easily withdrawn.[79] The recent review of the Privacy Law has also recommended, and the Government has accepted, the recommendation that the definition of consent must be voluntary, informed, current, specific, and unambiguous.[80]

Default "privacy on" settings, with individuals having to give express affirmative consent for uses and disclosures (opt-in) also gives far more control than "opt-out" opportunities.

The approach to automatic renewal and consent under the Code therefore is out of sync with general consumer expectations and appropriate practice.

Moreover, we note that the UK have introduced rules in 2021 to address poor automatic renewal practices in their market where insurers make it more difficult for customers to make informed decisions and raised barriers to switch. These new rules – including amongst other things providing consumers with a range of accessible and easy options to stop their policy from auto-renewing - are solid, baseline principles that should be committed to in Australia.

These changes will also contribute to addressing affordability and switching issues.

Recommendations | Automatic Renewals

74. Clause 49 re: automatic renewals should be updated to provide the following commitments:

a. at initiation, require explicit, unbundled consent to auto-renew – not simply provide the option to opt-out

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[78] Page 9, ACCC, Unfair terms in small business contracts, A review of selected industries, November 2016

[79] Competition and Consumer (Consumer Data Right) Rules 2020

[80] See Recommendation11.1 Privacy Act Review Final Report 2022

b. **provide consumers with a range of accessible and easy options (including by telephone, post, and email or online) to stop their policy from auto renewing**

c. **allow consumers to opt out of auto renewal at any point during the contract term**

d. **allow consumers to opt out of existing auto renewal**

e. **commit to not placing unnecessary barriers on consumers wanting to opt out of or stop auto renewal, including dark patterns such as "Hotel California" tricks**

f. **introduce a timeframe of 1 month around when an insurer will remind the consumer about the automatic renewal process.**

Sum insured

The way retail insurance products work in Australia places almost the entire onus for setting one's sum insured on the consumer. This has left consumers underinsured at claims time[81] and has contributed to a spate of underinsurance. This is for a number of reasons.

Firstly, people have underestimated the appropriate sum insured. This is not necessarily the consumer's fault. Determining what it will cost to rebuild after a total loss is difficult. Variations in estimates on sum insured calculators are common. Insurers do not use standardised calculators and many have customised their building cost estimations (including varying the questions that consumers are asked).[82] In some cases consumers cannot accurately answer questions asked about their property because of language difficulties, literacy levels, basic numeracy or an inability to estimate size areas or accurately describe building materials

Secondly, building code standards increase as do rebuilding costs especially after an extreme weather event. Sum insured calculators do not necessarily incorporate the most up-to-date information about inflation or a property's building code requirements. Sum insured calculators are not transparent enough to know definitively. Even if a consumer has chosen an accurate sum insured when they were first insured, many do not update the amount in light of renovations, building code changes or changes natural hazard risks.

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[81] For example see case study 32 in, Joint consumer submission, Flood Inquiry (2023), and Harry's Story in Financial Rights, Exposed, (2021)

[82] See Julia Davis, Loyalty taxes and the other problems with insurance in Australia, 22 February 2024

Thirdly, the costs of debris removal are generally a part of the sum insured rather than in addition to it – thereby eating into the total amount available for a rebuild. People do not always appreciate this distinction and underestimate the likely cost of same, professional clean up services. Government sponsored programs have helped in this regard but the benefits have not always been passed on consistently by the insurer.

There is also a number of structural and behavioural biases at play. There is for example, a lack of incentive for consumers to update their sum insured at renewal time, especially if they are facing affordability constraints. They do not update it because it is not structurally built into the renewal process, and automatic renewals encourage disengagement. Consumers also tend to let their insurance product roll over year to year without updating the sum insured amount, often mistakenly assuming that rising premiums equate to a rising sum insured. People don't always check the sum insured on their renewal notices. Disclosure methods including informing an insured to update a sum insured are next to useless.

Insurers can and should be doing more to help consumers keep their sum insured amount up to date. Almost half, 45%, of those with home insurance had not updated their policy for more than 12 months.[83] Insurers should be required to proactively warn consumers if they think they are potentially underinsured. This warning should be built into the purchase journey.

Insurers should also include a warning on renewal notices and include records of the annual sum insured calculations insurers have done which resulted in the underinsurance warning. This was a key recommendation of the ACCC's Northern Australia inquiry, which has yet to be adopted.

We are not recommending that insurers provide tailored financial advice to their customers, only that they ensure their own sum insured calculators are up to date with the latest climate peril, inflation and building code data, and that each year insurers compare the sum insured set for the property with their own total rebuild cost calculations. If a customer is underinsured, a (consumer-tested) warning should appear on the renewal notice telling the consumer to review their sum insured. This should also be supplemented with other methods of communication to ensure the customer's is alerted to the problem.

Ultimately, insurers need to be doing more to assist consumers in this complex process. There needs to be a shift in responsibility from individuals to insurers to ensure that the sum insured remains up to date.

[83] CHOICE Impact of Climate Crisis on Insurance research included in CHOICE et al, Weathering the Storm: Insurance in a changing climate, August 2023

Recommendations | Sum Insureds

75. **Insurers need to provide commitments on sum insured beyond that currently found in Clause 48 including:**

    a. **ensuring that sum calculators are accurate and standardised across the industry**

    b. **providing a receipt produced by a sum calculator for the consumer and the insurer's records**

    c. **proactively warning customers if they are underinsured (by calculator standards) at inception and renewal**

    d. **providing an estimated updated sum insured for home insurance customers and advise them of this estimate on their renewal notice. This estimate should note when the information used by the insurer to form the estimate was last updated by the consumer and direct the consumer to contact the insurer if renovations/ alterations to their home had occurred since then**[84]

    e. **debris removal and architectural fees should not be included in the sum insured but should be provided as benefits over and above the sum insured**

    f. **alternatively insurers should clearly disclose the types of costs that will count towards the sum insured amount for buildings (such as the costs of demolition, debris removal or for professional fees) where these are not provided for through a separate allowance under the policy.** [85]

Renewal notices:

Renewal notices are a crucial prompt to consumers to consider premium increases, switching or updating their sum insured and coverage. The *Insurance Contracts Act 1984*currently requires insurers to provide written notice no later than 14 days before a contract is due to expire. The ACCC found in its Northern Australia report that 14 days does not provide consumers with sufficient time to consider their renewal quote and explore their insurance options.[86] It may also not provide sufficient time for some consumers to have ready access

[84] Rec 18.4 ACCC, (2020)
[85] Rec 18.5 ACCC, (2020)
[86] Page 456, ACCC, (2020)

to funds to make their payment by the time it falls due, or to pay in an annual lump sum to avoid an instalment surcharge.

The ACCC also recommended that insurers provide prominent information regarding excesses and sum insured in order to allow easily identify how the insurer proposes to vary these terms from the previous year and seek explanation of any changes. These need to be supplemented with explicit and proactive prompts to update sum insureds, as outlined above.

There issues can be easily addressed in the Code.

Recommendations | Renewal Notices

76. **Provide renewal notices for home, contents and strata insurance no less than 28 days before the expiration of their insurance cover, with a reminder to be sent no less than 7 days before expiration if it has not been renewed.** [87]

77. **Disclose the premium, sum insured and excess on a renewal notice and provide this information upon request at all other times.** [88]

78. **Clearly inform consumers about the Australian Government's MoneySmart website using uniform wording provided on new quotes and renewal notices.** [89]

Accessing Disclosure Information held by Insurers

Financial Rights examined the problem of claims denials based on non-disclosure in 2021. The Insurance Law Service run by Financial Rights regularly receives calls from Australians complaining about insurers declining their claims because they failed to include a piece of information in their application at the time of purchasing their insurance policy.

Callers describe making a claim on their insurance following an accident or after their vehicle has been stolen. When they contact their insurer, they are informed that their claim is denied because they have not disclosed to the insurer an important piece of information. The insurer has checked say, a driving history database, or an insurance claims database, and discovered that the driver has not included all of the necessary information about

[87] This would be higher than the 14 days currently required under the *Insurance Contracts Act*. Rec 18.8 ACCC, (2020)
[88] Rec 18.9, ACCC, (2020)
[89] Re 18.2, ACCC, (2020)

themselves at the time of signing up for their insurance – a previous accident, lost licence points, a criminal conviction, insolvency history. The insurer tells the policyholder had they known all the information they would never have insured them in the first place and will not pay the claim now. In some instances the insurer repays 12 months of the claimant's premiums, or more rarely all of the premiums paid depending on the circumstances.

Practically speaking, the caller may have been driving around uninsured for the entire period that they have been paying premiums - despite, at times, paying for years on end. The caller could in some cases have been paying another insurer instead who would have taken on the risk. Even where insurance was not available, the person could have chosen to drive less, or not at all, rather than pay for worthless insurance.

Driving the streets in the belief that they are insured involves serious financial risk for these callers and other road users. They remain on the hook for all the costs of the other party or parties, their own vehicle, and in some cases, expensive public infrastructure.

Callers also complain that the insurer could or should have checked that their information was complete in the first place. If the insurer had just taken 30 seconds to check at the time of the insurance quote and purchase, they argue, there would be no problem now.

There is no obligation on the insurer under the current law to check disclosure information provided at the point of policy inception.

In examining AFCA decisions on non-disclosure cases the reasons for non-disclosure vary. Many claim that they forgot about an accident at the time of buying the insurance. Some were confused by ambiguous application questions themselves, not understanding what was being asked of them. Others were not asked at all. A small number of people openly admit to misrepresenting the information on their disclosure form, fearful that they would not be insured if the insurer knew.

While the insurer has the right at law to not cover somebody who lies or even forgets to mention relevant information under the duty to take reasonable care not to make a misrepresentation to the insurer, the variety of human failings intervene – we forget things, can't find information, we are in a hurry or in some cases, we are answering on behalf of others and make assumptions.[90]

The Financial Rights report argues that there are ways for insurers to act to more fairly assist consumers to avoid these non-disclosures. The key recommendation is for insurers is to

[90] We also note that insurers don't seem to be applying the duty in accordance with the *Insurance Contracts Act, see* InsuranceNews, FCA examines its approach to disclosure, 29 April 2024

automate the disclosure of driving histories and insurance claims information, with consent and where it is safe and secure to do so. However, the driving history part of this recommendation requires working with government to enable this outcome – something this Code cannot address.

Nevertheless, insurers can and should commit to assisting applicants and insured with their insurance claims histories since they are the ones that hold them.

Previously the insurance sector had a clunky, error-filled way of accessing one's insurance claims history via the Insurance Reference Service, managed by Illion. Following another report from Financial Rights,[91] this service has been shuttered.[92]

However, in line with recommendations at **Question 3.15** below, it is within the power of insurers to establish a standard process and form in relation to actioning and fulfilling consumer requests for insurance histories to fulfil disclosure requirements. This is in the interests of consumers (to obtain accurate information), insurers to underwrite risk accurately, and society to better cover risks.

Recommendation | Accessing Disclosure Information

79. Provide the means for people to automate the access to and sharing of their insurance histories to fulfil disclosure requirements.

See further pricing suggestions under **Affordability section 4.1**

[91] Roger Clarke and Nigel Waters, Privacy Practices in General Insurance, April 2022

[92] InsuranceNews, Insurers wind up claims history database, 8 March 2024

Claims Handling

3.9 Do you have any feedback about the practical operation of Part 8 of the Code and its effectiveness in protecting consumers during the claims process? What improvements, if any, to Part 8 of the Code would be desirable, particularly in light of recent law reforms such as the inclusion of claims handling as a financial service?

The run of 15 catastrophes and publishing of multiple reports since 2018 have evidenced a mountain of poor claims handling practices that need to be addressed. Consumer groups identified claims handling as the key issue that face the clients that we serve in evidence and submissions to the Flood Inquiry. ASIC and the CGC have undertaken specific investigations into insurance claims handling with extensive insights and recommendations. The issues identified range from poor communications practices and endemic delays to poor quality service providers, assessment processes and reports and poor quality repairs.

We will not repeat the evidence already gathered by ourselves, ASIC and the CGC but simply direct the reviewers to those papers.[93]

Claims handling issues have not arisen solely from the result of the 2022 floods or any other extreme weather event. The issues seen in the aftermath of these events are exemplars of the problems insureds face every day, and particularly impact people experiencing a range of vulnerabilities in negative ways.

With the introduction of licensing for claims handling from 2022, ASIC has produced high level guidance to licensees on how to meet licence obligations in InfoSheet 153 and provided some further guidance in their letter of expectations[94]. However much of this remains high level principles. In the absence of any more specific ASIC regulatory guide proscribing minimum standards, the Code is the most appropriate place to expand upon and fill out these principles.

This section details recommendations to improve consumer outcomes regarding the following issues:

[93] CGC, General Insurance Industry Data and Compliance Report 2022–23, May 2024, ASIC, ASIC's expectations of general insurers: Insurance claims and severe weather events, 7 November 2022; Joint consumer submission to the Parliamentary Inquiry into insurers' responses to 2022 major floods, November 2023; ASIC, Navigating the storm: ASIC's review of home insurance claims Report 768 | August 2023; CHOICE et al, Weathering the Storm: Insurance in a changing climate, August 2023; Financial Rights, Exposed, (2021)

[94] ASIC, Obligations of general insurers: Insurance claims and severe weather events, 6 March 2024

- Communications and Information sharing
- Claims management processes
- Identifying and managing vulnerability
- Managing third party service suppliers
- Quality of repairs
- Temporary accommodation
- Claims decision making
- Fulfilment project management
- Changes to timeframes
- Catastrophes, extreme weather events and surge periods
- Use of technology

Communications and Information sharing

Poor communications practices and a lack of information are at the core of most friction and complaints that our organisation here from consumers. The Code can assist in making clear that insurers should be more proactive in their information provision leading to greater transparency and a more meaningful interaction with their customers.

Recommendations | Claims Communications

80. **Clause 58 should be updated to shift the onus from the insured having to ask about their cover ("If you ask us…"), to insurers taking proactive steps leading conversations at initial contact to inform insureds about their cover, what they can claim, the impact of making a claim and provide an outline of the claims process – before making a claim.**[95]

81. **Clause 59 should be updated to specifically include:**

    a. **information about an insured's cover and their claimable items, including temporary accommodation entitlements**

    b. **how the insurer will assess the validity of the consumer's claim**

    c. **the insurer's preferred repairer policy and in what circumstances a consumer can use their preferred repairer**

    d. **how decisions are made on cash settlements**

[95] See Pages 10-11, ASIC Rep 768

e. **who will be managing the claim (for example, the name and contact details of a contracted claims company if relevant): (see below under Appropriate claims management process)**

f. **the impact of making a claim**

g. **providing a map of the claims process**

h. **the consumer's right to make a complaint to the insurer and the Australian Financial Complaints Authority**

i. **disclose all claim-related information to consumers upon request, except for sensitive matters**

j. **supply a complete list of all documents related to the claim whenever requested by consumers.**

82. **Update Clause 72 to clarify that the External Expert, Loss Assessor, Loss Adjuster or Investigator is acting on behalf of the insurer and not the consumer.**[96]

83. **Clause 81 should be improved by including a commitment to:**

a. **detailing aspects of a claim that are accepted (where there is a partial denial)**

b. **clear and direct language explaining that there is in fact a denial – rather than simply implying a denial by saying that a claim would be accepted if issues with the property were accepted**

c. **providing adequate evidence to support the reasons for denial (see Expert Reports)**

d. **explaining how the denial and evidence relates to specific terms under the policy**

e. **explicitly providing contact details for IDR – not merely the process for making a complaint**

f. **providing contact details for AFCA.**

84. **Insurers should commit to recording claims decisions, claims decision dates and when it is communicated**[97]

85. **The right under Clauses 112, 124, and 129 for customers who are experiencing financial hardship to nominate their own preferred method of communications**

[96] Rec 20.1, ACCC, (2020)
[97] p24 ASIC Rep 768

should be extended to all customers, including older Australians, in line with inclusive design principles.

Claims management processes

ASIC found in its claims handling report that having dedicated claims managers to maintain direct contact with consumers resulted in better management of consumer expectations and a better claims experience overall.[98] It also avoids insureds having to repeat stories and ensure a more streamlined claims process. Our experience aligns with this observation. This would also align with Clause 5.4 of the Life Insured Code that commits life insurers to assigning a "primary contact person."

Recommendations | Claims Management

86. **The Code should commit insurers to having a dedicated/assigned claims manager for each claimant.**
87. **Insurers should commit to having adequate systems in place to:**
    a. **ensure that facts and information are recorded and accessible**
    b. **track and monitoring temporary accommodation bookings and payments, and**
    c. **staff are trained to proactively manage benefits like temporary accommodation.**

Identifying and managing vulnerability

In line with recommendations under the Vulnerability section above and the principles of inclusive design, specific commitments need to be made in the Claims Handling section to ensure those with extra needs set the minimum standards that insurers will meet.

Recommendations | Claims Handling and Vulnerabilities

88. **Proactively identifying the full scope of needs and vulnerabilities of claimants in initial claims conversations.**

[98] p11, ASIC Rep 768

89. **Seek the explicit consent to flag vulnerabilities identified at claims initiation (unless already flagged)**[99]

90. **Once identified and flagged, commit to treat claimants accordingly including by:**

    a. **increasing contact with consumers**

    b. **referring vulnerable consumers to external support services**

    c. **making emergency payments for essentials**

    d. **waiving excesses**

    e. **offering project management in appropriate circumstances where a decision is made to cash settle**

    f. **offering to provide assistance to meet the terms of an insurance product.**[100]

Managing third party service suppliers

Insurers need to commit to monitoring and maintaining adequate oversight of service suppliers including External Experts, Loss Assessors, Loss Adjusters and Investigators.

This should include a commitment to notify consumers about the order and timing of attendance at their homes: See **Case study 8–Gary's story** and **Service Suppliers section**.

Quality of repairs

Concerns about the quality of repairs is a common complaint from the insureds we speak to. Clauses 86 and 87 commits insurers to take responsibility for the quality and workmanship of their authorised repairers, and handle complaints.

While insurers are usually very good about accepting responsibility for poor quality repairs, it can take a long time and cause a lot of stress for the consumer before an insurer is satisfied that repairs require rectification. In the meantime, further damage from mould can turn a relatively simple claim into one that is costly and complex.

Insurers need to commit to better project managing and overseeing third party contractors in line with the recommendations above. Consideration should be given to ways to speed up the process of rectification with specific timeframes in place for these circumstances.

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[99] p15 ASIC Rep 768
[100] As above

Temporary accommodation

Securing temporary accommodation is a common concern for policy holders.

Many of the issues that arise relating to temporary accommodation are related to poor communication from the insurer. Often temporary accommodation is paid for by the insurer for a few months at a time. When the expiry date for a period of temporary accommodation is coming up, people become understandably anxious about what is going to happen. They want to know if payments for temporary accommodation will be extended, whether their home is habitable yet, whether their current temporary accommodation will remain available or whether they will need to move to a new location. Insurers do not always adequately communicate with their customers in time and the customer is left holding the bill for rental payments or is told by a temporary landlord that they need to vacate.

Insurers also do not plan well. For example, according to financial counsellors, insurers in Far North Queensland are putting people into tourist accommodation but don't seem to have made a contingency plan for the imminent arrival of tourists who have bookings in place for the peak season. Insureds are being made homeless because of this lack of planning.

Another common problem with claims involving extensive building repairs is that temporary accommodation benefits run out before the home is habitable again. Sometimes this arise due to no fault of the insurer but other times it is because insurer-led delays. We have heard from clients whose insurer insist on expert reports being produced which cause lengthy delays, and ultimately turn out to validate an insured's claim anyway. This means that by the time the work finally begins, the temporary accommodation has run out. This is unfair and in these situations the insurer should be made to foot the bill for additional temporary accommodation when they are the cause of the delay.

We also hear from people who were entitled to temporary accommodation but were unaware of their entitlement and were not informed of their entitlement by their insurer. This simply exacerbates an already stressful situation.

The common limit of 12 months is presumably based on the capacity to complete repairs or rebuild within the 12-month period and likely based on single claim accidents rather than multiple claim disasters. It is widely acknowledged that more frequent disasters combined with material and labour shortages have pushed repair and rebuilding timelines out to 18-30 months. It appears that for the foreseeable future it is unlikely that insurers will be able to complete repairs within a 12 month-period.

The industry has failed to acknowledge that the emergency accommodation benefit may not be sufficient to ensure housing during the entire period of repairs or rebuilding. Nor has the

industry produced guidelines to explain how any shortfall will be dealt by insurers or insureds.

It's unfair for consumers to face penalties from delays caused by insurers or their contractors, for instance where accommodation or loss of rent benefits are capped at 12 months or 10% of the sum insured. Insurers have up to a year to make a determination on claims, leading consumers to exhaust their benefits well before the claim is finalised. The Code should be amended to protect consumers from the loss of these benefits due to such delays, placing the responsibility on insurers if a claim cannot be resolved within a year or up to the sum insured.

Temporary accommodation entitlements need to be improved. This can and should be addressed through updating policy designs to ensure that they meet the needs of policyholders especially in areas subject to extreme weather events.

This should include at least 24 months, building in flexible approaches. Landlord insurance policies should include temporary accommodation for people who rent. Insurance companies should include cover for temporary accommodation for tenants in landlord insurance policies when their home is uninhabitable due to an insured event.

Recommendations | Temporary Accommodation

91. Insurers should proactively:

- **a. raise temporary accommodation entitlements with insureds in initial conversations.**
- **b. arrange and communicate temporary accommodation entitlements.**
- **c. manage extensions of temporary accommodation and communicate these well in advance of any lapsing of leases.**
- **d. provide temporary accommodation extensions where there have been delays due to insurer action or inaction.**

92. Insurers need to apply inclusive design principles to temporary accommodation entitlements in their products to:

- **a. build in more flexible approaches and longer entitlements for those impacted by extreme weather events.**
- **b. include temporary accommodation for tenants in landlord insurance products**

c. **provide specific coverage for owners in an owners' corporation in receipt of temporary accommodation following extreme weather events.**

Claims decision making

In addition to improving information provision regarding a claims decision, further improvements can be made regarding decision timeframes and the over-reliance on exceptional circumstances.

The timeframes under Part 15 of the Code supersede the timeframes at Clauses 77 and 78.[101] This leads to some perverse outcomes when an investigator is needlessly appointed.

Case study 13.– Robert's story –Westjustice

Robert (name changed), a recently arrived refugee who spoke no English and no experience with insurance, was involved in a minor motor vehicle accident and notified his insurer. In his first phone conversation with the insurer using an interpreter, Robert frankly admitted circumstances which meant that the insurer could have denied the claim.

Rather than doing so, the insurer held off making a decision on the claim for six and a half months, during which time Robert was asked to attend multiple investigator interviews but did not receive an update on the insurer's decision. Robert did not fully understand the insurance process and was dependent on the insurer's good judgment in claims handling.

During the time the insurer took to decide on the claim, letters of demand were sent to it by two different parties relating to the accident, and a Magistrates' Court complaint was filed. The insurer had filed a Notice of Defence on Robert's behalf before its claims department finally denied the claim, at which point the insurer's lawyers immediately ceased to act.

Robert was left facing the increased cost and stress of being abandoned in the middle of legal proceedings, when a prompt decision denying the claim would have enabled him to negotiate lower costs with the other parties much sooner.

When Westjustice first raised its concerns to the insurer about the extra cost and risk exposed by a six and a half month delay on a car accident claim, the insurer purported to rely on its appointing an investigator as an argument that Clause 73 of the Code, and the

[101][101] see the preamble to Part 15

timeframes under Part 15 of the Code for review, superseded Clauses 77 and 78 in terms of claim timeframes.

Clause 78(d) re: exceptional circumstances should be removed as it's unclear exactly what sort of circumstance beyond an insurer's control it anticipates. Insurers can already rely on Clause 78(a) out for surge events that may create a resourcing challenge, and it appears to be to be a cover-all for failing to adhere to fairly generous standards.

Recommendations | Claims Decision-making

93. Clause 73 needs to be redrafted so that Clauses 77 and 78 apply in all circumstances.

94. Clause 78(d) should be removed.

Fulfilment project management

ASIC observed in its claims handling report that:

> very few insurers appointed an internal project manager, meaning the often-complex assessment and repair process was regularly managed by the consumer.

This reflects our organisation's experiences with insurers and should be addressed.

Recommendations | Project Management

95. Where a claim has been accepted, insurers should commit to assigning an internal professional project manager to manage complex repair processes[102]

96. Commit to ensuring project managers and repairers are trained to understand the logical order of trades placement[103]

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[102] p26 ASIC Rep 768
[103] As above

Changes to timeframes

Clause 84 provides significant scope to avoid claims handling timeframes. Sub-clause 84(b) particularly provides a get-out-of-gaol-free card that is wholly within the power of insurers to interpret broadly. Given the immense increase in delays that have occurred and complained about,[104] and the new expectations of ASIC to address surges in demand[105] we recommend that sub-clause 84(b) be removed.

Recommendations | Claims Timeframes

97. Clause 84(b) should be removed.

Use of technology

Our organisations are concerned that insurers are employing technological solutions or innovations to address a number of the concerns raised about poor claims handling by consumer groups and others.

The adoption of some technology will create some efficiencies – using databases in smarter ways to identify vulnerabilities, employing project management software to assist with more proactive engagement. However, other technologies such as the development of consumer claims portals are already creating frustrations and failing to serve those with extra needs including those who are less comfortable using technology, cannot afford to use technology or prefer not to use technology.

The use of and reliance on new technology by insurers in claims handling has the potential to alienate and frustrate certain cohorts of consumers with extra needs included older Australians, people from refugee backgrounds and First Nations people in remote and regional areas. It has the potential to exacerbate the digital divide.

Case study 14.–Irene's story –Financial Rights - S309000

Around Christmas 2023 Irene's home was impacted by big storm. Her insurer required her to engage with the insurer's new claims portal. Using the portal was frustrating for Irene but she

[104] See AFCA, Annual Review 2022–23 – General Insurance Complaints
[105] See ASIC, ASIC's expectations of general insurers: Insurance claims and severe weather events, 7 November 2022

was forced to since her insurer was difficult to get in touch with over the phone with long waits on the line for extended periods of time.

Irene felt pressured to accept a settlement offer from the insurer made on the portal with no breakdown of costs. This was because Irene couldn't get in touch with her insurer to discuss the offer. Ultimately Irene "gave up" and accepted the offer, despite not being happy about it.

Case study 15.– Yolande's story –Financial Rights - C26195

Yolande's mobile home was damaged in a storm in 2023. The insurer was able to send down repairers fairly quickly to carry out some roof repairs, and then sought to recover the excess of $750 from Yolande. Yolande is a Centrelink aged pensioner who lives on a shoe-string budget and was experiencing genuine financial hardship.

Financial Rights acted for Yolande in preparing a financial hardship application, requesting compassionate consideration. This was sent at the beginning of April. The request was handballed inexplicably from IDR to the claims team for review.

The insurer took close to two months to respond to the request.

Yolande's claim had to be managed via a claim's portal, with updates provided only via this portal. Both Yolande and Financial Rights found it difficult to deal with the portal and the insurer.

The portal does not give consumer representatives such as the solicitors on the Insurance Law Service the authority to discuss a claim.

Financial Rights would then regularly attempt to call the claims line but would be put on hold for significant periods of time before being able to speak with a representative. During the hold we would be delivered automated messages saying that due to the recent weather events they were experiencing delays.

Once through, the insurer didn't accept our authority to act and had to jump further hurdles before they would talk to us.

Financial counsellors have also heard from older policyholders in Far North Queensland who are struggling with lodging documentation online.

Use of automated systems, adoption of AI and other technological fixes can lead to what is known as engineered insincerity – where technology simply lacks empathy and builds discontinuity in service and resistance from consumers. Chatbots or automated phone trees that fail to understand customer inquiries or provide irrelevant answers frustrate and anger consumers and produces poor outcomes in terms of service quality.[106]

Given the rise of scams and a growing awareness of privacy and security risks arising out of the collection and use of data by financial firm technologies, insurers need to be wary of over-relying on innovation as the silver bullet to their claims woes.

Insurers also need to be careful of building dark patterns into their digital user interfaces. Dark patterns are user interface techniques and designs that manipulate or deceive the user into making choices or decisions that deliver profit over the user's needs. Techniques that insurers need to be mindful of include:

- social proofing (the use of testimonials)
- "confirm-shaming" (where specific language is used to suggest that a particular choice is shameful or inappropriate)
- forced action (inducing people they cannot get a quote with following indications of an online platform)
- scarcity cues, and
- a sense of urgency.

Not all problems require technological innovation – improving the basics by managing and resourcing well-trained front-line staff and call centres can address many of the problems seen in claims handling.

Seeing technology as the sole fix can fall into the trap of designing for the 'mythical average user' that looks and thinks like you: an insurance employee, comfortable with computers, able to access and afford the internet at any moment and use their smart phone without even thinking. Insurers need to talk to people with additional or out of the ordinary needs when designing technological solutions and building claims and complaints systems.

In line with the ISO standard, when deciding to utilise technology, it needs to be accessible for people with visual impairment, learning difficulties or cognitive impairments and those with manual dexterity impairments. Digital communication pathways should not be prioritised over other consumer contact channels, with fewer resources dedicated to those

[106] See European Insurance and Occupational Pensions Authority, Dark patterns in insurance: practices that exploit consumer biases

alternative, more direct channels like telephone services or face to face communication. Support should be offered to those struggling with portals.

Recommendations | Use of Technology

98. **Apply inclusive design, privacy by design, safety by design and human rights by design principles to the design and deployment of technologies.**
99. **Meet:**
    a. **ISO/IEC 40500, Information technology — W3C Web Content Accessibility Guidelines (WCAG) 2.1**
    b. **EN 301549, Accessibility requirements for ICT products and services**
    c. **ISO 9241-129, Ergonomics of human-system interaction — Part 129: Guidance on software individualisation**
    d. **ISO 9241-210, Ergonomics of human-system interaction — Part 210: Human-centred design for interactive systems.**
100. **Prohibit the use of dark pattern techniques in user interfaces.**
101. **Meet the Artificial Intelligence (AI) Ethics Principles to ensure AI use in insurance is safe.**
102. **Work with consumer groups to standardise and streamline authorities to act on behalf of clients.**

Catastrophes, extreme weather events and surge periods

As mentioned, it is incumbent on insurers to provide further commitments regarding claims handling, including in line with the recent letter of expectations from ASIC with respect to insurance claims and severe weather events.[107] These should be included in the Code.

The existing provision allowing insurers up to 12 months to address catastrophe-related claims is excessively prolonged and does not align with consumer expectations. Timelines should be reduced to ensure swifter, more effective claim processing.

[107] ASIC, ASIC's expectations of general insurers: Insurance claims and severe weather events, 7 November 2022

We address other elements of the claims handling process:

- cash settlements
- scope of works
- external reports

below in answer to the specific consultation questions.

Recommendations | Catastrophes

103. Establish comprehensive severe weather event response plans addressing assessment, assistance, vulnerability and emergency repairs for claimants.

104. Review the timeliness and efficiency of operations following surge periods.

105. Adequately resource claims handling capacity and response teams including during severe weather events.

106. Keep insureds informed of the progress of a claim in ways that obviate the need for the insured to regularly follow up with an insurer or a service provider.

107. In line with recommendations under the Vulnerability section, proactively work to identify vulnerabilities in addition to acknowledging and working with consumer who are facing difficulties following extreme weather events.

108. Remove Clause 78(a) to ensure insurers prioritise the resolution of claims arising from extreme weather events.

3.10 How could the Code be enhanced to improve understanding and better protect customers where cash settlements are used? For example:

(a) Should the Code be more prescriptive in outlining better practice in administering the legal requirements for cash settlement payments?

(b) Should paragraph 79 be extended to all cash settlement payments?

(c) Should the Code mandate consideration of a contingency uplift factor for cash payments over a certain dollar value to better manage the risk of higher repair costs?

(d) How could the Code assist in consumer understanding of cash settlement payments, the risks associated with the same, and the need to obtain independent advice before accepting the cash settlement?

Cash settlements

Cash settlement is a common issue raised by clients affected by storms and floods. Consumer groups reported that one in five storm and flood clients (19.5%) from 1 January 2022 to 30 September 2023 raised an issue with cash settlement.[108]

Deciding whether to accept a cash settlement - especially in the wake of an extreme weather event like a flood or bushfire, is not easy. In many circumstances it may not be the best option for the insured person, although it may seem like the best resolution at the time. For people with project management, building or architectural skills and qualifications, or access to such skills, a cash settlement may suit very well. However, we also see people accepting cash settlements because at that moment it is a more attractive option than continuing to deal with the insurer, rather than being in their longer-term best interests.

Cash settlement offers are largely in the hands of the insurer and are regularly used as a go-to when a claim becomes too difficult or complex. In the case of significant or total rebuilds, they simply shift all the risk on to the insured.

Our organisations have provided significant evidence of the problems we have seen in our case to the Flood Inquiry and in various reports.[109] In summary our organisations have seen:

- Cash settlements where consumers were offered either the lowest quote obtained by an insurance company, or quotes based on costs that they alone can obtain through their own supplier networks, without considering any of the additional challenges that a consumer is likely to face given they do not possess the same commercial experience, industry connections and bulk buying capacity as the insurer.[110]
- Over-reliance on cash settlement clauses placing all the burden to undertake the work – project managing repairs, covering cost rises and other unforeseen issues etc. on the insured, something that is particularly problematic for vulnerable clients.[111]

[108] Joint consumer submission, Flood Inquiry (2023)

[109] Pages 33-37 and Case Studies 19-23 - Joint consumer submission, Flood Inquiry (2023), FCA, Flood Inquiry Submission (2023); see pages 22-25 Financial Rights, Exposed, (2021);.

[110] See Case study 19 and 23, Joint consumer submission, Flood Inquiry (2023); Evan's story, Everly's story, and Mary's story, Financial Rights, Exposed, (2021); Case study 2 and 4, FCA, Flood Inquiry Submission (2023)

[111] See Case studies 20 and 21, Joint consumer submission, Flood Inquiry (2023); Annie's story Financial Rights, Exposed, (2021)

Cash settlements frequently do not account for unexpected complications or variations, and they generally fail to compensate for the transfer of risk, such as the loss of an insurer's lifetime warranty on repairs.

- Real difficulties in comprehending and understanding what a cash settlement is and when and where it is appropriate to accept an offer, with poor language and terminology in communications with policyholders and a lack of independent advice.[112]

We note that there is only *one* Code commitment (Clause 79) to address the multitude of issues with cash settlements, one that is essentially duplicative of a requirement under the law to provide a cash settlement fact sheet which can, and has, caused confusion.

The Code is the appropriate place to address many of the issues that have been identified and there are a significant number of commitments that insurers could take in the Code to improve consumer outcomes by:

- re-empowering consumers in the cash settlement process
- shifting the onus back on to the insurer
- embedding inclusive design principles to ensure all consumers including those experiencing vulnerability and those experiencing the impact of extreme weather events, are provided with the services they need
- tracking cash settlement rates to improve consumer outcomes and identify where improvements to the process can be made.

Recommendations | Cash settlements

109. Provide insureds – including those impacted by an extreme weather event - with the right to choose whether their home building insurance claim is settled through a cash settlement or with a repair/rebuild managed by the insurer.[113]

110. Provide an explicit acknowledgement that a cash settlement is not appropriate in many cases due to vulnerability.

111. Provide insureds with information on how and where to obtain independent legal advice regarding cash settlement offers before accepting the settlement.

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[112] See Case study 11, FCA, Flood Inquiry Submission (2023), Alice and Travis' Story, Financial Rights, Exposed, (2021)

[113] Recommendation 20.1, ACCC, (2020)

112. Maintain but enhance Clause 79 re: cash settlement tailored information so that insurers commit to explain in plain English the specific cash settlement offer to the claimant, including:

- **a. why they are offering a cash settlement in this specific circumstance**
- **b. other types of settlement that might be available**
- **c. the impact of a cash settlement in this situation, and**
- **d. whether they have included an uplift payment to recognise the transfer of risk as part of the component breakdown required in the *Corporations Act*.**

113. If a consumer cash settles within 12 months of a disaster occurring, they have 12 months in which to ask the insurer to review the amount of the cash settlement if the amount is inadequate due to circumstances which were unforeseen at the time of the settlement. Where it was clearly insufficient at the time, a customer should be provided the opportunity to make a complaint. Alternatively, the Code should eliminate the requirement for consumers to sign release forms before receiving a settlement offer, thereby permitting consumers to initiate dispute resolution concerning an insurer's proposed settlement.

114. Insurers base their cash settlement offers on genuine repair quotes, premised on the likely cost to the consumer at the time of the re-build or repairs, not the insurer.[114]

115. Where an insured is experiencing vulnerability, insurers should offer the services of a project manager in a cash settlement.

116. Proactively identify and clarify that cash settlement may be inappropriate due to customer's vulnerability and provide alternative claim resolutions.

117. To address increases in costs, insurers include a 25% buffer in home insurance policies for total loss after an extreme weather event in high-risk areas.[115]

118. Work with consumers who do not want to rebuild in high-risk areas to provide options to relocate, for example, rebuilding elsewhere for the same sum insured.

119. Cash settlement rates and the reasons for cash settlement rather than rebuild or repair should be tracked, analysed and provided to the CGC and/or the ASIC/APRA under its data project.

120. Clause 61 re: scope of works should be expanded to include the following commitments:

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[114] Recommendation 20.1, ACCC, (2020)

[115] See recommendations, Financial Rights, Exposed, (2021)

a. **Insurers will provide all details, including sub-totals, in a scope of works document in cash settlement offers,**

b. **Insurers will only rely on quotes for scopes of works that are actionable.**

Scope of Works

In working with insured clients subject to extreme weather events we have been provided with quotes and scopes of works that apply to cash settlements that have been redacted. When the customer asks for the sub-totals to be provided in an un-redacted version they are told by the insurer that they are unable to, that it is standard practice and that they can only get an un-redacted copy if they sign off on a scope of works.

Case study 16.– James and Candice's story –Consumer Action

James and Candice's home was inundated in the 2022 Rochester floods. Their contents claim was settled quickly and they were provided with temporary accommodation. They lodged a claim on their home insurance and agreed to a statement of works for repairs in December 2022. In April 2023 the builders found termite damage in the home and works halted because the insurer could not warranty the works.

James and Candice sought help from Rochester Community House in June 2023. A financial counsellor assisted them to obtain the Scope of Works from their insurer, but the costings were redacted, making it impossible to get a comparison quote.

#	Area	Dimensions	Description
			up to 110mm - to match existing or similar - [x4]
9	All of Building		Entry, Bedroom 2, Living, Kitchen/Dining, Bedroom 3, Master Bedroom, Pantry, Granny Flat. Remove and replace - pine window/door architraves up to 140mm - to match existing size and profile or similar - [130LM]. (4 x internal doors / 2 x external doors / 2 x sliding door / 6 x windows)
10	All of Building		Bedroom 2, Living, Bedroom 3, Master Bedroom. Supply and install internal hollow core door - up to 820 x 2040mm - to match existing or similar - includes re-using existing hardware - [x4 units]
11	All of Building		Entry, Laundry. Supply and install external solid core door - up to 820 x 2040mm - to match existing or similar - includes re-using existing hardware - [x2 units]
12	All of Building		Entry, Bedroom 2, Living, Kitchen/Dining, Bedroom 3, Master Bedroom, Pantry, Granny Flat. Prepare and paint ALL walls after new wall lining installation approx. [370m2] with x1 undercoat and x2 top coat. Dispose of rubbish.
14	All of Building		Entry, Master, Kitchen, Pantry, Dining, Living, Hallway, Bedroom 2, Study. Prepare and paint ALL skirting boards to property after installation approx. [130LM] with x1 undercoat and x2 top coat.
15	All of Building		Bedroom 2, Living, Kitchen/Dining, Bedroom 3, Master Bedroom, Granny Flat. Prepare and paint ALL timber internal door jamb after installation approx. [12LM @ x4 jambs]. X1 undercoat and x2 top coat.
16	All of Building		Entry, Bedroom 2, Living, Kitchen/Dining, Bedroom 3, Master Bedroom, Pantry, Granny Flat. Prepare and paint ALL architraves to window/door surround after installation approx. [130LM] with x1 undercoat and x2 top coat.
17	All of Building		Bedroom 2, Living, Bedroom 3, Master Bedroom. Prepare and paint ALL internal doors after new installation due to flood damage [x4 units] with x1 undercoat and x2 top coat.

[redacted]

They had to lodge an internal dispute resolution complaint to receive the unredacted SOW which totalled $165,000. They then went through the process of getting their own quote for the same works, which totalled $230,000.

In light of the new quote and the fact that their insurer would only offer a cash settlement, James and Candice decided the best course of option was to demolish and rebuild their home so as to include flood mitigation measures.

Their financial counsellor assisted them to lodge another IDR complaint to get their insurer to accept their builder's quote and agree to an uplift payment. Their final cash settlement was $275,000.

It is hard to see how James and Candice could have received an appropriate cash settlement from their insurer without the assistance of their financial counsellor.

Redacting scope of works is confusing and leads to difficulties with:

- obtaining independent quotes
- understanding whether quotes are based on prices only able to be obtained by insurers through economies of scale
- making cash settlement decisions based on insufficient information.

Insurers have relied on an assertion that the amounts are commercial in confidence however doing so is anti-competitive and leads to significantly poor outcomes for consumers.

In our view this approach does not meet the duty of utmost good faith.

Recommendations | Scope of Works

121. Clause 61 re: scope of works should be expanded to ensure:

- **a. insurers will not redact details of a scope of works document provided in cash settlement offers,**
- **b. insurers will only rely on quotes for scopes of works that are actionable.**

122. A standard form for scope of works should also be considered to ensure greater consistency.

We note that the consultation asks whether Clause 79 should be extended to all cash settlement payments.

We think this is worth doing at least for motor vehicle insurance. For example, questions and concerns regarding the circumstance of a motor vehicle being written off remains one of the key issues raised on the Insurance Law Service line. The service's Written-Off Vehicles fact sheet is regularly the most visited page on the website. This is demonstrative of a real confusion faced by consumers with respect to how these claims are settled and a lack of plain English information provided by insurers explaining the process.

Recommendation | Written-Off Vehicles

123. Information should be provided with respect to the way motor vehicle insurance is settled including how Written-off Vehicle Registers work and the consumer rights, including an explanation of the deductions made when an insurer pays a sum insured.

3.11 Should the Code prescribe minimum content requirements for external experts' reports (including Scope of Works) or are their other mechanisms that would better address concerns about the quality, consistency and accessibility of experts reports?

Minimum content requirements for external experts' reports should be prescribed.

Our organisations regular see significant deficiencies in expert reports, including inadequate evidence to support conclusions, incorrect interpretations of regulatory standards, failure to conduct necessary additional investigations, incomplete investigations, and inconclusive

findings that overlook potential causes. Other issues include reports that mirror insurer exclusions verbatim and overstate the extent of necessary remediation work. To address these concerns, it is imperative that the Code be revised to incorporate stringent standards for expert evaluations.

The CGC report[116] too found that there were both systemic issues in decision-making on claims involving maintenance and wear and tear, with consumers unaware of what they need to avoid an exclusion,[117] and that expert reports were of low quality including a lack of consistent information and evidence supplied. The Code needs to address both issues.

Recommendations | Expert Reports

124. A standardised industry approach should be established for reports on exclusions that involve subjective assessments (including maintenance, wear and tear, defect, and pre-existing damage reports). The approach should include commitments to:

- **a. identify what damage occurred to the property with evidence**
- **b. (in the case of maintenance and wear and tear reports) identify what (if any) reasonable maintenance has not been undertaken by the consumer**
- **c. outline how any exclusion being examined (e.g. failure to maintain) would have made a significant difference to the outcome and damage sustained to the property**
- **d. identify and explain the causal link between the claimed exclusion being relied upon (for example, the lack of maintenance) and how that resulted in a significant contribution to the damage sustained to the property**
- **e. be provided in a standard format to obtain more consistent and higher quality input, and**
- **f. identify the individuals who conducted site visits or provided opinions and detail their qualifications.**

125. Insurers should also commit to:

- **a. only relying on reports containing clear and cogent reasoning, by appropriately qualified experts**

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[116] CGC, Making better claims decisions A thematic inquiry, July 2023

[117] This was also supported by findings in Financial Rights research: Grace and Platow, (2022)

b. **training and monitoring experts including checking for copy/paste scenarios, analysing the proportion of claims in favour vs against**

c. **providing the opportunity to insureds to contribute any evidence to the development of a report before its finalisation**

d. **proactively and automatically sharing final assessment reports with insureds as soon as they become available**

e. **pooling funds to allow consumers to obtain independent expert reports in a timely manner when they have complaints in AFCA**

f. **providing people affected by extreme weather events with greater support and community education to ensure they understand what is required to meet the terms of their insurance including maintenance and wear and tear clauses, and**

g. **proactively implementing initiatives to assist consumers to carry out maintenance where they have neither the resources nor the physical capacity to do so.**

3.12 In what circumstances if any, should the Code allow insurers to vary the prescribed Code timeframes in paragraphs 68 -71 and 76 -77?

AFCA and CGC data demonstrate the reliance on exceptional cases to not meet timelines has gone through the roof. This is unacceptable. While some flexibility may be warranted following a natural disaster, if insurer preparedness and planning were improved, and resourcing boosted in line with ASIC expectations, then such flexibility would not be overly relied upon.

Complaints

3.13 Do you have feedback about the practical operation of Part 11 of the Code relating to complaints, or have any suggestions for how it could be enhanced for the benefit of consumers?

3.14 Do the Code commitments relating to complaints need to be amended or clarified in light of ASIC's new guidance on internal dispute resolution, including its imposition of enforceable standards?

Part 11 should remain and be enhanced.[118]

ASIC has identified issues with dispute resolution and made recommendations to insurers to lift its game around resourcing and training of staff.[119]

In line with the principles of inclusive design mentioned above, the complaints section needs to be considered with an eye to vulnerability. This should include specific communication commitments regarding identifying issues that may relate to vulnerabilities or providing shorter timeframes and fast track processes where vulnerabilities have been identified.

It is not necessarily clear whether the commitment under Clause 141 commits insurers to meeting the entirety of RG 271[120] including both the enforceable paragraphs identified and the guidance/non-binding aspects of the RG, or whether it is solely focussed on the enforceable paragraphs. We presume the former but would appreciate clarification in this respect.

We note that Clause 142 of the Code re: acknowledgement of receiving a complaint does not include a timeframe, whereas RG271.51 expects firms will acknowledge the complaint within 24 hours (or one business day) of receiving it, or as soon as practicable. Making a commitment of 24 hours in the Code would be an important commitment to make.

The Code also lacks provisions for adequately disputing expert findings, placing a financial burden on consumers who must pay for an alternative expert to challenge the conclusions. This creates an unequal power dynamic, as many consumers hesitate to bear such costs. To address this imbalance, insurers should be mandated to offer a second opinion from an

[118] See **Question 2.8(e)** above
[119] p33 ASIC Rep 768
[120] ASIC, Regulatory Guide 271, Internal dispute resolution, September 2021

independently appointed service supplier at no cost to the consumer when disputes arise regarding a service supplier's opinion or work: See **Recommendation 65**.

Finally, Westjustice has had recent experience with an insurer undertaking prejudicial action against an insured during a complaint process.

Case study 17.– Samantha's story –Westjustice

Samantha (name changed) made a claim for repairs arising from extensive water damage to her home. Samantha's insurer initially purported to deny the claim on the basis that, as Samantha had housemates who paid her rent each month, she was operating a 'boarding house'.

The claim progressed without resolution through IDR, and then to AFCA. Midway through the AFCA process and before any determination on whether Samantha had breached the terms of her insurance, the insurer separately sent Samantha a letter saying her insurance had been cancelled with retrospective effect to the date she had taken it out, as it had been issued on the basis of alleged misrepresentation. Samantha was placed in extreme distress at finding out she was now uninsured and questioned whether she should continue to press her complaint.

The subsequent AFCA determination held that the insurer should have honored the water damage claim and that Samantha's living arrangements did not vitiate her contract of insurance.

While this is at the AFCA rather than IDR stage, **Samantha's case** highlights a gap in the Part 11 provisions. There is nothing in either Part 11 or the AFCA Rules requiring that while a complaint is on foot, an insurer not do anything to prejudice or disadvantage the customer's position in terms of the issues in dispute.

Recommendations | Complaints

126. **Commit to adequately resourcing dispute resolution teams.**
127. **Explicitly reference training relevant staff to recognise and respond to expressions of dissatisfaction.**
128. **Clarify Clause 141 to ensure that it commits insurers to meeting the entirety of RG 271.**

129. **Commit to not undertaking Prejudicial action against an insured during a complaint process.**

130. **Update Clause 142 to include a timeframe to acknowledge the receipt of a complaint.**

131. **Commit to continually monitor and evaluate complaints and disputes to ensure improvement of service provision for consumers in vulnerable situations.**

132. **Commit to apply inclusive design principles to complaints handling processes taking into account the needs of consumers in vulnerable situations.**

Other Feedback

3.15 Do you have feedback on the practical operation of the Code that is not covered elsewhere?

Advertising

ASIC recently released a report detailing 35 interventions it has made in response to its greenwashing surveillance activities from July 2022 to March 2023.[121] With an increasing focus on climate change in the insurance industry, insurers may be vulnerable to overstepping the mark when it comes to pledges and representations made in respect of environmental policies, solutions and products. We note for example the advertising of

[121] ASIC, REP 763 ASIC's recent greenwashing interventions, May 2023

NRMA that featured billboards and newspaper ads with the phrase "Until the climate stops changing," which chafes given NRMA's move away from covering rainwater run-off in flood.

It is important that insurers avoid terms and language that may mislead.

Also see **Question 2.7(c)**.

Recommendation | Greenwashing

133. Avoid greenwashing terms such as 'carbon neutral', 'clean' or 'green' in any advertising or PDSs.

Investigations

Commitments regarding investigations have been a positive addition to the Code with improved consumer outcomes and, anecdotally at least, fewer complaints regarding investigations reaching our lines.[122]

Nevertheless, in July 2019 ASIC released its report into how general insurers investigate comprehensive car insurance claims where fraud is suspected.[123] It found that insurers were investigating claims in ways that are causing significant consumer harm, eroding trust in insurance and without fair process. It included a number of recommendations that have yet to be taken up by insurers in the Code. These should be embedded in the Code.

In addition to the above, further commitments should be made to embed further universal standards to better service those people experiencing vulnerability.

Recommendations | Investigations

134. Clause 194 and 195 re: a quality assurance programs should include a commitment to collect and evaluate data on conduct risks and outcomes for investigated claims.

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[122] Counter to this trend has been a very recent uptick in numbers of callers to the Insurance Law Service at Financial Rights seeking advice and assistance with respect to general insurance investigations.

[123] ASIC, REP 621, Roadblocks and roundabouts: A review of car insurance claim investigations, July 2019

135. **Clause 207 re: independent interpreters should be updated to ensure that clause explicitly requires that insurers consider if an interpreter or support person should be offered before investigating a claim.**

136. **Clause 222 re: transcripts should be provided to consumers by default rather than simply being offered.**

137. **Clause 205 re: steps taken before an interview takes place, should be updated to ensure that face-to-face interviews only occur if the information cannot be obtained in a less intrusive way.**

138. **Clauses 213 and 231 re: the conduct of investigators should be updated to ensure that insurers and investigators specifically:**

    a. **treat consumers respectfully,**

    b. **approach investigations with an open mind,**

    c. **avoid acting in ways that are likely to intimidate or unduly pressure consumers (in addition to the commitment not to make a threat under Clause 213(e)),**

    d. **clearly communicate why each item of information is necessary (in addition to collecting only relevant information under Clause 213(a), and**

    e. **avoid multiple requests.**

139. **Consumers whose claims are paid should not be declined further insurance unless compelling and exceptional reasons exist.**

140. **Clause 209 re: requesting investigators of the same gender should be updated to remove the caveat "We may not be able to do this if it is not reasonably practical for us to do so." This could have negative impacts upon those experiencing gender-based violence, or those from particular cultural backgrounds. It should be a policy of insurers to ensure that a diversity of genders are made available otherwise. If they are not then this is an internal issue of panel selections.**

141. **Clause 224: re: contracts with investigators should be clarified to commit insurers' contracts to outline the standards that investigators will need to meeti "and what they need to do including when investigating people who may be vulnerable." The clause currently reads as though it only applies to standards applying to people experiencing vulnerability, when minimum standards should apply to all.**

142. **Clause 227 re: investigators trained in working with "vulnerable customers" should be updated to include a reference (or cross-reference) to specific forms of training including trauma-informed service provision, LGBTIQA+ and Aboriginal and Torres Strait Islander cultural training etc. as outlined above at Question 2.4.**

143. **Clause 235 re: communicating with neighbours should be expanded in line with the Life Insurance Code commitments at Clause 5.43 that insurers:**

    a. **not intentionally film family members, neighbours, friends, acquaintances, or colleagues with the insured and**

    b. **if filming them cannot be avoided, to pixelate or blur any video they appear in before giving it to any external party such as a court or External Dispute Resolution Body.**

Data handling practices and privacy (Part 12: Your access to information)

In 2022, Financial Rights released a report examining the data access and handling practices of general insurers, including the accuracy of claims data contained in My Insurance Claim Reports.[124]

The report involved asking consumers to access personal data held by their insurers as well as their My Insurance Claims Report via the Insurance Reference Service (**IRS**) – the then industry scheme for sharing personal data, which has subsequently ben shut down,[125] following criticisms in the Financial Rights' report. In summary the report found that:

- every My Insurance Claims Report obtained by consumers as part of the field study contained at least one material error such as additional or missing claims, misleading or inconsistent information, and incorrect personal details such as addresses.
- profound difficulties in accessing personal data. The IRS was selling its My Insurance Claims Report through its partner Ilion and consumers needed to "apply" for an application" form to receive their My Insurance Claims Report between 4-6 days later. The form was extremely difficult to fill out with consumers needing to navigate 4-point fonts and wingdings.
- processes for obtaining personal data from insurers were also convoluted, confusing and unnecessarily difficult despite it being a legal right under the *Privacy Act*.
- even when information was obtained, it was often either so little as to be of no utility, or so voluminous that it was incomprehensible. Two consumers received around 150 pages of jargon and screenshots.

[124] Roger Clarke and Nigel Waters, Privacy Practices in General Insurance, April 2022
[125] InsuranceNews, Insurers wind up claims history database, 8 March 2024

Making it difficult for consumers to access one's own personal data, and providing that data riddled with errors has significant consequences for consumers.

Placing roadblocks and hurdles in the way of consumers to obtain information on say their insurance claims history too can undermine consumers ability to obtain information they are required to disclose to insurers at product initiation and claims time.

Incorrectly attributing a claim to a policyholder and wrong claims statuses, if relied on by an insurer, could affect the determination of a claim or a premium.

Not being able to obtain the correct information also serves to sustain the problem of illusory insurance that Financial Rights identified in its report *Automating General Insurance Disclosure*, i.e. driving an insured car under the mistaken belief that it is insured but is not able to be relied upon at claims time due to errors made at the time of disclosure.[126] This report evidenced circumstances where insurers were not even confirming insurance claims histories that they themselves hold.

Not properly resourcing the creation of a free, straightforward, standard process to obtain your own data from your insurer for disclosure and other purposes merely serves the bottom-line interests of insurers, and fails consumers. Inaction serves the interests of insurers since it maintains the ability to deny claims after years of collecting premiums and is cheaper to maintain a 20th century data access and handling approach.

Collecting, handling and analysing data is the bread and butter of the general insurance sector - it is their core business. It is therefore ironic that they have been shown to fall profoundly short of community expectations with respect to their data handling and access processes.

ASIC has already called out the general insurance sector for persistent underinvestment in "systems, controls and data" and "multiple and legacy systems outpaced by the complexity of their products and distribution channels".[127] Financial Rights research referenced above evidences this lag from the perspective of the consumer.

It is therefore key that insurers step up and invest in systems that work for their customers in the 21st century.

[126] Financial Rights, Automating General Insurance Disclosure Report, October 2021
[127] Speech by ASIC Deputy Chair Karen Chester, 'The Princess and the Pea': Getting the basics right in insurance" presented at the ICA Annual Conference, 12 October 2023.

It is however likely that insurers will consider this issue and dismiss it as a lesser priority than other issues that we have raised in this submission. Those issues are key to improving outcomes for consumers.

However, if insurers were take this view, it would be a missed opportunity at a time when consumer expectations with respect to data are increasing, particularly in an age of increased data breaches and scams.

There a number of simple commitments that should be made under the Code.

Recommendations | Data Handling Practices

144. **In line with ACCC's Recommendation 18.2 of the Northern Australia report, insurers should commit to providing clear and prominent notice to consumers that they can obtain a copy of the information that the insurer holds about them and contact details for doing so. The notice should not be buried in a privacy policy. It should be provided on a certificate of insurance and any renewal notices.**

145. **Insurers should commit to establishing a standard process and form in relation to actioning and fulfilling consumer data access requests, which are currently falling far short of the requirements of Australian Privacy Principle 12.**

146. **Insurers should provide plain English explanations of the data provided to consumers as well as support and education to assist consumers to comprehend the material.**

147. **Provide a simple and accessible mechanism for consumers to obtain a reliable claims history from insurer to greatly reduce the risk of unfair claim refusals based on low quality data.**[128]

148. **Insurers should commit to checking their own data with respect to insurance claims histories at the time of a quote and inception.**

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[128] Clarke and Water, (2022)

Emerging Issues

Affordability

4.1 Is it appropriate for the Code to address affordability issues, such as those outlined above? If so, how might this be done without raising competition law concerns or creating an expectation that insurers will provide regulated personal financial advice?

Insurance unaffordability is widespread across the community and a growing concern - particularly in disaster-prone regions where premiums have rapidly escalated. This issue disproportionately impacts people on lower incomes who tend to occupy a greater proportion of housing in more disaster-prone areas. This exacerbates what is known as the poverty premium.[129]

The Actuaries Institute found that 1.24 million households are currently experiencing extreme home insurance affordability pressure, spending on average 8.8 weeks of their income on home insurance.[130] AI found that these impacted those older, retired and renting Australians, with lower insurance literacy, living in socioeconomically disadvantaged areas and having lower current savings balances.

The South Australian Council of Social Services reported in 2022 that approximately 6% to 10% of low-income home owning households do not have home insurance.[131]

A Climate Council national survey found that 1 in 20 people had cancelled their insurance coverage due to an increase in their home and contents premium and 1 in 9 had reduced their overall coverage[132]. A further 1 in 20 people had been told by their insurance provider that they could not be insured and a third of people that did have insurance said they were struggling to afford their premiums. The Climate Council found that nearly two thirds of people reported that their premiums had increased in the last two years.

The Code already touches upon some aspects of pricing and affordability. For example, Clause 49 addresses automatic renewals, Clause 50 addresses premium comparisons and Clause 51 addresses no claims discounts. It is therefore more than appropriate for the Code to address issues of concern to consumers regarding pricing practices and affordability.

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[129] Anglicare, The Poverty Premium, The High Cost of Poverty in Australia, September 2023.
[130] Actuaries Institute, Home Insurance Affordability Update, August 2023
[131] South Australian Council of Social Service, Protecting the Basics: Insurance access for people on low incomes at risk from climate emergencies, 2022,
[132] Climate Council, Uninsurable Nation: Australia's most climate-vulnerable places, 2022

We do agree with the consultation paper that there may be aspects of pricing and affordability that may unable to be addressed within the remit of the Code. For example, many in the consumer movement supports the ACCC's recommendation that targeted subsidies on both premium level and income eligibility requirements would be the most economically effective measure to address affordability.[133] We also support microfinance solutions. Both of these are likely to be more appropriately tackled outside of the Code. We note that debate and advocacy around these solutions may be more appropriately aired in the recently announced Senate Inquiry into Impact of Climate Risk on Insurance Premiums and Availability.[134]

Nevertheless, there are several aspects of the pricing and affordability dilemma faced by consumers that insurers *can* and *should* address via the Code. These include the following:

- Pricing offers and promises
- Loyalty and/or claims discounts
- Component pricing
- Impacts of optional inclusions and exclusions on premiums
- Hidden costs disclosures
- Premium instalments

Pricing offers and promises

ASIC released its report into insurance pricing practices in June 2023.[135] The report outlines pricing failures identified by general insurers after an ASIC-initiated review of their pricing practices, and the improvements required to fix them. The report identified a series of poor pricing practices by insurers. These included:

- Placing the onus on consumers to request discounts and provide eligibility information where insurers may already have the information
- Applications of pricing floors that deny consumers full discounted pricing promises
- Incorrect order of pricing algorithms
- Poor disclosure of pricing floors

[133] See Weathering the Storm (2023) and Recommendation 8.1 of the ACCC, 2020, Northern Australia Insurance Inquiry – Final Report,

[134] Senate Select Committee on the Impact of Climate Risk on Insurance Premiums and Availability, 16 May 2024

[135] ASIC, REP 765 When the price is not right: Making good on insurance pricing promises, June 2023

ASIC then provides a series of recommended improvement to address these issues. These improvements are expectations and guidance that ASIC recommends general insurers meet to fulfill their legal obligations under section 912A of the *Corporations Act*, the *ASIC Act's* consumer protection provisions and section 13 of the *Insurance Act*.

It would therefore be appropriate for general insurers to make commitments under the Code.

Recommendations | Pricing Offers and Promises

149. As a principle, insurers should commit to not engaging in unfair pricing practices, rely only on reasonably relevant information and be transparent in its approach to pricing.

150. Proactively offer price discounts/promises where an insurer already holds the required information.[136]

151. Proactively use data to determine eligibility for pricing offers and promises.[137]

152. Proactively obtain information regarding the eligibility of a pricing offer or promise in any sales conversation.[138]

153. Disclose the existence of pricing floors in any promotional material and disclosure documents in ways to ensure consumers clearly understand them.

154. Regularly review pricing algorithms to ensure that they are operating as expected and are not contravening the law.[139]

155. Express discounts in definitive and fixed terms rather than ranges to avoid intentionally or unintentionally misleading consumers[140]

156. Ensure that any statement or representation that offers consumers a competitive price is not false or misleading.

157. Adequately and regularly monitor third party distributors (including through the collection and sharing of data) to ensure that consumers are receiving the full discounts promised.[141]

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[136] p16, ASIC, Rep765 (2023)
[137] As above
[138] As above
[139] As above
[140] p18-20, ASIC Rep765 (2023)
[141] In line with **recommendations 61 and 62** above, and ASIC Rep765 (2023)

Loyalty and no claims discounts

The "loyalty tax" or loyalty penalty" is well documented and refers to the hidden premium that loyal customers pay for sticking with a brand or service – i.e. charging renewing consumers who are less likely to shop around a higher premium than other consumers. The issues is one that has been highlighted by a number of organisations, including ASIC in its recent pricing report, CHOICE., and the NSW Emergency Services levy who found in 2018 that the average base premium for renewals in NSW is 27% higher than for new policies.[142] Slater and Gordon launched investigations into potential class action lawsuit against two subsidiaries of the Australian Insurance Group. These insurers allegedly implemented a "loyalty tax" by discreetly increasing base premiums for long-standing policyholders, offsetting the loyalty discounts initially promised.[143]

The "loyalty tax" essentially involves insurers taking advantage of the complexity in the market and behavioural biases.

The UK FCA have investigated the same problem and introduced a series of rules to ensure that renewal quotes for home and motor insurance consumers are not more expensive than they would be for new customers.[144] The UK Association of British Insurers also launched a set of Guiding Principles which may provide further guidance to insurers in Australia.[145]

ASIC identified instances of "soft promises" – that is unsubstantiated statements or language that cause cost-conscious consumers to believe that they were receiving a reward for loyalty. This should be addressed by insurance companies. We note that the Code does not include any commitments related to the advertising and marketing of general insurance products. However, we feel it is appropriate that the insurers should make commitments in line with the approach taken by life insurers in the Life Insurance Code.[146]

[142] InsuranceNews ,Industry fumes as Fels attacks 'loyalty tax, 21 November 2018
[143] Victoria Devine. Loyalty a burden as faithful customers are taken for a ride, SMH, 3 September 2023
[144] UK FCA, FCA confirms measures to protect customers from the loyalty penalty in home and motor insurance markets, 28 May 2021
[145] BBC, Insurers pledge fairer premiums for long-term customers, 9 May 2018
[146] see Section 2 Clause 11, Life Insurance Code of Practice 2.1.1, 12 December 2023

Recommendations | Loyalty and no claims discounts

158. **Only offer a renewal price to a consumer that is no greater than the equivalent new business price that it would offer a new customer.**

159. **Not promise consumers that they are being rewarded for loyalty unless this is objectively true in an overall sense.**

160. **Ensure that any statement or representation that offers consumers a loyalty or no claims discount is not misleading including the making soft promises such as the use of terms like "competitive price or "reward for your loyalty."**

161. **Clause 51 re: no claims discounts should be expanded to include all forms of loyalty discount.**

Component pricing

The consumer movement has long supported the need to break premiums down into components, and Government has long recommended its introduction.[147]

The ACCC found in its Northern Australia Insurance report that consumers with a clear understanding of the pricing components of their insurance products are likely to make more informed decisions about their choice and have an improved capacity to shop around and switch insurers.

Component pricing would be straightforward way for a consumer to better identify risks that can be controlled and mitigated, and can encourage consumers to act accordingly, i.e. it would encourage consumers to do something to mitigate against the risks they are paying for.

When an insurer provides a quote for a new or renewing insurance policy, this should include a breakdown of the components of the premium, including controllable risks, non-controllable risks and statutory charges. For the non-controllable risks, this should be broken down further to each type of natural hazard affecting the risk of the insured property.

[147] See Recommendations 4 and 12, The Senate Economics References Committee Australia's general insurance industry: sapping consumers of the will to compare, 2017

Component pricing is possible, and the ICA have agreed.[148] Component pricing would provide the much needed, clear price signal, about the risks people face and would enable them to make more informed decisions around mitigation.

See further below at **Question 4.2** re: reflecting risk mitigation in pricing.

Recommendations | Component Pricing

162. Detail the components of an insurance premium including those that are based on natural hazard risks for new and renewing home and contents policies.

163. Provide full explanations of any premium increases including those that relate to specific risks.

Impacts of optional inclusions and exclusions on premiums

The ACCC's Northern Australia Insurance report also recognised the importance of consumers considering other factors such as excess and sum insured alongside premium prices that insurers advise of in renewal notices.[149] The ACCC's report extended the recommendation from the Senate report into the general insurance industry to require disclosure of any excess and the sum insured alongside previous year's premiums on the renewal notice for expiring home, contents, and strata insurance policies. The ACCC considered disclosing such details would provide a holistic view to consumers during policy renewal and would help consumers in identifying how the insurer proposes to vary terms from the previous year.

Recommendation | Premium Cost Saving Disclosure

164. Disclose the premium cost or saving for each optional inclusion or exclusion offered at quoting and renewal and indicate the premium cost or saving associated with incremental changes in excess levels and sums insured.

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[148] Evidence provided to the Senate in 2017 by Mr Rob Whelan, Executive Director and Chief Executive Officer, ICA, supports this see: Para 3.37 Senate Economics Committee (2017). Further Andrew Hall of the ICA presented a state-by-state breakdown of premium prices at the Insurance Brokers Conference in October 2023 including natural hazards, administration and taxes.

[149] Rec 18.6, ACCC, (2020)

Hidden Costs Disclosures

A key insight in the Standardising General Insurance Definitions report[150] was that exclusions and qualifications such as "wear and tear" and "maintenance" are all associated with a requirement for the consumer to act to undertake such maintenance and thereby prevent the wear and tear, and that this involves an additional cost to consumers beyond the monetary fees paid for in an insurance premium. These costs are incurred in the form of consumers' time and effort, as well as financially through the provision of additional resources and or personal (say to hire someone to clean gutters). Explaining these costs to consumer is important. The research found that consumer believed that payment of the premium buys the insurance coverage without further costs, which is not correct.

See further recommendations re: addressing "maintenance" and "wear and tear" at **Question 3.10 (d**).

Recommendation | Hidden Costs Disclosure

165. **Provide all costs associated with the purchase of a home insurance policy, including any costs beyond the relevant premium, should be required to be clearly explained to the consumer at the time of purchase.**

Premium instalments

Payment of premiums in instalments is a common and convenient form for many consumers, particularly those who cannot afford lump sum payments or are experiencing financial hardship However in doing so these cohorts pay a penalty since a surcharge is added. The ACCC found that that surcharge equated to $20 million (or 2.2% of the total gross written premium in northern Australia and around $113 million (1.4% of gross written premium for the rest of Australia, in 2018/19.[151]

[150] Grace and Platow, (2022)
[151] Page 368, ACCC, (2020)

This is generally justified on the basis that it represents a credit risk for the insurer if the consumer fails to keep up the payments as well as representing increased costs for the insurer through associated administration burden.

However, surcharging customers who pay in instalments in practice penalises those who can least afford it and contradicts the principles of taking extra care for those experiencing vulnerability. This again is a form of "poverty premium."

The ACCC also noted that while most insurers premium quotes are reasonably clear, providing this premium difference consistently across the industry would increase transparency and assist customers to make more informed decisions.[152]

Further, consumer advocates and the ACCC have previously raised the potential for low income and those consumers experiencing financial difficulty to have access to fortnightly instalments and the ability to pay via Centrepay.[153]

These proposals were previously rejected in the last review by the ICA on the basis that more accessible payment options, including Centrepay and fortnightly payment options, are already open to insurers to utilise.

We however agree with ACCC that insurers committing to providing more flexible options for people on low income is consistent with the Codes commitment to supporting customers experiencing vulnerability and offering Centrepay in a fair and reasonable way, as well as fortnightly payments, is consistent with this commitment and will improve the accessibility of insurance to low-income customers and is therefore in the public interest.

Recommendations | Premium Instalments

166. Customers who choose to pay in instalments should not be penalised for doing so.

167. Alternatively, in line with Recommendation 15.1 of the ACCC Northern Australia Report provide, in a standard form, the premium difference (if any) over the life of a policy between paying annually and paying by instalments, in dollar terms, at the time they provide an insurance quote, including on renewal notices.

168. Offer flexible payment options including offering:

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[152] Page 369, ACCC, (2020)

[153] Pages 370-376 and Rec 15.2, ACCC, (2020); Consumers' Federation of Australia, Joint Consumer Submission to the Insurance Council of Australia's General Insurance Code of Practice 2017 Review: Interim Report, January 2018, Good Shepherd Microfinance, Covering the essentials—Increasing access and affordability of insurance for people on low incomes, July 2013,

a. **fortnightly payments and**

b. **fair and reasonable Centrepay options for home and contents and motor vehicle insurance, with commitments to provide improved communications especially with respect to renewals, and guardrails to prevent inappropriate withdrawals.**

See further recommendations regarding sum insured and autorenewals at Section 3.7.

Helping Reduce Risks

4.2 Should the Code include provisions that encourage or require insurers to respond to consumers risk-mitigation efforts where appropriate and reasonable? If so, how might the Code do this?

For insurance to work, and individuals and society are to benefit from the mitigation of controllable risks, there needs to be a genuine risk mitigation partnership between insurers and insureds. As Assistant Treasurer and Financial Services Minister Stephen Jones has said:

> Home owners who renovate their houses to better withstand natural disasters and other insurance customers who take steps to mitigate against effects of climate change should get cheaper premiums than those who do not.[154]

Consumers must know what the risks are to be able to act on them and should be provided with appropriately transparent pricing signals – that indicate the existence of risks with price increases and the mitigation of risks with price decreases.

People need clear guidance about the steps they could or should take to reduce their exposure to insurable events. These messages need to be simple and actionable, with tangible benefits. Actively involving communities in the dissemination of risk mitigation information can also spread the burden of knowledge across the whole community.

[154] Hannah Wooton, Disaster-ready home owners 'should get cheaper insurance, Australian Financial Review, 29 May 2023

For example, after the 2011 Brisbane floods, the Yeronga Community Centre was funded to help the local community prepare for disasters and assist in the recovery phase too.

The Climate Council observed that property-level, risk mitigation is occurring across Australia:

> *"People will do stuff every year to manage the fire risk around their property and a lot of that is not big investment. There is a lot of stuff that people can do to reduce risk significantly, but [they] do require some prior knowledge and a bit of work."*[155]

There is considerable value in both community-level and property-level risk mitigation. Resilient homes and communities will still be affected by hazards such as extreme weather, but their recovery will likely be quicker and cost less.

People should be able to take simple steps to make their home more resilient and reduce their risks. Insurers should be required to consider the impact of any measures that a person has taken to reduce risks when determining the price of a new or renewing insurance policy and should explain how this has been assessed. The insurance industry should work with consumer stakeholders to develop tools, where necessary, for consumers to easily verify mitigation works.[156]

Recommendations | Reducing Risks

169. All quotes and renewal notices for home insurance should be required to provide a schedule of mitigation measures which customers of the insurer have undertaken for properties with similar characteristics in order to improve their risk rating. This should include a guide to the premium reductions (in percentage terms) that consumers have received for undertaking these measures.[157]

170. In addition, insurers should share all known natural hazard risks that impact a property with the policyholder in a plain English, standardised format, in order to assist consumers to mitigate against these risks.[158]

171. Reflect identified risk mitigation measures in the premium.

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[155] Page 27, CHOICE et al, Weathering the Storm: Insurance in a changing climate, August 2023
[156] In line with recommendation 19.2 of the Royal Commission into National Natural Disaster Arrangements Report 28 October 2020
[157] Rec 21.2, ACCC, (2020)
[158] Recommendation 19.2 Royal Commission (2020)

172. **Explain these premium adjustments to the policyholder, i.e. insurers' should commit to expressly show what discounts have been applied (if any) to reflect mitigation measures undertaken on that property in quotes and renewal notices for that property.** [159]

173. **Raise awareness of possible insurance implications of design choices for new construction and renovation** [160]

174. **Proactively direct consumer to any relevant building code changes at renewal.**

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[159] Rec. 21.1, ACCC, (2020)

[160] Rec 13.3, ACCC, (2020)

Code Structure, Enforceability and Governance

Structure of the Code

5.1 Should the primary audience for the Code be insurers? Or is it consumers and other stakeholders? Considering these questions, would it be appropriate to revise the structure and content of the Code to more appropriately reflect its intended audience or audiences? If so, how?

Identifying the primary audience for a Code is not a fruitful exercise. The audiences of the Code are equally consumers, their representatives, insurers, and external dispute resolution. Re-designing the Code to suit one over the other can lead to poor outcomes for other just as relevant audiences.

Put simply, the Code should be:

- clear
- in plain English and
- robust and unambiguous for enforceability purposes

The Code's language and structure should support this. If this were the case, all audiences will benefit.

We therefore do not recommend a reconsideration of the structure or re-write of the Code for plain English reasons since this exercise was already undertaken during the last review process and undertaking a new restructure or review can lead to significant delays in implementing new consumer rights.

Having said that, the independent reviewers should make recommendations relating to the language used in the Code to ensure that the Code commitments are clear and robust to ensure that they meet the standards required to be enforceable.

We have no concerns about increasing the length of the document. The more rights available to address the issues raised in this submission and others, the better.

Most consumers will not sit and read the Code cover to cover but seek out specific information when and where they need it. The current format and structure ensure that this works well.

Recommendation | Structure and Content of the Code

175. The independent review should make recommendations relating to the language used in the Code to ensure that the Code commitments are clear and robust to ensure that they meet the standards required to be enforceable.

5.2 For which sections of the Code, if any, would more detail (similar to Part 15) be helpful and why? For example, would there be merit in providing more detail in relation to the conduct of employees, distributors and services suppliers?

We have outlined recommendations for further specific commitments to be made throughout this submission including sections on vulnerability, the conduct of employees, distributors and services suppliers, claims handling, buying and cancelling insurance.

Code Governance and Compliance

5.3 What measures would improve governance of the Code and promote enhanced compliance with Code commitments?

We address the specific questions and potential improvements outlined in the consultation paper below.

However, one mechanism to promote enhanced compliance that is not referenced is the idea put forward by the independent Banking Code Reviewer in his final report that subscribers take all reasonable steps to have in place the appropriate systems, processes, and programs to support compliance with the Code.[161] As Callaghan put it:

> The effectiveness of the Code critically depends on the extent to which banks meet their commitments. Concrete steps towards strengthening Code compliance would help reinforce consumer and community trust…
>
> Where the Code is viewed as central to outlining the customer outcomes that will facilitate … ongoing success, this is more likely to contribute to a proactive culture of compliance. [162]

This should include a program of periodically reviewing the effectiveness of their compliance framework through their internal and external audit arrangements and to reporting the detail of the outcomes of these audits to the CGC. A summary of the audits should be included in each banks published annual reports. This commitment would be suitable for designation as enforceable under the enforceable code provision regime.

The CGC have identified poor monitoring and reporting of compliance systems with its Code obligations as a reason for significant breaches of the Code.

It is not however sufficient to say – as the ABA did in rejecting this recommendation - that having the appropriate mechanism for compliance is implied in the existing commitment. Clearly insurers need to lift compliance systems and processes to meet the promises made

[161] Mike Callaghan AM PSM, Independent Review of the Banking Code of Practice 2021 Final Report November 2021

[162] Page 8, Callaghan (2021)

under the Code. Insurers can't use natural disasters as an excuse for poor service and other compliance failures.

Recommendation | Improving Code Complaince

176. The Code should commit subscribers to take all reasonable steps to have in place the appropriate systems, processes, and programs to support compliance with the Code.

(a) Are the sanctions in Part 13 a sufficient deterrent to misconduct. Should they be strengthened? If so, how?

AFCA amended its rules in May 2019 to identify all financial firms in its published decisions. This was done to be more open, transparent and accountable to the public. Unless there are compelling reasons not to publish, the decision will be published.

We note that the ICA previously rejected consumer calls to name insurers subject to breaches as "publicly naming a breaching insurer is the most serious sanction open to the CGC to use."[163] We reject this justification. We note that there has been no systemic or specific impact upon financial firms because of AFCA's policy and has allowed for great transparency in news reporting – for example, in reports on AFCA decisions in Insurance News. The world has not fallen in.

One argument commonly made against naming is that it may incentivise subscribers to not report breaches. This would be a fundamental break of the promise of the Code and would demonstrate serious bad faith from any subscriber who took this position. Improving consumer outcomes via the Code should not be prevented by such an attitude.

Community expectations have shifted. Transparency is required. Naming insurers who breach the Code should be standard operating procedure.

Naming subscribers should not be a sanction under the Code. It should be an automatic base line to incentivise subscribers to meet their commitments to the Code.

[163] Page 70, ICA (2018)

Recommendation | Naming Code Subscribers

177. All subscribers who breach the Code should be named in line with AFCA practice (unless there are compelling reasons not to do so).

(a) A number of the sanctions available to the Code Governance Committee are restricted to a significant breach of the Code (defined in Part 16). Should the additional sanctions in paragraph 174 apply to any breach of the Code?

The demarcation is artificial, vague and removes the ability for the CGC to apply more minor sanctions to minor breaches, and significant sanctions to significant breaches.

(b) Should the Code definition of 'significant breach' be aligned to the ASIC reportable situations regime, in RG 78 and if so, how?

Yes. This would make the process more streamlined for all those involved.

5.4 Does the requirement to report significant breaches of the Code to the CGC duplicate or create inefficiencies related to the obligation on AFS Licensees to report reportable situations to ASIC? If so, how should this be managed given the role of the CGC in monitoring and enforcing the Code?

There may be overlap but this can be dealt with through an agreed alignment of processes and information/data standards between insurers, ASIC and the CGC.

Other issues:

We note that Eric Insurance (a subscriber to the Code) made the commercial decision in 2023 to enter run-off and will no longer write new business or renew policies. Catholic Church Insurance also announced in 2023 that it would stop issuing renewals or new policies.

We understand that there may be issues with respect to whether these insurers will still meet the requirements of the Code during their run-off period.

To dispel any doubts, we believe that the Code needs to explicitly address this situation and ensure that the rights of consumers who have purchased insurance products via a Code subscriber continue to hold these rights until they no longer hold the insurance.

Recommendation | Code subscription status

178. **All Code subscribers who decide to close business or enter a run-off should remain a member until they no longer exist. They should inform their customers of this ongoing commitment and provide this information prominently on their website.**

Enforceable Code Provisions

5.5 Which provisions of the Code could be considered for designation as Enforceable Code Provisions and what changes to the Code would be needed to support that?

The enforceable code regime is not well designed and there are in-built incentives that encourage industry to be circumspect about either what provisions they are willing to put in their codes or which provisions they are willing to be made enforceable.

The consumer position however has consistently been that as much of any code of practice that can be made enforceable, should be made enforceable. We understand that this may not be the position of the ICA, but picking and choosing a subset of provisions from those that are able to be made enforceable is difficult if not impossible or even appropriate for consumer representatives to do. The enforceable code regime should not require us to pick winners and losers.

Tas outlined above, the Code language should also be considered and if required re-drafted with an eye to enhance the clarity and robustness of the commitments to ensure that they meet the standards required to be enforceable.

The Code should be made a term of the contract with consumers in line with the Banking and Customer Owned Banking codes.

Recommendations | Enforceability

179. **The Code should be made a term of the contract with consumers in line with the Banking and Customer Owned Banking codes.**

180. **As many Code provisions that can be made enforceable, should be made enforceable.**

Resourcing for the CGC

A key form of enforcing self-regulation is via a Code's monitoring and compliance mechanisms. This is the most practical way to ensure that it effectively enforces subscriber commitments made under the Code and holds subscribers who do not meet the standards to account.

That requires significant resourcing. It is our view that the General Insurance Code's current model for budgetary decision-making via the separate legal subsidiary of the ICA, Code Governance Committee Association[164] (**the Association**) is industry best practice. This is because resourcing decisions are made with significant input from consumer representatives in a committee distinct from the peak body – unlike any other Code arrangements. Membership of the Association is split between consumer representatives nominated by the Consumer Representatives on the AFCA Board and industry representatives determined by the ICA Board. The Chair is the ICA CEO. The CGC then develop a workplan and corresponding budget which is then provided to the Association to approve or amend.

Whether these arrangements need to be amended to deal with issues of indemnity that have been raised by the CGC, we will not comment upon. We do however support the ICA maintaining the core principles of an independent process of budgetary decision-making with balanced consumer representative input.

Recommendation | CGC Resourcing

181. Resourcing for the CGC must be adequate and determined by an independent process of budgetary decision-making with balanced consumer representative input.

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[164] See Constitution of Code Governance Committee Association Inc.

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